The Charlotte Hungerford Hospital

January 5, 2009

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

Reference: Letter of Intent
Termination of Mobile PET Service at Winsted Location

Dear Commissioner Vogel:

Enclosed please find The Charlotte Hungerford Hospital's Letter of Intent to terminate its Mobile PET service at its Winsted site. The mobile service was available in Winsted one service day per month.

We appreciate your consideration of this request.

Sincerely,

John J. Capobianco
Vice President, Patient Care Services
and Administration

Enclosures

c: Daniel McIntyre
John Doyle, President, Winsted Health Center

540 Litchfield Street
P.O. Box 988
Torrington, CT 06790-0988
(860) 496-6666
www.charlottesweb.hungerford.org

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	The Charlotte Hungerford Hospital	
Doing Business As		
Name of Parent Corporation		
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)		
Identify Applicant Status: P for Profit or NP for Nonprofit		
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.	John J. Capobianco Vice President Patient Care Services and Administration	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	540 Litchfield Street P.O. Box 988 Torrington, CT 06790	
Contact Person Telephone Number	860-496-6611	
Contact Person Fax Number	860-482-8627	
Contact Person e-mail Address	jcapobianco@hungerford.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Termination of PET services at Winsted location.

b. Project Proposal: Discontinue Mobile PET at Winsted site.

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 **X** 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.?

X 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 **X** 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 X 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:

115 Spencer Street, Winsted, CT 06098

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

Winsted, CT

h. Estimated starting date for the project: 12/08/08

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

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:

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:

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)* _____

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.

In the fall of 2008 we were notified by our provider of mobile Pet services that a PET only service would no longer be available as of December 2008. Given the limited volume (18 in the last calendar year) at the Winsted site, and with the availability of using an established fixed site PET in Torrington, we respectfully submit our request to terminate the mobile Winsted PET service.

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.
   Mobile PET service one day per month.

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

3. Identify the current population served and the target population to be served.
   We have performed 17 PET scans at the Winsted site in 2007 out of a total of 127 patients, and 18 scans in 2008 out of a total of 116 patients. Between both of our PET sites (Winsted and Torrington) in calendar year 2008 we scanned 18 patients from the town of Winsted – 11.6% of volume.

4. Identify any unmet need and describe how this project will fulfill that need.
   Current volume performed at this site can easily be absorbed in the Torrington Kennedy Drive location, which is only 5 miles away from the present Winsted site.

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

   Yes, Connecticut Oncology and Hematology Associates operates a PET scanner limited to patients of their private practice at 200 Kennedy Drive, Torrington, Connecticut.

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.
   None anticipated, access to PET will continue to be provided at a location on Kennedy Drive in Torrington, adjacent to the Hospital's Cancer Center which is located midway between the Hospital's main campus and its Winsted campus.

7. Who will be responsible for providing the service?
   n/a, service is being discontinued.

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

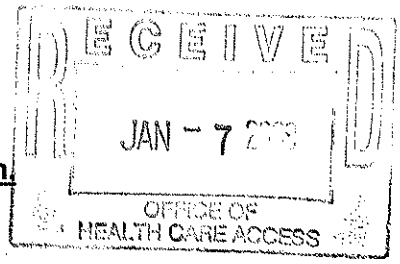
Current payees include:

	FY 2008	***3 months FY 2009 (October – December)***
Medicare	***39.3%***	***61.2%***
Medicaid	***10%***	***5.8%***
Commercial	***47.6%***	***27%***
Self-pay	***3.1%***	***6.0%***
Workers Comp	***0%***	***0%***

We anticipate no change in payor mix.

AFFIDAVIT

To be completed by each Applicant



Applicant: **The Charlotte Hungerford Hospital**

Project Title: **Termination of PET Services at Winsted location**

I, **Daniel J. McIntyre, President and Executive Director of The Charlotte Hungerford Hospital,**
(Name) (Position – CEO or CFO)

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 **The Charlotte Hungerford Hospital**
(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.

Daniel J. McIntyre 1/2/09
Signature: *Daniel J. McIntyre* Date

Subscribed and sworn to before me on 2nd January, 2009

Annamarie Carrolo
Notary Public/~~Commissioner of Superior Court~~

My commission expires: 4/30/2011

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 14, 2009

John Capobianco
Vice President, Patient Care Services and Administration
The Charlotte Hungerford Hospital
540 Litchfield Street
Torrington, CT 06790

Re: Letter of Intent, Docket Number 09-31297
Proposal to Terminate Mobile PET Service in Winsted
Notice of Letter of Intent

Dear Mr. Capobianco:

On January 7, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of The Charlotte Hungerford Hospital ("Applicant") for the proposal to terminate Mobile PET Service in Winsted, with no capital expenditure.

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

January 14, 2009

Requisition # HCA09-096
Fax: (860) 489-6790

The Register Citizen
190 Water Street
Torrington, CT 06790-0058

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, January 18, 2009.**

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

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

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

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:LG:lmg

c: Sandy Salus, OHCA

The Register Citizen **Letter of Intent**
Docket Number 09-31297 **January 14, 2009**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	The Charlotte Hungerford Hospital
Town:	Winsted
Docket Number:	09-31297-LOI
Proposal:	Proposal to Terminate Mobile PET Service in Winsted
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between March 8, 2009 and May 7, 2009. 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 at OHCA or on OHCA's website at www.ct.gov/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 Applicants.

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

TRANSMISSION OK

TX/RX NO	4628
RECIPIENT ADDRESS	918604896790
DESTINATION ID	
ST. TIME	01/14 14:24
TIME USE	00'29
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 14, 2009

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 14, 2009

John Capobianco
Vice President, Patient Care Services and Administration
Charlotte Hungerford Hospital, The
540 Litchfield St.
Torrington, CT 06790 0988

RE: Certificate of Need Application Forms, Docket Number 09-31297-CON
Charlotte Hungerford Hospital, The
Proposal to Terminate Mobile PET Service in Winsted

Dear Mr. Capobianco:

Enclosed are the application forms for Charlotte Hungerford Hospital, The's Certificate of Need ("CON") proposal for the Proposal to Terminate Mobile PET Service in Winsted with no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between March 8, 2009, and May 7, 2009.

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 Laurie Greci. Please contact her at (860) 418-7001 if you have 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 March 8, 2009, and may be submitted no later than May 7, 2009. The Analyst assigned to your application is Laurie Greci and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	09-31297-CON
Applicant Name:	Charlotte Hungerford Hospital, The
Contact Person:	John Capobianco
Contact Title:	Vice President, Patient Care Services and Administration
Contact Address:	Charlotte Hungerford Hospital, The 540 Litchfield Street Torrington, CT 06790-0988
Project Location:	Winsted
Project Name:	Proposal to Terminate Mobile PET Service in Winsted
Type proposal:	Section 19a-638, C.G.S.
Est. Capital Expenditure:	$ 0

1. State Health Plan (No questions at this time).

2. Is this application consistent with your long-range plan?

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

3. Clear Public Need

   A. Explain in detail why the Hospital proposes to terminate the PET service in Winsted.

   B. Provide a copy of the minutes for the meeting or meetings of the Hospital's Board of Directors at which this termination was discussed and voted on.

   C. Provide the units of service for the past three fiscal years and the current fiscal year-to-date by patient town.

   D. Provide the units of service for the past three fiscal years and the current fiscal year-to-date by purpose and type of scan performed (i.e., disease detection, progression, etc.).

   E. Describe the population that has been receiving PET service in Winsted.

   F. Provide the following information applicable to the termination of the PET Service:

      i) Identify the existing providers of the proposed service in your service area using the following tabular format:

Legal Name of Provider Street Town, Zip Code	**Names of Affiliated Physicians**	**Hours and Days of Operations**	**Current Utilization (most recent 12 month period, if known)**

      ii) What will be the effect of the termination of PET service in Winsted on the Hospital and the existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

      iii) Where will the patients previously served in Winsted receive PET service?

4. Will your proposal remedy any of the following barriers to access?

☐ Cultural	☐ Transportation
☐ Geographic	☐ Economic
☐ None	☐ Other (Identify) _____

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

5. Provide copies of any epidemiological, public information or other similar studies related to your proposal. If there are none, please explain why none are available for submission.

6. 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:

7. 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.

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

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

9. 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.

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

☐ Yes ☐ No If you checked "Yes," please provide an explanation.

11. Provide a copy of the State of Connecticut Department of Public Health license currently held.

12. Financial Information

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

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

B. Provide the following financial information:

i) Provide the total current assets balance as of the date of submission of this application.

ii) Provide a copy of the most recently completed internal monthly financial statements.

13. Revenue, Expense and Volume Projections

A. Payer Mix Projection

Please provide both the current payer mix for the PET service in Winsted as well as the current and projected payer mix for the Hospital based on Gross Patient Revenue in the following reporting format:

Total Facility Description	FY____ Current Payer Mix PET only	FY____ Current Payer Mix	FY____ Year 1 Projected Payer Mix	FY____ Year 2 Projected Payer Mix	FY____ 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					
Total Payer Mix	100.0%	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

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

14. Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

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

A. 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.

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

i) 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.). ***Note**: Include consideration of The Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development of the financial projections.*

ii) 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.

iii) Provide a copy of the rate schedule for the Hospital's PET service.

iv) Describe how this proposal is cost effective.

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

of _____ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☐ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

09-31297-CON

15. A. Report one year of actual results and three years of projections of Community CancerCare 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										
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.

*List individually as appropriate.

09-31297-CON

15. B. Report 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 _____ (Year _) **FY Projected Incremental** Total Incremental Expenses:	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Other Government*										
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0		$0				$0	$0	$0
Uninsured		$0		$0				$0	$0	$0
Total NonGovenrment		$0	0	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	0	$0	$0	$0	$0	$0	$0	$0

* List individually as appropriate.

Our Classified Team

Donna Musler
Classified Sales Manager

860.489.5555 Ext. 309
dmusler@registercitizen.com

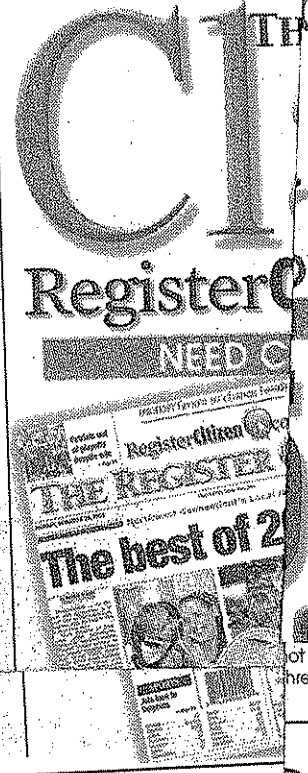
Kelly Jean Whiting
Classified Sales Representative

860.489.5555 Ext. 307
kwhiting@registercitizen.com

Rick DiPippo
Classified Sales Representative

Monday - Friday 8 a.m. to 5 p.m.

VISA DISCOVER



860.489.5555

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...ot apply to real estate, employment, ...
...hree lines, $2 for each additional line. All ads are subject to credit

Legal Notices

LEGALS

LEGAL NOTICE

Statute Reference: 19a-638
Applicant: The Charlotte Hungerford Hospital
Town: Winsted
Docket Number: 09-31297-LOI
Proposal: Proposal to Terminate Mobile PET Service Winsted
Capital Expenditure: $0

The Applicant may file its Certificate of Need application between March 8, 2009 and May 7, 2009. Interested persons are invited to submit written comments to Christine A. Vogal, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308

The Letter of Internet is available at OHCA or on OHCA's website at www.ct.gov/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 Applicants.

230 APARTMENTS UNFURNISHED

TORRINGTON Spacious, 5rms, In Excellent Condition, Use as a 2 or 3 bdr, Plus Garage, $800/mo **489-5377**

TORRINGTON Spacious 2 bd, 5 rms avail immed laundry on prem off ST, prkg, heat included $825/month Call 860-485-9566

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WINSTED 1 BR Apts for lease w/stove & refrigerator. $530/mo. Off street parking. Credit app. & security req'd. No pets. Call Mike (860) 496-9042

WINSTED 2 bd townhouse, appl, ww carpet, heat & water incl. $821/mo Call (860)-379-7881 www.equitymanagement.com EOH

WINSTED 2nd Floor 2br, W/D hkkups Off St prkg, Dogs Consid $650/mo +utilities Call 860-379-1166

WINSTED Near Lake, 2 bd, near lake, off ST PRKG, no smoking, wash/dry incld $800/mo Special. Ask. 860-978-0556

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MANAGER RETAIL
(WINSTED)

Manage retail business including purchases and sales. Resolve pr... complaints, manage inventory supplys, 2 years exp. requi... 40hrs/wk. Tues-Sat 1pm to...
Send Resume to:
Normand Wine & Spi...
361 North Main ST, Winsted,

COOK / DIETARY A...

Part Time to Full Ti...
Evening & Weekends h...
Contact Nancy O'Brien
(413)-258-4731
Berkshire Rehabilitation and Skille...
7 Sandisfield Road
Sandisfield, MA 0125...

Managers

Movie Theat...

Attention Getters draw ATTENTION to your Classified Ad. Add one for just a few dollars extra. There are many to choose from.

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645 GENERAL HELP WANTED

PART TIME
...enue Collections Agent

...ation Department of The Register Citizen ... a part-time Single Copy Collector. Re...ies include making collections at local ...sites and area racks where individual ...rs are sold. Calculate dealer bills by ver...rns and collect money due in a defined ...ic area. Requirements: Must have basic ...s, good communication skills, the ability ...50 lbs, and be able to work/drive in all ...onditions. Collectors use their own vehi...rform collection tasks; we require a valid ...license and an insured, reliable vehicle. ...position 3 days, Monday through Wednes...ours per week; 6:30 am-1:00 pm.

...ntact Jake Albrecht at 860-489-1450 ext 366 for more information.
EOE/AAE

650 HEALTH CARE OPPORTUNITIES

Medical Receptionist

Busy, growing Internal Medicine office located in Hamden is looking for a mature, experienced individual with knowledge of medical terminology, insurance, ICD-9 coding, collections, and direct patient care. Other duties include filing, faxing, answering phones, and managing provider schedules. Applicants must have a minimum of 2 years of experience. Please fax resumes to (203) 288-5059, attn: Practice Manager. EOE M/F/D/V.

RN Supervisor
3-11p Shift
LPN Charge Nurse
11p-7a Shift
RN Supervisor
Per Diem, 11p-7a

The Jewish Home for the Aged offers an excellent salary & benefits including medical/dental, 403B, vacation, sick time, 12 paid holidays & free secure parking. Reply to Margie Graham, DNS, Jewish Home for the Aged, 169 Davenport Avenue, New Haven, CT 06519. mgraham@jhanh.org; 203-789-1650; fax 203-787-0071. EOE

The Register Citizen
Main number: 489-3121