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CONNECTICUT OFFICE OF HEALTH CARE ACCESS

State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form 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 there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One
Full legal name	**Stonington Behavioral Health, Inc.**
Doing Business As	**Stonington Institute**
Name of Parent Corporation	**Universal Health Services of Delaware, Inc.**
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	**75 Swantown Hill Road North Stonington, CT 06359**
Applicant type (e.g., profit/non-profit)	**Profit**
Contact person, including title or position	**Thomas Gilman Adolescent Program Advisor**
Contact person's street mailing address	**75 Swantown Hill Road North Stonington, CT 06359**
Contact person's phone #, fax # and e-mail address	**Phone (860) 535-1010 x234 Fax (860) 535-3835 thomas_gilman@charter.net**

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

RTC Expansion

b. Type of Proposal, please check all that apply:

x Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

New (F, S, Fnc)	☐ Replacement	☐ Additional (F, S, Fnc)
x Expansion (F, S, Fnc)	☐ Relocation	☐ Service Termination
☐ Bed Addition	☐ Bed Reduction	☐ Change in Ownership/Control

Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

Project expenditure/cost cost greater than $ 1,000,000

☐ Equipment Acquisition greater than $ 400,000

☐ New	☐ Replacement	☐ Major Medical
☐ Imaging	☐ Linear Accelerator	

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address):

75 Swantown Hill Road
North Stonington, CT 06359

d. List all the municipalities this project is intended to serve:

State-Wide

e. Estimated starting date for the project: **November 15, 2004**

f. Type of project: 9

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
RTC	45	45	10	55

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $30,000.00

b. Please provide the following breakdown as appropriate:

Construction/Renovations	
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	$30,000.00
Sales Tax	$900
Delivery & Installation	
Total Capital Expenditure	**$30,900.00**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$30,900.00**

Major Medical and/or Imaging equipment acquisition: NA

Equipment Type	Name	Model	Number of Units	Cost per unit

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

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

x	Applicant's Equity	☐	Lease Financing	☐	Conventional Loan
☐	Charitable Contributions	☐	CHEFA Financing	☐	Grant Funding
☐	Funded Depreciation	☐	Other (specify): _____		

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

Stonington Institute
Office of Healthcare Access
Letter of Intent Form (Form 2030)
Section IV Proposal Description
August 19, 2004

PROPOSAL DESCRIPTION

Stonington Institute currently provides residential treatment services to adolescent males and females between the ages of 12 and 18 years old who have a dual diagnosis. The proposed services are identical. The proposal is a 10- bed expansion of the current 45 bed program. The target population for the additional beds is exactly the same as described above. Stonington Institute currently provides RTC services under contract to the Department of Children & Families. The expanded services, however, will be available to DCF referrals and non-DCF children in need of services. The capital expenditures associated with the expansion are approximately $30,000, all of which is related exclusively to furniture and equipment associated with the residential unit. The purpose of the expansion is to accommodate the significant number of out-of-state placements awaiting appropriate community placements within Connecticut and to serve those adolescents with a dual diagnosis that are inappropriately held at higher levels of care due to the lack of available residential capacity.

Confirmation Report – Memory Send

Time : Aug-20-2004 11:15
Tel line : 8604187053
Name : OFFICE OF HEALTHCARE

Job number : 333

Date : Aug-20 11:04

To : 912035765172

Document pages : 009

Start time : Aug-20 11:04

End time : Aug-20 11:15

Pages sent : 009

Status : OK

Job number : 333

*** SEND SUCCESSFUL ***

OFFICE OF HEALTH CARE ACCESS — 186MMos — FINANCIAL REVIEW AND FORECASTING GROUP

SAINT VINCENT'S		(1)	(2)	(3)	(4)
		FY04 1ST 6 MOS	FY03 1ST 6 MOS	DIFFERENCE	% DIFF
MEDICARE INPATIENT					
MCARE INPAT. CHARGES		$87,921,106	$79,224,935	$8,696,170	12%
MCARE INPAT. PMTS		$45,119,875	$42,731,451	$2,382,424	6%
MCARE INPAT. PMTS / MCARE INPAT. CHGS		51%	55%	-3%	-6%
MCARE DISCHARGES		4,395	4,159	239	6%
MCARE CMI		1.5896	1.5969	(0.0073)	0%
MCARE CMAD		6,947	6,835	382	5%
MCARE IP PMT /CMAD		$6,494	$6,479	$16	0%
MCARE PATIENT DAYS		28,079	27,433	1,646	6%
MCARE PMT / PATIENT DAY		$1,561	$1,556	($6)	0%
MEDICARE OUTPATIENT					
MCARE OUTPAT. CHARGES		$17,899,690	$15,264,567	$2,634,113	17%
MCARE OUTPAT. PMTS		$7,174,949	$6,004,464	$1,170,485	19%
MCARE OP PMTS / OP CHGS		40%	39%	1%	2%
MCARE OUTPAT. CHGS / INPAT. CHGS		20%	20%	1%	5%
MCARE OPED		839	811	87	11%
MCARE OP PMT / OPED		$7,992	$7,459	$863	6%
TOT. MEDICARE CHARGES		$105,519,705	$93,489,502	$12,030,283	13%
TOT. MEDICARE PMTS		$52,288,824	$48,755,535	$3,532,889	7%
MEDICARE AS A % OF TOT.					
INPATIENT CHGS		55.5%	57.5%	-1.6%	-2.7%
INPATIENT PMTS		55.6%	58.2%	-2.7%	-4.6%
DISCHARGES		46.2%	48.7%	-0.6%	-1.1%
OUTPATIENT CHGS		31.1%	28.0%	3.0%	10.6%
OUTPATIENT PMTS		25.7%	22.9%	2.0%	12.3%
TOTAL CHGS		46.2%	48.1%	0.2%	0.5%
TOTAL PMTS		47.9%	48.9%	-1.0%	-2.0%

Post-it® Fax Note 7671 Date 8/20/04 # of pages ▶ 9

To Shannon St. Willard From Sharon M.

Co./Dept. St. Vincents Co. OHCA

Phone # 203-576-5390 Phone # 860-418-7031

Fax # 203-576-5172 Fax # 860-418-7053

Stonington Institute

An affiliate of
Rutgers University
School of
Alcohol Studies

75 Swantown Hill Road
North Stonington, CT
06359

860 / 535.1010
toll-free
800 / 832.1022
fax
860 / 535.4820

August 19, 2004

VIA FACSIMILE (860) 418-7053 AND REGULAR MAIL

Kimberly Martone, Analyst
Office of Health Care Access
State of Connecticut
410 Capitol Avenue, MS #13HCA
PO Box 340308
Hartford, CT 06134-0308

Re: CON Determination Request
Stonington Behavioral Health, Inc.

Dear Kim:

Enclosed please find two Letters of Intent - Form 2030 with respect to two separate project proposals. We are writing to seek a determination of whether and to what extent either or both projects require a Certificate of Need determination.

Thank you very much for assistance in this matter.

Very truly yours,

Teri Frechette-Brainerd
Assistant to the CEO

Teresi Frechette-Brainerd

CC: Tom Gilman

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