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 Wellspring Foundation, Inc.	
Doing Business As	Angelus House	
Name of Parent Corporation	The Wellspring Foundation, In c.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	21 Arch Bridge Road Bethlehem, CT 06751	
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.	Mayda Capozzi Executive Assistant	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	21 Arch Bridge Road Bethlehem, CT 06751	
Contact Person Telephone Number	Mayda Capozzi 203-266-8003	
Contact Person Fax Number	203-266-5487	

Contact Person e-mail Address	mayda.capozzi@wellspring.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Termination of DPH License #0263 Facility for the Care or Treatment of Substance Abuse OR

b. Project Proposal: Dependant persons.

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:

☐ 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:

158 Flanders Road, Bethlehem CT. 06751

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

NA

h. Estimated starting date for the project: Immediately

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: $ NA

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.

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.

   na

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

   na

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

   na

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

   na

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

   na

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.

   na

7. Who will be responsible for providing the service?

   na

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

   na

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 19, 2008

Mayda Capozzi
Executive Assistant
The Wellspring Foundation, Inc.
d/b/a Angelus House
21 Arch Bridge Road
Bethlehem, CT 06751

RE: Certificate of Need Letter of Intent Form, Report Number: 08-31112-LOI
The Wellspring Foundation, Inc. d/b/a Angelus House
Termination of Substance Abuse Outpatient Treatment Services in Bethlehem
Letter of Intent Completeness Letter

Dear Ms. Capozzi:

On March 3, 2008, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") Letter of Intent ("LOI") Form 2030, regarding The Wellspring Foundation, Inc. d/b/a Angelus House ("Applicant") which, proposed the termination of substance abuse outpatient treatment services in Bethlehem at no associated estimated total project expenditure cost. OHCA has reviewed the form pursuant to Section 19a-643-74 of OHCA's Regulations and finds that the information submitted is deficient, and that additional information and/or clarification is required.

1. The LOI Form 2030 submitted on March 3, 2008, does not specify or include the following items. Please address the following:

    a. Please provide or explain in detail summary the type of project description that was originally ask in questions 1 through 8, on page 5 of the LOI Form 2030.

    b. Please submit a signed Affidavit along with a revised LOI Form 2030

    c. Please provide proof of the certified State of Connecticut, Department of Public Health License No. 0263.

In responding to the questions contained in this letter, please submit a revised LOI Form 2030 providing your response. **Paginate and date** your response, i.e., each page in its entirety, and submit an original and six (6) copy sets of your responses to the Office of Health Care Access. Please reference Docket No.: 08-31112-LOI in your response submission.

If you have any questions concerning this letter, please feel free to contact me at OHCA at (860) 418-7007.

Sincerely,

Diane Duran
Health Care Analyst

Wellspring

21 Arch Bridge Road
PO Box 370
Bethlehem, CT 06751

April 10, 2008

Ms. Diane Duran
Health Care Analyst
410 Capitol Avenue
MS#13HCA
PO Box 2340308
Hartford, CT 06134-0308

Re: LOI Form 203 – Report # 08-31112-LOI

Dear Ms. Duran:

This letter is in response to your letter of March 19th, 2008. Attached you will find the items you requested.

- Please provide or explain a detail summary the type of project description that was originally asked in questions in 1-8 of page 5 of the LOI form 2030.
- Please submit a signed Affidavit along with a revised LOI Form 2030.
- Please provide proof of the certificate State of Ct, DPH License No. 0263.

If you have any questions regarding our response please do not hesitate to contact me at 203-266-8003.

Regards,

Mayda Capozzi
Executive Assistant

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 Wellspring Foundation, Inc.	
Doing Business As	Angelus House	
Name of Parent Corporation	The Wellspring Foundation, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	21 Arch Bridge Road Bethlehem, CT 06751	
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.	Mayda Capozzi Executive Assistant	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	21 Arch Bridge Road Bethlehem, CT	
Contact Person Telephone Number	Mayda Capozzi 203-266-8003	
Contact Person Fax Number	203-266-8050	
Contact Person e-mail Address	mayda.capozzi@wellspring.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Termination of License # 0263 Facility for the Care or Treatment of Substance Abusive or Dependant Person.

b. Project Proposal: Termination

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:

☐ 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:

158 Flanders Road, Bethlehem CT 06751

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

The project is intended to terminate licensure never used.

h. Estimated starting date for the project: Termination immediately.

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
NA				

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $ NA

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
na				

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.

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.

None we have never used the license.

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

Nothing being propose to begin only to terminate the license.

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

None

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

None as we have never served anyone with the license.

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

Not in the town of Bethlehem.

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.

None as we have not utilized the license at any time.

7. Who will be responsible for providing the service?

NA

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

NA

AFFIDAVIT

To be completed by each Applicant

Applicant: The Wellspring Foundation, Inc. Angelus House

Project Title:

Termination of License #0263 Facility for the Care or Treatment of Substance Abusive or Dependant Persons.

I, Harvey I. Newman, (Name) Chief Executive Officer (Position – CEO or CFO)

of The Wellspring Foundation, 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 The Wellspring Foundation, Inc. complies with the appropriate and (Facility Name)

applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486

and/or 4-181 of the Connecticut General Statutes.

Signature April 10, 2008 Date

Subscribed and sworn to before me on April 10, 2008

Ursula E. Stutzel
Notary Public/Commissioner of Superior Court

My commission expires: March 31, 2010

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0263

Facility for the Care or Treatment of Substance Abusive or Dependent Persons

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

Wellspring Foundation, Inc. of Bethlehem, CT, d/b/a Angelus House is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Angelus House is located at 158 Flanders Road, Bethlehem, CT 06751 with:

Harvey I. Newman as Executive Director

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

Outpatient Treatment

This license expires **March 31, 2008** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 2006.

License revised to reflect:
CHANGE OF EXECUTIVE DIRECTOR EFF: 8/27/07

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

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

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 19, 2008

Mayda Capozzi
Executive Assistant
The Wellspring Foundation, Inc.
d/b/a Angelus House
21 Arch Bridge Road
Bethlehem, CT 06751

RE: Certificate of Need Letter of Intent Form, Report Number: 08-31112-LOI
The Wellspring Foundation, Inc. d/b/a Angelus House
Termination of Substance Abuse Outpatient Treatment Services in Bethlehem
Letter of Intent Completeness Letter

Dear Ms. Capozzi:

On March 3, 2008, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") Letter of Intent ("LOI") Form 2030, regarding The Wellspring Foundation, Inc. d/b/a Angelus House ("Applicant") which, proposed the termination of substance abuse outpatient treatment services in Bethlehem at no associated estimated total project expenditure cost. OHCA has reviewed the form pursuant to Section 19a-643-74 of OHCA's Regulations and finds that the information submitted is deficient, and that additional information and/or clarification is required.

1. The LOI Form 2030 submitted on March 3, 2008, does not specify or include the following items. Please address the following:

    a. Please provide or explain in detail summary the type of project description that was originally ask in questions 1 through 8, on page 5 of the LOI Form 2030.

    b. Please submit a signed Affidavit along with a revised LOI Form 2030

    c. Please provide proof of the certified State of Connecticut, Department of Public Health License No. 0263.

In responding to the questions contained in this letter, please submit a revised LOI Form 2030 providing your response. **Paginate and date** your response, i.e., each page in its entirety, and submit an original and six (6) copy sets of your responses to the Office of Health Care Access. Please reference Docket No.: 08-31112-LOI in your response submission.

If you have any questions concerning this letter, please feel free to contact me at OHCA at (860) 418-7007.

Sincerely,

Diane Duran
Health Care Analyst

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 25, 2008

Mayda Capozzi
Executive Assistant
The Wellspring Foundation, Inc.
d/b/a Angelus House
21 Arch Bridge Road
Bethlehem, CT 06751

RE: Certificate of Need Application Forms, Docket Number 08-31112-CON
The Wellspring Foundation, Inc. d/b/a Angelus House
Termination of Substance Abuse Outpatient Treatment Services in Bethlehem

Dear Ms. Capozzi:

Enclosed are the application forms for Connecticut Renaissance, Inc's Certificate of Need ("CON") proposal for the termination of substance abuse outpatient treatment services in Bethlehem 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 15, 2008, and August 14, 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 Diane Duran. Please feel free to contact her at (860) 418-7001, if you have any questions.

Sincerely,

Barbara Durdy
Director of Operations

Enclosures

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____	FOR OHCA USE ONLY:	DATE	INITIAL
PROJECT TITLE: _____	1. Check logged (Front desk)	_____	_____
DATE: _____	2. Check rec'd (Clerical/Cert.)	_____	_____
	3. Check correct (Superv.)	_____	_____
	4. Check logged (Clerical/Cert).)	_____	_____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION

1. Check statute reference as applicable to CON application (see statute for detail):

_____ 19a-638.Additional function or service, change of ownership, service termination.
No Fee Required.

_____ 19a-639 Capital expenditure exceeding $3,000,000, or capital expenditure exceeding $3,000,000 for major medical equipment, or CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator.
Fee Required.

_____ 19a-638 and 19a-639.
Fee Required.

2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.

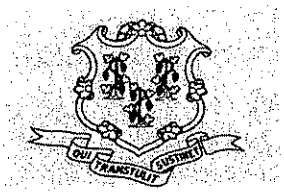
3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000

4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked):

a. Base fee: _____	$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment)_____	$_____.00
(To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005)	
c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____	$_____.00
d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	

SECTION B TOTAL FEE DUE:_____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)



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 15, 2008, and may be submitted no later than August 14, 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:	08-31112-CON
Applicant(s) Name:	The Wellspring Foundation, Inc. d/b/a Angelus House
Contact Person: **Contact Title:**	Mayda Capozzi Exective Assistant
Contact Address:	The Wellspring Foundation, Inc. d/b/a Angelus House 21 Arch Bridge Road Bethlehem, CT 06751
Project Location:	Bethlehem
Project Name:	Termination of Substance Abuse Outpatient Treatment Services in Bethlehem
Type proposal:	Section 19a-638, C.G.S.
Est. Capital Expenditure:	$ 0

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: _____

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 Bethlehem, please answer the following:

i) Explain in detail the Applicant's rationale for this termination of services. Identify the process undertaken by the Applicant in making the decision to terminate.

ii) Did the Applicant determine there was no or insufficient public need for the continuation of this program? Please explain.

iii) Is the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?

iv) Will this termination require the vote of the Board of Directors of the Applicant? If so, please provide a copy of the minutes (excerpted for other unrelated business) for the meeting(s) at which this termination was discussed and voted on.

B. Provide or answer the following:

i) Provide a detailed description of the specific service components (i.e. description of the programs, age groups) that are available and provided at the Bethlehem 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 Bethlehem service location.

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

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

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

iii) Provide the information as outlined in the following table concerning the existing providers services in the Bethlehem 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 Bethlehem 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 Bethlehem 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 Bethlehem 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 a copy of the State of Connecticut Department of Public Health license(s) currently held by Community Mental Health Affiliates, Inc. d/b/a Family Services of Central CT in Bethlehem.

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]

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

6. Improvements to Productivity and Containment of Costs

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

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

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

☐ Other (identify)_____

7. Miscellaneous

A. Are there any unique characteristics of your patient/physician mix?

☐ Yes ☐ No

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

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

☐ Yes ☐ No

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

C. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

8. Financial Information

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

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify):

_____

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

C. Verify that this termination of services has not resulted in any capital expenditures or capital costs to the Applicant.

9. Revenue, Expense and Volume Projections

A. Provide the following financial information for the Bethlehem service location:

i) Please submit one of the following.

(a) an Audited or Unaudited Balance Sheet.

(b) an Income Statement or Statement of Operations for the two most recently completed fiscal years.

Note: These statements should be externally prepared and submitted on the preparer's letterhead.

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

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

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

*Includes managed care activity.

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

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.

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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 25, 2008

Mayda Capozzi
Executive Assistant
The Wellspring Foundation, Inc.
21 Arch Bridge Street
Bethlehem, CT 06751

Re: Letter of Intent, Docket Number 08-31112
The Wellspring Foundation, Inc.
Termination of Substance Abuse Outpatient Treatment Services in Bethlehem
Notice of Letter of Intent

Dear Ms. Capozzi:

On April 16, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of The Wellspring Foundation, Inc. ("Applicant") to terminate substance abuse outpatient treatment services in Bethlehem, with no capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published in the *Waterbury Republican American* 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:DD:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 25, 2008

Requisition # HCA08-185
(203) 754-0644

Waterbury Republican American
389 Meadow Street
Box 2090
Waterbury, CT 06722-2090

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 Wednesday, April 30, 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

Waterbury Republican American **Letter of Intent**
Docket Number 08-31112 **April 25, 2008**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Wellspring Foundation, Inc.
Town:	Bethlehem
Docket Number:	08-31112-LOI
Proposal:	Termination of Substance Abuse Outpatient Treatment Services in Bethlehem
Total Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between June 15, 2008 and August 14, 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	3459
RECIPIENT ADDRESS	912037540644
DESTINATION ID	
ST. TIME	04/28 09:24
TIME USE	00'18
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 25, 2008

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(203) 754-0644

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389 Meadow Street
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Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

RepublicanAmerican

389 Meadow Street - P.O. Box 2090
Waterbury, CT 06722-2090
Phone: 203-574-3636 Fax: 203-573-0090 Toll Free: 800-992-3282
e mail: advbilling@rep-am.com

Fed EIN 06-0581760

Customer	A/C #	Billing Period
HEALTH CARE ACCESS	R18404	04/01/08-04/30/08

PAYMENT TERMS	30 DAYS
TOTAL AMOUNT DUE	$ 79.10

* Please See Reverse Side for Pub Index

DATE	AD # / INV #	CUST ORDER #	PUB*	DESCRIPTION	SIZE	BILLED UNITS	TIMES RUN	RATE	BILLED AMOUNT
				PREVIOUS BALANCE					$0.00
04/29/08	RA0220476 / INV000324860	Req #HCA08-185	RA	PUBLIC NOTICE Statute Reference: 19a-638 Applicant:	1x	3	1	4	
				CURRENT AMOUNT DUE					
				TOTAL AMOUNT DUE					$

PUBLIC NOTICE

Statute Reference: 19a-638
Applicant: Wellspring Foundation, Inc.
Town: Bethlehem
Docket Number: 08-31112-LOI
Proposal: Termination of Substance Abuse Outpatient Treatment Services in Bethlehem
Capital Expenditure: $0

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R-A April 29, 2008

Past due balance accrues finance charge of 1.5% per month

All charges include any applicable Connecticut State sales tax

REMITTANCE ADVICE - PLEASE RETURN WITH PAYMENT

REMITTANCE ADDRESS

REPUBLICAN AMERICAN
PO BOX 2090
WATERBURY, CT 06722-2290

CUSTOMER	A/C #	BILLING PERIOD	TOTAL AMOUNT DUE	AMOUNT REMITTED
HEALTH CARE ACCESS	R18404	04/01/08-04/30/08	$	

CREDIT CARD #	
EXPIRATION DATE	
SIGNATURE	

HEALTH CARE ACCESS
MS 13HCA POBOX 340308
410 CAPITOL AVENUE
HARTFORD CT 06134

CHECK #	