Stonington Institute

234A Bank Street
5th Floor
New London, CT
06320-4615

860 / 439.6000
1.800 / 832.1022 toll free
860 / 439.6010 fax
www.stoningtoninstitute.com

September 28, 2009

Christine Vogel, Commissioner
Office of Health Care Access
State of Connecticut
410 Capitol Avenue, MS #13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Commissioner Vogel:

Enclosed please find a completed Form 2030 for the relocation of our Ambulatory Detox Program to our North Stonington Campus. Please do not hesitate to contact me with any questions regarding this Form.

Sincerely,

William A. Aniskovich
CEO

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
Full legal name	Stonington Behavioral Health, Inc.
Doing Business As	Stonington Institute
Name of Parent Corporation	UHS, Inc.
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	234A Bank Street, 5th Fl New London, CT 06320
Identify Applicant Status: P for Profit or NP for Nonprofit	P
Does the Applicant have Tax Exempt Status?	Yes **No**
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Mary Minton, CFO
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Same as above
Contact Person Telephone Number	860-439-6005
Contact Person Fax Number	860-439-6008
Contact Person e-mail Address	Mary.minton@uhsinc.com

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Ambulatory Detox Program

b. Project Proposal: Service Relocation

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:

75 Swantown Hill Road, North Stonington, CT 06359

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

Bozrah, Colchester, East Lyme, Franklin, Griswold, Groton, Hanover, Lebanon, Ledyard, Lisbon, Lyme, Montville, Mystic, New London, North Stonington, Norwich, Old Lyme, Preston, Salem, Sprague, Stonington, Voluntown, Waterford.

h. Estimated starting date for the project: November 1, 2009

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

NOT APPLICABLE

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

Please provide the following tentative capital expenditure/costs related to the proposal: **NOT APPLICABLE**

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.

b. 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 **NOT APPLICABLE**

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: **NOT APPLICABLE**

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): **NOT APPLICABLE**

- ☐ 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.

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

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

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

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

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

7. Who will be responsible for providing the service?

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

SECTION IV. PROPOSAL DESCRIPTION

The proposed project involves returning the Applicant's currently licensed Ambulatory Chemical Detoxification Treatment Service ("Ambulatory Detox") from 333 Long Hill Road, Groton, CT, 06340 ("Groton Clinic") to its main campus at 75 Swantown Hill Road, North Stonington, CT, 06359 ("North Stonington Campus").

There is no change in service proposed. The Applicant currently provides Ambulatory Chemical Detoxification Treatment under DPH License No. 0299 (Facility for the Care and Treatment of Substance Abusive or Dependent Persons). A copy of the license is provided with this Application. [1]

On January 5, 2004, OHCA granted a CON to Applicant for the establishment of an Ambulatory Detox service at the North Stonington Campus. (Docket 03-30142-CON) That CON was subsequently modified (03-30142-MDF) to allow for the change of address to the Groton Clinic.

The Applicant's Lease at the Groton Clinic is expiring and this Application seeks to return the service to its originally approved location at the North Stonington Campus. No change in licensure is required by the proposal.

Applicant currently serves adults ages 18-65 with a primary substance abuse diagnosis in its Ambulatory Detox service. The proposed population is the same population.

There is also no change in the entity providing and billing for the service.

Applicant currently owns the physical space proposed for the project and it currently operates its residential detoxification program at the proposed site. The average daily census in the Ambulatory Detox program has been approximately **1** for 2006, 2007, 2008 and 2009 to date and thus the current/projected size of the program is well within the capacity of the North Stonington campus, as it was originally approved in 2004.

The relocation of the service will allow Applicant to continue to provide detox services to clients that do not meet criteria for residential detox, but need outpatient treatment for withdrawal.

To our best knowledge, Hartford Dispensary is currently the only other provider of outpatient detox services in the geographical region, at two separate sites: New London and Norwich.

The current payers of this service include all contracted commercial insurance/HMO plans, Medicaid, and self-pay. There is no change in payor source expected or planned for the proposal.

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[1] A separate Form 2020 Application has been filed with respect to the relocation of the Day/Evening and Outpatient treatment offered at the Groton clinic in light of the fact that the relocation of those services is proposed to an address within the same Town.

AFFIDAVIT

To be completed by each Applicant

Applicant: Stonington Behavioral Health, Inc.

Project Title: Ambulatory Detox Program

I, Mary Minton (Name), CFO (Position – CEO or CFO)

of Stonington Behavioral Health, 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 Stonington Institute (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.

Mary Minton
Signature

9/28/09
Date

Subscribed and sworn to before me on September 28, 2009

Notary Public/Commissioner of Superior Court

My commission expires:

RECEIVED
2009 SEP 29 P 12:16
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

October 20, 2009 via fax and email only

Mary Minton
Chief Financial Officer
Stonington Institute
234A Bank Street, 5th Floor
New London, CT 06320

RE: Certificate of Need Application Forms; Docket Number: 09-31477-CON
Stonington Institute
Relocate Ambuatory Detoxification Service from Groton to North Stonington

Dear Ms. Minton:

Enclosed are the application forms for Stonington Institute's Certificate of Need ("CON") proposal for the relocation of its ambuatory detoxification service from Groton to North Stonington, Connecticut, at 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 November 28, 2009, and January 27, 2010.

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 OHCA analyst assigned to the CON application is Jack A. Huber. Please contact him at (860) 418-7034 if you have questions.

Sincerely,

Kaila J. Riggott

Kaila J. Riggott
Planning Specialist

Enclosure

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 a response of "Not Applicable" may be an acceptable answer. Your Certificate of Need application will be eligible for submission no earlier than November 19, 2009, and may be submitted no later than January 27, 2010. The OHCA Analyst assigned to your application is Jack A. Huber. He may be reached at the Office of Health Care Access at (860) 418-7034.

Docket Number:	09-31477-CON
Applicant Name:	Stonington Institute
Contact Person:	Mary Minton
Contact Title:	Chief Financial Officer
Contact Address:	Stonington Institute 234A Bank Street, 5th Floor New London, CT 06320
Project Location:	North Stonington
Project Name:	Ambulatory Detoxification Service Relocation
Proposal Type:	Section 19a-638, C.G.S.
Estimated Total Capital Expenditure:	$0

Service Relocation Application

1. Project Description and Need

A. Provide a narrative detailing the proposal.

B. Provide the following regarding the proposed new service location:

i) The rationale for choosing the proposed service site.

ii) Identify the service area towns for the service's current site.

iii) Identify the service area towns for the proposed service site.

iv) Explain any anticipated variation in the service area towns between the current and proposed service sites.

v) Identify the population currently served by the service.

vi) Will the population currently served by the service change with the proposed relocation to a different site.

vii) Identify the existing chemical detoxification providers (name and address) in the proposed service area towns listed above.

viii. Identify the effect of the relocation proposal on the providers listed above.

2. Actual and Projected Volume

A. Complete the following table for the last three fiscal years ("FY") of the current service plus the current partial FY.

Table 1: Actual Volume

	Actual Volume (Last 3 Full Operational FYs Plus Partial Current FY)**			
	FY****	FY****	FY****	Current FY****
Chemical Detoxification Service				
Total				

** Provide the last three full FYs plus the current partial FY.
**** Fill in years. In a footnote, identify the period covered by the Applicant's partial FY (e.g. July 1-June 30, calendar year, etc.).

B. Explain the reason(s) for any observed volume decreases between the three full FYs.

C. Complete the following table for the first three fiscal years ("FY") of the service at the proposed site.

Table 2: Projected Volume

	Projected Volume (First 3 Full Operational FYs)**			
	FY****	FY****	FY****	FY****
Chemical Detoxification Service				
Total				

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs.
**** Fill in years. In a footnote, identify the period covered by the Applicant's partial FY (e.g. July 1-June 30, calendar year, etc.).

D. Provide an explanation of all assumptions used in the derivation/ calculation of the projected volume.

3. Quality Measures

A. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

B. Explain how this proposal contributes to the quality of health care delivery in the region.

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

D. Identify the Standard of Practice Guidelines that have been utilized in relation to the current service.

4. Organizational and Financial Information

A. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

B. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☐ No

C. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant for the chemical detoxification service.

D. Provide audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

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

Table 3: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
Total Capital Expenditure	$
Medical Equipment Lease (Fair Market Value) ***	$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost	$
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.
** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross sq. feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.
*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

F. List all funding or financing sources for the proposal, and the associated dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges received to date; letter of interest or approval from a lending institution.

5. Revenues, Expenses, and Patient Population Projections

a. Patient Population Mix

i. Provide the current and projected patient population mix (based on the number of patients, not on revenue) for the relocated service.

Table 4: Patient Population Mix

	Current FY *****	**Year 1 FY *****	**Year 2 FY *****	**Year 3 FY *****
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix				

* Includes managed care activity.
** New programs may leave the "current" column blank.
*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

ii. Provide the basis for/assumptions used to project the patient population mix.

b. Financial Attachments I & II

i. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

ii. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

iii. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iv. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

v. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

vi. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the proposal.

vii. Describe how this proposal is cost effective.

6. Other Review Criteria

A. Describe the proposal's relationship to the Applicant's long-range plans. Provide supporting documentation.

B. Specify whether any of the following apply to the proposal. If so, provide an explanation and supporting documentation.
i) Voluntary efforts to improve productivity and contain costs;
ii) Changes to the Applicant's teaching or research responsibilities; and/or
iii) Special characteristics of the Applicant's patient or physician mix.

5.b.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 Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$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.

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		$0				$0	$0	$0
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0	0	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	0	$0	$0	$0	$0	$0	$0	$0

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 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 $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	$ 1,000.00 $_____.00 $_____.00
SECTION B TOTAL FEE DUE:_____	$_____.00

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

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: _____

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

TRANSMISSION OK

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STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: MARY MINTON

FAX: (860) 439-6008

AGENCY: STONINGTON INSTITUTE

FROM: JACK HUBER

DATE: 10/20/2009 **Time:** ~9:40 am

NUMBER OF PAGES: 12
(including transmittal sheet)

Comments: Please find with this transmission:
Certificate of Need Forms; Docket Number: 09-31477-CON
Proposal Seeking Relocation of Detoxification Services

PLEASE PHONE Jack A. Huber at (860) 418-7034
IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

October 21, 2009

Mary Minton, CFO
Stonington Behavioral Health, Inc.
d/b/a Stonington Institute
234A Bank Street, 5th Floor
New London, CT 06320

Re: Letter of Intent; Docket Number: 09-31477-LOI
Termination of the Ambulatory Detoxification Service in Groton
and the Reestablishment of the Service in North Stonington
Notice of Letter of Intent

Dear Ms. Minton,

On September 29, 2009 Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Stonington Behavioral Health, Inc. d/b/a Stonington Institute ("Applicant") for the termination of the ambulatory detoxification service in Groton and the re-establishment of the service in North Stonington, at no capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Day Publishing Company* 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
Director of Operations

KRM:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

October 21, 2009

Requisition # 102009*
Email: Legal@Theday.com

***Please bill to Dept of Public Health**

The Day Publishing Company
47 Eugene O'Neill Drive
Box 1231
New London, CT 06320

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, October 25, 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 Jack Huber at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:JAH:lmg

c: Barbara Olejarz, OHCA

The Day Publishing Company
Docket Number 09-31477

Letter of Intent
October 21, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Stonington Behavioral Health, Inc. d/b/a Stonington Institute
Town:	North Stonington
Docket Number:	09-31477-LOI
Proposal:	Termination of the Ambulatory Detoxification Service in Groton and the Reestablishment of the Service in North Stonington
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between November 28, 2009 and January 27, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner, Department of Public Health, 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 Applicant.

Greer, Leslie

From: Anderson, Holly [H.Anderson@theday.com]
To: Undisclosed recipients
Sent: Wednesday, October 21, 2009 12:00 PM
Subject: Read: Legal Ad 09-31477

Your message

To: H.Anderson@theday.com
Subject:

was read on 10/21/2009 12:00 PM.

Updike, Kelly & Spellacy, P.C. Counselors at Law

Jennifer L. Groves
(203) 786-8316
(203) 772-2037 FAX

One Century Tower
265 Church Street
New Haven, Connecticut 06510

FACSIMILE TRANSMITTAL SHEET

TO: **Office of Health Care Access**
ATTN: Kimberly Martone

FACSIMILE: (860) 418-7053

DATE: **October 26, 2009**

Re: ***Stonington Behavioral Health d/b/a Stonington Institute***
Relocation of Ambulatory Chemical Detoxification Treatment Service

TOTAL NUMBER OF PAGES (INCLUDING THIS SHEET):

MESSAGE

IF YOU HAVE ANY PROBLEMS WITH RECEIPT OF THIS TRANSMITTAL, PLEASE CALL DEB ALEXA AT (203) 786-8300, EXTENSION 3353. THANK YOU.

UPDIKE, KELLY & SPELLACY, P.C.
Connecticut's law firm with a worldwide reach

MERITAS LAW FIRMS WORLDWIDE

JENNIFER L. GROVES
T: 203.786.8316
F: 203.772.2037
jgroves@uks.com

October 26, 2009

VIA FACSIMILE & REGULAR MAIL

Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: Stonington Behavioral Health d/b/a Stonington Institute
Relocation of Ambulatory Chemical Detoxification Treatment Service

Dear Ms. Martone:

This office represents Stonington Behavioral Health, Inc. d/b/a Stonington Institute ("Stonington"). On October 15, 2009, Stonington filed a CON Determination Form 2020 for the relocation of its Ambulatory Chemical Detoxification Treatment Service from Groton to North Stonington. Stonington requests that this Form 2020 be withdrawn. Its Letter of Intent Form 2030 for the same proposal should remain pending.

If you have any questions, please feel free to call me at (203) 786.8316.

Very truly yours,

Jennifer L. Groves

cc: William A. Aniskovich, CEO

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October 26, 2009

VIA FACSIMILE & REGULAR MAIL

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Director of Operations
Department of Public Health
Office of Health Care Access Division
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cc: William A. Aniskovich, CEO