



RECEIVED

2010 MAR 26 P 2:19

CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Date: 3/26/2010 Time: 2:00 PM

To: Cristine A. Vogel, Agency
Commissioner

Company: Office of Health Care Access
Fax Number: 1-860-418-7053

From: Lynn Tripp, Extension 3017
Phone: (203) 756-8021
Fax: (203) 596-9038

SUBJECT: Letter of Intent Form (Form 2030)
Number of Pages
(including this cover sheet) 2

Notes: _____
Feel free to contact me with any questions.
Thanks, Lynn

Confidentiality Note: This facsimile is intended only for the person(s) to which it is addressed and may contain information that is privileged, confidential or otherwise protected from disclosure. Dissemination, distribution or copying of this e-mail or the information herein by anyone other than the intended recipient, or an employee or agent responsible for delivering the message to the intended recipient, is prohibited. If you have received this facsimile in error, please call 203-756-8021 and destroy the original facsimile and all copies.

80 Phoenix Avenue Waterbury, CT 06702 Tel: (203) 756-8021
Main Fax: (203) 596-9038



RECEIVED

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

MAR 26 P 2:19
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

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	StayWell Health Care, Inc.	
Doing Business As	Not Applicable	
Name of Parent Corporation	Not Applicable	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	80 Phoenix Avenue, Suite 201, Waterbury, CT 06702	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Donald Thompson President / CEO	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	80 Phoenix Avenue, Suite 201, Waterbury, CT 06702	
Contact Person Telephone Number	(203) 756-8021, Ext. 3016	
Contact Person Fax Number	(203) 596-9038	
Contact Person e-mail Address	DThompson@StayWellHealth.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Termination of Psychiatric Outpatient Services – 114 Benedict Street, Waterbury, CT

b. Project Proposal: N/A

c. Type of Project/Proposal, please check all that apply: Not Applicable

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:

114 Benedict Street, Waterbury, CT 06706

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

Waterbury

h. Estimated starting date for the project: March 31, 2010

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

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: \$ N/A

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

Major Medical Equipment Purchases*	<u>N/A</u>
Medical Equipment Purchases*	<u>N/A</u>
Non-Medical Equipment Purchases*	<u>N/A</u>
Land/Building Purchases	<u>N/A</u>
Construction/Renovation	<u>N/A</u>
Other (Non-Construction) Specify: _____	<u>N/A</u>
Total Capital Expenditure	
Major Medical Equipment – Fair Market Value of Leases Medical	<u>N/A</u>
Equipment – Fair Market Value of Leases	<u>N/A</u>
Non-Medical Equipment – Fair Market Value of Leases*	<u>N/A</u>
Fair Market Value of Space – Capital Leases Only	<u>N/A</u>
Total Capital Cost	<u>N/A</u>
Total Project Cost	<u>N/A</u>
Capitalized Financing Costs (Informational Purpose Only)	<u>N/A</u>

* 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

- 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
- Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. Major Medical and/or Imaging Equipment Acquisition: N/A

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): N/A

<input type="checkbox"/> Applicant's Equity	<input type="checkbox"/> Capital Lease	<input type="checkbox"/> Conventional Loan
<input type="checkbox"/> Charitable Contributions	<input type="checkbox"/> Operating Lease	<input type="checkbox"/> CHEFA Financing
<input type="checkbox"/> Funded Depreciation	<input type="checkbox"/> Grant Funding	
<input type="checkbox"/> 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.

Outpatient Mental Health Services are licensed but not currently provided at this specific Homeless Shelter (Health Care for the Homeless) site.

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

Termination of Services – Relinquishment of License

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

Health Care for the Homeless – Outpatient Psychiatric Services are provided at a different StayWell site (1302 South Main Street, Waterbury, CT)

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

N/A

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

N/A

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

N/A

7. Who will be responsible for providing the service?

N/A

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

N/A

AFFIDAVIT

To be completed by each Applicant

Applicant: StayWell Health Care, Inc.

f. Project Title: Termination of Psychiatric Outpatient Services – 114 Benedict Street, Waterbury, CT

I, Donald Thompson, President / CEO of StayWell Health Care, 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 StayWell Health Care, Inc. complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

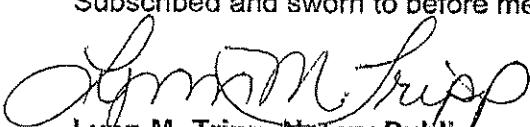


March 24, 2010

Date

Subscribed and sworn to before me on March 24, 2010




Lynn M. Tripp, Notary Public
Notary Public/Commissioner of Superior Court

My commission expires: January 31, 2015

Lynn M. Tripp
Notary Public
State of Connecticut
My Commission Expires
January 31, 2015



RECEIVED

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

CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

10/20/2011 11:51

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Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Donald Thompson President / CEO	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	80 Phoenix Avenue, Suite 201, Waterbury, CT 06702	
Contact Person Telephone Number	(203) 756-8021, Ext. 3016	
Contact Person Fax Number	(203) 596-9038	
Contact Person e-mail Address	DThompson@StayWellHealth.org	

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

Waterbury

h. Estimated starting date for the project: March 31, 2010

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Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed

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Non-Medical Equipment – Fair Market Value of Leases*	<u>N/A</u>
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* 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).

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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.

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Termination of Services – Relinquishment of License

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

N/A

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N/A

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

N/A

7. Who will be responsible for providing the service?

N/A

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

N/A

AFFIDAVIT

To be completed by each Applicant

Applicant: StayWell Health Care, Inc.

f. Project Title: Termination of Psychiatric Outpatient Services – 114 Benedict Street, Waterbury, CT

I, Donald Thompson, President / CEO of StayWell Health Care, 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 StayWell Health Care, Inc. complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

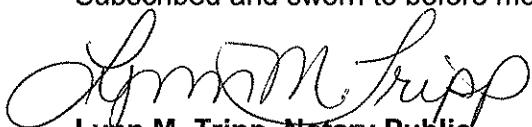
Signature



March 24, 2010

Date

Subscribed and sworn to before me on March 24, 2010



Lynn M. Tripp, Notary Public

Notary Public/Commissioner of Superior Court

My commission expires: January 31, 2015

Lynn M. Tripp
Notary Public
State of Connecticut
My Commission Expires
January 31, 2015

CONNECTICUT OFFICIAL
HEALTHCARE AGENCY
REC'D BY

200 MAD 30 A 11:51



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

April 12, 2010

Facsimile Only

Donald Thompson
Executive Director
StayWell Health Care, Inc.
232 North Elm Street
Waterbury, CT 06702

Re: Letter of Intent; Docket Number: 10-31576
StayWell Health Care, Inc.
Terminate Outpatient Psychiatric Services in Waterbury

Dear Mr. Thompson,

On March 26, 2010, the Office of Health Care Access (“OHCA”) received the Letter of Intent (“LOI”) Form of StayWell Health Care, Inc. (“Applicant”) for the termination of outpatient psychiatric services in Waterbury, with no capital expenditure.

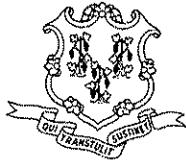
A notice to the public regarding OHCA’s receipt of a LOI was published in *The Republican American* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

A handwritten signature in black ink, appearing to read "Kimberly R. Martone".

Kimberly R. Martone
Director of Operations

KRM:img



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

April 12, 2010

Requisition # 30994

American Republican
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 **Friday, April 16, 2010**.

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 or Olga Armah at 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim Martone".

Kimberly R. Martone
Director of Operations

Attachment

KRM:LKG:OA:lmg

c: Danielle Pare, DPH

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	StayWell Health Care, Inc.
Town:	Waterbury
Docket Number:	10-31576-LOI
Proposal:	Termination of Outpatient Psychiatric Services
Capital Expenditure:	\$0

The Applicant may file its Certificate of Need application between May 25, 2010 and July 24, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner Office of Health Care Access, Division of Department of Public Health, 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.

*** TX REPORT ***

TRANSMISSION OK

TX/RX NO 1442
RECIPIENT ADDRESS 912035969038
DESTINATION ID
ST. TIME 04/12 14:14
TIME USE 01 '43
PAGES SENT 4
RESULT OK



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: DONALD THOMPSON

FAX: (203) 596-9038

AGENCY: STAYWELL HEALTH CARE, INC.

FROM: LAURIE GRECI

DATE: 4/12/10 TIME: _____

NUMBER OF PAGES: 4
(including transmittal sheet)

~~~~~

Comments: Docket 10-31576

***PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.***

**Greer, Leslie**

---

**From:** ads [ads@graystoneadv.com]  
**Sent:** Monday, April 12, 2010 3:48 PM  
**To:** Greer, Leslie  
**Subject:** Re: Legal Ad 10-31576

Good day!

Thanks so much for your ad submission.  
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,  
Graystone Group Advertising

2710 North Avenue  
Bridgeport, CT 06604  
Phone: 800-544-0005  
Fax: 203-549-0061  
E-mail: ads@graystoneadv.com  
<http://www.graystoneadv.com/>

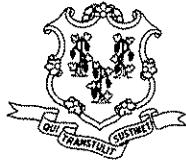
On 4/12/10 3:12 PM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

To Whom It May Concern,  
Please run the attached public notice in The Republican-American by April 16, 2010. For billing  
please refer to requisition 30994. If you have any questions feel free to call me.

Thank you,

Leslie M. Greer  
Office of Health Care Access  
A Division of Department of Public Health  
State of Connecticut  
410 Capitol Avenue, MS#13HCA  
Hartford, CT 06134  
Phone: (860) 418-7001  
Fax: (860) 418-7053  
Website: [www.ct.gov/ohca](http://www.ct.gov/ohca) <<http://www.ct.gov/ohca>>

 Please consider the environment before printing this message



## STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

*Office of Health Care Access*

M. JODI RELL  
GOVERNOR

CRISTINE A. VOGEL  
DEPUTY COMMISSIONER

April 15, 2010

via fax and email only

Donald Thompson  
Executive Director  
StayWell Health Care, Inc.  
80 Phoenix Avenue, Suite 201  
Waterbury, CT 06702

RE: Certificate of Need Application Forms, Docket Number 10-31576-CON  
StayWell Health Care, Inc.  
Terminate Outpatient Psychiatric Services at 114 Benedict St., Waterbury.

Dear Mr. Thompson:

Enclosed are the application forms for StayWell Health Care, Inc.'s Certificate of Need ("CON") proposal for the termination of outpatient psychiatric services at 114 Benedict St., Waterbury, 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 May 25, 2010, and July 24, 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.

An Equal Opportunity Employer  
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308  
Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688  
Fax: (860) 418-7053

- 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.

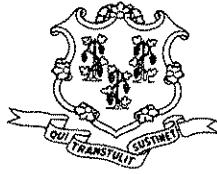
The analysts assigned to the CON application are Laurie Greci and Olga Armah. Please contact them at (860) 418-7001 if you have questions.

Sincerely,



Kaila Riggott  
Planning Specialist

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 May 25, 2010, and may be submitted no later than July 24, 2010. The analysts assigned to your application are Laurie Greci and Olga Armah. They may be reached at the Office of Health Care Access at (860) 418-7001.

**Docket Number:** 10-31576-CON

**Applicant(s) Name:** StayWell Health Care, Inc.

**Contact Person:** Donald Thompson

**Contact Title:** Executive Director

**Contact Address:** StayWell Health Care, Inc.  
80 Phoenix Avenue, Suite 201

Waterbury, CT 06702

**Project Location:** Waterbury

**Project Name:** Terminate Outpatient Psychiatric Services  
at 114 Benedict St., Waterbury

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

**Est. Capital Expenditure:** \$ 0

## **1. Project Description and Need**

- A. For each of the Applicant's programs, identify the location, population served, hours of operation, and whether the program is proposed for termination.
- B. Describe the history of the services proposed for termination, including when they were begun and whether CON authorization was received.
- C. Explain in detail the Applicant's rationale for this termination of services, and the process undertaken by the Applicant in making the decision to terminate.
- D. Did the proposed termination require the vote of the Board of Directors of the Applicant? If so, provide copy of the minutes (excerpted for other unrelated material) for the meeting(s) the proposed termination was discussed and voted.

## **2. Impact on Patient and Provider Community**

- a. List all existing providers (name, address, services provided, hours and days of operation, and current utilization) of the services proposed for termination in the towns served by the Applicant, and in nearby towns.
- b. Discuss what steps the Applicant has undertaken to ensure continued access to the services proposed for termination for the Applicant's patients.
- c. For each provider to whom the Applicant proposes to transfer or refer clients, provide the current available capacity, as well as the total capacity and actual utilization for the current year and last completed year.
- d. Identify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes.
- e. Provide evidence (e.g. written agreements or memorandum of understanding) that other providers in the area are willing and able to absorb the displaced patients.
- f. Describe how clients will be notified about the termination and transferred to other providers.

## **3. Actual and Projected Volume**

- A. Provide volumes for the most recently completed FY by town.
- B. Complete the following table for the past three fiscal years ("FY") and current fiscal year ("CFY"), for both number of visits and number of admissions, by service.

**Table 1: Historical, Current, and Projected Visits & Admissions**

|              | Actual Volume<br>(Last 3 Completed FYs) |        |        | CFY<br>Volume* |
|--------------|-----------------------------------------|--------|--------|----------------|
|              | FY ***                                  | FY *** | FY *** |                |
| Service**    |                                         |        |        |                |
|              |                                         |        |        |                |
|              |                                         |        |        |                |
|              |                                         |        |        |                |
| <b>Total</b> |                                         |        |        |                |

\* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

\*\* Identify each service type and add lines as necessary. Provide both number of visits and number of admissions for each service listed.

\*\*\* Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

- C. Explain any increases and/or decreases in volume seen in the tables above.
- D. For DMHAS-funded programs only, provide a report that provides the following information for the last three full FYs and the current FY to-date:
  - i) Average daily census;
  - ii) Number of clients on the last day of the month;
  - iii) Number of clients admitted during the month; and
  - iv) Number of clients discharged during the month.

#### **4. 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 when the Applicants' funding and/or licensing agencies (e.g. DPH, DMHAS) were notified of the proposed termination, and when the Applicants' licenses will be returned.

#### **5. 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. Financial Statements

- i) If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.
- ii) If the Applicant is not a Connecticut hospital (other health care facilities): 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.)
  - a. Submit a final version of all capital expenditures/costs.
  - a. List all funding or financing sources for the proposal and the 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.

**6. Financial Attachments I & II**

- A. 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.
- B. 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.
- C. 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.).
- D. 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 service(s).
- E. Was the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?

- F. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.
- G. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.
- H. Describe how this proposal is cost effective.

## **7. 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.

6. A. Please provide one year of actual results and three years of projections of Total Facility revenue, expense and if applicable, volume statistics without, incremental to and with the proposal in the following reporting format:

| Total Facility:              | FY<br>Actual<br>Results | FY<br>Projected<br>W/out Project | FY<br>Projected<br>Incremental | FY<br>Projected<br>With Project | FY<br>Projected<br>W/out Project | FY<br>Projected<br>Incremental | FY<br>Projected<br>With Project | FY<br>Projected<br>W/out Project | FY<br>Projected<br>Incremental | FY<br>Projected<br>With Project |
|------------------------------|-------------------------|----------------------------------|--------------------------------|---------------------------------|----------------------------------|--------------------------------|---------------------------------|----------------------------------|--------------------------------|---------------------------------|
| Description                  |                         |                                  |                                |                                 |                                  |                                |                                 |                                  |                                |                                 |
| Revenue from Operations      |                         |                                  |                                |                                 |                                  |                                |                                 |                                  |                                |                                 |
| Non-Operating Revenue        |                         |                                  |                                |                                 |                                  |                                |                                 |                                  |                                |                                 |
| Total Revenue:               | \$0                     | \$0                              | \$0                            | \$0                             | \$0                              | \$0                            | \$0                             | \$0                              | \$0                            | \$0                             |
| Total Operating Expenses     |                         |                                  |                                |                                 |                                  |                                |                                 |                                  |                                |                                 |
| Revenue Over/(Under) Expense | \$0                     | \$0                              | \$0                            | \$0                             | \$0                              | \$0                            | \$0                             | \$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.

6. B. Please provide **three** years of projections of incremental revenue, expense and volume statistics attributable to the proposal in the following reporting format:  
Use a separate form for each year.

| Type of Service Description        |            | Type of Unit Description: |          | # of Months in Operation |       |                 |               |            |                        |     |              |     |          |     |             |                |                    |                |                             |
|------------------------------------|------------|---------------------------|----------|--------------------------|-------|-----------------|---------------|------------|------------------------|-----|--------------|-----|----------|-----|-------------|----------------|--------------------|----------------|-----------------------------|
| FY                                 | (1)        | (2)                       | Rate     | (3)                      | Units | (4)             | Gross Revenue | (5)        | Allowances/ Deductions | (6) | Charity Care | (7) | Bad Debt | (8) | Net Revenue | (9)            | Operating Expenses | (10)           | Gain/(Loss) from Operations |
| FY Projected Incremental Expenses: |            |                           |          |                          |       | Col. 2 * Col. 3 |               |            |                        |     |              |     |          |     |             | Col. 4 - Col.5 |                    | Col. 1 Total * | Col. 4 / Col. 4 Total       |
| Total Facility by Payer Category:  |            |                           |          |                          |       |                 |               |            |                        |     |              |     |          |     |             |                |                    |                |                             |
| Medicare                           | \$0        |                           |          |                          |       |                 |               | \$0        |                        |     |              |     |          |     |             | \$0            |                    | \$0            | \$0                         |
| Medicaid                           | \$0        |                           |          |                          |       |                 |               | \$0        |                        |     |              |     |          |     |             | \$0            |                    | \$0            | \$0                         |
| CHAMPUS/TriCare                    | \$0        |                           |          |                          |       |                 |               | \$0        |                        |     |              |     |          |     |             | \$0            |                    | \$0            | \$0                         |
| <b>Total Governmental</b>          | <b>0</b>   |                           |          |                          |       |                 |               | <b>\$0</b> |                        |     |              |     |          |     |             | <b>\$0</b>     |                    | <b>\$0</b>     | <b>\$0</b>                  |
| Commercial Insurers                | \$0        |                           |          |                          |       |                 |               | \$0        |                        |     |              |     |          |     |             | \$0            |                    | \$0            | \$0                         |
| Uninsured                          | \$0        |                           |          |                          |       |                 |               | \$0        |                        |     |              |     |          |     |             | \$0            |                    | \$0            | \$0                         |
| <b>Total NonGovernment</b>         | <b>\$0</b> |                           | <b>0</b> |                          |       |                 |               | <b>\$0</b> |                        |     |              |     |          |     |             | <b>\$0</b>     |                    | <b>\$0</b>     | <b>\$0</b>                  |
| <b>Total All Payers</b>            | <b>\$0</b> |                           | <b>0</b> |                          |       |                 |               | <b>\$0</b> |                        |     |              |     |          |     |             | <b>\$0</b>     |                    | <b>\$0</b>     | <b>\$0</b>                  |

13.C(x). 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               | CT Services     | (1)        | (2)              | (3)   | (4)                              | (5)                       | (6)          | (7)        | (8)                                                | (9)                                  | (10)                                              |
|-------------------------------------------|-----------------|------------|------------------|-------|----------------------------------|---------------------------|--------------|------------|----------------------------------------------------|--------------------------------------|---------------------------------------------------|
| Type of Unit Description:                 | CT Scan         |            | Rate             | Units | Gross Revenue<br>Col. 2 * Col. 3 | Allowances/<br>Deductions | Charity Care | Bad Debt   | Net Revenue<br>Col. 4 - Col. 5<br>-Col. 6 - Col. 7 | Operating Expenses<br>Col. 1 Total * | Gain/(Loss)<br>from Operations<br>Col. 8 - Col. 9 |
| # of Months in Operation                  | 3               |            |                  |       |                                  |                           |              |            |                                                    |                                      |                                                   |
| <b>Year 1</b>                             |                 |            |                  |       |                                  |                           |              |            |                                                    |                                      |                                                   |
| <b>FY Projected Incremental Expenses:</b> | <b>\$53,513</b> |            |                  |       |                                  |                           |              |            |                                                    |                                      |                                                   |
| <b>Total Incremental Expenses:</b>        | <b>\$53,513</b> |            |                  |       |                                  |                           |              |            |                                                    |                                      |                                                   |
| <b>Total Facility by Payer Category:</b>  |                 |            |                  |       |                                  |                           |              |            |                                                    |                                      |                                                   |
| Medicare                                  | \$1,000         | 42         | \$42,000         |       | \$28,467                         | \$0                       | \$0          | \$0        | \$13,533                                           | \$17,838                             | (\$4,305)                                         |
| Medicaid                                  | \$1,000         | 3          | \$3,000          |       | \$1,963                          | \$0                       | \$0          | \$0        | \$1,037                                            | \$1,274                              | (\$237)                                           |
| CHAMPUSTriCare                            | \$1,000         | 0          | \$0              |       | \$0                              | \$0                       | \$0          | \$0        | \$0                                                | \$0                                  | \$0                                               |
| <b>Total Government</b>                   | <b>\$1,000</b>  | <b>45</b>  | <b>\$45,000</b>  |       | <b>\$30,430</b>                  | <b>\$0</b>                | <b>\$0</b>   | <b>\$0</b> | <b>\$14,570</b>                                    | <b>\$19,112</b>                      | <b>(\$4,542)</b>                                  |
| Commercial Insurers                       | \$1,000         | 79         | \$79,000         |       | \$42,229                         | \$2,000                   | \$0          | \$0        | \$34,771                                           | \$33,552                             | \$1,219                                           |
| Uninsured                                 | \$1,000         | 2          | \$2,000          |       | \$900                            | \$1,050                   | \$0          | \$0        | \$50                                               | \$849                                | (\$79)                                            |
| <b>Total NonGovernment</b>                | <b>\$1,000</b>  | <b>81</b>  | <b>\$81,000</b>  |       | <b>\$43,129</b>                  | <b>\$3,050</b>            | <b>\$0</b>   | <b>\$0</b> | <b>\$34,821</b>                                    | <b>\$34,401</b>                      | <b>\$420</b>                                      |
| <b>Total All Payers</b>                   | <b>\$1,000</b>  | <b>126</b> | <b>\$126,000</b> |       | <b>\$73,559</b>                  | <b>\$3,050</b>            | <b>\$0</b>   | <b>\$0</b> | <b>\$49,391</b>                                    | <b>\$53,513</b>                      | <b>(\$4,122)</b>                                  |

## GENERAL AFFIDAVIT

Applicant: \_\_\_\_\_

Project Title: \_\_\_\_\_

I, \_\_\_\_\_, \_\_\_\_\_  
(Name) (Position – CEO or CFO)

of \_\_\_\_\_ being duly sworn, depose and state that  
the (Facility Name) said facility complies with the appropriate and applicable  
criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486  
and/or 4-181 of the Connecticut General Statutes.

---

Signature

---

Date

Subscribed and sworn to before me on \_\_\_\_\_

---

\_\_\_\_\_  
Notary Public/Commissioner of Superior Court

My commission expires: \_\_\_\_\_



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
*OFFICE OF HEALTH CARE ACCESS*

***FAX SHEET***

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AGENCY: StayWell Health Care, Inc.  
FROM: Laurie Greci  
DATE: 4/15/10 TIME: 2:40 PM  
NUMBER OF PAGES: 12  
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**Comments:**

## CON Application & Forms

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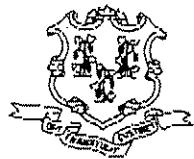
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