Employment Options, LLC
91 Willenbrock Road, Unit A-3
Oxford, CT 06478
Phone: 203-267-3810 Fax: 203-267-3813

RECEIVED
2009 NOV 20 A 11:31
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

November 18, 2009

To Whom It May Concern:

Enclosed please find the Letter of Intent Form along with the Project Description.

Thank you.

Sincerely,

MZSmith

Michele Zurko-Smith
CEO

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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	Michele Zurko-Smith	
Doing Business As	Litchfield Hills Retreat L.L.C.	
Name of Parent Corporation	Employment options L.L.C.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	12 Trefoil Rd Oxford, CT 06478	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes (No)	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Michele Zurko-Smith CEO member L.L.C	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	12 Trefoil Rd Oxford, CT 06478	
Contact Person Telephone Number	203-206-8212 203-267-3818	
Contact Person Fax Number	203-267-3813	
Contact Person e-mail Address	MLZURKO@AOL.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Litchfield Hills Retreat L.L.C

b. Project Proposal: Substance Abuse Services + Behavioral Health

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:

64 Double Hill Rd, Bethlehem, CT 06751

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

State wide

h. Estimated starting date for the project: Feb, 2010

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: $ 2,500,000.

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	2,000,000 –
Other (Non-Construction) Specify: Furinshings + recreational equip.	500,000
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.

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?

AFFIDAVIT

To be completed by each Applicant

Applicant: Michele Zurko-Smith

Project Title: Litchfield Hills Retreat L.L.C
High End Treatment Center for substance abuse

I, Michele Zurko-Smith (Name), CEO/member L.L.C. (Position – CEO or CFO)
of Employment options L.L.C 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 Litchfield Hills (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.

Signature 11/18/09
Date

Subscribed and sworn to before me on 11/18/2009

Amy H. Cravetz
Notary Public/Commissioner of Superior Court

AMY H. CRAVETZ
NOTARY PUBLIC
My Comm. Expires Dec. 31, 2009

My commission expires:

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11/10/09

Project Description

Employment Options L.L.C. is a private social service agency that was established in 1994. Michele Zurko-Smith is the CEO and a member of the L.L.C. of this company which currently employs one hundred thirty eight people. Employment Options has a vocational contract with the Bureau of rehabilitation services and is also the largest provider for the Acquired Brain Injury waver in the state of Connecticut, offering residential supports, independent living skills training, as well as vocational services. Employment Options services twenty two individual private service plans through the Department of Developmental Services, supporting people in the community residentially and vocationally. Employment Options also works with a number of different school districts through out the years, assessing students and working with them towards reaching their life goals.

A large number of people we serve have or have had, substance abuse issues.

Employment Options would like to expand into substance abuse residential treatment for individuals over the age of eighteen. We will accept a person into residential treatment after they are medically cleared by a physician (we will not be offering Detox or any other medical service). We will have a License drug and alcohol counselor on staff and will offer treatment plans that incorporate nationally accepted addiction treatment models. We anticipate the length of stay to be a minimum of twenty eight days.

Employment Options purposes a new free standing Facility which will be located in Bethlehem, CT. We would like to have a total of twenty eight beds. This facility will be located on sixty two, very private acres, offering private and semi private rooms. This facility will be private pay and be marketed to a higher level professional and or their family member. This facility is intended to serve people whose public visibility, wealth, fame or social position would make it impossible for them to begin recovery in a traditional residential treatment center that currently exists in Connecticut.

Currently there is not a Connecticut based facility that can offer this type of service. Professional residents (Physicians, Attorneys, Politicians, Actors, etc.) are greatly under served in our state. We have a number of residents needing substance abuse residential treatment, that fit the criteria and must leave the state to find a substance abuse treatment center that is suitable for their recovery.

This will be a confidential treatment center that is offered in Connecticut to serve Connecticut (and out of state) professionals. People that live in our state and need this type of service, could benefit from a closer proximity to family and after care supports. Keeping the professional in his home state *may* also allow him to continue working during residential treatment.

Employment Options has created a separate company. The name for this residential treatment center will be Litchfield Hills Retreat L.L.C. The property in Bethlehem, is currently owned by Litchfield Hills Retreat L.L.C. and there is an eight bed , 7,500 sq ft. home on the property. An additional building would be built for the additional beds, office and program space. Money from the CEO of the company, Michele Zurko-Smith, as well as a traditional construction loan would finance this project.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 7, 2009 Facsimile Only

Michele Zurko-Smith
CEO Member LLC
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
12 Trefoil Road
Oxford, CT 06478

Re: Letter of Intent; Docket Number: 09-31500
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Establish a Free Standing Substance Abuse Facility in Bethlehem
Notice of Letter of Intent

Dear Ms. Zurko-Smith:

On November 20, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC ("Applicant") to establish a free standing substance abuse facility in Bethlehem, with a total capital expenditure of $2,5000,000.

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,

Kimberly R. Martone
Director of Operations

KRM:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 7, 2009 Requisition # 029695

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 **Friday, December 11, 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 Steven Lazarus at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:SWL:lmg

c: Danielle Pare, DPH

Republican American
Docket Number: 09-31500

Letter of Intent
December 7, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Town:	Bethlehem
Docket Number:	09-31500-LOI
Proposal:	Establish a Free Standing Substance Abuse Facility
Capital Expenditure:	$2,5000,000

The Applicant may file its Certificate of Need application between January 19, 2010 and March 20, 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 Applicants.

Greer, Leslie

From: ads [ads@graystoneadv.com]
Sent: Monday, December 07, 2009 2:56 PM
To: Greer, Leslie
Subject: Re: Requisition 029695
Importance: High

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 12/7/09 2:24 PM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

> To Whom It May Concern,
> Please run the attached public notice s in the attached mentioned newspapers. I have attached a hearing notice that has to run in tomorrow s newspaper. Please let me know if this is a problem, call with any questions.
>
> Thank you,
>
> Leslie M. Greer
> Office of Health Care Access
> A Division of Department of Public Health
> tate 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>
> 1 Please consider the environment before printing this message

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

TRANSMISSION OK

TX/RX NO	0948
RECIPIENT ADDRESS	912032673813
DESTINATION ID	
ST. TIME	12/07 17:23
TIME USE	01'01
PAGES SENT	4
RESULT	OK

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

FAX SHEET

TO: MICHELE ZURKO-SMITH

FAX: (203) 267-3813

AGENCY: EMPLOYMENT OPTIONS D/B/A LITCHFIELD HILLS RETREAT, LLC

FROM: STEVEN LAZARUS

DATE: 12/7/09 **TIME:**

NUMBER OF PAGES: 4
(including transmittal sheet

Comments: Docket 09-31500-LOI

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 8, 2009

via fax and email only

Michele Zurko-Smith
Lithcfield Hills Retreat, LLC
12 Trefoil Road
Oxford, CT 06478

RE: Certificate of Need Application Forms, Docket Number 09-31500-LOI
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Establishment of a Free Standing Outpatient Adult Substance Abuse and Behavioral Health Services Facility in Bethlehem, Connecticut

Dear Ms. Zurko-Smith:

Enclosed are the application forms for Employment Options, LLC d/b/a Litchfield Hills, LLC's Certificate of Need ("CON") proposal for the establishment of a free standing outpatient adult substance abuse and behavioral health services facility in Bethlehem, Connecticut with an associated capital expenditure of $2,500,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between January 19, 2010, and March 20, 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 analyst assigned to the CON application is Steven W. Lazarus. Please contact him at (860) 418-7012 if you have questions.

Sincerely,

Kaila Riggott

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 January 19, 2010, and may be submitted no later than March 20, 2010. The Analyst assigned to your application is Steven W. Lazarus and he may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 09-31500-CON

Applicant(s) Name: Employment Options, Inc d/b/a Litchfield Hills Retreat, LLC
Contact Person: Michele Zurko-Smith
Contact Title: Chief Executive Officer
Litchfield Hills Retreat, LLC
Contact Address: 12 Trefoil Road
Oxford, CT 06478

Project Location: Bethlehem

Project Name: Establishment of a Free Standing Outpatient Adult Substance Abuse and Behavioral Health Services Facility

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

Est. Capital Expenditure: $2,500,000

1. Project Description and Need

a. Provide a narrative detailing the proposal.

b. Provide the following regarding the proposal's location:

i. The rationale for choosing the proposed service location;

ii. The service area towns and the basis for their selection;

iii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

iv. How and where the proposed patient population is currently being served;

v. All existing providers (name, address, services provided) of the proposed service (similar and related services) in the towns listed above and in nearby towns; and

vi. The effect of the proposal on existing providers.

2. Projected Volume

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

Table 1: Projected Volume

	Projected Volume (First 3 Full Operational FYs)**			
	FY****	FY****	FY****	FY****
Service type***				
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. Add columns as necessary.
*** Identify each service/procedure type and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

b. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

c. Provide historical volumes for three full years and the current year to date for any of the Applicant's existing services that support the need to implement the proposed service.

d. Provide a copy of any articles, studies, or reports that support the statements made

in this application justifying need for the proposal, along with a brief explanation regarding the relevance of the selected articles.

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 will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

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 and indicate any additional licensure categories being sought in relation to the proposal.

d. Financial Statements

i. <u>If the Applicant is a Connecticut hospital:</u> 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. <u>If the Applicant is not a Connecticut hospital (other health care facilities):</u> 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 2: 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 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 proposed program.

Table 3: 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 CON 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.

				Financial Attachment 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		$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

Financial Attachment I

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	FY	FY	FY	FY	FY	FY	FY	FY	FY
	Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
Description	Results	W/out Project	Incremental	With Project	W/out Project	Incremental	With Project	W/out Project	Incremental	With Project
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
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.

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, December 08, 2009 12:59 PM
To: mlzurko@aol.com
Cc: Greer, Leslie
Subject: CON Applicaiton for Docket No.: 09-31500-LOI
Attachments: 09-31500-Cover Letter.doc; 09-31500-CON Application.doc; 09-31500 FA1.xls; Financial Attachment II.xls; CON Affidavit-General.doc

Ms. Zurko-Smith,

Attached is a copy of the CON Application for Litchfield Hills Retreat, LLC. Please feel free to contact me if you have any further questions. A copy is also being faxed out to you shortly.

Have a great day,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

Commercial for sale, lease, rent

WATERBURY LEASE 495 W.Main St. 12005F. space. $1200/mo. Ideal for retail store. Good visibility and high traffic. 718-437-5915 ext. 102.

WATERTOWN 900 or 1800 sq. ft. next to Burger King. 1-800-801-8277; (203) 729-8277

Announcements

Absolutely free
Lost & found
Special notices

Absolutely free

FREE KITTEN long hair, brown /black9 wks old. Adorable Christmas Gift 203-723-1676

Giving It Away? So Are We!

If you are giving something away for FREE, we'll give you a FREE 4 line ad in our "Absolutely FREE" column for 4 days!" Place Your FREE classified ad online. www.rep-am.com Include an online photo with extended online content for FREE!

KITCHEN Table and 4 chairs. Good shape. Free 203-729-7631

KITTENS FREE 7 Weeks Old 2 Female, 1 Male. Please call 203-709-1 3 5 5

WARNING! ADS FOR FREE PETS

Your beloved pet deserves a loving caring home. The ad for your free pet may draw responses from individuals who will sell your animal for research, breeding or other purposes. Please screen respondents carefully when giving an animal away. Your pet will thank you!

Lost & found

FOUND CAT black cat, area of Mount Olivet Cemetery in Watertown. Call 203-228-4432

IMPOUNDED-MIDDLEBURY White long haried Dog found in Yale Ave area. redeem or adopt. call 203-577-4028

IMPOUNDED WATERBURY Chihuahua mix black/tan, Redeem or adopt. 203-574-6909

LOST: Black Labrador Retriever, female, tall, thin, energetic. Lost since 12/5 from Town Plot area of Waterbury. Call 203-598-6033

LOST CAT Black/White "Clyde" Robinwood Wtby Hosp. area (203) 560-3330 12/10

LOST CAT large mostly orange w. white stomach/neck, orange spot on nose/ orangish eyes 111 albion street call 2037291005

Lost Dog 12/01, Pomeranian

Tan & grey Homestead Av Fairlawn Park area. Missing collar. Daughter heartbroken. 203-755-6451. REWARD

LOST DOG ChiHuaHua Mix, Bwn/tan. Saturday around Highland Ave/Nicholas Dr. 203-573-1784

LOST DOG! Mini-Pinscher, "Bella" female, brown/tan, 15 months old, from Wolcott. *REWARD* no questions asked! 203-465-2427

LOST hearing aide in Waterbury or Naugatuck, if found please call 203-729-7609.

LOST YOUR PET? Let a picture make it easier to identify your little loved one. To place your lost pet picture ad call 203-574-3616 or place your ad online @ www.rep-am.com

Special notices

ADVERTISERS

Please read your ad on the first day it appears and report any errors in time for the next insertion. The Republican-American is responsible for only one incorrect insertion for any advertisement and then only to the extent of a "make good" insertion. Errors which do not lessen the value of the advertisement will not be corrected by "make good" insertion.

ANNOUNCEMENT

Legals/ Public Notices

LEGAL NOTICE

At the regular meeting on Wednesday, December 9, 2009 the Sharon Planning & Zoning Commission voted unanimously to: Approve the application of Lynn Humeston for an accessory apartment at 35 White Hollow Road; Approve the application of Bettie Snyder for an accessory apartment at 45 Herrick Road; Approve, with conditions, the applications of Gary Olsen for a Country Inn at 3 Joray Road, 13 Joray Road, 15 Joray Road and 29 Joray Road. The application for shop & storage for local contractor owned by William Paley at Sharon Station Road was tabled. Copies of these decisions will be on file with the Sharon Town Clerk.

Dated at Sharon, Connecticut, this 10th Day of December, 2009

Barclay Prindle, Chairman
Sharon Planning & Zoning Commission
R-A December 11, 2009

LEGAL NOTICE
PROSPECT PLANNING & ZONING COMMISSION
NOTICE OF PUBLIC HEARING

The Prospect Planning & Zoning Commission will hold a public hearing on Wednesday, December 16, 2009 at 7:20 p.m. in the lower level conference room of the Prospect Town Hall, 36 Center Street on the following applications:

Villa Rosa, LLC, 157 Waterbury Road. Proposed text amendment change to Section 12.6-Sanitary Permit of the Zoning Regulations. The proposed change replaces the existing requirement of an approval from either the Chesprocott Health District or the Water Pollution Control authority before the Planning & Zoning Commission can issue a Special Permit, with an amendment that requires a feasibility letter from the Chesprocott Health District or the Water Pollution Control Authority of the municipality receiving proposed sewage discharge before the Planning & Zoning Commission can issue a Special Permit. The complete file on this proposed zoning amendment is available for review at the Land Use Office, Prospect Town Hall.

Donald Pomeroy, Chairman
R-A December 4 & 11, 2009

LEGAL NOTICE

The Borough of BANTAM ZONING BOARD OF APPEALS will hold a Public Hearing in the Conference Room of the Bantam Borough Hall on Monday, December 14, 2009 at 7:00 PM.

On the application #475 submitted from Maureen E. Steckowell, 1186 Bantam Rd., Bantam for an 18ft. variance on the eastside setback for plans for an addition.

A special Zoning Board of Appeals meeting will follow hearing.

At this time all interested persons may appear and be heard and written communications received.

A copy of this application is on file with the Bantam Borough Clerk.

Dated in Bantam, CT this 20th day of November 2009.

Tom Gillman, Chairperson

Borough of Bantam ZBA

ATTEST: Kim Griffen, Clerk
Borough of Bantam
R-A December 4 & 11, 2009

COURT OF PROBATE
DISTRICT OF WATERBURY
NOTICE OF HEARING
ESTATE OF ALBERTO CODIANI
(09-0425)

Pursuant to an order of the Court dated December 9, 2009, a hearing will be held on an application for authority to sell real property, as in said application on file more fully appears, at the Court of Probate on December 17, 2009 at 10:00 AM.

By Order of the Court
Thomas P. Brunnock, Judge
R-A December 11, 2009

LEGAL NOTICE

The Town of Plymouth will accept sealed bid proposals for code updates at the Terryville Public Library located at 238 Main Street, CT 06786. Bid proposals will be accepted at the Dept. of Public Works at 80 Main Street, Terryville, CT until 10:00 a.m. on Wednesday, December 30, 2009 at which time they, will be opened and read aloud.

Copies of the bid specifications and plan sheets may be obtained after December 14, 2009 at the Terryville Library at 238 Main St., Terryville, CT 06786, Monday through Friday 10:00 a.m. to 5:00 p.m. or by calling (860) 582-3121.

The Town reserves the right to accept or reject any or all bids if it deems it in the best interest of the town.

Dated at Plymouth, Connecticut This 10th day of December, 2009

Anthony A. Lorenzetti, P.E.
Director of Public Works
R-A December 11, 2009

LEGAL NOTICE
Town of Kent Zoning Board of Appeals

At a meeting of the Zoning Board of Appeals on December 8, 2009, the following variance of this Kent Zoning Regulations was granted:

#14-09 - Scott and Jill Tully, at 383 Kent Cornwall Road, Map 8 Block 19, Lot 12, seeking relief from Section 5.5 pertaining to the side yard setback to permit the installation of a 10' x 15' storage shed within said setbacks.

Dated at Kent, CT, this 11th Day of December, 2009
Anthony DiPentima, Chairman
R-A December 11, 2009

NOTICE TO CREDITORS
ESTATE OF CHERYL L. THRALL
(09-0707)

The Hon. Thomas P. Brunnock, Judge of the Court of Probate, District of Waterbury, by decree dated November 12, 2009, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Thomas P. Brunnock, Judge
The fiduciary is:
MARIE MESEROLE
c/o ATTY. GEORGE H. ROMANIA
2862 Whitney Avenue
Hamden, CT 06514
R-A December 11, 2009

PROSPECT ZONING BOARD OF APPEALS
NOTICE OF PUBLIC HEARINGS

The Prospect Zoning Board of Appeals will hold Public Hearings on Tuesday, December 15, 2009 in the lower level conference room of the Prospect Town Hall, 36 Center Street on the following applications:

7:10 p.m. Application 12-2009 of Matthew Butler, 12 Karyl Lane for a 15 foot front yard setback variance of Section 3.2.4.1 and a 21 foot side yard setback variance of Section 3.2.4.2 for a house addition.

7:20 p.m. Application 13-2009 of Chester Falkowski, 24R Cornwall Avenue for a 2,444 square foot variance of Section 5.2.2.1 and a 5 foot variance of Section 5.2.2.2 for a 3,244 square foot detached barn with a height of 29 feet.

7:30 p.m. Application 14-2009 of Leonel Ferland, 43 Summit Road for a 20 foot side yard setback variance of Section 3.2.4.2 and a 610 square foot variance of Section 5.2.2.1 for a 1,300 square foot detached garage.

Complete files may be reviewed at the Land Use Office in the Prospect Town Hall, 36 Center Street, Prospect.

Marianne Byrne, Chairman
R-A December 3 & 11, 2009

Request for Grant Applications

The Connecticut Department of Agriculture, Marketing Bureau is requesting grant applications for projects with a maximum award of $75,000. Applications are required to have projects that solely enhance the competitiveness of specialty crops. Specialty crops are defined as fruits and vegetables, dried fruit, tree nuts, maple syrup, honey, horticulture, and nursery crops (including floriculture).

Projects must impact and produce measurable outcomes for the specialty crop industry and/or the public rather than a single organization, institution, or individual. Single organizations, institutions, and individuals are encouraged to participate as project partners. Submitted applications can have projects that last the duration of up to three years.

Workshops on how to write a successful project and submit a quality application will be held in the eastern and western areas of CT. Information on these workshops will be posted on the Department of Agriculture's website www.ct.gov/doag.

For complete application guidelines please contact Jaime Smith at 860-713-2559 or jaime.smith@ct.gov or visit the Department of Agriculture website to download a copy.

Applications are due to the State Department of Agriculture by March 1, 2010.
R-A Nov. 24, 2009; Dec. 2, 11, 14, 2009; Jan. 5, 13, 21, 29, 2010; Feb. 10, 18, 19, 2010

Request For Quotation #02-9018

The State of Connecticut Judicial Branch invites vendors to submit quotations to provide certified deaf interpreter services at Judicial locations statewide.

Sealed quotations must be received by 11:30 A.M. on December 29, 2009. Immediately thereafter all quotations will be publicly opened and prices read aloud.

VENDORS CURRENTLY REGISTERED UNDER THE STATE'S SMALL BUSINESS SET-ASIDE PROGRAM ARE ENCOURAGED TO BID.

Bid package may be picked-up at Judicial Purchasing Services, 90 WASHINGTON Street, 4th Floor, Hartford, CT or call 860/706-5200 to request by mail.

PLEASE CHECK THE JUDICIAL WEB SITE AT:
www.jud.ct.gov/external/news/busopp/Default.htm

JUDICIAL BRANCH
PURCHASING SERVICES
90 WASHINGTON STREET
HARTFORD, CT 06106

An Equal Opportunity/Affirmative Action Employer
R-A December 11, 2009

COURT OF PROBATE
DISTRICT OF THOMASTON
NOTICE OF HEARING

IN THE MATTER OF:
HILLSIDE CEMETERY

Pursuant to an order of the court dated 12/07/2009, a hearing will be held on an application for the allowance of the accounts of the fiduciary for the period of July 1, 2008 - June 30, 2009, as in said application on file more fully appears, at the Court of Probate on January 8, 2010 at 10:00 a.m.

Tanya Matulis, Clerk
R-A December 11, 2009

PUBLIC NOTICE

Statute Reference: 19a-638
Applicant: Employment Options, LLC dba Litchfield Hills Retreat, LLC
Town: Bethlehem
Docket Number: 09-31560-LOI
Proposal: Establish a Free Standing Substance Abuse Facility
Capital Expenditure: $2,5000,000

The Applicant may file its Certificate of Need application between January 19, 2010 and March 30, 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 Applicants.
R-A December 11, 2009

WATERBURY ZONING COMMISSION
PUBLIC HEARINGS

Notice is hereby given that the following Public Hearings will be held at a meeting of the Zoning Commission at the date, time and place noted below:

DATE: THURSDAY, DECEMBER 17, 2009

TIME: 7:00 P.M.

PLACE: FIRST FLOOR CONFERENCE ROOM,
ROOM 116
CITY BUILDING
236 GRAND STREET
WATERBURY, CT
(Please use the Grand Street Entrance.)

(1) Special Permit for Earth Excavation: Location: 299 Sheffield Street; Applicant: Level Development, Inc. 299 Sheffield Street, Waterbury, CT 06704

Applications are on file and available for public inspection in the Office of the City Plan Department, 26 Kendrick Street, Waterbury, Connecticut 06702 Tel. 203-574-6819

ATTEST: James A. Sequin, AICP
City Planner
R-A December 4 & 12, 2009

LEGAL NOTICE

Notice of sales or other disposition, pursuant to Connecticut State Statutes Sec. 42-106 TO 42-168.

Notice is hereby given that "P.S. ORANGE CO, INC." will sell at PUBLIC AUCTION the personal property contained within the following units to satisfy unpaid storage rental accounts:

SALE TO BE HELD ON 1/16/09 AT 9:30 A.M. AT PUBLIC STORAGE INC., 76 CAPTAIN NEVILLE DRIVE, WATERBURY, CT 06705

C048 NATALIE BROCKETT: Electronics, furniture
C084 RICHARD J. WHITE, JR.: boxes, bags, totes, furniture
C099 LEAH LEVESQUE: electronics, furniture, tools
C116 LILLIAN WRIGHT: boxes, bags, totes
C178 ANN PRIVEE: boxes, bags totes, electronics
C220 ANDREA HAMILTON: furniture
C330 YOLANDA BREWER: boxes, bags, totes, furniture
E002 TOM DIFOLCO: boxes, bags, totes, furniture
E021 MATTHEW SUMMA: boxes, bags, totes, electronics, furniture
E025 JOSHUA SPINDEL: boxes, bags, totes, furniture
C180 KIMBERLY GOW: boxes, bags, totes, furniture

SALE TO BE HELD ON 12/16/09 AT 9:30 A.M. AT PUBLIC STORAGE, INC., 100 Spring Street, Southington, CT 06489

B128 GEORGE MOESER: boxes, totes, end table
CC011 BIL COOK: boxes furniture electronics
CC014 BIL COOK: furniture
A008 DAVID OUELLETTE: totes, electronics, tools
EE029 ROSHIDA SPRUILL: 4 Wheeler, fish tank
CC114 STEVEN CARNEY: totes, furniture
E231 ROSEMARIE BELLINGHAUSEN: boxes, totes
FF010 SHAREE DIONNE: boxes, totes, furniture
AA031 JANICE SCHMIDT: boxes, totes, furniture
J467 KRISTIN TOTH: boxes, furniture electronics
D220 DAWN TORFASON: boxes, stove, tool box
C190 LEONARD JOHNSTON: boxes

SALE TO BE HELD ON 12/16/09 AT 9:30 a.m. at PUBLIC STORAGE, INC., 120 Berlin Turnpike, Berlin, CT 06037

B072 DARRELL BAILEY: boxes, furniture, electronics
A017 TANYA ATKIELSKI: boxes, electronics
D048 JASON WEBER: boxes, totes, furniture
C031 ERICA TINYSZIN: boxes, furniture
D006 JACOB FILLPEK: furniture, tools

SALES TO BE PAID BY CASH OR CREDIT CARD ONLY AT TIME OF SALE. CONTENTS TO BE REMOVED OFF THE PREMISES WITHIN 24 HOURS. TENANTS MAY CLAIM THEIR GOOD UP TO THE TIME OF AUCTION BY PAYING THEIR JUST DEBTS AND VACATING THE STORAGE UNIT.

SALE DATE IS 12/16/2009 AT 9:30 A.M. AT P.S. ORANGE CO., INC. LISTED ABOVE.
R-A December 4 & 11, 2009

Visit our community's most popular local web site for a short-cut to everything you need!

Local news, sports, classifieds, stoc quotes, personal financial news, heal news, travel tips, world news Yellov Page, White Pages, Internet search engines and much much more are just a click away!

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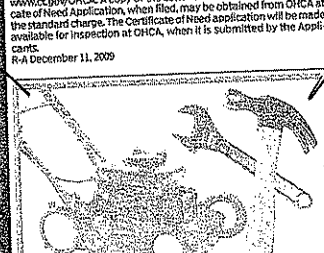

AT YOUR SERVICE
DIRECTORY

Carpentry

ALAN LANDUETTE Carpentry LLC New, remodel, siding, kitchen & baths, Ins. Lic# 579668. 203-592-0631

PAUL'S CARPENTRY decks, trim, bath,

Electrical

CICCHETTI ELECTRIC CONTRACTOR Over 30 yrs exp., Ins'd. No job too small! Lic'd E-1, 103809. 203-754-7537

DW ELECTRICAL Any size jobs, Service upgrades, remodel work,

Handyman

ALL ABOUT SERVICE S&P CARTING Roll-Off Dumpsters 10-30 Yd. Same Day Service. Fully Insured VISA/MC 203-753-4896

CREST RUBBISH REMOVAL 10-30 yard dumpsters Loading avail. Cleanouts estates/basmts 24/7. Veteran, GIB

Home Improvement

ROYAL TOUCH Hardwood Floors, installation & refinish. Free est #576411. Ins 203-757-9092

SOUSA CONSTRUCTION Remodel & Repair, etc CT#624100 Call 203-668-4019

Plumbing

BILL GERVICKAS PLUMBING 45 yrs. exp. Small repair specialty. 203-527-3102. #203205

CAPINERA PLUMBING & HEATING Repairs, New Install. MC/Visa OK. 3202362. 203-575-1551/560-9680

Roofing

ALBERTS HOME REPAIR roofs, gutters, windows, snowplowing & much more, Lic. 0622637 203-879-4731

B&D CONTRACTOR snowplowing & sanding Comm/Res. Fully Insd Free Est. reasonable rates 203-575-9082

Snow Removal

HOLIDAY
Dec
Lesson's, Renta
57
Woodbury Mid A

Commercial Plowing & Sanding

Litchfield Hills Retreat, 64 Double Hill Rd, Bethlehem..Ct (203)206-8212

Mailing address: 12 Trefoil Rd. Oxford Ct, 06478

RECEIVED

2010 FEB -5 A 11:00

CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

February 03, 2010

Honorable Christine Vogel

Commissioner

Office of Health Care Access

Dear Commissioner Vogel:

Enclosed is the Certificate of Need Application Docket Number 09-31500-CON.

Thank you for your time and consideration.

Sincerely,

Michele Zurko-Smith

Litchfield Hills Retreat, LLC

Establishment of Free Standing Residential Adult Substance Abuse

and Behavioral Health Services Facility

Certificate of Need Application

Docket # 09-31500-CON

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FEB 0 3 2010

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FEB 0 3 2010

Litchfield Hills Retreat L.L.C.

Michele Zurko-Smith CEO

Establishment of a free Standing Residential Adult Substance Abuse and Behavioral Health Services Facility

Bethlehem Ct.

Certificate of need application

Docket # 09-31500-CON

February 03, 2010

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 January 19, 2010, and may be submitted no later than March 20, 2010. The Analyst assigned to your application is Steven W. Lazarus and he may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 09-31500-CON

Applicant(s) Name: Employment Options, Inc d/b/a Litchfield Hills Retreat, LLC
Contact Person: Michele Zurko-Smith
Contact Title: Chief Executive Officer
Litchfield Hills Retreat, LLC
Contact Address: 12 Trefoil Road
Oxford, CT 06478

Project Location: Bethlehem

Project Name: Establishment of a Free Standing Residential Adult Substance Abuse and Behavioral Health Services Facility

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

Est. Capital Expenditure: $2,500,000

FEB 0 3 2010

1. Project Description and Need

a. Provide a narrative detailing the proposal.

Litchfield Hills Retreat, LLC will provide residential substance abuse treatment in a private and secluded setting. Located in Bethlehem, the proposed facility will treat individuals 18 years of age and older, whose high level of public visibility, wealth, and/or social status makes it difficult for them to begin a successful recovery in the existing residential treatment settings. A host of treatment modalities and amenities (see Attachment XVIII) will be employed in a highly confidential and nurturing environment which embraces elements of compassion, trust, respect, dignity and peer support. Caring, dedicated and professionally credentialed staff will strive to provide a gentle, unique and results oriented experience while treating clients. Emphasis will be on guiding clients in their journey of self awareness, while helping them to build a strong foundation in the life changing journey of recovery. Client's family members will be involved in the treatment process whenever possible. Residential treatment will be a minimum of 30 days at a cost of $50,000.

b. Provide the following regarding the proposal's location:

i. The rationale for choosing the proposed service location;

The rationale for selecting this proposed location originally arose from there being a great need for this service in Connecticut. Several sites in Litchfield and Fairfield counties were considered before this location was selected. Unique physical characteristics combined with other factors including amenable zoning conditions, made this location the best choice. This location was selected because it is large in size, at 62 +/- acres, and thus offers privacy while also insuring anonymity. The current structure is set back from the rural road, and is not visible from any direction. The serenity and natural beauty of the location is conducive to the treatment and recovery process. Additionally, this location will facilitate effective family therapy and will foster ongoing engagement with Connecticut based family members. Family member involvement at the treatment stage is a vitally important element in the recovery process. Family participation will be greatly enhanced by this proposed Connecticut location. This level of family participation by family members residing in Connecticut would be greatly hindered if this treatment facility were to be located out of state and/or across the country.

ii. The service area towns and the basis for their selection;

Clients from throughout the state of Connecticut will be served by this proposed facility. Residential substance abuse treatment is often sought outside one's local area in order to protect the privacy of the individual seeking treatment. This facility will be located in a rural area in the southwest part of the state which provides an optimal setting for Connecticut residents who desire to receive treatment in their home state. Clients from throughout the state of Connecticut will receive treatment in a therapeutic environment that is located in a convenient yet private setting, while interacting with other clients who are experiencing similar problems with substance abuse and related issues.

iii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

FEB 0 3 2010

iii The population to be served:

FEB 0 3 2010

Litchfield Hills Retreat will serve adults, eighteen years and older, who have a drug and/or alcohol addiction. They will be ready for treatment and will be medically cleared prior to acceptance into this program.

FEB 0 3 2010

Evidence of Incidence, Prevalence, and Demographics

FEB 0 3 2010

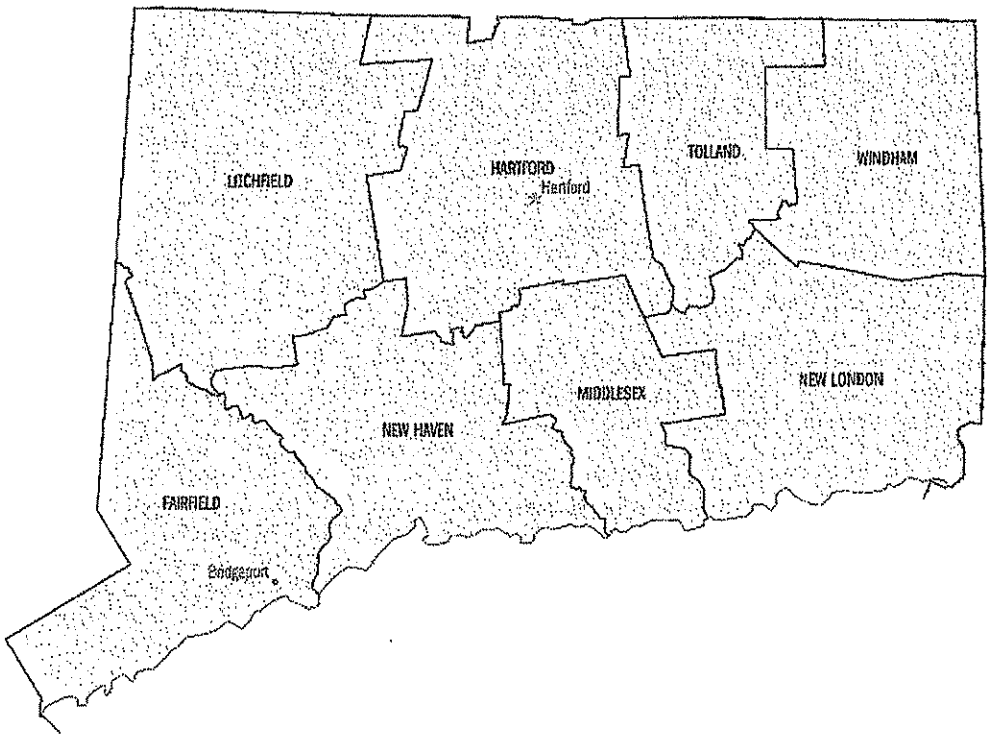
Office of National Drug Control Policy

Drug Policy Information Clearinghouse

State of Connecticut

Profile of Drug Indicators

June 2006



ONDCP Drug Policy Information Clearinghouse staff compiled this profile by using the most recent data available from open sources. The data presented are as accurate as the sources from which they were drawn. The information contained in this profile should not be used to rank or compare States or jurisdictions, due to differences in data collection and reporting methods.

FEB 0 3 2010

Connecticut

The following profile contains information on demographics, political figures, funding, programs, crime, drug use, drug trafficking, and enforcement statistics.

Demographics

- Population (2004 American Community Survey): 3,389,483[1]
- Race/Ethnicity (2004 American Community Survey): 80.1% white; 9.3% black/African American; 0.2% American Indian/Alaskan Native; 3.0% Asian; 0.0% Native Hawaiian/other Pacific Islander; 5.5% other race; 1.8% two or more races; 10.6% Hispanic/Latino (of any race)[2]

Politics

- Governor: M. Jodi Rell[3]
- Lt. Governor: Kevin Sullivan[4]
- Attorney General: Richard Blumenthal[5]
- Secretary of State: Susan Bysiewicz[6]
- U.S. Senators: Christopher J. Dodd (D); Joseph I. Lieberman (D)[7]
- U.S. Representatives (Districts 1-5, respectively): John B. Larson; Rob Simmons; Rosa L. DeLauro; Christopher Shays; Nancy L. Johnson[8]
- Capital: Hartford[9]

Programs/Initiatives

- High Intensity Drug Trafficking Area (HIDTA)[10]
  Designated in 1999, the New England HIDTA is responsible for areas of Connecticut, Massachusetts, Rhode Island, Vermont, Maine, and New Hampshire. The Connecticut counties involved in New England HIDTA activities are Fairfield, Hartford, and New Haven.
- Governor's Prevention Initiative for Youth[11]
  Established in 1998 with a grant from the Center for Substance Abuse Prevention, the Governor's Prevention Initiative for Youth has two overall purposes: to coordinate and/or redirect all substance abuse prevention funding within the state, and to develop a comprehensive prevention strategy to reduce substance use by youth ages 12-17.
- Alcohol and Drug Policy Council[12]
  The Alcohol and Drug Policy Council was created in 1997 and is charged with examining and improving the statewide substance abuse system and developing plan and action strategies to reduce the harmful effects of the problem. The Council is organized into three major working committees (prevention, treatment, and criminal justice) to support coordinated planning.

Crime and Drug-Related Crime

- During 2005, the Drug Enforcement Administration (DEA) made 404 drug arrests in Connecticut.[13]

FEB 0 3 2010

Number of DEA Drug Arrests, Connecticut, 2001-2005

Year	Arrests
2001	283
2002	286
2003	163
2004	312
2005	404

- Connecticut law enforcement agencies reported 14,904 arrests for drug abuse violations during 2004.[14]

Number of Arrests, Select Offenses, Connecticut, 2004

Offense	Under age 18	Total all ages
Murder/non-negligent manslaughter	6	88
Forcible rape	44	239
Robbery	301	1,282
Aggravated assault	623	3,355
Burglary	685	2,415
Larceny-theft	2,856	11,764
Motor vehicle theft	263	833
Arson	145	341
Drug abuse violations	1,867	14,904
Driving under the influence	134	8,999

Drugs

- Cocaine
  Cocaine is widely abused in Connecticut, with crack being preferred over powder.[15]
- Heroin
  Heroin has equaled crack cocaine as the greatest drug threat in Connecticut. Demand for heroin is increasing dramatically in the state. It is easily accessible, and selling at remarkably low prices and high-purity levels (an average of 70-80% purity reported by DEA laboratories).[16]
- Marijuana
  The majority of the commercial grade marijuana available in Connecticut comes from either Mexico and/or the Southwest area of the U.S.[17]
- Club Drugs
  MDMA is readily available and abused in Connecticut. It has become a popular drug of choice among college age and, more recently, high school students.[18]
- Other Drugs
  Current investigations indicate that diversion of Vicodin®, oxycodone products such as OxyContin®, and Ambien® continues to be a problem in Connecticut.[19]
- According to 2003-2004 data from the National Survey on Drug Use and Health (NSDUH), approximately 247,000 (8.54%) Connecticut citizens (ages 12 or older) reported past month use of an illicit drug.[20]

Citizens (Ages 12 or Older) Reporting Drug Use, Connecticut, 2003-2004 Data

	Number *	Percent
Past month illicit drug use	247	8.54%
Past year marijuana use	361	12.50
Past month marijuana use	204	7.06
Past month use of illicit drug other than marijuana	93	3.21
Past year cocaine use	65	2.24
Past year non-medical pain reliever use	125	4.34

* The number of users is in thousands

- Approximately 979,000 (33.84%) Connecticut citizens reported that using marijuana occasionally (once a month) was a "great risk".[21]
- Additional 2003-2004 NSDUH results indicate that 87,000 (3.02%) Connecticut citizens reported illicit drug dependence or abuse within the past year. Approximately 56,000 (1.93%) reported past year illicit drug dependence.[22]

Juveniles

- Approximately 40% of Connecticut high school students surveyed in 2005 reported using marijuana at least once in their lifetime.[23]

Percent of High School Students Reporting Drug Use, Connecticut, 2005

	Female	Male	Total
Lifetime marijuana use	37.2%	42.2%	39.8%
Past month marijuana use	20.0	25.9	23.1
Lifetime cocaine use	4.9	10.2	7.8
Past month cocaine use	1.8	6.0	4.1
Lifetime inhalant use	11.0	10.9	11.1
Lifetime heroin use	1.3	6.9	4.3
Lifetime methamphetamine use	3.3	8.1	5.9
Lifetime illegal use of steroids	1.6	7.7	4.9
Lifetime ecstasy (MDMA) use	3.5	8.6	6.4
Tried marijuana before age 13	5.1	11.7	8.5

- Half of Connecticut high school seniors surveyed in 2005 reported lifetime marijuana use.[24]

Percent of High School Students Reporting Drug Use, Connecticut, 2005

	9th	10th	11th	12th
Lifetime marijuana use	27.3%	33.7%	50.4%	50.0%
Past month marijuana use	15.0	20.8	27.6	30.1
Lifetime cocaine use	4.1	7.5	9.5	9.7
Past month cocaine use	1.9	3.5	5.8	4.8
Lifetime inhalant use	11.3	9.4	12.4	9.7
Lifetime heroin use	3.3	2.3	4.2	6.8
Lifetime methamphetamine use	4.9	4.1	6.6	7.2

Lifetime illegal use of steroids	3.3	4.0	4.3	7.5
Lifetime ecstasy (MDMA) use	5.6	4.3	6.0	8.8
Tired marijuana before age 13	8.6	6.3	9.0	9.2

- According to 2003-2004 NSDUH data, approximately 35,000 (11.69%) Connecticut 12-17 year olds reported past month use of an illicit drug.[25]

Youth (12-17 Year Olds) Reporting Drug Use, Connecticut, 2003-2004 Data

	Number*	Percent
Past month illicit drug use	35	11.69%
Past year marijuana use	55	18.53
Past month marijuana use	26	8.66
Past month use of illicit drug other than marijuana	15	5.12
Past year cocaine use	5	1.81
Past year non-medical pain reliever use	18	5.97

* The number of users is in thousands

Enforcement

- As of October 31, 2004, there were 9,701 full-time law enforcement employees in Connecticut (7,898 officers and 1,803 civilians).[26]

Trafficking and Seizures

- Located between New York and Boston, Connecticut is an important transit and destination area for drugs.[27]
- Interstate 95 extends through Connecticut and connects New York City with Boston and continues on to the U.S./Canada border. Interstate 91 extends from New Haven north to Massachusetts, Vermont, and the U.S./Canada border. These interstates form what is known by law enforcement as the New England Pipeline.[28]
- Approximately 230 kilograms of marijuana were seized by Federal agencies in Connecticut during 2005.[29]

Amount of Federal Drug Seizures, Connecticut, 2005

Drug Type	Amount Seized
Cocaine	51.9 kilograms
Heroin	0.6 kilograms
Methamphetamine	0.9 kilograms
Marijuana	230.3 kilograms
MDMA	0.0 kilograms/130 dosage units

- During 2005, there were 3 methamphetamine laboratories seized in Connecticut by the DEA and state and local authorities.[30]

Number of Methamphetamine Laboratories Seized, Connecticut, 2001-2005

Year	Labs Seized
2001	0
2002	1

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2003	1
2004	0
2005	3

- During 2005, more than 1,000 cultivated marijuana plants were eradicated and seized in Connecticut as part of the DEA's Domestic Cannabis Eradication/Suppression Program.[31]

Number of Marijuana Plants Eradicated and Seized, Connecticut, 2005

Outdoor Operations		Indoor Operations		Total
Eradicated Plots	Cultivated Plants Eradicated	Grows Seized	Plants Eradicated	Cultivated Plants Eradicated
16	946	6	403	1,349

Courts

- Drug Courts[32]
  As of April 2006, there were 2 drug courts in Connecticut that had been operating for more than 2 years and one that had recently been implemented. There were no additional drug courts in existence or being planned in Connecticut at that time.
- During FY 2003, 39.8% of the Federally-sentenced defendants in Connecticut had committed a drug offense. Approximately 58% of the drug cases involved crack cocaine.[33]

Federal Sentencing Statistics, Drug Cases, Connecticut, FY 2003

Drug Type Involved	Offenses	% of Total
Cocaine – crack	92	57.5%
Cocaine – powder	37	23.1
Heroin	17	10.6
Marijuana	6	3.8
Methamphetamine	2	1.3
Other	6	3.8

Corrections

- On January 1, 2006, the Connecticut incarcerated population totaled 17,928. Approximately 1,600 of the inmates committed an offense involving the sale of a hallucinogenic/narcotic substance.[34]

Incarcerated Sentenced Population, Top Ten Offenses, Connecticut, January 1, 2006

Top Ten Offenses Committed	Number of Offenders
Violation of probation or conditional discharge	2,111
Sale of hallucinogen/narcotic	1,668
Robbery, first degree	968
Possession of narcotic substance	853
Burglary, third degree	658

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Murder	638
Sexual assault, first degree	580
Assault, first degree	569
Criminal attempt	487
Conspiracy	445

- The number of Connecticut offenders being supervised in the community on January 1, 2006 totaled 4,621.[35]
- The Department of Corrections' Objective Classification System indicates that more than 85% of the inmates coming into the system have a substance abuse history that suggests a significant need for some level of substance abuse treatment.[36]

Consequences of Use

- According to the El Paso Intelligence Center, there were no children injured at or affected by methamphetamine laboratories in Connecticut during 2005.[37]

Treatment

- During 2004, there were 48,218 admissions to drug/alcohol treatment in Connecticut.[38] There were 45,749 admissions during 2003.[39]

Admissions to Treatment, Connecticut, 2003-2004

	2003		2004	
Drug Type	#	%	#	%
Alcohol only	8,111	17.7%	8,455	17.5%
Alcohol with secondary drug	8,366	18.3	7,988	16.6
Cocaine	5,754	12.6	5,695	11.8
Marijuana	3,286	7.2	3,580	7.4
Heroin	17,609	38.5	17,942	37.2
Other opiates	1,236	2.7	19,627	3.4
PCP	193	0.4	185	0.4
Hallucinogens	71	0.2	74	0.2
Amphetamines	114	0.2	99	0.2
Other stimulants	9	0.0	14	0.0
Tranquilizers	192	0.4	165	0.3
Sedatives	102	0.2	93	0.2
Inhalants	23	0.1	25	0.1
Other unknown	683	1.5	2,276	4.7
Total	45,749	100.0	48,218	100.0

- According to 2003-2004 NSDUH data, approximately 79,000 (2.74%) Connecticut citizens reported needing but not receiving treatment for illicit drug use within the past year.[40]

Sources

[1] U.S. Census Bureau, American Community Survey Profile: http://factfinder.census.gov/
[2] Ibid.
[3] Connecticut Governor Web site: http://www.ct.gov/governorrell/site/default.asp
[4] Connecticut Lt. Governor Web site: http://www.ct.gov/ltgovksullivan/site/default.asp
[5] Connecticut Attorney General Web site: http://www.ct.gov/ag/site/default.asp
[6] Connecticut Secretary of State Web site: http://www.sots.state.ct.us/
[7] U.S. Senate Web site: http://www.senate.gov/
[8] U.S. House of Representatives Web site: http://clerk.house.gov/members/index.php
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[11] Governor's Prevention Initiative for Youth Web site: http://www.dmhas.state.ct.us/sig/initiative.htm
[12] Connecticut Department of Mental Health and Addiction Services, Alcohol and Drug Policy Council Web site: http://www.dmhas.state.ct.us/ADPC.htm
[13] Drug Enforcement Administration, Connecticut State Factsheet: http://www.dea.gov/pubs/states/connecticut.html
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[19] Drug Enforcement Administration, Connecticut State Factsheet: http://www.dea.gov/pubs/states/connecticut.html
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[22] Substance Abuse and Mental Health Services Administration, *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health*, March 2006: http://oas.samhsa.gov/2k4State/toc.htm
[23] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System, Youth Online: Comprehensive Results, June 2006: http://apps.nccd.cdc.gov/yrbss/
[24] Ibid.
[25] Substance Abuse and Mental Health Services Administration, *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health*, March 2006: http://oas.samhsa.gov/2k4State/toc.htm
[26] Federal Bureau of Investigation, *Crime in the United States, 2004*, October 2005: http://www.fbi.gov/ucr/cius_04/index.html
[27] Drug Enforcement Administration, Connecticut State Factsheet: http://www.dea.gov/pubs/states/connecticut.html
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[32] Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project, *Summary of Drug Court Activity by State and County*, April 14, 2006:
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[40] Substance Abuse and Mental Health Services Administration, *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health*, March 2006:
http://oas.samhsa.gov/2k4State/toc.htm

iv. How and where the proposed patient population is currently being served;

Proposed patient population is currently being served at select facilities located throughout the country. Extensive research has determined that similar treatment is offered at a relatively small number of facilities which include Cirque Lodge in Sundance, Utah, Sierra Tucson in Tucson, Arizona, Passages Malibu in Malibu, California, Sunset Malibu in Malibu, California, Meadows Clinic in Phoenix, Arizona, and Cottonwood de Tucson, Tucson, Arizona. Each of these facilities offers a variety of treatment modalities which reflect their respective make up of staff, philosophies, geographic locations, and other factors.

v. All existing providers (name, address, services provided) of the proposed service (similar and related services) in the towns listed above and in nearby towns; and
See Attachment A

vi. The effect of the proposal on existing providers.

There are no facilities in Connecticut comparable to the proposed facility.
The target population for the proposed facility, Litchfield Hills Retreat, LLC, in Bethlehem, CT, would not impact existing providers as it is a completely different model, price point and will be private pay. Currently Connecticut residents either leave the state, or do not seek treatment, to ensure their privacy and anonymity regarding their substance abuse issues. Litchfield Hills retreat is a small, private and more personal facility with the majority of the rooms being single occupancy. In additional to the conventional twelve step education piece, it will offer amenities that other facilities do not (i.e. equine assisted therapy, spiritual enhancement, yoga, massage therapy, relapse prevention programs, etc.). This facility will promote more personal space, privacy, and anonymity that is necessary for the recovery of the professional who due to social, economic, and public status needs to be in this type of facility.

2. Projected Volume

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

The table below summarizes the total projected admissions for the first three years and what percent of the projected admissions are expected to be Connecticut residents. Out of state residents represent the difference between the projected total admissions and those from Connecticut.

Existing Providers

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Attachment A

Litchfield Hills Retreat, LLC
09-31500-CON

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v. All existing providers (name, address, services provided) of the proposed service (similar and related services) in the towns listed above and in nearby towns;

The response included in the second column in the table below is "yes" indicating that similar services are provided. It should be stressed that this affirmative response relates to the fact that these providers offer addiction treatment.
The proposed facility and individual treatment services that will be provided by Litchfield Hills Retreat will be uniquely different from those offered by other providers in the State. It will offer a smaller more private setting with different amenities.

Name/Address of Short Term Substance Abuse Residential Provider	Program, Department, Division Services Provided	Similar Services Provided? (Yes/No)
Alcohol and Drug Recovery Centers Inc. 500 Blue Hills Ave - 9th Floor Hartford, CT 06112	Residential Program Intensive	Yes
Alliance Treatment Center 121 West Avon Road Avon, CT	Short Term Substance Abuse	Yes
Bristol Hospital Newell Road Bristol, CT	Behavioral Health Services Inpatient Program	Yes
Cedarcrest Hospital 500 Vine Street Hartford, CT	Blue Hills Substance Services	Yes
Connecticut Valley Hospital Silver Street Middletown, CT	Addiction Services Division	Yes

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Norwalk Hospital 24 Stevens Street Norwalk, CT	Department of Psychiatry and Addiction	Yes
Hall Brooke 47 Long Lots Road Westport, CT	Behavioral Health Services	Yes
Hartford Hospital 200 Retreat Avenue Hartford, CT	Institute of Living Addiction Recovery Services	Yes
Rushford Center, Inc. 1250 Silver Street Middletown, CT	Intensive Residential Unit	Yes
Lib House 119 Main Street Stamford, CT	Liberation Programs	Yes
McCall Foundation, Inc. 127 Migeon Avenue Torrington, CT	Carnes Weeks Center Intensive Residential	Yes
MCCA McDonough House 38 Old Ridgebury Road Danbury, CT	Intensive Residential Halfway House	Yes
High Watch Farm 62 Carter Road Kent, CT	Ministry of the High Watch	Yes
Mountainside Lodge, Inc 187 South Canaan Road Canaan, CT	Short Term Substance Abuse Residential	Yes
Greenwich Hospital 5 Perryridge Road Greenwich, CT	Recovery Program	Yes
Silver Hill Hospital 208 Valley Road New Canaan, CT	Short Term Substance Abuse Residential	Yes
Stonington Institute 75 Swantown Road North Stonington, CT	Short Term Substance Abuse	Yes

Source: samhsa.bov/ufds/list search

After extensive research, Mountainside Lodge, Inc. is the closest model in Connecticut based on a private pay model. It is a sixty-six bed facility, all rooms are shared, it is visible from the road, and the price point is lower. It does not lend itself to the privacy and anonymity that we are offering.

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Table 1: Projected Volume

Litchfield Hills Retreat, LLC	Projected Volume (First 3 Full Operational FYs)**			
CT vs. Out of State Admissions	Current Year Attached	Year 1 Jan1-Dec31 2011	Year 2 Jan1-Dec31 2012	Year 3 Jan1-Dec31 2013
Total Beds	N/A	28	28	28
Total Available Bed Days	N/A	10,220	10,220	10,220
Projected Total Occupancy	N/A	40%	65%	85%
Projected Bed Days	N/A	4,088	6,643	8,687
Projected Total Admissions	N/A	131	221	289
Connecticut Admissions	N/A	87	160	220
Out of State Admissions	N/A	44	61	69
% of Connecticut Admissions	N/A	66%	72%	76%

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. Current year date to coincide with CON.

We will begin our fiscal year the day we open our doors. Current year for this table reflects the timeline that we are currently in and not in operation.

*** Identify each service/procedure type and add lines as necessary.

Mathematical Calculations for above table:
Total Beds: Determined number of beds by applicant – 28
Total Beds Available: Number of beds multiplied by 365 days in a year (28*365)
Projected Total Occupancy: Projected occupancy rates estimated by applicant.(See Attachment)
Projected Bed Days: Total available beds days multiplied by occupancy rate (i.e. Year 1: 10,220 * .40 = 4,088 projected bed days)
Projected Total Admissions: Total projected bed days divided by an average length of stay (30 days). (i.e. Year 1: 4,088 projected bed days @ 30 days each = 131 admissions.
Connecticut Admissions: Determined by Need Methodology for Connecticut residents.
Out of State Admissions: Difference between CT admissions and projected total admissions.(i.e. Year 1: 131 total admissions less 87 projected Connecticut admissions = 44 out of State admissions.
% of Admissions from Connecticut: Projected Connecticut admissions divided by projected total admissions. (i.e. Year 1: 87/131=66%).

Length of stay in a residential substance abuse treatment facility varies by individual; however, the norm in the treatment field is that individuals remain in a residential treatment program for an average of 30 days. Abuse and Mental Health Services Administration, Office of Applied Studies, the average length of stay for short term residential/rehabilitation treatment was 30 days (in the year 2000).

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The current year of operations will open with eight beds. We will add ten beds to increase to eighteen in three months. The remaining additional ten beds will be added five month latter.

The profit and loss run is for three full years of operation when all the buildings are up and operational. (See financial attachment 1)

The current year will be based on :

Three months - Eight beds x 90= 720 days(30 day average length of stay) = 24possible admissions x 50% 12 admission

Five months-Eighteen beds x150 = 2700 days (30 day average length of stay) =90possible admissions x 50% 27 admissions

Four months-twenty eight beds x 125=3500 (30 day average length of stay)= 116possible admission x 50% 35 admissions

Total numbers of beds for the first year 138 admissions

$50,000.00 a bed x 74=3,700,000

Expenses for the current year:

Salaries with benefits: Three months $317,000.00

Five months $557,142.00

Four months $669,142.00

Total for the current year salary: $ 1,543,284.00

Other expenses:

Professional services	1,250,897.00
Travel and training	200,000.00
Supplies and drug s	170,000.00
Leases of cars	24,000.00
Other operating expenses;	1,200,000.00
Total operating expenses	**$4 ,389,179.00**

Income $3,700,000.00

Expenses$4,389,179.00 **(--69,179.00)**

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

b. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

Based on the N-SSATS Profile – Connecticut 2005, utilized rates for residential beds were between 91% - 93%. We estimated conservatively based on start up time and these figures. (N-SSATS profile attached).

c. Provide historical volumes for three full years and the current year to date for any of the Applicant's existing services that support the need to implement the proposed service.
N/A – New facility

d. Provide a copy of any articles, studies, or reports that support the statements made in this application justifying need for the proposal, along with a brief explanation regarding the relevance of the selected articles.

Please See Attached.

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.

The proposed facility would be the first licensed facility for the care and treatment of substance abuse and addictive disorders that is specifically tailored to high level professionals, executives, celebrities, public officials and others who seek a discreet, highly confidential and secluded treatment setting. The proposed facility would address and remedy the significant geographic obstacles which currently exist for this population. Furthermore, the proposed facility will provide an environment and culture that is more consistent with the background and lifestyle of its clients. By providing substance abuse treatment services to this vastly underserved population, the proposed facility, will by definition, greatly contribute 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 service

Consumers of health care services will be positively impacted by the proposed facility. By making substance abuse treatment services available to a vastly underserved population, individuals and families in

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Job Descriptions

FEB 0 3 2010

Litchfield Hills Retreat will be hiring qualified people that, meet or exceeds, these current job descriptions.

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Michele Zurko-Smith
12 Trefoil Drive
Oxford, Ct 06478
(203)206-8212

1992-Present: Employment Options L.L.C.
91 Willenbrock Rd.
Unit 3A
Oxford, Ct. 06478

Owner/Operator

Employment Options L.L.C. is a for-profit social service agency that helps people with disabilities live successfully in the community.

I developed a vocational and residential program for people that needed supports to be successful with their goals of living in the community. Grew this program from a independent contactor to a business that now employees over one hundred and sixty employees.

As a company we work collaboratively on people service plans with, Hospitals, Doctors, the department of Mental Health and Addition Services, Behaviorists, Case Managers, Social Workers, Conservators and Family Members. We work with their team following their directives, programs, and behavioral plans so that person reaches their potential. We keep data, documentation and report back to the team and their funding source.

-- Vender for the Bureau of Rehabilitation Services - State of Ct.
Helping people with disabilities find and keep employment-through job assessment, training and job placement.

--Vender Department of Developmental Services - State of Ct.
Developed, and successfully running, an alternative day program for people with mental retardation. Other services include job training, placement and residential supports.

--Vender for the Acquired Brain Injuried Waiver - State of Ct.
Employment Options is one of the largest vender in the state for this program.
Independent living skills training, prevocational training, job development, job coaching, residential supports, recreational actives.

--Work in different School districts helping students with disabilities in career choices, vocational assessments and job training and placement.

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Litchfield Hills Retreat, LLC

Job Description

Job Title: Chief Executive Officer

Summary

The CEO has overall responsibility for the operation of the facility, including general supervision of all staff, direction and control of all the affairs of the facility and will be responsible to the state licensing authority for the center's program and maintaining quality of services.

Essential Duties and Responsibilities

- Establish major strategies, objectives and policies for the operation of the facility.
- Prepare reports which summarize and forecast business activity and financial position in areas of income, expense, and earnings based on past, present and expected operations.
- Ensure necessary reports required for federal and state regulatory agencies are prepared and filed timely.

Qualifications

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. Specific requirements include relevant education and/or experience, strong language, mathematical and reasoning skills. In addition, strong leadership skills are required.

Special Certficates, Licenses and/or Registrations

None Required

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Job Description

Job Title: Chief Financial Officer

Reports to: Chief Executive Officer

Summary

The CFO shall have overall responsibility for all financial aspects of the facility including, but not limited to, preparation of an annual budget for the center, the custody of the company funds, and maintaining a full and accurate account of receipts and disbursements. The CFO will render to the CEO financial transactions and keep them informed of the financial condition.

Essential Duties and Responsibilities

- Prepare reports which summarize and forecast business activity and financial position in areas of income, expense, and earnings based on past, present and expected operations.
- Direct preparation of budgets, review budget proposals, and prepare necessary supporting documentation and justification.
- Advise management about insurance coverage for protection against property losses and potential liabilities.
- Provide management with timely review of organization's financial status and progress in its various programs and activities.
- Arrange for audits of facility accounts.

Qualifications

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. Specific requirements include relevant education and/or experience, strong language, mathematical and reasoning skills. CPA preferred.

Special Certificates, Licenses and/or Registrations

CPA preferred

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Job Description

Job Title: Clinical Director

Reports to: Chief Executive Officer

Summary

The Clinical Director will be responsible for the treatment program and supervising the treatment staff.

Essential Duties and Responsibilities

- Supervise the treatment staff to ensure that all individuals are having their issues addressed and that each individual's treatment plan is in place and is being followed.
- Responsible for regular review of clients' records, including treatment planning and progress being made by individual counselors.
- Evaluate all admissions and ensure appropriateness for admission.
- Work with the Treatment Tech to ensure that the client is getting the care needed.
- Work with counselors and Treatment Tech in determining that the client's condition remains stable and that he/she is in the proper level of care and whether he/she needs a different level of care; when needed, work with other staff to arrange for necessary referral.

Qualifications

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. Specific requirements include license in alcohol and drug counseling.

Special Certficates, Licenses and/or Registrations

LADC

Licensed Alcohol and Drug Counselor State of Ct.

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Litchfield Hills Retreat, LLC

Job Description

Job Title: Treatment Tech

Reports to: Director

Summary

The Treatment Tech will participate in the individual treatment plan and provide direct client care on a daily basis.

Essential Duties and Responsibilities

- Facilitate individual participation.
- Monitor condition of client to evaluate success and assess needs.
- Maintain client records and reports.
- In consultation with Director refer client to other support services as needed depending upon the client's state of mind and/or physical condition.
- Attend outside activities, meetings, work, and social events with client to assure sobriety.
- Peer mentor.

Qualifications

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. Life experience is required.

Special Certificates, Licenses and/or Regitrations

None required.

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Connecticut will have access to services not currently available. Increased availability of substance abuse treatment is in the best interest of all residents, including the consumers of health care services and the payers of such services. According to the National Institute on Drug Abuse, drug abuse and addiction are a major burden to society. Estimates of the total overall costs of substance abuse in the United States, including health and crime related costs as well as losses in productivity, exceed half a trillion dollars annually. Additional societal costs include family disintegration, loss of employment, domestic violence, child abuse, and other crimes.

d. Identify the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

Not applicable. There are no Standards of Practice Guidelines that apply to the proposed facility. All counselors to be employed by the facility will be either individually certified by the Connecticut Certification Board, Inc., or individually licensed by the Connecticut Dept. of Public Health.

4. Organizational and Financial Information

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

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

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

N/A

d. Financial Statements

i. <u>If the Applicant is a Connecticut hospital:</u> 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.
N/A

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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.)
New Facility

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Table 2: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$ 0
Imaging Equipment Purchase	$ 0
Non-Medical Equipment Purchase	$ 0
Land/Building Purchase *	N/A
Construction/Renovation **	$ 450,000
Other Non-Construction (Specify) Furniture	$ 50,000
Total Capital Expenditure	**$ 500,000**
Medical Equipment Lease (Fair Market Value) ***	N/A
Imaging Equipment Lease (Fair Market Value) ***	N/A
Non-Medical Equipment Lease (Fair Market Value) ***	N/A
Fair Market Value of Space ***	$ 2,500,000
Total Capital Cost	**$ 0**
Capitalized Financing Costs (Informational Purpose Only)	$ 0
Total Capital Expenditure with Cap. Fin. Costs	$ 500,000

* 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.

This property is already owned by Michele Zurko-Smith CEO of Litchfield Hills Retreat. I have owned it for all most three years. It has been renovated during that time for this facility using my own personal finances. I will only need to invest an additional 500,000 dollars for the construction cost of two houses on this property for the additional beds.
In my letter of intent I projected 2.5 million dollars for this project. I was taking into consideration the amount of money already spent toward this facility.
The additional 500,000 dollars I have in cash and equity lines that are available to me as I build these structures.

** 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.

Attached are the plans for the additional structures. We would begin building the first building as soon as we receive approval for the certificate of need. Contractors estimate that the project would take two to three months to complete. The second building will follow within five months after the first building is open. That, too, is estimated to take two to three months to complete

*** 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.
N/A

f. 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.

Currently the property is owned by Michele Zurko-Smith the mortgage holder for this property is Chase Bank, P.O. Box 78148, Phoenix, AZ.

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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 proposed program.

Table 3: Patient Population Mix

	Current** FY CON	Year 1 FY 2011	Year 2 FY 2012	Year 3 FY 2013
Medicare*		0	0	0
Medicaid*		0	0	0
CHAMPUS & TriCare		0	0	0
Total Government		**0**	**0**	**0**
Commercial Insurers*		0	0	0
Uninsured		0	0	0
Workers Compensation		0	0	0
Private Pay		**100%**	**100%**	**100%**
Total Non-Government		**0**	**0**	**0**
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.
Litchfield Hills Retreat is a private pay model.

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

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Financial

Attachment 1 * 11

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The first page represents the first year taking into consideration the time line on building the additional houses to in crease the available beds.

The attachment 1 represents the current year as not operating, the first year months, one through twelve, Operating with all twenty eight beds available.

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The current year of operations will open with eight beds. We will add ten beds to increase to eighteen in three months. The remaining additional ten beds will be added five month latter.

The profit and loss run is for three full years of operation when all the buildings are up and operational. (See financial attachment 1)

The current year will be based on :

Three months - Eight beds x 90= 720 days(30 day average length of stay) = 24possible admissions x 50% 12 admission

Five months-Eighteen beds x150 = 2700 days (30 day average length of stay) =90possible admissions x 50% 27 admissions

Four months-twenty eight beds x 125=3500 (30 day average length of stay)= 116possible admission x 50% 35 admissions

Total numbers of beds for the first year 138 admissions

$50,000.00 a bed x 74=3,700,000

Expenses for the current year:

Salaries with benefits: Three months $317,000.00

Five months $557,142.00

Four months $669,142.00

Total for the current year salary: $ 1,543,284.00

Other expenses:

Professional services	1,250,897.00
Travel and training	200,000.00
Supplies and drug s	170,000.00
Leases of cars	24,000.00
Other operating expenses;	1,200,000.00
Total operating expenses	**$4 ,389,179.00**

Income $3,700,000.00

Expenses$4,389,179.00 **(--69,179.00)**

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Lithchfield Hills Retreat, LLC
Docket Number: 08-31500-CON

Financial Attachment I

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

Total Facility: / **Description**	**FY Current Actual Results**	**Months 1-12 Projected W/out CON**	**Months 1-12 Projected Incremental**	**Months 1-12 Projected With CON**	**Months 12-24 Projected W/out CON**	**Months 12-24 Projected Incremental**	**Months 12-24 Projected With CON**	**Months 24-36 Projected W/out CON**	**Months 24-36 Projected Incremental**	**Months 24-36 Projected With CON**
Govt. Gross Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Govt. Gross Revenue	$0	$0	$4,350,000	$4,350,000		$8,000,000	$8,000,000		$11,000,000	$11,000,000
Total Gross Patient Revenue:	$0	$0	$4,350,000	$4,350,000	$0	$8,000,000	$8,000,000	$0	$11,000,000	$11,000,000
Less: Uncompensated Care	$0	$0	$100,000	$100,000	$0	$200,000	$200,000	$0	$300,000	$300,000
Total Net Patient Revenue	$0	$0	$4,250,000	$4,250,000	$0	$7,800,000	$7,800,000	$0	$10,700,000	$10,700,000
Salaries and Benefits	$0	$0	$2,587,762	$2,587,762	$0	$2,887,762	$2,887,762	$0	$3,850,000	$3,850,000
Professional Services	$0	$0	$1,250,897	$1,250,897	$0	$1,250,897	$1,250,897	$0	$1,500,000	$1,500,000
Travel and Training	$0	$0	$200,000	$200,000	$0	$200,000	$200,000	$0	$200,000	$200,000
Supplies and Drugs	$0	$0	$170,000	$170,000	$0	$60,000	$60,000	$0	$80,000	$80,000
Lease Expense cars	$0	$0	$24,000	$24,000	$0	$24,000	$24,000	$0	$24,000	$24,000
Other Operating Expense	$0	$0	$1,200,000	$1,200,000	$0	$1,200,000	$1,200,000	$0	$1,200,000	$1,200,000
Total Operating Expense	$0	$0	$5,432,659	$5,432,659	$0	$5,622,659	$5,622,659	$0	$6,854,000	$6,854,000
Gain/(Loss) from Operations			-$1,182,659	-$1,182,659		$2,177,341	$2,177,341		$3,846,000	$3,846,000
Number of Full Time Employees			31	31		36	36		48	48
*Volume Statistics (Admissions):			87	87		160	160		220	220

*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.

This represents Connecticut admissions only.

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Lithchfield Hills Retreat, LLC
Docket Number: 08-31500-CON

Financial Attachment I

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: Description	FY Current Actual Results	Months 1-12 Projected W/out CON	Months 1-12 Projected Incremental	Months 1-12 Projected With CON	Months 12-24 Projected W/out CON	Months 12-24 Projected Incremental	Months 12-24 Projected With CON	Months 24-36 Projected W/out CON	Months 24-36 Projected Incremental	Months 24-36 Projected With CON
Govt. Gross Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Govt. Gross Revenue	$0	$0	$6,550,000	$6,550,000		$11,492,000	$11,492,000		$14,450,000	$14,450,000
Total Gross Patient Revenue:	$0	$0	$6,550,000	$6,550,000	$0	$11,492,000	$11,492,000	$0	$14,450,000	$14,450,000
Less: Uncompensated Care	$0	$0	$100,000	$100,000	$0	$200,000	$200,000	$0	$300,000	$300,000
Total Net Patient Revenue	$0	$0	$6,450,000	$6,450,000	$0	$11,292,000	$11,292,000	$0	$14,150,000	$14,150,000
Salaries and Benefits	$0	$0	$2,587,762	$2,587,762	$0	$2,887,762	$2,887,762	$0	$3,850,000	$3,850,000
Professional Services	$0	$0	$1,250,897	$1,250,897	$0	$1,250,897	$1,250,897	$0	$1,500,000	$1,500,000
Travel and Training	$0	$0	$200,000	$200,000	$0	$200,000	$200,000	$0	$200,000	$200,000
Supplies and Drugs	$0	$0	$170,000	$170,000	$0	$60,000	$60,000	$0	$80,000	$80,000
Lease Expense cars	$0	$0	$24,000	$24,000	$0	$24,000	$24,000	$0	$24,000	$24,000
Other Operating Expense	$0	$0	$1,200,000	$1,200,000	$0	$1,200,000	$1,200,000	$0	$1,200,000	$1,200,000
Total Operating Expense	$0	$0	$5,432,659	$5,432,659	$0	$5,622,659	$5,622,659	$0	$6,854,000	$6,854,000
Gain/(Loss) from Operations			$1,017,341	$1,017,341		$5,669,341	$5,669,341		$7,296,000	$7,296,000
Number of Full Time Employees			31	31		36	36		48	48
*Volume Statistics (Admissions):			131	131		221	221		289	289

*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.

This represents Connecticut and Out of State admissions.

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Other Monthly Operating costs category on attachment 1

$1,200,000yr

Mortgage	$11,000	$132,000yr
Utilities and cell phones	$ 6,000	$72,000yr
Food	$12,000	$144,000yr
Contract labor	$3,000	$36,000yr
Insurance	$11,000	$132,000yr
Maintenance	$5,000	$60,000yr
Program expense	$8000	$96,000yr
Marketing	$40,000	$480,000yr
Events	$4,000	$48,000yr

Under the category of professional services attachment 1

$1,250,897.00

Professional services under this category refers to outside additional marketer, attorney services, personal trainers, massage therapists, equine therapists, music and art therapists, hired as needed.

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.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: Substance Abuse Treatment
Type of Unit Description: Residential
# of Months in Operation: 12.

Current Year 2010	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Projected Incremental		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	Operating Expenses	Gain/(Loss) from Operations
Total Incremental Expenses:	4,389,179			Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Total Facility by Payer Category: Private 100%										
Medicare	0	0	0	0	0	$0	$0	0	0	0
Medicaid	0	0	0	0	0	$0	$0	0	0	0
CHAMPUS/TriCare	0	0	0	$0	$0	$0	$0	0	0	$0
Total Governmental	0	0	0	0	0	$0	$0	0	0	0
Private Pay	100%									
~~Commercial Insurers~~		50,000	74	3,700,000	0	0	$0	3,700,000	4,389,179	(68,179)
Uninsured		4	0	0	0	0	$0	0	0	0
Total NonGovenrment		50,000	74	3,700,00	0	0	$0	3,700,000	4,389,179	(68,179)
Total All Payers		50,000	74	3,700,00	0	0	$0	3,700,000	4,389,179	(68,179)

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.C(x). Please provide three years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

pe of Service Description	Substance Abuse Treatment									
pe of Unit Description:	Residential									
of Months in Operation	12									
ar 2011	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
tal Incremental Expenses:	5,432,659			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
tal Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
yer Category:										
edicare	0	0	0	0	0	$0	$0	0	0	0
edicaid	0	0	0	0	0	$0	$0	0	0	0
HAMPUS/TriCare	0	0	0	$0	$0	$0	$0	0	0	$0
tal Governmental	0	0	0	0	0	$0	$0	0	0	0
Private Pay	100%									
~~ommercial Insurers~~	10	50,000	131	6,550,000	0	100,000	$0	6,450,000	5,432,659	1,017,341
insured		0	0	0	0	0	$0	0	0	0
tal NonGovenrment		50,000	131	6,550,000	0	100,000	$0	6,450,000	5,432,659	1,017,341
tal All Payers		50,000	131	6,550,000		100,000	$0	6,450,000	5,432,659	1,017,341

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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: Substance Abuse Treatment
Type of Unit Description: Residential
# of Months in Operation: 12

Year 2012

FY Projected Incremental	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Total Incremental Expenses: 5,622,659		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category: Private Pay 100 %										
Medicare	0	0	0	0	0	$0	$0	0	0	0
Medicaid	0	0	0	0	0	$0	$0	0	0	0
CHAMPUS/TriCare	0	0	0	$0	$0	$0	$0	0	0	0
Total Governmental	0	0	0	0	0	$0	$0	0	0	0
Private Pay										
~~Commercial Insurers~~	0	50,000	221	11,492,000	0	200,000	$0	11,292,000	5,622,659	5,669,341
Uninsured	0	0	0	0	0	0	$0	0	0	0
Total NonGovenrment	0	50,000	221	11,492,000	0	200,000	$0	11,292,000	5,622,659	5,669,341
Total All Payers		50,000	221	11,492,000	0	200,000	$0	11,292,000	5,622,659	5,669,341

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3.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	Substance Abuse Treatment									
Type of Unit Description:	Residential									
# of Months in Operation	12									
Year 2013	(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:	6,854,000			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: Private Pay	100%									
Medicare	0	0	0	0	0	$0	$0	0	0	0
Medicaid	0	0	0	0	0	$0	$0	0	0	0
CHAMPUS/TriCare	0	0	0	$0	$0	$0	$0	0	0	$0
Total Governmental	0	0	0	0	0	$0	$0	0	0	0
Private Pay										
Commercial Insurers	0	50,000	289	14,450,000	0	300,000	$0	14,150,000	6,854,000	7,296,000
Uninsured	0	0	0	0	0	0	$0	0	0	0
Total NonGovenrment	0	50,000	289	14,450,000	0	300,000	$0	14,150,000	6,854,000	7,296,000
Total All Payers		50,000	289	14,450,000	0	300,000	$0	14,150,000	6,854,000	7,296,000

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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.
See Attached

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

vii. Describe how this proposal is cost effective.
See Attached

6. Other Review Criteria

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

The long range plans for this project is to continue to run this business as a twenty eight bed free standing residential adult substance abuse and behavioral health facility. Although there is no decision at this time for expansion above the said amount of beds, if the need arises, we may consider expanding. At that point we will apply to increase the certificate of need. Expansion would be revisited if the current amount of beds remains full and we turn away 20% of referrals due to that issue.

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;
   N/A
   ii. Changes to the Applicant's teaching or research responsibilities; and/or
   N/A
   iii. Special characteristics of the Applicant's patient or physician mix.
   N/A

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i.v. Documentation to support the proposed rates.

Proposed patient population is currently being served at select facilities located throughout the country. Extensive research has determined that similar treatment is offered at a relatively small number of facilities which include Cirque Lodge in Sundance, Utah, Sierra Tucson in Tucson, Arizona, Passages Malibu in Malibu, California, Sunset Malibu in Malibu, California, Meadows Clinic in Phoenix, Arizona, and Cottonwood De Tucson, Tucson, Arizona. Each of these facilities offers a variety of treatment modalities which reflect their respective make up of staff, philosophies, geographic locations, and other factors.

These prices for the facilities used in the above paragraph were verified on 2/3/10 via phone.

Cirque Lodge in Sundance, Utah: $47,850 for 30 days inpatient
Sierra Tucson in Tucson, Arizona: $45,000 for 30 days inpatient
Passages Malibu in Malibu, California: $78,550 for 30 days inpatient
Sunset Malibu in Malibu, California: $47,000 for 31 days inpatient
Meadows Clinic in Phoenix, Arizona: $39,700 for 35 days inpatient
Cottonwood De Tucson in Tucson, Arizona: $30,845 for 31 days inpatient

Average: $48,157.50 per month

v. Provide the minimum number of units required to show a gain.

Current year (2010) – 76 units

First year (2011) – 109 units

Second year (2012) – 113 units

Third year (2013) – 138 units

With 28 beds at 365 days per year with an average of a thirty day stay at 100% occupancy would allow 341 admissions.

The minimum number of units required to show a profit is approximately 1/3 of occupancy.

v.i. Explain losses...implementing the operation of the CON proposal.

With every new business there is a start up cost, it takes time to establish referrals, training curve for staff, and front loaded marketing costs. Employment Options, LLC, the parent company of Litchfield Hills Retreat, LLC, recognizes this process and has the cash flow to compensate for this project.

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Vii This proposal is cost effective because it is private pay. The entire project will be funded by Michele Zurko-Smith's personal finances. It will create jobs in Connecticut as well as give people that live in Connecticut a local option for their addiction recovery.

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Project Description

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Project Description

Employment Options L.L.C. is a private, for profit, social service agency that was established in 1994 . Michele Zurko-Smith is the CEO and a member of the L.L.C. of this company which currently employs one hundred thirty eight people. Employment Options has a vocational contract with the Bureau of Rehabilitation Services and is also the largest provider for the Acquirer Brain Injury waver in the State of Connecticut, offering residential supports, independent living skills training, as well as vocational services. Employment Options services twenty two individual private service plans through the Department of Developmental Services supporting people in the community residentially and vocationally. Employment Options also works with a number of different school districts, assessing students and working with them towards reaching their life goals.

A large number of people we serve have or have had, substance abuse issues.

Employment Options would like to expand into substance abuse residential treatment for individuals over the age of eighteen. We will accept a person into residential treatment after they are medically cleared by a physician. (We will not be offering Detox or any other medical service) We will have a Licensed drug and alcohol counselor on staff and will offer treatment plans that incorporate nationally accepted addiction treatment models. We anticipate the length of stay to be a minim of thirty days.

Employment Option proposes a new, free standing, facility which will be located in Bethlehem CT. We would like to have a total of twenty eight beds. This facility will be located on sixty two, very private acres, offering private and semi private rooms. This facility will be private pay and be marketed to a higher level professional and /or their family member. This facility is intended to serve people whose public visibility, wealth, fame or social position would make it impossible for them to begin recovery in a traditional residential treatment center that currently exists in Connecticut. This is based on inquiries we have received by phone and on our web site.

Litchfield Hills Retreat currently has a web site that generates and average of six inquires a week. There has been calls from Silver Hills, Griffin Hospital, Rushford Hospital, Hallbrook, private people, clinicians and doctors, all asking about availability at this facility. The reasons for referrals from other facilities was because they were either full or not the right fit for an individual. The doctors and clinicians that made calls were looking for a different type placement for the person they were referring due mostly to social status in the community. A number of West Coast entities have also called looking for open beds for people in Connecticut and New England. They had received numerous calls inquiring about a East Coast similar setting of which they were not able to offer help in this area. These referrals were not willing to go as far as California and wanted to stay closer to home, family and work. They were not able to assist those people. They did not know of such said facility and were excited about the prospect of this new facility.

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We intend to market aggressively once we open our doors. In the preparation for starting this facility we have attended resource fairs for recovery, training that other facilities offered, and networking with facilities that inquire about possible services.

At this current time there is not a facility that can offer this type of service operating in Connecticut. Professional residents (Physicians, Attorneys, Politicians, Actors, etc.) are greatly under served in our state. We have a number of residents needing substance abuse residential treatment, that fit this criteria and must leave the state to find a substance abuse treatment center that is suitable for their recovery.

This will be a confidential treatment center that is offered in Connecticut to serve Connecticut (and out of state) professionals. People that live in our state and need this type of service, could benefit from a closer proximity to family and after care supports. Keeping the professional in his home state *may* also allow him to continue working during residential treatment.

Employment Options has created a separate company. The name for this residential treatment center will be Litchfield Hills Retreat L.L.C. The property in Bethlehem, Connecticut, is currently owned by Michele Zurko-Smith, CEO. There is an eight bed, 7,500 sq ft. home on the property. Two additional buildings would be built for additional beds, office and program space. Money from the CEO of the company, Michele Zurko-Smith, would finance this project.

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Litchfield Hills Retreat, L.L.C.

Description of Services

Litchfield Hills Retreat will provide residential drug and alcohol treatment in a safe, private and secluded setting. Clients will be referred from a variety of settings including detox facilities, and will be carefully evaluated by admissions staff to determine whether they are appropriate for this level of care. Addiction treatment will be provided by highly skilled, experienced and properly credentialed staff. A full range of traditional methods including group and individual therapy with be combined with a myriad of amenities and alternative healing practices such as yoga, reiki and massage therapy, to provide the highest quality of care available. Treatment will include relapse prevention and education regarding the 12-step philosophy. Discharge planning will take place for each client, and appropriate referrals will be made. Minimum length of stay will be 30 days.

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Facility Capacity and Utilization

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Type of Care

	Facilities[1]		Clients in Treatment on March 31, 2005				
			All Clients			Clients Under Age 18	
	No.	%	No.	%	Median No. of Clients Per Facility	No.	%
Outpatient	**161**	**75%**	**19,044**	**89%**	**51**	**672**	**80%**
Regular outpatient	130	60%	7,704	36%	37		
Intensive outpatient	76	35%	1,566	7%	13		
Day treatment/partial hospitalization	40	19%	524	2%	11		
Detoxification	31	14%	367	2%	9		
Methadone	38	18%	8,883	41%	245		
Residential	**66**	**31%**	**1,826**	**8%**	**18**	**106**	**13%**
Short term	19	9%	470	2%	18		
Long term	48	22%	1,243	6%	17		
Detoxification	8	4%	113	1%	14		
Hospital Inpatient	**17**	**8%**	**632**	**3%**	**16**	**58**	**7%**
Treatment	11	5%	249	1%	9		
Detoxification	15	7%	383	2%	10		
Total	**216**		**21,502**	**100%**	**45**	**836**	**100%**

[1] Facilities may be included in more than one category.

Opioid Treatment Programs (OTPs)

	No.	%
Facilities with OTPs		
Maintenance only	9	23%
Detoxification only	6	15%
Both maintenance and detoxification	24	62%
Total	**39**	**100%**
Clients in Facilities with OTPs	**9,340**	
Methadone	9,226	
Buprenorphine	114	

Type of Payment Accepted

	Facilities	
	No.	%
Cash or self-payment	199	92%
Private health insurance	151	70%
Medicare	95	44%
Medicaid	161	75%
Other State-financed health insurance	139	64%
Federal military insurance	73	34%
No payment accepted	5	2%
Other type of payment	3	1%
Sliding fee scale	166	77%
Treatment at no charge for clients	136	63%

Facility Capacity and Utilization[1]

	Residential	Hospital Inpatient
No. of facilities	63	8
No. of clients	1,750	469
Designated beds	1,886	536
Utilization rate	93%	91%
Designated beds per facility (average)	30	536

[1] Excludes facilities not reporting both client counts and number of beds, facilities whose client counts were reported by another facility, facilities that included client counts from other facilities, and facilities that did not respond to this question.

Facility Licensing, Approval, Certification, or Accreditation

	Facilities	
	No.	%
Any listed agency/organization	206	95%
State substance abuse agency	120	56%
State mental health department	88	41%
State public health department/board of health	190	88%
Hospital licensing authority	19	9%
JCAHO (Joint Commission on Accreditation of Healthcare Organizations)	87	40%
CARF (Rehabilitation Accreditation Commission)	63	29%
NCQA (National Committee for Quality Assurance)	--	--
COA (Council for Accreditation for Children and Family Services)	12	6%
Other State/Local Agency/Organization	10	5%

Facility Administrative and Funding Characteristics

	Facilities	
	No.	%
Has agreements or contracts with managed care organizations for provision of substance abuse treatment services	164	76%
Receives Federal, State, county, or local government funds for substance abuse treatment programs	173	80%

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Quality Assurance Plan

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Litchfield Hills Retreat, LLC
(to be determined)
Quality Assurance Plan

I. Mission:

Litchfield Hills Retreat, LLC's mission is provide the highest quality treatment and services to those in need of residential drug and alcohol treatment. Treatment and services will be provided in a safe, clean and secure facility.

II. Objectives:

To ensure the highest quality of care for clients.
To provide the highest quality trained and qualified staff.
To ensure the safety and cleanliness of the residential facility, and to be in full compliance with all pertinent local, state and federal laws and regulations.
To maintain sound fiscal policy and stability.

III. Responsibilities of Management:

Management will be responsible for the operation and overall direction for the residential treatment facility and will formulate, delegate and implement written policies in accordance with all local, state and federal laws. Management is also responsible for proper documentation of all agreements with consultants and practitioners employed by the facility in the delivery of services. Additionally, management will be responsible for overseeing all aspects of the facility's operation, and supervision of all staff. Furthermore, management will contract with an independent certified public accountant to conduct an annual audit.

IV. Implementation of Program Services:

Litchfield Hills Retreat, LLC will employ individuals who meet professional qualifications per job descriptions.
Each employee will be expected to comply with all local, state and federal laws in meeting the needs of Litchfield Hills Retreat, LLC's clients, and treatment services being provided.
The services of consultants will be utilized where applicable in order to meet the needs of the facility and/or its clients. Clinical supervision will be provided by a designated individual.
The CEO, Executive Director and Clinical Director will share in overall supervisory duties.
Litchfield Hills Retreat, LLC will have a minimum of one direct care staff person in each building when a client is known to be present. This staff person will have immediate access to additional personnel for emergencies and other situations of an urgent nature.
Management will devise and outline all responsibilities for each staff person.
There will be a Code of Ethics implemented that will be given to each newly hired staff person, and each newly hired staff person will be expected to agree to abide by this Code of Ethics.
Each newly hired staff person with be provided with an Orientation Packet which will include Personnel Policies and Procedures implemented by management.

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Management will institute a weekly review of all aspects of the facility's operation to ensure that it is being run in accordance with all Policies and Procedures and all applicable local, state and federal laws and regulations.

Protocols for Service:

During intake, each client will be fully oriented to the Litchfield Hills Retreat, LLC program and will be provided with the Nature and Goals of Treatment and Client Expectations.

Upon Admission, each client will be assigned to a counselor who will perform an evaluation of the client to determine strengths, weaknesses, problems and needs, so that an effective treatment plan can be developed. Together, the counselor and client will identify and prioritize problems needing resolution, and will establish short-term and long-term goals. Treatment methods to be implemented will then be determined.

The Litchfield Hills Retreat, LLC treatment program will include:

Addiction Education
Adventure Based Initiatives
Aftercare Planning and Program
Age Specific Issues
Art, Music, Writing Workshops
Career/Profession Specific Issues
Exercise Program with Trainer
Family Counseling
Gender Specific Issues
Individual and Group Counseling
Leisure Time
Motivational Interviewing
Notoriety Specific issues
Relapse Prevention
Self-Help (12-Step) Education and Orientation
Spiritual Enhancement: Yoga, Meditation, Hypnosis, Qi Jong Therapy
Therapeutic Challenge

Patient Selection Criteria:

Patients (i.e., clients) will be 18 years of age and older, and will undergo a screening process by telephone to provide information regarding the appropriateness for admission to Litchfield Hills Retreat, LLC's residential treatment program.

The screening process will address:

1) Addiction history with specific information obtained as to Primary Drug Use, Secondary Drug Use, age of first use, frequency of usage, previous
   treatments for same.
2) Any psychiatric issues in the individual's life, past or current.
3) Existing medical conditions and prescribed medication.
4) Pending legal issues.
5) Matters of sleep disturbance, depression, anxiety, and withdrawal history will be addressed.

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6) Medical clearance will be required prior to admission.
7) Referral documentation will be required.

The Pre-Admission Form will be reviewed by the Executive Director and/or the Clinical Director to determine that the individual is appropriate for the level of care to be provided. Discussions will take place, where necessary, with the referral source, personal physicians, and other treatment providers who have seen that individual.

It will be the responsibility of the Executive Director and/or the Clinical Director to accept the individual for treatment at Litchfield Hills Retreat, LLC.

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Resume CEO

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Michele Zurko-Smith
12 Trefoil Drive
Oxford, Ct 06478
(203)206-8212

1992-Present: Employment Options L.L.C.
91 Willenbrock Rd.
Unit 3A
Oxford, Ct. 06478

Owner/Operator

Employment Options L.L.C. is a for-profit social service agency that helps people with disabilities live successfully in the community.

I developed a vocational and residential program for people that needed supports to be successful with their goals of living in the community. Grew this program from a independent contactor to a business that now employees over one hundred and sixty employees.

As a company we work collaboratively on people service plans with, Hospitals, Doctors, the department of Mental Health and Addition Services, Behaviorists, Case Managers, Social Workers, Conservators and Family Members. We work with their team following their directives, programs, and behavioral plans so that person reaches their potential. We keep data, documentation and report back to the team and their funding source.

-- Vender for the Bureau of Rehabilitation Services - State of Ct.
Helping people with disabilities find and keep employment-through job assessment, training and job placement.

--Vender Department of Developmental Services - State of Ct.
Developed, and successfully running, an alternative day program for people with mental retardation. Other services include job training, placement and residential supports.

--Vender for the Acquired Brain Injuried Waiver - State of Ct.
Employment Options is one of the largest vender in the state for this program.
Independent living skills training, prevocational training, job development, job coaching, residential supports, recreational actives.

--Work in different School districts helping students with disabilities in career choices, vocational assessments and job training and placement.

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Facts About

Drug and Alcohol Addiction, Treatment, Recovery and Use

FEB 0 3 2010

This Drug Indicator Profile was prepared by the White House Office of National Drug Control Policy (ONDCP) Drug Policy Information Clearinghouse. The Clearinghouse is funded by ONDCP and is a component of the National Criminal Justice Reference Service. For further information concerning the contents of this Profile or other drug issues, please contact:

ONDCP Drug Policy Information Clearinghouse
PO Box 6000
Rockville, MD 20849-6000

Web Site: http://www.whitehousedrugpolicy.gov

Email Form: http://www.whitehousedrugpolicy.gov/utilities/contact.html

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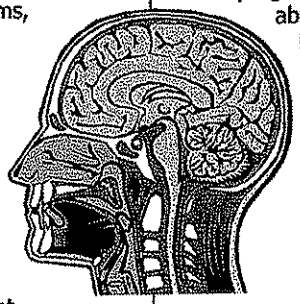
FACTS ABOUT Drug and Alcohol Addiction, Treatment, Recovery and Use

A Library and Resource Center on Alcohol, Tobacco, Other Drugs, Mental Health and Wellness

Drug and alcohol use, abuse, and addiction continue to be among the nation's leading public health problems. Millions of Americans struggle every day with their own drug and alcohol problems. The toll these problems take on these individuals is considerable, as they are at increased risk for very serious health problems, criminal activity, automobile crashes, and lost productivity in the workplace. But individuals with drug and alcohol problems are not the only casualties. Their families, friends, and communities, in fact, society as a whole, also suffer greatly.



The good news is that treatment from drug and alcohol addiction is available and effective. Run by qualified, accredited, and dedicated professionals, treatment programs and services that meet rigorous state standards are the backbone of the public health response needed to address this nationwide epidemic. The range of treatment and recovery program options is considerable; however, it is still not as comprehensive, available, or affordable as it needs to be to ensure that everyone who needs effective treatment can get it. In fact, of the five million people with severe drug or alcohol addiction, only a little more than two million receive treatment – a gap of almost 60 percent.

For those individuals who are able to receive treatment for their drug or alcohol problems, one irrefutable fact remains – the support of family, friends, and the community at large is a critical facet of the overall recovery process. Their role in timely intervention, motivating the individual with the problem to seek help and supporting that person throughout his or her efforts to maintain sobriety cannot and should not be underestimated.

Here are some key facts about addiction, treatment, recovery, and alcohol and drug use that everyone should know:

Understanding Addiction and the Recovery Process

- Although addiction to drugs or alcohol begins with a personal choice to use these substances, research shows that, for many, a physiologically based dependence soon sets in. Drug dependence produces significant and lasting changes in brain chemistry and function.

- Most individuals who use illicit drugs or alcohol stop at the "experimental" or "recreational" stage. For a variety of complex reasons, which may involve heredity, social or environmental factors, or other variables, some individuals' use progresses to a more problematic phase, or substance abuse. Without appropriate intervention, use may become habitual and evolve into physical and psychological dependency, or addiction.

- Research has shown that long-term drug use results in significant changes in brain function that persist long after the individual stops using drugs. These drug-induced changes in brain function may have behavioral consequences, including the compulsion to use drugs despite adverse consequences – the defining characteristic of addiction.

- Alcoholism comprises a set of complex behaviors in which an individual becomes increasingly preoccupied with obtaining alcohol. These behaviors ultimately lead to a loss of control over consumption of the drug and to the development of tolerance, dependence, and impaired social and occupational functioning.

- Addiction is a chronic medical illness, much like type 2 diabetes mellitus and hypertension, that can be treated. Often it is the result of some combination of genetic heritability, personal choice, and environmental factors.

- In the past, drug dependence has been treated like an acute illness, one that can and should be "cured" virtually overnight. More often than not, this unrealistic expectation is not met. However, when addiction is treated as the long-term, chronic, relapsing illness it really is, success rates are comparable to those associated with treating other chronic health problems, such as hypertension, diabetes, and asthma.

- Recovery from drug or alcohol addiction is a process, one that by its very nature may include relapse. Occasional relapses during recovery are to be expected and are not indications of failure. For some individuals, recovery is a more lengthy process than it is for others. So long as efforts are being made on the part of the recovering individual to maintain sobriety and adhere to treatment and recovery program guidelines, progress in the process is being made.

(continued)

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- Family members and friends of individuals with drug and alcohol problems also experience a host of negative physical, emotional, and spiritual repercussions. They too need ongoing support programs and services to help them cope with addiction, understand and deal with the recovery process, and support their loved one's efforts to get well.

Social Benefits of Drug and Alcohol Treatment

- Treatment for drug and alcohol addiction cuts drug use in half, reduces criminal activity up to 80%, increases employment, decreases homelessness, improves physical and mental health, reduces medical costs, and reduces risky sexual behaviors.

- The cost of untreated drug and alcohol addiction in the U.S. in a given year is estimated at $276 billion in lost productivity, law enforcement, health care, justice, welfare, and other programs and services. That's an annual cost of $1,050 for every man, woman, and child in America. In contrast, it would cost about $45 per year per each American to provide the full continuum of services needed to effectively treat addictive disorders. Of course, the return on investment in terms of restored lives is incalculable.

- According to several conservative estimates, every $1 invested in addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1.

- Treatment also produces major savings to the individual and society in the form of significant drops in interpersonal conflicts, improvements in workplace productivity, and reduction in drug-related accidents.

Understanding Effective Drug Addiction Treatment

- Drug addiction treatment should include behavioral therapy such as counseling, cognitive therapy or psychotherapy, or any combination thereof and may include medications.

- In order to be truly effective, especially when treating at-risk or hard-to reach populations, treatment programs must provide a combination of culturally competent therapies and other services. Factors that must be considered include: age, race, culture, language, sexual orientation, gender, pregnancy status, parental responsibilities, housing and employment, physical disability, the existence of co-occurring mental illness, and any past history of physical and sexual abuse.

- Because drug and alcohol addiction is typically a chronic disorder characterized by occasional relapses, a short-term, one-time treatment often is not sufficient. For many, treatment is a long-term process that involves multiple interventions and attempts at abstinence.

The Role of Family, Friends, and Community in Treatment and Recovery

- Successful treatment outcomes often depend upon retaining the person with the drug or alcohol problem long enough to gain the full benefits of treatment. Whether or not a person stays in treatment depends on a number of factors, including; personal motivation to change behavior; the degree of support provided by family and friends; and whether or not there is pressure to stay in treatment from the criminal justice system, child protection services, employers, or the family.

- Community-based recovery groups, most often in the form of 12-step programs, can complement and extend the effects of professional treatment by supporting individuals throughout the recovery process.

- Family and friends can play critical roles in motivating individuals with drug and alcohol problems to enter treatment, stay in it, and maintain sobriety. Family therapy is also important, especially for adolescents. Additional support is available through the recovery community in the form of 12-step programs.

- Family members and friends who attend 12-step support programs report strong improvements in their mental health/well-being, ability to function each day at home/work/school, and overall health status.

Information Provided by:
National Clearinghouse for Alcohol and Drug Information, 2001
1-800-729-6686

Factsaboutdrugalcohol080701

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The 12-Month Prevalence and Trends in DSM-IV Alcohol Abuse and Dependence

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The 12-Month Prevalence and Trends in DSM–IV Alcohol Abuse and Dependence

United States, 1991–1992 and 2001–2002

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Background: ***Alcohol abuse and dependence can be disabling disorders, but accurate information is lacking on the prevalence of current*** **Diagnostic and Statistical Manual, Fourth Edition** ***(DSM–IV) alcohol abuse and dependence and how this has changed over the past decade. The purpose of this study was to present nationally representative data on the prevalence of 12-month DSM–IV alcohol abuse and dependence in 2001–2002 and, for the first time, to examine trends in alcohol abuse and dependence between 1991–1992 and 2001–2002.*** **Methods:** ***Prevalences and trends of alcohol abuse and dependence in the United States were derived from face-to-face interviews in the National Institute on Alcohol Abuse and Alcoholism's (NIAAA) 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC: n = 43,093) and NIAAA's 1991–1992 National Longitudinal Alcohol Epidemiologic Survey (NLAES: n = 42,862).*** **Results:** ***Prevalences of DSM–IV alcohol abuse and dependence in 2001–2002 were 4.65 and 3.81 percent. Abuse and dependence were more common among males and among younger respondents. The prevalence of abuse was greater among Whites than among Blacks, Asians, and Hispanics. The prevalence of dependence was higher in Whites, Native Americans, and Hispanics than Asians. Between 1991–1992 and 2001–2002, abuse increased while dependence declined. Increases in alcohol abuse were observed among males, females, and young Black and Hispanic minorities, while the rates of dependence rose among males, young Black females, and Asian males.*** **Conclusions:** ***This study underscores the need to continue monitoring prevalence and trends and to design culturally sensitive prevention and intervention programs.***

KEY WORDS: *DSM–IV alcohol abuse and dependence; Epidemiology; Secular trends*

INTRODUCTION

Alcohol use disorders are among the most prevalent mental disorders worldwide and rank high as a cause of disability burden in most regions of the world (World Health Organization, 2001). In 2003, the prevalence of alcohol use disorders was estimated at 1.7 percent globally, and these disorders accounted for 1.4 percent of the total world disease burden (World Health Organization, 2003).

Alcohol use disorders (i.e., alcohol abuse and dependence) also are among the most prevalent mental disorders in the United States and are associated with substantial personal and societal costs (Goetzel et al., 2003; Roy-Byrne et al., 2000; Sanderson and Andrews, 2002; Stewart et al., 2003). These alcohol use disorders have enormous consequences not only for the health and welfare of those afflicted with the disorders, but also for their families and children, their employers, and the larger society. For example, approximately one in four children under 18 years old in the United States is exposed to alcohol abuse or alcohol dependence in the family (Grant, 2000). More than one-half of American adults have a family member who has or has had alcohol dependence (Dawson

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and Grant, 1998). Of the 11.1 million victims of violent crime each year, almost one in four, or 2.7 million, report that the offender had been drinking prior to the crime (Greenfield, 1998). The economic costs of alcohol abuse and dependence were $184.6 billion for 1998 (the last year for which figures are available), or roughly $638 for every man, woman, and child living in the United States (Harwood, 1998). Thus, alcohol use disorders impose a staggering, but potentially preventable, burden.

Despite the importance of accurate prevalence information on alcohol abuse and dependence, especially on changes in the prevalence of these disorders over time, the information available to date has been surprisingly sparse. Time (secular) trends in yearly per capita alcohol consumption have been available from the founding days of the United States. However, these are not informative about whether time trends have occurred in lower or higher consumption levels, which have considerably different public health implications. Time trend data are also available on alcohol-related fatal automobile crashes, but these may reflect factors unrelated to alcohol that are not measured in large statistical reporting systems. Similarly, time trends in alcohol-related liver cirrhosis mortality may reflect the influence of causes other than alcohol. Some papers on time trends in drinking and alcohol-related problems have been published over the years (Greenfield et al., 2000; Hasin et al., 1990; Midanik and Greenfield, 2000). However, these studies did not cover abuse and dependence as defined in the standard nomenclatures, and were based on very small samples. Thus, trivial changes in numbers from one survey to the next may have given rise to misleading impressions. Finally, three earlier surveys were conducted on alcohol abuse and dependence as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association: the 1980 Epidemiologic Catchment Area Survey (ECA) (Robins and Regier, 1991), the 1990–1992 National Comorbidity Survey (NCS) (Kessler et al., 1996), and the 2001–2002 NCS–Replication Survey (NCS–R) (Kessler and Walters, 2002). However, in addition to major differences in survey designs that preclude clear information about time trends, each of these studies was based on a different nomenclature—*Diagnostic and Statistical Manual, Third Edition* (DSM–III) (American Psychiatric Association, 1980); *Diagnostic and Statistical Manual, Third Edition, Revised* (DSM–III–R) (American Psychiatric Association, 1987); and *Diagnostic and Statistical Manual, Fourth Edition* (DSM–IV) (American Psychiatric Association, 1994)—making between-survey comparisons for the purpose of time trend analysis impossible.

Change or stability in the prevalence of alcohol abuse and dependence has important research and public health implications in a number of areas. For research on the etiology of alcohol dependence (a complex disorder with both genetic and environmental influences), understanding true changes in prevalence over time may be crucial in interpreting familial aggregation and gene–phenotype associations (Rice et al., 2003). Since the distribution of risk or protective genotypes does not vary within a period as short as a decade, changing prevalence suggests changes in the level of environmental risk. Incorporation of this information into the design of genetic studies may sharpen our ability to detect genetic effects. For policy and prevention efforts, accurate information on changes in potentially vulnerable groups may highlight the need for focused planning on both the national and local levels. The fact that accurate data on time trends in the prevalence of alcohol abuse and dependence have not been available reflects a major gap in public health information. The present study was designed, in part, to address this gap and provide the information.

Accordingly, this report presents data on the 12-month prevalence of alcohol abuse and dependence in the United States assessed in the National Institute on Alcohol Abuse and Alcoholism's (NIAAA) 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) (Grant et al., 2003b). This report also presents, for the first time, trends in the prevalence of alcohol abuse and dependence between 1991–1992 and 2001–2002 using the NIAAA NESARC and NIAAA's 1991–1992 National Longitudinal Alcohol Epidemiologic Survey (NLAES) (Grant et al., 1994) as the baseline. The 1991– 1992 NLAES and 2001–2002 NESARC are the only two national surveys conducted over the last decade to use consistent diagnostic definitions of alcohol abuse and dependence, both of which were based on the most current psychiatric nomenclature, the DSM–IV.

Methods

NESARC Sample

The 2001–2002 NESARC is a representative sample of the United States sponsored by NIAAA that has been described in detail elsewhere (Grant et al., 2003b). The target population of NESARC was the civilian noninstitutionalized population, age 18 and older, residing in the United States and the District of Columbia, including Alaska and Hawaii. The sample included persons living in households, the military living off base, and the following group quarters: boarding houses, rooming houses, nontransient hotels and motels, shelters, facilities for housing workers, college quarters, and group homes. Face-to-face personal interviews were conducted with 43,093 respondents. The fieldwork for NESARC was conducted by the United States Census Bureau. The sampling frame response rate was 99 percent, the household response rate was 89 percent, and the person response rate was 93 percent, yielding an overall survey response rate of 81 percent.

The sampling frame of housing units for NESARC is the Census

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Supplementary Survey (C2SS), which included 2,000 primary sampling units (PSUs) consisting of all 3,142 counties and county equivalents in the United States. The C2SS sample consisted of 655 PSUs. For NESARC, a sample was drawn from each of the C2SS's 655 PSUs in addition to a group quarters sampling frame selected from the Census 2000 Group Quarters Inventory. Group quarter units were converted to housing unit equivalents and sampled together with other NESARC housing units. To prevent potential respondent disclosure, smaller PSUs were collapsed so that the final NESARC data file shows 435 PSUs.

Oversampling of Blacks and Hispanics was accomplished at the design phase of the survey. Oversampling increased the proportion of Hispanic and Black households to approximately 20 percent each of the total sample. For each housing unit, one person was selected randomly from a roster of persons living in the household. At this stage in the survey design, young adults (ages 18–24) were oversampled at a rate of 2.25:1.00.

The NESARC data were weighted to reflect the probabilities of selection of PSUs within strata and for the selection of housing units within the sample PSUs. The data were also weighted: (1) to account for the selection of one sample person from each household; (2) to account for oversampling of young adults; (3) to adjust for nonresponse at the household level and person level; and (4) to reduce the variance arising from selecting two PSUs to represent an entire stratum. The weighted data were then adjusted to be representative of the civilian noninstitutionalized population of the United States for a variety of socioeconomic variables including region, age, sex, race, and ethnicity using the 2000 Decennial Census of Population and Housing.

NLAES Sample

The 1991–1992 NLAES is a nationally representative survey of the United States population sponsored by NIAAA and has been described in more detail elsewhere (Grant et al., 1992, 1994). This survey has been a source of much important information on alcohol use disorders in the United States during the last decade (Grant, 1997a,b, 2000; Grant and Dawson, 1997). Fieldwork for NLAES also was conducted by the United States Census Bureau. Direct face-to-face interviews were administered to 42,862 respondents, age 18 and older, residing in the noninstitutionalized population of the contiguous United States, including the District of Columbia. The household response rate for this survey was 92 percent, and the sample person response rate was 98 percent, for an overall survey response rate of 90 percent.

NLAES featured a complex multistage design. PSUs were stratified according to sociodemographic criteria and were selected with probability proportional to their population size. From a sampling frame of approximately 2,000 PSUs, 198 were selected for inclusion in the NLAES sample. Within PSUs, geographically defined secondary sampling units, referred to as segments, were selected systematically for sample. Oversampling of the Black population was accomplished at this stage of sample selection in order to secure adequate numbers for analytic purposes. Within each household, one randomly selected respondent, age 18 or older, was selected to participate in the survey. Oversampling of young adults, ages 18–29, was accomplished at this stage of the sample selection. This subgroup of young adults was randomly sampled at a ratio of 2.25:1.00.

The NLAES data were weighted: (1) to adjust for probabilities of selection; (2) to account for the selection of one sample person from each household; (3) to account for oversampling young adults; and (4) to account for nonresponse at the household and person levels. Once weighted, the data were adjusted to be representative of the United States civilian noninstitutionalized population for a variety of sociodemographic variables, including region, age, sex, race, and ethnicity using the 1990 Decennial Census of Population and Housing.

Interviewers and Interviewer Training

Experienced lay interviewers from the U.S. Census Bureau administered the NLAES and NESARC interviews. On average, the 1,000 NLAES and 1,800 NESARC interviewers had 5 years' experience working on Census and other health-related surveys. NLAES used a paper-and-pencil survey instrument, whereas the NESARC survey instrument was computerized with software that included built-in skip, logic, and consistency checks. The NLAES and NESARC interviewers completed a rigorous 5-day self-study at home and participated in a 5-day in-class training session at one of the Bureau's 12 regional offices. NESARC training supervisors from each regional office also were required to complete the home study and to attend a centralized training session, where they completed the in-class training under the direction of NIAAA sponsors and Census Field and Demographics Surveys Division Headquarters Staff.

Regional supervisors recontacted a random 10 percent of all the NLAES and NESARC respondents by telephone for quality control purposes and to verify the accuracy of the interviewer's performance. During this quality control interview, respondents were reasked a set of 30 questions from different sections of the interview to verify their answers. In addition, 2,657 NESARC respondents were randomly selected to participate in a face-to-face reinterview study after completion of their NESARC interview. Each of these respondents was readministered one to three complete sections of the NESARC survey instrument. These interviews not only served as an additional rigorous check on survey data quality, but they also formed the basis of the test–retest reliability study of the new modules of the survey instrument (Grant et al., 2003a). Thus, the field procedures in the two surveys were rigorous and highly similar.

Diagnostic Assessment

The diagnoses of alcohol abuse and dependence in NLAES and NESARC were made according to the DSM–IV

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criteria. The diagnostic interview used to generate these diagnoses was the NIAAA Alcohol Use Disorder and Associated Disabilities Interview Schedule–DSM–IV (AUDADIS–IV: Grant et al., 2001), a state-of-the-art structured diagnostic interview designed for use by lay interviewers who are not clinicians. Although the DSM–IV classification was not published until the second quarter of 1994, all of the specific diagnostic criteria for DSM–IV alcohol abuse and dependence (American Psychiatric Association, 1991) were known prior to the fieldwork for NLAES and, therefore, were incorporated into the AUDADIS–IV in their entirety. What was not known at the time was which diagnostic criteria would be assigned to the abuse or dependence categories. However, since all relevant DSM–IV diagnostic criteria had been incorporated into the AUDADIS–IV, computer algorithms were designed to produce diagnoses of abuse and dependence that accurately represented the placement of the criteria within abuse and dependence categories consistent with the final DSM–IV criteria.

DSM–IV alcohol abuse and dependence are defined as maladaptive patterns of drinking, leading to clinically significant impairment or distress. DSM–IV alcohol abuse is manifested by one or more of the following symptoms: recurrent drinking resulting in failure to fulfill major role obligations; recurrent drinking in hazardous situations; recurrent drinking-related legal problems; and continued drinking despite recurrent social or interpersonal problems caused or exacerbated by drinking. DSM–IV alcohol dependence is defined by seven diagnostic criteria: tolerance; the withdrawal syndrome or drinking to relieve or avoid withdrawal symptoms; drinking larger amounts or for a longer period than intended; persistent desire or unsuccessful attempts to cut down on drinking; spending a great deal of time obtaining alcohol, drinking, or recovering from the effects of drinking; giving up important social, occupational, or recreational activities in favor of drinking; and continued drinking despite a physical or psychological problem caused or exacerbated by drinking.

Consistent with the DSM–IV, NLAES and NESARC 12-month diagnoses of alcohol abuse required a respondent to meet at least one of four criteria defined for abuse in the 12-month period preceding the interview and not concurrently meet criteria for DSM–IV alcohol dependence. To be classified with a diagnosis of 12-month alcohol dependence, respondents were required to satisfy at least three of the seven DSM–IV criteria for dependence during the last year. The withdrawal criterion of the alcohol dependence diagnosis was measured as a syndrome, requiring at least two positive symptoms of withdrawal as defined in the DSM–IV alcohol withdrawal diagnosis.

Both the NLAES and NESARC versions of the AUDADIS–IV represented the duration criteria of both the alcohol abuse and dependence diagnoses. The duration criteria relate to specific abuse and dependence criteria, define the repetitiveness with which these diagnostic criteria must occur in order to be positive, and are operationalized by means of qualifiers, such as "recurrent," "often," and "persistent." Duration criteria are not associated with all abuse and dependence criteria. In NLAES, the duration criteria were operationalized by asking respondents if a symptom item had happened more than once. In NESARC, duration criteria associated with abuse and dependence criteria were embedded directly into the symptom questions (e.g., "more than once" want to stop or cut down on your drinking; have "periods" when you ended up drinking more than you meant to).

The NESARC measure of dependence included two new questions, one to measure the "tolerance" criterion, and one to measure the "continued to drink despite persistent or recurrent physical or psychological problems caused or exacerbated by drinking" criterion. The abuse measure included one additional question to operationalize the "hazardous drinking" criterion. To determine the extent to which the addition of these questions might have influenced the comparability of NLAES and NESARC definitions, the questions were removed from the NESARC algorithms used to arrive at abuse and dependence diagnoses, and the associated prevalences were recalculated. Once removed, the NESARC rates of abuse and dependence decreased by 0.30 percent and 0.36 percent. These results indicate that any differences in the operationalizations of alcohol abuse and dependence due to the addition of the new NESARC questions had a trivial impact on the comparability of NESARC and NLAES definitions and were highly unlikely to account for the trends reported here.

The reliability and validity of AUDADIS–IV alcohol abuse and dependence diagnoses are well documented in numerous national and international psychometric studies. These have been conducted in clinical, and particularly in general population samples, the population for which it was designed (Canino et al., 1999; Cottler et al., 1997; Grant, 1992, 1996a, b,c; Grant and Harford, 1989, 1990; Grant et al., 1995, 2003a; Harford and Grant, 1994; Hasin and Paykin, 1999; Hasin et al., 1996, 1997a,c,d, 2000; Muthen et al., 1993). Further, the psychometric properties of the AUDADIS–IV alcohol and drug modules were examined in numerous countries in the World Health Organization–National Institutes of Health Joint Project on Reliability and Validity (Chatterji et al., 1997; Hasin et al., 1997b; Nelson et al., 1999; Pull et al., 1997; Ustun et al., 1997; Vrasti et al., 1998).

Analysis Procedures

As a result of the complex sample design of NLAES and NESARC, specialized software was required to estimate the standard errors of all prevalence estimates. Standard errors presented here were estimated separately for NESARC and NLAES using SUDAAN (Research Triangle Institute, 2002), a software program that uses Taylor series linearization to adjust for complex survey sample design characteristics. For trend analyses, prevalence estimates, and standard errors that were derived separately for NLAES and NESARC were compared using *t*-tests designed for independent samples. In analyses comparing 12-month prevalences among subgroups of the population defined

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by age, sex, and race–ethnicity using NESARC, significance levels were conservatively adjusted downwards to $P < 0.01$ to account for multiple testing.

Results

Prevalence of DSM–IV Alcohol Abuse: 2001–2002

The 12-month prevalence rates, standard errors, and population estimates of DSM–IV alcohol abuse in 2001–2002 are presented in Table 1. Overall, the 12-month prevalence of abuse was 4.65 percent, representing 9.7 million adult Americans.

Gender. Overall, rates of DSM–IV alcohol abuse in 2001–2002 were substantially and significantly higher for males (6.93 percent) than females (2.55 percent), a ratio of about 2.72. This large and significant gender difference also was found among Whites, Blacks, and Hispanics. Similar gender differences were found among Asians and Native Americans, although these did not reach statistical significance. The sex differential in the prevalence of DSM–IV alcohol abuse was significant within all age groups of the White, Black, and Hispanic subgroups except for Hispanics age 65 and older, where the gender difference was in the same direction but not significant.

Race–Ethnicity. The prevalence of alcohol abuse was significantly greater among Whites (5.10 percent) compared to Blacks (3.29 percent), Asians (2.13 percent), and Hispanics (3.97 percent). When race–ethnicity was addressed by gender, White female rates significantly exceeded those of their Black, Asian, and Hispanic counterparts, but White male rates significantly exceeded only those of Black and Asian males. The prevalence of abuse was significantly greater among Native Americans (5.75 percent) and Hispanics (3.97 percent) compared to Asians (2.13 percent), but when broken down by gender, only the Hispanic male rate (6.21 percent) was significantly greater than the Asian male rate (3.20 percent).

Age. Overall, each successively older age group demonstrated decreases in the prevalence of alcohol abuse. All age differences were significant except the decline from ages 18–29 to 30–44, which was significant only for women and Hispanics. When examined within race–ethnic and sex groups, these age differences were less consistently significant. For example, the prevalence of abuse among 30- to 44-year-olds was significantly lower than that of 18- to 29-year-olds only among Hispanic males and Asian females. Rates of abuse for 45- to 64-year-olds compared to 30- to 44-year-olds and rates among the oldest age group (age 65 and older) compared to the 45- to 64-year-old age group were significantly lower among all males, all females, and Whites. Significant declines in prevalence between these age groups were also found when male and female Whites were considered separately. Among Blacks taken as a whole, and among Black males and Black females, the rates of abuse were only significantly lower among the oldest age group compared to the 45- to 64-year-old age group.

Prevalence of DSM–IV Alcohol Dependence: 2001–2002

The prevalence of 12-month DSM–IV alcohol dependence in 2001–2002 was 3.81 percent, representing 7.9 million Americans (Table 2).

Gender and Race–Ethnicity. Although the rates of dependence for the total sample were significantly greater for males (5.42 percent) than females (2.32 percent), a ratio of approximately 2.34, this difference was significant only for Whites, Blacks, and Hispanics when sex differences were assessed within each race–ethnic subgroup of the population. Whites (3.83 percent), Native Americans (6.35 percent), and Hispanics (3.95 percent) had a significantly higher prevalence of dependence than Asians (2.41 percent), but no significant differences were found in the rates of dependence between any of the other race–ethnic groups. There were a number of differences at the subgroup level; for example, at ages 18–29, Whites (10.71 percent) had higher rates of dependence than Blacks (6.03 percent) or Hispanics (6.92 percent). Also, at ages 30–44, Asians (0.44 percent) had lower rates of dependence than all other race–ethnic groups.

Age. A significant inverse relationship between rates of dependence across each successively older age group was found for the sample as a whole, and also when males and females were considered separately. The same significant relationship of age to rates of dependence was found for White males and females. In other race-by-gender groups, the prevalence of dependence for Black males was significantly lower among the oldest age group (1.10 percent) compared to the 45- to 64-year-old age group (3.98 percent). Also, the prevalence of dependence for Hispanic males was significantly lower in the 30- to 44-year-old age group (5.33 percent) than in the youngest age group (9.58 percent) and significantly lower in the 45- to 64-year-old age group (2.06 percent) than in the 30- to 44-year-old age group.

Trends in DSM–IV Alcohol Abuse Between 1991–1992 and 2001–2002

The prevalence of 12-month DSM–IV alcohol abuse significantly increased over the last decade, from 3.03 percent in 1991–1992 to 4.65 percent in 2001–2002 (Table 3). For the total sample, the increases were significant for males (4.67 percent to 6.93 percent) and females (1.51 percent to 2.55 percent) and for each age–gender group except 18- to 29-year-olds.

Between 1991–1992 and 2001–2002, the prevalence of abuse increased among all race–ethnic groups except Native Americans. The increases were significant among Whites, Blacks, and Hispanics. Further, the increases were significant within both genders in each of these three race–ethnic groups.

Among Whites, there was a significant increase in the rate of abuse among all male and female age groups, except 18- to 29-year-olds. Among Black males, there were significant increases in the prevalence of abuse among all age groups. Among Black females, alcohol

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Table 1 Twelve-Month Prevalence of DSM-IV Alcohol Abuse by Age, Sex, and Race–Ethnicity: 2001–2002

Sociodemographic Characteristic	Male			Female			Total		
	%	S.E.	Population Estimate[a]	%	S.E.	Population Estimate[a]	%	S.E.	Population Estimate[a]
Total									
Total	6.93	0.28	6906	2.55	0.16	2762	4.65	0.18	9668
18–29	9.35	0.61	2110	4.57	0.39	1041	6.95	0.39	3151
30–44	8.69	0.49	2742	3.31	0.28	1080	5.95	0.31	3822
45–64	5.50	0.43	1719	1.70	0.20	566	3.54	0.25	2286
65+	2.36	0.32	335	0.38	0.11	75	1.21	0.15	410
White									
Total	7.45	0.33	5276	2.92	0.19	2236	5.10	0.21	7511
18–29	10.19	0.81	1405	5.56	0.54	777	7.86	0.50	2182
30–44	10.10	0.63	2166	4.13	0.38	902	7.09	0.40	3068
45–64	5.97	0.51	1425	2.02	0.26	499	3.96	0.30	1925
65+	2.38	0.35	279	0.36	0.10	58	1.21	0.16	336
Black									
Total	5.71	0.58	574	1.41	0.19	182	3.29	0.30	756
18–29	6.92	1.28	166	2.10	0.45	68	4.28	0.67	254
30–44	7.04	0.95	238	1.51	0.30	65	3.95	0.46	302
45–64	4.48	0.74	132	1.25	0.37	47	2.66	0.40	178
65+	1.79	0.59	19	0.12	0.12	2	.78	0.25	21
Native American[b]									
Total	7.47	1.65	157	4.18	1.25	97	5.75	1.02	253
18–29	15.25	5.68	56	6.68	3.34	33	10.35	3.11	89
30–44	7.67	3.00	54	6.52	3.01	49	7.07	2.13	102
45–64	4.85	2.12	39	0.00	0.00	0	2.57	1.14	39
65+	3.59	2.49	8	4.12	4.00	15	3.91	2.63	24
Asian[c]									
Total	3.20	0.79	140	1.13	0.41	53	2.13	0.46	193
18–29	4.77	1.81	63	3.89	1.38	47	4.35	1.25	110
30–44	4.22	1.54	64	0.23	0.22	4	2.18	0.79	68
45–64	1.13	0.78	13	0.20	0.20	4	0.61	0.32	16
65+	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0
Hispanic/Latino									
Total	6.21	0.50	759	1.65	0.23	195	3.97	0.30	953
18–29	9.08	1.07	400	3.04	0.63	116	6.26	0.63	516
30–44	4.88	0.59	219	1.46	0.33	61	3.23	0.37	281
45–64	4.35	0.84	111	0.63	0.36	17	2.43	0.39	128
65+	3.69	1.62	29	0.00	0.00	0	1.56	0.66	29

[a] Population counts are in thousands.
[b] Includes American Indians and Alaska Natives.
[c] Includes Native Hawaiians and other Pacific Islanders.

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Table 2 Twelve-Month Prevalence of DSM–IV Alcohol Dependence by Age, Sex, and Race–Ethnicity: 2001–2002

Sociodemographic Characteristic	Male			Female			Total		
	%	S.E.	Population Estimate[a]	%	S.E.	Population Estimate[a]	%	S.E.	Population Estimate[a]
Total									
Total	5.42	0.21	5397	2.32	0.13	2515	3.81	0.14	7912
18–29	13.00	0.68	2934	5.52	0.40	1256	9.24	0.41	4190
30–44	4.98	0.34	1570	2.61	0.26	851	3.77	0.23	2422
45–64	2.67	0.25	837	1.15	0.17	383	1.89	0.15	1220
65+	0.39	0.11	56	0.13	0.06	25	0.24	0.06	80
White									
Total	5.41	0.26	3832	2.37	0.16	1811	3.83	0.16	5642
18–29	15.10	0.91	2083	6.38	0.57	891	10.71	0.57	2974
30–44	5.13	0.44	1101	2.84	0.33	621	3.98	0.28	1722
45–64	2.56	0.30	611	1.15	0.21	285	1.84	0.18	895
65+	0.32	0.11	37	0.08	0.05	13	0.18	0.05	50
Black									
Total	5.09	0.52	512	2.39	0.31	309	3.57	0.29	821
18–29	8.75	1.53	235	3.79	0.74	124	6.03	0.82	359
30–44	4.40	0.81	149	2.53	0.43	108	3.36	0.42	257
45–64	3.98	0.76	117	1.74	0.54	65	2.72	0.43	182
65+	1.10	0.58	12	0.71	0.47	12	0.87	0.36	23
Native American[b]									
Total	8.38	1.84	176	4.49	1.32	104	6.35	1.17	280
18–29	15.96	5.61	59	8.73	3.62	43	11.83	3.31	102
30–44	10.94	3.43	77	5.77	3.16	43	8.27	2.32	120
45–64	5.11	2.33	41	2.53	1.70	18	3.90	1.48	59
65+	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0
Asian[c]									
Total	3.56	0.74	156	1.34	0.49	63	2.41	0.38	218
18–29	10.22	2.33	135	4.27	1.81	51	7.39	1.15	186
30–44	0.28	0.29	4	0.59	0.44	9	0.44	0.27	14
45–64	1.42	0.89	16	0.15	0.14	2	0.72	0.41	18
65+	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0
Hispanic/Latino									
Total	5.90	0.72	721	1.94	0.27	229	3.95	0.44	950
18–29	9.58	1.33	422	3.85	0.60	147	6.92	0.80	569
30–44	5.33	1.04	240	1.65	0.53	69	3.55	0.72	309
45–64	2.06	0.63	53	0.46	0.19	13	1.23	0.31	65
65+	0.85	0.86	7	0.00	0.00	0	0.36	0.36	7

[a] Population counts are in thousands.
[b] Includes American Indians and Alaska Natives.
[c] Includes Native Hawaiians and other Pacific Islanders.

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abuse increased somewhat among all ages, although the increase reached significance only for the 45- to 64-year-old age group. Among Hispanics, the rates of alcohol abuse increased slightly in all age groups from 2001–2002 compared to 1991–1992 for each gender, although the increase reached significance only among males ages 18–29. Among Asians, increases in abuse reached significance only for 18- to 29-year-old females and all persons age 65 and older, although nonsignificant increases occurred in several other age groups. Among Native Americans, a significantly increased rate of abuse was found only among 45- to 64-year-old males.

Trends in DSM–IV Alcohol Dependence Between 1991–1992 and 2001–2002

The prevalence of DSM–IV alcohol dependence significantly decreased, from 4.38 percent to 3.81 percent, over the past decade (Table 4). Rates significantly decreased among males (6.33 percent to 5.42 percent), but remained relatively unchanged among females. Rates also significantly decreased among Whites (4.35 percent to 3.83 percent) and Hispanics (5.78 percent to 3.95 percent) but remained relatively stable among Blacks, Native Americans, and Asians.

When prevalence rates within subgroups of the population were examined, significant increases in dependence were observed for 18- to 29-year-old Black females (2.14 percent to 3.79 percent) and 18- to 29-year-old Asian males (4.09 percent to 10.22 percent). Significant decreases in the rates of dependence occurred among White males (6.16 percent to 5.41 percent), Whites age 65 and older (0.38 percent to 0.18 percent), 30- to 44-year-old Asian males (3.02 percent to 0.28 percent), Hispanic males (9.40 percent to 5.90 percent), 18- to 29-year-old Hispanic males (15.44 percent to 9.58 percent), 45- to 64-year-old Hispanic males (6.70 percent to 2.06 percent), and all 45- to 64-year-old Hispanics (3.65 percent to 1.23 percent). All other subgroup rates of alcohol dependence remained stable over the past decade, neither increasing nor decreasing.

Discussion

The total prevalence of 12-month DSM–IV alcohol abuse and dependence in 1991–1992 was 7.41 percent, representing 13.8 million adult Americans. In 2001–2002, this prevalence rose to 8.46 percent, representing 17.6 million adult Americans. Given the harmful effects of alcohol use disorders on the afflicted individuals as well as on those around them and society as a whole, alcohol use disorders continue to represent a substantial public health problem.

The high degree of comparability between NLAES and NESARC definitions of alcohol abuse and dependence made it possible, for the first time, to accurately determine trends in these disorders over the course of a decade. During this time, the prevalence of alcohol dependence significantly declined, from 4.38 percent to 3.81 percent. With regard to specific groups, the prevalence of alcohol dependence decreased over the past decade in males while remaining stable in females, resulting in a somewhat smaller current gender difference than had been found previously. Dependence also decreased among Whites and Hispanics. However, in contrast, there was a significant increase in the prevalence of alcohol abuse, from 3.03 percent in 1991–1992 to 4.65 percent in 2001–2002. This increase was apparent in both genders and was especially marked in young Black and Hispanic minorities.

The first-time availability of trend data allows constant as well as emerging high-risk subgroups to be identified with much greater clarity and specificity than in the past. For example, Whites, Native Americans, and males remain high-risk subgroups for abuse in 2001–2002, while rates in the other subgroups increased to approach those of these stably high-risk groups. Among the stable high-risk subgroups for dependence were young adults, especially Whites and Native Americans. A group that showed an especially sharp increase was young adult Asian males, a group that has not previously attracted attention as being at elevated risk for alcohol use disorders. Consistent with earlier patterns, respondents in the youngest age groups (ages 18–29 and 30–44) continue to have the highest prevalence of alcohol abuse and dependence. Taken together, these results highlight the need to strengthen existing prevention efforts and to develop new programs designed with the sex and race–ethnic differentials observed in 2001–2002 in mind. Moreover, these findings underscore the need for early prevention programs among all youth, regardless of sex or race–ethnicity.

Male and female rates of abuse have converged over the last decade. Overall, the male to female ratio for alcohol abuse declined from 3.09 in 1991–1992 to 2.72 in 2001–2002. The narrowing in the gap between male and female rates of abuse also was observed among Whites (2.98–2.55), Native Americans (2.97–1.79), Asians (3.5 1–2.83), and Hispanics (4.77–3.76), but not among Blacks. Although convergence in the rates of abuse was found for most age groups among Whites and Hispanics, it was only observed in the youngest age groups (ages 18–29) among Asians (4.46–1.23) and Native Americans (3.40–2.28).

In contrast, a male–female convergence in the prevalence of dependence was found among the 30- to 44-year-old (2.46–1.91) and 45- to 64-year-old (2.85–2.32) age groups in the total sample, a pattern that also was observed among Whites of those ages. Convergence was found among all Blacks and Hispanics and particularly among 18- to 29-year-old Blacks (3.99–2.31) and Hispanics (5.20–2.49). Over the next decade, the design and implementation of programs targeted at females, especially 30- to 44-year-old Whites and 18- to 29-year-olds of each race–ethnic subgroup, can go a long way in reducing the convergence observed among the male and female rates of alcohol abuse and dependence, that is, in the phenomenon of women's rates rising to match those of men.

One of the interesting results of the trend analysis was that rates of alcohol dependence had declined slightly,

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Table 3. Trends in the 12-Month Prevalence of DSM–IV Alcohol Abuse by Age, Sex, and Race–Ethnicity: 1991–1992 and 2001–2002

Sociodemographic Characteristic	Male		Female		Total	
	NLAES (1991–1992)	NESARC (2001–2002)	NLAES (1991–1992)	NESARC (2001–2002)	NLAES (1991–1992)	NESARC (2001–2002)
Total						
Total	4.67	6.93[a]	1.51	2.55[a]	3.03	4.65[a]
18–29	9.26	9.35	3.83	4.57	6.54	6.95
30–44	4.58	8.69[a]	1.50	3.31[a]	3.02	5.95[a]
45–64	2.38	5.50[a]	0.38	1.70[a]	1.35	3.54[a]
65+	0.55	2.36[a]	0.04	0.38[a]	0.25	1.21[a]
White						
Total	5.09	7.45[a]	1.71	2.92[a]	3.33	5.10[a]
18–29	10.75	10.19	4.83	5.56	7.83	7.86
30–44	5.16	10.10[a]	1.68	4.13[a]	3.41	7.09[a]
45–64	2.55	5.97[a]	0.44	2.02[a]	1.47	3.96[a]
65+	0.52	2.38[a]	0.04	0.36[a]	0.24	1.21[a]
Black						
Total	2.38	5.71[a]	0.73	1.41[a]	1.46	3.29[a]
18–29	3.38	6.92[b]	1.27	2.10	2.44	4.28[a]
30–44	2.54	7.04[a]	1.00	1.51	1.70	3.95[a]
45–64	1.19	4.48[a]	0.02	1.25[a]	0.54	2.66[a]
65+	0.00	1.79[b]	0.00	0.12	0.00	0.78[a]
Native American						
Total	12.80	7.47	4.31	4.18	8.14	5.75
18–29	27.88	15.25	8.19	6.68	17.59	10.35
30–44	2.64	7.67	3.73	6.52	3.22	7.07
45–64	0.00	4.85[b]	0.00	0.00	0.00	2.57[b]
65+	0.00	3.59	0.00	4.12	0.00	3.91
Asian						
Total	1.65	3.20	0.47	1.13	1.08	2.13
18–29	3.30	4.77	0.74	3.89[b]	2.02	4.35
30–44	1.67	4.22	0.21	0.23	0.93	2.18
45–64	0.00	1.13	0.66	0.20	0.30	0.61
65+	0.00	0.00	0.00	0.00	0.00	0.00
Hispanic/Latino						
Total	4.15	6.21[b]	0.87	1.65[b]	2.52	3.97[a]
18–29	5.85	9.08[b]	1.56	3.04	3.71	6.28[a]
30–44	3.30	4.88	0.86	1.46	2.15	3.23
45–64	3.08	4.35	0.13	0.63	1.60	2.43
65+	2.90	3.69	0.00	0.00	1.16	1.56

[a] $P < 0.01$.
[b] $P < 0.05$.

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Table 4 Trends in the 12-Month Prevalence of DSM-IV Alcohol Dependence by Age, Sex, and Race–Ethnicity: 1991–1992 and 2001–2002

Sociodemographic Characteristic	Male		Female		Total	
	NLAES (1991–1992)	NESARC (2001–2002)	NLAES (1991–1992)	NESARC (2001–2002)	NLAES (1991–1992)	NESARC (2001–2002)
Total						
Total	6.33	5.42[a]	2.58	2.32	4.38	3.81[a]
18–29	12.81	13.00	6.01	5.52	9.40	9.24
30–44	6.07	4.98[b]	2.47	2.61	4.25	3.77
45–64	3.19	2.67	1.12	1.15	2.12	1.89
65+	0.63	0.39	0.23	0.13	0.39	0.24
White						
Total	6.16	5.41[b]	2.67	2.37	4.35	3.83[b]
18–29	13.59	15.10	7.28	6.38	10.48	10.71
30–44	6.12	5.13	2.43	2.84	4.27	3.98
45–64	2.80	2.56	1.03	1.15	1.89	1.84
65+	0.57	0.32	0.24	0.08	0.38	0.18[b]
Black						
Total	5.86	5.09	2.21	2.39	3.84	3.57
18–29	8.54	8.75	2.14	3.79[b]	5.07	6.03
30–44	6.13	4.40	3.26	2.53	4.57	3.36
45–64	4.05	3.98	1.95	1.74	2.89	2.72
65+	0.83	1.10	0.00	0.71	0.32	0.87
Native American						
Total	11.00	8.38	7.38	4.49	9.01	6.35
18–29	13.34	15.96	14.67	8.73	14.03	11.83
30–44	8.85	10.94	2.15	5.77	5.32	8.27
45–64	4.61	5.11	4.73	2.53	4.68	3.90
65+	25.39	0.00	0.00	0.00	9.75	0.00
Asian						
Total	3.06	3.56	1.41	1.34	2.26	2.41
18–29	4.09	10.22[b]	3.77	4.27	3.93	7.39
30–44	3.02	0.28[b]	0.00	0.59	1.50	0.44
45–64	2.90	1.42	0.73	0.15	1.90	0.72
65+	0.00	0.00	0.00	0.00	0.00	0.00
Hispanic/Latino						
Total	9.40	5.90[a]	2.15	1.94	5.78	3.95[b]
18–29	15.44	9.58[b]	2.97	3.85	9.21	6.92
30–44	6.56	5.33	2.70	1.65	4.74	3.55
45–64	6.70	2.06[b]	0.63	0.46	3.65	1.23[b]
65+	0.00	0.85	0.62	0.00	0.37	0.36

[a] $P < 0.01$.
[b] $P < 0.05$.

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whereas rates of abuse had increased. The decrease in the rate of dependence is not surprising, in that most measures of alcohol consumption have also declined slightly over the same period. The National Health Interview Survey found that the percentage of heavy drinkers fell from 7.9 percent to 7.1 percent, and the percentage of adults who drank 5+ drinks monthly or more often fell from 15.6 percent to 14.4 percent (National Center for Health Statistics, 2002). Earlier data from the National Alcohol Surveys conducted in 1990 and 1995 showed stable rates of drinking, any binge drinking, and frequent binge drinking during that period (Greenfield et al., 2000). Similarly, the National Household Survey on Drug Abuse (Substance Abuse and Mental Health Services Administration, 1995, 2002) found little change between 1992 and 2001 in the rates of any past-month drinking (47.8 percent and 48.3 percent, respectively) and heavy past-month drinking (5+ drinks on the same occasion on each of 5 or more days in the past 30 days, 5.0 percent and 5.7 percent, respectively).

What is surprising, then, is that the prevalence of alcohol abuse increased in the face of slightly declining rates of heavy drinking. One possible factor underlying this could be changes in drinking norms as heavy consumption has declined. With the decrease in heavy drinking, social attitudes may have become more negative toward drinking at levels that were previously accepted. If so, this could have led to increased social/interpersonal conflict about drinking even though overall levels have declined. Since social/interpersonal problems related to drinking constitute one of the DSM–IV criteria for alcohol abuse, such interpersonal conflict would be reflected in the increased prevalence of alcohol abuse. The possibility of such environmental influences on alcohol abuse as distinct from dependence has long been recognized (Rounsaville et al., 1986).

Alternatively, alcohol abuse may be related to complex drinking patterns, not measured in previous trend studies of heavy drinking. Drinking patterns related to the development of alcohol abuse may be quite different from those associated with alcohol dependence. Identifying these drinking patterns is a potentially important area for future research. The observation that alcohol abuse is most prevalent among the youngest age groups underscores the need for continued research on drinking pattern trajectories that, for the most part, are initiated in adolescence.

One of the most striking findings from the trend analysis of 12-month DSM–IV alcohol abuse between 1991–1992 and 2001–2002 was that rate of abuse had not increased among White young adults (ages 18–29) but had increased among minority young adults, specifically Black males, Asian females, and Hispanic males. Similarly, the prevalence of 12-month DSM–IV alcohol dependence significantly increased among Black females and Asian males in the 18- to 29-year-old age group, while no such increases were noted for White, Native American, and Hispanic young adults. It should also be noted the prevalence rates of abuse and dependence among Native American young adults are quite high, even though these rates have not significantly increased over the last decade.

The reasons for the rise of alcohol abuse and dependence among these minority young adults are not known. Recently, researchers have highlighted the impact on drinking patterns, abuse, and dependence of acculturative stress felt by immigrants who are faced with adapting to a new society. Socioeconomic stress experienced by race–ethnic minorities because of inadequate financial resources and limited social class standing, and stress or tensions that minorities experience as a result of discrimination have also been implicated (Al-Issa, 1997). Alternatively, the growing numbers of minority youth attending college may increasingly have exposed them to the risks of heavy drinking commonly noted among college students (U.S. Department of Education, 2001). Other researchers have argued that alcohol advertising targeting Black communities has promoted heavier drinking, particularly of malt liquor, among young adults of this group (Hacker et al., 1987; Herd, 1993). Therefore, achieving an understanding of the changes in prevalence among minority young adults over time will require further research, but is an important public health priority.

What is clear is that no single environmental factor can explain the increases in alcohol abuse and dependence prevalence observed in this study among certain minority subgroups of the population. Numerous environmental factors, including social and economic factors, are all likely to serve as mediators of the observed temporal or secular rate changes. With regard to putative economic factors, there is a clear need for additional studies to ascertain how changes in alcoholic beverage prices, taxes, and availability affect the prevalence of alcohol use disorders among race–ethnic and other subgroups of the population. Historical and cultural factors that shape the life history of various race–ethnic minorities in the United States are potentially equally important in understanding the observed secular changes. Within this context, future research will need to more fully address the extraordinary heterogeneity within race–ethnic groups in the search for the explanations of why rates of alcohol abuse and dependence have increased among some minority young adults as opposed to White young adults. For example, rates of heavy drinking, abuse, and dependence differ vastly among Chinese Americans, Japanese Americans, Cambodian Americans, Korean Americans, and Filipino Americans (Price et al., 2002). Similar differentials have also been found among Mexican Americans, Cuban Americans, and Puerto Rican Americans and among some of the over 300 different tribal and language groups that define Native Americans and Alaska Natives living in the United States (Aguirre-Molina and Caetano, 1994; Beauvais, 1998). Understanding and working effectively with cultural beliefs and practices of individuals from diverse race–ethnic backgrounds will be of paramount importance in the development of successful intervention and prevention programs.

At present, research aimed at identifying independent environmental risk

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factors for alcohol abuse and dependence is hindered by a limited number of reliable and valid measures of relevant environmental conditions. Once these measures are developed, environmental risk conditions can be studied along with new evidence arising from genetic studies in order to guide the search for environmental factors that might modify specific genetic liabilities and thereby reduce the risk of alcohol use disorders. Understanding the gene–environment interaction also will rely heavily on the sharing of conceptual models and assessment methods across traditional disciplines. In the final analysis, attention to environmental factors that might modify genetic liabilities will lead to more effective prevention and control initiatives in the future. ■

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Addiction and Lawyers

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This report emphasizes the occurrence of substance abuse among Attorneys. These are high profile professional that would benefit from a smaller more private setting such as Litchfield Hills Retreat L.L.C..

Recently there has been a high profile Attorney arrested for driving while intoxicated in Connecticut. This was not his first arrest and it was a violation of his probation. He has a wife and children and his own practice.

If this Attorney needs residential substance treatment (court ordered or an independent decision) and wants to stay in Connecticut, he would need to go to a larger less personal treatment center. The current residential treatment centers in Connecticut do not specialize in treating professionals. This population has different stressors, such as higher profiles and the need for confidently due to their status in the community.

The other option for this Attorney would be to leave the state for treatment to seek out a smaller setting that specializes in treating professionals. This would separate him from his family and practice.

Litchfield Hills Retreat would be a good option for people such as the above mentioned Attorney. Professionals that live in Connecticut would benefit from treatment in Connecticut.

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Addiction and Lawyers: Substance Abuse in the Legal Profession

By Ed Jennett

The official web site of the Michigan Bar Association discusses the origins of the problem. Larry Dubin, a professor of law at the University Detroit Mercy School of Law, explains that the substance abuse of lawyers actually begins when they are in college.

According to Dubin when students attend law school they are going in order to obtain the skills they must acquire to be successful lawyers. But they
also are exposed to the lifestyles of lawyers. Once aspect that they are exposed to is substance abuse.

Dubin, who has taught Professional Responsibility for the past 30 years, explains that student's will learn that they must ignore their emotional and personal reactions, and represent positions that may be in disagreement with their own opinions and belief systems. The best interests of their client, which they have to represent, may be in opposition to the best interests of society. Dubin says that these professional pressures can adversely affect lawyer's personal lives and cause substance abuse problems.

It is pointed out by Dubin that research shows attorneys are more likely to have substance abuse problems than the average person. 1 These problems are also of greater concern to the general public than the average person's because the lawyer's addiction to drug and alcohol doesn't just affect that attorney. The addiction also negatively affects the client's of that attorney.

Research doesn't just show the substance abuse troubles of attorneys. There is also research that shows that law students increase their usage of drugs and alcohol while in law school. 2 Dubin explains that the Bar and legal educators have not shown interest in this issue and that could be part of the reason a large number of attorneys abuse alcohol and drugs. 3 Dubin adds that some lawyers are courageous enough to tell others about their problems, 4 but they sometimes do so anonymously to protect their reputations. 5 In Dubin's state of Michigan lawyers are being offered encouragement and assitance by the Lawyers and Judges Assistance Program of the State Bar of Michigan. The only other positive news in Dubin's article is that there are statistics which show more attorneys are seeking help. 6

The results are for the state of Florida. But if Florida is similar to the rest of the nation, then the legal profession throughout the country has a huge problem. Not only are the lawyers dealing with several issues that negatively impact their performance, these issues erode the public's confidence in both the legal profession and the legal system.

It is in fact quite apparent that the issue is a national one.

Florida Lawyer's Assistance, Inc. posted an article "Impairment in the Legal Profession" that is an invaluable resource for understanding these issues. Although the article was written for judges, it is useful for anyone who wants to gain a greater understanding of this complex problem.

According to the article, 10% of lawyers have some sort of problem with addiction, whether it be drugs, alcohol, gambling, sex, work, or food. This shocking number increases to an estimated 20% during their careers. Short-term or chronic symptoms of depression or stress affect 33% of legal professionals. These issues lead to a myriad of problems for the clients of the afflicted professionals. Some of the adverse effects for clients includes: missed court dates, violations of trust, poor decisions, and inadequate preparation.

The article explains that addiction can take years before it begins to negatively impact the daily life of the addict. Although there is a great deal of evidence that addictions stem from biochemical body processes, the evidence that legal professionals have higher rates of addiction is indisputable.

There are many common myths about addictions in the legal profession. The article proves all of these myths to be false. Some lawyers believe that they are just "recreational" users of drugs and/or alcohol, and that this will not harm them. This could not be further from the truth. Lung cancer and strokes and heart attacks can be caused by marijuana and cocaine respectively. Heroin can lead to mental disorders, death from respiratory collapse, infection, and AIDS if the heroin was taken by sharing needles. Barbiturate usage can also lead to death from respiratory collapse. Use of amphetamines can cause mental disorders and strokes. Alcohol abuse can lead to cancer as well as brain damage, heart disease, impaired muscular coordination and memory loss. Clearly "recreational" usage of drugs and alcohol can have negative affects.

The myth that drug use is none of the Bar's business and is strictly a personal and private matter of the attorney is incorrect. Due to the fact that drugs can still affect the user 24 hours after the drugs were taken, the attorney would still be under the influence even if they did not take the drugs while working.

A popular myth among alcoholics is that they can not be alcoholics because they show up to work every day. What they fail to realize is that the even though they are technically at work, they are not fully there mentally or physically, and because of this their performance is frequently inadequate. As the lawyer's alcoholism progresses their professional and personal life will both spiral downward.

Another erroneous myth is that alcoholics drink every day. How often someone drinks is not the determining factor of alcoholism. The determining factor is the person's ability to control their drinking once they have started. The comical belief that coffee and/or a cold shower will sober up a drunk is obviously false.

While the beliefs that overcoming depression is just a matter of time and that stress is a necessary part of the legal profession do have some merit, these are oversimplifications. Not all depression can be overcome with time. Clinical depression can only be defeated with treatment and proper medication because it is a biochemical illness. Stress is a part of the legal profession, but not every one responds to it in a healthy manner.

According to the piece there are many types of treatment ranging from inpatient detoxification, inpatient hospitalization, and outpatient and aftercare counseling. In order to be successful the treatment must deal with all aspects of the person's life, their mental, physical and emotional state, personal and family relationships, legal problems, financial status, how leisure time is spent, and of course their professional life.

While most addicts seem to believe they can stop whenever they want, and that if they ever felt they were addicted they would then seek help, both of these theories are unfortunately often incorrect. The article explains that addicts usually seek help due to an external factor. This occurs when their substance abuse causes them a legal, professional, or family problem.

Legal problems often involve driving under the influence charges, possession of controlled substances, and disturbing the peace. Since receiving treatment is deemed a better alternative than receiving punishment, addicts can be set on the right path after legal problems force them into treatment.

Professional pressure can arise when a lawyer is referred for help by their firm, a grievance committee a local judge, or their state's Bar. The possibility of losing their job or even their profession is strong motivation for attorneys to seek help with their substance abuse problems.

Family problems can begin when the lawyer's substance abuse causes friction with family members. If this friction reaches the point that the attorney is concerned about doing serious or permanent damage to their family relationships it can cause the addict to seek help.

There are numerous clear warning signs that a lawyer has developed a substance abuse problem. The first is absenteeism – repeated and/or unexplained absences or lateness. Also falling under this category would be unusual or unlikely excuses for absences or lateness. The second warning sign would be confusion or having difficulty concentrating. Examples of this would be inability or difficulty remembering details, instructions, etc. Progressively more difficult time with completing complicated tasks. Greater effort required for work than should be necessary.

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Brochure From Lawyers for Lawyers

Connecticut

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What is Lawyers Concerned for Lawyers?

Lawyers Concerned for Lawyers – Connecticut, Inc. ("LCL-CT") is a Connecticut non-profit corporation created to

- Provide assistance to Connecticut lawyers and judges who experience alcoholism, drug addiction, depression, anxiety, compulsive disorders (including gambling addiction), stress or other distress that impairs that individual's ability to function;

- Aid in the curtailment of malpractice claims and disciplinary complaints;

- Educate the legal community about the diseases of alcoholism, chemical dependency, depression and other distress that impacts the ability to practice law effectively; and

- Educate the legal community and the families of Connecticut lawyers and judges about the scope of services offered by the Connecticut lawyer assistance program.

LCL services are voluntary and available to all attorneys and judges in the State of Connecticut, whether or not the attorney or judge is a member of the Connecticut Bar Association.

All LCL services are strictly confidential and protected under C.G.S. §51-81d(a), as amended.

Contact LCL today for FREE, CONFIDENTIAL support.

HOTLINE: 1-800-497-1422

Facts About Alcoholism, Drug Abuse, Depression and Stress

Alcoholism is a treatable disease.

Alcohol is a depressant, not a stimulant. It is similar in effect to either valium, Librium or phenobarbitol.

Marijuana affects memory and concentration.

Early intervention with substance abuse problems most often leads to recovery.

Addiction may be arrested (not cured) by treatment.

More than half the car accidents in the U.S. are related to alcohol and other drug abuse.

Depression affects mood, thought, body and behavior.

Unmanaged stress can be deadly.

Attorneys can and do suffer from substance abuse problems and depression.

HOTLINE: 1-800-497-1422

If you have ever thought what a relief it would be to talk frankly with a person who is sensitive to problems like yours...

If you want support to stop using alcohol or other drugs...

If you have ever been concerned about someone else's alcohol or drug use...

Use the LCL Hotline...leave your first name and telephone number...

Expect a call back...peer support will be made available to you.

LCL-CT, Inc.
2080 Silas Deane Highway
Rocky Hill, CT 06067
860/563-4900

LAWYERS CONCERNED FOR LAWYERS – CONNECTICUT, INC.

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Crisis Intervention and Referral Services for the Connecticut Legal Community

A Non-Profit Corporation
Pursuant to IRC §501(c)(3)

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What services are offered by LCL?

- Early identification of impairment.
- Intervention and motivation of attorneys to seek help.
- Referral for assessment, evaluation and development of an appropriate treatment plan.
- Referral to appropriate mental health and community resources, self-help groups, outpatient counseling, detoxification and rehabilitation services.
- Information and referral for depression and stress.
- Informational programs on substance abuse and addiction.
- Statewide support network of attorneys in recovery.

"Every profession has its occupational hazards. Lawyers head the list when it comes to depression."

Professor William W. Eaton
Department of Mental Health
Johns Hopkins University

Practicing law is a consuming endeavor. We are required to be productive, face adversity and balance the demands of the workplace with quality personal lives. Those demands sometimes lead to depression, anger, anxiety, procrastination, family conflicts and substance abuse.

The Treatable Illness

Alcoholism or drug addiction is not a moral issue. It is a treatable illness. The stigma is not in having this illness; the stigma is in failing to seek treatment.

Medical authorities have established that addiction is a disease in which there is a preoccupation with alcohol or other drugs, coupled with a loss of control over their consumption.

Addiction may be arrested (not cured) by treatment. It is perfectly acceptable social behavior to seek treatment; it is anti-social to continue the denial.

Some symptoms of addiction are:

- The inability to guarantee one's actions after starting to drink or use drugs.
- Deteriorating health accompanying a pattern of heavy drinking or drug use, impaired ability to work and concentrate.
- Disrupted personal relationships, denial that drinking or drug use is a problem when it is obvious to others.
- Defiance, impatience, intolerance or impulsiveness associated with heavy drinking or drug use.

Addiction is a progressive disease; without treatment it only gets worse, never better.

In the makeup of the person suffering from an active addiction, there exists a condition relieved only by a drink or a drug and which, once relieved, sets up the body's demand for more.

The repetitious use of alcohol or other drugs as a medication for stress firmly establishes this progressive addiction. When the person with an addiction starts using alcohol or other drugs again after a period of "being on the wagon," the condition is as bad or worse in no time at all.

Self Diagnosis

(Answer these questions to yourself as honestly as you possibly can)

1. Are my associates, clients or others alleging that my drinking/drug use is interfering with my work?
2. Do I plan my office routine or appointments around my drinking/drug use?
3. Do I ever feel that I need a drink/drug to face certain situations?
4. Have I ever had a loss of memory when apparently functioning (e.g., a blackout) because of my drinking/drugging?
5. Do I ever drink or use drugs before a meeting or court appearance to calm my nerves, gain courage or improve my performance?
6. Have I missed or postponed closings, court appearances or other appointments because of my drinking/drugging?
7. Because of my drinking/drugging, have I ever felt any of the following: fear, remorse, guilt, real loneliness, depression, severe anxiety, terror or a feeling of impending doom?
8. Is drinking/drugging making me careless of my family's welfare or other personal responsibilities?
9. Have I ever neglected my office administration or misused funds because of my drinking/drugging?
10. Am I becoming increasingly reluctant to face my clients and colleagues in order to hide the effects of my drinking/drugging?
11. Have I ever had the shakes, the sweats or hallucinations as the result of my drinking/drugging?
12. Have I ever been hospitalized or treated by a doctor directly or indirectly as a result of my drinking/drugging?

If you have answered YES to one or more of the above questions, then you owe it to yourself, your family, your profession and your clients to contact your Connecticut lawyer assistance program.

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Substance Abuse among Physicians

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This study emphasizes substance abuse among physicians. These are professionals that have great responsibility in their career choice. Their decisions in the medical field can make the difference between life and death for some of the people they treat.

When a physician seeks help for an addiction he needs a very specialized setting to work through his/her issues. Professionals face embarrassment, and loss of credibility in their field. A small personalized treatment can be therapeutic for physicians. Being in a treatment center with people with similar occupations and social status helps in the recovery process. They are supported by their peers who are experiencing similar issues and addictions.

The need for this type of setting in Connecticut is great. We need to serve our professionals in the state where they live and work.

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About AMA

About AMA
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Report 1 of the Council on Scientific Affairs (A-95)

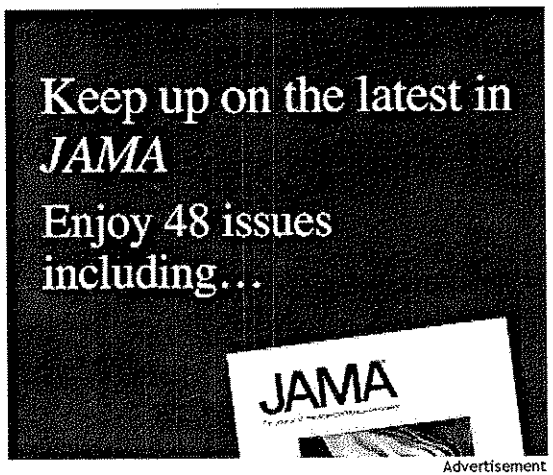
Substance abuse among physicians: Full text

Note: This report represents information and AMA policy on this subject as of June 1995.

Resolution 401, adopted, at the 1994 Annual Meeting, called for a report on substance abuse and dependency among physicians. This report addresses those and related issues and provides an update of the Council on Mental Health's 1972 report on The Sick Physician,[1] which is often credited as being responsible for the rapid spread of physician health programs sponsored by state medical societies.

Existing American Medical Association (AMA) policy clearly recognizes that physicians may develop substance abuse problems. Moreover, AMA policy is clear on the ethical responsibilities of physicians who are aware of colleagues with such problems. Policy 275.952 (AMA Policy Compendium) states "Physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues. Physicians should be familiar with the reporting requirements of their own state and comply accordingly."

While acknowledging that physicians are subject to this illness, the AMA is clearly supportive of efforts to prevent substance abuse and to treat physicians who have become impaired by substance abuse in order to facilitate their return to practice. Policy 275.964, for



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problems (e.g., Policies 295.979 and 295.987).

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More recent policies express concern over discrimination against physicians with a history of substance abuse. (See for example, Policies 180.969 and 275.949.) Board of Trustees Report 18-(I-93) examined issues of discrimination against physicians with a history of substance abuse by health care plans and developed policy in this area (Policy 285.985), and the AMA Patient Protection Act's call for third party payors to disclose selection criteria is based on this report.

Data on substance abuse among physicians

Beliefs and reports that physicians are more likely than members of other occupational groups to develop problems with alcohol and other drugs are common. This idea appeared early in the medical literature [2] and persists today, often in the absence of good or reliable data. In the 1960s, physicians were reported to be 30 to 100 times more likely than the general population to become dependent on narcotic drugs.[3] Despite the lack of evidence supporting this figure, it continues to appear, even in relatively contemporary writing. (See, for example, Domenighetti et al.[4]) In contrast to these extreme statements, there was growing recognition throughout the 1980s that the prevalence of problems with alcohol or other drugs among physicians was not really known and that more data were needed.[5,6,7] Most studies up to that time had been of small samples or clinical populations, which, while informative in many ways, do not give estimates of the prevalence of drug use or drug-related problems in the population. More recent data have been based on surveys, which though not without difficulties (eg, nonresponse bias), provide a more reliable basis for making projections.

Table: Rates of substance abuse among physcians

U.S. prevalence studies: It is routinely reported that one in ten physicians is likely to become dependent on drugs or alcohol in the course of his or her career,[8] though the data underlying this assertion are unknown. Since the mid 1980's there have been two

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major surveys of drug use among U.S. physicians. McAuliffe and colleagues[9] surveyed 500 practicing New England physicians (response rate of 70%) and found overall levels of use of drugs were comparable to the general population. While substantial minorities of physicians had used drugs recreationally or had self-treated, most such use was experimental or occasional. In the study, 3.3% of physicians reported having been drug dependent, and 1.5% had obtained professional help for drug dependence. Using multiple criteria, the McAuliffe research determined that 4.2% of physicians were ever "at risk of abusing drugs at some time."[9(p807)] In a later report on the alcohol use data from the same survey, 2% of physicians were reported to have a current drinking problem, and 3% had ever received treatment for alcohol-related problems.[10] There was no discussion of whether there was overlap between those receiving treatment for alcohol problems and those reported earlier to have been treated for drug dependence. The authors concluded that "Physicians were no more likely to abuse substances nonmedically than were other professionals," but, in discussing alcohol, "any group in which alcohol use is nearly universal incurs a risk of abuse and impairment that cannot be ignored."[10 (p177)]

More recently, Hughes and colleagues surveyed a nationwide sample of 9600 U.S. physicians, with a response rate of 59 percent.[11] They found that physicians were less likely to use tobacco and illicit substances than were members of the general population, but they were more likely to use alcohol and to self-treat with prescription medications (minor opiates such as codeine and benzodiazepine-like tranquilizers). In the Hughes et al study, 9.3 percent of physicians reported having had 5 or more drinks on at least one day in the past month, and 0.6 percent had had five or more drinks on 20 or more days in the past month. Respondents were asked whether they had "ever abused or been dependent on" alcohol or other drugs. Combining alcohol and other drugs, 7.9 percent answered this question positively. (In surveys of the general population, using data collected from diagnostic surveys rather than self reports, the lifetime risk of any substance use disorder is estimated to range from 13 percent to 26 percent.[12,13,14]) In total, 4.9 percent of the respondents had ever received treatment for problems with alcohol or other drugs.

Lutsky and colleagues surveyed 824 physicians who had been trained at the Medical College of Wisconsin, obtaining an overall

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response rate of 57.8 percent.[15]These authors defined "impairment" as meeting any one of a number of criteria such as having received treatment, answering yes to two or more CAGE (a four-item alcoholism screen; see Appendix) questions, or acknowledgement that drug use had affected professional functioning. Respondents were divided into medical specialists, surgeons, and anesthesiologists. Overall, from 14.4 percent to 19.9 percent of these groups met the definition of impairment. These authors do not report the numbers meeting the individual criteria for impairment, and the data showing drug use are reported separately for impaired and non-impaired groups. In addition, the reported drug use data are apparently for any lifetime use only.

Among other US studies, the longitudinal Johns Hopkins Precursors Study reported that, among their 1014 male physicians, the prevalence of alcohol abuse (multiply defined) on any of their follow-up questionnaires was 12.9 percent.[16] The staff of a California teaching hospital were surveyed using the SMAST (the 13-item Short Michigan Alcoholism Screening Test; see Appendix) by Siegel and Fitzgerald.[17] While 569 questionnaires were sent, a response rate of less than 50 percent was obtained, but they report that 4 percent of respondents were classified as alcoholic, and 10 percent were classified as possibly alcoholic.

Canadian studies: Brewster recently undertook a study of drug use patterns among Canadian physicians, pharmacists, and lawyers, surveying 1500 members of each profession, with corrected response rates of at least 75 percent from each.[18,19] The study found that physicians and pharmacists used tobacco and alcohol less frequently than did lawyers, but that prescription and non-prescription drugs such as codeine (available without prescription in Canada) and benzodiazepine-type tranquilizers were used more frequently by the members of the two health professions. Heavy drinking (defined as an average of more than four drinks per occasion, or more than 60 drinks per month), was reported by 6 percent of physicians, the lowest level of the three professions. Current regular (more than once per month) use of benzodiazepines was reported by 7.5 percent of physicians, 7.2 percent of pharmacists, and 3.4 percent of lawyers. The reported level of use of illicit drugs was very low. This study is unique among large-scale surveys of drug use patterns of physicians in including other professions which do and do not have access to drugs in their work.

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A major conclusion of this study was that, in estimating overall levels of drug use and drug-related problems in a population, alcohol and other drugs should be considered together because the pattern of use, and choice of specific drugs, may differ among groups. When all drugs (excluding tobacco & caffeine) were considered together in this study, the overall level of use of any drug did not differ among the three Canadian professions studied. With respect to treatment, 1.8 percent of physicians reported ever having received professional treatment for problems with alcohol or other drugs, and 2% of responding physicians had attended Alcoholics Anonymous (AA), other than as a guest or speaker. There was undoubtedly some overlap between this group and those receiving professional treatment.[18]

A recent survey of Quebec physicians (response rate of 51.3 percent from a sample of 2974) found that 2.6 percent of respondents reported having been dependent on alcohol, and 14.4 percent had used benzodiazepines without a prescription more than five times in their lives.[20] This latter behavior may not necessarily be associated with drug-related problems. Indeed, compared with a group of university-educated women, female physicians were less likely to use alcohol. In a 1983 survey of Ontario physicians, Brewster[7] found that 1.3 percent had received treatment for problems with alcohol or other drugs, a figure comparable to that in the Ontario population at that time.[21]

Other countries: In Switzerland, Domenighetti and colleagues found that Swiss physicians were more likely to use sleeping pills and tranquilizers than were the general population (sample size of 621 and a response rate of 77 percent).[4] Of physicians, 4.1 percent used these drugs at least once a week, compared to 1.1 percent of the general population. This study did not examine the pattern of use of any drugs other than these sedatives. Juntunen and colleagues surveyed 3496 Finnish physicians (response rate of 76 percent) with respect to their consumption of alcohol and calculated that 19 percent of male general practitioners and 25 percent of male specialists consumed more than 200 grams of absolute alcohol per week.[22] On the Index of Drinking Habits, a measure of alcohol-related problems, 31 percent of male general practitioners and 24 percent of male specialists achieved a score greater than or equal to six, which indicates heavy drinking. These findings represent a higher level of alcohol consumption than in the Finnish population.

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Residents and students: Limited data on students and residents are also available. The most recent work in this area is from Hughes and his colleagues[23,24] who collected self-report survey data. Among resident physicians, the use of psychoactive substances was generally lower than it was among similar age groups in the general population, although like their older colleagues, the use of benzodiazepines was greater, with self-treatment generally being cited as the reason for such use.[23] A study of former anesthesiology residents has reported lower lifetime use of marijuana and cocaine among this group than among other groups of residents, suggesting possible self-selection for drug use and specialty, but in all cases, the use of these drugs was lower among residents than among similarly aged groups in the general population.[25]

The picture among medical students is less clear. In a survey of 2046 (with a 67 percent response rate) senior students at 23 medical schools, lower rates of substance use were reported for most drugs as compared with comparable age groups in the general population.[24] However, for some drugs, namely alcohol, tranquilizers and psychedelics other than LSD, the usage rates were somewhat higher among the students. The data further indicate that, except for the use of tranquilizers, the use of which did increase after entry into medical school, patterns of drug use are generally established prior to beginning medical education. In a study of alcohol use among one class at one midwestern medical school, Clark[26] reported that alcohol use by students tended to decline over the students' careers in school but that as many as 18 percent were alcohol abusers (using research diagnostic criteria) during the first two years of medical education.

Characteristics related to the use of alcohol and other drugs

Like the issue of substance use and abuse among physicians, much has been made of supposed patterns of use within the profession. But again, the pronouncements and subjects overstate the available data. For this review, only specialty and gender are considered.

Specialty: Among physicians in treatment for problems with alcohol and other drugs, anesthesiologists, psychiatrists, and family practitioners have been reported to be over-represented.[27,28,29,30] However, the pattern of specialty representation differs widely among reports of treatment

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programs, and there are many that do not report over-representation of particular specialties. Also, because of the differences among treatment programs in their attractiveness to, or recruitment of, particular specialties, these data cannot be taken to indicate differences among specialties in the prevalence of problems with alcohol and other drugs. In their recent survey of Medical College of Wisconsin graduates, Lutsky and colleagues found no difference among anesthesiologists, medical specialists, and surgeons in the numbers who met their criteria for impairment.[15] The study of Swiss physicians found that psychiatrists were more likely to use sleeping pills and tranquilizers than were other specialists; 10.6% of their respondent psychiatrists reported daily use of sleeping pills or tranquilizers.[4] Psychiatrists were also most likely to report all types of drug use, and current self-treatment in McAuliffe's survey of drug use among New England physicians.[9] Surveys of drug use patterns among resident physicians have reported higher levels of use of some drugs in some specialties psychiatry, anesthesia, surgery, and emergency medicine.[31,32,33] However, in these studies the numbers of respondents in some individual specialties were small, so patterns across specialties cannot be reliably measured.

In the Survey of Drug Use Patterns by Canadian Professionals, the drug use patterns of anesthesiologists and psychiatrists were examined separately from those of other specialists and primary care physicians.[18] Psychiatrists were most likely to be daily smokers, frequent (more than 20 days per month) users of alcohol, and regular (more than once per month) users of benzodiazepines. Primary care physicians were least likely to be daily smokers, frequent users of alcohol and to have ever used sedative-hypnotics.

Gender: Among physicians in treatment for problems with alcohol and other drugs, women are usually under-represented relative to their numbers among practicing physicians.[34,35] This is consistent with general population data, where women are also under-represented in treatment programs.[36] In describing a group of physicians in treatment in the United Kingdom, Brooke and colleagues report that, although women are under-represented in their sample, the numbers are consistent with the numbers of women in the population experiencing problems with alcohol and other drugs.[27] These studies are subject to the same caveats as the specialty data from treatment programs discussed above and cannot be taken to indicate the prevalence of drug-related

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problems among women physicians.

None of the U.S. surveys of prevalence of drug use among physicians have reported gender comparisons. Preliminary analyses of the Canadian Survey of Drug Use among Professionals suggest that female physicians are less likely than their male colleagues to be current tobacco smokers and frequent users of alcohol (use on 20 days per month or more).[18] On the other hand, women physicians were more likely than men to be occasional (less than once per month) users of analgesics and to have used codeine in the past year. The Quebec survey reported that women were less likely to report alcohol dependence (1.2 percent) than were men (4.6 percent). [20] Women physicians were also less likely (12.1 percent) than were men (17.6 percent) to have used benzodiazepine-type tranquilizers more than five times in their lives without a prescription. Female physicians were more likely to be abstinent from alcohol, or to be regular drinkers, than were other university educated women in Quebec, who were more likely to be occasional drinkers. Juntunen and colleagues found that women physicians consumed much less alcohol than did their male colleagues.[22] With the growing numbers of women in medicine, one research priority should be study of the use of alcohol and other drugs, and other health issues, among women physicians.

Other impairments

Data on other conditions that lead to impairment among physicians are even less common than are data on substance use and abuse. While it is commonly agreed that substance abuse problems are the most common impairing condition handled by physician assistance committees, other problems do present to these programs. For example, the Medical Society of New Jersey's program widely regarded as one of the premier programs in the nation reports that about one-fifth of its cases deal with a psychiatric impairment (other than alcohol or dementia).[37] Data collected in 1986 as part of the American Medical Association's Socioeconomic Monitoring System revealed that 2.6 percent of responding physicians reported having some physical condition that limited their ability to practice. About 3 percent of the nation's population have disabilities performing daily activities.[38]

Treatment issues

On the whole, data suggest that physicians who are treated for

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abusing alcohol or other drugs do quite well, with success rates of 70 percent or more,[28,37] and some data indicate better recovery for physicians than the general population.[39] As a rule, state programs develop treatment programs with their clients, which lay out the terms of treatment and monitoring as well as indicate the consequences for failure to comply. Although inpatient treatment seems to be the preferred mode for treating chemical dependency among physicians, there is in fact no empirical evidence to suggest that impatient treatment is better than alternatives.

Anecdotally, it seems that options for physicians with impairments due to other illness or conditions are much more constrained. Calls to the AMA's Physician Health Program on these issues are not uncommon. In addition, support for recovering physicians is lacking; one state program director has noted the discrimination and lack of empathy for physicians who have been diagnosed with a mental illness (other than substance abuse), particularly for those who have suffered from bipolar disorder.

Conclusion

The surveys of patterns of drug use among physicians that have been conducted in the last decade generally indicate that, overall, physicians are not more likely than other members of the population to use alcohol and other drugs or to require treatment for problems associated with such use. While there may be some indication that physicians are more likely to use some of the prescription drugs, particularly for the purposes of self-treatment, this may be balanced by reduced overall levels of use of alcohol or some other drugs. When all drugs are considered together, physicians' overall prevalence of use is not outstanding. Also, the suggestive findings of increased levels of use of prescription drugs, and reduced levels of alcohol use, are relative to other groups. It is clear that, among physicians as well as among other members of society, alcohol is by far the most popular drug and is the drug that is most frequently associated with problems.

The finding that physicians may not be more likely than other members of the population to experience problems with alcohol and other drugs does not mean that the profession should not address this issue. All US states and Canadian provinces now have programs to help physicians who develop problems, and the profession is developing an increasing interest in the prevention of drug use and associated problems. Future research should be

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aimed at collecting information that would support the development of prevention programs. While some research has been conducted on personal risk factors, attention might be more profitably turned to research on structural risk factors: the ways that medicine and medical education are organized. Issues that might be explored are undergraduate medical education and postgraduate training, the role of the increasing numbers of women physicians, the effect of changes in the health care delivery system to more community-based and preventive models, and the resulting changes in physician practice situations. Similarly, additional information should be sought on the range of impairing conditions that affect physicians.

Recommendations

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1995 Annual AMA meeting.

1. The AMA defines physician impairment as any physical, mental, or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program.
2. The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health.
3. The AMA encourages additional research in the area of physician impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems.

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34. Glaser FB, Brewster JM, Sisson BV. Alcohol and drug problems in Ontario physicians: Characteristics of the physician sample. *Canadian Family Physician* 1986;32:993-999.
35. Martin CA, Talbott GD. Women physicians in the Georgia impaired physicians program. *J Am Med Women's Association* 1987;42:115-121.
36. Ellis K, Rush B. *Alcohol and other Drug Services in Ontario: Results of a provincial survey, 1992.* Toronto: Addiction Research Foundation, 1993.
37. Reading EG. Nine years experience with chemically dependent physicians: The New Jersey experience. *MMJ* 1992;41:325-329.
38. American Medical Association. *Guides to the Evaluation of Permanent Impairment.* (4th ed.) Chicago: American Medical Association; 1993.
39. Morse RM, Martin MA, Swenson WM, Niven RG. Prognosis of physicians treated for alcoholism and drug dependence. *JAMA* 1984;251:743-746.

Table. Rates of substance abuse among physicians

Study	Rate*	Comments
Baldwin et al[24]	3.4%	Self-identified as alcohol dependent, for cocaine, .7%; anonymous survey of senior medical students
Brewster[18]	6%	Heavy drinkers; survey of Canadian physicians

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Clark et al[26]	18%	Alcohol abusers by RDC criteria; longitudinal study of students at one midwestern medical school
de Koninck et al[20]	2.6%	Self reports of alcohol dependence; Quebec physicians
Hughes et al[11]	8%	Self identified drug dependency; US physician mail survey
Hughes et al[23]	0.2%	Self identified alcohol dependence in last year, 0.2% for marijuana, 0.1% for amphetamines; anonymous mail survey of US resident physicians
Juntunen et al[22]	24-31%	Heavy drinking; survey of Finnish physicians on alcohol use
Lutsky et al[15]	14.4-19.9%	Impairment defined broadly; survey of physicians trained at Medical College of Wisconsin
Lutsky et al[25]	15.8%	Self-admitted substance abusers; survey of use during residency training by former Medical College of Wisconsin residents
McAuliffe et al[9]	3.3%	Self-reported drug dependency, with 4.2% "at risk;" survey of 500 physicians in New England
McAuliffe et al[10]	2%	Current drinking problem; further analysis of data from reference 9
Moore et al[16]	12.9%	Prevalence of alcohol abuse multiply defined; longitudinal data from Johns Hopkins Precursors Study
Siegel and Fitzgerald[17]	4%	Alcoholic as defined by SMAST, 10% possibly alcoholic; survey of staff in California teaching hospital

*__Note:__ See comments for explanation of the rate. The figures reflect impairment, abuse, study-specific definitions and clinical

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diagnoses dealing with substance use or abuse. Studies using diagnostic surveys have estimated the lifetime risk of any substance use disorder in the general population to range from 13 to 26 percent.[12-14]

CAGE screening tool for alcoholism:

Have you ever felt you ought to **Cut** down on your drinking?

Have people **Annoyed** you by criticizing your drinking?

Have you ever felt bad or **Guilty** about your drinking?

Have you ever had a drink first thing in the morning (**Eye** opener)

to steady your nerves or get rid of a hangover?

Two or more positive answers indicate probable alcoholism. One positive answer merits further evaluation

SMAST: Short Michigan alcoholism screening test

1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.) [No=1 point]
2. Does your wife, husband, a parent or other near relative ever worry or complain about your drinking? [Yes=1 point]
3. Do you ever feel guilty about your drinking? [Yes=1]
4. Do friends or relatives think you are a normal drinker? [No=1]
5. Are you able to stop drinking when you want to? [No=1]
6. Have you ever attended a meeting of Alcoholics Anonymous? [Yes=1]
7. Has drinking ever created problems between you and your wife, husband, parent, or other near relative? [Yes=1]
8. Have you ever gotten into trouble at work because of your drinking? [Yes=1]
9. Have you ever neglected your obligations, your family, or your work for 2 or more days in a row because you were drinking? [Yes=1]
10. Have you ever gone to anyone for help about your drinking? [Yes=1]
11. Have you ever been in a hospital because of drinking? [Yes=1]
12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic

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beverages? [Yes=1]

13. Have you ever been arrested, even for a few hours, because of drunken behavior? [Yes=1]

Reports by topic

FEB 0 3 2010

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Floor Plan For Current Structure

FEB 0 3 2010

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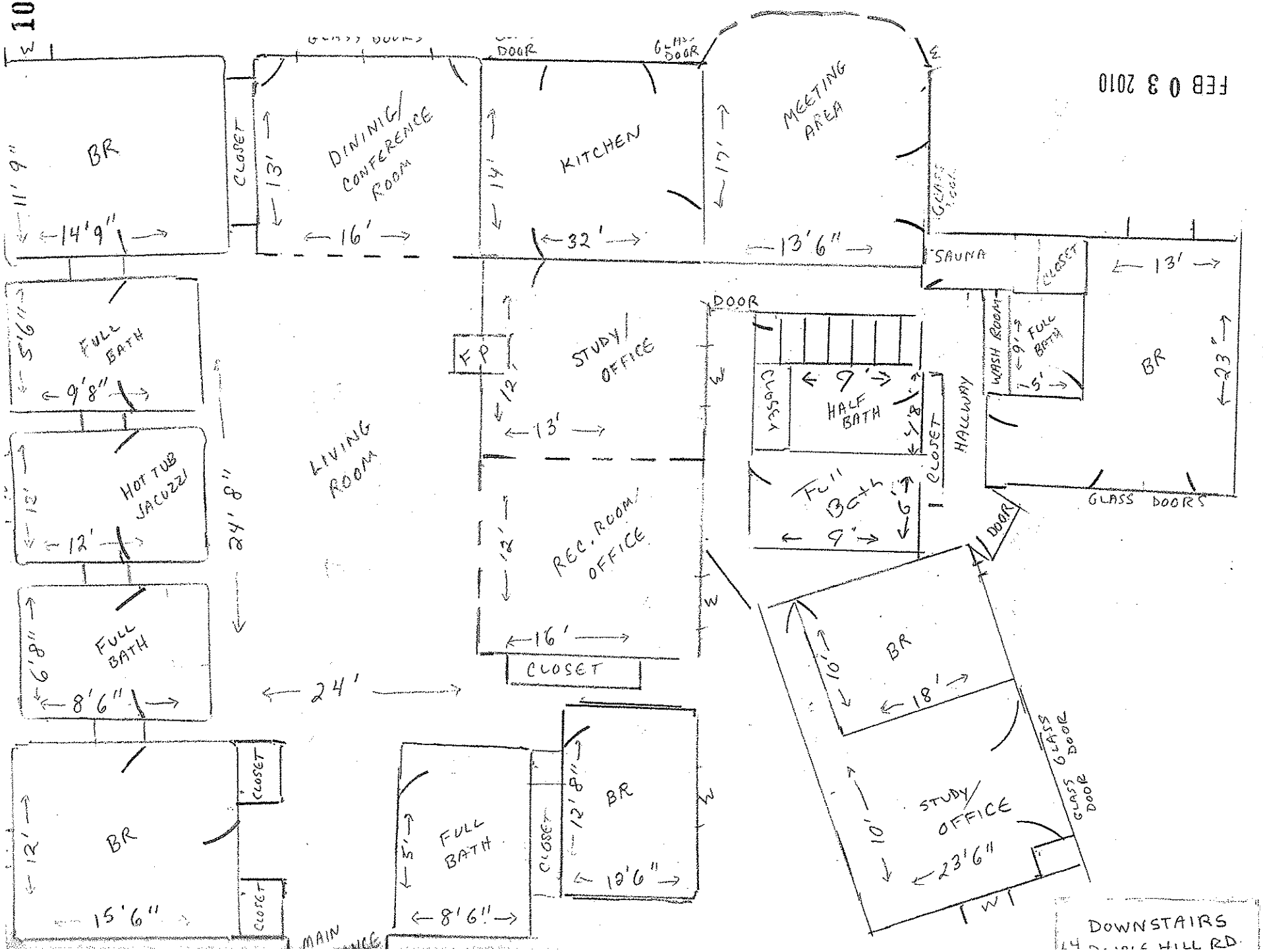
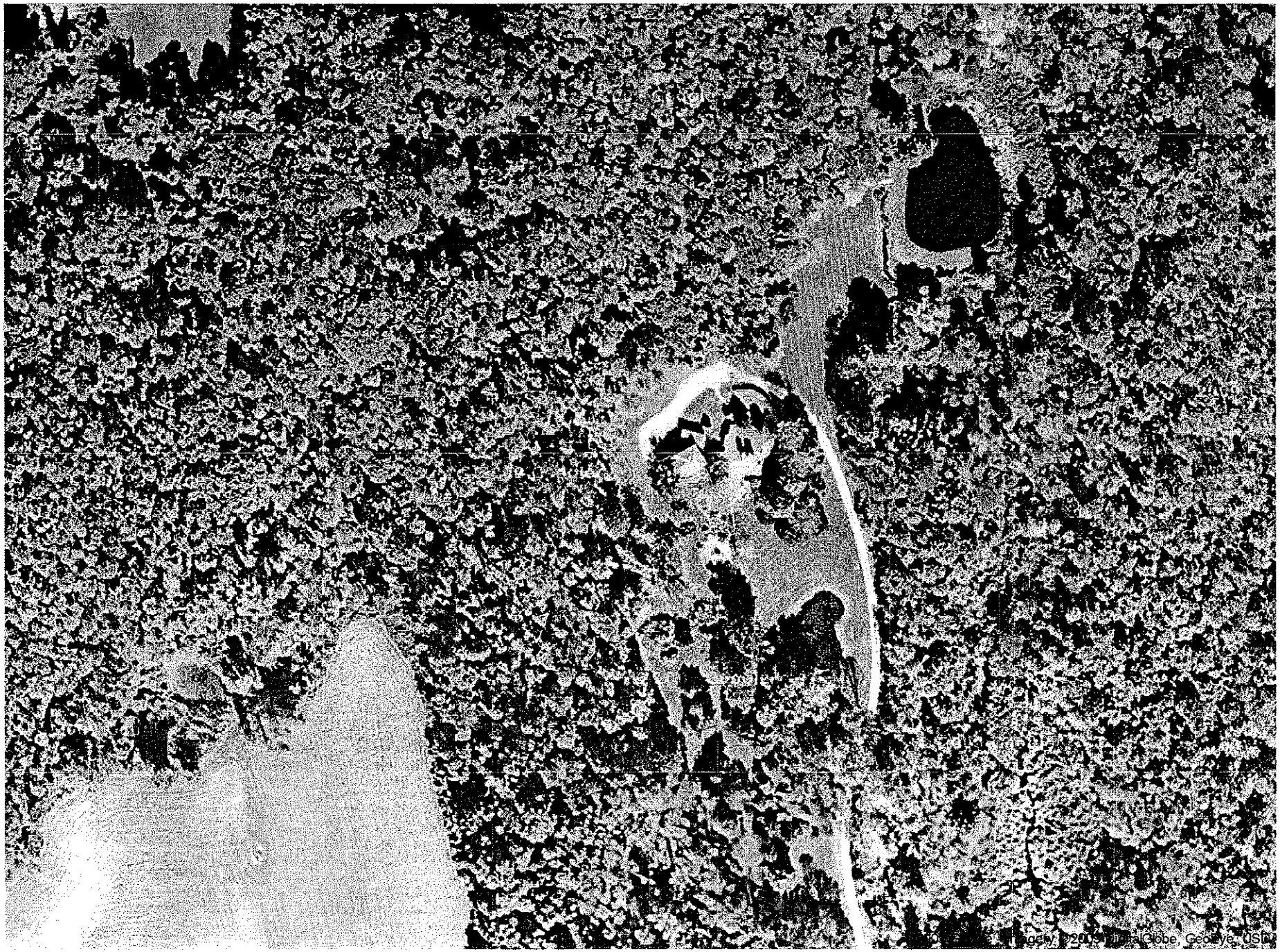
FEB 03 2010



UPSTAIRS
Double Hill Rd
Bethlehem, CT

FEB 03 2010



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FEB 0 3 2010

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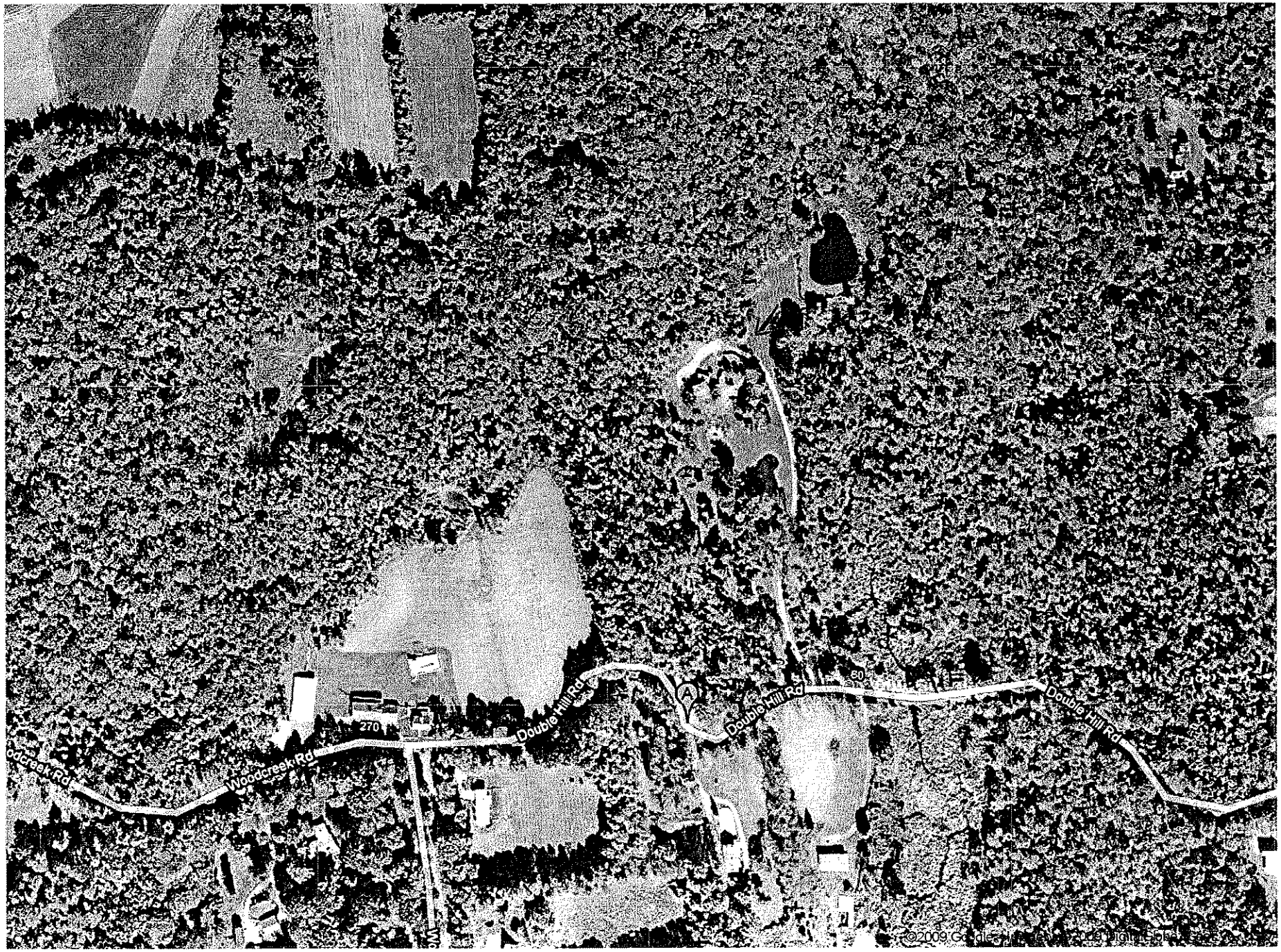

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Litchfield Hills Retreat Brochure

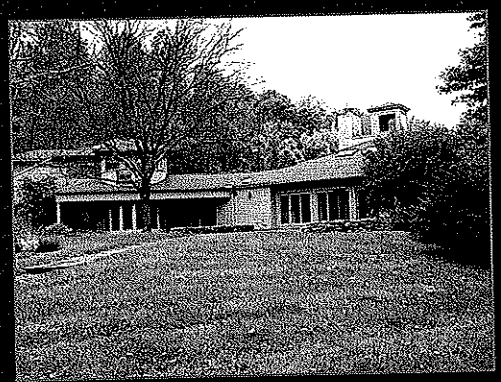
FEB 0 3 2010

Welcome...

Welcome to Litchfield Hills Retreat, a luxurious holistic center for health and healing. We recognize there are many paths to recovery, and our guests are supported in their journey to find the right path. Our compassionate, dedicated and professional staff strive to provide a gentle and unique experience in the journey of recovery.

We invite you to embark on this life changing transition with us, in a place of unparalleled comfort, peace and serenity. A place of inspiring beauty, nestled amidst 70 secluded acres in the majestic hills of Connecticut's Litchfield County. A place of hope, healing and freedom from addiction.

A place...like no other.



Mission...

Our mission is to promote the health and well-being of our guests in their journey of recovery from addiction. We do this by providing a confidential and nurturing environment which utilizes holistic practices and emphasizes personal and spiritual growth.

Through a gentle process embracing elements of compassion, trust, respect, dignity and peer support, we guide our guests in finding the right path to the life-changing journey of recovery. Our exceptional setting further enhances a sense of well being which greatly contributes to the building of a strong foundation of recovery.

Philosophy...

We believe that addiction manifests itself mentally, physically and spiritually. It is this core belief that guides our approach at Litchfield Hills Retreat. We strive to address the needs of the mind, body and spirit, so that our guests can experience a renewed sense of well being, self-awareness and hope.

The unmatched beauty of our serene New England environment, combined with a rich abundance of amenities and deeply caring staff, uniquely position us to assist our guests in finding the path to recovery. A lasting recovery which will provide the cornerstone to a fulfilling and contented life.

Guidelines...

Guidelines for acceptance:

We are pleased to welcome guests at all stages of recovery, and from any form of addiction, who are able to commit to a minimum three week stay. Please note you must be 18+ years of age, must have completed a medical detoxification for drugs and alcohol, possess a desire for recovery and sobriety, and be able to live respectfully with others in a sober, recovery oriented environment.

LITCHFIELD HILLS
RETREAT

Bethlehem, CT

For more information call:
203.266.7065

VISA MasterCard

www.litchfieldhillsretreat.com

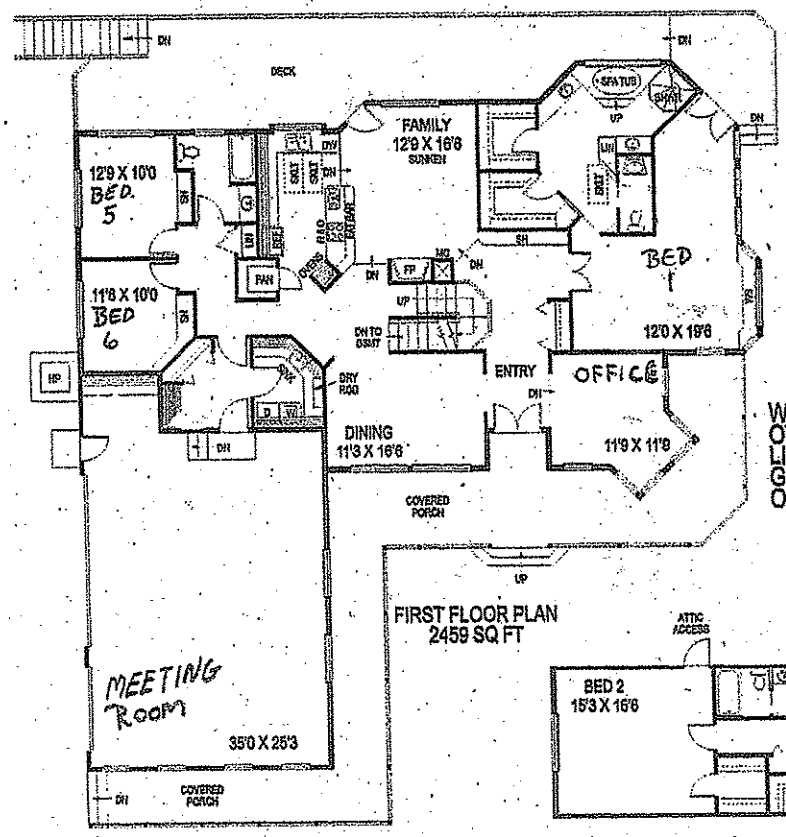
Building Plans

FEB 0 3 2010

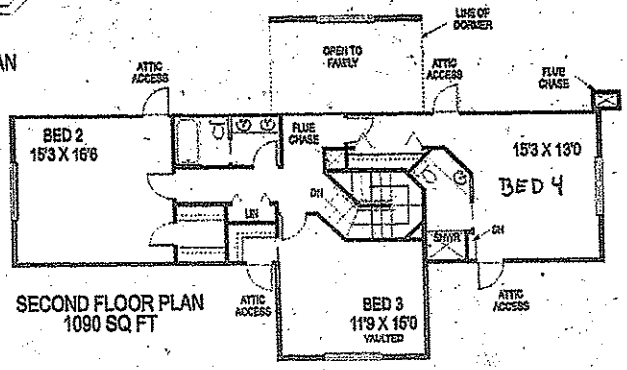
The buildings will be identical and the plans reflect that.

FEB 0 3 2010

DESIGNER HOMES



FIRST FLOOR PLAN
2459 SQ FT



SECOND FLOOR PLAN
1090 SQ FT

WELLINGS (407-61)
OVERALL DIMENSIONS: 74'-0" X 72'-0"
LIVING: 3549 square feet
GARAGE: 985 square feet
OPT. BSM'T: 1939 square feet

FEB 0 3 2010

DESIGNER HOMES
WELLINGS (407-61)
OVERALL DIMENSIONS: 74'-0" X 72'-0"
LIVING: 3549 square feet
GARAGE: 985 square feet
OPT. BSMT: 1939 square feet
FIRST FLOOR PLAN
2459 SQ FT
SECOND FLOOR PLAN
1090 SQ FT
BED 1
120 X 166
OFFICE
119 X 119
ENTRY
FAMILY
129 X 166
SUNKEN
DINING
119 X 169
COVERED PORCH
129 X 100
BED 5
118 X 100
BED 6
MEETING
ROOM
350 X 253
COVERED PORCH
BED 4
153 X 130
BED 3
119 X 160
BED 2
153 X 166
OPEN TO FAMILY
LINE OF DORMER
ATTIC ACCESS
FLUE CHASE

FEB 0 3 2010

Letters of Support

FEB 0 3 2010

Developmental Disability Counseling Services, LLC
21 Catlin Place, Shelton, CT 06484

January 24, 2010

Honorable Christine Vogel
Commissioner,
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06106-1367

To The Honorable Vogel:

There is a growing need for substance abuse treatment facilities in the state of Connecticut, specifically to treat individuals who are well-known to the public or of prominent social status. It is essential for a successful recovery process for individuals to receive treatment with the utmost privacy. In order to achieve this level of privacy, it may require that these individuals seek treatment out-of-state in a secluded facility. Due to the location of Litchfield Hills Retreat in Bethlehem, Connecticut, this facility is able to provide individuals with what is needed for a successful recovery process.

Sincerely,

Tina Scandul, MA
Licensed Professional Counselor
CT Lic# 001477

FEB 0 3 2010

Counseling Center of Waterbury
525 Wolcott St.
Waterbury, Ct. 06705
(203) 596-7870

January 21, 2010

The Honorable Cristine A. Vogel
Commissioner
Office of Health Care Access
410 Capitol Ave.
MS #13HCA
Hartford, CT 06134

Dear Commissioner Vogel,

We wanted to take this time and send you a letter in support of the proposed Litchfield Hills Retreat.

I am the director here at this outpatient counseling facility, Counseling Center of Waterbury. This agency has been serving Waterbury and the surrounding communities for over 20 years. Having heard of the Litchfield Hills Retreat, we have all been very excited about this agency because we feel that such a retreat could be very helpful in this area to both ourselves and our client base.

Throughout this agency's existence we have had many clients who have needed a more intensive program than what we can provide. Because of this, we have referred these clients to inpatient programs and various retreats around the country. The needs of clients vary and we try to select the most appropriate facility for each individual. One of the concerns that we have had is where to refer people who may have a particular social, wealth or maybe political status issue. Because of this type of concern, their public visibility becomes a real concern for them. Unfortunately, most of these clients eventually sought out facilities long distances away or maybe even out of the State of Connecticut.

This is why we are so pleased to hear about this proposed Litchfield Hills Retreat. Such a facility will provide exactly what we would be looking for. We would no longer have to refer clients so far away.

Thank you very much for your time and support.

Respectfully,

Edward Edgar, LADC

FEB 0 3 2010

Transitions
Bradley Professional Building
61 Bradley Street Suite One
Bristol, CT 06010
860-585-9906

To: The Honorable Cristine Vogel
Commissioner
Office of Health Care Access

Date: January 20, 2010

Re: Litchfield Hills Retreat
Bethlehem, CT

Dear Commissioner Vogel:

This letter is to inform you as to what I believe to be a need for a treatment center such as Litchfield Hills Retreat. As the director and a clinician at Transitions I see a diverse client population Over the years, I have seen and experienced the need for one particular segment of the population. That population happens to be in the public eye and having notoriety with financial means and/or social status that is looking for a residential treatment center that fits their needs. At this time, there are very few, if any, residential treatment programs in Connecticut that fit the requirements of this particular client. Consequently, these clients go out of state to seek treatment.

After hearing about the proposed Litchfield Hills Retreat, I hope that you would give it a favorable judgment since it is my true belief that there is a need for just such a program to service the above client in the state of Connecticut.

Thank you for your time in this matter. If I can be of further service, please feel free to contact me at the above address.

Sincerely,

Rick J. Yatsenick, M.S.

FEB 0 3 2010

KEVIN M. CURRY, CADC
660 Main St. South, Suite 5
Woodbury, CT 06798
(203) 263-3228

January 21, 2010

The Honorable Cristine A. Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134

Dear Commissioner Vogel:

This letter serves to support the opening of a Substance Abuse Facility for Professionals in Litchfield, CT. I am an addiction practitioner located in Woodbury and feel a program such as this would be beneficial when I am presented with clients who need residential programs. Currently clients who would be appropriate for this level and type of care are often referred to programs out of state that have a specialty in that area. I hope you consider approval of such a program as it would assist our efforts to effectively deal with addictive disorders among the professional community.

Thank you for your attention to this matter.

Sincerely,

Kevin M. Curry, CAC, ICADC
Certified Addictions Counselor
Ct. License #000431

FEB 0 3 2010

Neuropsychology & Brain Injury Rehabilitation Services, P.C.
P.O. Box 185088, Hamden Connecticut 06518

Eugene B. Piasetsky, Ph.D.
Clinical Neuropsychologist
CT State License # 1445
NY State License # 7636

Offices at:
2558 Whitney Avenue
Hamden, CT 06518

Phone 203-230-2199
FAX 203-230-2242
Email nbirs@comcast.net

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January 21, 2010

Honorable Cristine Vogel
Commisioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Docket Number: 09-31500-CON

Dear Commissioner Vogel:

As a healthcare provider and resource for several Connecticut State sponsored treatment programs, I have only the highest regard for State efforts in promoting recovery and return to community involvement for persons with brain injuries, substance abuse and mental health disorders. Of particular note are attempts to individualize treatment programs to meet the specialized needs of various subgroups of persons within multiple community based contexts. Notwithstanding these efforts, there remain persons who require drug and alcohol rehabilitation services but will not seek these services because of the lack of availability of programs that meet their specialized needs and/or who reside in areas of the state that are underserved. The shortfall in services is particularly acute for working professionals, business executives and persons who otherwise engage in high profile jobs and whose need of flexible programming and privacy results in their failure to seek needed treatment in existing facilities. The proposed facility in Bethlehem offers a treatment model that draws directly from residential programs in California with a proven track record in serving this target population. As such, the proposed facility offers to meet the need of a segment of the population for whom treatment options are substantially limited and is tactically well located within the Northwest region of the state. Accordingly, I urge your favorable action on the Litchfield Hills Retreat application.

Respectfully,

Eugene B. Piasetsky, PhD
Clinical neuropsychologist

FEB 0 3 2010

Buyer's closing statement

64 Double Hill Bethlehem Ct.

Proof of ownership

FEB 0 3 2010

BUYER'S CLOSING STATEMENT

BUYER(S): MICHELE ZURKO-SMITH

SELLER(S): DALE S. COENEN AND JOAN COENEN

PROPERTY: 64 DOUBLE HILL ROAD, BETHLEHEM, CT

CLOSING DATE: 05/21/07

ADJUSTMENTS

	SELLER(S)	BUYER(S)
PURCHASE PRICE:	$1,250,000.00	
DEPOSIT:		$62,500.00
REAL ESTATE TAX ADJUSTMENT:		
ANNUAL: G.L. 2005 = : $11,870.30		
05/21 - 06/30		
$32.52 X 41 DAYS	$1,333.32	
PROPANE 200 gallons @ $2.599	$ 519.80	
TOTAL CREDIT:	$1,251,853.12	$ 62,500.00
ADJUSTED PURCHASE PRICE:		**$1,189,353.12**

SUMMARY OF DISBURSEMENTS

1)	**Lender - 1st mortgage**			
	Tax Research Fee	$50.00		
	Tax Procurement Fee	$31.00		
	Flood Certification Fee	$8.00		
	Funding & Review Fee	$405.00		
	Payment Processing Fee	$200.00		
	Wire Transfer Fee	$35.00		
	Interest from 5/21 - 6/01 @$265.18/day	$2,916.98		
	4 Mos. Hazard Ins. Escrow @$205.17/mo.	$1,000.68		
	2 Mos. Tax Escrow @$989.24/mo.	$1,978.48		
	Aggregate Adjustment	($500.34)		
			$6,124.80	
2)	Broker Fees - 1st Mortgage			
	Appraisal Fee	$625.00		
	Credit Report	$55.00		
	Processing Fee	$450.00		
	Deferred Premium - $23,750.00 POCL			
			$1,130.00	
3)	**Lyons Tuccio & Tuccio, LLC**			
	Legal fee for closing - 1st mortgage		$1,500.00	
4)	**Title search and review**		$157.00	
5)	**Courier processing fee**		$30.00	
6)	**Town Clerk of Woodbury**			
	Record Warranty Deed		$55.00	
	Record 1st Mortgage Deed		$168.00	
7)	**Rundown and recording fee**		$75.00	
8)	**Title Insurance Policy**		$3,878.00	
9)	**Estimated July Tax Half**		$6,850.00	
		TOTAL DISBURSEMENTS:		$19,967.80
		TOTAL DUE FROM BUYER(S):		$1,209,320.92
		PLUS MORTGAGE PROCEEDS:		$1,000,000.00
		TOTAL DUE FROM BUYER(S):		$209,320.92

COPY

AUTHORIZATION

The undersigned does hereby authorize the expenses and disbursements as set forth on the Closing Statement. Subject to change if errors and/or omission are found to exist.

Michele Zurko-Smith , Buyer

Jeffrey W. Tuccio, Settlement Agent

FEB 0 3 2010

Employment Options, LLC
91 Willenbrock Road, Unit A-3
Oxford, CT 06478
Phone: 203-267-3810 Fax: 203-267-3813

February 11, 2010

Dear Mr. Lazarus,

As we spoke about today, I inadvertently omitted the general affidavit.

Please include it as page 124 of the Certificate of Need, docket 09-31500-CON, Litchfield Hills Retreat, LLC.

Sorry for any inconvenience this may have caused.

Please send any correspondence to my home address listed below.

Sincerely,

Michele Zurko-Smith
CEO, Litchfield Hills Retreat
12 Trefoil Road
Oxford, CT 06478
203-206-8212 (cell)

RECEIVED
2010 FEB 16 A 11:41
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

GENERAL AFFIDAVIT

RECEIVED
2010 FEB 16 A 11:41
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Applicant: Michele Zurko-Smith

Project Title: Litchfield Hills Retreat

I, Michele Zurko-Smith, CEO
(Name) (Position – CEO or CFO)

of Litchfield Hills Retreat 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

2/11/10
Date

Subscribed and sworn to before me on 2/11/10

Notary Public/Commissioner of Superior Court

My commission expires: AMY H. CRAVETZ
NOTARY PUBLIC
MY COMM. EXPIRES DEC. 31, 2014

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

February 23, 2010 VIA FAX & EMAIL ONLY

Michele Zurko-Smith
CEO & Member
Employment Options, LLC
12 Trefoil Road
Oxford, CT 06478

RE: Certificate of Need Application, Docket Number 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Establishment of a Free-Standing Substane Abuse Facility In Bethlehem, Connecticut

Dear Ms. Zurko-Smith:

On February 5, 2010, the Office of Health Care Access ("OHCA") received your initial Certificate of Need application filing on behalf of Employment Options, LLC d/b/a Litchfield Hills ("Applicant") for the establishment of free-standing adult outpatient substance abuse facility in Bethlehem, Connecticut for adults, with an associated capital expenditure of $500,000.

OHCA has reviewed the CON application 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 as outlined below:

1. Provide a narrative and an analysis of the data contained within the report from the office of National Drug Control Policy, as submitted on page 9-17 of the CON Application and explain how it demonstrates a need for this specific proposal.

2. On page 19 of the CON Application, the Applicant states that the target population is currently traveling out–of-state to receive such services or do not seek them due to privacy reasons. Please document and provide the number of individuals from the target population that sought treatment out-of-state last fiscal year?

3. On pages 21-22 the Applicant list 17 providers of similar services in the area, including Mountainside. Please discuss in detail how the Applicant's proposed facility is different from the existing providers and how it will not impact other similar providers, such as Mountainside Lodge, Inc.

4. Provide documentation on how the Applicant determined the need for a 28 bed Facility?

5. Please address the following questions regarding the projected admission's table and the mathematical calculation provided on page 23 of the CON Application:

    a. Please provide the basis for the projected admissions.
    b. Please document how the projected 30 days for the average length of stay for each client is reasonable.
    c. For the Projected Total Occupancy, the Applicant states that the projected occupancy rates estimated by applicant (see Attachment). OHCA is unable to locate the "Attachment" referenced in that statement, please submit the aforesaid Attachment and explain the basis for the projected total occupancy and how it is utilized in the mathematical calculation.
    d. The Applicants state that the "Connecticut admissions were determined by Need Methodology for Connecticut residents." Please explain the basis for the Connecticut admissions.

6. Please address the following questions regarding the articles submitted (pages 80&87) regarding addiction and lawyers and substance abuse among physicians:
    a. The number of lawyers and physicians needing the proposed service for each of the first three years of this proposal.
    b. Provide the basis of the projected numbers as stated in the response to question above.
    c. The break out of the actual number physicians and lawyers included the projected volumes calculations, as noted on page 23 of the CON Application.

7. On Financial Attachment I for the projected financial projections, it appears that the Applicant utilized only the number of patients projected from Connecticut not all the patients serviced in the respective years. Please explain the reasoning for doing so and please resubmit Financial Attachment I based on all the patients serviced at the proposed facility in each of the projected years, including out-of-state.

8. On page 48 of the CON Application, the Applicant state that the first year losses experienced by Litchfield Hills Retreat, LLC, will be covered by the parent company, Employment Options, LLC. However, the CON Application also states (as on page 52) that the proposal will be financed by Ms. Zurko-Smith. Please clarify who will be responsible for the losses that may be experienced by Litchfield Hills Retreat?

9. Please provide a copy of the audited financial statements of responsibility entity (Employment Options, LLC) or person (Ms. Zurko-Smith) for Litchfield Hills Retreat, LLC.

In responding to the questions contained in this letter, please repeat each question before providing your response. **Paginate and date** your response, i.e., each page in its entirety. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony,

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. Please reference "Docket Number: 09-31500-CON" and submit one (1) original and six (6) hard copies of your response. In addition, please submit a scanned copy of your response, in An Adobe format including all attachments on CD.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7012.

Sincerely,

Steven W. Lazarus
Associate Health Care Analyst

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

TRANSMISSION OK

TX/RX NO	1261
RECIPIENT ADDRESS	912032673813
DESTINATION ID	
ST. TIME	02/23 17:15
TIME USE	01'32
PAGES SENT	4
RESULT	OK

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

FAX SHEET

TO: Michelle Zurico-Smith

FAX: (203) 267-3813

AGENCY:

FROM: OHCA

DATE: 2/23/0 **TIME:** 4:10PM

NUMBER OF PAGES: 4
(including transmittal sheet

Comments: Completeness Letter Enclosed.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

March 1, 2010

RECEIVED
2010 MAR -2 P 12: 12
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Steven W. Lazarus
Associate Health Care Analyst
State Of Connecticut
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

RE: Certificate of Need Application, Docket Number 09-31500-CON
Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC
Establishment of a Free-Standing Substance Abuse Facility in Bethlehem, Connecticut

Dear Mr. Lazarus

Enclosed please find information and clarification in response to your letter dated February 23, 2010.

I can be reached at (203) 206-8212 for any further questions or comments.

Thank you again for all of your help.

Sincerely,

Michele Zurko-Smith
CEO & Member
Employment Options, LLC

MAR 0 1 2010

1. **Provide a narrative and an analysis of data contained within the report from the office of National Drug Control Policy, as submitted on page (9-17) of the CON Application and explain how it demonstrates a need for this specific proposal.**

This narrative demonstrates the volume of people in our state, Connecticut, that have issues with substance abuse. It shows, through the data, that (2.74%)(page 16) reported needing but not receiving treatment for illicit drug use. It demonstrates the number of people that commit crimes under the influence and end up in Connecticut correctional system(that cost tax payers money) which may have been avoided if substances were not involved (Driving under the influence etc.).The study also depicts the type of drugs that are being used and how wide spread drug use is in our state.

This demonstrates the need for this proposal because substance abuse crosses all levels of society. People with means, professionals, people in the public spot light, are not immune to this disease. Connecticut has 39.1 percent of the population working in Management, professional and related occupations (Ct. US Census 2000). Connecticut has a large population of professional people and 229,017 households that make over $100,000 a year (Ct. U.S. Census 2000) This type of setting would offer an additional option for substance abuse treatment for people in need, that is not currently offered in Connecticut.

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U.S. Census Bureau
American FactFinder

DP-3. **Profile of Selected Economic Characteristics: 2000**
Data Set: Census 2000 Summary File 3 (SF 3) - Sample Data
Geographic Area: Connecticut

NOTE: Corrected counts are available for one or more geographies displayed in this table.

NOTE: Data based on a sample except in P3, P4, H3, and H4. For information on confidentiality protection, sampling error, nonsampling error, definitions, and count corrections see http://factfinder.census.gov/home/en/datanotes/expsf3.htm.

Subject	Number	Percent
EMPLOYMENT STATUS		
Population 16 years and over	**2,652,316**	**100.0**
In labor force	1,765,319	66.6
Civilian labor force	1,757,108	66.2
Employed	1,664,440	62.8
Unemployed	92,668	3.5
Percent of civilian labor force	5.3	(X)
Armed Forces	8,211	0.3
Not in labor force	886,997	33.4
Females 16 years and over	**1,390,047**	**100.0**
In labor force	839,492	60.4
Civilian labor force	838,665	60.3
Employed	796,380	57.3
Own children under 6 years	**258,382**	**100.0**
All parents in family in labor force	159,876	61.9
COMMUTING TO WORK		
Workers 16 years and over	**1,640,823**	**100.0**
Car, truck, or van -- drove alone	1,312,700	80.0
Car, truck, or van -- carpooled	154,400	9.4
Public transportation (including taxicab)	65,827	4.0
Walked	44,348	2.7
Other means	12,130	0.7
Worked at home	51,418	3.1
Mean travel time to work (minutes)	24.4	(X)
Employed civilian population 16 years and over	**1,664,440**	**100.0**
OCCUPATION		
Management, professional, and related occupations	651,385	39.1
Service occupations	237,406	14.3
Sales and office occupations	440,288	26.5
Farming, fishing, and forestry occupations	3,446	0.2
Construction, extraction, and maintenance occupations	132,878	8.0
Production, transportation, and material moving occupations	199,037	12.0
INDUSTRY		
Agriculture, forestry, fishing and hunting, and mining	7,445	0.4
Construction	99,913	6.0
Manufacturing	246,607	14.8
Wholesale trade	53,231	3.2
Retail trade	185,633	11.2
Transportation and warehousing, and utilities	64,662	3.9
Information	55,202	3.3
Finance, insurance, real estate, and rental and leasing	163,568	9.8
Professional, scientific, management, administrative, and waste management services	168,334	10.1
Educational, health and social services	366,568	22.0
Arts, entertainment, recreation, accommodation and food services	111,424	6.7
Other services (except public administration)	74,499	4.5
Public administration	67,354	4.0
CLASS OF WORKER		
Private wage and salary workers	1,330,368	79.9

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Subject	Number	Percent
Government workers	221,412	13.3
Self-employed workers in own not incorporated business	108,945	6.5
Unpaid family workers	3,715	0.2
INCOME IN 1999		
Households	**1,302,227**	**100.0**
Less than $10,000	91,721	7.0
$10,000 to $14,999	64,895	5.0
$15,000 to $24,999	126,157	9.7
$25,000 to $34,999	130,916	10.1
$35,000 to $49,999	188,021	14.4
$50,000 to $74,999	265,470	20.4
$75,000 to $99,999	172,569	13.3
$100,000 to $149,999	152,405	11.7
$150,000 to $199,999	48,533	3.7
$200,000 or more	61,540	4.7
Median household income (dollars)	53,935	(X)
With earnings	1,057,417	81.2
Mean earnings (dollars)	74,838	(X)
With Social Security income	351,235	27.0
Mean Social Security income (dollars)	12,180	(X)
With Supplemental Security Income	43,618	3.3
Mean Supplemental Security Income (dollars)	6,708	(X)
With public assistance income	47,914	3.7
Mean public assistance income (dollars)	3,511	(X)
With retirement income	229,679	17.6
Mean retirement income (dollars)	18,121	(X)
Families	**885,747**	**100.0**
Less than $10,000	33,423	3.8
$10,000 to $14,999	23,593	2.7
$15,000 to $24,999	63,262	7.1
$25,000 to $34,999	75,413	8.5
$35,000 to $49,999	120,134	13.6
$50,000 to $74,999	198,924	22.5
$75,000 to $99,999	141,981	16.0
$100,000 to $149,999	132,177	14.9
$150,000 to $199,999	42,472	4.8
$200,000 or more	54,368	6.1
Median family income (dollars)	65,521	(X)
Per capita income (dollars)	28,766	(X)
Median earnings (dollars):		
Male full-time, year-round workers	45,787	(X)
Female full-time, year-round workers	33,318	(X)
POVERTY STATUS IN 1999 (below poverty level)		
Families	**49,983**	**(X)**
Percent below poverty level	(X)	5.6
With related children under 18 years	39,015	(X)
Percent below poverty level	(X)	8.6
With related children under 5 years	19,314	(X)
Percent below poverty level	(X)	10.9
Families with female householder, no husband present	**29,897**	**(X)**
Percent below poverty level	(X)	19.6
With related children under 18 years	26,802	(X)
Percent below poverty level	(X)	26.6
With related children under 5 years	13,097	(X)
Percent below poverty level	(X)	37.2
Individuals	**259,514**	**(X)**
Percent below poverty level	(X)	7.9
18 years and over	173,606	(X)
Percent below poverty level	(X)	7.0
65 years and over	30,818	(X)
Percent below poverty level	(X)	7.0
Related children under 18 years	82,866	(X)
Percent below poverty level	(X)	10.0
Related children 5 to 17 years		

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Subject	Number	Percent
	58,246	(X)
Percent below poverty level	(X)	9.6
Unrelated individuals 15 years and over	95,731	(X)
Percent below poverty level	(X)	16.8

(X) Not applicable.
Detailed Occupation Code List (PDF 42KB)
Detailed Industry Code List (PDF 44KB)
User note on employment status data (PDF 63KB)
Source: U.S. Census Bureau, Census 2000 Summary File 3, Matrices P30, P32, P33, P43, P46, P49, P50, P51, P52, P53, P58, P62, P63, P64, P65, P67, P71, P72, P73, P74, P76, P77, P82, P87, P90, PCT47, PCT52, and PCT53

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2. On page 19 of the CON Application, the Applicant states that the target population is currently traveling out-of-state to receive such services or do not seek them due to privacy reasons. Please document and provide the number of individuals from the target population that sought treatment out-of-state last fiscal year?

The only providers which are similar to our proposed facility in terms of level of privacy, upscale amenities, treatment modalities, and price point, are located out-of-state. Therefore, any Connecticut resident seeking this type of upscale residential treatment, including but not limited to our target population, must currently travel elsewhere to receive it. Moreover, this travel can be quite distant, involving destinations such as Arizona, Utah and California. Extended stays in distant locations such as these can pose considerable challenges and obstacles to treatment, including significant disruption to family life.

It is difficult to determine the exact number of individuals from our target population who sought treatment out-of-state last fiscal year, because to our knowledge, this information is not readily available to the public. As we have indicated however, this type of upscale treatment is only available elsewhere, so out-of-state travel is currently necessitated in order to receive it. In a telephone survey of other similar providers nationwide, including those referenced in our application [Cirque Lodge, Sierra Tucson, Passages Malibu, Cottonwood De Tucson, etc.], all stated that they routinely receive referrals from the Tri-State area [CT, NY and NJ]. The specific figures were not made available to us, however these facilities universally confirmed that they receive referrals from our region on a regular basis .We have also gotten calls from a number of out of state facilities(generated from our web site) inquiring about opening at Litchfield Hills. These calls had been made because their facility was contacted and asked if there was a similar program in the New England area. Consumers wanted that level of program but did not want to leave the area they reside in.

3. On pages 21-22 the Applicant lists 17 providers of similar services in the area, including Mountainside. Please discuss in detail how the

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Applicant's proposed facility is different from the existing providers, such as Mountainside Lodge, Inc.

Our proposed facility is markedly different from other similar providers in the area. Our location is extremely private and our building is not visible from the road. Whereas at Mountainside [the provider referenced in the question], patients receive treatment in a high visibility location directly on a major road. Another significant difference is the array of treatment methods and amenities that will be provided by our proposed facility. Massage therapy, rakki, art, music, outdoor recreational activates as well as Equine Assisted Psychotherapy [EAP] which involves the use of horses.

Another notable difference is the availability of private rooms, which we will offer. Many entering residential treatment strongly prefer a private room, however private rooms are not available at facilities such as Mountainside. Also, our price point point will be higher than other similar providers in Connecticut, thus attracting a different population and creating a unique treatment setting. The vast majority of those receiving treatment at Mountainside are under the age of 25, whereas our treatment demographic will be targeted towards a more mature age group. This will include seasoned professionals such as lawyers, physicians and CEOs, as well as high profile personalities in the sports and entertainment industries.

We view facilities like Mountainside not as competitors, but rather as prospective partners in substance abuse treatment. For example, within the last month we have been contacted by Mountainside, Silver Hill Hospital, and others, all of whom expressed an interest in referring patients to our proposed facility. The motivation for these inquiries varies, however with Mountainside, stated reason was to secure a more suitable setting for a mature patient. We have the utmost respect for facilities like Mountainside, which has an excellent and well deserved reputation. We fully expect to compliment these facilities, and to work closely with them to insure that the optimal setting is provided for those in need of treatment.

4. Provide documentation on how the Applicant determined the need for a 28 bed Facility?

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A principal factor in determining the number of beds was the capacity of other facilities providing similar treatment.
Four such providers referenced in our application are Sierra Tucson which has 139 beds, Meadows Clinic with 82 beds, Passages Malibu with 76 beds, and Circa Lodge with 60 beds. The need for this type of high end treatment is well established, as evidenced by these totals. In comparison with these other providers, however, the capacity of our proposed facility is very conservative. We want a smaller more personalized setting for this facility.

Another factor considered was the number of beds at other Connecticut facilities providing residential substance abuse treatment. Three such facilities are Silver Hill Hospital in New Canaan which has 129 beds, High Watch Recovery Center in Kent with 78 beds, and Mountainside in Canaan with 64 beds. Although our proposed facility will be different in many respects from these other Connecticut providers, they are engaged, as we will be, in the delivery of residential substance abuse treatment. These capacities demonstrate a well established need in Connecticut for residential substance abuse treatment.

These examples vividly illustrate the need for residential substance abuse treatment, and the sustainability of larger capacities. Despite overwhelming evidence which supports the need for a larger capacity, we believe it is prudent to start on a relatively small scale. By definition, a 28 bed capacity will enable us to develop and operate a treatment program that is more easily managed than one which is larger. At the same time, we believe that a capacity any smaller will risk leaving our target population under served. Providing effective treatment will always be our highest priority, and doing so in the context of a manageable size will help us to achieve this objective.

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5. Please address the following questions regarding the projected admission's table and the mathematical calculation provided on page 23 of the CON Application.

a. Please provide the bases for projected admissions.

The projected admission is conservative based on other similar programs that are offer out of state, the number of professionals in the state, and the ramp up time for advertising the program. We also took into consideration the number of inquiries generated from our web site and speaking with professionals in Ct.

b. Please document how the projected 30 days for an average length of stay for each client's is reasonable.

We have done research in this area and found that a thirty day stay is the national standard for this industry. This data was gather from other treatment centers and taken from the Office of Applied Studies Substance Abuse and Mental Health Adminisrtion,2001 Treatment Episode Data TEDS 5.31.03

C. For the projected total Occupancy, the applicant states that the projected occupancy rates estimated by application (see Attachment) OHCA is unable to locate the attachment referenced in that statement, please submit the aforesaid Attachment and explain the bases for the project total occupancy and how it is utilized in the mathematical calculation.

The attachment was put on page 55 of the original CON application. That page will now have attachment C on it and will be number 134

The bases for the project total occupancy and the calculation on the number of admission :

We came up with the mathematical calculation by taking into consideration the amount of time it will take to advertise our facility, the amount of current call volume the web site is now generating, and the interest that professionals have expressed for a need for such a facility. The national Connecticut 2005 N-SSATS Profile that states facilities capacity is running at 90%. We are conservative in our three year projection by projecting less than the ninety percent.

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Lithchfield Hills Retreat, LLC
Docket Number: 08-31500-CON

Financial Attachment I

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: Description	FY Current Actual Results	Months 1-12 Projected W/out CON	Months 1-12 Projected Incremental	Months 1-12 Projected With CON	Months 12-24 Projected W/out CON	Months 12-24 Projected Incremental	Months 12-24 Projected With CON	Months 24-36 Projected W/out CON	Months 24-36 Projected Incremental	Months 24-36 Projected With CON
Govt. Gross Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Govt. Gross Revenue	$0	$0	$6,550,000	$6,550,000		$11,492,000	$11,492,000		$14,450,000	$14,450,000
Total Gross Patient Revenue:	$0	$0	$6,550,000	$6,550,000	$0	$11,492,000	$11,492,000	$0	$14,450,000	$14,450,000
Less: Uncompensated Care	$0	$0	$100,000	$100,000	$0	$200,000	$200,000	$0	$300,000	$300,000
Total Net Patient Revenue	$0	$0	$6,450,000	$6,450,000	$0	$11,292,000	$11,292,000	$0	$14,150,000	$14,150,000
Salaries and Benefits	$0	$0	$2,587,762	$2,587,762	$0	$2,887,762	$2,887,762	$0	$3,850,000	$3,850,000
Professional Services	$0	$0	$1,250,897	$1,250,897	$0	$1,250,897	$1,250,897	$0	$1,500,000	$1,500,000
Travel and Training	$0	$0	$200,000	$200,000	$0	$200,000	$200,000	$0	$200,000	$200,000
Supplies and Drugs	$0	$0	$170,000	$170,000	$0	$60,000	$60,000	$0	$80,000	$80,000
Lease Expense cars	$0	$0	$24,000	$24,000	$0	$24,000	$24,000	$0	$24,000	$24,000
Other Operating Expense	$0	$0	$1,200,000	$1,200,000	$0	$1,200,000	$1,200,000	$0	$1,200,000	$1,200,000
Total Operating Expense	$0	$0	$5,432,659	$5,432,659	$0	$5,822,659	$5,822,659	$0	$6,854,000	$6,854,000
Gain/(Loss) from Operations			$1,017,341	$1,017,341		$5,669,341	$5,669,341		$7,296,000	$7,296,000
Number of Full Time Employees			31	31		36	36		48	48
*Volume Statistics (Admissions):			131	131		221	221		289	289

*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.

This represents Connecticut and Out of State admissions.

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Attachment C
Duplicate of
Page 041

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Duplicate of Page 055

Type of Care

	Facilities[1] No.	Facilities[1] %	Clients in Treatment on March 31, 2005: All Clients No.	All Clients %	All Clients Median No. of Clients Per Facility	Clients Under Age 18 No.	Clients Under Age 18 %
Outpatient	**161**	**75%**	**19,044**	**89%**	**51**	**672**	**80%**
Regular outpatient	130	60%	7,704	36%	37		
Intensive outpatient	76	35%	1,566	7%	13		
Day treatment/partial hospitalization	40	19%	524	2%	11		
Detoxification	31	14%	367	2%	9		
Methadone	38	18%	8,883	41%	245		
Residential	**66**	**31%**	**1,826**	**8%**	**18**	**106**	**13%**
Short term	19	9%	470	2%	18		
Long term	48	22%	1,243	6%	17		
Detoxification	8	4%	113	1%	14		
Hospital Inpatient	**17**	**8%**	**632**	**3%**	**16**	**58**	**7%**
Treatment	11	5%	249	1%	9		
Detoxification	15	7%	383	2%	10		
Total	**216**		**21,502**	**100%**	**45**	**836**	**100%**

[1] Facilities may be included in more than one category.

Opioid Treatment Programs (OTPs)

	No.	%
Facilities with OTPs		
Maintenance only	9	23%
Detoxification only	6	15%
Both maintenance and detoxification	24	62%
Total	**39**	**100%**
Clients in Facilities with OTPs	**9,340**	
Methadone	9,226	
Buprenorphine	114	

Type of Payment Accepted

	Facilities No.	Facilities %
Cash or self-payment	199	92%
Private health insurance	151	70%
Medicare	95	44%
Medicaid	161	75%
Other State-financed health insurance	139	64%
Federal military insurance	73	34%
No payment accepted	5	2%
Other type of payment	3	1%
Sliding fee scale	166	77%
Treatment at no charge for clients	136	63%

Facility Capacity and Utilization[1]

	Residential	Hospital Inpatient
No. of facilities	63	8
No. of clients	1,750	489
Designated beds	1,886	536
Utilization rate	93%	91%
Designated beds per facility (average)	30	536

[1] Excludes facilities not reporting both client counts and number of beds, facilities whose client counts were reported by another facility, facilities that included client counts from other facilities, and facilities that did not respond to this question.

Facility Licensing, Approval, Certification, or Accreditation

	Facilities No.	Facilities %
Any listed agency/organization	206	95%
State substance abuse agency	120	56%
State mental health department	88	41%
State public health department/board of health	190	88%
Hospital licensing authority	19	9%
JCAHO (Joint Commission on Accreditation of Healthcare Organizations)	87	40%
CARF (Rehabilitation Accreditation Commission)	63	29%
NCQA (National Committee for Quality Assurance)	--	--
COA (Council for Accreditation for Children and Family Services)	12	6%
Other State/Local Agency/Organization	10	5%

Facility Administrative and Funding Characteristics

	Facilities No.	Facilities %
Has agreements or contracts with managed care organizations for provision of substance abuse treatment services	164	76%
Receives Federal, State, county, or local government funds for substance abuse treatment programs	173	80%

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d. The Applicants state that the "Connecticut admissions were determined by need methodology for Connecticut residents" Please explain the basis for the Connecticut admissions.

The basis for the Connecticut admissions is that there is a large number of professionals living in Connecticut. Connecticut does not currently offer this type of small, private, high end facility that meets the needs of our professionals.

The basis that Connecticut admission would not be the only admission is based on our proximity to other states, such as New York, Massachusetts, and Rhode Island. These states are an easy drive away, and our facility will target professionals from these areas.

6. Please address the following questions regarding the articles submitted on (pages 80&87) regarding addiction and Lawyers and substance abuse among physicians.

A. The number of lawyers and physicians needing the proposed service for each of the three years of this proposal.

It is not possible to get an accurate number of admissions on these professions.

There are 19,427 active licensed Attorneys in Connecticut as stated in the Connecticut Bar Association CABA 2008 Data. There are 11,228 active licensed physicians in Ct. according to Folio, a leading provider of Physician Data to the state medical society CSMS 2010.

The report on page 82, Addiction and Lawyers Substance Abuse states that 20% of lawyers have a problem at sometime in their career.

The report on page 91 McAuliffe and Colleagues surveyed 500 practicing Physicians in New England with a response rate of 70% and found the overall levels of drug abuse were comparable to that of the general population. 3.3% of Physicians reported having been drug dependant.

These are examples of a population- Lawyers and Physicians – that could benefit from this treatment Facility. There are also professionals in the entertainment

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industry, CEO of large companies, people in public office, faculty at universities, family members of high profile people etc. The census bureau 2000, states there is 651,385 or 39.1% of state residents working in the capacity of management and in professional fields.

b. Provide the basis of projected numbers as stated in the response to question above.

Projections of accurate numbers of admission from those professions are not available. The articles were to demonstrate a need among that population and the need for a private, smaller facility for treatment because of their status in the community. The admission is not limited to Lawyers and doctors as the Census demonstrates as there are a large number of professionals in other areas of business in our state.

c. The break out of the actual number physicians and lawyers included the projection volumes calculations, as noted on page 23 of the CON application.

The only data available is that which shows there are more Lawyers in the state (19,427) than active licensed Physicians (11,228).The research showed that up to20% of lawyers had some history of abuse during their career and that Physicians were about 3.3%. Lawyers would probably have more admissions based solely on these numbers.

On the financial Attachment 1 for the projected financial projections, it appears that the Applicant utilized only the number of patients projected from Connecticut not all patients serviced in the respective years Please explain the reasoning for doing so and resubmit Financial Attachment I based on all patients serviced at the proposed facility in each projected year.

page 41 of the CON application addresses this question and shows patients serviced for all states.

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8. On page 48 of the CON Application, the Applicant states that the first year losses experienced by Litchfield Hills Retreat, L.L.C., will be covered by the parent company, Employment Options, LLC. However, the CON Application also states (as on page 52) that the proposal will be responsible for the losses that may be experience by Litchfield Hills Retreat?

I am the sole owner of Employment Options LLC and Litchfield Hills Retreat. I, Michele Zurko-Smith, will be responsible for all the cost accrued.

9. Please provide a copy of the audited financial statements of responsibility entity (Employment Options, LLC) or person (Michele Zurko-Smith) for Litchfield Hills Retreat, LLC.

I do not have an audited financial statement but when I, along with my accountant, spoke to the Associate Health Care Analyst he felt a tax return would be enough information to cover this inquiry.

Enclosed is my 2008 tax return.

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Form **1040** **U.S. Individual Income Tax Return** **2008** (99) IRS Use Only - Do not write or staple in this space.

Label (See instructions on page 14.) Use the IRS label. Otherwise, please print or type. **Presidential Election Campaign**

For the year Jan. 1-Dec. 31, 2008, or other tax year beginning , 2008, ending , 20		OMB No. 1545-0074
Your first name and initial: DONALD F.	Last name: SMITH	Your social security number: [redacted]
If a joint return, spouse's first name and initial: MICHELE L.	Last name: ZURKO-SMITH	Spouse's social security number: [redacted]
Home address (number and street). If you have a P.O. box, see page 14.: 12 TREFOIL ROAD	Apt. no.	You must enter your SSN(s) above.
City, town or post office, state, and ZIP code. If you have a foreign address, see page 14.: OXFORD, CT 06478-1661		Checking a box below will not change your tax or refund.

Check here if you, or your spouse if filing jointly, want $3 to go to this fund (see page 14) ▶ [X] You [X] Spouse

Filing Status Check only one box.

1 [ ] Single
2 [X] Married filing jointly (even if only one had income)
3 [ ] Married filing separately. Enter spouse's SSN above and full name here. ▶
4 [ ] Head of household (with qualifying person). If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 [ ] Qualifying widow(er) with dependent child (see page 16)

Exemptions

6a [X] **Yourself.** If someone can claim you as a dependent, do not check box 6a
b [X] **Spouse**

Boxes checked on 6a and 6b: 2

c **Dependents:**

(1) First name Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if qualifying child for child tax credit (see page 17)
MADISON M SMITH		DAUGHTER	X
DANIEL L SMITH		SON	X
ANDREA E SMITH		DAUGHTER	X

No. of children on 6c who:
- lived with you: 3
- did not live with you due to divorce or separation (see page 18):

Dependents on 6c not entered above:

If more than four dependents, see page 17.

Add numbers on lines above ▶: 5

d Total number of exemptions claimed: 5

Income

Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a W-2, see page 21.

Enclose, but do not attach, any payment. Also, please use Form 1040-V.

7	Wages, salaries, tips, etc. Attach Form(s) W-2	7	
8a	Taxable interest. Attach Schedule B if required	8a	4,699.
b	Tax-exempt interest. Do not include on line 8a (8b)		
9a	Ordinary dividends. Attach Schedule B if required	9a	95.
b	Qualified dividends (see page 21) (9b)		
10	Taxable refunds, credits, or offsets of state and local income taxes STMT 1 STMT 3	10	0.
11	Alimony received	11	
12	Business income or (loss). Attach Schedule C or C-EZ	12	1,643,824.
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ [ ]	13	
14	Other gains or (losses). Attach Form 4797	14	
15a	IRA distributions (15a) b Taxable amount	15b	
16a	Pensions and annuities (16a) b Taxable amount	16b	
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E	17	-1,284,615.
18	Farm income or (loss). Attach Schedule F	18	
19	Unemployment compensation	19	
20a	Social security benefits (20a) b Taxable amount (see page 26)	20b	
21	Other income. List type and amount (see page 28)	21	
22	Add the amounts in the far right column for lines 7 through 21. This is your total income ▶	22	364,003.

Adjusted Gross Income

23	Educator expenses (see page 28)	23	
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24	
25	Health savings account deduction. Attach Form 8889	25	
26	Moving expenses. Attach Form 3903	26	
27	One-half of self-employment tax. Attach Schedule SE	27	28,336.
28	Self-employed SEP, SIMPLE, and qualified plans	28	
29	Self-employed health insurance deduction (see page 29)	29	
30	Penalty on early withdrawal of savings	30	
31a	Alimony paid b Recipient's SSN ▶	31a	
32	IRA deduction (see page 30)	32	
33	Student loan interest deduction (see page 33)	33	
34	Tuition and fees deduction. Attach Form 8917	34	
35	Domestic production activities deduction. Attach Form 8903	35	
36	Add lines 23 through 31a and 32 through 35	36	28,336.
37	Subtract line 36 from line 22. This is your adjusted gross income ▶	37	335,667.

810001 11-10-08

LHA **For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see page 88.** Form 1040 (2008)

MAR 0 1 2010

09-31500-CON

140

Form 1040 (2008) DONALD F. SMITH & MICHELE L. ZURKO-SMIT

Tax and Credits

Standard Deduction for -
- People who checked any box on line 39a, 39b, or 39c or who can be claimed as a dependent.
- All others: Single or Married filing separately, $5,450; Married filing jointly or Qualifying widow(er), $10,900; Head of household, $8,000

38	Amount from line 37 (adjusted gross income)		38	335,667.
39a	Check if: ☐ You were born before January 2, 1944, ☐ Blind. ☐ Spouse was born before January 2, 1944, ☐ Blind. Total boxes checked ▶ 39a			
b	If your spouse itemizes on a separate return or you were a dual-status alien, see page 34 and check here ▶ 39b			
c	Check if standard deduction includes real estate taxes or disaster loss (see page 34) ▶ 39c			
40	Itemized deductions (from Schedule A) or your standard deduction (see left margin)		40	110,441.
41	Subtract line 40 from line 38		41	225,226.
42	If line 38 is over $119,975, or you provided housing to a Midwestern displaced individual, see page 36. Otherwise, multiply $3,500 by the total number of exemptions claimed on line 6d		42	12,950.
43	Taxable income. Subtract line 42 from line 41. If line 42 is more than line 41, enter -0-		43	212,276.
44	Tax. Check if any tax is from: a ☐ Form(s) 8814 b ☐ Form 4972		44	48,780.
45	Alternative minimum tax. Attach Form 6251		45	13,554.
46	Add lines 44 and 45 ▶		46	62,334.
47	Foreign tax credit. Attach Form 1116 if required	47		
48	Credit for child and dependent care expenses. Attach Form 2441	48		
49	Credit for the elderly or the disabled. Attach Schedule R	49		
50	Education credits. Attach Form 8863	50		
51	Retirement savings contributions credit. Attach Form 8880	51		
52	Child tax credit (see page 42). Attach Form 8901 if required	52		
53	Credits from Form: a ☐ 8396 b ☐ 8839 c ☐ 5695	53		
54	Other credits from Form: a ☐ 3800 b ☐ 8801 c ☐	54		
55	Add lines 47 through 54. These are your total credits		55	
56	Subtract line 55 from line 46. If line 55 is more than line 46, enter -0- ▶		56	62,334.

Other Taxes

57	Self-employment tax. Attach Schedule SE		57	56,672.
58	Unreported social security and Medicare tax from Form: a ☐ 4137 b ☐ 8919		58	
59	Additional tax on IRAs, other qualified retirement plans, etc. Attach Form 5329 if required		59	
60	Additional taxes: a ☐ AEIC payments b ☐ Household employment taxes. Attach Schedule H		60	
61	Add lines 56 through 60. This is your total tax ▶		61	119,006.

Payments

If you have a qualifying child, attach Schedule EIC.

62	Federal income tax withheld from Forms W-2 and 1099	62		
63	2008 estimated tax payments and amount applied from 2007 return	63	110,000.	
64a	Earned income credit (EIC)	64a		
b	Nontaxable combat pay election ▶ 64b			
65	Excess social security and tier 1 RRTA tax withheld (see page 61)	65		
66	Additional child tax credit. Attach Form 8812	66		
67	Amount paid with request for extension to file (see page 61)	67		
68	Credits from Form: a ☐ 2439 b ☐ 4136 c ☐ 8801 d ☐ 8885	68		
69	First-time homebuyer credit. Attach Form 5405	69		
70	Recovery rebate credit (see worksheet on pages 62 and 63)	70		
71	Add lines 62 through 70. These are your total payments ▶		71	110,000.

Refund

Direct deposit? See page 63 and fill in 73b, 73c, and 73d, or Form 8888.

72	If line 71 is more than line 61, subtract line 61 from line 71. This is the amount you overpaid		72	
73a	Amount of line 72 you want refunded to you. If Form 8888 is attached, check here ▶ ☐		73a	
b	Routing number ▶ c Type: ☐ Checking ☐ Savings ▶ d Account number			
74	Amount of line 72 you want applied to your 2009 estimated tax ▶	74		

Amount You Owe

75	Amount you owe. Subtract line 71 from line 61. For details on how to pay, see page 65 ▶		75	9,220.
76	Estimated tax penalty (see page 65)	76	214.	

Third Party Designee

Do you want to allow another person to discuss this return with the IRS (see page 66)? ☒ Yes. Complete the following. ☐ No

Designee's name ▶ PREPARER Phone no. ▶ Personal identification number (PIN) ▶

Sign Here

Joint return? See page 15. Keep a copy for your records.

Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Your signature	Date	Your occupation	Daytime phone number
Spouse's signature. If a joint return, both must sign.	Date	Spouse's occupation	

Paid Preparer's Use Only

Preparer's signature		Date	Check if self-employed ☐
Preparer's SSN or PTIN	P00134835		
Firm's name (or yours if self-employed), address, and ZIP code	KONOWITZ, KAHN & COMPANY P.C. P.O. BOX 190 NORTH HAVEN, CT 06473-0190	EIN	06-0886723
		Phone no.	(203)239-6888

510002 11-10-08

** INTEREST NOT INCLUDED 182.

MAR 01 2010

**** TOTAL DUE 9,402.

09-31500-COW

RECEIVED
2010 MAR 18 P 3:29
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

LOUIS B. TODISCO
203.772.7718 DIRECT TELEPHONE
860.240.5715 DIRECT FACSIMILE
LTODISCO@MURTHALAW.COM

March 18, 2010

VIA HAND DELIVERY

Cristine A. Vogel, Deputy Commissioner
Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, Inc. d/b/a Litchfield Hills Retreat, LLC
Establishment of a Free Standing Substance Abuse Facility
in Bethlehem, Connecticut
Request for Hearing Pursuant to Conn. Gen. Stat. § 19a-638(c)(3)

Dear Deputy Commissioner Vogel:

This firm represents Silver Hill Hospital.

Pursuant to Section 19a-638(c)(3) of the Connecticut General Statutes and the notice posted on the Office of Health Care Access website, I am here requesting, on behalf of Silver Hill Hospital, an entity with five or more people, that the Department of Public Health, Office of Health Care Access Division hold a public hearing with respect to the above proposal.

I am filing here an original and three copies of this request as required by the regulations.

Please provide us with notice of the scheduling of the hearing so that Silver Hill Hospital may file a timely petition to participate as a party or intervenor.

If you have any questions regarding this matter, please feel free to contact me at your earliest convenience.

Sincerely yours,

Louis B. Todisco

Louis B. Todisco

Enclosure

ROBINSON & COLE LLP

RECEIVED
2010 MAR 22 A 11:25
CONNECTICUT
HEALTH CARE ACCESS

BRIAN D. NICHOLS
280 Trumbull Street
Hartford, CT 06103-3597
Main (860) 275-8200
Fax (860) 275-8299
bnichols@rc.com
Direct (860) 275-8354

March 22, 2010

Via Hand Delivery - Return Receipt Requested
The Honorable Cristine A. Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134

RE:	Certificate of Need Application
Project:	Establishment of a Free Standing Residential Adult Substance Abuse and Behavioral Health Facility in Bethlehem, Connecticut
Docket No.:	09-31500-CON
Applicant:	Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Analyst:	Steven Lazarus

Dear Commissioner Vogel:

Pursuant to Connecticut General Statute §19a-638, this letter serves as a request, on behalf of High Watch Recovery Center, Inc. ("High Watch"), an entity comprised of more than five (5) people, that the Office of Health Care Access conduct a public hearing on Docket No. 09-31500-CON (Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC; Establishment of a Free Standing Residential Adult Substance Abuse and Behavioral Health Facility in Bethlehem, Connecticut). The proposed facility would be located in High Watch's service area and would have an adverse impact on High Watch.

Thank you for your consideration of this matter.

Very truly yours,

Brian D. Nichols

Law Offices
BOSTON
HARTFORD
NEW LONDON
STAMFORD
WHITE PLAINS
NEW YORK CITY
SARASOTA
www.rc.com

St. Vincent's Behavioral Health Services
Hall-Brooke Behavioral Health Services
1-800-LIFE-NOW
www.stvincentsbehavioralhealth.org
St. Vincent's Medical Center
Behavioral Health Service, Westport Campus
47 Long Lots Road
Westport, CT 06880
203-227-1251

RECEIVED
2010 MAR 29 P 12:08
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

March 22, 2010

Deputy Commissioner
Cristine A. Vogel
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134-0308

Dear Commissioner Vogel:

I am writing to express Hall-Brooke's concern about Certificate of Need Application 09-31500 for Litchfield Hills Retreat, LLC. As a provider of substance abuse and behavioral health services in Connecticut, we know first hand of the complexity of treating these illnesses and the current landscape of available services. Our concerns regarding the application are as follows:

- Adequate beds and services available: As listed in the CON application, there are a number of providers who currently offer the same and similar services in Connecticut.
- Confidentiality of patient: The CON application states that Litchfield Hills will provide an enhanced level of privacy and confidentiality to patients. As a behavioral health care provider for over 100 years, our organization and many others ensure complete patient confidentiality and comply with all HIPPA regulations.
- No apparent medical services available or affiliation with a medical provider: Substance abuse and co-occurring disorder side effects can be significant and severe for individuals with behavioral health issues and sometimes require medical intervention. Litchfield Hills does not appear to have a link to medical services in place.
- Need of service: As pointed out in the CON, drug abuse is devastating to the economy, individuals and their families. However the population identified in the statistics is Connecticut's most vulnerable and needy. This population is not the same as the target patients for this program who have the ability to pay privately and afford $50,000 for four weeks of treatment.

Thank you for reviewing our concerns and please do not hesitate to contact me if you have any questions.

Sincerely,

James McCreath, PhD
President/CEO
Hall-Brooke Behavioral Health Services

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF COMMISSIONER

FROM: J. Robert Galvin, M.D. M.P.H., M.B.A., Commissioner

TO: Melanie Dillon, Staff Attorney

DATE: April 7, 2010

RE: *Employment Options, Inc d/b/a Litchfield Hills Retreat, LLC*, CON # 09-31500 re Proposed Free Standing Substance Abuse Facility

---

Notwithstanding the November 10, 2009 delegation to Cristine A. Vogel to serve as the presiding officer with sole authority to render final decisions, I hereby designate Melanie Dillon serve as the hearing officer in the above-captioned matter to rule on all motions, recommend findings of fact and conclusions of law, and issue a proposed decision. Deputy Commissioner Vogel shall retain sole authority to render the final decision, as provided in the November 10, 2009 delegation.

PHONE: (860) 509-7101 FAX: (860) 509-7111
410 CAPITOL AVENUE - MS#13COM, P.O. BOX 340308, HARTFORD, CONNECTICUT 06134-0308
Affirmative Action / Equal Employment Opportunity Employer

FAX TRANSMISSION

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET
THIRD FLOOR
NEW HAVEN, CT 06511
(203) 777-5800 Fax: (203) 777-5806

RECEIVED
2010 APR 13 P 12:29
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

FAX #: (860) 418-7053
TO: Honorable Cristine Vogel
Office of Health Care Access

DATE: April 13, 2010

PAGES: 3 including this page

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Facility in Bethlehem

CONFIDENTIALITY NOTICE
Please note that the information contained in this fax is confidential and privileged and is intended only for use by the named receiver. If you have received this fax in error, please call 203-777-5800. Any use of this fax or its contents, including any dissemination or copying, is prohibited. Attorneys receiving this fax in error are directed to review ABA formal ethics opinion no. 92-368.

COMMENTS:

Dear Commissioner Vogel:

Please see the attached.

Thank you.

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

RECEIVED
2010 APR 13 P 12: 29
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

April 13, 2010
Via Facsimile (860) 418-7053
and USPS 1st Class Mail

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Facility in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find an original and six (6) copies of this firm's Notice of Appearance regarding the above referenced docket.

Should you require anything further, please feel free to contact me.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosure

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (filing Appearance) 4.13.10.doc

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING SUBSTANCE ABUSE FACILITY IN BETHLEHEM	:	**April 13, 2010**

NOTICE OF APPEARANCE

Please enter the appearance of Bershtein, Volpe & McKeon P.C. as counsel on behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC in the above-captioned proceeding.

Respectfully Submitted,

By: _____

Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

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

April 14, 2010

Michele Zurko-Smith
CEO & Member
Employment Options, LLC
12 Trefoil Road
Oxford, CT 06478

Re: Certificate of Need Application; Docket Number: 09-31500
Establishment of a Free-Standing Mental Health and Substance Abuse Treatment Facility in Bethlehem, CT
Notice of Public Hearing

Dear Ms. Zurko-Smith:

With the receipt of the completed Certificate of Need ("CON") application information submitted by Employment Options, LLC d/b/a Litchfield Hills Retreat ("Applicant") on March 2, 2010, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to Section 19a-638 of the Connecticut General Statutes ("C.G.S."), OHCA may hold a hearing whenever a health care facility or institution proposes to introduce a new or additional function or service, or terminate a service.

This hearing notice is being issued pursuant to Section 19a-638, C.G.S.

Applicant:	Employment Options, LLC d/b/a Litchfield Hills Retreat
Docket Number:	09-31500-CON
Proposal:	Establishment of a Free-Standing Mental Health and Substance Abuse Treatment Facility in Bethlehem, CT with a total capital expenditure of $500,000.

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: April 29, 2010

Time: 9:00 a.m.

Place: Office of Health Care Access, Third Floor Hearing Room,
410 Capitol Avenue, Hartford, Connecticut

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *The Republican-American* pursuant to Section 19a-643-85(c) of OHCA's Regulations.

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Wendy Furniss, Department of Public Health
Irving Moy, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

April 14, 2010

Requisition # 31018

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 **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 Steven Lazarus at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:lmg

The Republican-American **April 14, 2010**
Notice of Public Hearing, Docket Number 09-31500-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicants:	Employment Options d/b/a Litchfield Hills Retreat
Town:	Bethlehem
Docket Number:	09-31500-CON
Proposal:	Establishment of a Free-Standing Mental Health and Substance Abuse Treatment Facility in Bethlehem, CT with a total capital expenditure of $500,000
Date:	April 29, 2010
Time:	9:00 a.m.
Place:	Office of Health Care Access, Third Floor Hearing Room, 410 Capitol Avenue, Hartford, Connecticut

Any person who wishes to request status in the above listed public hearing may file a written petition no later than April 24, 2010 (5 calendar days before the date of the hearing) pursuant to Sections 19a-643-37/38/39 of OHCA's Regulation. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. The ninety-day review period for the Certificate of Need application will end on May 31, 2010.

Greer, Leslie

From: ads [ads@graystoneadv.com]
Sent: Wednesday, April 14, 2010 2:47 PM
To: Greer, Leslie
Subject: Re: Legal Ad 09-31500

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 4/14/10 2:43 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 purposes refer to requisition 31018, 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>
> Please consider the environment before printing this message

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

RECEIVED
2010 APR 15 P 12:00
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

April 13, 2010
Via Facsimile (860) 418-7053
and USPS 1st Class Mail

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Facility in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find an original and six (6) copies of this firm's Notice of Appearance regarding the above referenced docket.

Should you require anything further, please feel free to contact me.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosure

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (filing Appearance) 4.13.10.doc

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING SUBSTANCE ABUSE FACILITY IN BETHLEHEM	:	**April 13, 2010**

NOTICE OF APPEARANCE

Please enter the appearance of Bershtein, Volpe & McKeon P.C. as counsel on behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC in the above-captioned proceeding.

Respectfully Submitted,

By: _____

Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

April 20, 2010

Michele Zurko-Smith
CEO & Member
Employment Options, LLC
12 Trefoil Road
Oxford, CT 06478

Re: Certificate of Need Application; Docket Number: 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Request for Prefiled Testimony

Dear Ms. Zurko-Smith:

The Office of Health Care Access ("OHCA") will hold a public hearing on April 29, 2010, at 10:00 a.m. in OHCA's third floor hearing room, 410 Capitol Avenue, Hartford, regarding the Certificate of Need ("CON") application identified above. Pursuant to Section 19a-643-51(e) of OHCA's Regulations, OHCA hereby requires any party or other participant to prefile in written form all substantive, technical or expert testimony that it proposes to offer at the hearing. It is the responsibility of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC ("Applicant) to present their "Case in Chief" in the CON application and provide prefiled testimony prior to the hearing.

The Applicant's prefiled testimony must be submitted to OHCA no later than 4:30 p.m. on Monday, April 26, 2010. As required by the Regulation identified above, all persons responsible for providing prefiled evidence must be present at the public hearing to adopt their written testimony under oath, and such persons must be available for cross-examination for the entire duration of the hearing.

If the Applicant is unable to meet the specified time for filing the prefiled testimony, the Applicant must request a time extension in writing to the hearing officer detailing the reasons for not being able to meet the specified deadline. When submitting the prefiled testimony, please provide one original and six copies. Please number and date each page sequentially from the Applicant's document immediately preceding it.

Please contact Steven W. Lazarus at (860) 418-7012, if you have any questions concerning this request.

Sincerely,

Melanie A. Dillon
Hearing Officer

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

TRANSMISSION OK

TX/RX NO	1470
RECIPIENT ADDRESS	912032673813
DESTINATION ID	
ST. TIME	04/20 12:38
TIME USE	00'49
PAGES SENT	3
RESULT	OK

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

FAX SHEET

TO: Ms. Zurko-Smith

FAX: (203) 267-3813

AGENCY:

FROM: OHCA (Steven Lazarus)

DATE: 4/26/10 **TIME:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:
Request for Pre-file Testimony Enclosed. FAXED ONLY!
A copy is being faxed to Attorney Volpe also.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

TRANSMISSION OK

TX/RX NO	1471
RECIPIENT ADDRESS	912037775806
DESTINATION ID	
ST. TIME	04/20 12:39
TIME USE	01'00
PAGES SENT	3
RESULT	OK

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

FAX SHEET

TO: Attorney Volpe

FAX: (203) 777-5806

AGENCY:

FROM: OHCA (Steven Lazarus)

DATE: 4/20/10 **TIME:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: Request for Pre-file Testimony re: Litchfield Hills Retirement

A copy was also forwarded directly to Ms. Zurcher-Smith.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

TRANSMISSION OK

TX/RX NO	1472
RECIPIENT ADDRESS	912032673813
DESTINATION ID	
ST. TIME	04/20 13:26
TIME USE	00'49
PAGES SENT	3
RESULT	OK

✓
12:38p

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

FAX SHEET

TO: Ms. Zurko-Smith

FAX: (203) 267-3813

AGENCY:

FROM: OHCA (Steven Larams)

DATE: 4/26/10 **TIME:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:
Request for Pre-file Testimony Enclosed. FAXED ONLY!
A copy is being faxed to Attorney Volpe also.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

TRANSMISSION OK

TX/RX NO	1473
RECIPIENT ADDRESS	912037775806
DESTINATION ID	
ST. TIME	04/20 13:27
TIME USE	00'59
PAGES SENT	3
RESULT	OK

V 12:36P

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

FAX SHEET

TO: Attorney Volpe

FAX: (203) 777-5806

AGENCY:

FROM: OHCA (Steven Lazarus)

DATE: 4/20/10 **TIME:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: Request for Pre-file Testimony re: Litchfield Hills Retirement

A copy was also forwarded directly to Ms. Zurcher-Smith.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

RECEIVED
2010 APR 22 P 3:15
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

LOUIS B. TODISCO
203.772.7718 DIRECT TELEPHONE
860.240.5715 DIRECT FACSIMILE
LTODISCO@MURTHALAW.COM

April 22, 2010

VIA HAND DELIVERY

Cristine A. Vogel, Deputy Commissioner
Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, Inc. d/b/a Litchfield Hills Retreat, LLC
Establishment of a Free Standing Substance Abuse Facility
in Bethlehem, Connecticut

Dear Deputy Commissioner Vogel:

This firm represents Silver Hill Hospital.

Enclosed please find an original and six copies of the Petition of Silver Hill Hospital, Inc. to be Designated as an Intervenor with Full Rights of Participation and the Testimony of Dr. Sigurd Ackerman.

If you have any questions, please feel free to contact me.

Sincerely yours,

Louis B. Todisco

Louis B. Todisco

Enclosures

cc: Vincent M. Marino, Esq.
Cohen and Wolf, P.C.

Michele Zurko-Smith

RECEIVED
2010 APR 22 P 3:16
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS DIVISION

IN THE MATTER OF THE APPLICATION OF EMPLOYMENT OPTIONS, INC. D/B/A/ LITCHFIELD HILLS RETREAT, LLC FOR THE ESTABLISHMENT OF A FREE-STANDING MENTAL HEALTH AND SUBSTANCE ABUSE FACILITY IN BETHLEHEM, CONNECTICUT, WITH A TOTAL CAPITAL EXPENDUTRE OF $500,000

DOCKET NO. 09-31500-CON

APRIL 21, 2010

PETITION OF SILVER HILL HOSPITAL, INC. TO BE DESIGNATED AS AN INTERVENOR WITH FULL RIGHTS OF PARTICIPATION

Silver Hill Hospital, Inc. (the "Petitioner"), is a psychiatric hospital located in New Canaan, Connecticut. Petitioner requests that the Department of Public Health, Office of Health Care Access Division ("OHCA") designate Petitioner as an Intervenor in the Application of Employment Options, Inc., d/b/a Litchfield Hills Retreat, LLC, (the "Applicant") for the establishment of a freestanding mental health and substance abuse facility in Bethlehem, Connecticut. Petitioner requests that OHCA grant Petitioner full rights of participation, including, but not limited to, the right to inspect and copy documents filed with OHCA, to be copied on all pleadings, correspondence and filings submitted from this time forward, and to present evidence, argument and to cross-examine witnesses at the hearing. See Conn. Gen. Stat. § 4-177a (b); Reg. Conn. State Agencies (R.C.S.A.) § 19a-643-38.

Petitioner submits that its participation in this matter will furnish assistance to OHCA in resolving the issues in this case, add evidence and argument that would not

otherwise be available to OHCA, is in the interest of justice and will not impair the orderly conduct of this proceeding. See R.C.S.A § 19a-643-38(c).

Pursuant to Section 19a-643-38 of the Regulations of Connecticut State Agencies, the Petitioner submits the following:

1. **Petitioner's Name and Address.** The Petitioner is Silver Hill Hospital, Inc., 208 Valley Road, New Canaan, CT 06840.

2. **The Manner in Which Petitioner is Affected by this Application.**

This application, if granted, will have a serious negative effect on Petitioner. Petitioner provides substance abuse services to the population which the Applicant seeks to serve and has the capacity to serve more patients. The Applicant's proposal, if successful, will affect Petitioner by diverting patients from Petitioner's programs which can accommodate additional patients. Most significantly, the Applicant's program will divert the most profitable patients from the Petitioner. This will affect Petitioner by impairing the ability of Petitioner both to offset losses from other programs and to provide scholarships for less financially able persons which now allow such persons to receive needed substance abuse treatment.

With respect to capacity in general, Petitioner's occupancy rate for its 52 beds for residential substance abuse/dual disorder treatment was 77.7% for fiscal year 2009 and 76% for fiscal year 2010. Petitioner achieved 100% occupancy for only 23 days in fiscal year 2009 and 13 days in fiscal year 2010. Thus, Petitioner's programs are not near full capacity. Petitioner has the capacity to care for more patients and will lose revenue if patients should seek treatment at the Applicant's facility.

Moreover, the patients whom Petitioner would lose are the highest paying patients who allow Petitioner to offset losses and provide care to less wealthy patients. The Applicant's proposed program is a "private pay model." (See Application, p. 36). In the Applicant's own words, its program is "specifically tailored to high level professionals, executives, celebrities, public officials and others" who can afford to pay, on a private pay basis, $50,000 for a thirty day admission. (See Application, pp. 6, 25, 39). The Applicant seeks to serve solely private pay patients - - the highest paying patients. The Applicant asserts that this population is "vastly underserved" and that there are no comparable facilities in Connecticut serving this population. The Applicant also states that existing providers will not be affected as the Applicant's proposal "is a completely different model, price point, and will be private pay." (See Application p.19).

The Applicant's assertions that there are no comparable facilities serving this population and that existing providers will not be affected are untrue. The Petitioner does now, and has for many years, served the same population which the Applicant now seeks to serve. Silver Hill offers a self-pay, four week substance abuse treatment program which has treated many patients with high levels of public visibility including persons of wealth, celebrity status, political figures, professionals and others. However, contrary to the Applicant, Petitioner also accepts insurance, and treats less affluent persons who lack the capacity to pay of the patients sought by the Applicant.

If the Applicant's proposal is successful, the Applicant can only divert private pay patients from Petitioner's residential programs. This will adversely affect Petitioner's ability both to offset losses from the treatment of less wealthy patients and to assist such patients through the provision of scholarships. Petitioner's residential and self pay

programs help offset substantial losses from its inpatient programs. To the extent that self pay patients are diverted from these programs to the Applicant (who plans to serve only private-pay patients) Petitioner's ability to offset losses and assist patients of more moderate means to receive treatment will be impaired.

Petitioner has an interest in responding to untrue assertions in the Application, especially those which suggest that: Petitioner does not serve the population targeted by the Applicant; Connecticut residents either leave Connecticut or do not seek treatment; professionals are greatly underserved in Connecticut; Petitioner does not offer the level of privacy, amenities or treatment modalities offered by the Applicant; and other providers, in particular Petitioner, will not be adversely affected by Applicant's proposal. Petitioner's participation will ensure that OHCA will have an accurate factual basis on which to base its decision, and in particular Petitioner will demonstrate that the services offered by Petitioner are far superior to those envisioned by Applicant..

3. The Manner in Which Petitioner Proposes to Participate and Summary of the Evidence that Petitioner Proposes to Offer.

The manner is which Petitioner proposes to participate is through the testimony of its President and Medical Director, Sigurd Ackerman, M.D., and cross-examination of witnesses proffered by the Applicant, as allowed by the Presiding Officer. The Petitioner would offer testimony in several areas, all of which Petitioner believes would be helpful to OHCA in its review of this Application.

First, Petitioner would provide testimony as to the inadequacies in the Applicant's analysis of need and the failure of the Applicant to establish a "clear public need" for the services proposed by the Applicant. See Conn. Gen. Stat. § 19a-637. Petitioner would

provide testimony that it has long provided services to the population targeted by the Applicant which the Applicant claims is underserved, in particular Connecticut residents. This would include testimony that Silver Hill: has referral relationships with various major corporations which regularly refer executives and others to Silver Hill; has a relationship with Lawyers Concerned for Lawyers, Connecticut, Inc. and has otherwise provided services to the population which the Applicant claims, wrongly, is underserved. The Petitioner would provide testimony as to its capacity and demonstrated ability to serve additional patients within the group targeted by the Applicant.

Second, the Petitioner would provide testimony as to the impact on Petitioner, and persons seeking care from Petitioner, if self-pay patients are diverted from Petitioner to the Applicant's facility. Specifically, Petitioner would provide testimony as to losses suffered by its inpatient programs, the "profit" from residential programs which helps to offset these losses and its scholarship program which allows individuals of limited means to receive needed psychiatric and substance abuse treatment. This testimony would address the impact of the proposal on the consumers of substance abuse care services, i.e. patients of lesser means seeking such services, as well as the impact on Petitioner to provide such services. Only Petitioner can provide testimony as to the impact of the diversion of profitable patients on the Petitioner.

Third, Petitioner would provide testimony as to the services which it provides to persons in need of mental health and substance abuse treatment as compared to those which the Applicant intends to offer. Specifically, Petitioner would provide testimony as to the operation of its programs and the trained and licensed personnel who provide services to its patients. Petitioner will contrast its programs, which are staffed by

psychiatrists, licensed clinical social workers, nurses, drug and alcohol counselors and other trained personnel with the staff and programs proposed by the Applicant. Petitioner will provide testimony as to the greater range of services which can be provided by Petitioner. Petitioner submits that this testimony will show the superiority of Petitioner's services.

Petitioner will also testify as to the Applicant's apparent intention not to seek licensure, although its application is inconsistent on this issue.

Finally, the Petitioner will provide testimony as to its understanding that the Town of Bethlehem has enacted an ordinance which prevents the development of the property in the manner envisioned in the Application, the Applicant has sued the Town of Bethlehem in Federal Court on this issue, but that a moratorium remains in effect.

Applicant has attached to this Petition the proposed testimony of Sigurd Ackerman, M.D., its President and Medical Director.

4. Petitioner will Add Evidence and Argument that Would not Otherwise be Available to OHCA.

As discussed above, Petitioner is a long standing provider of substance abuse services to patients in need of such services. It also provides services to the precise population to which the Applicant seeks to provide services - - and has done so for many years. Petitioner is expert in the components of a substance abuse treatment program which are necessary to make such a program effective. Consequently, Petitioner is in a unique position to provide highly relevant information on treatment of persons with substance abuse problems and the relevant statutory criteria. Petitioner's

testimony will address the relevant statutory criteria of clear public need, cost effectiveness, accessibility, and effect on consumers.

The Petitioner will present this testimony through its President and Medical Director, Sigurd Ackerman, M.D. Dr. Ackerman has a lifetime of experience in training as a psychiatrist and extensive experience in this field. Dr. Ackerman will offer useful information to OHCA and be in a position to respond to questions of OHCA.

The evidence which Petitioner will offer is highly relevant and there is no entity in a better position to provide this evidence. The participation of the Petitioner in this proceeding will be of substantial assistance to OHCA in its review of this Application.

5. Petitioner Meets the Requirements for Intervenor Status.

For the foregoing reasons Petitioner requests that it be designated as an Intervenor with full rights of participation, i.e., to inspect and copy documents filed with OHCA, to be copied on all pleadings, correspondence and filings submitted from this time forward, and to present evidence, argument and to cross-examine witnesses at the hearing.

Petitioner meets the requirements for designation as an Intervenor contained in Section 4-177a(b) of the Connecticut General Statutes and Section 19a-643-38(c) of Regulations of Connecticut State Agencies. Petitioner's participation will furnish assistance to OHCA in resolving the issues in this case and add relevant evidence and argument on the issues in this case. Since granting this Application would have a substantial effect on Petitioner as set forth above, it is in the interests of justice for Petitioner to be designated as an Intervenor.

Petitioner will, of course, comply with OHCA's Rules of Practice and orders regarding its participation and Petitioner's participation will not impair the orderly conduct of these proceedings and is in the interest of justice.

Respectfully submitted,

SILVER HILL HOSPITAL, INC.

By Paul E Knag

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ltodisco@murthalaw.com
Its Attorneys

ORDER

The foregoing Petition for Intervenor Status having been considered, it is hereby Ordered that:

1. Silver Hill Hospital is designated as an Intervenor with full rights of participation, including the right to inspect and copy documents filed with OHCA, to be copied on all pleadings, correspondence and filings submitted from this time forward, and to present evidence, argument and to cross-examine witnesses at the hearing.

_____

Presiding Officer

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Petition was sent by overnight mail, this 22nd day of April, 2010, to:

Vincent M. Marino, Esq.
Cohen and Wolf, P.C.
1115 Broad Street
Bridgeport, CT 06604

and

Michele Zurko-Smith
12 Trefoil Road
Oxford, CT 06478

Paul E Knag
Paul E. Knag

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF THE APPLICATION OF EMPLOYMENT OPTIONS, INC. D/B/A/ LITCHFIELD HILLS RETREAT, LLC FOR THE ESTABLISHMENT OF A FREE-STANDING RESIDENTIAL SUBSTANCE ABUSE FACILITY IN BETHLEHEM, CONNECTICUT

DOCKET NO. 09-31500-CON

APRIL 21, 2010

Testimony of Dr. Sigurd Ackerman

I am President and Medical Director of Silver Hill Hospital. Silver Hill Hospital asks the Office of Health Care Access to deny the application for a CON submitted by Litchfield Hills Retreat for a 28 bed drug rehabilitation unit which will cater to professional, economically privileged and/or well-known patients, at a cost of $50,000 for thirty days. The proposed rehabilitation program will not accept private insurance or other third party payments.

We believe that the Applicant has not established a need for such service, and that the target population is being well served by existing providers, including Silver Hill Hospital. Moreover, the Town of Bethlehem has enacted a moratorium on development of this type of facility, and while that moratorium is being challenged in federal court by the Applicant, it remains in effect.

Second, approval of the application would have a negative effect on Silver Hill Hospital and other existing providers, compromising their ability to provide other needed services for this and other populations. Silver Hill is a non-profit hospital, and currently uses the profits from its self-pay population to create scholarships for less financially able persons, and to offset losses from insured and government pay patients. The Applicant, a for-profit entity, would service the profitable business currently serviced by Silver Hill and others but not provide other important but unprofitable services provided by Silver Hill. The Applicant should not be permitted to "skim the cream" in this way.

Thirdly, we believe that Silver Hill currently provides treatment services for the population under consideration that are far superior to those being proposed by the applicant facility.

The Applicant Has Failed to Prove a Need for the Proposed Service

The Applicant has failed to prove that additional substance treatment beds dedicated to a privileged target population are needed. To the contrary, the fact is that there is ample current capacity for such persons at Silver Hill and other facilities currently existing within the state. In bolstering their argument the applicant facility makes a series of statements that are patently false:

- On page 6 of the CON, Litchfield Hills Retreat defines the target population as "... individuals 18 and older whose high level of pubic visibility, wealth, fame and/or social status makes it difficult for them to begin successful recovery in the existing residential treatment settings."

- "Currently, Connecticut residents either leave the state, or do not seek treatment..." (page 19)

- "Professional residents (physicians, attorneys, politicians, actors, etc.) are greatly underserved in our state." (page 52)

- "The only providers which are similar to our proposed facility in terms of level of privacy, upscale amenities, treatment modalities and price point are located out-of state. Therefore, any Connecticut resident seeking this type of upscale residential treatment, including but not limited to our target population, must currently leave/travel elsewhere to receive it...It is difficult to determine the exact number of individuals from our target population who sought treatment out-of-state last fiscal year, because to our knowledge, this information is not readily available to the public. As we have indicated however, this type of upscale treatment is only available elsewhere, so out-of-state travel is currently necessitated in order to receive it." (page 130)

Silver Hill Hospital has long treated patients with high levels of public visibility, including persons of wealth, celebrity status, royalty, political figures, corporate leaders, attorneys, physicians and other professionals. Silver Hill has vast experience treating such high profile patients and has been able to meet the particular needs of this population, including the need for confidentiality. Psychiatrists and AiR (Assistance in Recovery) frequently refer these patients to Silver Hill Hospital for treatment. A copy of the letters from these entities is attached as Exhibit A.

This fact has been well recognized. For example, the website NNDB states that Silver Hill's "relative seclusion makes Silver Hill a favorite of troubled celebrities", and then goes on to provide a long list of international celebrities whom published sources have identified as having been patients at Silver Hill. http://www.nndb.com/detox/246/000043117/ Of course, Silver Hill never reveals the names of persons who obtain its services, so for every celebrity who has publicly acknowledged being treated at Silver Hill there are many who have not been so identified.

Silver Hill has referral relationships with various major corporations such as Goldman Sachs, Merrill Lynch, General Electric, IBM and many others. These entities regularly refer top executives and others to Silver Hill. Silver Hill also has a close relationship with Lawyers Concerned for Lawyers—Connecticut, Inc. This organization is established under Section 51-81d of the Connecticut General States. Its mission is to provide referrals to lawyers who suffer from depression, stress, career problems, relationship issues, financial problems, or alcohol and substance abuse. Physicians and dentists also find Silver Hill a good choice, and every year we serve several dozen physicians and dentists. Silver Hill Hospital also sponsors a weekly Caduceus AA meeting for physicians and other healthcare professionals.

I have included below a chart which shows professional admissions to Silver Hill Hospital for fiscal years 2009 and 2010.[1]

Professional Admissions		
	Inpatient	Residential
FY09	565	175
FY10	778	114
Total	1343	289

Silver Hill is very flexible in accommodating the special needs of wealthy people. For example, several years ago, a member of the royal family of a Middle Eastern country became a patient and occupied an entire house at the Silver Hill campus for almost a year, accompanied by a large personal staff.

Silver Hill Hospital currently operates 52 beds for residential substance abuse/dual disorders treatment. The cost for this self-pay program is $26,000 and private rooms are available at a rate of $49,280. The occupancy rate for our 52 beds for fiscal years 2009 and 2010 was 77.7% and 76%. We achieved 100% occupancy for only 23 days in FY09 and 13 days in FY10. Therefore, Silver Hill Hospital has the capacity to provide services for additional patients. There are also several other existing facilities which have that capacity. Like the proposed facility, Silver Hill services the entire state and receives many referrals from out of state as well.

- Therefore, we believe there is no need for the new facility proposed by the Applicant and the data submitted by the Applicant in no way proves a need for the services proposed. The Admissions to Treatment data in the National Drug Control Policy report (CON, page 16, footnotes 38 and 39) cited by the Applicant references Treatment Episode Data Sets (TEDS). In general, this data only refers to facilities which receive state alcohol and/or drug agency funds, including Federal Block Grant funds, for the provision of alcohol and/or drug treatment services. This data is not applicable to the population identified in this proposal since the proposed services will be an out-of-pocket expense and therefore the target population will come from an entirely different socio-demographic group.

- In addition, data has not been presented to demonstrate the number of individuals from the target population which sought out-of-state treatment.

[1] In determining the level of professional admissions, Silver Hill treated persons identifying themselves as being the following occupations as professionals: Healthcare: orthodontist, dentist, physician, hospital CEO; Executive: President, Administrator, Vice President; Other: attorney, investment banker, professor, chief information officer, equity trader, actress, model, comedian.

- On page 131 of the CON, the Applicant states "...within the last month we have been contacted by Silver Hill Hospital who expressed an interest in referring patients to our proposed facility." Silver Hill Hospital has not contacted the proposed facility to express an interest in making referrals.

- Finally, we have been informed by the Northwest Regional Mental Health Board that it has reviewed the proposal, and has concluded that there is no need for the proposed services to the target population as defined. It believes that the need is for more services of this type for persons in the lower economic ranks. A copy of the letter from this entity is attached as Exhibit B.

In summary, Silver Hill Hospital has a long record of servicing the Applicant's target population. So have several other existing providers. Silver Hill and other existing providers have adequate capacity to serve that population. Further, the Applicant has failed to prove otherwise.

The Proposal if Successfully Implemented Would Have a Devastating Impact on Silver Hill Hospital

The CON asserts that the proposed facility would not adversely affect existing treatment providers:

- On page 19 of the CON, it is stated that "there are no facilities in Connecticut comparable to the proposed facility" and therefore the facility "would not impact existing providers as it is a completely different model, price point and will be private pay."

- "Many entering residential treatment strongly prefer a private room, however private rooms are not available at facilities..." (page 131)

However, the proposed facility would, if successful, have a strong negative effect on Silver Hill Hospital.

Silver Hill Hospital is comparable to the proposed facility in the sense that its target populations include the target population of the proposed facility. Silver Hill Hospital is a non-profit psychiatric hospital with 79 years of experience treating patients with psychiatric and/or substance use disorders. We offer a self-pay, 4-week substance use treatment program and have treated many highly visible and/or wealthy patients with great success.

If successful, the proposed program would divert patients from Silver Hill Hospital to the new facility, and divert the profits currently used by Silver Hill to assist less wealthy patients. Our residential self-pay programs help offset the substantial losses from our inpatient treatment programs. The fees collected in our residential self-pay programs cover the loss on our inpatient services without burdening state and local funding sources as shown by the following:

  - FY09: loss for inpatient programs $ 4,315,587; residential programs excess revenue over expenses $ 2,476,914

- FY10: loss for inpatient programs $ 2,982,624; residential programs excess revenue over expenses $ 4,034,393

Ironically, compromising our ability to provide inpatient services would also adversely affect the very population addressed in the CON application since those patients typically need inpatient treatment before they are ready for a rehabilitation program.

Further, at Silver Hill patients with limited resources who cannot afford the $26,000 cost of the rehabilitation program are considered for scholarship assistance. Silver Hill Hospital provides $1,000,000 annually in scholarship assistance for patients being admitted to our residential programs. In the last fiscal year, Silver Hill Hospital provided scholarships ranging from 25% to 100% of the program fees for 40 patients. Without scholarship assistance, these patients would not have received the psychiatric or substance use treatment they needed. And all of this scholarship funding comes from profits generated in our self-pay rehabilitation programs.

Thus, our ability to continue to operate our inpatient services and our ability to provide scholarship assistance will be severely affected by this proposal.

Silver Hill Hospital is the last free standing private psychiatric hospital left in this state. It has been able to survive and prosper based on its quality and ability to attract self-pay as well as insured patients. The Applicant's cream skimming proposal should not be allowed to disrupt this, and therefore the proposal should be denied.

Services Provided by Silver Hill are Far Superior to those to be Provided in the Proposed Facility

Silver Hill Hospital is licensed as a psychiatric hospital. It has 24/7 coverage by psychiatrists, and a wealth of other talent—including social workers, nurses, dieticians, drug counselors, a chaplain and various other personnel. It has the ability to deal with detox and a variety of physical and psychiatric issues which often accompany drug or alcohol dependence.

Approximately sixty percent of patients requiring rehabilitation for substance or alcohol use have an additional psychiatric disorder. Treating both disorders simultaneously reduces the risk of relapse for each disorder. The proposed program requires patients to be drug free and psychiatrically stable because the only professional staff it intends to employ initially is a licensed drug and alcohol counselor. It does not plan to have psychiatric, nursing, social work or psychology staff such as is found at Silver Hill Hospital or other similar facilities. If patients need to be started on psychiatric medications, or maintained on them, they will not have access to a psychiatrist 24 hours a day, 7 days per week.

I think it would be useful to discuss briefly our residential programs. Patients admitted to Silver Hill Hospital's residential programs are part of a supportive community of peers that participate in highly structured 12-14 hour days of therapeutic programs and activities. Typical days begin with a community meeting and self-reflection or journaling time. In the afternoon, psychoeducational, skills building and process groups led by licensed clinical social workers provide patients insight on how to manage emotions, education about their illness and/or

recovery process, and help to identify ways to manage sobriety and/or the symptoms of a psychiatric illness.

Patients meet with their psychiatrist at least weekly and more often when needed. Patients also have individual meetings with their licensed clinical social worker to review treatment planning issues, for family meetings, and to discuss discharge plans. The treatment team also includes residential counselors, a full-time nurse, and a recreation therapist who helps patients identify more constructive uses of leisure time, leading to a healthier lifestyle. Patients also have access to the Wellness Program, which offers a holistic approach to recovery. When combined with medical treatment, complementary and alternative therapies help alleviate symptoms such as stress, anxiety, pain and cravings. Wellness Program services include Acupuncture, Reiki, Massage, Jin Shin Acupressure, Yoga and Pilates.

The proposed program would hire only a drug counselor and a tech. Apparently, it would not employ any of the other classes of professionals which are found at Silver Hill.

Without the additional staff which Silver Hill utilizes, it will be impossible for the Applicant to begin to replicate the program that Silver Hill conducts for substance abuse and dual diagnostic patients. Copies of the daily treatment schedule used by Silver Hill for its chemical dependency and dual diagnosis programs are attached as Exhibit C.

It does not appear that the Applicant can meet the accreditation requirements of the Commission on Accreditation of Rehabilitation Facilities (CARF). The accreditation requirements include a team approach to treatment. Based on the information included in the Certificate of Need application, the Applicant will not have a team approach.

It also appears that the Applicant inappropriately does not intend to seek licensure (CON, p.33) although the application is inconsistent on this point (CON, p.25). Any facility of this type should be licensed as a psychiatric hospital or a Private Freestanding Facility for the Care or Treatment of Substance Abusive or Dependent Persons pursuant to Regs. Conn. State Agencies 19a-495-570. Our attorneys reviewed this application informally with DPH staff, and were advised that licensure will be required.

It is worthwhile to take a moment to address our workforce. Silver Hill Hospital employs a total of 273 employees and 15% have worked at Silver Hill Hospital for ten or more years. Our experienced clinical staff includes 11 full-time physicians, social workers, nurses, residential counselors, psychiatric technicians, quality improvement and laboratory staff as well as a recreation therapist, art therapist, horticultural therapist and several wellness practitioners. The point is that Silver Hill has experienced and well-trained clinical staff to provide services to its patients.

There is also a big difference in the proposed leadership. I, as President and Medical Director of Silver Hill, have a lifetime of experience and training as a psychiatrist, with extensive work in the field, and serving as a CEO of a major New York City hospital. My resume is attached as Exhibit D. The CEO of the Applicant, however, appears to have no training or experience in the

field of psychiatry or drug treatment, much less in providing leadership to an organization of the type proposed.

Ignoring these obvious benefits to patients, the Applicant suggests that there is nothing in Connecticut like what it will offer.

- "The only providers which are similar to our proposed facility in terms of level of privacy, upscale amenities, treatment modalities and price point are located out-of state." (page 130)

- "In addition to the conventional twelve step education piece, it will offer amenities that other facilities do not (i.e. equine assisted therapy, spiritual enhancement, yoga, massage therapy, relapse prevention programs, etc.) (page 19)

Silver Hill Hospital replicates these aspects in addition to having far superior depth and treatment capability. Located on 45 acres in New Canaan, Silver Hill Hospital strictly maintains the confidentiality of all patients we treat. Often, patients choose to use a pseudonym to further ensure confidentiality. Silver Hill's "seclusion" is therefore frequently cited as one of its attractions, as the above cited quote from NNDB illustrates.

Silver Hill's treatment programs include a twelve-step model and relapse prevention. In addition, Silver Hill provides amenities such as Acupuncture, Reiki, Massage, Yoga and Pilates. Private yoga classes are also available. These services are an adjunct to the Twelve-Step programming and not the primary treatment provided to patients.

The Town of Bethlehem has a Moratorium in Effect which Prevents the Development of the Facility

Further, although the Applicant does not disclose this fact, the Town of Bethlehem, where the Applicant's property is located, has an enacted an ordinance which prevents the development of the property in the manner envisioned in the CON. The Applicant has responded to this by suing the Town of Bethlehem and its officials in federal court. This suit has recently been commenced, and remains pending. Meanwhile, the moratorium remains in effect. Exhibit E is the complaint and answer as filed in federal court. Further, we are advised that the Town of Bethlehem is holding a special town meeting on April 29 to consider an ordinance, which, if enacted, would require the Applicant to obtain a special permit to pursue her proposed use.

OHCA should further note that the Applicant represented to the United States District Court that the Applicant spent a "year and a half preparing the Property for the opening of the Rehabilitation Center" and that "The Rehabilitation Center was ready to open in April 2009." (Complaint, par.4) Of course, what this completely ignores is that the Applicant did not even apply for a CON until 2010. Moreover, although the Applicant detailed proposed construction in its CON, Applicant is telling the United States District Court that Applicant is not proposing new construction. (Complaint, par. 65)

The application should be denied.

Sigurd Ackerman, President

Subscribed and sworn to, before me, this 21ST day of April, 2010.

Notary Public
Commissioner of the Superior Court

My Commission Expires: 3/31/2012

ASSISTANCE IN RECOVERY
Improving lives together

April 16, 2010

Sigurd Ackerman, MD
President
Silver Hill Hospital
208 Valley Road
New Canaan, CT 06840

Dear Dr. Ackerman,

We provide intervention and recovery assistance services for many prominent people from the professional, business and arts communities. As you are very aware, their demands are often unusual and their expectations are high. It is therefore reassuring to know that Assistance In Recovery can confidently refer patients to Silver Hill Hospital whenever they need psychiatric or substance abuse treatment, including rehabilitation services.

I look forward to our continuing relationship.

Sincerely,

Andrew Wainwright
President/CEO
Assistance In Recovery

Joanne Intrator, M.D.
610 Park Avenue
New York, New York 10065
212.737.6231

Diplomate American Board of Psychiatry and Neurology

April 15, 2010

Sigurd Ackerman, MD

PresidentSilver Hill Hospital

208 Valley Road

New Canaan, CT 06840

Dear Dr. Ackerman,

My psychiatric practice includes many prominent professional people, business executives and people in the performing arts. Not surprisingly their demands are often unusual and their expectations are high. It is reassuring to know that I can confidently refer patients to Silver Hill Hospital whenever they need psychiatric or substance abuse treatment, including rehabilitation services.

I look forward to our continuing relationship.

Sincerely,

Joanne Intrator

Joanne Intrator, M.D.

NORTHWEST
REGIONAL MENTAL HEALTH BOARD, INC.

Central Naugatuck Valley Catchment Area Council #20
Housatonic Mental Health Catchment Area Council #21
Northwest Mental Health Catchment Area Council #22

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TEL./FAX (203) 757-9603
nwrmhb@snet.net website: www.nwrmhb.org

April 20, 2010

Sigurd Ackerman, M.D., President and Medical Director
Silver Hills Hospital
208 Valley Road
New Canaan, CT 06840

Brian Nichols, on behalf of
High Watch Recovery Center, Inc.
Kent, CT

Dear Dr. Ackerman and Mr. Nichols,

On April 1, 2010, the Northwest Regional Mental Health Board, Inc. took under consideration your request that we send a letter to the Office of Health Care Access regarding the Certificate of Need application by Employment Options LLC to develop "Litchfield Hills Retreat", a for-profit 28-bed substance abuse residential treatment facility in Bethlehem, CT.

The request resulted in serious discussion. The following considerations were noted:

- This board's mission (see below) and legislative mandate refer to evaluation, needs assessment and planning for mental health and substance abuse services. Our focus is, however, more generally on the needs of persons who are poor and often on entitlements, and with serious and prolonged mental illness and/or serious substance abuse issues. Neither Silver Hills nor High Watch take SAGA or Title XIX patients, and it is for that population where there is still unmet need for such services as are proposed under this application. Additional resources for this population would be welcomed.
- **Regarding the need or lack thereof for such a facility as proposed, for the population that could/would use these services** (i.e. with the ability to pay privately or with private insurance resources) at this time there are several private, nonprofits which do the exact same work and according to the information available, **there appears to be adequate or even excess capacity in this region** (Region 5, serving the 43 towns of northwest Connecticut).

Sincerely,

Janine Sullivan-Wiley
Executive Director, Northwest Regional Mental Health Board

"The Northwest Regional Mental Health Board is dedicated to improving the quality of life for people in their recovery from mental illness and addiction. The Board advises, advocates, plans, educates, and assesses needs and programs which promote enhanced services."

DAY AT A TIME

Silver Hill Hospital
Chemical Dependency Program

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	
8:30 – 9:30 Breakfast	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	8:30 – 9:30 Breakfast
	9:30 – 10: Meditation @ House	9:30 – 10:00 Mediation @ House	9:45 – 10:30 Creative Spirituality	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:30 – 12:00 Patient Workshop
10:00 Meditation @ House	10:00 – 11:30 Gym/Journaling	10:00 – 11:30 Gym/Journaling 10:30-11:15 Smoking Cessation @ JB	10:30 – 11:30 Gym/Journaling	10:00 – 11:30 Gym/Journaling	10:00 – 11:30 Gym/Journaling	@ JB1
11:00 – 11:45 Topic Group @ House	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	12:00 Check-in @ House
12:00 – 1:00 Lunch	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:00 – 1:30 Lunch
1:00 Check-in @ House	1:00- 1:45 Men's/Women's @ JB	1:00- 1:45 Cognitive Behavioral Changes @ JB	1:00- 1:45 Yoga or Meditation @ JB	1:00- 1:45 Attitude of Gratitude @ JB	1:00- 1:45 Hitting Bottom @ JB	
12:00 – 3:30 Visiting 1:00 – 3:00 Gym	2:00- 2:45 Mindfulness @ JB	2:00- 2:45 Medication Education @JB	2:00- 2:45 Daily Inventory @ JB	2:00- 2:45 Self Esteem @ JB	2:00- 2:45 Recovery Planning @ JB	12:00 – 3:30 Visiting 1:00 – 3:00 Gym
	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	
3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House
3:45 – 4:45 Promises @ House	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	3:45 – 4:45 As Bill Sees It @ House
5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	5:00 - 5:45 Dinner
6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House
6:00 – 6:45 Slogans @ House	7:00 – 8:00 Acceptance @ House	7:00 – 8:00 Step One Workbook @ House	7:00 – 8:00 Living Sober @ House	6:45 – 7:30 Alumni Aftercare @ House	7:00 – 8:00 Relapse Prevention @ House	6:00 – 7:00 Big Book Study @ House
7:30 – 8:30 AA Meeting	8:30 – 9:30 NA Meeting	8:30 – 9:30 AA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 NA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 AA Meeting
8:45 Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 – 9:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 Wrap Up @ House
10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores
11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room
11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out

*FREE TIME TO BE USED FOR CALLING SPONSORS, STEP WORK, JOURNALING, RECOVERY READING
Individual Case Management/Dr's Appointments to be individually arranged
Library Hours Vary, Please See Posted Schedule

Revised 10/14/09

SELF-AWARENESS

Silver Hill Hospital
Dual Diagnosis Program

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	
8:30 – 9:30 Breakfast	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	8:30 – 9:30 Breakfast
	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:45 – 10:30 Creative Spirituality	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:30 – 12:00 Patient Workshop
10:00 Meditation @ House	10:00 – 11:30 Gym/Computer Lab	10:00 – 11:30 Gym/Computer Lab 10:30-11:15 Smoking Cessation @ JB	10:30 – 11:30 Gym/Computer Lab	10:00 – 11:30 Gym/Computer Lab	10:00 – 11:30 Gym/Computer Lab	@ JB1
11:00 – 11:45 Topic Group @ House	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	12:00 Check-in @ House
12:00 – 1:00 Lunch	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:00 – 1:30 Lunch
1:00 Check-in @ House	1:00- 1:45 Men's/Women's @ JB	1:00- 1:45 Cognitive Therapy @ JB	1:00- 1:45 Yoga or Meditation @ JB	1:00- 1:45 Medication Education @ JB	1:00- 1:45 Self Awareness – Shame Based @ JB	
12:00 – 3:30 Visiting 1:00 – 3:00 Gym	2:00- 2:45 Mindfulness Wise Mind @ JB 3:00-3:45 Primary Group @ JB	2:00- 2:45 Mindfulness What Skills / How Skills @ JB 3:00-3:45 Primary Group @ JB	2:00- 2:45 Mindfulness Middle Path @ JB 3:00-3:45 Primary Group @ JB	2:00- 2:45 Self Esteem @ JB 3:00-3:45 Primary Group @ JB	2:00- 2:45 Mindfulness Validation @ JB 3:00-3:45 Primary Group @ JB	12:00 – 3:30 Visiting 1:00 – 3:00 Gym
3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House
3:45 – 4:45 Intro to 12 Step Mtgs @ House	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	3:45 – 4:45 As Bill Sees It @ House
5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	5:00 - 5:45 Dinner
6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House
6:00 – 6:45 Slogans @ House	7:00 – 8:00 Denial @ House	7:00 – 8:00 Step One Workbook @ House	7:00 – 8:00 Living Sober @ House	6:45 – 7:30 Alumni Aftercare @ House	7:00 – 8:00 Relapse Prevention @ House	6:00 – 7:00 Big Book Study @ House
7:30 – 8:30 AA Meeting	8:30 – 9:30 NA Meeting	8:30 – 9:30 AA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 NA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 AA Meeting
8:45 Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 – 9:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 Wrap Up @ House
10:30 House Chores 11:00 In Room 11:30 Lights Out	10:30 House Chores 11:00 In Room 11:30 Lights Out	10:30 House Chores 11:00 In Room 11:30 Lights Out	10:30 House Chores 11:00 In Room 11:30 Lights Out	10:30 House Chores 11:00 In Room 11:30 Lights Out	10:30 House Chores 11:00 In Room 11:30 Lights Out	10:30 House Chores 11:00 In Room 11:30 Lights Out

Revised 10/14/09

*FREE TIME TO BE USED FOR CALLING SPONSORS, STEP WORK, JOURNALING, RECOVERY READING
Individual Case Management/Dr's Appointments to be individually arranged
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INTERPERSONAL SKILLS

Silver Hill Hospital
Dual Diagnosis Program

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	
8:30 – 9:30 Breakfast	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	8:30 – 9:30 Breakfast
	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:45 – 10:30 Creative Spirituality	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:30 – 12:00 Patient Workshop @ JB1
10:00 Meditation @ House	10:00 – 11:30 Gym/Computer Lab	10:00 – 11:30 Gym/Computer Lab 10:30-11:15 Smoking Cessation @ JB	10:30 – 11:30 Gym/Computer Lab	10:00 – 11:30 Gym/Computer Lab	10:00 – 11:30 Gym/Computer Lab	
11:00 – 11:45 Topic Group @ House	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	12:00 Check-in @ House
12:00 – 1:00 Lunch	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:00 – 1:30 Lunch
1:00 Check-in @ House	1:00- 1:45 Men's/Women's @ JB	1:00- 1:45 Behavioral Chain Analysis @ JB	1:00- 1:45 Yoga or Meditation @ JB	1:00- 1:45 Medication Education @ JB	1:00- 1:45 Relapse Prevention Strategies @ JB	
12:00 – 3:30 Visiting	2:00- 2:45 Interpersonal Effectiveness Overview @ JB	2:00- 2:45 Getting What You Want @ JB	2:00- 2:45 Keeping the Relationship @ JB	2:00- 2:45 Triggers @ JB	2:00- 2:45 Maintaining Self-Respect/ Co-Dependency @ JB	12:00 – 3:30 Visiting
1:00 – 3:00 Gym	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	1:00 – 3:00 Gym
3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House
3:45 – 4:45 Spirituality @ House	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	3:45 – 4:45 As Bill Sees It @ House
5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	5:00 - 5:45 Dinner
6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House
6:00 – 6:45 Slogans @ House	7:00 – 8:00 People, Places, Things @ House	7:00 – 8:00 Step One Workbook @ House	7:00 – 8:00 Living Sober @ House	6:45 – 7:30 Alumni Aftercare @ House	7:00 – 8:00 Relapse Prevention @ House	6:00 – 7:00 Big Book Study @ House
7:30 – 8:30 AA Meeting	8:30 – 9:30 Na Meeting	8:30 – 9:30 AA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 NA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 AA Meeting
8:45 Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 – 9:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 Wrap Up @ House
10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores
11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room
11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out

Revised 10/14/09

*FREE TIME TO BE USED FOR CALLING SPONSORS, STEP WORK, JOURNALING, RECOVERY READING
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HONESTY

Silver Hill Hospital
Chemical Dependency Program

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	
8:30 – 9:30 Breakfast	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	8:30 – 9:30 Breakfast
	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:45 – 10:30 Creative Spirituality	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:30 – 12:00 Patient Workshop @ JB1
10:00 Meditation @ House	10:00 – 11:30 Gym/Journaling	10:00 – 11:30 Gym/Journaling 10:30-11:15 Smoking Cessation @ JB	10:30 – 11:30 Gym/Journaling	10:00 – 11:30 Gym/Journaling	10:00 – 11:30 Gym/Journaling	
11:00 – 11:45 Topic Group @ House	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	12:00 Check-in @ House
12:00 – 1:00 Lunch	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:00 – 1:30 Lunch
1:00 Check-in @ House	1:00- 1:45 Men's/Women's @ JB	1:00- 1:45 Loss & Grief @ JB	1:00- 1:45 Yoga or Meditation @ JB	1:00- 1:45 Biology of Addiction (Marijuana) @ JB	1:00- 1:45 Biology of Addiction (Cocaine) @ JB	
12:00 – 3:30 Visiting 1:00 – 3:00 Gym	2:00- 2:45 Honesty @ JB	2:00- 2:45 Medication Education @ JB	2:00- 2:45 Biology of Addiction (Opiates) @ JB	2:00- 2:45 Biology of Addiction (Alcohol) @ JB	2:00- 2:45 Urges & Cravings @ JB	12:00 – 3:30 Visiting 1:00 – 3:00 Gym
	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	
3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House
3:45 – 4:45 Intro to 12 Step Mtgs @ House	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	3:45 – 4:45 As Bill Sees It @ House
5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	5:00 - 5:45 Dinner
6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House
6:00 – 6:45 Slogans @ House	7:00 – 8:00 Denial @ House	7:00 – 8:00 Step One Workbook @ House	7:00 – 8:00 Living Sober @ House	6:45 – 7:30 Alumni Aftercare @ House	7:00 – 8:00 Relapse Prevention @ House	6:00 – 7:00 Big Book Study @ House
7:30 – 8:30 AA Meetings	8:30 – 9:30 NA Meeting	8:30 – 9:30 AA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 NA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 AA Meeting
8:45 Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 – 9:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 Wrap Up @ House
10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores
11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room
11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out

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OPEN-MINDEDNESS

Silver Hill Hospital
Chemical Dependency Program

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	
8:30 – 9:30 Breakfast	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	8:30 – 9:30 Breakfast
	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:45 – 10:30 Creative Spirituality	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:30 – 12:00 Patient Workshop
10:00 Meditation @ House	10:00 – 11:30 Gym/Journaling	10:00 – 11:30 Gym/Journaling 10:30-11:15 Smoking Cessation @ JB	10:30 – 11:30 Gym/Journaling	10:00 – 11:30 Gym/Journaling	10:00 – 11:30 Gym/Journaling	@ JB1
11:00 – 11:45 Topic Group @ House	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	12:00 Check-in @ House
12:00 – 1:00 Lunch	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:00 – 1:30 Lunch
1:00 Check-in @ House	1:00- 1:45 Men's/Women's @ JB	1:00- 1:45 Defense Mechanisms @ JB	1:00- 1:45 Yoga or Meditation @ JB	1:00- 1:45 Who am I? @ JB	1:00- 1:45 Relapse Prevention @ JB	
12:00 – 3:30 Visiting	2:00- 2:45 Step Two (Open- Mindedness) @ JB	2:00- 2:45 Medication Education @ JB	2:00- 2:45 Communication Skills @ JB	2:00- 2:45 Triggers @ JB	2:00- 2:45 Codependency @ JB	12:00 – 3:30 Visiting
1:00 – 3:00 Gym	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	1:00 – 3:00 Gym
3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House
3:45 – 4:45 Intro to 12 Step Mtgs @ House	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	3:45 – 4:45 As Bill Sees It @ House
5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	5:00 - 5:45 Dinner
6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House
6:00 – 6:45 Slogans @ House	7:00 – 8:00 Surrender @ House	7:00 – 8:00 Step One Workbook @ House	7:00 – 8:00 Living Sober @ House	6:45 – 7:30 Alumni Aftercare @ House	7:00 – 8:00 Relapse Prevention @ House	6:00 – 7:00 Big Book Study @ House
7:30 – 8:30 AA Meeting	8:30 – 9:30 NA Meeting	8:30 – 9:30 AA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 NA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 AA Meeting
8:45 Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 – 9:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 Wrap Up @ House
10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores
11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room
11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out

*FREE TIME TO BE USED FOR CALLING SPONSORS, STEP WORK, JOURNALING, RECOVERY READING
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Library Hours Vary, Please See Posted Schedule

Revised 10/14/09

REGULATING EMOTIONS

Silver Hill Hospital
Dual Diagnosis Program

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	
8:30 – 9:30 Breakfast	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	8:30 – 9:30 Breakfast
	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:45 – 10:30 Creative Spirituality	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:30 – 12:00 Patient Workshop @ JB1
10:00 Meditation @ House	10:00 – 11:30 Gym/Computer Lab	10:00 – 11:30 Gym/Computer Lab 10:30-11:15 Smoking Cessation @ JB	10:30 – 11:30 Gym/Computer Lab	10:00 – 11:30 Gym/Computer Lab	10:00 – 11:30 Gym/Computer Lab	
11:00 – 11:45 Topic Group @ House	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	12:00 Check-in @ House
12:00 – 1:00 Lunch	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:00 – 1:30 Lunch
1:00 Check-in @ House	1:00- 1:45 Men's/Women's @ JB	1:00- 1:45 Loss and Grief	1:00- 1:45 Yoga or Meditation @ JB	1:00- 1:45 Medication Education @ JB	1:00- 1:45 Urges and Cravings	
12:00 – 3:30 Visiting	2:00- 2:45 The Function of Emotion Overview @ JB	2:00- 2:45 Cognitive Distortions	2:00- 2:45 Increasing Pos. Emotions/ Decreasing Vulnerability @ JB	2:00- 2:45 Biology of Dual Diagnosis @ JB	2:00- 2:45 Opposite to Emotion Action @ JB	12:00 – 3:30 Visiting
1:00 – 3:00 Gym	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	3:00-3:45 Primary Group @ JB	1:00 – 3:00 Gym
3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House
3:45 – 4:45 Intro to 12 Step Mtgs @ House	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	3:45 – 4:45 As Bill Sees It @ House
5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	5:00 - 5:45 Dinner
6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House
6:00 – 6:45 Slogans @ House	7:00 – 8:00 Surrender @ House	7:00 – 8:00 Step One Workbook @ House	7:00 – 8:00 Living Sober @ House	6:45 – 7:30 Alumni Aftercare @ House	7:00 – 8:00 Relapse Prevention @ House	6:00 – 7:00 Big Book Study @ House
7:30 – 8:30 AA Meeting	8:30 – 9:30 Na Meeting	8:30 – 9:30 AA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 NA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 AA Meeting
8:45 Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 – 9:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 Wrap Up @ House
10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores
11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room
11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out

Revised 10/14/09

*FREE TIME TO BE USED FOR CALLING SPONSORS, STEP WORK, JOURNALING, RECOVERY READING
Individual Case Management/Dr's Appointments to be individually arranged
Library Hours Vary, Please See Posted Schedule

WILLINGNESS

Silver Hill Hospital
Chemical Dependency Program

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	
8:30 – 9:30 Breakfast	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	8:30 – 9:30 Breakfast
	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:45 – 10:30 Creative Spirituality	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:30 – 12:00 Patient Workshop
10:00 Meditation @ House	10:00 – 11:30 Gym/Journaling	10:00 – 11:30 Gym/Journaling 10:30-11:15 Smoking Cessation @ JB	10:30 – 11:30 Gym/Journaling	10:00 – 11:30 Gym/Journaling	10:00 – 11:30 Gym/Journaling	@ JB1
11:00 – 11:45 Topic Group @ House	11:45 – 12:30 Lunch @	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	12:00 Check-in @ House
12:00 – 1:00 Lunch	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:00 – 1:30 Lunch
1:00 Check-in @ House	1:00- 1:45 Men's/Women's @ JB	1:00- 1:45 Creating a Life Worth Living @ JB	1:00- 1:45 Yoga or Meditation @ JB	1:00- 1:45 Post Acute Withdrawal Syndrome @ JB	1:00- 1:45 Anger Management @ JB	
12:00 – 3:30 Visiting 1:00 – 3:00 Gym	2:00- 2:45 Identifying Stress/Reduction @ JB 3:00-3:45 Primary Group @ JB	2:00- 2:45 Medication Education @ JB 3:00-3:45 Primary Group @ JB	2:00- 2:45 Radical Acceptance @ JB 3:00-3:45 Primary Group @ JB	2:00- 2:45 Step 1 @ JB 3:00-3:45 Primary Group @ JB	2:00- 2:45 Just Do It- The 5 Behaviors @ JB 3:00-3:45 Primary Group @ JB	12:00 – 3:30 Visiting 1:00 – 3:00 Gym
3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House
3:45 – 4:45 Spirituality @ House	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	3:45 – 4:45 As Bill Sees It @ House
5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	5:00 - 5:45 Dinner
6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House
6:00 – 6:45 Slogans @ House	7:00 – 8:00 People, Places, Things @ House	7:00 – 8:00 Step One Workbook @ House	7:00 – 8:00 Living Sober @ House	6:45 – 7:30 Alumni Aftercare @ House	7:00 – 8:00 Relapse Prevention @ House	6:00 – 7:00 Big Book Study @ House
7:30 – 8:30 AA Meeting	8:30 – 9:30 Na Meeting	8:30 – 9:30 AA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 NA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 AA Meeting
8:45 Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 – 9:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 Wrap Up @ House
10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores
11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room
11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out

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Revised 10/14/09

PROBLEM SOLVING

Silver Hill Hospital
Dual Diagnosis Program

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	7:45 -8:30 Wake Up/Breakfast	
8:30 – 9:30 Breakfast	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/Orientation/ Goal Planning @ House	9:00 -9:30 Community Mtg/ Orientation/ Goal Planning @ House	8:30 – 9:30 Breakfast
	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:45 – 10:30 Creative Spirituality	9:30 – 10:00 Meditation @ House	9:30 – 10:00 Meditation @ House	9:30 – 12:00 Patient Workshop @ JB1
10:00 Meditation @ House	10:00 – 11:30 Gym/Computer Lab	10:00 – 11:30 Gym/Computer Lab 10:30-11:15 Smoking Cessation @ JB	10:00 – 11:30 Gym/Computer Lab	10:00 – 11:30 Gym/Computer Lab	10:00 – 11:30 Gym/Computer Lab	
11:00 – 11:45 Topic Group @ House	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	11:45 – 12:30 Lunch	12:00 Check-in @ House
12:00 – 1:00 Lunch	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:30 Check-in @ House	12:00 – 1:30 Lunch
1:00 Check-in @ House	1:00- 1:45 Men's/Women's @ JB	1:00- 1:45 Creating a Life Worth Living @ JB	1:00- 1:45 Yoga or Meditation @ JB	1:00- 1:45 Medication Education @ JB	1:00- 1:45 Anger Management @ JB	
12:00 – 3:30 Visiting 1:00 – 3:00 Gym	2:00- 2:45 Crisis Survival Skills @ JB 3:00-3:45 Primary Group @ JB	2:00- 2:45 Pros and Cons @ JB 3:00-3:45 Primary Group @ JB	2:00- 2:45 Radical Acceptance @ JB 3:00-3:45 Primary Group @ JB	2:00- 2:45 Step One @ JB 3:00-3:45 Primary Group @ JB	2:00- 2:45 Turning the Mind @ JB 3:00-3:45 Primary Group @ JB	12:00 – 3:30 Visiting 1:00 – 3:00 Gym
3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House	3:45 Check-in @ House
3:45 – 4:45 Promises @ House	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	4:00 – 6:30 Gym/Computer Lab	3:45 – 4:45 As Bill Sees It @ House
5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	4:45 – 6:45 Visiting 5:00 - 5:45 Dinner	5:00 - 5:45 Dinner
6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House	6:00 Check-in @ House
6:00 – 6:45 Slogans @ House	7:00 – 8:00 Acceptance @ House	7:00 – 8:00 Step One Workbook @ House	7:00 – 8:00 Living Sober @ House	6:45 – 7:30 Alumni Aftercare @ House	7:00 – 8:00 Relapse Prevention @ House	6:00 – 7:00 Big Book Study @ House
7:30 – 8:30 AA Meeting	8:30 – 9:30 Na Meeting	8:30 – 9:30 AA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 NA Meeting	8:30 – 9:30 AA Meeting	7:30 – 8:30 AA Meeting
8:45 Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 – 9:15 Goals Review/ Wrap Up @ House	9:45 – 10:15 Goals Review/ Wrap Up @ House	8:45 Wrap Up @ House
10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores	10:30 House Chores
11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room	11:00 In Room
11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out	11:30 Lights Out

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Library Hours Vary, Please See Posted Schedule

CURRICULUM VITAE

Sigurd H. Ackerman, M.D.

Business Address: Silver Hill Hospital
208 Valley Road
New Canaan, CT, 06840
203-801-2215
Fax: 203-966-1075
e-mail: sackerman@silverhillhospital.org

Home Address: 97 Sagamore Rd.
Stamford, CT, 06902
203-978-0347

ACADEMIC TRAINING:

A.B. (Cum Laude), Harvard College, Cambridge, Mass., 1962

M.D. Tufts University School of Medicine, Boston, Mass., 1966

RESIDENCIES:

Internal Medicine; King's County Hospital, Downstate University Medical Center, Brooklyn, New York 1966 - 1968

Psychiatry; Montefiore Medical Center, Bronx, New York, 1970 – 1973

RESEARCH FELLOWSHIP

National Institutes of Mental Health (NRSA), "Research Training-Psychobiological Sciences" (T32 MH14612); Department of Psychiatry, Montefiore Medical Center 1973-1975

BOARD CERTIFICATION :

Diplomate, American Board of Psychiatry and Neurology, Inc., 1975

ACADEMIC APPOINTMENTS :

Assistant Instructor, Department of Medicine, Downstate University Medical Center, 1967 - 1968

Instructor of Psychiatry, Albert Einstein College of Medicine, Montefiore Medical Center, 1973 – 1975

Assistant Professor of Psychiatry, Albert Einstein College of Medicine, Montefiore Medical Center, 1975 – 1980

Associate Professor of Psychiatry, Albert Einstein College of Medicine, Montefiore Medical Center, 1980 – 1984

Associate Professor of Psychiatry, (Unmodified Tenure) Cornell University Medical College, 1984 – 1989

Professor of Clinical Psychiatry, Columbia University College of Physicians & Surgeons, 1989-

HOSPITAL AND UNIVERSITY POSITIONS:

Coordinator, Undergraduate Education in Psychiatry, Albert Einstein College of Medicine at Montefiore Medical Center, 1973 - 1975

Co-Director, Postgraduate Research Training Program in Psychobiology, Department of Psychiatry, Montefiore Medical Center, 1977 – 1984

Director, In-patient Psychiatry, Montefiore Medical Center, 1982 - 1984

Unit Chief, Clinical Research Unit for Affective Disorders, New York Hospital, Cornell University Medical Center – Westchester Division, 1984 – 1989

Associate Director for Clinical Affairs and Research, Eating Disorders Institute, New York Hospital, Cornell University Medical Center - Westchester Division, 1984-1989

Chair, Department of Psychiatry, St. Luke's-Roosevelt Hospital Center, 1989-1998

Executive Vice President and Medical Director, St. Luke's-Roosevelt Hospital Center, 1991-1993

Associate Dean (for St. Luke's-Roosevelt), Columbia University College of Physicians & Surgeons, 1991-1993

Associate Vice Chair (for St. Luke's-Roosevelt), Department of Psychiatry, Columbia University College of Physicians & Surgeons, 1996-1998

President and CEO, St. Luke's-Roosevelt Hospital Center, New York, NY, 1998-2001

President and CEO, Silver Hill Hospital, Inc., New Canaan, CT, 2003-

HOSPITAL STAFF APPOINTMENTS:

Assistant Attending, Department of Psychiatry, Montefiore Medical Center, 1973 – 1975

Adjunct Attending, Department of Psychiatry, Montefiore Medical Center, 1975 – 1980

Associate Attending, Department of Psychiatry, Montefiore Medical Center, 1980 - 1984

Associate Attending, Department of Psychiatry, New York Hospital, Westchester Division, 1984 - 1989

Senior Attending Psychiatrist, St. Luke's-Roosevelt Hospital Center, 1989 –

Senior Attending, Silver Hill Hospital, 2003-

NATIONAL STUDY SECTIONS AND EXAMINING BOARDS:

Merit Review Board for Behavioral Sciences, Veterans Administration, Department of Medicine and Surgery, 1978 - 1981

Examiner, American Board of Psychiatry and Neurology (Psychiatry), 1988- 2000

NIH Office of Alternative Medicine Study Section; Diet, Nutrition and Lifestyle (SSS-F-S2); 1993 –1995

FOUNDATION BOARDS

The McCarton School [School for Autistic Children]; 2002 –

The Public Health Foundation of Connecticut; 2004 –

The National Foundation for Mental Health; 2005 -

SOCIETIES:

American Psychiatric Association (Distinguished Fellow, 2001), 1985-
American Psychosomatic Society, 1972 -
American Association for the Advancement of Science, 1973 -
New York Academy of Science, 1974-
Psychiatric Research Society, 1978-
American Psychopathological Association, 1980 -

Academy of Behavioral Medicine Research, 1982 -
The Society of Behavioral Medicine (Fellow), 1984 -
Society for the Study of Ingestive Behavior, 1986 -2001
Society for Neuroscience, 1987 -
New York Academy of Medicine, 1989 -
New York Psychiatric Society, 1989 –

MILITARY SERVICE :

Department of Medicine, Walson Army Hospital, Fort Dix, New Jersey (USAF), 1968 - 1970

GRANTS, AWARDS AND FUNDING HISTORY:

Principal Investigator; The Grant Foundation "Critical Factors in Gastric Ulcer Formation in the Rat." (#4175317); 1973 - 1975 ($60,000)

Research Scientist Development Award, Type I (1K01 MH00077), National Institute of Mental Health, 1975 - 1980.

Henry L. Moses Prize for Basic Research, Montefiore Medical Center, 1983.

Research Scientist Development Award, Type II (2K02 MH00077), National Institutes of Mental Health, 1980 - 1984.

Principal Investigator; National Institutes of Health, Division of Arthritis, Metabolism and Digestive Diseases, "Psychobiologic Mechanisms of Stress Ulcer in the Rat" (RO1 AM18804), 1976-1981 ($251,600)

Principal Investigator; National Institutes of Health, Division of Arthritis, Metabolism and Digestive Diseases, "Psychobiologic Mechanisms of Stress Ulcer in the Rat" (RO1 AM18804); Competing renewal 1981 - 1986 ($358,875).

Research Training Grant (Co-Director, Co-PI), National Institutes of Mental Health (NRSA), "Research Training-Psychobiological Sciences" (T32 MH14612), 1981 - 1984.

Research Training Grant (Co-Director), National Institutes of Mental Health, "Postdoctoral Training in Eating Disorders" (T32 MH18390-01A1), 1987 - 1992.

Principal Investigator; ADAMHA, Office of Treatment Improvement (OTI); "Treatment Resource Program for MICA and Dual Diagnosis Patients", 1990 – 1993 ($2,350,689).

Principal Investigator; American Cyanamid Company; Phase II Trial of Sleep Inducing Compound CL 284,846, 1993 - 1994. ($209,185).

Co-principal Investigator (with Gary Zammit, Ph.D., PI): American Cyanamid Company; Phase III Trial of CL 284-846 (Zelaplon) in Elderly Outpatients With Insomnia, 1995-1996 ($141,230).

Principal Investigator; Eli Lilly & Co. "Olanzapine Added to Mood Stabilizers in the Treatment of Bipolar Disorder (F1D-MC-HGFU),1997-1998 ($232,125.)

Co-Principal Investigator [P.I. Susan Tross, Ph.D.] "Imipramine and Relapse Prevention in Depressed Methadone Patients"; (NIDA; RO1# DA09583-01): 1996-2000. ($3,994,351.)

EDITORIAL POSITIONS:

Book Review Editor, Psychosomatic Medicine, 1978 - 1985

Manuscript reviewer for:
American Journal of Psychiatry
Appetite
Archives of General Psychiatry
Biological Psychiatry
Brain Behavior & Immunity
Developmental and Behavioral Pediatrics
Eating Disorders
Gastroenterology
Health Psychology
Life Sciences
Psychosomatic Medicine
Psychosomatics
Regulatory Peptides
Science

PUBLICATIONS:

*Ackerman, S.H. and Sachar, E.J.: The lactate theory of anxiety: A review and reevaluation. Psychosom. Med., 36:69-81, 1974.

*Ackerman, S.H., Hofer, M.A. and Weiner, H.: Age at maternal separation and gastric erosion susceptibility in the rat. Psychosom. Med., 37: 180-184, 1975.

*Ackerman, S.H. and Shindledecker, R.: Factors in the etiology of restraint erosions in parabiotic rats. Gastroenterology, 71: 426-428, 1976.

*Ackerman, S.H. and Weiner, H.: Peptic ulcer disease: Some considerations for psychosomatic research. In: O.W. Hill (ed.), Modern Trends in Psychosomatic Medicine, 3, Butterworth, London, 363-381;1976.

*Ackerman, S.H., Hofer, M.A. and Weiner, H.: Some effects of split litter cross foster design applied to 15-day-old rat pups. Physiol. Behav., 19: 433-436, 1977.

*Ackerman, S.H.: Gastrointestinal psychosomatic disorders. In: B.B. Wolman (ed.), International Encyclopedia of Neurology, Psychiatry, Psychoanalysis and Psychology, Aesculapius Publications, New York, 159-165, 1977.

*Ackerman, S.H. and Shindledecker, R.: A method for artificial feeding of motherless 2-week-old rat pups. Develop. Psychobiol., 11: 385-391, 1978.

*Ackerman, S.H., Hofer, M.A. and Weiner, H.: Early maternal separation increases gastric ulcer risk in rats by producing a latent thermo-regulatory disturbance. Science, 201:373-376, 1978.

*Ackerman, S.H., Hofer, M.A. and Weiner, H.: Predisposition to gastric erosions in the rat: Behavioral and nutritional affects of early maternal separation. Gastroenterology, 75: 649-654, 1978.

Melinek, M., Ackerman, S.H., Sharpless, N.S., Hofer, M.A. and Weiner, H.: Gastric erosions following sympathetic denervation in the maternally deprived rat. Life Sciences, 25: 61-66, 1979.

*Ackerman, S.H., Hofer, M.A. and Weiner, H.: Sleep and temperature regulation during restraint stress in rats is affected by prior maternal separation. Psychosom. Med., 41: 311-319, 1979.

Manaker, S., Ackerman, S.H. and Weiner, H.: Intra-cerebroventricular pentagastrin fails to affect feeding and acid Secretion in the rat. Physiol. Behav., 23: 395-396, 1979.

*Ackerman, S.H.: Early life events and peptic ulcer susceptibility: An experimental model. Brain Res. Bull., 5: 43-49, 1980.

Skolnick, N.J., Ackerman, S.H., Hofer, M.A. and Weiner, H.: Vertical transmission of acquired ulcer susceptibility in the rat. Science, 208: 1161-1163, 1980.

*Ackerman, S.H., Manaker, S. and Cohen, M.I.: Recent Separation and the onset of peptic ulcer disease in older children and adolescents. Psychosom. Med., 43: 305-310, 1981.

*Ackerman, S.H.: Premature weaning, thermoregulation and the occurrence of gastric pathology. Brain, Behavior and Bodily Diseases (ARNMD Research Publication); H. Weiner, M. Hofer and A.J. Stunkard (Eds.), Raven Press, New York, 67-85, 1981.

Vollhardt, B.R., Ackerman, S.H., Grayzel, A.I. and Barland, P.: Psychologically distinguishable groups of rheumatoid arthritis patients. Psychosom. Med., 44: 353-362, 1982.

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2/4/09

RECYCLED

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

MICHELE ZURKO-SMITH,	:	
Plaintiff,	:	Civil Action No.
v.	:	
TOWN OF BETHLEHEM, TOWN OF BETHLEHEM PLANNING COMMISSION AND ROBERT GALLO, INDIVIDUALLY AND AS THE CHAIRMAN OF THE TOWN OF BETHLEHEM PLANNING COMMISSION	:	
Defendants.	:	October 19, 2009

COMPLAINT AND JURY TRIAL DEMAND

The plaintiff, Michele Zurko-Smith ("Ms. Zurko-Smith" or "Plaintiff"), by way of complaint against the defendants, Town of Bethlehem (the "Town" or "Defendant"), Town of Bethlehem Planning Commission (the "Commission" or "Defendant") and Robert Gallo ("Mr. Gallo" or "Defendant") (all collectively referred to as "Defendants"), states:

NATURE OF ACTION

1. This is a civil action arising under the Fair Housing Act, 42 U.S.C. Sections 3601, *et seq.* (the "FHA"), Title II of the Americans With Disabilities Act, 42 U.S.C. Sections 12131, *et seq.* (the "ADA"), and 42 U.S.C. Section 1983 ("Section 1983"). Plaintiff also seeks declaratory relief pursuant to Fed. R. Civ. P. 57 and 28 U.S.C. Section 2201.

2. Plaintiff seeks redress for Defendants' intentional and unlawful discrimination and deprivation of property rights including, but not limited to, injunctive relief, compensatory monetary damages, punitive damages, attorneys' fees and costs.

3. On October 15, 2009, plaintiff caused a Notice of Intent to be served on the Town in accordance with Conn. Gen. Stat. secs. 7-101a and 7-465.

JURISDICTION AND VENUE

4. This Court has jurisdiction over Plaintiff's claims pursuant to 28 U.S.C. Sections 1331 and 1343(a)(4). This court has supplemental jurisdiction pursuant to 28 U.S.C. Section 1367.

5. Venue in this jurisdiction is proper pursuant to 28 U.S.C. 1391(b) because the events or omissions giving rise to Plaintiff's claims occurred within this judicial district.

PARTIES

6. Ms. Zurko-Smith is an individual resident of the State of Connecticut whose address is 12 Trefoil Drive, Oxford, Connecticut.

7. The Town is a municipal corporation organized and existing under the laws of the State of Connecticut with a business address of 36 Main Street South, Bethlehem, Connecticut.

8. The Commission is an agency of the Town, established in accordance with Chapter 126 of the Connecticut General Statutes, pursuant to the Code of the Town of Bethlehem (the "Town Code").

9. Mr. Gallo was the Chairman of the Commission at all times relevant to this Complaint.

GENERAL ALLEGATIONS

BACKGROUND

10. Ms. Zurko-Smith is the owner of property located at 64 Double Hill Road, Bethlehem, Connecticut (the "Property"). Ms. Zurko-Smith purchased the Property in May 2007.

11. The Property consists of about 62 acres of land. Situated on the Property is a five bedroom residence (the "Residence").

12. Prior to purchasing the Property, Ms. Zurko-Smith called the Commission's office to inform the Commission that she intended to use the Residence as an eight bed addiction rehabilitation center (the "Rehabilitation Center"). A representative of the Commission informed Ms. Zurko-Smith that there was no zoning in the Town and that there would be "no problem" with her intended use.

13. In reliance on the Commission's representation, Ms. Zurko-Smith spent the next year and a half preparing the Property for the opening of the Rehabilitation Center, including repairing the roof on the Residence, painting the Residence, landscaping the Property, and purchasing furniture for the Rehabilitation Center. Ms. Zurko-Smith also printed marketing materials and began advertising.

14. The Rehabilitation Center was ready to open in April 2009.

15. By letter dated April 20, 2009, Ms. Zurko-Smith informed Roger Natush ("Mr. Natush"), the Town's Building Official, that she planned to use the Residence as the Rehabilitation Center.

16. On or about April 20, 2009, in her effort to be as conscientious as possible, Ms. Zurko-Smith called the Town's Building Department to inquire if the Rehabilitation Center needed to be inspected prior to opening. Mr. Natush informed Ms. Zurko-Smith for the first time that her plan constituted a "change of use" that needed to

be presented to the Commission, after receiving approval from the Torrington Area Health Department (the "TAHD"). Ms. Zurko-Smith was given a form application (the "Change of Use Application").

17. On April 28, 2009, Ms. Zurko-Smith hand-delivered the Change of Use Application to the TAHD so that she could comply as quickly as possible with what she had been told was necessary for her to implement her plan to open the Rehabilitation Center.

INITIAL ROADBLOCKS PLACED IN PLAINTIFF'S WAY TO PREVENT HER FROM OPENING THE REHABILITATION CENTER

18. By letter dated April 29, 2009, Jean Donegan ("Ms. Donegan"), the Commission's land use coordinator, informed Ms. Zurko-Smith for the first time that she may be required to get a "septic variance" to change the use of the Residence on the Property. Ms. Donegan also informed Ms. Zurko-Smith that the TAHD reviews such applications and the Commission administers them.

19. Included with Ms. Donegan's April 29, 2009 letter was a "Town of Bethlehem Septic System Ordinance Application." This application is commonly referred to as a "waiver application."

20. In or around the beginning of May 2009, Ms. Zurko-Smith contacted the TAHD to check on the status of the Change of Use Application. The TAHD Sanitarian,

Richard Rossi ("Mr. Rossi") told Ms. Zurko-Smith that he was waiting to hear from Mr. Gallo as to whether the additional testing requirements set forth in the Town's septic ordinance applied to her plans to open the Rehabilitation Center.

21. Shortly thereafter, Mr. Rossi informed Ms. Zurko-Smith that Mr. Gallo had stated that the Town's septic ordinance did not apply so that no additional testing was required, and that a routine septic inspection would be sufficient.

22. Ms. Zurko-Smith scheduled a date for an engineer, Dennis McMorrow ("Mr. McMorrow"), to perform a routine septic inspection on the Property's septic system and informed Mr. Rossi of that date. Mr. Rossi then told Ms. Zurko-Smith that Mr. Gallo had suddenly changed his mind and now wanted all additional testing as required by the Town's septic ordinance. Mr. Rossi further informed Ms. Zurko-Smith that he had never heard of such a thing, the way Mr. Gallo had changed his mind.

23. Mr. Gallo changed his mind about the septic testing for the sole purpose of delaying and ultimately preventing Ms. Zurko-Smith from opening the Rehabilitation Center.

24. In her effort to comply with what Mr. Gallo led her to believe was required of her, on May 6, 2009, Ms. Zurko-Smith had Mr. McMorrow conduct all the testing on the Property's septic system that Mr. Gallo claimed was necessary. Mr.

McMorrow informed Ms. Zurko-Smith that the testing was favorable and that the septic system would be sufficient for the use associated with the Rehabilitation Center.

ADDITIONAL UNREASONABLE ROADBLOCKS: PLAINTIFF'S WAIVER APPLICATIONS AND THE FIRST MORATORIUM

25. The Commission held a regular meeting on May 14, 2009 and Ms. Zurko-Smith attended that meeting. At that time, Mr. Gallo told Ms. Zurko-Smith that she needed to file an application for a variance from the Town's septic ordinance, and that a $250 fee and waiver application must be submitted to the Commission, along with test results required under the Town's septic ordinance. Ms. Zurko-Smith was also told that these test results would be submitted to the TAHD for review and subsequent recommendation to the Commission.

26. Ms. Zurko-Smith told the Commission that the septic test had been completed, the results of the septic test were favorable, and that a written report would be received shortly.

27. In furtherance of his objective and that of the Commission to prevent the Rehabilitation Center from opening, Mr. Gallo then stated that Ms. Zurko-Smith could return to the Commission only after obtaining approval from the Town's Inland Wetlands Agency (the "IWA").

28. The Town's Board of Selectmen held a regular meeting on May 19, 2009, only five days after the Commission's May meeting. Realizing that Mr. Gallo and the Commission could not indefinitely delay the opening of the Rehabilitation Center, Ms. Donegan, acting as an agent of Mr. Gallo and the Commission, requested that an ordinance addressing change of use be drafted immediately.

29. In direct response to Ms. Donegan's request, the Board of Selectmen approved a six month moratorium prohibiting any conversion of a single family dwelling to a commercial use as defined in the State Building Code and the State Health Code (the "First Moratorium").

30. The First Moratorium was adopted for the specific purpose of preventing Ms. Zurko-Smith from opening the Rehabilitation Center.

31. Upon information and belief, legal notice of the adoption of the First Moratorium was not published as required by statute and the First Moratorium never became effective.

32. At Ms. Zurko-Smith's request, on June 25, 2009, the Town's Fire Marshal came to the Property to inspect the Residence. The Fire Marshal informed Ms. Zurko-Smith that a few locks needed to be changed, but the Residence was otherwise safe for operation of the Rehabilitation Center.

33. Mr. Natush accompanied the Town's Fire Marshal on June 25, 2009 when he inspected the Residence. At that time, he handed Ms. Zurko-Smith a letter stating that a moratorium on commercial uses was in place. This letter was drafted and given to Ms. Zurko-Smith for the specific purpose of leading her to believe that she could not proceed with her plan to open the Rehabilitation Center, despite the fact that the First Moratorium was ineffective.

34. In early July 2009, Ms. Zurko-Smith received a written engineering report from Mr. McMorrow confirming that all testing performed on the Property's septic system was favorable and that the septic system would be sufficient for the use associated with the Rehabilitation Center.

35. Immediately after receiving the written engineering report, Ms. Zurko-Smith delivered the report, together with Property maps and a waiver application, to the TAHD.

36. The Commission held a regular meeting on July 9, 2009 and Ms. Zurko-Smith attended that meeting. She told the Commission that she had filed the necessary documents, including a waiver application, with the TAHD. Ms. Zurko-Smith was then informed that a waiver application had to be filed with the Commission.

37. In response, Ms. Zurko-Smith sat in the back of the room and prepared another waiver application which she filed with the Commission, but the Commission refused to accept it, claiming the application was incomplete.

38. On August 4, 2009, Ms. Zurko-Smith appeared before the IWA so as to comply with the demands of Mr. Gallo and the Commission. The IWA informed Ms. Zurko-Smith that she needed a report from a soil scientist before a wetlands application could be approved.

THE ULTIMATE UNREASONABLE ROADBLOCK: THE TOWN'S MORATORIUM ON ESTABLISHMENT OF SERVICE RELATED HOUSING

39. On August 4, 2009, a Petition and Application for Town Meeting to Adopt Ordinance (the "Petition"), seeking a moratorium on the establishment of service-related housing for a period of nine months, was submitted to the Town's Board of Selectmen.

40. The Petition was submitted in direct response to Ms. Zurko's plan to open the Rehabilitation Center and to prevent her from doing so.

41. In response to the Petition, the Town held a Special Town Meeting on August 11, 2009, and the Town adopted the following ordinance (the "Second Moratorium"):

> . . . [T]he Town of Bethlehem hereby enacts a moratorium on establishment of service-related housing for a period of nine months, commencing on the effective date of this ordinance. During the moratorium, no building, sanitary, or other

permits or approvals shall be issued by or on behalf of the Town of Bethlehem for, or in connection with, the establishment of any service-related housing with the Town of Bethlehem, with the following exceptions:

A. Permits or approvals may be issued for temporary housing for seasonal farm or agricultural workers;

B. Permits or approvals may be issued for buildings that are owned and/or operated by an educational institution whose primary purpose is to provide living accommodations for individuals associated with the institution.

This ordinance shall become effective fifteen days after publication in accordance with Section 7-157 of the Connecticut General Statutes.

42. The Second Moratorium was adopted for the specific purpose of preventing Ms. Zurko-Smith from establishing the Rehabilitation Center.

43. The TAHD approved the Change of Use Application on August 12, 2009 (the "TAHD Approval"). The TAHD Approval states:

> Approval is based upon favorable B-100a soil testing and renovation analysis performed by Dennis McMorrow, P.E. on May 6, 2009 in conjunction with the TAHD. See plan dated 6/30/09.

44. At the time Mr. Rossi forwarded the TAHD Approval to Ms. Zurko-Smith, he said to her that he was "doing the right thing" by giving his approval, although he knew that his action would make the Town "mad."

45. Legal notice of the Town's adoption of the Second Moratorium was published in the Waterbury Republican American newspaper on August 13, 2009.

46. The Commission held a regular meeting on August 13, 2009. At that meeting, Ms. Zurko-Smith filed another waiver application with a $250 fee and the TAHD Approval.

47. Upon receiving Ms. Zurko-Smith's waiver application and the TAHD Approval, Mr. Gallo expressed his shock and disbelief that Ms. Zurko-Smith got the approval. Mr Gallo also stated that it had nothing to do with the Commission, in direct contrast to representations made by him at the Commission's May 14, 2009 meeting; and further stated that the waiver application would not be accepted by the Commission because there was no IWA approval. Mr. Gallo returned the waiver application to Ms. Zurko-Smith.

48. The Second Moratorium became effective on August 28, 2009.

49. The IWA held a regular meeting on September 1, 2009. Yet again, in an effort to comply with demands made by Mr. Gallo and the Commission, Ms. Zurko-Smith presented to the IWA an application in connection with her plan to open the Rehabilitation Center, including a favorable report from a soil scientist, and the IWA approved Ms. Zurko-Smith's application.

50. The Commission held a regular meeting on September 10, 2009. Prior to that meeting, Ms. Zurko-Smith filed her waiver application again, with the IWA approval.

51. At the September 10, 2009 meeting, Mr. Gallo attempted to return the previously filed waiver application to Ms. Zurko-Smith. Mr. Gallo stated that the waiver application could not be accepted by the Commission because the Second Moratorium prevented her from proceeding with her plan to open the Rehabilitation Center. Mr. Gallo also stated that if Ms. Zurko-Smith's attorney, Jeffrey W. Tuccio, did not take the waiver application back, it would be put in the trash.

52. The refusal of the Commission and Mr. Gallo to accept and grant Ms. Zurko-Smith's waiver application based on the Town's adoption of the Second Moratorium was a pretext, because the waiver application had been properly filed prior to the date the Second Moratorium became effective. Accordingly, the Second Moratorium was not applicable to Ms. Zurko-Smith's plan to open the Rehabilitation Center.

DEFENDANTS' LACK OF AUTHORITY TO ACT PURSUANT TO STATUTE

53. As creatures of statute, municipal entities, such as the Town and the Commission, may only act within the powers given to them by statute.

54. Pursuant to Connecticut General Statutes Section 8-19, any municipality may create a planning commission by ordinance. As set forth above, the Town established the Commission as a planning commission pursuant to statute. The Commission has only those powers given to planning commissions, as set forth in Chapter 126 of the Connecticut General Statutes.

55. Pursuant to Connecticut General Statutes Section 22a-42(c), each municipality must establish an inland wetlands agency or authorize an existing board or commission to regulate activities affecting wetlands and watercourses within the municipality's territorial limits. The Town established the IWA as an inland wetlands agency pursuant to Section 27-1 of the Town Code. The IWA has only those powers given to inland wetlands commissions, as set forth in Chapter 440 of the Connecticut General Statutes.

56. Pursuant to Connecticut General Statutes Section 8-1, any municipality may adopt the provisions of Chapter 124 of the statutes and exercise through a zoning commission the powers granted thereunder.

57. Pursuant to Connecticut General Statutes Section 8-2, a zoning commission is authorized to regulate, *inter alia*, the use of buildings or structures and the use of land.

58. At all times relevant to this action, the Town had not adopted the provisions of Chapter 124 of the Connecticut General Statutes or established a zoning commission. Therefore, any use of the Property has always been, and remains, permissible, including use of the Residence on the Property as a rehabilitation center.

59. The Town's septic ordinance referred to herein is in Chapter 109 of the Town Code. Section 109-3 of the Town Code states:

> On and after the effective date hereof, where private subsurface septic disposal systems are required, no commercial, industrial, institutional or any other structure or land use that is not a single-family or multifamily dwelling shall be constructed in the Town of Bethlehem on any piece or parcel of land without applying for a waiver herefrom under this chapter.

60. Section 109-4 of the Town Code provides for an application to the Commission for waiver of Section 109-3.

61. Section 109-5 of the Town Code states:

> A. The Bethlehem Planning Commission with the advice and consent of the Torrington Area Health District, shall grant, grant with conditions or deny any such application in accordance with standards set forth in "Seepage and Pollution Renovation Analysis For Land Treatment, Sewage Disposal Systems," dated 1982. Additionally the applicant shall provide adequate notice to the Torrington Area Health District prior to the applicant's field data collection as outlined in said analysis, such as deep test pits, borings, standpipes, piezometers, topographic measurements and permeability measurements, and allow the Torrington Area Health District, or its designated representative, the ability to observe said field data collection. The application shall be certified by a professional engineer or another individual acceptable to the Torrington Area Health District.

> B. If the waiver application satisfies the standards contained in said analysis, the Torrington Area Health District shall so advise the Bethlehem Planning Commission, which, in turn, shall, after approval at its next regular legally constituted meeting, issue a letter of approval forthwith. . . .

62. Section 109-6 of the Town Code states:

> For the purposes contained herein, said Bethlehem Planning Commission and the applicant for waiver hereunder shall follow the procedures set forth in Section 2 of the Subdivision Regulations of the Town of Bethlehem. . .

63. Section 2.3.9 of the Subdivision Regulations of the Town of Bethlehem (the "Subdivision Regulations") applies to a subdivision application or resubdivision application involving land regulated as an inland wetland or watercourse under the provisions of Chapter 440 of the Connecticut General Statutes, and requires submission, pursuant to statute, of an application to the IWA no later than the day the subdivision or resubdivision application is filed.

64. The Town had no statutory authority to appoint the Commission to grant or deny waiver applications as set forth in Chapter 109 of the Town Code, and the Commission had no statutory authority to act in such a capacity. Therefore, Mr. Gallo and the Commission improperly required Ms. Zurko-Smith to file a waiver application.

65. At no time has Ms. Zurko-Smith proposed construction in connection with her plan to use the Residence on the Property as the Rehabilitation Center. Therefore,

even if the Commission generally had the authority to require the filing of waiver applications, the provisions of Chapter 109 of the Town Code did not apply to Ms. Zurko-Smith, and Mr. Gallo and the Commission improperly required that she file the waiver application.

66. Neither the Town nor the Commission had the statutory authority to require that a wetlands application be filed or approved in connection with waiver applications as set forth in Chapter 109 of the Town Code. Therefore, even if the Commission generally had the authority to require the filing of waiver applications and the provisions of Chapter 109 of the Town Code applied to Ms. Zurko-Smith, at the Commission's August 13, 2009 meeting, Mr. Gallo and the Commission improperly refused to accept Ms. Zurko-Smith's filing because there was no IWA approval.

67. Ms. Zurko-Smith's waiver application had been properly filed prior to the date the Second Moratorium became effective. Therefore, even if the Commission generally had the authority to require the filing of waiver applications and the provisions of Chapter 109 of the Town Code applied to Ms. Zurko-Smith, at the Commission's September 11, 2009 meeting, Mr. Gallo and the Commission improperly relied on the adoption of the Second Moratorium as a basis to return Ms. Zurko-Smith's waiver application to her.

FIRST COUNT (VIOLATION OF THE FHA AS TO ALL DEFENDANTS)

1 – 67. Paragraphs 1 through 67 above are hereby repeated, realleged and incorporated by reference as paragraphs 1 through 67 of this First Count.

68. The intended residents of the Rehabilitation Center are persons with a disability who are handicapped within the meaning of 42 U.S.C. Section 3602(h).

69. The Rehabilitation Center is a dwelling within the meaning of 42 U.S.C. Section 3602(b).

70. Defendants' actions as described herein were taken based on the handicap of the prospective residents of the Rehabilitation Center, in violation of 42 U.S.C. Section 3604(f)(1), which provides, in pertinent part, that it shall be unlawful to make unavailable or deny a dwelling to any buyer or renter because of a handicap of that buyer or renter, a person residing in or intending to reside in that dwelling, or any person associated with that buyer or renter.

71. Mr. Gallo's conduct as described herein was willful and taken in reckless disregard of the rights of others, including Plaintiff.

72. Plaintiff, as owner of the Property and of the Residence where the Rehabilitation Center is to be located, and intended provider of dwellings to handicapped

individuals, is the victim of Defendants' discriminatory practices and is an aggrieved person, as defined in 42 U.S.C. Section 3602(i).

73. As a result of Defendants' actions, Plaintiff has suffered and will continue to suffer damages.

SECOND COUNT (VIOLATION OF THE FHA AS TO THE TOWN AND THE COMMISSION)

1 – 69. Paragraphs 1 through 69 above are hereby repeated, realleged and incorporated by reference as paragraphs 1 through 69 of this Second Count.

70. By requiring that Plaintiff file a waiver application, requiring that Plaintiff obtain IWA approval, and refusing to accept and grant Plaintiff's waiver application, the Commission failed and refused to make a reasonable accommodation in its rules, policies, practices, or services, in violation of 42 U.S.C. Section 3604(f)(3)(B).

71. By adopting the Second Moratorium for the purpose of preventing Plaintiff from opening the Rehabilitation Center, the Town failed and refused to make a reasonable accommodation in its rules, policies, practices, or services in violation of 42 U.S.C. Section 3604(f)(3)(B).

72. Plaintiff, as owner of the Property and of the Residence where the Rehabilitation Center is to be located, and intended provider of dwellings to handicapped

individuals, is the victim of Defendants' discriminatory practices and is an aggrieved person, as defined in 42 U.S.C. Section 3602(i).

73. As a result of the actions of the Town and the Commission, Plaintiff has suffered and will continue to suffer damages.

THIRD COUNT (VIOLATION OF THE ADA AS TO THE TOWN AND THE COMMISSION)

1 – 67. Paragraphs 1 through 67 above are hereby repeated, realleged and incorporated by reference as paragraphs 1 through 67 of this Third Count.

68. The Town and the Commission are each a public entity within the meaning of 42 U.S.C. Section 12131(1).

69. The intended residents of the Rehabilitation Center are qualified individuals with a disability within the meaning of 42 U.S.C. Section 12131(2).

70. The actions of the Town and the Commission as described herein were taken based on the dsability of the prospective residents of the Rehabilitation Center, in violation of 42 U.S.C. Section 12132, which provides, in pertinent part, that no person with a disability shall "be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."

71. Plaintiff, as owner of the Property and of the Residence where the Rehabilitation Center is to be located, and intended provider of services to disabled individuals, is the victim of Defendants' discriminatory practices, and has the right to seek relief pursuant to 42 U.S.C. Section 12133.

72. As a result of the actions of the Town and the Commission, Plaintiff has suffered and will continue to suffer damages.

FOURTH COUNT (VIOLATION OF SECTION 1983 AS TO ALL DEFENDANTS)

1 – 67. Paragraphs 1 through 67 above are hereby repeated, realleged and incorporated by reference as paragraphs 1 through 67 of this Fourth Count.

68. Plaintiff, as the owner of the Property, has a constitutionally protected property right to use the Residence on the Property as a rehabilitation center.

69. Defendants acted under color of ordinance and regulation, pursuant to municipal policy, custom or practice, to deprive Plaintiff of her property right without due process, in violation of the Fourteenth Amendment to the United States Constitution and Article First, Section 10 of the Connecticut Constitution.

70. Mr. Gallo's conduct as described herein was willful and taken in reckless disregard of the rights of others, including Plaintiff.

71. As a result of Defendants' actions, Plaintiff has suffered and will continue to suffer damages.

FIFTH COUNT (DECLARATORY RELIEF AS TO ALL DEFENDANTS)

1.- 67. Paragraphs 1 through 67 above are hereby repeated, realleged and incorporated by reference as paragraphs 1 through 67 of this Fifth Count.

68. An actual controversy exists between Plaintiff and Defendants concerning the authority of Defendants to act as set forth in Chapter 109 of the Town Code, whether the provisions of Chapter 109 were properly applied to Plaintiff, and whether the First and Second Moratorium could be applied to Plaintiff.

69. Plaintiff seeks a declaration of rights by this Court pursuant to Fed. R. Civ. P. 57 and 28 U.S.C. Section 2201 that Defendants had no statutory authority to act as set forth in Chapter 109 of the Town Code, that Mr. Gallo and the Commission improperly applied the provisions of Chapter 109 to Plaintiff, and that the First and Second Moratoriums do not affect Plaintiff's plan to open the Rehabilitation Center.

DEMAND FOR RELIEF

WHEREFORE, Plaintiff demands that judgment enter in her favor and against Defendants for the following relief:

1. A preliminary injunction whereby Defendants are restrained and enjoined from taking any action that hinders or prevents Plaintiff from establishing and operating an eight bed rehabilitation center on her property located at 64 Double Hill Road, Bethlehem, Connecticut, pursuant to the FHA and the ADA;

2. A permanent injunction whereby Defendants are restrained and enjoined from taking any action that hinders or prevents Plaintiff from establishing and operating an eight bed rehabilitation center on her property located at 64 Double Hill Road, Bethlehem, Connecticut, pursuant to the FHA and the ADA;

3. Compensatory damages, punitive damages, reasonable attorneys' fees and costs pursuant to the FHA;

4. Compensatory damages, reasonable attorneys' fees and costs pursuant to the ADA;

5. Compensatory damages, punitive damages, reasonable attorneys' fees (42 U.S.C. Section 1988) and costs pursuant to Section 1983;

6. Prejudgment interest;

7. A judgment declaring that the Town had no statutory authority to appoint the Commission to grant or deny waiver applications as set forth in Chapter 109 of the Town Code;

8. A judgment declaring that the Commission had no statutory authority to grant or deny waiver applications as set forth in Chapter 109 of the Town Code;

9. A judgment declaring that Mr. Gallo and the Commission had no authority to require Plaintiff to file a waiver application in connection with her plan to use the residence on her property as a rehabilitation center;

10. A judgment declaring that Mr. Gallo and the Commission had no statutory authority to require that a wetlands application be filed or approved in connection with waiver applications as set forth in Chapter 109 of the Town Code;

11. A judgment declaring that the First Moratorium adopted by the Town's Board of Selectmen on May 19, 2009 has no effect on Plaintiff's plan to use the residence on her property as a rehabilitation center because the First Moratorium never became effective.

12. A judgment declaring that the Second Moratorium adopted by the Town, which became effective on August 28, 2009, has no effect on Plaintiff's plan to use the

residence on her property as a rehabilitation center, because Plaintiff's waiver application had been properly filed prior to the date the Second Moratorium became effective.

13. Such other and further legal and/or equitable relief to which Plaintiff may be entitled.

Respectfully Submitted,

THE PLAINTIFF,

By: _____

Vincent M. Marino (ct 17186)
Patricia C. Sullivan (ct 04765)
Barbara M. Schellenberg (ct02400).
Cohen and Wolf, PC
1115 Broad Street
Bridgeport, CT 06601-1921
Tel: (203) 368-0211
Fax: (203) 394-9901
vmarino@cohenandwolf.com
psullivan@cohenandwolf.com
bschellenberg@cohenandwolf.com

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

MICHELE ZURKO-SMITH,	:	
Plaintiff,	:	Civil Action No.
v.	:	
TOWN OF BETHLEHEM, TOWN OF BETHLEHEM PLANNING COMMISSION AND ROBERT GALLO, INDIVIDUALLY AND AS THE CHAIRMAN OF THE TOWN OF BETHLEHEM PLANNING COMMISSION	:	
Defendants.	:	October 19, 2009

REQUEST FOR TRIAL BY JURY

Plaintiff respectfully requests a trial by jury as to all claims and issues so triable in the above-captioned case.

Respectfully Submitted,

THE PLAINTIFF,

By: _____

Vincent M. Marino (ct 17186)
Patricia C. Sullivan (ct 04765)
Barbara M. Schellenberg (ct02400).
Cohen and Wolf, PC
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UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

MICHELE ZURKO-SMITH Plaintiff, V. TOWN OF BETHLEHEM, TOWN OF BETHLEHEM PLANNING COMMISSION AND ROBERT GALLO, INDIVIDUALLY AND AS THE CHAIRMAN OF THE TOWN OF BETHLEHEM PLANNING COMMISSION Defendants.	:	CIVIL NO. 309CV1667(WWE) APRIL 5, 2010

ANSWER AND SPECIAL DEFENSES TO COMPLAINT

NATURE OF ACTION

1. As to the allegations set forth in paragraph 1 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

2. As to the allegations set forth in paragraph 2 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof. The allegations of unlawful conduct are denied.

3. Paragraph 3 is admitted.

JURISDICTION AND VENUE

4-5. As to the allegations set forth in paragraphs 4 and 5 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

PARTIES

6. As to the allegations set forth in paragraph 6 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

7-9. Paragraphs 7 through 9 are admitted.

GENERAL ALLEGATIONS

BACKGROUND

10-11. As to the allegations set forth in paragraphs 10 and 11 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

12. That portion of paragraph 12 as alleges "A representative of the commission informed Ms. Zurko-Smith that there was no zoning in the Town and that there would be 'no problem' with her intended use" is denied. As to the remaining allegations set forth in paragraph 12 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

13. That portion of paragraph 13 as alleges "In reliance on the Commission's representation" is denied. As to the remaining allegations set forth in paragraph 13 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

14. As to the allegations set forth in paragraph 14 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

15. Paragraph 15 is admitted.

16. As to the portion of paragraph 16 as alleges "in her effort to be as conscientious as possible" and "for the first time", the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof. The remaining allegations set forth in paragraph 16 are admitted.

17. As to the allegations set forth in paragraph 17 the defendants have insufficient information and knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

"INITIAL ROADBLOCKS PLACED IN THE PLAINTIFF'S WAY TO PREVENT HER FROM OPENING THE REHABILITATION CENTER"

18. That portion of paragraph 18 as alleges "septic variance" is denied. The remaining allegations set forth in paragraph 18 are admitted.

19. Paragraph 19 is admitted.

20-22. As to the allegations set forth in paragraph 20 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

23. Paragraph 23 is denied as to the alleged charge and as to the alleged motive.

24. As to the allegations set forth in paragraph 24 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

"ADDITIONAL UNREASONABLE ROADBLOCKS: PLAINTIFF'S WAIVER APPLICATIONS AND THE FIRST MORATORIUM"

25. That portion of paragraph 25 that alleges "At that time, Mr. Gallo told Ms. Zurko-Smith that she needed to file an application for a variance from the Town's septic ordinance" is denied. The remaining allegations set forth in paragraph 25 are admitted.

26. As to the allegations set forth in paragraph 26 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

27. That portion of paragraph 27 that alleges "In furtherance of his objective and that of the Commission to prevent the Rehabilitation Center from

opening" is denied. The remaining allegations set forth in paragraph 27 are admitted.

28-30. Paragraphs 28 through 30 are denied.

31. As to the allegations set forth in paragraph 31 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

32. Paragraph 32 is admitted.

33. That portion of paragraph 33 that alleges "Mr. Natush accompanied the Town's Fire Marshal on June 25, 2009 when he inspected the Residence. At that time, he handed Ms. Zurko-Smith a letter stating that a moratorium on commercial uses was in place" is admitted. The remaining allegations set forth in paragraph 33 are denied.

34-35. As to the allegations set forth in paragraphs 34 and 35 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

36. Paragraph 36 is admitted.

37. Paragraph 37 is denied.

38. Paragraph 38 is admitted.

"THE ULTIMATE UNREASONABLE ROADBLOCK: THE TOWN'S MORATORIUM ON ESTABLISHMENT OF SERVICE RELATED HOUSING"

39. Paragraph 39 is admitted.

40. As to the allegations set forth in paragraph 40 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

41. Paragraph 41 is admitted.

42. Paragraph 42 is denied.

43-44. As to the allegations set forth in paragraphs 43 and 44 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

45. Paragraph 45 is admitted.

46. Paragraph 46 is admitted.

47. That portion of paragraph 47 that alleges "the waiver application would not be accepted by the Commission because there was no IWA approval. Mr. Gallo returned the waiver application to Ms. Zurko-Smith" is admitted. The remaining allegations set forth in paragraph 47 are denied.

48-49. Paragraphs 48 and 49 are admitted.

50. As to paragraph 50, the first sentence is admitted and the defendants have insufficient knowledge to admit or deny the second sentence, and so leave the plaintiff to her proof.

51. That portion of paragraph 51 that alleges "Mr. Gallo stated that the waiver application could not be accepted by the Commission because the Second Moratorium prevented her from proceeding with her plan to open the Rehabilitation Center" is admitted. The remaining allegations set forth in paragraph 51 are denied.

52. Paragraph 52 is denied.

DEFENDANTS' LACK OF AUTHORITY TO ACT PURSUANT TO STATUTE

53. Paragraph 53 is admitted.

54-57. The defendants neither admit nor deny paragraphs 54 through 57 as they are statements of law proposed by the plaintiff.

58. That portion of paragraph 58 that alleges "At all times relevant to this action, the Town had not adopted the provisions of Chapter 124 of the Connecticut General Statutes or established a zoning commission" is admitted. As to the remaining allegations set forth in paragraph 58 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

59-60. Paragraphs 59 and 60 are admitted.

61. Paragraph 61 is admitted.

62. Paragraph 62 is admitted.

63. The defendants neither admit nor deny paragraph 63 as it reflects a statement of law proposed by the plaintiff.

64. That portion of paragraph 64 that alleges "Therefore, Mr. Gallo and the Commission improperly required Ms. Zurko-Smith to file a waiver application" is denied. The defendants neither admit nor deny the remaining allegations set forth in paragraph 64 as it reflects a statement of law proposed by the plaintiff.

65. As to the allegations set forth in paragraph 65 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

66. Paragraph 66 is denied.

67. That portion of paragraph 67 that alleges "Ms. Zurko-Smith's waiver application had been properly filed prior to the date the Second Moratorium became effective" is denied. As to the remaining allegations set forth in paragraph 67 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

FIRST COUNT (VIOLATION OF THE FHA AS TO ALL DEFENDANTS)

1-67. The responses to paragraphs 1 through 67 above are hereby incorporated and made the responses to paragraphs 1 through 67 of this First Count as if more fully set forth herein.

68-69. As to the allegations set forth in paragraphs 68 and 69 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

70-73. Paragraphs 70 through 73 are denied.

SECOND COUNT (VIOLATION OF THE FHA AS TO THE TOWN AND THE COMMISSION

1-69. The responses to paragraphs 1 through 69 above are hereby incorporated and made the responses to paragraphs 1 through 60 of this Second Count as if more fully set forth herein.

70-73. Paragraphs 70 through 73 are denied.

THIRD COUNT (VIOLATION OF THE ADA AS TO THE TOWN AND THE COMMISSION)

1-67. The responses to paragraphs 1 through 67 above are hereby incorporated and made the responses to paragraphs 1 through 67 of this Third Count as if more fully set forth herein.

68. The defendants neither admit nor deny paragraph 68 as it reflects a statement of law proposed by the plaintiff.

69. As to the allegations set forth in paragraph 69 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

70-72. Paragraphs 70 through 72 are denied.

FOURTH COUNT (VIOLATION OF SECTION 1983 AS TO ALL DEFENDANTS)

1-67. The responses to paragraphs 1 through 67 above are hereby incorporated and made the responses to paragraphs 1 through 67 of this Fourth Count as if more fully set forth herein.

68. As to the allegations set forth in paragraph 68 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

69-71. Paragraphs 69 through 71 are denied.

FIFTH COUNT (DECLARATORY RELIEF AS TO ALL DEFENDANTS)

1-67. The responses to paragraphs 1 through 67 above are hereby incorporated and made the responses to paragraphs 1 through 67 of this Fifth Count as if more fully set forth herein.

68. As to the allegations set forth in paragraph 68 the defendants have insufficient information or knowledge upon which to base a belief and, therefore, leave the plaintiff to her proof.

69. The defendants neither admit nor deny paragraph 69 as it reflects a statement of law proposed by the plaintiff.

SPECIAL DEFENSES

FIRST SPECIAL DEFENSE

The complaint fails to state a claim upon which relief can be granted against the Town of Bethlehem, in that it alleges no municipal policy or custom that would subject the Town to any liability for the acts of the other defendants. Moreover, the plaintiff's complaint fails to state any actionable acts or omissions by the defendant Town, relying instead on mere conclusions of law.

SECOND SPECIAL DEFENSE

The municipal defendants, including the Town, are immune from liability under the doctrines of municipal and/or sovereign immunity, pursuant to Conn. Gen. Stat. §52-557n, subsections (a)(2), in that the municipality may not be liable for damages to person or property caused by acts or omissions of any employee, officer or agent which constitute criminal conduct, fraud, actual malice or wilful misconduct; or negligent acts or omissions which require the exercise of judgment or discretion as an official function of the authority expressly or impliedly granted by law.

Likewise, pursuant to Conn. Gen. Stat. § 52-557n (b)(7) the municipal defendants may not be held liable for damage to person or property resulting from the issuance, denial, suspension or revocation of, or failure or refusal to issue,

deny, suspend or revoke any permit, license, certificate, approval, order or similar authorization, when such authority is a discretionary function by law, unless such issuance, denial, suspension or revocation or such failure or refusal constitutes a reckless disregard for health or safety.

Finally, the individual municipal defendant, insofar as he serves without monetary compensation, is immune to the claims made here pursuant to §52-557n (c), which holds that such persons shall not be personally liable for damage or injury occurring on or after October 1, 1992, resulting from any act, error or omission made in the exercise of such person's policy or decision-making responsibilities on such board, commission, committee or agency if such person was acting in good faith, and within the scope of such person's official functions and duties, and was not acting in violation of any state, municipal or professional code of ethics regulating the conduct of such person, or in violation of subsection (a) of § 9-369b or subsection (b) or (c) of § 1-206.

THIRD SPECIAL DEFENSE

The individual defendant is immune under the common-law doctrine of qualified immunity for any acts and omissions set forth by way of facts (as opposed to mere conclusions) alleged in the complaint.

FOURTH SPECIAL DEFENSE

Pursuant to Conn. Gen. Stat. § 52-557(n)(b)(6) the municipal defendants are not liable for damages to the person resulting from the act or omission of someone other than these defendants or an employee, officer or agent of the Town of Bethlehem. The plaintiff alleges that some or all of her injuries were sustained as a result of the action of unidentified petitioners. Because the plaintiff's injuries, if any, may have resulted from the acts of persons other than an employee, officer or agent of the Town, the municipal defendants are not liable to the plaintiffs.

THE DEFENDANTS,

By /s/
FREDERICK M. O'BRIEN (ct08989)
Regnier, Taylor, Curran & Eddy
100 Pearl Street, 10th Floor
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860/249-9121
FAX: 860/527-4343
E-Mail: fobrien@rtcelaw.com
Their Attorney

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

MICHELE ZURKO-SMITH Plaintiff, V. TOWN OF BETHLEHEM, TOWN OF BETHLEHEM PLANNING COMMISSION AND ROBERT GALLO, INDIVIDUALLY AND AS THE CHAIRMAN OF THE TOWN OF BETHLEHEM PLANNING COMMISSION Defendants.	:	CIVIL NO. 309CV1667(WWE) April 5, 2010

CERTIFICATE OF SERVICE

On the date above stated, a copy of the Defendants' Answer and Special Defenses was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System.

Vincent M. Marino, Attorney at Law
Patricia C. Sullivan, Attorney at Law
Barbara M. Schellenberg, Attorney at Law
Cohen and Wolf, PC
1115 Broad Street
Bridgeport, CT 06601-1921

/s/
Frederick M. O'Brien

RECEIVED
2010 APR 23 P 1:50
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

STONINGTON INSTITUTE

FACSIMILE TRANSMITTAL SHEET

TO: Commissioner Vogel	FROM: William A. Aniskovich
FAX NUMBER: 860-418-7002	DATE: 4/23/10
COMPANY: OHCA	TOTAL NO. OF PAGES INCLUDING COVER: 4
PHONE NUMBER: 860-418-7053	SENDER'S REFERENCE NUMBER:
RE:	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

This transmission and all the information contained herein is the property of Stonington Institute, and, as such, it is strictly confidential. It is for the limited use of the named addressee only. If you have received this communication in error, please notify us immediately at 860-445-3008. Thank-you.

75 SWANTOWN HILL ROAD • NORTH STONINGTON, CT 06359
PHONE: 860-445-3000

RECEIVED
2010 APR 23 P 1:50
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

April 24, 2010

Cristine A. Vogel
Deputy Commissioner
Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: Employment Options, LLC d/b/a Litchfield Hills Retreat
Docket No. 09-31500-CON

Dear Deputy Commissioner Vogel:

I am writing on behalf of Stonington Institute, a freestanding substance abuse and mental health treatment center with service locations throughout eastern Connecticut, in opposition to the CON Application filed by Litchfield Hills Retreat to establish a 28-bed residential substance abuse treatment facility in Bethlehem. The Applicant proposes to establish a facility that will service exclusively private pay "high profile" clients, at a cost of $50,000 per month. However, the Applicant has not made even a basic showing of need for an additional facility of this type in Connecticut. Nor has the Applicant considered the impact of its proposal on existing providers of residential substance abuse services or on consumers of behavioral health services in this state. The CON Application is seriously flawed and should be denied by OHCA.

Stonington Institute Background & Programs

Stonington Institute has been providing substance abuse services to Connecticut residents since 1957. We began as Starlight Farms, a working farm where adults in recovery were introduced to the principles of Alcoholics Anonymous. Stonington is the longest continuously operating freestanding substance abuse treatment facility in New England. Today, Stonington offers inpatient detoxification, ambulatory detoxification and partial hospital and structured/intensive outpatient services to individuals with substance abuse and co-occurring disorders. Stonington is owned by Universal Health Services, Inc., which owns and operates behavioral health facilities throughout the United States.

Stonington provided adult residential substance abuse services at its North Stonington campus from its inception in 1957 to 2000, when adolescent services were instituted at the facility. In February of 2009, OHCA gave Stonington permission to convert its 45-bed residential substance abuse treatment program for adolescents back to a residential substance abuse treatment program for adults. This has created significant increased adult residential bed capacity in the market.

No Clear Public Need for Litchfield Hills Retreat

The Applicant claims that there is a population of high profile, wealthy individuals in Connecticut who cannot access residential substance abuse services near their homes. However, the Applicant has provided no evidence whatsoever to support its claim that there is a population of lawyers, doctors, executives, celebrities, politicians, and other people of means who cannot access appropriate levels of care at existing facilities in this state. The Applicant is basing its projections regarding bed need and utilization on the experiences of facilities as far away as California, without any regard to the demographics and experiences of individuals and facilities in Connecticut. The reality is that facilities such as Stonington Institute, Silver Hill, High Watch and others can and do provide services to the target population for this proposal. For years, Stonington has had evening intensive outpatient services geared towards professionals and we intend to target these same individuals as we expand our approved adult residential substance abuse program.

Applicant also claims that Litchfield Hills Retreat will offer patients of a certain status a level of privacy that is not available at other residential treatment programs in Connecticut. This is simply not true. Federal and state confidentiality laws surrounding the provision of substance abuse services are some of the strictest laws of their kind. Stonington Institute abides by the letter and spirit of these laws and is steadfast in its protection of the privacy rights of clients. Moreover, Stonington's residential substance abuse program is located on its Main Campus in North Stonington on a heavily wooded street, which affords clients a similar level of seclusion to that being proposed in Bethlehem.

Stonington is also concerned about the fact that Litchfield Hills Retreat will exclude all patients except those who can afford to pay $50,000 per month for treatment. To the extent that there is a need for additional residential substance abuse treatment beds in Connecticut, they should be open to everyone. Substance abuse touches individuals at every socioeconomic level. Our CON laws exist to ensure that all Connecticut residents, not just those with money, have access to appropriate healthcare services. OHCA should not approve a CON application for a service that is intended for wealthy individuals only and that specifically excludes some of our most vulnerable populations. Every behavioral health facility must do its part in providing safety net services and Stonington is proud of its history of providing services to any and all individuals in need of care.

Adverse Impact on Existing Providers

Existing providers of adult residential substance abuse services will suffer if OHCA allows the Applicant to establish the proposed facility. The Applicant is not correct in stating that Litchfield Hills Retreat will be a one-of-a-kind provider in Connecticut. As mentioned previously, there are numerous facilities, including Stonington Institute, that are capable of providing the level of care that the Applicant is proposing. Litchfield Hills Retreat will be in direct competition with Stonington and other providers that offer adult residential substance abuse services to individuals statewide. It is Applicant's stated intention to provide services only to private pay clients, more specifically, those private pay clients who can afford $50,000 per month for residential treatment. For every client that Litchfield Hills Retreat admits, that is one less client of this type that can be

admitted to a Stonington Institute program. These clients and this revenue are critical in that they subsidize the care that Stonington and others provide to less wealthy individuals. The Applicant has undertaken no demand analysis or review of existing capacity and utilization of adult residential substance abuse services by the target population to determine if there is, in fact, a need for the proposed service. In light of the foregoing, it is disingenuous at best for the Applicant to say that Litchfield Hills Retreat will not have an adverse impact on facilities like Stonington.

Quality of Care Issues

Stonington Institute shares others' concern that Litchfield Hills Retreat does not have appropriate linkages in place for the provision of necessary medical services to clients. The management of substance abuse and co-occurring disorders is a complex process. We question whether the Applicant has thought through how medical issues will be handled and made arrangements to ensure that services are available as needed. We also question whether the Applicant fully understands what is required from a regulatory perspective to operate a freestanding substance abuse facility. When asked to "indicate any ... [Department of Public Health] licensure categories being sought in relation to the proposal" the Applicant responds "N/A". It appears the Applicant may be unaware that a DPH license is necessary in order to operate a residential substance abuse treatment facility.

***

Stonington Institute urges OHCA to consider the impact of this Application on the public and on existing providers and to deny the Applicant's request to establish a significant and costly behavioral health facility for which there is no clear public need.

Very truly yours,

William A. Aniskovich, CEO

cc: Jennifer L. Groves, Esq.

FAX TRANSMISSION

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET
THIRD FLOOR
NEW HAVEN, CT 06511
(203) 777-5800 Fax: (203) 777-5806

FAX #: (860) 418-7053
TO: Honorable Cristine Vogel
Office of Health Care Access

DATE: April 26, 2010

PAGES: 10 including this page

CC: Theodore Tucci
Robinson & Cole LLP
Via Facsimile (860) 275-8299

FROM: Michele M. Volpe

MATTER #: 105056

RECEIVED
2010 APR 26 P 12:12
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Facility in Bethlehem

CONFIDENTIALITY NOTICE
Please note that the information contained in this fax is confidential and privileged and is intended only for use by the named receiver. If you have received this fax in error, please call 203-777-5800. Any use of this fax or its contents, including any dissemination or copying, is prohibited. Attorneys receiving this fax in error are directed to review ABA formal ethics opinion no. 92-368.

COMMENTS:

Dear Commissioner Vogel:

Please see the attached Motion to Disqualify the law firm of Robinson & Cole LLP.

Thank you.

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

Christopher M. McKeon
Direct Dial (203) 777-5805

April 26, 2010
Via Facsimile (860) 418-7053
and Federal Express

RECEIVED
2010 APR 26 P 12:12
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Facility in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Motion to Disqualify the law firm of Robinson & Cole LLP.

Thank you.

Very truly yours,

Christopher M. McKeon

CMM/bt
Enclosures

cc: Theodore Tucci, Robinson & Cole LLP

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Motion to Disqualify) 4.26.10.doc

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING ADULT SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 26, 2010**

MOTION TO DISQUALIFY ROBINSON & COLE LLP FROM REPRESENTATION OF HIGH WATCH RECOVERY CENTER INC. AND MOTION TO PRECLUDE CONSIDERATION OF ANY DOCUMENTATION, PETITION OR OTHER REQUEST SUBMITTED BY ROBINSON & COLE ON BEHALF OF HIGH WATCH RECOVERY CENTER INC.

Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC ("Applicant"), makes this motion to disqualify the law firm of Robinson & Cole LLP ("R&C") from representing High Watch Recovery Center Inc. ("High Watch"), a potential Intervenor in this matter. The Applicant further moves to preclude from consideration any documentation, petition or other request submitted to the Department of Public Health's Office of Health Care Access Division ("OHCA") by R&C. In support of this Motion, Applicant submits the following:

1. On December 29, 2009, prior to the filing of the Application at issue in this matter, Michele Zurko-Smith, Brian Gwozdz, and Patricia Happy, as representatives of the Applicant, met with R&C Attorneys Ted Tucci and Brian Nichols at R&C's Hartford offices.

2. The purpose of the meeting was to discuss the Application at issue in this matter and the Applicant's possible retaining of R&C in connection therewith.

3. The meeting lasted for approximately one and one-half hours and at the meeting, the Applicant's representatives disclosed virtually every aspect of the substance abuse facility it seeks to establish in its Application.

4. At this meeting, Ms. Zurko-Smith specifically asked Attorney Tucci and Attorney Nichols if all information being communicated to R&C would be held in strict confidence and be subject to the attorney-client privilege.

5. In response to Ms. Zurko-Smith's inquiry, Attorney Tucci and Attorney Nichols assured all present at the meeting that all information disclosed and discussed at the meeting would be kept confidential and was attorney-client privileged.

6. After obtaining such assurance, Applicant's representatives fully disclosed and shared with Attorneys Tucci and Nichols confidential and strategic information regarding the planned facility, and Attorney Tucci and Attorney Nichols rendered and communicated certain impressions, opinions and advice to the Applicant.

7. The Applicant elected not to retain R&C or any attorney for that matter and chose instead to prepare and file its Application on its own which it did on February 5, 2010.

8. On March 22, 2010, R&C, through Attorney Nichols, issued a letter to Commissioner Cristine Vogel on behalf of High Watch as an objector, seeking a hearing on the Applicant's Application and indicating that High Watch will allegedly be adversely impacted if the facility sought by Applicant is established.

9. The Applicant engaged the undersigned's law firm on April 10, 2010 in connection with the hearing on this matter which is now scheduled for April 29, 2010.

10. As a result of R&C's meeting and consultation with Applicant's representatives on December 29, 2009, and R&C's subsequent decision to represent High Watch in direct opposition to Applicant on the very same Application for which Applicant consulted with R&C, R&C's representation of High Watch in this matter would seem to be in direct violation of Rule 1.18 of the Rules of Professional Conduct which provides as follows:

> (a) A person who discusses or communicates with a lawyer concerning the possibility of forming a client-lawyer relationship with respect to a matter is a prospective client.
>
> (b) Even when no client-lawyer relationship ensues, a lawyer who has had discussions with a prospective client shall not use or reveal information learned in the consultation, except as Rule 1.9 would permit with respect to information of a former client.
>
> (c) A lawyer subject to subsection (b) shall not represent a client with interests materially adverse to those of a prospective client in the same or a substantially related matter if the lawyer received information from the prospective client that could be significantly harmful to that person in the matter, except as provided in subsection (d). If a lawyer is disqualified from representation under this paragraph, no lawyer in a firm with which that lawyer is associated may knowingly undertake or continue representation in such a matter, except as provided in subsection (d).
>
> (d) When the lawyer has received disqualifying information as defined in subsection (c), representation is permissible if:
>
> (1) both the affected client and the prospective client have given informed consent, confirmed in writing, or
>
> (2) the lawyer who received the information took reasonable measures to avoid exposure to more disqualifying information than was reasonably necessary to determine whether to represent the prospective client; and
>
> (i) the disqualified lawyer is timely screened from any participation in the matter; and
>
> (ii) written notice is promptly given to the prospective client.

11. At no time during or after Applicant's meeting with Attorneys Tucci and Nichols did either inform the Applicant that if R&C was not retained by Applicant, that R&C would or could represent another party to the same proceeding.

12. The Applicant did not and does not consent to R&C's representation of High Watch in this proceeding.

13. R&C's representation of High Watch in this matter in any capacity is unfair and improper and it calls into question the fair and efficient administration of justice in this matter.

The Affidavit of Michele Zurko-Smith, which attests to the foregoing, is attached hereto and submitted herewith.

WHEREFORE, it is respectfully requested that Robinson & Cole LLP be disqualified from representing High Watch Recovery Center Inc. or any other party in opposition to the Applicant in this proceeding because it was and is privy to confidential information communicated to it by the Applicant for the purpose of seeking legal representation in connection with the Application at issue in this proceeding. To the extent that Robinson & Cole LLP has or will submit any documentation, petition or other request on behalf of High Watch prior to the Department of Public Health's Office of Health Care Access Division's ("OHCA") decision on this motion, the Applicant further moves that any such documentation, petition or other request be precluded from consideration by OHCA inasmuch as any such documentation, petition or other request prepared by Robinson & Cole LLP is tainted by the unfair and improper advantage obtained by and through Robinson & Cole LLP's prior consultation with the Applicant as set forth above.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: _____

Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
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ORDER

The foregoing motion having been duly heard, it is hereby **GRANTED/DENIED.**

_____
Presiding Officer

CERTIFICATION

This is to certify that a copy of the foregoing was faxed and mailed by first class mail, postage prepaid, this 26th day of April, 2010 to:

Theodore J. Tucci
Robinson & Cole LLP
280 Trumbull Street
Hartford, CT 06103-3597
Facsimile (860) 275 8299

_____
Christopher M. McKeon

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING ADULT SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 26, 2010**

AFFIDAVIT OF MICHELE ZURKO-SMITH

The undersigned, being duly sworn, hereby deposes and says:

1. I am over the age of eighteen years and believe in the obligations of an oath.

2. On December 29, 2009 at approximately 11:00 a.m., as a representative of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC ("Applicant"), I, along with my colleagues, Brian Gwozdz and Patricia Happy, had a meeting at the offices of the law firm of Robinson & Cole LLP ("R&C") located on the 28th floor of 280 Trumbull Street, Hartford, Connecticut, with Attorneys Ted Tucci ("Attorney Tucci") and Brian Nichols ("Attorney Nichols").

3. The purpose of the meeting was to discuss our plans to establish a substance abuse treatment facility in Bethlehem, Connecticut for which we had already filed a Letter of Intent with the State of Connecticut Department of Public Health Division of Office of Health Care Access ("OHCA").

4. At the time of the meeting, we were in the process of preparing an Application for Certificate of Need consistent with the Letter of Intent we had previously filed with OHCA and we were considering retaining R&C to represent Applicant in connection therewith.

5. Our meeting with Attorney Tucci and Attorney Nichols lasted for approximately one and one-half hours and at the meeting, we disclosed every aspect of the substance abuse facility we seek to establish, as well as our theories and analyses as to the need for such a facility, the identity of our consultant's and advisors, the hurdles we had overcome to date in connection with our plans, and the remaining issues and obstacles that stood in the way of our carrying out of our plans to establish a unique substance abuse treatment facility the likes of which do not exist in the State of Connecticut.

6. At this meeting, I specifically and pointedly asked Attorneys Tucci and Nichols if all information being communicated to R&C would be held in confidence.

7. In response to my inquiry, Attorney Tucci assured us that all information disclosed and discussed at the meeting would be kept confidential and was attorney-client privileged.

8. After obtaining such assurance, we fully disclosed and shared with Attorneys Tucci and Nichols confidential and strategic information regarding the planned facility and our Application, and Attorneys Tucci and Nichols rendered and communicated to us certain impressions, opinions and advice.

9. We elected not to retain R&C or any attorney for that matter and chose instead to prepare and file our Application on our own, which we did on February 5, 2010.

10. We were shocked when we learned that R&C was representing High Watch in opposing our Application. We learned that Attorney Nichols issued a letter to OHCA, on behalf of High Watch as an objector, seeking a hearing on our Application and indicating that High Watch will allegedly be adversely impacted if we are permitted to establish the very facility we had described to Attorneys Tucci and Nichols at our December 29, 2009 meeting.

11. At no time during our meeting or afterward did Attorney Tucci or Attorney Nichols indicate that R&C would or could represent another party in this proceeding in the event that we did not retain R&C.

12. We do not and did not consent to R&C's representation of High Watch or any other party or potential party to this proceeding.

13. We feel very strongly that R&C's representation of any party opposing the Application we had consulted R&C about is unfair, unethical and improper and had we known that R&C could or would agree to represent any party in direct opposition to our Application, we would have never disclosed the information we did at our December 29, 2009 meeting.

Michele Zurko-Smith

STATE OF CONNECTICUT)
) ss. New Haven
COUNTY OF NEW HAVEN)

On this the 26th day of April, 2010, before me, the undersigned officer, personally appeared Michele Zurko-Smith, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that he executed the same for the purposes therein contained.

IN WITNESS WHEREOF, I hereunto set my hand.

Commissioner of the Superior Court
~~Notary Public~~ Christopher M. McKeon

My Commission Expires:

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FAX TRANSMISSION

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FAX #: (860) 418-7053
TO: Honorable Cristine Vogel
Office of Health Care Access

DATE: April 26, 2010

PAGES: **34** including this page

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Facility in Bethlehem

CONFIDENTIALITY NOTICE
Please note that the information contained in this fax is confidential and privileged and is intended only for use by the named receiver. If you have received this fax in error, please call 203-777-5800. Any use of this fax or its contents, including any dissemination or copying, is prohibited. Attorneys receiving this fax in error are directed to review ABA formal ethics opinion no. 92-368.

COMMENTS:

Dear Commissioner Vogel:

Please see the attached Pre Filed Testimony of David Sack, M.D.

Thank you.

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CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

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Michele M. Volpe
Direct Dial (203) 777-6995

April 26, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
and Federal Express

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

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2010 APR 29 P 4:29
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of the Prefiled Testimony of David Sack, M.D.

This Prefiled testimony is being submitted in accordance with Section 19a-643-51(e) of the OHCA Rules of Practices. Dr. Sack will be present at the April 29, 2010 public hearing to adopt his testimony under oath and be available for cross-examination.

Should you require anything further, please feel free to contact me.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
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DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING ADULT SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 26, 2010**

RECEIVED
2010 APR 26 P 4:
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

PREFILED TESTIMONY OF EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC BY DAVID SACK, M.D.

Good Morning Deputy Commissioner Vogel and members of the OHCA staff. My name is David Sack, M.D. I have been retained as a consultant by Litchfield Hills Retreat, LLC ("Litchfield Hills" or "Center") to assist in the development of its substance abuse treatment program. I thank you for this opportunity to appear before you today in support of Litchfield Hills' pending Certificate of Need ("CON") Application. On behalf of Litchfield Hills, I respectfully request that the Office of Health Care Access ("OHCA") approve its pending CON Application and permit the establishment of the proposed freestanding adult substance abuse center in Bethlehem. Our request is based on the following:

1. Qualification to Testify

In addition to providing consulting services to entities that seek to establish drug and alcohol treatment centers, I currently serve as the Chief Executive Officer of Elements Behavioral Health, Inc., located in Cerritos, California, as well as the Chief

Executive Officer of the Promises Treatment Centers, located in Malibu and West Los Angeles, California.

I am board certified in Psychiatry, Addiction Psychiatry and Addiction Medicine. I have extensive clinical experience in treating substance abusive and dependent persons. In addition, I am well-versed in the establishment and management of specialized residential and outpatient treatment programs. In my capacity as CEO for Promises Treatment Centers and Elements Behavioral Health, as well as my history as a Medical Director for various organizations, I maintain a strong background in the effective management and operation of rehabilitation centers. (See CV attached as Exhibit A).

My background has equipped me to serve as a consultant to entities that desire to establish high-quality substance abuse treatment centers, such as Litchfield Hills. I will lend my experience in the establishment of alcohol and drug abuse treatment facilities to Litchfield Hills to develop clinically appropriate treatment protocols and procedures. I will work hand and hand with the management of Litchfield Hills to develop an effective treatment program in a manner that is consistent with the internationally recognized standards established by the Commission on Accreditation of Rehabilitation Facilities.

2. Background

The founder and CEO of Employment Options LLC ("Employment Options"), Michele Zurko-Smith (sometimes referred to as the "founder"), is the driving force behind the proposal to establish the Litchfield Hills substance abuse treatment center. Employment Options has been providing vocational and residential support and independent living skills training to Connecticut residents for over fifteen (15) years. It has a deeply rooted reputation for quality. In its provision of residential and vocational

services, Employment Options works collaboratively with the Department of Mental Health and Addition Services, hospitals, physicians, behaviorists, case managers, social workers, conservators and family members. (See CON Application p. 28)

3. Litchfield Hills is Professionally Competent to Operate a Substance Abuse Treatment Center

Litchfield Hills is competent to provide high-quality substance abuse treatment services to that portion of the public comprised of "high-profile" individuals that it will be tailored to serve. The proposal to establish the Litchfield Hills substance abuse treatment center is technically, financially and managerially sound (efficient).

Litchfield Hills has the resources necessary to implement a quality substance abuse center. These resources include: (1) the proven track record and history of success of Employment Options; (2) the founder's work and experience with individuals with substance abuse issues; (3) the relatively low cost of the proposal; (4) the founders private funding source for the proposed center; (5) the expert consulting services Litchfield Hills has retained; (6) the internationally-recognized certification it will seek; and (7) the highly trained professionals Litchfield Hills will employ.

a. The Proposal is Managerially and Financially Efficient

Ms. Zurko-Smith has a proven track record in operating Employment Options. She grew the company from an independent contractor model to one that now employs over one hundred sixty (160) people. Employment Options quickly developed into an established and reliable residential and vocational assistance provider in Connecticut. It is now a vendor for the Bureau of Rehabilitation Services, the Department of Developmental Services, the state's Acquired Brain Injury Waiver program and it is contracted with various school districts to assist students with disabilities in career

choices, vocational assessments and job training and placement. (See CON Application p. 51)

Ms. Zurko-Smith's experience and success in establishing and operating Employment Options illustrates her ability and competency to establish and operate the proposed Litchfield Hills center. As a seasoned businesswoman, Ms. Zurko-Smith will lend her talent to Litchfield Hills as its Chief Operating Officer. In addition, Litchfield Hills will hire an experienced individual to serve as Litchfield Hills' Chief Financial Officer who will report to the Chief Executive Officer and oversee the financial operations of Litchfield Hills. (See CON Application p. 30) Keith Arnold, Vice President of Operations for Elements Behavioral Health who is present here today will provide guidance in retaining the Chief Financial Officer for Litchfield Hills, as well as additional members of the senior administrative staff f the Center. A bio for Mr. Arnold is attached to my prefile as Exhibit B.

It is also relevant that the cost to establish the proposed Litchfield Hills center is relatively low compared to other proposals to establish similar treatment facilities. Ms. Zurko-Smith already owns the real estate that will be the site for the proposed center and she will personally fund the project. (See CON Application p. 35) The establishment of Litchfield Hills will benefit the community not only in its provision of needed substance abuse treatment services but also in terms of job creation. (See CON Application p. 49)

Based on these facts, the proposal to establish the Litchfield Hills center is both managerially and financially competent and its establishment will therefore directly benefit the public in an efficient manner.

b. Litchfield Hills is Poised for Entry as a Substance Abuse Treatment Provider

The professional competence of Litchfield Hills to establish a residential substance abuse treatment center can be further evidenced by the fact that Ms. Zurko-Smith and the staff of Employment Options are well-versed on substance abuse issues. Through their work they have encountered numerous individuals with substance abuse and dependency problems. It is this exposure that has prompted Ms. Zurko-Smith to establish the proposed Litchfield Hills substance abuse treatment center.

Specifically, based on the substantial work that Employment Options provides to the population of people with Acquired or Traumatic Brain Injury, Ms. Zurko-Smith and the staff of Employment Options has identified a very high incidence of substance abuse within this population, as well as the population of residents with other disabilities. This correlation has been well documented.

Ms. Zurko-Smith and the Employment Options staff have a great deal of experience working with individuals' substance abuse issues and their respective substance abuse treatment providers. This experience, as well as Ms. Zurko's successful business history, will translate over directly to the work required to establish and successfully operate Litchfield Hills.

c. The Proposal is Technically Efficient

The proposal is technically efficient based on: (1) Litchfield Hills' employment of licensed and trained staff; (2) its Quality Assurance Plan and protocols regarding medical care and coordination; (3) its engagement of an expert consultant; (4) its attainment of DPH licensure; and (5) its compliance with internationally-recognized rehabilitation facility certification requirements.

i. Licensed and Trained Staff

All of the staff employed by Litchfield Hills will be competent, licensed and certified to provide substance abuse treatment, all as required by law and industry standards. Litchfield Hills will hire a Connecticut-licensed alcohol and drug counselor to serve as its Clinical Director responsible for the establishment of treatment programs and clinical protocols and supervision of the treatment staff. (See CON Application pp. 31 & 57) It will operate its treatment programs in accordance with nationally recognized and established treatment plan models.

Litchfield Hills will hire its Clinical Director and treatment staff upon approval from OHCA. Based on the assessment conducted by Litchfield Hills on the number of qualified professionals available in the state to service the clients of the proposed center, we are confident that Litchfield Hills will be able to obtain and retain the needed high-quality professionals. As of the end of 2009, there were more than one thousand (1,000) credentialed substance abuse professionals in Connecticut[1]. This number breaks down to approximately three hundred (300) certified substance abuse counselors and over seven hundred (700) licensed substance abuse counselors. These figures speak to the sizable pool of available talent available to Litchfield Hills. In addition, Litchfield Hills intends to employ other adjunct professionals, such as clinical social workers, to serve its residents.

ii. Quality Assurance Plan

Litchfield Hills will operate in accordance with an established Quality Assurance Plan. (See CON Application pp. 56-59) This Plan: (1) sets forth the Center's mission and objectives; (3) delineates the responsibilities of the management team; (3) ensures the implementation of program services; (4) provides for the development of a Code of

[1] Based on telephone call on April 14, 2010 with the practitioner licensing unit of DPH.

Ethics; (5) establishes protocols for service; and (6) outlines the patient selection criteria. (See CON Application p. 58).

Litchfield Hills will regularly revisit its Quality Assurance Plan. This Plan will be updated and built upon, as needed, to accommodate developments in the field of substance abuse treatment and the needs of the center's patients. Litchfield Hills' adherence to a structured Quality Assurance Plan, and its dedication to the continued development of that Plan, will help to ensure the provision of high-quality substance abuse treatment services to the patients of Litchfield Hills.

iii. Medical Care Coordination

As you heard earlier today, Litchfield Hills will be markedly different in the types of services it will provide and the population that it will serve, compared to the existing substance abuse providers in the state.

Litchfield Hills' clients will be comprised of individuals who have already received detoxification treatment and who have been cleared medically by a referring physician (CON p. 51).

Litchfield Hills Retreat will implement a comprehensive program to meet the needs of individuals with alcohol and drug abuse. It is well recognized that individuals with substance abuse problems often have a co-occurring disorder such as anxiety or depression. This Center will be staff and equipped to deal with this population. As we proceed to licensure will develop a definitive client activity schedule that describes the frequency and duration of each therapeutic modality. The core of our program is that abstinence from psychoactivie substances is best long term solution for individuals with

drug and alcohol problems and that we achieve this goal through the application of a number of evidence based strategies described below.

One such approach that Litchfield Hills will utilize is a self help framework such as the 12 Step Facilitation Therapy. The focus of this treatment is to encourage the individual to accept that they have become powerless over the use of drugs/alcohol and that they need to turn to a higher power for help to overcome their addiction. It relies on participation in peer support groups and a process of mentorship that guides them through the twelve steps, overcoming the guilt and shame caused by their addiction and a commitment to life free of drugs.

Motivational Interviewing. Based on the concept that drug and or alcohol users go through Stages of Change in order to overcome their dependencies. It recognizes that most individuals who have drug problems are ambivalent about continued treatment. It addresses issues of motivation to change and preparedness to take action.

Cognitive Behavioral Therapy. The efficacy of this treatment was first established for depression and anxiety disorders and has been replicated in the treatment of alcohol and drug dependencies. Central to this approach is that the individual with drug misuse has distorted beliefs that underlie their behaviors. Therapy is focused at making the client conscious of these cognitive distortions, and to develop new strategies for responding to these thoughts.

These treatments will be provided in a range of individual and group psychotherapy sessions that reinforce the skills that acquired. In addition, Litchfield Hills Retreat recognizes that a substantial proportion of individuals seeking treatment for alcohol or drug problems experience co-occurring emotional problems that may require

treatment during their stay. These problems may include marital difficulties (including domestic violence), depressive and anxiety disorders, insomnia and other impulse disorders such as gambling. LHR will maintain a licensed professional staff experienced in treating these disorders and may employ a number of modalities including individual and family psychotherapy, biofeedback, meditation, and yoga and exercise therapies.

LHR is a non-medical facility but will support the medical needs of its clients in a number of ways. A comprehensive health survey will be obtained at the time of admissions along with a physical examination by a consulting physician. Only healthy individuals or those with stable medical problems will be admitted for treatment. In those cases where individuals require medication to treat a medical problem, LHR will secure the medications, and provide them to their clients for self-administration according to the schedule indicated by the client's physician. The dose and timing of self administered medications will be observed by LHR staff and recorded in the chart. Clients with medical issues that emerge during their stay at LHR will be referred for treatment to a community physician.

Litchfield Hills' sole focus will be substance abuse/dependency treatment. The staff at Litchfield Hills will ensure that each client will be thoroughly interviewed and assessed prior to acceptance into the Litchfield Hills program. After this assessment, the Clinical Director, in conjunction with the admissions staff, will make an informed decision regarding whether it is appropriate to admit the individual into the Litchfield Hills program in accordance with its licensure and treatment models or whether another, higher level of treatment is required for the individual. (See CON Application p. 53).

In cases where a client is not cleared for admission by the Clinical Director, they will be referred to an alternative facility that offers the specific type of care that is demanded by the individual, whether it is inpatient psychiatric care, detoxification or other specialty care. Any referrals made by the Clinical Director will be coordinated with the client and his or her referring physician.

Once a client is admitted into the Litchfield Hills program, the staff will regularly track the client's progress and response to the established treatment plan. If it becomes apparent that a client requires a higher level of treatment, transfer to another facility will be discussed with the client and his or her treating physician. Once it is decided that a client should be transferred to a different facility, the staff will work with the client's physician in choosing the most appropriate facility and arranging for the transfer.

Based on a thorough admission assessments and continued monitoring, the Litchfield Hills staff will ensure that only appropriate clients enter and remain in its program. The Litchfield Hills staff will work hand and hand with its clients' treating physicians to ensure that all clients are receiving appropriate treatment and will transfer clients to other facilities, as needed. (See CON Application p. 59) It is notable that this referral model is virtually identical to that proposed by Vista Partners LLC, and approved by OHCA, in its proposal to establish and alcohol and drug treatment center in Sharon. (Docket Number 07-30928-CON).

iv. Expert Consultant

Litchfield Hills has retained my services on a consulting basis as another means of ensuring the success of Litchfield Hills and its provision of the quality substance abuse treatment services in accordance with nationally and internationally recognized standards.

I will use my experience to assist in the establishment of appropriate clinical protocols and treatment plans that will be tailored to Litchfield Hills' target population's substance abuse and dependency issues.

My experience in the field of substance abuse treatment will help to ensure that the Litchfield Hills program is developed in accordance with the most current clinical protocols and plans of treatment. In addition, I will assist Litchfield Hills in attaining accreditation from the Commission on Accreditation of Rehabilitation Facilities.

v. DPH Licensure

Litchfield Hills will provide substance abuse treatment services in accordance with its licensure from the Connecticut Department of Public Health as a private freestanding facility for the care or treatment of substance abusive or dependent persons. Accordingly, Litchfield Hills will operate in accordance with the Department's established quality and safety standards regarding such facilities.

vi. CARF Certification

Litchfield Hills's standards of high-quality substance abuse treatment services will be further evidenced by its accreditation from the Commission on Accreditation of Rehabilitation Facilities ("CARF").

CARF is a private, independent, not-for-profit organization that promotes quality rehabilitation services. It does this by establishing standards of quality for organizations to use as guidelines in developing and offering programs or services to consumers. To obtain CARF accreditation, facilities must demonstrate that they substantially meet certain internationally recognized standards applicable to rehabilitation facilities.

Litchfield Hills will seek CARF accreditation and be subject to the CARF guidelines, thereby ensuring the high-quality treatment services. CARF will send professionals in the field to conduct an on-site survey of the Litchfield Hills center to determine the degree to which Litchfield Hills meets the established CARF quality standards. Litchfield Hills recognizes that it is of utmost importance to adhere to the CARF guidelines and obtain accreditation to align the programs and treatment plans with CARF's internationally recognized standards.

To give OHCA an idea as to the types of guidelines that Litchfield Hills will generally be required to adhere to, I have outlined some of the principles that CARF base its standards on. Litchfield Hills will have to satisfactorily demonstrate the following through policy and practice:

- Partnership with the persons served in the development of treatment services and individualized program goals.
- Service design and delivery that focus on the needs of the persons served.
- A service delivery process that uses a multi-disciplinary approach.
- Program accessibility and assignment of qualified staff members to provide behavioral health services.
- A system of accountability that evaluates the outcomes achieved by the persons served as a measure of the success of the behavioral health programs.

In addition, Litchfield Hills will be required to demonstrate conformance to standards highlighting its values and approaches in at least the following areas:

- Organizational leadership
- Corporate compliance (U.S. only)
- Information management and performance management
- Fiscal management (including risk management)
- Human resources
- Communication
- Accessibility
- Health, safety, and transportation
- Information analysis
- Outcomes management
- Rights of the persons served

- Program structure and staffing
- Screening and access to services
- Individual planning
- Transition/recovery support services
- Pharmacotherapy (if applicable)
- Seclusion and restraint (if applicable)
- Records of the persons served
- Quality records review

Litchfield Hills' dedication to employing highly-trained staff, establishing protocols that serve to ensure that Litchfield Hills provides treatment to appropriately admitted clients, its compliance with the state's licensure requirements, its adherence to CARF certification standards, and its willingness to engage a professional in the field, such as me, all lend to the technical efficiency of the proposal.

4. Conclusion

Litchfield Hills is poised to enter into the field of substance abuse treatment; it is professionally competent to establish a center to provide these services to the high-profile population that it intends to serve.

The success of Employment Options and its experience with substance abusing/dependent individuals, the personal financing of the proposed center and the fact that the real estate is already owned by Ms. Zurko-Smith all evidence the managerial and financial efficiency of the proposal, as well as the certainty of implementation.

Furthermore, the technical efficiency of the proposal is evidenced by Litchfield Hills' dedication to engaging experts in the field to establish clinical protocols and treatment plans, hiring only highly-trained and appropriately licensed professionals, adhering to a Quality Assurance Plan and referral protocol, as well as adhering to CARF certification requirements.

Based on the foregoing support evidencing the professional competence of Litchfield Hills, its managers and proposed staff, we ask that OHCA grant Litchfield Hills' pending CON Application to establish and operate the Litchfield Hills residential substance abuse treatment center.

I thank you for this opportunity to appear before you today to provide my testimony in support of the pending CON Application.

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Docs\Prefiled Testimony\Prefiled Testimony (Dr. Sack) (BVM 4.26.10).doc

EXHIBIT A

CURRICULUM VITAE

David A. Sack, MD
19456 Woodlands Lane
Huntington Beach, California, 92648

Telephone: 562-965-3193
Home: 714-969-7093
Fax: 630-982-3688
Email: david.a.sack@gmail.com

Professional Experience:

2008-Present	CEO, Elements Behavioral Health, Inc. CEO, Promises Treatment Centers
2007- 2008	Consultant, clinical trials protocol development primarily in schizophrenia and bipolar disorder.
Center, persistently ill	Attending psychiatrist, La Casa Mental Health Rehabilitation an intensive rehabilitation program for seriously and patients with schizophrenia and schizoaffective disorders.
2006-2007	*Senior Vice President,* Aspen Education Group, Inc., Cerritos California. Executive Director of Eating Disorders Division
2000 - 2005	*Senior Vice President,* National Director of Clinical Research, Comprehensive NeuroScience, Inc., White Plains, NY. Supervised all aspects of clinical trial protocol development and network services specializing in disorders of the central nervous and clinical pharmacology. The network includes a 70 bed Phase I program and 9 Phase II-IV sites.
1994 - 2004	*Principal Investigator* Clinical trials program limited to central nervous system diseases, in Cerritos, CA. Key accomplishments: Successful enrollment, retention and separation from placebo in numerous pivotal trials of antipsychotic medications, mood stabilizers, antidepressants, cognitive and sedative hypnotic medications.
1998 - 2001	*Senior Vice President, Clinical Services* Aspen Education Group, Cerritos, CA Built and managed the operations of the Community Services Division, the largest privately owned network of publicly funded

mental health and substance abuse treatment centers in California, specializing in the treatment of high risk youth.

President and Medical Director
College Health IPA, a managed behavioral health group practice
Cerritos, CA
As medical director developed utilization/managment guidelines and supervised clincal operations. Directly surpervised credentialling and care management. Developed financial models used to negotiate and manage capatiated and risk contracts for behavioral services. Developed a statewide provider network in California. In addition successfully implemented instensive rehabiliation programs and substance abuse treatment programs contracted to County Mental Health Agencies.

1982 - 1999

Private Practice Experience
Inpatient and outpatient treatment of patients with mood, anxiety and thought disorders. Developed and supervised ambulatory detoxification and substance abuse treatment programs. Extensive experience with treatment resistant depression including the use of electroconvulsive therapy.
Southern California

1993 - 1999

Senior Medical, Director
College Hospital
Cerritos, CA
Responsible for professional affairs, regulatory compliance and managed care contracting. Directly supervised credentialing, peer review and professional conduct, development of policies and procedures, and survey preparation.

1987 - 1993

Medical, Director
Los Altos Hospital and Mental Health Center,
Long Beach, CA
Responsible for medical affairs and regulatory compliance. Key Accomplishments: Awarded *Best New Hospital* recognition by national hospital corporation. Implemented specialized programs for Panic disorder and Post-traumatic stress disorder. Authored book on adult victims of sexual abuse. Implemented a successful electroconvulsive therapy program despite a hostile regulatory environment.

1983 - 1987	*Chief, Inpatient Unit* Clinical Psychobiology Branch, National Institute of Mental Health Bethesda, MD Supervised all research trials conducted on an inpatient mental health unit at the Clinical Center, NIH. Conducted independent research in biological rhythms, photobiology, and sleep deprivation.
1994 – 2005	Qualified Medical Examiner, State of California

Education:

1981 - 1983 Health	*Fellowship: Psychopharmacology,* National Institute of Mental Bethesda, MD
1979 - 1981	*Residency: Psychiatry,* UCLA Neuropsychiatric Institute Westwood, CA
1978 - 1979	*Internship: Psychiatry,* UCLA Neuropsychiatric Institute Westwood, CA
1978	*M.D.* Rush Medical College Chicago, IL
1974	*B.A. Psychology* Suma Cum Laude, SUNY at Buffalo Buffalo, NY

Licensure and Certifications:

10-31-2006	CA. License# G40374
02-28-2005	DEA License# AS9033983
	Certification: Department of Industrial Relations, Industrial Medical Council; Qualified Medical Evaluator, 1993 to present
	Diplomat: American Society of Addiction Medicine, 2000
	Diplomat: Added Qualification in Addiction Psychiatry, American Board of Psychiatry and Neurology, 1994
	Diplomat: Added Qualification in Geriatric Psychiatry, American Board of Psychiatry and Neurology, 1991

Diplomat: Psychiatry, American Board of Psychiatry and Neurology, January, 1984

Honor: 1978 – Phi Beta Kappa

PUBLICATIONS

1. Schauf CL, Davis FA, Sack DA, Reed BT, Kesler RL: Neuroelectric blocking factors in human and sera evaluated using the isolated frog spinal chord. *Journal of Neurology, Neurosurgery, and Psychiatry,* 39: 680-685, 1976.

2. Scharfstein SS, Sack DA, Fauci AS: Relationship between alternate day corticosteroid therapy and behavioral abnormalities. *Journal of the American Medical Association,* 248: 2987-2989, 1982

3. Wehr TA, Sack DA, Rosenthal NE, Duncan WK, Gillin JD, Gillin JC: Circadian rhythm disturbances in manic-depressive illness. *Federation Proceedings,* 42: 2809-2814, 1983.

4. Rosenthal NE, Sack DA, Wehr TA: Seasonal Variation in affective disorders, in Wehr TA, Goodwin FK (eds.), *Biological Rhythms in Psychiatry,* Boxwood Press, Pacific Grove, California, 1983, pp. 185-201.

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6. Rosenthal NE, Sack DA, Carpenter CJ, Parry BL, Mendelson WB, Wehr TA: Antidepressant effects of light in seasonal affective disorder. *American Journal of Psychiatry,* 142: 06-608, 1985.

7. Wehr TA, Sack DA, Duncan W, Rosenthal NE, Gillin JC, Goodwin FK: Sleep and circadian rhythms in affective patients isolated from external time cues. *Psychiatry Research,* 15: 327-339, 1985

8. Sack DA, Nurnburger J, Rosenthal NE, Ashburn E, Wehr TA: The potentiation of antidepressant medications by phase-advance of the sleep-wake cycle. *American Journal of Psychiatry,* 142: 606-608, 1985

9. Wehr TA, Rosenthal NE, Sack DA, Gillin JC: Antidepressant effects of sleep deprivation in bright and dim light. *Acta Psychiatrica Scandinavica,* 72: 161-165, 1985.

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13. Rosenthal NE, Sack DA, Wehr TA: Seasonal effects on mood: The role of light in Adelman G(ed.), *Encyclopedia of Neuroscience,* Birkhauser, Boston.

14. Wehr TA, Sack DA, Rosenthal NE: Antidepressant effects of sleep deprivation and phototherapy. *Acta Psychiatrica Belgica,* 85, 593-602, 1985.

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18. Mendelson WB, James SP, Rosenthal NE, Sack DA, Wehr TA, Garnett D, Weingartner H: The experience of insomnia. *Proceedings of the World Congress of Biological Psychiatry.*

19. Rosenthal NE, Sack DA, Jacobsen FM, Parry BL, James SP, Tamarkin L, Arendt J, Wehr TA: Consensus and controversy in seasonal affective disorder and phototherapy. *Proceedings of the World Congress of Biological Psychiatry.*

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65. Rosenthal NE, Carpenter CJ, Sack DA, Jacobsen FM, James SP, Wehr TA: The placebo effect and other methodological issues in phototherapy studies of seasonal affective disorder.

RECENT CLINICAL RESEARCH EXPERIENCE

1. "XXX Versus Haloperidol in the Treatment of Schizophrenia and Other Psychotic Disorders".

2. "A Comparative Cost Effectiveness Study of XXX and Usual Care versus Lithium and Usual care in the Treatment of Bipolar Disorder".

3. "XXX Plus XXX Versus XXX Plus Placebo in the Treatment of Major Depression".

4. "Double-Blind, Randomized, Placebo-Controlled Evaluation of the Safety, Tolerability and Parmacokinetics of Dehydoepiandrosterone (DHEA) in Patients with Alzheimer's Disease".

5. "An Open-Label, Multicenter Clinical Trial Evaluating the Safety and Efficacy of XXX Hydrochloride (E2020) in Patients with Alzheimer's Disease".

6. "Strategies for Switching from Conventional Antipsychotic Drugs to XXX".

7. "U-101387G: Double-Blind, Haloperidol-Controlled, Safety and Dose-Finding Study in the treatment of Schizophrenia".

8. "A Phase III Double-Blind Placebo-Controlled Study of XXX in the Treatment of Psychosis".

9. "An Open-label Follow-On Study of the Long-Term Safety of XXX in Patients with Psychosis".

10. "XXX Added to Mood Stabilizers in the Treatment of Bipolar Disorder".

11. "XXX Alone and in Combination with Fluoxetine versus Placebo in Major Depressive Disorder with Psychotic Features".

12. "A Multicenter, Placebo and Active Control, Double-Blind Randomized Study of the Efficacy and Safety of XXX (10 & 20 mg/day) in Schizophrenic and Schizoaffective Patients (3002)".

13. "A Multicenter, Open-Label, Long-Term, Follow-up Safety Study of XXX Tablets in Schizophrenic and Schizoaffective Subjects.

14. "A Prospective, Randomized, International, Parallel-Group Comparison of XXX Vs. XXX in the Reduction of Suicidality in Patients with Schizophrenia and Schizoaffective Disorder Who Are at Risk for Suicide".

15. "A Double-blind, Placebo-Controlled, Parallel- Group Assessment of the XXX Transdermal System in the Reappearance of Symptoms Associated with Major Depression."
16. "A Double-blind, Randomized, Multicenter, Parallel Group design Study to Evaluate the Efficacy and Safety of Two Dose Ranges of XXX in comparison with Placebo and Haloperidol in the Treatment of Schizophrenia."

17. "Protocol XXX, XXX, Placebo, and Paroxetine Comparison in Patients with Major Depressive Disorder."

18. "A Multi-center Placebo–Controlled Double Blind Study Comparing the Safety and Efficacy of XXX and Olanzapine in Subjects with Schizophrenia or Schizoaffective Disorder Needing Inpatient Care".

19. "A 52-week (1 year), Open Extension Study Evaluating The Safety and Efficacy Of Continued Administration of 40-160 mg Daily Of Oral XXX In the Treatment Of Subjects Who Have Participated In Previous XXX Trials" .

20. "XXX in the Management of Behavioral Disturbance and/or Psychosis in Demented Nursing Home Patients."

21. " A Double-Blind Randomized Comparison of the Efficacy and Safety of Short Acting Intramuscular XXX, Short Acting Intramuscular Haloperidol, and Intramuscular Placebo in Patients with Schizophrenia".

22. "The Efficacy of XXX and Adjunctive Lorazepam, as needed, to Treat Acute Behavioral Agitation in Schizophrenia".

23. "A Randomized Double-Blind Study to Evaluate the Anticholinergic Burden in Subjects with Psychosis of Dementia Treated with XXX or Olanzapine".

24. "A Multicenter, Randomized, Double-Blind, Placebo Controlled Study of Three Fixed Doses of XXX in the Treatment of Institutionalized Patients with Psychosis Associated with Dementia of the Alzheimer's Type".

25. "XXX Depot (microspheres) vs. Placebo in the Treatment of Subjects with Schizophrenia or Schizoaffective Disorder".

26. "A Three-Week, Multicenter, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group Safety and Efficacy Study of Extended-Release XXX in Patients With Bipolar Disorder".

27. "The Efficacy and Safety of Flexible Dose Ranges of XXX vs. Placebo or Divalproex Sodium in the Treatment of Manic or Mixed Episodes Associated with Bipolar I Disorder".

28. "A 9-Week, Open-Label, Multicenter, Safety Trial of Flexible Dose Ranges of XXX in the Treatment of manic or Mixed Episodes Associated with Bipolar I Disorder".

29. "A Controlled Trial of Olanzipine versus XXX in the Treatment of Schizophrenic and Schizoaffective Subjects with Prominent Negative Symptoms."

30. "A Multicenter, Randomized, Double-Blind Study of Flexible Doses of XXX vs. Perphenzaine in the Treatment of Patients with Treatment-Resistant Schizophrenia".

31. A Multicenter, Randomized, Double-Blind, Placebo Controlled, 26 Week Study of a Fixed Dose of XXX in the Treatment of Stabilized Patients with Chronic Schizophrenia".

32. "A Multicenter, Randomized, Double-Blind Safety and Tolerability Study of Flexible Doses of XXX and Olanzapine in the Treatment of Patients with Acute Schizophrenia".

33. "A Double-Blind, Placebo and Haloperidol-Controlled, Multicenter Study Evaluating the Safety and Efficacy of XXX in Schizophrenic patients".

34. "A Double-Blind, Placebo and Haloperidol-Controlled, Multicenter Study Evaluating the Safety and Efficacy of XXX in Schizophrenic Patients".

35. "Open Label Trial Exploring A Switching Regimen From Oral Neuroleptics, Other Than Risperidone, To XXX Depot Microspheres".

36. "A Phase III, Open-Label Study of the Safety and Efficacy of XXX in Patients with Major Depressvie Disorder with Psychotic Features Who Have Previously Demonstrated a Rapid Response to either C-1073 or Placebo in Study C-1073-02 or C-1073-03",

37. "A Multicenter, Double-blind, Randomized Comparison of the Efficacy and Safety XXX and Risperidone (RISPERDAL) in the Treatment of Patients with Schizophrenia".

38. "A Multicenter, Double-blind, Randomized Comparison of the Efficacy and Safety of Sustained-release Formulation XXX and Placebo in the Treatment of Patients with Schizophrenia".

39. "A Randomized, Double-Blind, Dose-Ranging Study Of Intramuscular XXX In The Treatment Of Acute Agitation In Patients With A Diagnosis Of Schizophrenia, Schizoaffective, Or Schizophreniform Disorder".

40. "A Double-Blind, Placebo-Controlled Trial To Estimate The Maximum Tolerated Dose (MTD) of XXX In Patients With Schizophrenia or Schizoaffective Disorder, Who Are Poor Metabolizers For The CYP2D6 Enzyme."

41. "A Phase III, Randomized, Double-Blind, Placebo-Controlled, Outpatient Study To Assess The Long-Term Safety And Efficacy Of Two Dose Levels Of XXX In Adult Patients With Primary Insomnia."

42. "A 21-day, double blind, placebo-controlled, parallel-group evaluation of the efficacy and safety of XXX in the treatment of the manic phase of bipolar disorder."

43. "A Randomized, double blind study of this safety and efficacy of XXX plus an atypical Antipsychotic vs. atypical Antipsychotic alone in the treatment of Schizophrenia."

44. "A Multicenter, randomized, parallel group, double blind, Phase III comparison of the efficacy and safety of XXX to placebo, when used as adjunct to mood stabilizers in the maintenance treatment of bipolar I disorder in adult patients."

45. "A Multicenter, open label, flexible dose, parallel-group evaluation of the cataractogenic potential of XXX and Risperidone (Risperdal) in the long term treatment of patients with Schizophrenia or Schizoaffective disorder."

46. A Multicenter, randomized, double blind, placebo controlled study of three fixed doses of XXX in the treatment of patients with acute schizophrenia.

47. "A randomized, double blind, comparison of the efficacy and safety of XXX in Intramuscular formula, Lorazepam or placebo in the treatment of acutely agitated patients diagnosed with bipolar I disorder, manic or mixed."

48. "A randomized, double blind, comparison of the efficacy and safety of XXX in Intramuscular formula, Haloperidol, or placebo in the treatment of acutely agitated patients with a diagnosis of Schizophrenia or Schizoaffective disorder."

49. "A randomized, double blind, dose-ranging study of Intramuscular XXX in the treatment of acute agitation in patients with a diagnosis of schizophrenia, schizoaffective or schizophreniform disorder."

50. "A Multicenter, randomized, double blind, parallel group, placebo controlled, flexible dose study evaluating efficacy, safety and tolerability of once-daily oral XXX (20-40-60-mg) vs. placebo in subjects with major depressive disorder over an eight-week treatment period."

51. "An open label study assessing XXX in subjects with major depressive disorder who discontinued treatment with selective Serotonin Reupdate Inhibitors or a selective Serotonin/Norepinephrine Reuptake Inhibitor due to intolerability."

52. "A randomized, double blind, placebo controlled dose response trial of XXX in the treatment of bipolar I disorder, most recent episode depressed."

53. "A Pharmacokinetics, tolerability and safety of XXX after repeated Intramuscular injection of XXX in the arm or the buttock of subjects with Schizophrenia."

54. "A comparison of steady state Pharmacokinetics of XXX after extended release OROS XXX 15mg and immediate release of Oral Risperidone 8mg b.i.d. in subjects with schizophrenia or schizoaffective disorder."

55. "An open label evaluation of the utility of the XXX Treatment Guidebook during transition of adult patients with schizophrenia or schizoaffective disorder to XXX."

56. "A 12-week, Multicenter, randomized, double blind, placebo-controlled evaluation of XXX as adjunctive therapy in the treatment of cognitive impairment of patients with schizophrenia or schizophrenia disorder."

57. "A randomized, double blind, placebo-controlled and Risperidone-referenced, parallel-group efficacy and safety study of two fixed doses of XXX in the treatment of schizophrenia."

58. "An open label, flexible dose, long term safety and efficacy study of XXX in the treatment of schizophrenia."

59. "A phase III, open-label, fixed dose study to determine the safety of long-term administration of XXX in subjects with chronic insomnia."

60. "A Multicenter, randomized, parallel-group, double blind, phase III comparison of the efficacy and safety of XXX (oral tablets 400mg to 800mg daily in divided doses) to placebo when used as adjunct to mood stabilizers (lithium or divalproex) in the maintenance treatment of bipolar I disorder in adult patients."

61. "A four-week, double blind, Multicenter study comparing the efficacy and safety of XXX to XXX in subjects with schizophrenia or schizoaffective disorder needing inpatient care."

62. "A randomized, double blind, placebo-controlled, dose response of XXX in subjects with schizophrenia who have predominantly negative symptoms."

63. "A Multicenter, double blind, randomized comparison of the efficacy and safety of XXX and Risperidone (RISPERDAL) in the treatment of patients with schizophrenia."

EXHIBIT B

Keith Arnold
Executive Vice President, Elements Behavioral Health

Keith P. Arnold is Vice President of Operations for Elements Behavioral Health and Promises Treatment Centers. He joined the company in August 2008 and is responsible for overseeing and contributing to sales and marketing, corporate branding, referent relations, intake, alumni services, clinical programming, and Internet operations.

Prior to joining Elements, Keith served as Executive Director of Sierra Tucson, a 139-bed dually licensed psychiatric and behavioral health hospital, where he was responsible for leading and directing all aspects of the operation. His 14-year tenure included being the director of marketing, intake, alumni services, and investor relations.

The majority of Keith's career prior to Sierra Tucson was as Director of Client Services for ExecuTrak Systems, an international consulting firm. There he was responsible for sales and marketing, facilitating merger and acquisition integration, strategic planning, rightsizing, quality programs, team building, and business values assessments. He worked with Fortune 100 companies nationally and internationally.

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, April 27, 2010 10:02 AM
To: Greer, Leslie
Subject: FW: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)
Attachments: Prefiled Testimony re Need (Gwozdz)(4 26 10).pdf

Please add to the record.

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
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From: Bettyanne Toole [mailto:bettyanne@bvmlaw.com]
Sent: Monday, April 26, 2010 3:28 PM
To: Lazarus, Steven
Cc: michelemvolpe@aol.com; Christopher McKeon; Aimee Onofrio
Subject: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

Steven: On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, attached please the Prefiled Testimony of Brian Gwozdz. Thank you.

Betty Anne Toole-Teasley
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
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Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, April 27, 2010 10:03 AM
To: Greer, Leslie
Subject: FW: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)
Attachments: Prefiled Testimony (Dr. Sack) (BVM 4.26.10).pdf

Please add to the record.

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Bettyanne Toole [mailto:bettyanne@bvmlaw.com]
Sent: Monday, April 26, 2010 3:29 PM
To: Lazarus, Steven; Martone, Kim
Cc: michelemvolpe@aol.com; Christopher McKeon; Aimee Onofrio
Subject: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

Steven: On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, attached please the Prefiled Testimony of David Sack, M.D. Thank you.

Betty Anne Toole-Teasley
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Facsimile: (203) 777-5806

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Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, April 27, 2010 10:03 AM
To: Greer, Leslie
Subject: FW: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)
Attachments: Request for Administrative Notice.pdf; Objection to Silver Hill Intervenor.pdf

Please add to the record.

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
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From: Bettyanne Toole [mailto:bettyanne@bvmlaw.com]
Sent: Monday, April 26, 2010 4:07 PM
To: Lazarus, Steven; Martone, Kim
Cc: michelemvolpe@aol.com; Christopher McKeon; Aimee Onofrio
Subject: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

Steven and Kim: Attached is our Request for Administrative Notice and our Object to the petition of Silver Hill Hospital Inc. (the "Petitioner") to be designated as an intervenor. Thank you.

Betty Anne Toole-Teasley
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
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Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, April 27, 2010 10:05 AM
To: Greer, Leslie
Subject: FW: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

Please add to the record.

Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
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Hartford, Connecticut 06134
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From: Bettyanne Toole [mailto:bettyanne@bvmlaw.com]
Sent: Monday, April 26, 2010 4:23 PM
To: Martone, Kim; Lazarus, Steven
Cc: michelemvolpe@aol.com; Christopher McKeon; Aimee Onofrio
Subject: RE: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

No, Steven Lazarus confirmed that we can overnight all the hard copies (for delivery tomorrow morning) and fax and email by 4:30 today. Thank you.

From: Martone, Kim [mailto:Kimberly.Martone@ct.gov]
Sent: Monday, April 26, 2010 4:23 PM
To: Bettyanne Toole
Subject: RE: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

Betty, are we getting hard copies delivered of all documents by 4:30?

Kimberly R. Martone
Director of Operations
Office of Health Care Access
860-418-7029

From: Bettyanne Toole [mailto:bettyanne@bvmlaw.com]
Sent: Monday, April 26, 2010 3:30 PM
To: Martone, Kim
Cc: michelemvolpe@aol.com; Christopher McKeon; Aimee Onofrio
Subject: FW: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

Kim: FYI below and attached. Thank you.

FAX TRANSMISSION

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET
THIRD FLOOR
NEW HAVEN, CT 06511
(203) 777-5800 Fax: (203) 777-5806

FAX #: (860) 418-7053
TO: Honorable Cristine Vogel
Office of Health Care Access

DATE: April 26, 2010

PAGES: 104 including this page

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Facility in Bethlehem

CONFIDENTIALITY NOTICE
Please note that the information contained in this fax is confidential and privileged and is intended only for use by the named receiver. If you have received this fax in error, please call 203-777-5800. Any use of this fax or its contents, including any dissemination or copying, is prohibited. Attorneys receiving this fax in error are directed to review ABA formal ethics opinion no. 92-368.

COMMENTS:

Dear Commissioner Vogel:

Please see the attached Pre Filed Testimony of Brian Gwozdz.

Thank you.

RECEIVED
2010 APR 26 P 4:29
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

BERSHTEIN, VOLPE & McKEON P.C.
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NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

Michele M. Volpe
Direct Dial (203) 777-6995

April 26, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
and Federal Express

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

RECEIVED
2010 APR 26 P 2:29
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of the Prefiled Testimony of Brian Gwozdz.

This Prefiled testimony is being submitted in accordance with Section 19a-643-51(e) of the OHCA Rules of Practices. Mr. Gwozdz will be present at the April 29, 2010 public hearing to adopt his testimony under oath and be available for cross-examination.

Should you require anything further, please feel free to contact me.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Prefiled - Gwozdz) 4.26.10.doc

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING RESIDENTIAL ADULT SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 26, 2010**

RECEIVED
2010 APR 26 P 4:
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

PREFILED TESTIMONY OF BRIAN GWOZDZ ON BEHALF OF LITCHFIELD HILLS RETREAT, LLC

Good Morning Deputy Commissioner Vogel and members of the OHCA staff. My name is Brian Gwozdz and I am the Acting Director of Litchfield Hills Retreat, LLC ("Litchfield Hills"). I thank you for this opportunity to appear before you today. As stated in our Certificate of Need Application ("CON"), Litchfield Hills respectfully requests that the Office of Health Care Access ("OHCA") approve its pending CON Application and permit the establishment of the proposed freestanding adult substance abuse center in Bethlehem. Our request is based on the following:

1. Clear Public Need for Litchfield Hills

    a. Background

As stated throughout our CON Application, Litchfield Hills will offer a highly specialized treatment program for adults with substance abuse disorders. Unlike any existing providers of substance abuse treatment in Connecticut, Litchfield Hills will be exclusively geared toward individuals whose public visibility, wealth or social position make it difficult to maintain and adhere to a lifestyle that fosters a successful recovery

from substance abuse disorders. These individuals demand a discreet, highly confidential and secluded environment. Socio-economic status should not operate to frustrate or prevent this group of individuals from seeking treatment for substance abuse/dependency in their home state. In recognition of the fact that people with different backgrounds, education and professions often require specific guidance and treatments, Litchfield Hills will offer treatment that is tailored toward this specific population's individualized needs. (See CON Application p. 51)

Litchfield Hills will seek licensure from Connecticut's Department of Public Health as a Facility for the Care or Treatment of Substance Abusive or Dependent Persons and accreditation from the Commission on Accreditation of Rehabilitation Facilities. Litchfield Hills will offer substance abuse rehabilitation care with individualized treatment plans incorporating nationally accepted addiction treatment modalities. The Litchfield Hills treatment plans will be established taking into consideration its clients' professional situations and the individual burdens brought on by their unique social backgrounds and family relationships.

b. Underserved Population

The existing providers of substance abuse treatment in Connecticut are not necessarily tailored to the needs of the specific "high-profile" population Litchfield Hills will serve. This population includes individuals whose public visibility, wealth or social position make it difficult to obtain treatment. The population of "high-profile" Connecticut residents that will benefit from the Litchfield Hills facility is substantial. (See CON Application p. 25)

The need for Litchfield Hills is based on the significant substance and alcohol dependency that exists in Connecticut, particularly among certain high-income individuals such as physicians, attorneys, executives and other high-earners, as well as the fact that there are no small residential alcohol and drug treatment facilities in the state that offer extremely private, discreet and individualized programs sought by this population and proposed by Litchfield Hills. (See CON Application p. 52)

According to a *Time* magazine article (See Exhibit 1), seventy percent (70%) of New York City's drug users are affluent. The article indicates that drug counselors in the United States report increasing numbers of professionals who seek treatment for substance abuse. The article evidences the need for facilities like the one proposed by Litchfield Hills to accommodate this specialized population.

Given that nearly forty percent (40%) of Connecticut's residents work in the fields of management, professional and related occupations (See Exhibit 2), there is undoubtedly a need for a residential treatment facility customized for this population in the state. Note that this percentage does not take into account the population of professional residents who travel outside of the state, for example to New York City, to work, or that population of professionals residing in border states who may need substance abuse treatment.[1]

According to the Department of Public Health, there are presently more than sixteen thousand (16,000) active licensed physicians in Connecticut. According to the state's Department of Labor, as of the first quarter of 2009, there are more than eight thousand (8,000) employed attorneys, four thousand seven hundred fifty (4,750) chief

[1] OHCA Declaratory Ruling 09-31433-DCL permits OHCA to take into consideration out-of-state residents in determining a need for health care services.

executives, and nearly twenty-two thousand (22,000) financial managers, analysts, examiners and other financial specialists. (See Exhibit 3). Again, these figures do not take into account those residents who travel outside of Connecticut for work.

Substance abuse and dependency among physicians is significant. According to the article, *Substance Abuse Among Physicians: What You Need to Know* by Roger S. Cicala, MD (See Exhibit 4), it is conservatively estimated that eight percent (8%) to twelve percent (12%) of physicians will develop a substance abuse problem at some point during their career and that at any given time, as many as seven percent (7%) of practicing physicians are active substance abusers.

The Cicala article states that treatment of physicians has shown to be more successful when it takes place in a facility that has a significant number of other physician patients. The reason for this is because, unless there are other similar patients in the program, the physician in treatment often gets special treatment from other patients and staff, thereby negating some of the benefits of treatment. This principle can be applied across the board to other individuals practicing in various professions.

Similar to physicians, attorneys represent another component within the specialized population that Litchfield Hills is intended to serve. According to the Ohio Lawyers Assistance Program, eighteen percent (18%) to twenty percent (20%) of attorneys suffer from alcoholism. This rate rises to twenty-five percent (25%) after twenty years of practice. (See Exhibit 5) (See also CON Application p.136).

Like physicians and attorneys, "corporate America" is greatly affected by substance abuse/dependency issues. Notwithstanding the highly-educated and career-minded individuals that work in this industry, they are not immune to the abuse of and

dependency on alcohol and drugs. In fact, industry "norms" themselves can be the catalyst for abuse. It is well-documented and written about that those working in the financial services industry are more prone to abusing drugs and alcohol because they are subject to an overwhelming pressure and anxiety about meeting profit goals (See Exhibit 6).

This industry as a whole has the disposable income and access to drugs, drug-using friends and associates. As individuals with management responsibility and power, it is often extremely important for them to be able to receive confidential treatment with similarly situated individuals in a private setting, such as the proposed Litchfield Hills center.

Litchfield Hills would serve this high-profile population comprised of physicians, attorneys, executives and other high-earning individuals by offering a setting where individuals with similar backgrounds and status can obtain treatment without being identified and treated as "special" or "extraordinary" within the facility. This is an important aspect in achieving successful recovery.

c. Connecticut's Population of High-Profile Substance Abusing/Dependent Persons that will Benefit from Establishment of Litchfield Hills

i. Number of Residents with a Substance Abuse Problem

As already stated, the population of professionals and others in high-profile positions is significant in Connecticut. Based on the available statistics, there is a population of approximately 21,389 people in Connecticut suffering from alcoholism and/or drug addiction who may potentially benefit from the establishment of the Litchfield Hills facility (please see below for support of the 21,389 number). This

specific population was considered in determining the need for the Litchfield Hills facility.

The U.S. Census Bureau estimates that for 2006-2008, a population of **2,673,711** adults exists in Connecticut. (See Exhibit 7) The U.S. Census Bureau also reports that for 2008, approximately **8%** of the Connecticut population had a household income of $200,000 or more. (See Exhibit 8) Therefore, by applying this 8% to the total Connecticut population, we estimate that there are **213,896** people in Connecticut with a household income of $200,000 or more. (2,673,711 x 8% = 213,896)

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that approximately (**10%**) of the population have a substance abuse or dependency problem[2]. (See Exhibit 9) By applying this SAMHSA percentage to the 213,896 people in Connecticut with an income of $200,000 or more, we estimate that there are **21,389** professionals or high-profile individuals in the state with a substance abuse problem and a household income of $200,000 or greater. (10% x 213,896 = 21,389). It is this population of 21,389 people that the Litchfield Hills center will provide greater access to for substance abuse and dependency problems.

ii. Projected Volumes.

Out of the **2,673,711**[3] adults in Connecticut, **10%** will have a substance abuse problem (according to SAMHSA). Therefore, the total number of adults in Connecticut with a substance abuse problem (not taking into account household income) is estimated to be **267,371**

[2] Data actually supports a higher percentage than 10% among the affluent community, as referenced herein and on the attached information. For example, 12% for physicians and 18% - 25% for attorneys. Therefore, our projection of 21,389 is conservative.

[3] Based on US Census Bureau data for Connecticut

According to SAMHSA data, in 2008, **45,338**[4] total adults were admitted for substance abuse treatment. (See Exhibit 10) By comparing this number of admissions to the total number of Connecticut adults with a substance abuse problem (267,371), we determined that approximately **17%** of Connecticut's adult population with a substance abuse problem sought treatment. (45,338/267,371=0.17) Therefore, there are approximately 3,636 adults in Connecticut with a household income of $200,000 or more and an alcohol or drug problem who require residential treatment. (21,389 x 17% = 3,636).

To estimate the Litchfield Hills volumes, we conservatively apply **15%** (instead of the 17%) admission rate to the population of **21,389** people that the Litchfield Hills center is intended to serve to estimate the target population for the proposed center. This amounts to **3,208** people. (21,389 x 15% = 3,208)

Admission projections for the first three years are then conservatively estimated at capture rates of 2.5%, 5% and 7% of the projected target population in Connecticut. Therefore, the projected number of admissions in year 1 is 80, in year 2 it is 160, and in year 3 it is 225. (See Exhibit 11)

It is expected that the Connecticut admissions will comprise between 59% and 78% of the total admissions during the first three years of operation. (See Exhibit 11) Projected total occupancy for the proposed Litchfield Hills center has been conservatively estimated at 40% in year 1, 65% in year 2 and 85% in year 3. These occupancy rates are conservative based on the average utilization rates of residential substance abuse centers in Connecticut. According to the National Survey of Substance

[4] Determined by calculating the percentage of population admitted in 2008 18 and older to be 98.6% (100% - 1.4%=98.6%) Then applied 98.6% to total admissions of 45,982 to determine that 45,338 admissions for the population 18 and older (45,982 x 98.6% = 45,338)

Abuse Treatment Services, in 2005, the average utilization rate for residential facilities was 93%. (See Exhibit 12).

The table on the attached Exhibit 11 summarizes the total projected admissions for the first three years and what percentage of the projected admissions is expected to be Connecticut residents.

Litchfield Hills is confident that it can support the projections above, based on the existing need and the potential referrals from existing substance abuse treatment providers in the state that are not tailored to the needs of the specific population. The admission estimates from Connecticut residents noted above are considered conservative. In addition, Litchfield Hills anticipates significant referrals from residents of other states. Upon OHCA approval, Litchfield Hills will expand its marketing activities and ensure that the industry is made aware of the options that it will offer in treating the specialized population of high-profile and professional individuals.

Litchfield Hills recognizes that the bed demand is substantially more than the number of beds proposed. The overall bed need for the target population is 264 beds. This is based on the following assumptions.

- Estimated total target population in the state is 3,208.
- Average length of stay is 30 days.
- Total bed days for total target population = 96,240 (3,208 x 30=96,240)
- Total beds required for above annual bed days is 264 (96,240/365=264)

However, Litchfield Hills firmly believes that the size of its center should be limited to just 28 beds in order to establish the type of individualized, therapeutic environment it desires to offer to the specialized population that it intends to serve. The

decision to establish a 28 bed facility was based in large part on the fact that the target population is made up of professionals and high-profile individuals that demand that the center be small and very private.

d. Need Evidenced by Support Letters

Litchfield Hills is supported by community providers. (See CON Application pp. 116-121) Specifically, community providers have supported the need for the Litchfield Hills center as follows:

> There is a growing need for substance abuse treatment facilities in the state of Connecticut, specifically to treat individuals who are well-known to the public or of prominent social status. It is essential for a successful recovery process for individuals to receive treatment with the utmost privacy. In order to achieve this level of privacy, it may require that these individuals seek treatment out-of-state in a secluded facility.
> **Letter of Support from Tina Scandul, MA of Developmental Disability Counseling Services, LLC (CON Application p. 117)**
>
> The needs of clients vary and we try to select the most appropriate facility for each individual. One of the concerns that we have had is where to refer people who may have a particular social, wealth or maybe political status issue. Because of this type of concern, their public visibility becomes a real concern for them. Unfortunately, most of these clients eventually sought out facilities long distances away or maybe even out of the state of Connecticut. This is why we are so pleased to hear about this proposed Litchfield Hills Retreat. Such a facility will provide exactly what we would be looking for. We would no longer have to refer clients so far away.
> **Letter of Support from Edward Edgar, LADC of Counseling Center of Waterbury (CON Application p. 118)**
>
> As the director and a clinician at Transitions I see a diverse client population. Over the years, I have seen and experienced the need for one particular segment of the population. That population happens to be in the public eye and having notoriety with financial means and/or social status that is looking for a residential treatment center that fits their needs. . . I hope that [OHCA] give[s] [Litchfield Hills] a favorable judgment since it is my true belief that there is a need for just such a program to service the above client in the state of Connecticut.
> **Letter of Support from Rick J. Yatsenick, M.S. of Transitions (CON Application p. 119)**

> I am an addiction practitioner located in Woodbury and feel a program such as this would be beneficial when I am presented with clients who need residential programs. . . I hope you consider approval of such a program as it would assist our efforts to effectively deal with addictive disorders among the professional community.
> **Letter of Support from Kevin M. Curry, CAC, ICADC (CON Application p. 120)**

> The shortfall in services is particularly acute for working professionals, business executives and persons who otherwise engage in high profile jobs and whose need of flexible programming and privacy results in their failure to seek needed treatment in existing facilities. The proposed facility in Bethlehem offers a treatment model that draws directly from residential programs in California with a proven track record in serving this target population. As such, the proposed facility offers to meet the need of a segment of the population for whom treatment options are substantially limited. . .
> **Support Letter from Eugene B. Piasetsky, PhD of Neuropsychology & Brain Injury Rehabilitation Services, P.C. (CON Application p. 121)**

Litchfield Hills has received overwhelming support from the provider community, as they clearly recognize the marked absence in treatment options for the high-profile population in the state. This community knows better than anyone that there is a need for a center such as Litchfield Hills, as they have firsthand experience with the issue of referring their high-profile clients to appropriate residential treatment centers close to home. Litchfield Hills is poised to fill the gap in treatment options for this high-profile population.

e. <u>OHCA Found a Need</u>

As you know, OHCA recently recognized the existence of a clear public need for a center such as Litchfield Hills when it granted a CON for a strikingly similar – if not identical – proposal in Docket Number 07-30928-CON on behalf of Vista Partners, LLC ("Vista Partners"). In that Docket, Vista Partners sought approval to establish a private twenty-four bed residential treatment facility in Sharon for high level professionals or

people within the public eye who have a history of alcohol or drug abuse or dependency. Vista Partners proposed to establish this facility at a site that is a mere twenty-nine (29) miles away from the proposed Litchfield Hills site (See Exhibit 13). Despite being granted a CON, Vista Partners did not move forward, and now has no intent to move forward, with establishment of the center. (See Exhibit 14). **Accordingly, the recognized need remains unmet.**

In granting the Vista Partners CON, OHCA expressly found that Vista Partners' proposed high-end residential treatment facility will serve individuals whose public visibility, wealth, public and/or social position make it virtually impossible for them to begin a successful recovery in the existing traditional residential treatment settings. (Final Decision, Docket No. 07-30928-CON p. 2 of 10) OHCA further found that Vista Partner's need was based on the significant health problem in Connecticut posed by substance and alcohol abuse/dependency, specifically among certain professionals (e.g. physicians, attorneys, financial services executives), and the fact that there are no small residential alcohol and drug treatment facilities in the state that offer extremely private, discreet and individualized programs for substance abusing professionals, public officials and other residents. (Final Decision, Final Decision, Docket No. 07-30928-CON p. 2 of 10)

In granting the CON, OHCA relied, in part, on the document provided by Vista Partners to evidence the significant substance abuse/dependency problem among certain professionals who have high pressure careers, such as physicians, attorneys, and financial services professionals. Specifically, OHCA found the following statistics: substance abuse among physicians is about 10%; 18% of attorneys practicing for less than twenty

years, and 20% of attorneys practicing for more than twenty years, suffer from alcoholism[5]; and 10% of financial service professionals have substance abuse problems. (Final Decision, Docket No. 07-30928-CON p. 3 of 10)

In granting a CON to Vista Partners, OHCA found the existence of a clear public need for a high-end, non-medical, residential treatment facility tailored toward high-profile individuals with substance abuse/dependency problems. **Because Vista Partners did not ultimately fulfill this need, it remains unmet.** Litchfield Hills will be competent to satisfy this need and it can do so in a very efficient and cost-effective manner.

2. No Negative Impact on other Substance Abuse Facilities in the State

Litchfield Hills will be different from, and therefore not competitive with, the existing substance abuse treatment facilities in the state. (See CON Application p. 19) Although Litchfield Hills will obtain the same licensure from DPH as many of the existing treatment facilities, it will be significantly different in that it will be a smaller, more private facility offering individualized care and programs that specifically address the professional and social characteristics of its mature clients and offer a peer group for clients with specific careers, such as physicians, attorneys, senior business executives and other individuals in the public eye.

Many of the existing providers of substance abuse treatment in the state offer detoxification services, treatment of behavioral and mood disorders, such as depression and bipolar disorders, schizophrenia and other psychoses, eating disorders, personality disorders and substance abuse disorders. Many of these facilities boast expertise in

[5] Note that Vista Partners actually asserted, as does Litchfield Hills (See Exhibit 5), that between 18% and 20% of attorneys practicing less than 20 years, and 25% of attorneys practicing more than 20 years, suffer from alcoholism.

treating patients who are dually-diagnosed with both a psychiatric illness and a substance abuse disorder. Some of the existing substance abuse treatment providers primarily utilize a twelve-step recovery model in which their core treatment is one of immersion.

Both the full-service, clinical approach and the twelve-step model utilized by existing providers are fundamentally different than the approach that will be employed by Litchfield Hills. Specifically, Litchfield Hills will not provide detoxification or other medical services and instead, it will focus primarily on treating substance abuse. (See CON Application p. 51) Virtually all of Litchfield Hills' beds will be dedicated to culturally similar substance abusing/dependent individuals, which is not true for the existing providers that offer an array of clinical, behavioral health and psychiatric services beyond substance abuse treatment to a broader range of the population.

In contrast to existing providers, the Litchfield Hills program will be structured to provide a supportive and safe setting for adults in the later stages of recovery to make the transition back into the community. Our clients will be able to customize their schedule from a range of clinical options, while allowing them more time to integrate back into the community.

Litchfield Hills will also offer a wider variety of therapy options tailored to the recovering individual in a spa-like retreat environment. For example, in addition to offering a full range of traditional methods, including group and individual therapy, family therapy and relapse prevention counseling, Litchfield Hills will offer a myriad of amenities and alternative practices. These amenities and practices will include equine assisted therapy, massage therapy, reiki, art, music, outdoor recreational activities and other modalities in a manner consistent with substance abuse treatment models. These

therapies, most of which are not employed by existing providers, will shape the core of the Litchfield Hills program. (See CON Application pp. 19 & 53)

Litchfield Hills will be a for-profit, high-end facility catering to an exclusive high-profile population that is presently underserved. Litchfield Hills will not pose competition to the existing providers, as its price point is higher than that of other facilities in the state, which offer "affordable" treatment options. The Litchfield Hills target demographic is different. (See CON Application p. 131) For example, based on information and belief, High Watch Recovery Center charges clients $303 per day of treatment, whereas Litchfield Hills will charge $900 per day. This price variation will ensure that there will be little to no adverse impact on existing providers' admissions.

In fact, Litchfield Hills will complement the existing substance abuse treatment facilities in Connecticut. We view the existing substance abuse providers as potential referral sources for the population that we cater to, as well as a potential referral destination for those individuals that we encounter who are not appropriate for our setting. (See CON Application p. 131)

3. Conclusion

There is a clear public need to justify the establishment of Litchfield Hills. Not only do the numbers support a large population of high-earning professionals and others within the public eye who may need treatment in a state without a treatment center solely and specifically tailored to their unique needs, OHCA found a need for the type of center proposed by Litchfield Hills in granting Vista Partners' CON Application. Because Vista Partners did not implement its proposal and notified OHCA of the same, the need remains unmet.

Litchfield Hills is poised to satisfy the unmet need for a high-end residential substance abuse treatment center tailored to high-profile individuals in Connecticut. Because no truly similar providers of substance abuse treatment exist in this state, establishment of the Litchfield Hills center will have no adverse effect on existing providers. Instead, Litchfield Hills and the existing providers will complement each other in the market by permitting the referral of clients who are better accommodated and treated in this type of treatment center.

Based on the foregoing support evidencing the need for the proposed Litchfield Hills substance abuse treatment center, we ask that OHCA grant our CON Application.

I thank you for this opportunity to appear before you today to provide my testimony in support of the Litchfield Hills CON Application.

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Docs\Prefiled Testimony\Brian Gwozdz\Prefiled Testimony re Need (Gwozdz)(4 26 10).doc

EXHIBIT 1

‹ Back to Article Click to Print

TIME
A PRIORITY SERVICE WITH CNN

Monday, Nov. 06, 1989

Behavior: A Plague Without Boundaries

By Philip Elmer-DeWitt;Jonathan Beaty/Los Angeles and Georgia Harbison/New York

The scene is South Central Los Angeles, but it could as easily be Detroit, Grand Rapids or Kansas City. A young white male driving a 1989 Thunderbird slowly circles one of the worst blocks in the city. He nods toward a group of blacks hanging out at a corner. As his smartly dressed date whirs up her electric window, a clamoring pack of drug dealers surrounds the car. Money is hastily exchanged for a tiny cellophane bag of off-white crystals. The car peels away, fleeing the inner city, headed toward suburban safety. But the driver of the Thunderbird, his supply exhausted, will be back in only three hours, slowly circling the block.

This is not the picture of the crack epidemic portrayed by the nightly news. On TV, crack addicts are almost invariably blacks and Hispanics from the ghetto. In real life, the problem is much broader: the number of white middle- and upper-class crack users may equal -- or even exceed -- the total from poor minority communities. No government studies break down crack use by economic status, but William Hopkins, a leading narcotics expert working for the state of New York, estimates that 70% of New York City's drug users are affluent. Across the U.S., drug counselors report rising numbers of professionals -- doctors, nurses, accountants, professors -- trying to kick crack habits gone out of control. "We've got Wall Street executives who buy crack in the middle of the day and smoke it in the office," says Alan Horowitz, program director at A.C.I., a treatment center in New York City. "We had one air- traffic controller at J.F.K. airport who was smoking crack on his breaks."

Crack, a smokable form of cocaine, is a drug that might have been designed for use on the job. It is easy to conceal, since it burns with virtually no odor, and the gratification is swift: an intense, almost sexual euphoria that lasts only about five minutes and is not accompanied by such telltale side effects as alcohol's slurred speech and heroin's drowsiness.

The problem of crack abuse among the affluent is especially disturbing because it comes at a time when the middle class seemed to be weaning itself from recreational drugs. Between 1985 and 1988, the number of casual drug users in the U.S. dropped from 23 million to 14.5 million, according to the National Institute on Drug Abuse. But according to another federal study, the number of Americans using crack cocaine at least once a week increased by one- third during that period, from under 650,000 to more than 860,000. "The poor people in the ghetto aren't buying all that cocaine," says William Smith, clinical director of California's Phoenix House. "This is a plague that knows no class or racial boundaries."

Psychologists say upwardly mobile Americans who turn to crack share personality traits that may make them vulnerable to the drug's siren call. Dr. Jeffrey Rosecan, director of the Cocaine Abuse Treatment Program at Manhattan's Columbia-Presbyterian Medical Center, sketches a profile of the typical crack user: a man in his 30s or 40s, single or divorced, with a high- pressure job, little inner peace and a history of moderate drug use and heavy drinking. "They're extremists, hard drivers, workaholics," says Rosecan. "With an all-or-nothing personality and a history of drug experimentation, you've got a formula for disaster when this person tries crack."

Crack is not for men only. One of the most striking developments of the past five years is the increase of crack abuse among middle-class women. The American Association for Clinical Chemistry, the organization whose members perform 80% of the drug tests in the U.S., reports that among people who test positive for drugs, the percentage of women jumped from 25% in 1972 to 40% in 1988. Many of them first used cocaine to help lose weight.

The rich have special problems procuring crack. They often have to make their buys in unfamiliar (and unsavory) neighborhoods, where they are prey to all kinds of rip-offs. Street crack is contaminated with an astonishing variety of chemicals, from amphetamines and meat tenderizers to pesticides. To make sure they are not being poisoned, some users are going back to a process popular years ago. They buy cocaine and convert it into a purer form of crack at home. This dangerous process, called free-basing, involves combining cocaine with baking soda and cooking the mixture. The latest trend among well- to-do users is to prepare their free base in microwave ovens.

Initially, a crack addict can continue to function at work. But that first euphoric kick can be followed by depression and paranoia, which the user suppresses by getting high again. So begins a cycle of compulsive binging known as "chasing the high." Five-dollar "nickels" give way to $40 "doves." Soon crack addicts are spending $200 and more every night.

The poor have a built-in defense against runaway crack abuse: they run out of money. The rich have the same limit; it just takes longer to get there. Stories abound of well-heeled users smoking their way through trust funds, savings accounts and charge-card credit lines. Some take out second mortgages and go on to sell jewelry and household items like TVs, VCRs and answering machines.

Having bought their way into addiction, affluent users often try to buy their way out. They can pick and choose from a long menu of treatments, from acupuncture to cocaine-blocking medications like imipramine and desipramine, but there are no quick fixes. In the end, all crack addicts, rich or poor, must put themselves back on their own feet -- a slow process that calls for professional counseling, steady support from family and friends, fearless self-examination and not a little pain.

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EXHIBIT2

U.S. Census Bureau

American FactFinder

Connecticut
Selected Economic Characteristics: 2006-2008
Data Set: 2006-2008 American Community Survey 3-Year Estimates
Survey: American Community Survey

NOTE. Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

For more information on confidentiality protection, sampling error, nonsampling error, and definitions, see Survey Methodology.

Selected Economic Characteristics	Estimate	Margin of Error	Percent	Margin of Error
EMPLOYMENT STATUS				
Population 16 years and over	2,773,920	+/-1,716	2,773,920	(X)
In labor force	1,888,489	+/-5,447	68.1%	+/-0.2
Civilian labor force	1,881,274	+/-5,572	67.8%	+/-0.2
Employed	1,765,164	+/-5,737	63.6%	+/-0.2
Unemployed	116,110	+/-3,293	4.2%	+/-0.1
Armed Forces	7,215	+/-689	0.3%	+/-0.1
Not in labor force	885,431	+/-5,423	31.9%	+/-0.2
Civilian labor force	1,881,274	+/-5,572	1,881,274	(X)
Percent Unemployed	6.2%	+/-0.2	(X)	(X)
Females 16 years and over	1,440,299	+/-1,439	1,440,299	(X)
In labor force	898,791	+/-4,391	62.4%	+/-0.3
Civilian labor force	898,238	+/-4,382	62.4%	+/-0.3
Employed	843,577	+/-4,633	58.6%	+/-0.3
Own children under 6 years	246,429	+/-2,021	246,429	(X)
All parents in family in labor force	159,193	+/-2,814	64.6%	+/-1.0
Own children 6 to 17 years	536,303	+/-2,623	535,303	(X)
All parents in family in labor force	392,607	+/-4,076	73.3%	+/-0.7
COMMUTING TO WORK				
Workers 16 years and over	1,718,856	+/-5,893	1,718,856	(X)
Car, truck, or van -- drove alone	1,362,603	+/-7,286	79.3%	+/-0.3
Car, truck, or van -- carpooled	142,655	+/-4,149	8.3%	+/-0.2
Public transportation (excluding taxicab)	73,825	+/-2,509	4.3%	+/-0.1
Walked	50,962	+/-2,734	3.0%	+/-0.2
Other means	23,000	+/-1,749	1.3%	+/-0.1
Worked at home	65,811	+/-2,159	3.8%	+/-0.1
Mean travel time to work (minutes)	24.6	+/-0.2	(X)	(X)
OCCUPATION				
Civilian employed population 16 years and over	1,765,164	+/-5,737	1,765,164	(X)
Management, professional, and related occupations	697,360	+/-5,907	39.5%	+/-0.3
Service occupations	287,358	+/-5,019	16.3%	+/-0.3
Sales and office occupations	451,546	+/-5,079	25.6%	+/-0.3
Farming, fishing, and forestry occupations	3,014	+/-662	0.2%	+/-0.1
Construction, extraction, maintenance and repair occupations	143,344	+/-3,130	8.1%	+/-0.2
Production, transportation, and material moving occupations	182,542	+/-3,656	10.3%	+/-0.2
INDUSTRY				

EXHIBIT3

Calendar Year End-2009
Total Active Licenses
From CT DPH

Physical Therapist Assistant	570
Physician Assistant	1690
Physician/Surgeon	16604
Podiatrist	311
Professional Counselor	1650
Psychologist	1821
Radiographer	4053
Registered Nurse	54249
Registered Sanitarian	424
Respiratory Care Practitioner	1707
Speech and Language Pathologist	2363
Sub-Surface Sewage Cleaner	273
Sub-Surface Sewage Installer	2523
Veterinarian	1228
Total	192148

OCCUPATIONAL EMPLOYMENT & WAGES: Total all industries in St... Page 1 of 1

TOTAL ALL INDUSTRIES
STATEWIDE

LEGAL OCCUPATIONS

Occupations	Estimated Employment	Mid-Wage	Average Wage	Entry Level Wage	Wage	Range
LEGAL OCCUPATIONS	14,100	77,070 37.06	96,302 46.30	43,315 20.82	37,456 18.01	>166,400 >80.00
Administrative Law Judges, Adjudicators, and Hearing Officers	200	84,612 40.68	95,089 45.71	74,502 35.81	70,446 33.87	144,173 69.31
Arbitrators, Mediators, and Conciliators	N/A	66,563 32.00	70,619 33.96	42,153 20.27	37,200 17.89	115,717 55.64
Judges, Magistrate Judges, and Magistrates	230	>166,400 >80.00	138,720 66.70	105,138 50.55	60,580 29.13	>166,400 >80.00
Law Clerks	210	48,013 23.08	55,637 26.75	29,250 14.06	27,294 13.13	110,346 53.05
Lawyers	8,090	115,014 55.30	126,521 60.82	67,439 32.42	60,315 29.00	>166,400 >80.00
Legal Support Workers, All Other	N/A	52,783 25.38	53,650 25.80	35,080 16.87	29,026 13.95	77,529 37.27
Paralegals and Legal Assistants	4,670	49,135 23.62	50,541 24.30	34,499 16.58	31,350 15.07	70,232 33.77
Title Examiners, Abstractors, and Searchers	170	49,583 23.84	46,413 22.31	21,647 10.41	18,203 8.75	71,169 34.21

NOTE: The mid-wage is the median wage. The average wage is the mean wage. The entry-level wage is equal to the average of the lower third of reported wages for the occupation. The wage range consists of the 10th and 90th percentiles; 80 percent of workers earn between this wage range, 10 percent earn less while 10 percent earn more.

Reference Date: 1st quarter 2009

OCCUPATIONAL EMPLOYMENT & WAGES: Total all industries in St... Page 1 of 2

TOTAL ALL INDUSTRIES
STATEWIDE

MANAGEMENT OCCUPATIONS

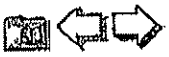
Occupations	Estimated Employment	Mid-Wage	Average Wage	Entry Level Wage	Wage	Range
MANAGEMENT OCCUPATIONS	N/A	97,396 46.82	109,996 52.86	56,729 27.27	48,441 23.28	>166,400 >80.00
Administrative Services Managers	4,260	76,309 36.68	81,582 39.22	46,124 22.17	39,101 18.80	128,393 61.73
Advertising and Promotions Managers	700	75,692 36.39	89,211 42.89	51,932 24.96	45,656 21.95	156,697 75.34
Chief Executives	4,750	>166,400 >80.00	178,686 85.90	99,796 47.98	88,898 42.74	>166,400 >80.00
Compensation and Benefits Managers	920	79,588 38.26	87,097 41.87	56,172 27.01	50,364 24.22	134,374 64.60
Computer and Information Systems Managers	6,280	111,221 53.47	117,758 56.62	76,289 36.67	71,007 34.14	>166,400 >80.00
Construction Managers	2,550	90,578 43.54	99,250 47.71	62,709 30.15	57,477 27.64	>166,400 >80.00
Education Administrators, All Other	260	88,331 42.47	93,694 45.05	50,060 24.06	37,067 17.82	135,871 65.32
Education Administrators, Elementary and Secondary School	3,150	111,342 N/A	107,052 N/A	79,042 N/A	65,067 N/A	138,027 N/A
Education Administrators, Postsecondary	1,850	97,691 46.97	105,989 50.95	58,236 28.00	50,971 24.51	>166,400 >80.00
Education Administrators, Preschool and Child Care Center/Program	990	41,489 19.95	47,449 22.82	29,326 14.10	25,895 12.45	75,550 36.32
Engineering Managers	3,900	109,976 52.87	118,082 56.77	81,561 39.21	75,075 36.10	>166,400 >80.00
Farm, Ranch, and Other Agricultural Managers	10	73,021 35.10	73,334 35.26	33,363 16.04	28,546 13.72	112,283 53.99
Financial Managers	13,640	101,405 48.75	112,486 54.08	62,517 30.05	56,263 27.05	>166,400 >80.00
Food Service Managers	2,650	48,987 23.55	54,330 26.12	33,677 16.19	31,420 15.11	87,157 41.90
Funeral Directors	310	71,594 34.43	81,824 39.34	46,144 22.18	43,725 21.03	110,715 53.23
General and Operations Managers	29,380	107,841 51.84	124,902 60.05	58,924 28.32	50,920 24.48	>166,400 >80.00
Human Resources Managers, All Other	1,420	100,646 48.39	110,229 52.99	68,669 33.02	61,242 29.45	>166,400 >80.00
Industrial Production Managers	3,050	92,875	94,969	66,180	61,394	132,785

OCCUPATIONAL EMPLOYMENT & WAGES: Total all industries in St... Page 2 of 2

		44.65	46.66	31.81	29.52	63.84
Legislators	500	29,892	33,110	16,656	16,636	56,961
		N/A	N/A	N/A	N/A	N/A

NOTE: The mid-wage is the median wage. The average wage is the mean wage. The entry-level wage is equal to the average of the lower third of reported wages for the occupation. The wage range consists of the 10th and 90th percentiles; 80 percent of workers earn between this wage range, 10 percent earn less while 10 percent earn more.

Reference Date: 1st quarter 2009



TOTAL ALL INDUSTRIES
STATEWIDE

BUSINESS AND FINANCIAL OPERATIONS OCCUPATIONS

Occupations	Estimated Employment	Mid-Wage	Average Wage	Entry Level Wage	Wage	Range
BUSINESS AND FINANCIAL OPERATIONS OCCUPATIONS	84,630	66,170 31.81	73,881 35.52	43,128 20.73	39,141 18.81	113,235 54.44
Accountants and Auditors	17,330	66,504 31.98	73,820 35.49	46,144 22.18	42,562 20.46	108,934 52.38
Appraisers and Assessors of Real Estate	760	66,099 31.77	65,725 31.60	37,593 18.07	32,361 15.56	91,893 44.18
Budget Analysts	1,080	72,980 35.08	73,800 35.48	57,316 27.55	54,806 26.35	99,240 47.71
Business Operations Specialists, All Other	6,650	63,276 30.42	63,438 30.50	35,316 16.98	19,469 9.36	97,560 46.90
Claims Adjusters, Examiners, and Investigators	7,250	60,584 29.12	61,080 29.37	43,806 21.06	40,598 19.52	84,263 40.52
Compensation, Benefits, and Job Analysis Specialists	1,320	62,709 30.16	65,097 31.30	40,639 19.54	36,591 17.59	101,162 48.63
Compliance Officers, Except Agriculture, Construction, Health and Safety, and Transportation	3,370	63,063 30.32	66,939 32.18	39,222 18.85	34,203 16.44	100,828 48.47
Cost Estimators	2,300	65,775 31.62	68,599 32.98	43,543 20.94	40,224 19.34	101,709 48.90
Credit Analysts	900	61,636 29.63	63,863 30.71	43,462 20.90	39,030 18.76	96,265 46.28
Emergency Management Specialists	220	68,669 33.01	67,172 32.29	45,253 21.76	40,740 19.59	94,069 45.22
Employment, Recruitment, and Placement Specialists	3,320	55,180 26.53	65,391 31.44	35,478 17.06	32,645 15.69	102,387 49.22
Financial Analysts	5,980	81,278 39.08	97,762 47.00	53,237 25.60	48,461 23.29	>166,400 >80.00
Financial Examiners	420	87,461 42.05	88,463 42.53	63,245 30.41	57,579 27.69	126,987 61.05
Financial Specialists, All Other	1,540	60,685 29.17	76,562 36.80	40,588 19.51	36,986 17.78	>166,400 >80.00
Human Resources, Training, and Labor Relations Specialists, All Other	1,930	68,113 32.75	68,103 32.75	46,863 22.54	42,784 20.57	98,076 47.16
Insurance Appraisers, Auto Damage	240	56,486 27.16	56,334 27.08	42,774 20.56	39,131 18.81	75,996 36.54
Insurance Underwriters	3,680	63,336 30.45	73,547 35.36	44,120 21.21	41,115 19.77	115,329 55.44

OCCUPATIONAL EMPLOYMENT & WAGES: Total all industries in St... Page 2 of 2

Loan Counselors	370	40,153	45,466	32,260	29,488	66,372
		19.31	21.86	15.51	14.18	31.91
Loan Officers	2,890	61,940	70,946	40,710	36,854	119,023
		29.78	34.11	19.57	17.72	57.22

NOTE: The mid-wage is the median wage. The average wage is the mean wage. The entry-level wage is equal to the average of the lower third of reported wages for the occupation. The wage range consists of the 10th and 90th percentiles; 80 percent of workers earn between this wage range, 10 percent earn less while 10 percent earn more.

Reference Date: 1st quarter 2009

EXHIBIT4

Career Pulse

Substance Abuse Among Physicians: What You Need to Know

Roger S. Cicala, MD

Most physicians are not surprised when told that more than 10% of Americans have a substance abuse problem at some time during their lives.[1] Anyone who has rotated through an emergency department is aware of the magnitude of the problem. However, many are unaware that physicians themselves develop substance abuse problems at least as frequently, and perhaps more frequently, than the population in general.[2,3]

Although the exact rate of substance abuse among physicians is uncertain, even the most conservative estimates are that 8% to 12% of physicians will develop a substance abuse problem at some point during their career.[2,3] At any given time, as many as 7% of practicing physicians—roughly 1 out of every 14—are active substance abusers.[3,5] No group of physicians are immune. The numbers are similar for every specialty, every region of the country, every age range, in urban or rural areas, and in academic medicine versus private practice.

The impact of the problem is severe. Chemical impairment has been shown to be a major risk factor for medical malpractice and negligence lawsuits,[6] the development of physical and psychological illness,[7] and adverse effects on the substance abuser's family.[2] Left untreated, the mortality rate of substance abuse among physicians has been reported as high as 17%.[7]

Despite its high prevalence among physicians, substance abuse is rarely discussed at professional meetings (with the exception of anesthesiology organizations) and receives limited coverage in medical school curricula. In the majority of cases, physicians with substance abuse problems remain undetected by their colleagues for several years before any intervention is made.[7,8]

How does such an endemic problem remain so ignored? Largely because physicians who are abusing drugs or alcohol work hard to keep their problem invisible. The physician abuser often becomes a loner, avoiding colleagues and friends who might notice the effects of abuse. Any suggestion that the person's behavior or performance has changed is first met with explanations and later with simply avoidance or outright anger. The abusing physician will often leave a job (or several jobs) rather than risk being identified as impaired.

The inability or unwillingness of physicians to recognize the signs and symptoms of substance abuse in their colleagues also contributes to the delay in identifying the physician with a substance abuse problem. Almost every physician is familiar with the patients with end-stage alcoholism or drug abuse who haunt emergency departments. However, far fewer physicians consider substance abuse as a possible diagnosis before that end stage is reached. Fewer than 40% of primary care physicians routinely question patients regarding alcohol abuse, and fewer than 20% screen for potential drug abuse.[9] Only a small minority of physicians feel they have a basic knowledge concerning the diagnosis and treatment of substance abuse.[8]

Diagnosing substance abuse in a physician is even more difficult than diagnosing the problem in the general population. Most physician substance abusers continue to function quite well until the problem is far advanced. Because their work provides either the income for drugs or access to drugs, physicians are very likely to protect their performance at work until the disease has neared end stage. The duration of this period varies largely according to the substance(s) involved. Alcoholics can often remain sober during working hours for many years, even though they drink large quantities at night and on weekends. Intravenous opiate or cocaine abusers, on the other hand, may go from experimentation to collapse in a matter of weeks or months.[10]

Nevertheless, signs of substance abuse are usually present to the objective evaluator, and certain risk factors for the problem are well recognized. Given that as many as 10%[3] to 15%[1] of our colleagues develop a substance abuse problem during their careers, each of us should become aware of the signs and symptoms of the

Dr. Cicala is an Associate Professor of Anesthesiology at the University of Tennessee College of Medicine and a staff physician at the Semmes-Murphey Neurologic and Spine Institute, Memphis, TN. He is also Assistant Medical Director for West Tennessee for the Tennessee Physician's Health Network.

problem, and know how to contact the appropriate support groups to provide treatment and aftercare to the physician when needed.

CHARACTERISTICS OF SUBSTANCE ABUSE

Unfortunately, the public and far too many physicians continue to think of substance abuse as a bad habit or a moral weakness rather than as a disease.[1,9] All modern medical authorities, however, consider substance abuse to be a neurologic or psychiatric illness that is contributed to by genetic, social, emotional, and psychological problems.[1,3,6,11,12] The individual with a true substance abuse disorder is no more able to control their disease without treatment than a person with severe endogenous depression is able to stop feeling depressed through will power.

While the term "drug addiction" remains in widespread use, it is generally avoided by substance abuse professionals because of its emotional connotations. The terms "substance abuse" or "substance dependence" are preferred for clinical diagnosis. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) defines substance abuse as a maladaptive pattern of use of a chemical substance within a 12 month period that significantly interferes with the person's life as indicated by any 1 of the following[13]:

1. Neglect of work, school, or home obligations
2. Recurrent use of the substance in hazardous situations (eg, driving, operating machinery, or—in the case of a physician—caring for patients)
3. Repeated substance-related legal problems
4. Continued use of the substance despite recurrent social or interpersonal problems associated with its use

A simple summary of the *DSM-IV* criteria for substance abuse is "repeated use of a mood altering chemical, despite adverse consequences from previous use." By such a definition, any individual who receives a second arrest for driving while intoxicated would be automatically be considered to have a substance abuse problem because he or she continued to drink and drive despite having previous adverse consequences.

Physical dependence, that is, the development of withdrawal symptoms when abstaining from the substance, is not necessary to make the diagnosis of substance abuse. Certain substances of abuse—notably the hallucinogens, marijuana, and, to some extent, cocaine—do not result in significant physical withdrawal symptoms even if taken in massive quantities for a prolonged period.[14] Even when abusing substances known to cause withdrawal symptoms, some abusers spend years in exhibiting a binge pattern of abuse and never experience classic withdrawal. Binge abuse—episodes of excessive drug or alcohol use followed by weeks or months of abstinence—is common early in the course of substance abuse.[1,8] A "binge alcoholic," for example, may go weeks or months without a drink to "prove" that they do not have a problem. When they do drink, however, they often drink far more than they had planned and frequently have adverse consequences.

As with most chronic diseases, the long-term course of substance abuse is one of deterioration over time. During the early phases of the disease, however, many individuals have a waxing and waning course as their efforts to control the problem have some short-term success. As the disease progresses, attempts at self control become shorter and less effective, and the effects on the individual, as well as on his or her family, become devastating.[6,10]

The time course of deterioration varies according to the individual and the substance of abuse. Alcohol, benzodiazepine, and marijuana abuse usually show a slow, indolent course. It is often years or even decades before the problem becomes clearly evident; of course, some persons suffer significant effects in a much shorter time. Conversely, intravenous opiate and cocaine abuse (and smoking crack cocaine) usually has a very rapid course; persons abusing these substances often suffer dramatic deterioration within months of their first experimentation.[6,10]

THE ETIOLOGIES OF SUBSTANCE ABUSE

While there is no single "cause and effect" factor for developing substance abuse, several risk factors that predispose individuals to developing the disease are known. Substance abuse has a strong familial association, often affecting multiple family members over several generations. The familial association apparently represents both a genetic predisposition and the influence of environmental factors. Genetically, it has been shown that in comparison to non-abusers, some substance abusers tend to have different central nervous system responses and form different metabolic byproducts after ingesting cocaine, opiates, or alcohol.[14,15] However, substance abusers are also likely to have grown up in dysfunctional homes and to have suffered physical or emotional abuse or family disruption during childhood.

Nearly 90% of substance abusers suffer additional psychiatric disorders.[12] Depressive illness, bipolar illness, and anxiety disorder are often either present in the affected individual or evident in the family history.[12,16] Personality

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Table 1. General Factors Associated with Substance Abuse

Depressive or bipolar illness
Divorced or separated marital status
Family history of alcoholism or substance abuse
Family history of psychiatric illness
History of childhood or adolescent abuse
Male gender

Table 2. Physician-Specific Factors Associated with Substance Abuse

Cigarette use > 1 pack per day
High stress or long work hours
History of multiple affairs and/or multiple marriages
History of multiple jobs, especially in multiple communities
Occupational access to controlled substances
Practice in academic medicine
Practice in emergency medicine, anesthesiology, psychiatry
Self-medicating or self-prescribing behavior

disorders also occur more frequently in substance abusers than in the general population.[10] It is not clear, however, whether the psychiatric illness predisposes to substance abuse, results from substance abuse, or whether both the substance abuse and the concurrent psychiatric diagnosis are different manifestations of an underlying pathology. In all likelihood, each of these possibilities exists in various cases. Particularly in physicians, some cases of substance abuse originate as attempts to "self medicate" an underlying depressive or bipolar illness.

There are gender differences in the frequency of substance abuse, which may be even more apparent among physicians than in the general population. Although nearly one third of physicians are female, nearly 90% of physicians referred for substance abuse treatment are male.[3] Compared to their male counterparts, female physicians who develop substance abuse problems are significantly more likely to suffer major depressive illness and less likely to have a personality disorder or to have criminal consequences of their abuse.[17] However, female physicians who do undergo substance abuse treatment are significantly more likely to have suffered permanent physical damage from their substance abuse than are their male counterparts.[18]

Females physicians are also more likely to have initiated substance abuse after a traumatic life event and to have a shorter course between the onset of abuse and the initiation of treatment.[14,15] Conversely, some reports indicate that whereas female physicians are less likely to use illicit substances or to be treated for substance abuse, they are far more likely to take prescribed tranquilizers and opioids than are male physicians.[16] Although taking prescribed medication does not represent substance abuse, the use of such medications while practicing may have significant medicolegal implications in the event of an adverse outcome or malpractice litigation.

ARE CERTAIN PHYSICIANS AT INCREASED RISK?

Minor differences exist in the frequency of abuse in certain medical subspecialties, with emergency medicine, psychiatry, and anesthesiology having slightly higher rates of substance abuse than other specialties.[2] Because this increased incidence is as apparent among residents as among long-term practitioners in these fields, it seems unlikely that the type of practice causes substance abuse.[2] Rather, it may be that persons with a predisposition toward substance abuse are more likely to choose these specialties. Some reports also indicate that physicians in academic medicine have a slightly higher incidence of substance abuse than those in private practice.[19]

Most of the risk factors for physician substance abuse parallel those of the general public (**Table 1**).[1,6,10,16] Although not absolute, the strongest risk factors appear to be a family history of substance abuse and the presence of psychological or psychiatric illness in the individual. There are also certain risk factors that are specific to physicians (**Table 2**).[3,5,6,10] Among the strongest physician-specific predispositions to developing substance abuse are (1) self-treatment with prescription medications, (2) high stress or long hours of practice, and (3) easy or constant access to controlled substances.[3,5,10] It should be noted that all of these risk factors are relative. Physicians with no apparent risk factors do develop substance abuse problems; conversely, a physician with every possible risk factor may never develop such a problem.

IDENTIFYING THE PHYSICIAN WITH A SUBSTANCE ABUSE PROBLEM

As most emergency department physicians can attest, it is fairly simple to detect an individual in the later stages of substance abuse, after the ravages of the disease have taken their emotional and physical toll. In the vast majority of cases, symptoms of substance abuse are minimal at first and only become evident over time. When symptoms first become evident, they can often be explained by a number of other possible

Table 3. Signs and Symptoms of Substance Abuse in Physicians

Professional activities
Behavior toward staff or patients becomes unpredictable
Closes and locks office door frequently
Frequently at hospital at unusual times or when not on call
Frequently gives others breaks (particularly in anesthesiology)
Frequently late or absent
Increased patient complaints about the physician
Quality of charting or notes deteriorates
Self prescribes or receives personal samples frequently
Spends long hours at office or hospital and may be less productive
Unavailable or behavior is inappropriate when on call
Physical status
Evidence of emotional distress or depression
Frequent medical illness
Multiple accidents or traumatic injuries
Personal hygiene or dress deteriorates
Social/family
Arrests for driving while intoxicated or other legal problems
Children develop problem behaviors
Heavy drinking or intoxication at parties or social functions
Isolated or withdraws from family and social activities
Marital discord or separation
Multiple affairs
Unpredictable personal behavior, including high risk behaviors
Professional history
Employed in positions not appropriate for training and qualifications
Frequent job changes, often with geographic relocations
Unexplained time lapses between jobs
Vague or indefinite letters of reference

Adapted from Talbott GD, Gallegos KV, Angres DH. Impairment and recovery in physicians and other health professionals. In: Graham AW, Schultz TK, Wilford BB, editors. Principles of addiction medicine. 2nd ed. Chevy Chase (MD): American Society of Addiction Medicine; 1998:1267.

causes. Substance abuse is even more difficult to detect in a physician because he or she is aware of the possible symptoms of abuse and makes every effort to conceal them. Additionally, common symptoms, such as daytime somnolence or inability to concentrate, are easily attributed to the high stress or long hours that most physicians experience. Signs of substance abuse in physicians are listed in Table 3.

Physicians with substance abuse problems rarely exhibit the obvious symptoms of intoxication, such as slurred speech, pinpoint pupils, or bizarre behavior. Somnolence occurs with certain drugs but is easily explained as exhaustion from being on call or working long hours. Because they have access to sterile, small bore needles, physicians who are intravenous substance abusers will rarely have obvious needle marks (ie, "tracks").

Directly questioning a physician about his or her substance abuse is rarely successful and will often lead to counteraccusations ("you're out to get me" and "you're trying to ruin my practice" are common) or other angry responses. A hallmark of substance abuse is a remarkable denial on the part of the abuser that there is a problem, even as they go to great lengths to hide the symptoms of the problem.[1,8,10] On some levels, this effort may be conscious, but the person involved has often elaborately rationalized and justified the substance abuse so that he or she truly does not believe there is a problem.

The most consistent initial symptoms of substance abuse problems in physicians tend to involve changes in personal relationships and community activities. Increasing isolation is often the most noticeable early sign. Substance abusers find reasons to miss parties, social activities, and even family vacations. Family members and close friends are usually the first to notice the effects but may deny that there is a problem, even to themselves; no one wants to discover that a friend or loved one is a "drug addict." Domestic strife, frequent arguments, and loss of sexual interest are also common early symptoms, although often not apparent to anyone other than the involved domestic partner. One symptom that may be apparent to outsiders is that the children of substance abusers frequently develop behavioral problems.[8]

At-work behavior may differ depending on the substance of abuse. If work provides access to the desired substances, the substance-abusing physician is often a stellar performer, frequently working long hours, even when not on call, in order to remain near the source of supply. Working long hours also makes coworkers likely to attribute some signs of substance abuse to fatigue or stress and allows the abuser to avoid family members and spouses who are more likely to notice such changes.[6,10]

Such individuals often prefer to work alone. Physicians working in areas with access to injectable medications, such as anesthesiologists or emergency department physicians, may frequently give others breaks, while rarely taking breaks themselves. However, intravenous abusers

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may need frequent restroom breaks and may lock the doors to their offices. More obvious, but less common, signs include heavy use of "sample" medications for their patients or having samples sent to their home.[10]

Physicians who abuse alcohol or illicit substances obtained away from the workplace often have quite different patterns of behavior. These physicians are often late to work, need to leave early, take long lunch hours or extended breaks during the workday, or are absent from work altogether as they fight the effects of binges and hangovers. Whereas cocaine and amphetamine abuse often causes noticeable personality changes within weeks or months, persons abusing alcohol or tranquilizers often have no apparent signs in the workplace for many years.[7,10]

Mood swings, depression, irritability, and inability to get along with coworkers are frequently seen in substance abusers, even early in the course of the disease. Affected individuals are likely to change jobs rather frequently as a means of avoiding suspicion or comments about their behaviors. The nonchemical problems common in substance abusers, such as numerous extramarital affairs, gambling problems, overspending or other financial difficulties, and behavior problems (particularly inappropriate anger or rage attacks) are often more apparent than the effects of the abused substance.[5]

Unfortunately, physicians are quite adept at hiding their problem from others until the end stage of the substance abuse is reached. Profound consequences, such as death from accidental overdose, criminal charges from self-prescribing or driving while intoxicated, loss of hospital privileges, malpractice suits from practicing while impaired, and suicide from severe depression, are often the first clear sign that a physician might have a substance abuse problem.[3,4,10] It is, therefore, of utmost importance that every physician become aware that ignoring the subtle symptoms in a friend and colleague will actually prevent that person from getting help and may ultimately have tragic consequences. Only a vanishingly small percentage of substance abusers will quit for more than a few months without treatment and aftercare.[1,3]

WHAT TO DO IF YOU SUSPECT A COLLEAGUE HAS A SUBSTANCE ABUSE PROBLEM

Physicians with substance abuse problems are occasionally detected in a way that is so obvious there can be no question the problem exists, such as when a physician is caught diverting medication or is arrested for buying drugs on the street. In most cases, however, enough signs of abuse (Table 3) are present to provide a reasonable degree of suspicion that the physician in question might have a problem but not to clearly prove that they do.

In such cases, it may be tempting for a well-intentioned colleague to privately question or confront the individual about the possibility of substance abuse, but this is rarely effective. As mentioned above, this approach often results in angry denial or counteraccusations. In other cases, the accused physician simply quits the practice and starts over elsewhere. There is also a potential for self harm when a physician with a substance abuse problem feels that he or she is about to be detected but does not believe that he or she will be able to live without the drug of abuse.[3,4]

Instead, the facts that lead to suspicion should be reported to a proper authority or group (eg, the department chair, the institution's physician's wellness committee) that can quietly investigate the situation and take effective action. Many states have a legal requirement that a physician must report any suspicions that a colleague may be practicing while impaired to the proper authorities. Failure to do so could theoretically result in sanctions against the physician who does not make such a report.[3]

Reporting also provides protection for the physician suspected of having a substance abuse problem. The resulting investigation is usually completely confidential and, in most cases, is protected from any outside legal discovery processes under peer review laws. If, however, the problem is not reported until legal issues or questions of competence are raised, the right of the physician to confidentiality may be lost and the problem becomes a matter of public record. Public awareness of the physician's problem may result in rejection of provider status by third party payers and inability to obtain future hospital privileges. Of more immediate concern are medical malpractice suits brought by attorneys and former patients who are well aware that informing a jury the physician was practicing while impaired is likely to result in a positive judgment, no matter what the facts of the case are.

If a peer investigation reveals evidence that a substance abuse problem is likely, it is rarely necessary to involve the state medical board or any legal agencies. Every state medical society has a program or committee dedicated to the identification, treatment, and support of physicians with substance abuse. These programs go under various names, such as "physicians' wellness committee," "physicians' health program," or "impaired physician program." These organizations, which can be located by contacting one's state medical society, are usually empowered by the state medical board to intervene with, and to direct treatment and aftercare of, physicians with substance abuse problems. Typically, as long as the physician remains in compliance with the

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wellness committee, no action will be taken by the state medical board, and the interaction remains protected by confidentiality laws.

Once the state physician wellness committee has been contacted and confirms that a problem exists, events generally proceed as follows: First, the committee organizes an intervention for the physician in question. The intervention is a planned confrontation by a small group (usually consisting of a colleague or supervisor, 1 or more addiction treatment professionals, a member of the local physician's wellness committee, and sometimes a family member) who attempt to break through the person's denial and help them see that their problem has become obvious to others. The intervention team presents a treatment option that would allow the physician to return to practice and provide hope that the problem can be solved. In cases in which it remains unclear whether substance abuse is involved, a 4- to 7-day evaluation at a treatment center is arranged.

In most cases, the individual will be immediately escorted to treatment or for evaluation. The potential for self harm at this time is very real; it is for this reason that well-meaning colleagues should not directly confront a physician with a substance abuse problem. By the time the problem has become obvious, the affected person has almost certainly realized that he or she cannot just "quit." Without the hope for successful treatment and a better outcome that is provided by having a planned intervention, the individual may simply become more hopeless and even suicidal.[19]

Although some persons are actually relieved that there is help available, others are unwilling to even consider that they have a problem. The intervention team should plan for the possible refusal, and a very real set of consequences (loss of licensure or job) will usually occur if the physician does not follow the recommendations of the team. Nevertheless, not all interventions are successful, and some people will choose to accept any consequences rather than to address the issue of substance abuse.

Such interventions, although sometimes emotionally traumatic, are necessary. Only a small percentage of physicians with substance abuse problems voluntarily enter treatment on their own.[5] Although accurate statistics are not available concerning the number of physicians who have overcome a substance abuse problem without treatment, figures regarding the general population indicate that fewer than 20% of substance abusers successfully stop for more than a few months without some form of treatment or support.[1,20] Because of high chronic stress levels, relatively easy access to drugs, and the widespread (although erroneous) belief that "self-prescription" is legal and legitimate, some authorities believe that physicians are even less likely than the general population to successfully stop abuse without treatment.[5,21]

SUBSTANCE ABUSE TREATMENT

Unfortunately, even some physicians mistakenly believe that if the individual can overcome the withdrawal syndrome for their drug of abuse, they will be able to stop their substance abuse problem. Although overcoming physical withdrawal is a precursor to successful treatment, it does nothing to eliminate the psychologic cravings and behaviors that are part of substance abuse problems. The relapse rate of persons who are simply detoxified (overcoming physical withdrawal) but do not receive other treatment is greater than 95%.

Treatment of physicians with substance abuse problems differs significantly from the treatment experienced by the general public for several reasons. Routine substance abuse treatment is usually short term (about 1 month) and often takes place in an outpatient setting. Such programs are known to have high relapse rates (greater than 60%) for any given treatment.[22,23] Because motivated individuals will return to treatment—often several times—the eventual success rate is reasonably high.

Nevertheless, such a high relapse rate is not acceptable for a physician who will return to an occupation in which his or her judgment must be impeccable. Since the 1980s, it has been widely recognized that extended treatment, usually lasting 3 to 4 months, significantly lowers the relapse rate of persons recovering from substance abuse.[2,5,10,23] It also has been shown that treatment of physicians is more successful if it takes place in a center that has a significant number of other physician-patients. Unless there are a number of physician-patients in the program, the physician in treatment often gets special treatment from other patients and staff, negating some of the benefits of treatment.[2,10]

Treatment usually begins in a hospital setting. This early phase of treatment focuses on the physical manifestations of substance abuse, such as preventing withdrawal syndrome and overcoming initial drug cravings. Depending upon the substance involved, this phase may take from a few days to 2 weeks. A program of emotional and psychological therapy, behavior modification, and education begins during this part of treatment and continues during an intermediate treatment period that lasts several weeks. Regular participation in self-help recovery programs, such as Alcoholics Anonymous or Narcotics Anonymous, is a major part of the intermediate phase of treatment.

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In most centers, the intermediate and late phases of treatment take place in a "residence recovery" setting. Usually, several persons share an apartment or halfway house, where persons further along in the treatment process can provide help and emotional support for newer arrivals. The late phase of treatment often involves a "mirror image" program, whereby recovering physicians work with persons in early recovery, gaining insight into their own disease by observing its effects in others. Family therapy is a significant part of most treatments, helping to heal the numerous effects that substance abuse has on family members.[3,14]

After successfully completing treatment, the vast majority of physicians return to practice. Although the actual process varies from state to state, in most regions, the physician will sign an aftercare contract with the state physician wellness committee. The contract, which lasts from 2 to 5 years, requires attendance at regular aftercare meetings, random drug screens, and participation in appropriate self-help or therapy groups.

Treatment centers experienced in working with physicians report long-term success rates of greater than 70%, but when such a structured aftercare program is undertaken, the success rate increase to approximately 90%.[1,10,22,25] Many of those who do relapse are quickly detected by an aftercare program and return to treatment, after which they eventually enter successful long-term recovery. The majority of relapses occur during the first 2 years after treatment. After 5 years of abstinence, the recovering physician is statistically less likely to suffer a future episode of substance abuse than are physicians in general.[3]

In addition to aiding and monitoring the recovery process, the wellness committee advocates for the physician. In most states, this advocacy is accepted by the state medical board, malpractice insurers, hospitals, and third party payers as evidence of fitness to return to practice. Advocacy goes much further in many states, actively assisting the physician by meeting with partners, colleagues, and hospital staffs, and sometimes negotiating changes in working conditions that may be necessary during early recovery. Although advocacy does not negate or overcome any legal charges that may have been made, it is often considered by judges during plea bargaining or sentencing efforts.

CONCLUSION

The central fact to remember concerning treatment of physicians with substance abuse is that it is usually successful. Treatment centers experienced in working with physicians report long-term success rates of 90% or higher. What cannot be described statistically, however, are the positive effects on the involved physicians and their families. The idea of substance abuse intervention and treatment may be thought of by the abusing physician as the worst thing that could happen. In reality, this is the best thing that could happen to a physician with a substance abuse problem. Although early recovery can be a difficult and emotionally painful process, most recovering physicians are happier and more satisfied than at any time in their lives. Nearly all return to practice, and they (and their coworkers) believe that they are far better physicians after treatment than they ever were before. HP

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EXHIBIT 5

SUBSTANCE ABUSE, CHEMICAL DEPENDENCY AND MENTAL HEALTH CONCERNS IN THE LEGAL PROFESSION

OHIO LAWYERS ASSISTANCE PROGRAM, INC.

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Funded By:

The Supreme Court of Ohio
Ohio State Bar Association
Ohio Bar Liability Company

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SUBSTANCE ABUSE, CHEMICAL DEPENDENCY & MENTAL HEALTH CONCERNS IN THE LEGAL PROFESSION

Ohio's integrated program:

The legal professions response to substance abuse, chemical dependency and mental health concerns in Ohio

I. **The Three Components**
Education
Advice and Intervention Assistance
Treatment and After-Care Support

II. **The Organizations**
The Lawyers Assistance Committee of the Ohio State Bar Association
The Ohio Lawyers Assistance Program, Inc. (OLAP)
The Lawyers Support System

III. **Key Rules and Statutes**
Gov. Rule I, Section 3(E)(2)
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DR 1-103(C)
Confidentiality

R.C. Section 2305.28
Qualified Immunity for Intervention Participant

Gov. Rule V, Section 9(B)
Monitoring

IV. **Funding and Other Support**
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INTRODUCTION

Since 1990 OLAP has assisted Ohio's judges, lawyers and law students obtain appropriate treatment for substance abuse and chemical dependency. Over 700 men and women have been helped. Recognizing that an impaired lawyer negatively affects nine other people each day, over 6,300 men, women and children have somehow been touched by OLAP.

OLAP and the profession in recent years have observed an increasing number of attorneys who have not only substance abuse problems, but also mental health problems. In addition, OLAP recognized that there are a growing number of attorneys who are suffering from untreated mental health illnesses, and who do not have a substance abuse problem, but need someone to intervene and help them seek appropriate treatment. Such untreated problems not only affect them and their families, but may also affect their clients.

The American Bar Association surveyed attorneys in 1990. Among the startling statistics at that time were that:

1. ⅓ of practicing lawyers suffer from depression, making lawyers 5 to 10 times more likely than other professionals to suffer from a major depressive disorder;

2. 18% - 20% of lawyers suffer from alcoholism, compared with 10% of the rest of Americans. After 20 years of practice, the rate rises to 25%. Alcohol and drug problems cause half the disciplinary cases involving lawyers (*Wall Street Journal*, 11/30/90); and

3. Lawyers are twice as likely as other professionals to commit suicide.

Florida Coastal School of Law Professor Susan Daicoff (formerly at Capital University Law School), who is also a psychologist, has studied this issue. In an article she wrote, which was published in *The Georgetown Journal of Legal Ethics* in Spring. 1998, she states the following:

> . . . "D. INCIDENCE OF SUBSTANCE ABUSE AND DEPRESSION AMONG LAWYERS.
>
> A serious influence complicating and compounding the . . . crisis is the incidence in substance abuse and depression among lawyers. Estimates of the frequency of substance abuse problems, including alcoholism, among lawyers range from three to thirty times that of the general population. About nine to ten percent of the general population in the United States is alcoholic, while empirical studies consistently show that about eighteen percent of lawyers and law students are alcoholic. Similarly, while three to nine percent in the

> general population in the United States is clinically depressed, as much as nineteen to twenty percent of practicing attorneys is depressed. A 1986 study found that only about ten percent of entering law students exhibited significant symptoms of psychological problems including depression, anxiety, hostility, paranoia, and obsessive-compulsive symptoms, but this percentage jumped dramatically to thirty-two percent by the end of the first year of law school. By the end of the third year of law school it was forty percent, and two years after graduation it was 17.9%. A 1995 study replicated these findings and found that problems did not significantly abate after the individuals entered the practice of law. Depression, anxiety, social isolation and alienation, hostility, paranoid ideation, and obsessive-compulsive symptoms were more frequent in attorneys than in the general population. Thus, a greater than average percentage of attorneys (as a group) is psychologically impaired in some way. Further, it appears that while the problems often do not appear until the first year of law school, lawyers do not return to their pre-law school level of psychological health after graduation." (pages 555-557)

In one of Professor Daicoff's footnotes, she cites a study by Connie A. Beck which was published in 1995-1996. Ms. Beck's findings are as follows:

	Base Rate		Among Lawyers	
	Male	Female	Male	Female
Depression	8.5%	14.1 %	21%	16%
Anxiety	4%	4%	30%	20%
Obsessive-Compulsive	1.4%-2%	1.4%-2%	21%	15%

Based upon the Ohio bar's experience and the empirical information cited above, OLAP sought and received additional support from The Supreme Court of Ohio to assist those in the profession with mental illness. Professional staff has been added, and additional professional assistance across the state is being secured. The purpose of this publication is to provide you with information, education and resources if you or someone else in the profession is in need of assistance.

DISCLAIMER/PUBLICATION NOTICE

This publication was funded by The Supreme Court of Ohio. However, the opinions expressed in this publication do not necessarily reflect the position of the Court, and no endorsement of the Court should be inferred.

These materials are published as part of the Ohio Lawyers Assistance Program, Inc.'s (OLAP) educational services. The purpose of this publication is to provide Ohio's legal profession with information, education and resources. This publication is not to be used to self-diagnose or to diagnose others. Contact OLAP for further assistance.

This publication does not reflect the position of the Ohio State Bar Association or Ohio Bar Liability Insurance Company.

SUBSTANCE ABUSE IN THE LEGAL PROFESSION

Causes, Prevention, Detection and Treatment Alternatives

I. WHAT ARE SOME FUNCTIONAL DEFINITIONS OF ADDICTION?

A. The inability to stop the use of the substance or behavior in question; the perceived inability to stay stopped.

B. Behavior characterized by:

1. Compulsion: an internal demand beyond intellectual resource or understanding.

2. Loss of control over amount consumed.

3. Continued use or activity despite adverse consequences.

C. Another way of saying it:

1. Psychoactive Substance Dependence (Addiction).

The essential feature of this disorder is a cluster of cognitive, behavioral, and physiological symptoms that indicate that the person has impaired control of psychoactive substances and continues to use the substance(s) despite adverse consequences.

D. A related term:

1. Psychoactive Substance Abuse.

Psychoactive Substance Abuse is a residual category for noting maladaptive patterns of substance use that have never met the criteria for dependence.

II. WHAT ARE THE PRIMARY CLASSIFICATIONS OF SUBSTANCE

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), American Psychiatric Association, 2000) has divided substances into 11 categories:

A. Alcohol - a drug in liquid form.

B. Sedatives, hypnotics and *antianxiety* drugs - sleeping pills and "nerve medication":

Barbituates	**Benzodiazepines**	**Date Rape Drugs**
Seconal	Zolpidem (Ambien)	GHB (Georgia Homeboy, Grievous Bodily Harm)
Pentobarbital (Nembutal)	Flurazepam (Dalmane)	Flunitrazepam (Rohypnol) ("Roofies", "Roffirs", "Rophirs", "Roche", "Forget Me Pill")
Tuinal	Lorazepam (Ativan)	(See: Ecstacy under amphetamines and hallucinogens since it has both properties. It is not classified as a sedative hypnotic.
Phenobarbital (Luminal)	Clorazepate (Tranzene)	
Secobarbital (Amytal)	Chlordiazepoxide (Librium)	
Anembutal	Oxazepam (Serax)	
Butalbital (Fiorinal, Fioricet)	Alprazolam (Xanax)	
	Meprobamate (Equanil, Miltown)	
Butabarbital (Butisol)	Diazepam (Valium)	
Talbutal (Lotusate)	Triaxolam (Halcion)	
Mephobarbital (Mebaral)	Estazolam (ProSam)	
Methohexital (Brevital)	Quazepam (Doral)	
Thiamylal (Surital)	Temazepam (Restoril)	
Thiopental (Pentothal)	Halazepam (Paxipam)	
	Prazepam (Centrax)	
	Midazolam (Versed)	

	Clonazepam (Klonopin)	

Older Sedative Hypnotics (not readily available)
Golutethimide (Doriden)
Noludar
Methaqualone (Quaalude, Soper)
Placidyl

C. Cannabis/marijuana/hashish/hash oil.

D. Cocaine/Crack

E. Amphetamines (Stimulants and Sympathomimetics):

Methamphetamine/"Crank"/"Ice" (smokable)/"Crystal"/"Chalk"/"Fire"/"Glass"
Ritalin (Metadate, Methylini)
Preludin ("Ecstacy")
Aderol
Cylert

F. Hallucinogens:

LSD
Psilocybin and Psilocyn
Mescaline and Peyote
DMT
MDMA ("Ecstacy", "XTC", "Adam", "Essence", "Clarity", "Lover's Speed")

G. Inhalants:

Gasoline, glue, paint thinners, spray paint, cleaners, typewriter correction fluid, spray-can propellants, nitrous oxide ("whip-its"), amyl and butyl nitrate ("poppers," "locker room")

H. Caffeine.

I. Nicotine.

J. Opiates

Thebaine	Loret	Tussionex
Anexsia	Hycodan	Hycomine
Hydrocodone	Oxymorphone	Nalbuphine

Nalonone	Naltrexone	Tylos
Lortab	Hydromorphone	Morphine (Roxanol)
Heroin	Darvon	Codeine
Dilaudid	Demerol	Oxycodone
Meperidine	Percodan	Methadone
Pentazocine	Buprenorphine	Fentanyl
Oxycontin	Duragesic patch (Fentanyl)	
Codeine	Vicoden	Percocet
Lomotil	Paragoric	MSIR
MS-Contin		

K. Phencyclidine (PCP, Hog, Tranq, Angel Dust and PeaCe Pill), Sernyl Arylcyclohexylamine

Ketamine (Ketalar, Ketaject, "Special K", "K", "Vitamin K", "Cut Valiums");
Cyclohexamine
Dizocilpine

III. WHAT DO WE MEAN WHEN WE SAY IT'S A DISEASE?

A. Since 1956, the American Medical Association has considered alcoholism (or chemical dependency) to be a disease, and the American Bar Association's Commission on Lawyers Assistance Programs has adopted this model as well.

B. Alcoholism is a primary, chronic, disease with genetic, psycho-social and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences and distortions in thinking, most notably denial. (American Society of Addiction Medicine (ASAM), National Council on Alcoholism and Drug Dependency (NCADD), 1990).

C. What are the principal characteristics of the disease?

1. Primary Disease

The disease itself causes the drinking or drug use. It is not secondary to some other disease of mental illness, etc.

2. Chronic

There is no cure for the disease, but it can be treated and controlled.

3. Progressive

The disease always gets worse, it does not get better and there is no turning back and beginning all over again as if one never drank or used.

4. Fatal

This is a fatal disease if not controlled. It always leads to premature death and serious health problems even if the death certificate indicates the cause of death to be one of the complications of the disease, e.g., heart problems, liver failure, bleeding ulcers, cancers, etc.

5. Treatable

The disease can be controlled if the drinking or drug use is stopped. It is much like diabetes in the sense that if body chemistry is stabilized by not drinking or using, then the alcoholic may lead a normal life. Recovery rate among the general population who have undergone appropriate treatment is around 70% and among some professional groups (including lawyers) as high as 90%.

D. What are the diagnostic criteria for substance abuse according to the DSM IV-TR (page 199)?

1. A maladaptive pattern of substance abuse leading to clinically significant impairment or distress, as manifested by one (or more) of the following within a 12-month period:

a. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated absences, poor performance, suspensions from school, neglect of children).

b. recurrent substance use in situations in which it is physically hazardous (e.g. driving, operating a machine, hunting, boating).

c. Recurrent substance – related legal problems (e.g. arrests)

d. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (arguments with spouse, physical fights).

2. The symptoms have never met the criteria for Substance Dependence/Addiction for this class of substance.

E. What are the diagnostic criteria for substance dependence (addiction) according to the DSM IV-TR (page 197)?

1. A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

a. Marked tolerance: need for markedly increased amounts of the substance in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount.

b. Characteristic withdrawal symptoms (increased pulse, respirations, blood pressure, tremors, nausea, vomiting, diarrhea, constipation, sweats). Use of substance to relieve or avoid withdrawal symptoms.

c. Substance is often taken in larger amounts or over a longer period than the person intended.

d. Persistent desire or one or more unsuccessful efforts to cut down or control substance use.

e. A great deal of time spent in activities necessary to get the substance, take the substance, or recover from its effects.

f. Important social, occupational, or recreational activities given up or reduced because of substance use.

g. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

F. Substance Abuse vs. Substance Dependence

a. Unlike the criteria for substance dependence, the criteria for substance abuse do not include tolerance, withdrawal or a pattern of compulsive use and only include the harmful consequences of repeated use. DSM IV-TR, p. 198.

b. Substance abuse is more likely in individuals who have begun to use substances recently. DSM IV-TR, p. 206.

c. Treatment, education and abstinence are critical for one diagnosed with substance abuse for at least three primary reasons:

i. to ensure the safety of the individual, the individual's family and the public;

ii. because the diagnosis of substance abuse indicates that the abuser is, for practical purposes, "out of control" due to "repeated" use in situations where use is inappropriate, harmful and even life threatening. Such "repeated" use may be tantamount to and easily confused with "compulsive" use which indicates dependence;

iii. because substance abuse often evolves into substance dependence. DSM IV-TR, p. 206.

IV. WHAT KIND OF A DISEASE IS IT?

A. It is a genetic and biochemical disease:

Just since 1980, there have been hundreds of studies and scholarly papers (including the discovery of perhaps one of the actual genes) corroborating a genetic or familial predisposition to the disease.

B. Two genetic varieties of the disease:

1. Highly heritable.

a. More likely in the male line.

b. Person can be alcoholic from first use or first drink.

c. Children as young as 8 years of age or younger can be alcoholic or drug dependent.

d. If you have one parent who is an alcoholic/addict, you have a 50% chance of being chemically dependent. If you have two parents who are chemically dependent, you have an 80% chance of becoming an alcoholic and/or an addict.

2. Milieu limited.

a. More likely to come on in 30's or 40's after a more prolonged period of use (average period being 7 years).

b. Can be associated with crisis events in life and inability to control amount used.

C. Biochemistry issues:

1. Brain chemistry affects how one feels.

How do the alcoholics or drug dependents feel that they want to drink for relief? Alcoholics are stimulus augmenters and live in a world that is too loud.

2. Brain Wave Studies.

Low amplitude "P-d" brain waves are too low or are missing. These waves affects cognitive ability to tolerate, interpret, and utilize stress. "Alpha" waves are also deficient or absent.

3. Brain chemistry.

a. Neurotransmitter and Opioid Deficiencies.

Is there something else missing that affects normally feeling good? In alcohol craving rats, there is a serotonin deficiency. Serotonin is a major "feel good" compound in the brain.

The brain has morphine receptor sites because it makes some form of endogenous morphine -- these are the endorphines we produce, e.g., "runner's high." Spinal fluid of alcoholic is deficient in "feel good" endorphines.

Alcoholic rats are deficient in enkephalines as well -- these

are other "feel good" chemicals in the brain.

Some research shows deficiencies in still others like noradrenaline.

b. At first, alcohol makes the alcoholic feel normal.

The alcoholic therefore begins to feel good or normal, like normal people, after he or she has begun to drink and the alcohol has begun to affect the amount of these feel good chemicals in the brain.

But, this is also the point at which the alcohol becomes a double bind because other chemical reactions going on in the alcoholic's chemical system begin to set up the craving process for more and more alcohol.

c. Then, the craving process begins. This craving is the alcoholic's allergic response.

When the alcohol is enough to overcome the normal metabolism of acetaldehyde there is production of dopamine (new gene research involves dopamine receptors) resulting in THIQ which when given to rats will cause them to drink themselves to death. In spinal fluid of an alcoholic, the THIQ is 1000 times greater than normal. Conclusion, craving can be explained biochemically.

D. Psychological Aspects of the Disease:

1. There is no alcoholic personality profile – the alcoholic personality does not exist.

2. But, there is evidence of poor identification with the parent of the same sex as a result of death, or parent's alcoholism, or parent's work-aholism.

This is the parent from whom we should learn our coping skills at the earliest age. Therefore, the alcoholic may not be learning good stress coping skills while also being genetically and biochemically pre-disposed to stimulus augmentation.

E. Social Aspects of the Disease:

1. Our society promotes and condones drinking and drug use.

2. The 10% to 20% of the general population who are at risk for alcoholism or chemical dependency see advertisements, etc., just like the other 80% to 90% who can handle alcohol in moderation.

3. Additionally, peer pressure to use easily available drugs is rampant among children, youth, and teens -- perhaps the single biggest factor for beginning use.

V. HOW WILL THE DISEASE MANIFEST ITSELF?

A. Home and Family:

1. Heavy drinking/using -- high tolerance.

2. Hide drug/alcohol -- secret use.

3. Broken promises to quit.

4. Behavior excused by family and friends (enablers, hero, scapegoat, mascot and lost child).

5. Mood swings and inconsistency.

6. Fights, arguments, violent outbursts, temper.

7. Drinking or drug use more important than other activities.

8. Children neglected, abused, or in trouble themselves, often with alcohol or drugs.

9. Sexual problems: no sex - rejection; impotence; affairs - change in value system.

10. Withdrawn, isolation and fragmentation of social and family life.

11. Family isolates itself from social supports.

12. Financial problems, e.g., get-rich-quick schemes, trouble with IRS and creditors.

13. Spouse in psychotherapy or taking psychoactive medications.

14. Separation or divorce.

B. Community and Professional:

1. Isolation and withdrawal from service clubs, church involvement, community activities, hobbies, leisure activities, old friends.

2. Withdrawal from bar association work and not completing continuing legal education.

3. Embarrassing behavior at clubs, parties, social functions, fundraisers.

4. Neglect of social commitments.

5. Financial difficulties and inappropriate spending.

6. Legal problems, OMVI, arrest, IRS.

7. Exaggerating work accomplishments and finances.

8. Missed legal deadlines (statute of limitations, motions).

9. Late for/missed court appearances/depositions.

10. Intoxicated after lunch.

C. Office Conduct:

1. Disruption of appointment schedule.

2. Hostile, withdrawn, unreasonable behavior to staff and clients.

3. Office staff assumes responsibility generally taken by attorney.

4. Power struggle within office staff.

5. Decrease in efficiency.

6. Stays late after office hours.

7. Absence from office unexplained or due to illness.

8. Complaints by clients to staff regarding behavior - alcohol on breath, slurred speech.

9. Drinking or drug taking at office.

10. "Locked door syndrome" - mood swings.

11. Experiences blackouts - forgotten phone calls.

12. Gossip regarding behavior changes.

D. Physical Status:

1. Deterioration in personal hygiene.

2. Deterioration in clothing and dressing habits.

3. Accidents.

4. Multiple physical signs and complaints.

5. Frequent visits to physicians/psychologists.

6. Pupil and eye change.

7. Inappropriate tremulousness or sweating.

VI. WHAT ARE THE ULTIMATE "PERSONAL COSTS" OF DOING NOTHING?

A. Loss of physical, emotional, spiritual health for the alcoholic/addict, and usually his or her family.

B. Codependence and Psychologically Damaging Roles in the alcoholic's/addict's family such as

i. the Enabler, who suffers the stress created by continual covering up for alcoholic/addict;
ii. the Hero, who is typically an older child who feels he or she has to excel at everything to save the family reputation; this facade masks internal feelings of inadequacy and anger;
iii. the Mascot, who acts the role of a clown to divert attention from the alcoholic/addict, but suffers repressed hurt and guilt;
iv. the Lost Child, who intensely withdraws into a private fantasy life; internalizing loneliness and feeling unimportant; and
v. the Scapegoat, who tries to take the focus off of the alcoholic/addict by

getting into trouble thereby masking an internal sense of fear.[1]

C. Damage to or loss of marriage.

D. Damage to or loss of parent-child relationships.

E. Loss of friends.

F. Sometimes OMVI's.

G. Sometimes suicide.

VII. WHAT ARE THE ULTIMATE PROFESSIONAL COSTS?

A. If nothing else, loss of real potential.

B. Eventually minor or isolated ethical problems - not yet real neglect because isolated.

C. Eventually it can cause:

1. Actionable misconduct.

2. Patterns of neglect.

3. Competency issues.

4. Loss of professional license, income, etc.

D. Remember, some of the things most likely to cause professional problems are:

1. Marital problems.

2. Financial problems.

3. Bad judgment.

4. Inappropriate disposition.

5. ALCOHOLISM/ADDICTION CAUSES ALL OF THESE.

[1]Information taken from: *The Family Trap* by Sharon Wegscheider, Johnson Institute, 1976.

VIII. WHY WOULD SOMEONE GENERALLY WANT TO AVOID TREATMENT?

A. The nature of the mechanism of disease activation may involve certain activities that, due to the patient's world view or the law, has the patient:

1. Thinking that the disease is sinful.
2. Thinking that the disease is based on weakness.
3. Thinking that it would only happen to an idiot.
4. Involved in criminal activity.
5. Thinking that it happens only to people who are "psychiatrically disturbed."
6. The perception of going to treatment involves a self-assessment more of wrongness than rightness. Note: Other volitional acts of irresponsibility often go uncondemned by others. When the hypertensive is non-compliant with diet, weight, medication, and smoking there is much more understanding when they enter the hospital than the untreated alcoholic/addict.

IX. WHAT OTHER MECHANISMS ARE ACTIVE THAT HELP THE INDIVIDUAL AVOID TREATMENT?

A. Irrational Beliefs:

1. I can't afford to go to treatment.
2. I'm not that sick.
3. I can quit any time I want.
4. Drinking is not my problem, my wife (my husband) is..., etc.,
5. I'll be branded for life if I go to treatment.
6. I'm not as bad as my partner.
7. My associates drink more than I do!
8. I may be a heavy drinker, but....

9. I may get drunk once in a while, but I'm not an alcoholic.

10. I only use cocaine recreationally.

11. My psychiatrist says I drink because of my anxiety disorder, see he even put me on . . . Valium or Xanax.

12. No way. My dad (my mom) was alcoholic and I'm nothing like him (or her).

13. I think everyone is overreacting.

14. It was 0.22, but the cop was pulling everyone over.

15. I did a lot of drugs experimentally as a kid, but...

16. I promise I'll come in for treatment after we close this deal.

17. Its only marijuana, we all know that its basically harmless.

B. Defense Mechanisms which are normal to all persons can be used by the alcoholic so as to blind himself or herself to reality:

1. Denial - "can't be true" regardless of factual evidence.

2. Minimizing - making something less important.

3. Externalizing - blaming external factors.

4. Rationalizing - giving excuses.

5. Intellectualizing - lengthy intellectual reason and arguments.

6. Displacement - taking it out on others.

7. Active Negativism - refusing to do.

8. Defocusing - wasting time on outside issues.

9. Projection - planning results.

10. Passive Negativism – inaction.

11. Fantasizing - day dreaming.

12. Hopeful Expectation.

13. Manipulating.

14. Undoing.

15. Generalizing.

16. Omnipotent Devaluation.

C. Enablers - Individuals who possess the same irrational beliefs and pathological defense mechanisms as the patient, who nonetheless facilitate the patient's avoidance of treatment.

1. Active Enabling - Purchasing or acquiring the chemical for the individual when he/she is too sick or indisposed to acquire the drug themselves.

2. Passive Enabling - Not acknowledging or exposing the reality of what is going on with the chemically dependent person.

3. Iatrogenic Enabling - The physician who does not diagnose the disease even when obvious or substitutes a second mood altering substance for the primary one. Treating cocaine dependency as a Bipolar illness with Lithium, or Alcoholism as an anxiety disorder with Xanax, Valium or Ativan.

4. Enabling by Omission - The OMVI offender who is referred to a diversion program when the blood alcohol level of record is sufficient to diagnose alcoholism.

X. WHAT CAN BE DONE TO PROMOTE RECOVERY?

A. Speaking to the person - often does not work.

B. Intervention - Collaboration of family, friends and colleagues who identify negative changes in the individual and its impact on relationships and professionalism prompting the impaired individual to seek help. Requires professional assistance - call OLAP.

C. Treatment - Options:

1. Self-help groups (Alcoholics Anonymous [A.A.], Narcotics Anonymous [N.A.], Cocaine Anonymous [C.A.], Al-Anon, Alateen).

2. Intensive outpatient.

3. Residential inpatient.

4. Residential inpatient followed by extended follow-up in halfway house care.

5. Detox-medically managed and monitored detoxification from the substance(s) most often requiring hospitalization.

XI. WHAT MUST BE ACCOMPLISHED AS PART OF ANY RECOVERY PROGRAM REGARDLESS OF THE TECHNIQUE OR TREATMENT MODALITY SELECTED?

A. Self Diagnosis - You cannot treat what the patient does not think he or she has or needs to be treated.

B. Education - Appropriate facts about the disease of addiction lessen the general obstacle or resistance to self diagnosis.

C. Self Treatment - The patient should be empowered with the tools to maintain abstinence and/or avoid relapse.

D. Self Responsibility - The essence of achieving long term remission via dealing with life's problems through a spiritually based self help/support program.

XII. WHAT IS THE "LAWYERS SUPPORT SYSTEM" AFTERCARE PROGRAM?

A. Lawyers Support System (LSS) is a program through which the Ohio Lawyers Assistance Program, Inc. (OLAP) will provide the following services for chemically dependent lawyers who are enrolled:

1. track lawyers through treatment, confirming admission to and successful completion of treatment;

2. assist the treatment provider in structuring aftercare and discharge planning for lawyers receiving treatment;

3. provide assistance for the lawyer's entry into appropriate aftercare and

professional peer support meetings;

4. assist the lawyer in obtaining a primary care physician;

5. establish a random urine drug screening program;

6. track the lawyer's aftercare, peer support, and twelve step meeting attendance;

7. provide assistance to the lawyer in obtaining a local LSS mentor attorney, who is in recovery;

8. provide documentation of compliance by the lawyer to those persons and/or agencies as required;

9. provide advocacy for those lawyers who are compliant with the requirements of the program; and

10. inform OLAP of the status of attendance/compliance.

B. OLAP/LSS will implement the program in the following manner:

1. Upon entrance by the lawyer into treatment, OLAP/LSS will contact the treatment provider requesting a letter documenting admission, progress reports, and documentation of successful completion of treatment. If the lawyer should leave treatment against medical advice or leave treatment before recommended treatment is completed, the treatment provider will be requested to contact OLAP/LSS immediately. The lawyer shall provide OLAP/LSS with a written release to such treatment provider allowing it to inform OLAP/LSS of the lawyer's status at all times.

2. As the lawyer nears the completion of treatment, OLAP/LSS will work with the treatment provider in formulating a discharge and aftercare plan as it relates to the lawyer's obligations as a participant in OLAP/LSS. This would include arranging a visit to the lawyer by a local OLAP/LSS liaison attorney for signing of OLAP/LSS contract.

3. As the lawyer nears the completion of treatment, OLAP/LSS will provide the treatment provider and the lawyer with a list of OLAP-approved aftercare providers and professional peer support groups to be incorporated into the aftercare plan.

4. OLAP/LSS will provide the lawyer with a list of physicians in his or her area who are knowledgeable of chemical dependency and who will provide primary medical care or consultation as required.

5. After the completion of treatment, OLAP/LSS will contact the lawyer on a regular, predetermined basis for monitored submission of any of the following: random urine drug screen, body fluid analysis, and/or breathalyzer test. The urine and/or body fluid test(s) will be forwarded to a National Institute of Alcoholism and Drug Abuse approved laboratory following established legal chain of custody. The results of the tests will be forwarded to OLAP/LSS by the laboratory on a predetermined, timely basis. OLAP/LSS will be notified of any positive test results. Results of breathalyzer tests will be forwarded to OLAP/LSS by the local agency (hospital, treatment center, etc.) that administers the test.

6. Approved aftercare providers will be requested to provide monthly written reports on the lawyer's compliance with attendance.

7. OLAP/LSS will provide the lawyer with the name of a local member of the OLAP/LSS who will act as a mentor attorney. The lawyer will be required to contact the mentor attorney on a weekly basis or other to report his or her progress in recovery. This contact may be made by phone or in person. The mentor attorney will provide OLAP/LSS with status updates on a regular basis.

8. OLAP/LSS will provide documentation of the lawyer's compliance and continuing recovery on a regular basis to any persons or agencies in need of such reports.

9. OLAP/LSS will provide documentation of the lawyer's compliance and continuing recovery, and may, assume an advocacy role in situations when required. This could include appearances with the lawyer before courts, disciplinary proceedings, agencies, employers, potential employers, law partners, etc.

10. OLAP/LSS may take such other actions and impose such additional requirements on the lawyer as it in good faith deems necessary to monitor the lawyer's recovery and to protect and preserve the integrity of the OLAP/LSS.

XIII. WHAT IS THE ROLE OF ALCOHOLICS ANONYMOUS [A.A.] AND OTHER PROGRAMS SUCH AS NARCOTICS ANONYMOUS [N.A.], COCAINE ANONYMOUS [C.A.], AND ALLIED PROGRAMS LIKE ALATEEN AND AL-ANON?

It is not our purpose to try to explain entirely how A.A. works, but it is a grassroots approach to alcoholism treatment that actually works where many times all else has failed. There is no general consensus as to why it works. But, it has had a striking effect on society since its advent in. This particular program addressed living, in the word's fullest sense, without alcohol via a 12-step spiritual program. The program has its roots in the Judeo-Christian ethic. Yet the religious caveats and moralizing are absent, and even an agnostic or atheist can be in the program. What the founders of A.A. discovered is that two or more alcoholics could help each other stay sober and succeed where the individual acting on his own would fail. Thus, while there are strong opinions about A.A., most of which are expressed outside the meetings and outside of the principles on which the program was built, as long as it actually works it must rank as the preeminent approach to the treatment of this particular problem. We would recommend to all of you, if you have not already done so, that you acquaint yourself with the fundamentals of the program.

Further, membership in A.A., N.A., C.A., and Al-Anon, and Alateen (allied programs for the family), has grown by leaps and bounds and the whole family has become part of the treatment and recovery process.

Though acceptance is not complete, there has been a general awakening within society, government, and the medical profession that the problem is treatable, and that A.A. and/or related programs actually work when all else has failed.

As the stigma has faded, industry and business have embraced the concept of early intervention and treatment programs. And, contrary to the experiences of the 50's and 60's, a working relationship has developed between the loosely knit organization of A.A. and a variety of community resources.

XIV. WHAT ARE THE STEPS OF ALCOHOLICS ANONYMOUS?

A. A suggested plan of recovery and relapse prevention.

1. We admitted we were powerless over alcohol (and all other mood altering substances) - that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact

nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics (addicts), and to practice these principles in all our affairs.

B. What, if any, are the guarantees if one chooses to seek help?

1. We are going to know a new freedom and a new happiness.

2. We will not regret the past nor wish to shut the door on it.

3. We will comprehend the word serenity and we will know peace.

4. No matter how far down the scale we have gone, we will see how our experience can benefit others.

5. That feeling of uselessness and self-pity will disappear.

6. We will lose interest in selfish things and gain interest in our fellows.

7. Self seeking will slip away.

8. Our whole attitude and outlook upon life will change.

9. Fear of people and of economic insecurity will leave us.

10. We will intuitively know how to handle situations which used to baffle us.

11. We will suddenly realize that a Higher Power is doing for us what we could not do for ourselves.

"Are these extravagant promises? We think not. They are being fulfilled among us - sometimes quickly, sometimes slowly." Handbook of Alcoholics Anonymous, 1939.

XV. WHAT CAN I DO?

A. Recognize that you have a personal and professional duty to act - to help, whether it is you, yourself, or a colleague or family member who has the disease.

B. The Lawyers Assistance Committee wants to help - and for obvious reasons the earlier the better:

1. Before it reaches even an isolated instance of professional misconduct try to get the person to call the committee.

2. If he or she won't do so - call a member of the committee yourself.

3. We want to help get treatment for the person and restore them to active, healthy and happy lives.

XVI. WHAT IS THE LAWYERS ASSISTANCE COMMITTEE OF THE OHIO STATE BAR ASSOCIATION AND ITS COMPANION ORGANIZATION THE OHIO LAWYERS ASSISTANCE PROGRAM, INC?

The Lawyers Assistance Committee of the Ohio State Bar Association was created in 1977. Its members include representatives of the judiciary, practicing bar, and legal education, many of whom are themselves recovering alcoholics, addicts, or persons recovering from mental health issues, while others are not, but serve only out of a special interest and desire to help.

In an effort to provide even greater service to those who have need of its help, the Lawyers Assistance Committee established the Ohio Lawyers Assistance Program, Inc. (OLAP) in 1991, a non-profit corporation qualified to receive tax deductible contributions under Sec. 501(c)(3) of the Internal Revenue Code., William X. Haase, Esq. (deceased), a retired lawyer with both small and large law firm experience, served as its first full-time Executive Director (1991-1999). Scott R. Mote, J.D., a Columbus attorney, was retained in 1996 as Associate Director to assist in OLAP's expanding workload, and became

Executive Director July 1, 1999. Both Paul A. Caimi, JD, CCDC-I and Stephanie S. Krznarich, MSW, LISW, CCDC-I were retained in early 2002 as Associate Directors to assist in OLAP's continually expanding workload as well as to address mental health concerns in addition to chemical dependency. Through OLAP, the following services are now provided on a full-time basis: (1) confidential advice about individual problems, (2) help in arranging and implementing formal interventions, (3) help in deciding between outpatient and inpatient treatment, and (4) monitoring and aftercare services. Through the so-called Broadbrush Program, OLAP is also presently providing similar services to assist Ohio lawyers who may be suffering from mental health issues other than chemical dependency issues. Any lawyer who feels that OLAP's services may be of help with regard to a lawyer suffering from a mental health issue is encouraged to contact OLAP.

XVII. HOW DO I ACTUALLY CONTACT OLAP?

A. Call OLAP at (1-800-348-4343) or (1-800-618-8606).

B. Anonymity and confidentiality built into procedure.

1. The Lawyers Assistance Committee formulated DR 1-103(C) giving it a privilege for things said to committee members:

Any knowledge obtained by a member of a committee or subcommittee of a bar association, or by a member, employee, or agent of a non-profit corporation established by a bar association, designed to assist lawyers with substance or mental health abuse problems shall be privileged for all purposes under DR 1-103, provided the knowledge was obtained while the member, employee, or agent was performing duties as a member, employee, or agent of the committee, subcommittee, or non-profit corporation.

C. Those seeking advice from the committee or its program and those working through it to carry out interventions are covered by the qualified immunity from a lawsuit in R.C. §2305.28.

D. The following tTreatment centers in the state of Ohio are recommended:

TALBOT HALL AT OSU HOSPITALS EAST
1492 East Broad Street
Columbus, Ohio 43205

(614) 257-3760; 1-800-875-4435

CLEVELAND CLINIC FOUNDATION
9500 Euclid Avenue
Cleveland, Ohio 44195
(216) 444-2200
Assessments: (216) 444-5812; 1-800-223-2273

GLENBEIGH HOSPITAL
2863 State Route 45
P.O. Box 298
Rockcreek, Ohio 44084
(440) 563-3400; 1-800-234-1001

You also can contact your local health department or Ohio Department of Alcohol and Drug Addiction Services (ODADAS) at 614-466-3445 for information.

Please contact OLAP about other treatment options both in and out of state.

XVIII. CONCLUSION.

Lawyers are lousy clients. Likewise, they are difficult patients. The reasons are simple enough: they are trained to deal with and solve problems, and they manage and manipulate people. Thus, it is most difficult for the attorney to seek help since by doing so he or she admits failure as a problem solver. This problem is exacerbated by the fact that the attorney has a tendency to block out the realities of his or her particular situation. Complicating this problem further is the tendency of the attorney's or judge's peers to indulge in a conspiracy of silence, and lighten the normal stresses of our profession. Such efforts accomplish nothing and usually are counterproductive. In a word, covering for good old Joe or Jane is folly or worse!

OLAP works in tandem with local bar lawyers assistance committees, which in turn work with local men and women who are associated with the fellowship of Alcoholics Anonymous and other related organizations in addition to mental health providers. We accept referrals from a judge, a partner or law associate, hospitals, the member himself, and in some cases his or her family.

OLAP hopes that the attorney, judge, law student, or law faculty member will be rehabilitated through hospitalization (if necessary), counseling, psychiatric assistance (if necessary), the application of A.A. principles and mental health support.
NOTE:

These materials on substance abuse originally were edited in 1990 by Prof. Michael Distlehorst, Esq., of the Ethics Institute of Capital University Law School, on behalf of the Lawyer's Assistance Committee of the Ohio State Bar Association, for use in continuing legal education seminars and other programs. The Committee would like to thank the following physicians for advice and consultation in the preparation of various segments of these materials: Dr. Burns Brady, M.D., Dr. Paul Redmond, M.D., and Dr. Craig T. Pratt, M.D.

Revised in December, 1996 by William X. Haase, Esq., Executive Director, and Scott R. Mote, Esq., Associate Director, Ohio Lawyers Assistance Program, Inc.

Revised in July, 2001 by Scott R. Mote, Esq., Executive Director, Ohio Lawyers Assistance Program, Inc.

Revised in May, 2002 by Scott R. Mote, J.D., Executive Director, Stephanie S. Krznarich, LISW, CCDC-I, and Paul A. Caimi, J.D., CCDC-I, Associate Directors, Ohio Lawyers Assistance Program, Inc.

Revised in February, 2003 by Scott R. Mote, J.D., Executive Director, Stephanie S. Krznarich, LISW, CCDC-I, and Paul A. Caimi, J.D., CCDC-I, Associate Directors, Ohio Lawyers Assistance Program, Inc.

EXHIBIT 6

REUTERS

Print This Article | Close this window

Wall Street's undertow: drugs and anxiety

Mon Jun 18, 2007 11:45AM EDT

By Tim McLaughlin

NEW YORK (Reuters) - Wall Street's push for record profits is ruining careers, tearing apart families and keeping drug dealers busy, mental health experts say.

While record bonuses make some Wall Street bankers feel invincible, others become emotional wrecks from pressure to perform and some hit rock bottom, experts say.

Harris Stratyner, a psychologist at Caron's New York Recovery Center, said some executives he treats are experimenting with cocaine, opiate-based drugs, Ecstasy and marijuana, as well as abusing alcohol.

"It's like they're chasing a dream. Even when they make tremendous profits, they're still worried," he said.

Alden Cass, a clinical psychologist who counsels Wall Streeters with drug addictions, said drug abuse and high anxiety are undercurrents to the current boom.

"When things are really good, they feel invulnerable," Cass said. "That can lead to adultery, substance abuse, problems with the law."

When it comes to profits, things are really good.

Six of the largest U.S. investment banks -- Goldman Sachs, Lehman Brothers, Citigroup, JPMorgan & Chase Co., Morgan Stanley and Bear Stearns -- combined for $17.6 billion in first-quarter profit this year. That's after shelling out $28.8 billion for pay and benefits, financial statements show.

Those profit and pay figures are more than double those seen in the first quarter of 2000, the last days before the dot-com bubble burst. New York's comptroller estimates Wall Street's 2006 bonuses will generate $1.6 billion in state tax revenue.

COCAINE AND HILLBILLY HEROIN

"To my knowledge, we have not seen an uptick in drug use," Morgan Stanley spokeswoman Jean Marie McFadden said.

The other five firms declined comment or did not return telephone calls.

But Cass said opiate abuse among his clients is rising and they openly talk about being hooked on prescription drugs like OxyContin, known as hillbilly heroin.

"That's what has changed from previous booms on Wall Street," he said.

Cass and Stratyner said their clients sometimes conceal their habits by taking prescription drugs they get for back surgery or sports-related injuries. The Internet has also expanded the black market for drugs.

Wall Street professionals in their 20s use Ritalin and Adderall, prescription drugs used to treat attention-deficit disorder and hyperactivity, to enhance their performance as they grind out 100-hour weeks, Cass said.

Big bonuses and the need to blow off steam have helped invigorate demand for cocaine in Manhattan, according to two junior bankers

who did not want to be named.

J[illegible]odriguez, convicted of selling drugs to investment bankers and other professionals, said his clients never complained about the p[illegible] of cocaine, even as it escalated.

"My customers were all business individuals," Rodriguez said, citing Morgan Stanley bankers as among his clients.

Morgan Stanley said the company has a strong policy against substance abuse and uses random drug testing.

PASSING THE TEST

One hiring manager at a major New York bank said new staff must take a urine test, which is typical for the industry. But he said new hires can choose when to schedule the test during a 45-day period before their start date.

"Our drug test is not so much a test of whether you actually take drugs as it is an intelligence test to see if you can figure out how long it takes to get traces of the drug out of your system," said the manager, who asked not to be named.

The hiring manager said his employer also had a policy of random drug tests for employees but that in several years he had never encountered anyone subjected to such a test.

Drugs are not the only reason for executive meltdowns.

Overwhelming pressure and anxiety to meet profit goals undid star trader David Becker as he rose the Citigroup ladder.

Nine months after becoming global commodities chief, Becker found himself on the fast track to prison. The largest U.S. bank di[illegible]ered in 2004 that Becker and others conspired to overstate profits by $20 million.

[illegible]er, 41, pleaded guilty and is serving a 15-month sentence in federal prison. He declined to comment.

Before he committed his crime, he sought psychiatric help to deal with the pressure of balancing family and career, court papers show.

A metaphor for his life was a painting he owned depicting a man being pulled by all four limbs, Becker's psychiatrist, Dr. Barbara Deutsch, wrote to the judge in the case.

"He felt enormous pressure to make the group's budget at all costs," Deutsch wrote. "He felt identified with this tortured man."

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Print Article

CHIEF EXECUTIVE

Issue Date: March 2002, Posted On: 3/1/2002

CEOs Anonymous

Hardly acknowledged, rarely confronted, alcoholism is a stealthy liability that pervades corporate America and puts some of its brightest leaders at risk.

C.J. PRINCE

So far, 2002 has been a rough year for Drew Lewis, former chairman and CEO of Union Pacific Corp. Arrested for drunk driving last July—his second charge—the 70-year-old was sentenced on Jan. 11 to 30 days in jail, which he served in an alcohol treatment center, a $5,000 fine and 40 days of community service. He also had his driver's license revoked for 23 months.

Perhaps more stinging than the particulars of his sentence, though, were the humiliating circumstances of his most recent episode: Lewis reportedly overturned his Lincoln Navigator while pulling out of his own driveway. When officers freed him from the car, he was tested and found to have a blood-alcohol content of 0.30 percent—three times the legal limit in Pennsylvania. CNN reported that, in an apologetic letter to the judge prior to sentencing, Lewis called the incident "a wake-up call I will never forget."

For Lewis' sake, one hopes it's true. Sadly, his long, colorful career, which includes service as Secretary of Transportation under Ronald Reagan, has been peppered with similar reality checks. In 1984, while still CEO of Union Pacific, Lewis was given a five-week pass to an alcohol rehabilitation clinic, and was issued an ultimatum by his board: get help or don't come back. Fourteen months later, he was arrested for driving while under the influence; the story made headlines in papers across the country. Lewis stayed on at Union Pacific until December 1996, when he retired as planned.

To those not familiar with alcoholism, Lewis' lapses in sobriety might look like a case of poor will power or a lack of self-control. And few CEOs could imagine themselves winding up in his shoes. But according to the National Institute on Alcohol Abuse and Alcoholism, one in every 13 adults in the United States abuses alcohol or is an alcoholic. While no similar statistics are available on the number of CEOs diagnosed with the dependency, there's no reason to believe that this disease—like diabetes or hypertension—does not pervade the CEO ranks just as it does any group, according to Dr. James Fearing, president and CEO of Minneapolis-based National Counseling Intervention Services. "It doesn't matter who you are, where you come from, what level you're at in the company, or how much money you have," he says. "It's an equal-opportunity disease."

Fearing estimates that in 2001 alone, his firm, which coordinates executive interventions and counsels companies on workplace addiction, intervened in 25 to 50 C-suite-level cases, primarily in mid- and large-size companies. "Prior to the last three or four years, it might have been upper management, but not top management," he says. "Now we're doing more interventions in the board room."

It's not that executives are drinking more, he adds, but that those around them are more aware of the problem. CEO health has gained greater attention in recent years. And with boards increasingly independent and shareholders more vigilant, CEOs are more likely today to be called on the carpet for any behavior considered unhealthy.

But despite a greater willingness to confront CEOs, the problem is still kept quiet. Stereotypes and misconceptions about alcoholism abound, making it a dirty word inside and outside corporate board rooms. While a CEO might be admired informally for recognizing his or her problem and seeking help for it, Wall Street typically doesn't applaud such candor and self-awareness. Over the years, a small handful of CEOs have gone public with their personal battles, but untold cases remain shuttered away, with boards, employees and CEOs themselves colluding to make addiction in the corner office one of the best-kept secrets in corporate America.

Denial: The CEO's first line of defense

As most recovering alcoholics attest, recovery starts with the addict's acknowledging the problem and admitting he or she needs help—a tall order for CEOs, who may be good at diagnosing problems within their companies, but are typically loathe to admit such weakness in themselves. Corporate culture itself helps to blur the line between social drinker and problem drinker. Five-martini lunches may be passé, but drinking is still prominent, particularly in industries such as advertising, entertainment and hospitality, according to Fearing. CEOs, like other executives, may see it as part of their job to have a few highballs at a business

dinner or to let loose a bit at the company holiday party. Certainly, Southwest Airlines' share price never suffered because of Kelleher's notorious Wild Turkey consumption; in fact, his party-boy image seemed only to endear him to employees and shareholders.

But experts say the stories of Kelleher's drinking were more fable than fact and that if he were consuming as much as he claimed, he'd be in for a rude awakening. For most, the addiction develops gradually, and those afflicted may not notice it until it's already a serious problem. Red McCombs, owner of the Minnesota Vikings and CEO of Red McCombs Enterprises, had his epiphany after 25 years of "moderate social drinking," as he describes it. "I realized it had become a negative issue with me," he says, "and it's quite a depressing thought because you think, 'this couldn't happen to me.'"

He's not alone. Sam Johnson, former CEO of consumer chemical products maker S.C. Johnson & Son, in his recently released autobiographical documentary, *Carnauba: A Son's Memoir*, candidly describes coming to terms with his addiction. During a period of denial in the early '90s, his wife and children pleaded with him to check into the Mayo Clinic to get help. Johnson refused twice before going. "I was struggling with that," he told the *Milwaukee Journal Sentinel* last August. "I was chairman of the Mayo Clinic."

Not surprisingly, the stereotypical images of addiction fail to line up with self-perceptions of successful corporate leaders. "We had one person who thought, 'I only have a substance abuse problem if I end up living in a cardboard box and eating out of dumpsters,'" says Dr. Scott Stacy, director of psychological services at the Professional Renewal Center, a Lawrence, Kans.-based clinic that offers a treatment program for professionals called INSIGHT Executive Consultation Services. "'So since I'm not, therefore, I'm not a drunk.'"

Other negative, albeit less dramatic associations—weakness, helplessness—don't sit well either. "Many CEOs want to be viewed as models of decisiveness and as being as totally together as possible, so it's very difficult for them," says Gene Morrissy, corporate psychologist with management consultancy RHR International. They also tend to hold themselves to inhumanly high standards, in part fueled by the expectations around them, adds Stacy. "There is a misconception that a strong leader has to be in control of everything," he says. "If a CEO's own life becomes unmanageable, the anxiety that goes along with admitting that can be very overwhelming. Some will do anything they can to avoid it."

That includes hiding their habit from others. McCombs managed to get through years of drinking without arousing the suspicion or concern of family, friends or colleagues. "When you become addicted, you become very much aware that you shouldn't show that in public places, so you become more and more of a closet drinker," he explains. "It's something you're trying to hide." But even without pressure from others, McCombs knew he had to quit. "Once you realize you're hooked on a chemical, you have to find a way to get off of it because it's so depressing that it's hard to live with it unless you stay high." After a year of praying for a way out, the answer arrived serendipitously: McCombs became ill with hepatitis and, through his hospitalization, detoxed. He's been sober for 24 years. "I feel like, at age 50, God gave me a new life," he says. "And it really energized me to realize I didn't have to drink anymore."

Intervention and counseling experts say that despite the fact that their performance is monitored, CEOs, isolated by power and position, have a relatively easy time concealing their addictions. "Generally speaking, there aren't a whole lot of people willing to tell them the truth," says Morrissy. "And in a situation like this, they may be even less likely to confront the issue. The CEO then becomes more isolated, which gives him or her more room to engage in that substance abuse."

Clifton Morris, co-founder, chairman and former CEO of AmeriCredit, an auto finance company in Fort Worth, Tex., with $818 million in revenues, sums it up more bluntly. "It's already lonely at the top. How is a CEO going to find anybody to talk to when he's a drunk?"

Morris would know. Though he wasn't a CEO yet, he had very few friends by the time he got sober in 1979. Even after he was fired in 1971 from his position as CFO of Service Corp. International, a Houston-based funeral services company he helped build, Morris still believed he could control his drinking. Eight years later he found himself living at the home of a waitress who served at the gin mill he frequented. By then he was in both physical and financial straits. "I had $13, 48 creditors, two default judgments, I weighed 140 pounds, and my liver weighed 40 pounds," Morris recounts in his thick, southern drawl, "and yellow was not my most becoming color."

Finally, one day, he was talking on the phone with the lawyer handling his third divorce, also a former fraternity brother from his university days. "He said, 'Cliff, you have to check into a hospital.'" The next morning, he did. Since entering Alcoholics Anonymous, Morris hasn't touched alcohol. "And my life has gotten better every single day for 23 years," he says. Morris has always credited AA with his recovery, and he is such a strong believer in its principles that he patterned much of AmeriCredit's corporate culture around them. He keeps a copy of the "Big Book"—a practical guide to AA's 12-step program—on a shelf in his

of ... in case he should come across someone who needs it.

Morris acknowledges that he had to hit bottom before he could seek help. But he adds that the interventions that have become more common today might have helped. "They weren't even on the map when I got sober," he says. "But they work. Because even if they don't work, they ruin your drinking for sure." Having the spotlight trained on the addiction drags the CEO out of denial. "You'll never have another happy drink," Morris promises.

Executive Interventions: Raising the bottom

That's what intervention specialists hope for when they convene groups to confront addicted professionals. It's also what Fearing of National Counseling Intervention Services calls "raising the bottom" for troubled CEOs. "All interventions are successful in that they break through the conspiracy of silence," he says. But the really successful interventions have to have some muscle behind them. That is, the team confronting the CEO must include colleagues he or she respects and admires, possibly family, and at least one board representative who has the power to unseat the CEO if he or she refuses treatment. The board has to have already considered the financial, operational and other implications of firing the chief, and has to be fully willing to make good on the threat.

That's a more complicated choice in cases where the CEO still seems to be performing well—or when it's not as clear that the situation is likely to worsen. A few years ago, Korn/Ferry International Vice Chairman Peter Crist got a call from a board member of a public company that had begun noticing their CEO was consuming a lot more alcohol than they thought appropriate. "They were struggling with this because, as a player, he was a very good CEO," recalls Crist. "I basically advised them that there was little they could do at that time because there was no performance issue." Over the course of the next year, however, as more incidences of excessive drinking were reported back to Crist, it became clear there was a problem and he recommended that the CEO's closest friend on the board have a private conversation with him, which he did. About four or five months later, Crist learned that after several conversations, the CEO had decided to seek help.

Fearing calls those CEOs who continue to perform well with an addiction the "not-yets." They don't know yet that there's a p... lem, he says. "But as the progressiveness of the illness takes its course, they will not be able to hide it." For boards, the q... tion becomes, how long should we wait?

... most cases, board members, who may themselves deny the problem exists, are not aware of all the risks involved in quietly hoping that the CEO sobers up and turns himself around. For one thing, a drinking CEO's distraction can lead to decreased productivity among others, says Morrissy. And the accompanying moodiness or unpredictability can inhibit direct reports from consulting with him or her on important decisions. "They don't know which CEO is going to show up on a given day," says Morrissy. "So the CEO who is usually in a bubble is now in a bubble within a bubble."

Add to that the exposure to lawsuits, from clients to shareholders to employees, and the costs start to add up, particularly when it takes only one incident of inappropriate behavior—say, sexual harassment or negligence—to tarnish a company's reputation and cost it millions in damages. During a company holiday party, for example, the senior executive just under the CEO at a mid-sized Minneapolis company drank a few too many and began misbehaving. "He was in the copy room, of all places, and grabbed a woman," recalls Fearing. "He was under the influence at the time, and she won the lawsuit for an awful lot of money."

To avoid that kind of grief, National Counseling Intervention Services advises early confrontation—assuming enough hard evidence is on hand, because without proof, most CEOs won't bite. When the president of one Midwestern company flatly denied having a problem with alcohol at his intervention, Fearing was ready with a list of specific incidents, including a report from the company's banker that the president had been slurring his speech in a meeting, and of the president driving a company car while intoxicated. "So I was able to say, 'Wait, let's look at the facts.' And once I did that, it changed the whole intervention from that point." The president opted for a five-week treatment program and returned to his job.

Seeking treatment: Public or private affair?

Most treatment programs involve at least a four-week stay at a rehabilitation clinic, followed by a plan for ongoing treatment and support, including individual or peer group therapy. The company typically foots the clinic bill—usually sans insurance, lest there be a record of the treatment, says Fearing. Experts estimate the monthly cost at anywhere from $15,000 to $40,000, depending on the facility and length of stay. "That's peanuts compared with how much it costs to bring in a new CEO," says Stacy. "... icularly if that CEO is otherwise a very creative, dynamic leader."

... uring out creative ways to explain the CEO's extended absence is another matter. Usually, the boss will be said to be ...velling on business" or vacationing, or both, says Fearing. But the company almost never reveals the truth. "I've gotten calls [from the press] regarding different cases and obviously I can't even acknowledge that I know the person, much less what's involved," he adds.

The secrecy is certainly understandable. Companies and boards have enough to cope with in terms of financial performance ...ut trying to explain away newly revealed liabilities in its leadership. And assuming the CEO returns, they don't want his or ...alcoholism to be a focus. They're also not required by SEC rules to disclose personal illnesses—though they are vaguely directed to reveal information considered "material."

To be sure, Union Pacific's decision to go public with Lewis' leave of absence when he entered treatment in 1994 was considered highly unusual—not to mention risky, given that the $15 billion railroad was right in the middle of a multi-billion-dollar bidding war with Burlington Northern over the acquisition of Santa Fe Pacific Corp. Their motives were never made public, but some speculated that UP's board was attempting to head off rumors or prevent fallout in the event that the truth leaked out some other way. They may even have been influenced by events six months earlier, when a CEO's addiction, previously undisclosed, made headlines when circumstances turned tragic. In May, 1994, Wardell Lazard, 44-year-old founder and CEO of W.R. Lazard & Co., was found dead of an accidental overdose of cocaine and alcohol, and the shocking news was ultimately a fatal blow for the investment bank, which was once the largest minority-owned underwriter in the country.

Board decisions aside, recovering CEOs themselves aren't motivated to tell all, particularly when it seems those who have disclosed are dogged by the label throughout their careers. While no CEO search experts would go on record saying so, at least one admitted he would have to think twice about recommending a recovering alcoholic, however talented, for a top spot—not because he would doubt that candidate's abilities, but because the stereotypes would cloud an otherwise positive story in the following day's financial pages. Tyson Foods CEO John Tyson, who declined to be interviewed, will likely always face questions about his cocaine and alcohol addiction, no matter what other successes—or troubles, more recently—the company trumpets. Sam Johnson, too, has buttoned up, after revealing his story in his documentary; in declining an interview for this piece, his spokesperson said Johnson "feels he's said all he needs to say about this topic."

Some CEOs may remain quiet simply because the principles of AA demand anonymity, even among celebrities. Morris, for example, expressed serious concerns about violating that principle for this article, although he had already told his story in other regional publications. One concern expressed by advocates of anonymity is that addicts will be deterred from seeking help for fear their illness will be disclosed. Others worry that a public figure's relapse, such as Lewis', will raise doubts about the p...gram's effectiveness.

...t the public needs to be educated that relapse is a part of recovery," says Professional Renewal Center's Stacy. "It's not a cure-all like an antibiotic. And if you're hiding the fact that relapse is a possibility, you're putting unrealistic expectations in people's hearts and minds."

It's a big responsibility to come clean, he adds, but stereotypes fade only when truth is revealed, and, in this case, when more CEOs are willing to risk bad publicity to raise awareness about the disease. "The less mental illness and addiction issues are stigmatized, the better," says Stacy, "and the easier it will be to have people get help without a tremendous amount of shame."

Please send your comments to *CE* at features@chiefexecutive.net.

When It's Time to Get Help

In a culture where deals are made on a handshake but sealed over a clink of glasses or two or three it's hard to tell how much is too much, or too often. Given that it's not a science, what are the signs that one's casual drinking has become an after hours problem?

That depends on whom you ask, and symptoms vary by individual. But "if you're even thinking it might be a problem, then it is," says Dr. Scott Stacy of the Professional Renewal Center. "You may not be dependent on that substance, but it calls for exploration."

Minnesota Vikings owner Red McCombs advises a trial separation. "Just try to stop for a couple of weeks, or even a week," he offers. "If you're addicted, you won't be able to."

AmeriCredit Chairman Clifton Morris, on the other hand, had proven he could sober up for months at a time. Yet without going ...ough the recovery steps of Alcoholics Anonymous and acknowledging his addiction, he always returned to the bottle and hit ...harder than he had before. Which is why he warns CEOs who have a problem that fear of losing their careers or their status isn't a good reason not to get help. "They're going to lose it anyway," he says. "You can't hide that for very long because of the ...rogressive nature of the disease."

Experts agree that alcoholism can and often does progress to tragic ends if left untreated, and they increasingly reject the

...on that one has to hit bottom before getting help. "Many people will die today in the United States based on that old idea," ... James Fearing, CEO of National Counseling Intervention Services. "We know better than that now."

Of course, not all casual indulgence leads to addiction, and recovering addicts say the key is for CEOs to monitor their own behavior as carefully as they do their companies' financials and to be brutally honest with themselves about what they see. "Most people can drink and don't have any addictive problems. Unfortunately some do," says McCombs. "When you do, it's something you have to take care of or it'll take care of you."

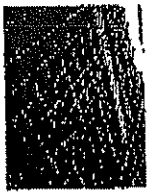
For more information on executive interventions, call National Counseling Intervention Services at 1 800 279 3321 or visit their Web site at www.nationalcounseling.com.

EXHIBIT 7

Connecticut - ACS Demographic and Housing Estimates: 2006-2008

U.S. Census Bureau

American FactFinder



Connecticut
ACS Demographic and Housing Estimates: 2006-2008
Data Set: 2006-2008 American Community Survey 3-Year Estimates
Survey: American Community Survey

NOTE. Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

For more information on confidentiality protection, sampling error, nonsampling error, and definitions, see Survey Methodology.

ACS Demographic and Housing Estimates	Estimate	Margin of Error	Percent	Margin of Error
SEX AND AGE				
Total population	3,493,006	*****	3,493,006	(X)
Male	1,701,789	+/-690	48.7%	+/-0.1
Female	1,791,217	+/-690	51.3%	+/-0.1
Under 5 years	211,752	+/-327	6.1%	+/-0.1
5 to 9 years	220,460	+/-3,211	6.3%	+/-0.1
10 to 14 years	236,542	+/-3,214	6.8%	+/-0.1
15 to 19 years	250,303	+/-791	7.2%	+/-0.1
20 to 24 years	221,310	+/-659	6.3%	+/-0.1
25 to 34 years	400,908	+/-913	11.5%	+/-0.1
35 to 44 years	525,691	+/-869	15.0%	+/-0.1
45 to 54 years	554,090	+/-767	15.9%	+/-0.1
55 to 59 years	220,106	+/-2,608	6.3%	+/-0.1
60 to 64 years	178,944	+/-2,561	5.1%	+/-0.1
65 to 74 years	229,910	+/-517	6.6%	+/-0.1
75 to 84 years	164,673	+/-1,745	4.7%	+/-0.1
85 years and over	78,327	+/-1,660	2.2%	+/-0.1
Median age (years)	39.1	+/-0.1	(X)	(X)
18 years and over	2,673,711	+/-223	76.6%	+/-0.1
21 years and over	2,523,810	+/-2,354	72.3%	+/-0.1
62 years and over	572,980	+/-2,406	16.4%	+/-0.1
65 years and over	472,910	+/-441	13.5%	+/-0.1
18 years and over	2,673,711	+/-223	2,673,711	(X)
Male	1,282,910	+/-335	48.0%	+/-0.1
Female	1,391,201	+/-318	52.0%	+/-0.1
65 years and over	472,910	+/-441	472,910	(X)
Male	194,583	+/-335	41.1%	+/-0.1
Female	278,327	+/-301	58.9%	+/-0.1
RACE				
Total population	3,493,006	*****	3,493,006	(X)
One race	3,422,833	+/-3,490	98.0%	+/-0.1
Two or more races	70,173	+/-3,490	2.0%	+/-0.1
One race	3,422,833	+/-3,490	98.0%	+/-0.1
White	2,790,080	+/-5,600	79.9%	+/-0.2
Black or African American	327,433	+/-2,881	9.4%	+/-0.1
American Indian and Alaska Native	7,990	+/-834	0.2%	+/-0.1
Cherokee tribal grouping	1,379	+/-471	0.0%	+/-0.1
Chippewa tribal grouping	147	+/-177	0.0%	+/-0.1

Connecticut - ACS Demographic and Housing Estimates: 2006-2008

ACS Demographic and Housing Estimates	Estimate	Margin of Error	Percent	Margin of Error
Navajo tribal grouping	33	+/-51	0.0%	+/-0.1
Sioux tribal grouping	53	+/-52	0.0%	+/-0.1
Asian	116,879	+/-1,341	3.3%	+/-0.1
Asian Indian	40,057	+/-2,261	1.1%	+/-0.1
Chinese	28,342	+/-2,066	0.8%	+/-0.1
Filipino	10,376	+/-1,332	0.3%	+/-0.1
Japanese	3,016	+/-663	0.1%	+/-0.1
Korean	9,016	+/-1,654	0.3%	+/-0.1
Vietnamese	8,443	+/-1,461	0.2%	+/-0.1
Other Asian	17,629	+/-1,946	0.5%	+/-0.1
Native Hawaiian and Other Pacific Islander	1,146	+/-235	0.0%	+/-0.1
Native Hawaiian	632	+/-325	0.0%	+/-0.1
Guamanian or Chamorro	146	+/-109	0.0%	+/-0.1
Samoan	26	+/-44	0.0%	+/-0.1
Other Pacific Islander	342	+/-187	0.0%	+/-0.1
Some other race	179,305	+/-6,428	5.1%	+/-0.2
Two or more races	70,173	+/-3,490	2.0%	+/-0.1
White and Black or African American	21,451	+/-1,972	0.6%	+/-0.1
White and American Indian and Alaska Native	10,587	+/-766	0.3%	+/-0.1
White and Asian	9,530	+/-1,164	0.3%	+/-0.1
Black or African American and American Indian and Alaska Native	4,398	+/-812	0.1%	+/-0.1
Race alone or in combination with one or more other races				
Total population	3,493,006	*****	3,493,006	(X)
White	2,847,338	+/-6,510	81.5%	+/-0.2
Black or African American	364,447	+/-2,573	10.4%	+/-0.1
American Indian and Alaska Native	27,075	+/-1,272	0.8%	+/-0.1
Asian	130,743	+/-1,016	3.7%	+/-0.1
Native Hawaiian and Other Pacific Islander	2,593	+/-588	0.1%	+/-0.1
Some other race	196,878	+/-6,028	5.6%	+/-0.2
HISPANIC OR LATINO AND RACE				
Total population	3,493,006	*****	3,493,006	(X)
Hispanic or Latino (of any race)	405,724	*****	11.6%	*****
Mexican	41,776	+/-3,798	1.2%	+/-0.1
Puerto Rican	222,072	+/-4,286	6.4%	+/-0.1
Cuban	7,521	+/-1,099	0.2%	+/-0.1
Other Hispanic or Latino	134,353	+/-4,995	3.8%	+/-0.1
Not Hispanic or Latino	3,087,282	*****	88.4%	*****
White alone	2,586,469	+/-1,833	74.0%	+/-0.1
Black or African American alone	315,348	+/-2,513	9.0%	+/-0.1
American Indian and Alaska Native alone	6,172	+/-681	0.2%	+/-0.1
Asian alone	115,444	+/-1,356	3.3%	+/-0.1
Native Hawaiian and Other Pacific Islander alone	1,101	+/-225	0.0%	+/-0.1
Some other race alone	14,710	+/-2,086	0.4%	+/-0.1
Two or more races	48,048	+/-2,618	1.4%	+/-0.1
Two races including Some other race	2,927	+/-712	0.1%	+/-0.1
Two races excluding Some other race, and Three or more races	45,121	+/-2,531	1.3%	+/-0.1
Total housing units	1,438,041	+/-227	(X)	(X)

Source: U.S. Census Bureau, 2006-2008 American Community Survey

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

Notes:
·For more information on understanding race and Hispanic origin data, please see the Census 2000 Brief entitled, Overview of Race and Hispanic Origin, issued March 2001. (pdf format)
·While the 2008 American Community Survey (ACS) data generally reflect the November 2007 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in ACS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities. The 2008 Puerto Rico Community Survey (PRCS) data generally reflect the November 2007 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in PRCS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities.
·Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2000 data. Boundaries for urban areas have not been updated since Census 2000. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Explanation of Symbols:

Connecticut - ACS Demographic and Housing Estimates: 2006-2008

1. An '**' entry in the margin of error column indicates that either no sample observations or too few sample observations were available to compute a standard error and thus the margin of error. A statistical test is not appropriate.
2. An '-' entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution.
3. An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution.
4. An '+' following a median estimate means the median falls in the upper interval of an open-ended distribution.
5. An '***' entry in the margin of error column indicates that the median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
6. An '*****' entry in the margin of error column indicates that the estimate is controlled. A statistical test for sampling variability is not appropriate.
7. An 'N' entry in the estimate and margin of error columns indicates that data for this geographic area cannot be displayed because the number of sample cases is too small.
8. An '(X)' means that the estimate is not applicable or not available.

The letters PDF or symbol indicate a document is in the Portable Document Format (PDF). To view the file you will need the Adobe® Acrobat® Reader, which is available for free from the Adobe web site.

EXHIBIT 8

U.S. Census Bureau

American FactFinder

Connecticut
S1901. Income in the Past 12 Months (In 2008 Inflation-Adjusted Dollars)
Data Set: 2006-2008 American Community Survey 3-Year Estimates
Survey: American Community Survey

NOTE. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see Survey Methodology.

Subject	Households	Margin of Error	Families	Margin of Error	Married-couple families	Margin of Error	Nonfamily households	Margin of Error
Total	1,325,680	+/-2,831	889,222	+/-4,690	676,359	+/-5,609	436,458	+/-4,097
Less than $10,000	5.3%	+/-0.2	3.0%	+/-0.2	0.8%	+/-0.1	10.5%	+/-0.4
$10,000 to $14,999	4.0%	+/-0.2	1.9%	+/-0.1	0.7%	+/-0.1	8.7%	+/-0.4
$15,000 to $24,999	8.0%	+/-0.2	5.1%	+/-0.2	2.9%	+/-0.2	14.4%	+/-0.5
$25,000 to $34,999	7.8%	+/-0.2	6.2%	+/-0.2	4.3%	+/-0.2	11.8%	+/-0.5
$35,000 to $49,999	11.5%	+/-0.2	9.9%	+/-0.3	8.1%	+/-0.3	14.9%	+/-0.6
$50,000 to $74,999	17.6%	+/-0.3	17.3%	+/-0.4	16.5%	+/-0.4	18.0%	+/-0.6
$75,000 to $99,999	14.2%	+/-0.3	16.0%	+/-0.4	17.3%	+/-0.4	9.8%	+/-0.4
$100,000 to $149,999	16.7%	+/-0.3	20.9%	+/-0.4	24.8%	+/-0.4	7.0%	+/-0.3
$150,000 to $199,999	6.8%	+/-0.2	8.9%	+/-0.2	11.0%	+/-0.3	2.1%	+/-0.2
$200,000 or more	6.1%	+/-0.2	10.9%	+/-0.2	13.7%	+/-0.3	2.3%	+/-0.2
Median income (dollars)	68,411	+/-584	84,657	+/-593	99,084	+/-885	39,021	+/-729
Mean income (dollars)	95,430	+/-826	114,065	+/-1,111	132,293	+/-1,408	54,156	+/-851
PERCENT IMPUTED								
Household income in the past 12 months	27.5%	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Family income in the past 12 months	(X)	(X)	27.9%	(X)	(X)	(X)	(X)	(X)
Nonfamily income in the past 12 months	(X)	(X)	(X)	(X)	(X)	(X)	25.1%	(X)

Source: U.S. Census Bureau, 2006-2008 American Community Survey

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

Notes:
-While the 2008 American Community Survey (ACS) data generally reflect the November 2007 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in ACS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities. The 2008 Puerto Rico Community Survey (PRCS) data generally reflect the November 2007 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in PRCS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities.
-Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2000 data. Boundaries for urban areas have not been updated since Census 2000. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Explanation of Symbols:
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EXHIBIT 9

PROBLEM-ORIENTED DIAGNOSIS

Recognition of Alcohol and Substance Abuse

DAVID J. MERSY, M.D., HealthPartners Spring Lake Park Clinic, Spring Lake Park, Minnesota

Ten percent of the population abuses drugs or alcohol, and 20 percent of patients seen by family physicians have substance-abuse problems, excluding tobacco use. These patients can be identified by relying on regular screening or a high index of suspicion based on "red flags" that can be noted in various clinical situations. The modified CAGE questionnaire is an excellent screening instrument, but several alternatives are available. The best screening test is one that the physician will routinely use well. Laboratory indicators such as gamma-glutamyl transpeptidase, mean corpuscular volume, and carbohydrate-deficient transferrin are nonspecific but can add to the evidence of alcohol abuse. If problem alcohol use is diagnosed, even brief physician advice can be helpful. If the problem has progressed to addiction, referral to an addiction specialist or treatment center is recommended. Special issues arise in dealing with substance abuse in adolescents, elderly patients, and patients with mental illness, but the family physician can play an important role in recognizing this common problem. (Am Fam Physician 2003;67:1529-32,1535-6. Copyright© 2003 American Academy of Family Physicians.)

A patient information handout on substance abuse and problem drinking, written by the author of this article, is provided on page 1535.

Members of various family practice departments develop articles for "Problem-Oriented Diagnosis." This is one in a series from the Department of Family and Community Medicine Education at Albany Medical College, Albany, N.Y. Guest editors of the series are Neil C. Mitnick, D.O., and Mary F. Smith, Ph.D.

Substance abuse, defined as the problematic use of alcohol, tobacco, or illicit drugs, has been called the nation's number one health problem.[1] The costs to society are enormous; the National Institute on Alcohol Abuse and Alcoholism estimates that alcohol and drug abuse are associated with 100,000 deaths per year and cost society $100 billion per year.[2]

It is thought that approximately 10 percent of American adults have a problem with drugs or alcohol, and an estimated 20 percent of patients seen by family physicians have substance-abuse problems, excluding tobacco use.[3] Patients who abuse alcohol and drugs are much more likely to develop medical problems than the general population.

Definitions

The American Medical Association recognized alcoholism as a disease in 1956. Early editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) required the presence of tolerance or withdrawal symptoms before a diagnosis of alcohol or drug dependence could be made. In the fourth edition of this publication, the requirements shifted to loss of control and failure to abstain from using the substance despite evidence of the problems it causes.[4] A practical approach for the family physician is to define addiction as the continued use of mood-altering chemicals despite an identified medical or social contraindication. This definition is helpful because physicians do not have to consider the amounts of substances being used or the duration of use.

The distinction between addiction and problem use is particularly important. The problem drinker or drug user may have undiagnosed medical or social problems but not yet have experienced a major loss of control. In full-blown addiction, patients continue using alcohol or drugs despite negative consequences, have a compulsion to continue using alcohol or drugs, and are in denial about the effects on themselves and others.

Approach to the Patient

Patients can present with "red flags" for alcohol and drug problems (*Table 1*).[5] These warnings can be detected during physical examinations or by screening during consultations for atypical progress of medical problems. Although none of the red flags is pathognomonic for alcohol or drug problems, the presence of even one should raise suspi-

See page 1413 for definitions of strength-of-evidence levels.

TABLE 1
"Red Flag" Complaints for Substance-Abuse Problems

Frequent absences from school or work	Gastrointestinal symptoms, such as epigastric distress, diarrhea, or weight changes
History of frequent trauma or accidental injuries	Sexual dysfunction
Depression or anxiety	Sleep disorders
Labile hypertension	

Adapted with permission from Schulz JE, Parran T Jr. Principles of identification and intervention. In: Graham AW, Schultz TK, Wilford BB, eds. Principles of addiction medicine. 2d ed. Chevy Chase, Md.: American Society of Addiction Medicine, 1998:250.

TABLE 2
Physical Findings that Suggest Alcohol and Other Drug Problems

Mild tremor
Odor of alcohol on breath
Enlarged, tender liver
Nasal irritation (suggestive of cocaine insufflation)
Conjunctival irritation (suggestive of exposure to marijuana smoke)
Labile blood pressure, tachycardia (suggestive of alcohol withdrawal)
"Aftershave/mouthwash" syndrome (to mask the odor of alcohol)
Odor of marijuana on clothing
Signs of chronic obstructive pulmonary disease, hepatitis B or C, HIV infection

HIV = human immunodeficiency virus.

Adapted with permission from Schulz JE, Parran T Jr. Principles of identification and intervention. In: Graham AW, Schultz TK, Wilford BB, eds. Principles of addiction medicine. 2d ed. Chevy Chase, Md.: American Society of Addiction Medicine, 1998:251.

cion. In addition to the typical signs, a history of relationship difficulties, poorly explained trauma, or convictions for driving while intoxicated (DWI) should raise suspicion.

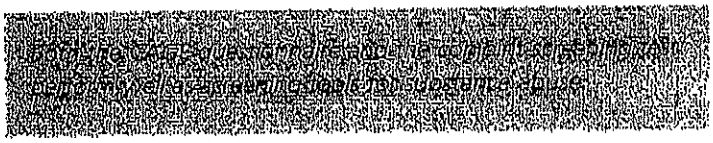
A number of physical findings can suggest alcohol or other drug problems *(Table 2)*.[5] Another warning flag pops up when a patient with a chronic disease fails to respond in the expected manner to treatment, such as a patient with diabetes whose glucose level becomes more difficult to control or a patient with hypertension whose blood pressure becomes more difficult to manage despite apparently optimal therapy and supposed compliance...

It is still important to screen all patients for drug and alcohol use when there are no obvious red flags, suspicious physical findings, or atypical features of chronic disease. Screening should be done whenever possible but particularly at the time of the periodic evaluation. In selecting a screening tool, the physician should decide between using a screening test or focusing on the amount of alcohol consumed.

The American Society of Addiction Medicine has developed standards for a positive screen based on the number of drinks ingested per week. Using this standard, a positive screen is considered consumption of more than 14 drinks per week or more than four drinks per occasion for men. For women, a positive screen is more than seven drinks per week or more than three drinks per occasion.[6] The numbers for women are lower because it takes fewer drinks for women to experience the negative consequences of alcohol consumption.[7] If the screen is positive, the physician should take a more extensive history and consider physical examination and laboratory evaluation. The latter can help rule out a false-positive screen and classify the patient as a problem drinker or an alcoholic.

Several other screening tools are available, but the CAGE questionnaire and the conjoint screening test are the most practical for family physicians. CAGE is a mnemonic for a questionnaire that asks about attempts to *C*ut down on drinking, *A*nnoyance with criticisms about drinking, *G*uilt about drinking, and using alcohol as an *E*ye opener.[8,9] The test requires approximately one minute to complete, and although it does not diagnose alcoholism or problem drinking, it should prompt the physician to look further.

The CAGE questionnaire does not differentiate between current and former problems, and it is more accurate in detecting alcoholism than problem drinking. Screening for other substances can be incorporated into the CAGE format by simply including references to them in the questions.[10] The CAGE questionnaire is thought to be 60 to 90 percent sensitive when two or more questions are positive and 40 to 60 percent specific for excluding substance abuse.



The conjoint screening test is even shorter, involving only two questions: "In the past year, have you ever drunk or used drugs more than you meant to?" and "Have you felt you wanted or needed to cut down on your drinking or drug use in the past year?"[11] When primary care patients were studied, at least one positive response detected current substance-use disorders with nearly 80 percent sensitivity and specificity. As with all screening tests, performance varies with the prevalence of substance abuse in the particular population screened.

It is more important for physicians to pick a screening tool and use it routinely than to try to find the best screening method in each situation. The best method is the one that physicians use on a regular basis. No single screening test can diagnose substance abuse, but a positive screen raises suspicion and should prompt physicians to investigate further.

Laboratory Evaluation

Although many laboratory tests have been used in the evaluation of substance abuse, none is diagnostic. The most useful laboratory tests to confirm alcohol-abuse problems are gamma-glutamyl transpeptidase (GGT), mean corpuscular volume (MCV), and carbohydrate-deficient transferrin (CDT). A urine toxicology screen is the best test to confirm problems with other drugs.

The serum GGT determination is one of the most widely used laboratory tests. This hepatic enzyme is elevated in patients who use alcohol excessively.[12] The test has a higher sensitivity than specificity because other conditions, such as nonalcoholic liver disease, hyperthyroidism, and use of anticonvulsants, can elevate GGT levels.[13]

MCV also has been used as a marker of heavy alcohol consumption. It tends to be less sensitive than measurement of the GGT level, but an elevated MCV level combined with an elevated GGT level should raise suspicion about alcohol abuse.[12]

CDT tests are available to screen for excessive alcohol consumption. It has been estimated that four to seven drinks per day for at least one week can significantly elevate CDT levels in patients with alcoholism.[14]

Special Populations

Recognition of substance abuse in adolescents, geriatric patients, and patients with mental illness provides special challenges.

Drug and alcohol use during adolescence differs from use in adults. The typical acting out of adolescents can be confused with the effects of drug and alcohol use. Adolescents' mistrust of adult authority frequently complicates the detection of substance abuse. A family physician who has interacted with an adolescent over time probably is trusted more than other adult authority figures. The best chance for the physician to detect problems is in the context of routine medical care.[15] Family physicians need to be aware of potential problems and modify the CAGE questionnaire to screen for both drugs and alcohol.

Older patients with alcoholism fall into two groups. The early-onset group had alcoholism earlier in life, while problems in the late-onset group begin after the age of 60.[16] Several studies have evaluated the efficacy of the CAGE questionnaire in elderly patients. While the overall sensitivity and specificity are quite good, this screening tool is not as effective in discriminating between current drinking and a past drinking problem. It is particularly important to modify the CAGE questionnaire to detect drug abuse, because elderly patients are prone to self-medication. The physician must be aware that cognitive impairment can affect the patient's ability to respond accurately to the questions.

The physician should be suspicious of substance abuse in patients with mental disorders. Results from the Epidemiologic Catchment Area study[17] demonstrated that 47 percent of patients with a lifetime diagnosis of schizophrenia or schizophreniform disorder met criteria for some form of substance abuse. In patients with antisocial personality disorder, the percentage was 83.6; in patients with anxiety disorders, the percentage was 23.7; and in patients with affective disorders, the percentage was 32. Suspicion of substance abuse is important not only because

of the prevalence of this disorder, but also because it is very difficult to treat mental illness if concomitant substance abuse is unrecognized.

Treatment

A detailed outline of the treatment of substance abuse is beyond the scope of this article. If problem drinking is identified, even brief physician advice can be helpful.[18] [Evidence level A, randomized controlled trial] These patients have experienced some negative consequences but have not yet experienced a major loss of control. The patient who has been diagnosed with substance abuse should be referred to an addiction-medicine specialist or an inpatient or outpatient treatment center. These steps give the patient a solid start on the recovery process.

If insurance problems or other factors prevent referral, it is possible to detoxify the patient on an outpatient basis. The patient then can be referred to Alcoholics Anonymous or Narcotics Anonymous for sustained follow-up support. Specific medical therapies are available for opioid addiction.

Whatever treatment the patient undergoes, it is important for the family physician to be supportive of the patient and the family in recovery and to be extremely careful about prescribing mood-altering drugs in the future. As a chronic disease, substance abuse tends to relapse. The family physician can play a pivotal role by dealing with the patient and family in a nonjudgmental manner.

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EXHIBIT 10

SAS Output

Substance Abuse Treatment Admissions by Primary Substance of Abuse, According to Sex, Age Group, Race, and Ethnicity

YEAR=2008

STATE: CONNECTICUT		Total	PRIMARY SUBSTANCE												
			Alcohol only	Alcohol with secondary drug	Cocaine (smoked)	Cocaine (other route)	Marijuana	Heroin	Other opiates	PCP	Hallucinogens	Amphetamines	Other stimulants	Tranquilizers	Sedatives
Total	No.	45,882	8,093	8,463	3,642	1,838	4,756	15,236	2,313	408	98	123	9	248	126
	%	100.0	17.6	18.4	7.9	4.0	10.3	33.1	5.0	0.9	0.2	0.3	0.0	0.5	0.3
SEX															
Male	%	71.0	74.1	73.4	56.2	70.8	77.1	71.5	62.2	60.8	68.4	74.0	77.8	58.0	52.4
Female	%	29.0	25.9	26.6	43.7	29.2	22.8	28.5	37.8	39.2	31.6	26.0	22.2	43.5	47.6
Unknown	%	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
AGE AT ADMISSION															
0-11 years	%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0
12-17 years	%	1.4	0.2	0.3	0.1	0.3	9.7	0.2	0.6	2.0	2.0	2.4	33.3	2.0	0.0
18-20 years	%	6.6	1.4	3.9	1.6	6.6	21.3	7.1	7.5	8.6	19.4	14.6	11.1	5.2	4.8
21-25 years	%	15.4	5.9	10.4	7.9	12.0	27.7	19.8	23.1	28.1	26.5	23.6	22.2	18.1	15.1
26-30 years	%	14.0	9.4	11.1	10.7	16.1	16.6	16.4	20.0	36.2	20.4	16.7	22.2	22.2	11.9
31-35 years	%	11.2	9.6	10.7	13.4	15.0	9.4	12.5	12.6	16.2	10.2	13.0	0.0	13.3	11.9
36-40 years	%	13.9	12.5	16.2	20.7	17.6	6.3	14.5	11.4	4.7	7.1	8.9	0.0	8.8	14.3
41-45 years	%	15.5	20.5	20.1	24.6	16.9	3.9	13.1	10.2	1.0	5.1	6.1	0.0	10.9	19.0
46-50 years	%	12.0	20.4	15.9	14.3	10.3	2.0	9.3	7.0	0.9	6.1	7.3	11.1	11.3	12.7
51-55 years	%	6.4	13.5	7.0	5.5	3.9	0.9	4.9	5.5	9.0	2.0	0.0	0.0	4.8	4.8
56-60 years	%	2.5	6.3	3.0	1.1	0.8	0.3	1.7	1.4	0.0	0.0	0.8	0.0	1.6	4.8
61-65 years	%	0.8	2.5	0.7	0.5	0.2	0.0	0.4	0.5	0.0	1.0	1.6	0.0	0.4	0.8
66 years and over	%	0.3	1.4	0.1	0.1	0.0	0.0	0.1	0.1	0.0	0.0	0.8	0.0	0.8	0.0
Unknown	%	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.4	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
RACE															
White	%	65.2	79.6	64.5	48.1	61.7	42.2	66.8	90.4	20.0	54.1	63.4	33.3	83.9	81.7
Black or African-American	%	17.5	8.7	22.8	37.6	19.0	35.7	10.1	2.6	49.0	28.6	8.9	44.4	5.6	7.9
American Indian or Alaska Native	%	0.4	0.3	0.3	0.5	0.5	0.5	0.3	0.5	1.0	1.0	0.8	0.0	0.4	0.0
Asian or Native Hawaiian or Other Pacific Islander	%	0.6	0.5	0.8	1.3	0.3	0.7	0.6	0.5	1.7	0.0	0.8	0.0	1.6	1.6
Other	%	16.0	10.1	11.6	12.2	18.2	20.4	22.0	5.8	28.3	15.9	25.2	22.2	8.1	8.7
Unknown	%	0.3	0.4	0.3	0.1	0.2	0.5	0.1	0.3	0.0	0.0	0.8	0.0	0.4	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ETHNICITY															

= 45,338 admissions for CT's 18+ population

SAS Output

Hispanic or Latino	%	16.5	10.7	12.9	13.0	23.6	27.6	25.0	6.6	34.5	23.5	22.0	33.3	8.7	7.1
Not Hispanic or Latino	%	80.8	88.6	86.6	86.6	76.0	70.9	74.6	92.5	65.0	74.5	77.2	66.7	89.1	92.9
Unknown	%	0.7	0.8	0.5	0.4	0.4	1.5	0.4	0.9	0.5	2.0	0.8	0.0	1.2	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Click here to view descriptions of drug categories
– Quantity is zero
SOURCE: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS).
Based on administrative data reported by States to TEDS through January 6, 2009.

EXHIBIT 11

Litchfield Hills-Potential Target Population in Connecticut & First 3 Year Admissions

CT Adult Population (2006-2008)[1]	2,673,711
Population with HH income $200K +[2]	213,896
# with drug/alcohol abuse/dependency problem[3]	21,389
# appropriate for residential rehabilitation[4]	3,636
Target population for proposed center[5]	**3,208**
Year 1 Projections (2.5%)	89
Year 2 Projections (5%)	160
Year 3 Projections (7%)	225

Litchfield Hills CT vs. Out of State Admissions (Years 1-3)

	Year 1	Year 2	Year 3
Total Beds	28	28	28
Total Available Bed Days[6]	10,220	10,220	10,220
Projected Total Occupancy[7]	40%	65%	85%
Projected Bed Days[8]	4,088	6,434	8,687
Protected Total Admissions[9]	136	221	290
CT Admissions[10]	80	160	225
Out of State Admissions[11]	56	61	65
% of Admissions from CT	59%	72%	78%

[1] Per U.S. Census Bureau for CT
[2] As per US Census Bureau for CT, 8% of population
[3] As per SAMHSA estimate of 10%
[4] Calculated percent of CT residents that sought residential treatment for substance abuse (17%)
[5] Estimated more conservatively the potential target population to be 15% of total substance abusing population
[6] 28 beds x 365 days
[7] As estimated by
[8] Percentage of projected total occupancy applied to total available bed days
[9] Based on average 30 day length of stay (i.e. 4088/30days = 136)
[10] Based on capture rates of 2.5, 5, and 7 percent for first 3 years, respectively.
[11] Difference between projected total admissions and projected CT admissions.

EXHIBIT 12

Type of Care

	Facilities[1] No.	Facilities[1] %	Clients in Treatment on March 31, 2006: All Clients No.	All Clients %	All Clients Median No. of Clients Per Facility	Clients Under Age 18 No.	Clients Under Age 18 %
Outpatient	161	75%	19,044	89%	51	672	80%
Regular outpatient	130	60%	7,704	36%	37		
Intensive outpatient	76	35%	1,566	7%	13		
Day treatment/partial hospitalization	40	19%	524	2%	11		
Detoxification	31	14%	387	2%	9		
Methadone	38	18%	8,863	41%	245		
Residential	66	31%	1,828	8%	18	106	13%
Short term	19	9%	470	2%	18		
Long term	48	22%	1,243	6%	17		
Detoxification	5	4%	113	1%	14		
Hospital Inpatient	17	8%	632	3%	16	58	7%
Treatment	11	5%	249	1%	9		
Detoxification	15	7%	383	2%	10		
Total	216		21,502	100%	46	836	100%

[1] Facilities may be included in more than one category.

Opioid Treatment Programs (OTPs)

	No.	%
Facilities with OTPs		
Maintenance only	9	23%
Detoxification only	6	16%
Both maintenance and detoxification	24	62%
Total	39	100%
Clients in Facilities with OTPs	9,340	
Methadone	9,226	
Buprenorphine	114	

Type of Payment Accepted

	Facilities No.	Facilities %
Cash or self-payment	199	92%
Private health insurance	151	70%
Medicare	95	44%
Medicaid	161	75%
Other State-financed health insurance	139	64%
Federal military insurance	73	34%
No payment accepted	5	2%
Other type of payment	3	1%
Sliding fee scale	166	77%
Treatment at no charge for clients	136	63%

Facility Capacity and Utilization[1]

	Residential	Hospital Inpatient
No. of facilities	63	6
No. of clients	1,760	489
Designated beds	1,886	536
Utilization rate	[illegible]	91%
Designated beds per facility (average)	30	536

[1] Excludes facilities not reporting both client counts and number of beds, facilities whose client counts were reported by another facility, facilities that included client counts from other facilities, and facilities that did not respond to this question.

Facility Licensing, Approval, Certification, or Accreditation

	Facilities No.	Facilities %
Any listed agency/organization	205	95%
State substance abuse agency	120	56%
State mental health department	88	41%
State public health department/board of health	190	88%
Hospital licensing authority	19	9%
JCAHO (Joint Commission on Accreditation of Healthcare Organizations)	87	40%
CARF (Rehabilitation Accreditation Commission)	63	29%
NCQA (National Committee for Quality Assurance)	—	—
COA (Council for Accreditation for Children and Family Services)	12	6%
Other State/Local Agency/Organization	10	5%

Facility Administrative and Funding Characteristics

	Facilities No.	Facilities %
Has agreements or contracts with managed care organizations for provision of substance abuse treatment services	164	76%
Receives Federal, State, county, or local government funds for substance abuse treatment programs	173	80%

EXHIBIT 13

40 Jackson Hill Rd, Sharon, CT 06069 to 64 Double Hill Rd, Bethlehem, C... Page 1 of 2

Google maps

Directions to 64 Double Hill Rd, Bethlehem, CT 06751
28.7 mi – about 50 mins

Save trees. Go green!
Download Google Maps on your phone at **google.com/gmm**

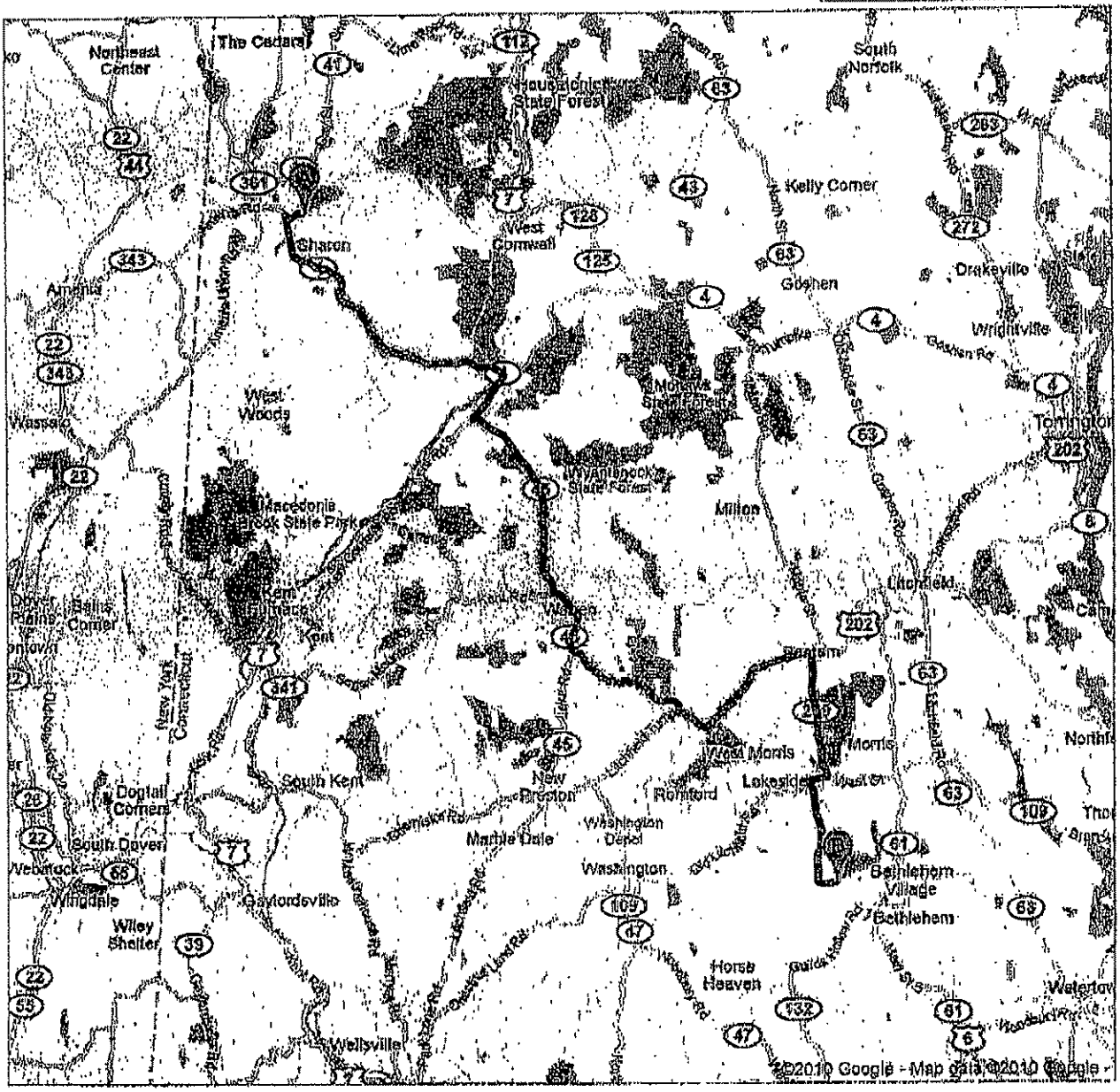

EXHIBIT 14

Roberts, Karen

From: Kennedy Hudner [KHUDNER@murthalaw.com]
Sent: Monday, April 05, 2010 10:14 AM
To: Roberts, Karen
Subject: CON - Vista Partners, LLC
Attachments: Kennedy Hudner.vcf

Dear Karen:

I am replying to your letter dated April 1, 2010 concerning the CON granted to Vista Partners, LLC (No. 07-30928) to establish an alcohol and drug treatment center in Sharon, Ct.

The applicant will not be going forward with this CON. At present, the applicant, Vista Partners, LLC has dissolved. My apologies to you for not notifying you about this sooner.

Very truly yours,

Kennedy Hudner

Kennedy Hudner
Partner
khudner@murthalaw.com

Murtha Cullina LLP
CityPlace I, 185 Asylum Street
Hartford, CT 06103-3469
Direct: 860-240-6029
Direct Fax: 860-240-5829
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Main Fax: 860-240-6150

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FAX TRANSMISSION

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ATTORNEYS AT LAW
105 COURT STREET
THIRD FLOOR
NEW HAVEN, CT 06511
(203) 777-5800 Fax: (203) 777-5806

RECEIVED
APR 26 2010
OFFICE OF
HEALTH CARE ACCESS

FAX #: (860) 418-7053
TO: Honorable Cristine Vogel
Office of Health Care Access

DATE: April 26, 2010

PAGES: **8** including this page

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

CONFIDENTIALITY NOTICE
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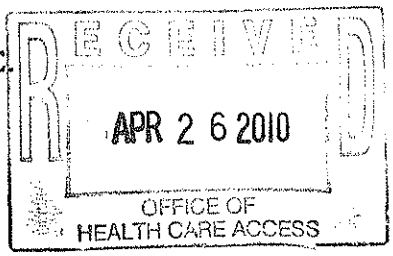
COMMENTS:

Dear Commissioner Vogel:

Please see the attached Legal Counsel's Opening and Closing Statement.

Thank you.

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806



Michele M. Volpe
Direct Dial (203) 777-6995

April 26, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
and Federal Express

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Legal Counsel's Opening and Closing Statement.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Legal Counsel Opening & Closing Statement) 4.26.10.doc

DEPARTMENT OF PUBLIC HEALTH
DIVISION OF OFFICE OF

HEALTH CARE ACCESS : **DOCKET NO. 09-31500-CON**

:

IN RE: EMPLOYMENT OPTIONS, LLC :
D/B/A LITCHFIELD HILLS RETREAT, LLC
PROPOSAL TO ESTABLISH A
FREE STANDING RESIDENTIAL ADULT
SUBSTANCE ABUSE CENTER IN
BETHLEHEM : **April 26, 2010**

Legal Counsel's Opening and Closing Statement

My name is Michele Volpe and my firm serves as legal counsel for Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC ("Applicant" or "Litchfield Hills"). We thank you for allowing us to appear before you today.

Litchfield Hills is proposing to establish an alcohol and drug treatment center in Bethlehem, with an associated capital expenditure of $2,500,000. Litchfield Hills will seek licensure from the Department of Public Health to operate a 28 bed, free standing substance abuse facility in accordance with the provisions of the General Statutes of Connecticut Section 19a-493 as a Facility for the Care or Treatment of Substance Abusive or Dependent Persons. *(CON p. 25)*.

The population to be served at Litchfield Hills will primarily include Connecticut residents, as well as individuals from neighboring states, with the following characteristics:

- Adults 18 and over (male and female) (*CON p. 8)*;
- Who have a history of alcohol or drug abuse or dependency (*CON p. 8)*;
- Who have been already been through Detox treatment and/or have been medically cleared by a physician *(CON p.51)*; and
- Who are part of the population of high income professionals, (lawyers and doctors), executives in senior management, and public officials (*CON pp. 51-52)*.

Litchfield Hills is intended to serve individuals whose public visibility, wealth and/or public and/or social position make it difficult for them to continue on the road to a successful recovery in the existing traditional residential treatment settings.

Litchfield Hills based the need for the proposal on the following:

- Substance and alcohol abuse/dependency is a significant health problem in Connecticut *(CON p. 64)*;

- Substance and alcohol abuse/dependency among certain professionals (e.g. physicians, attorneys, financial services executives) is a significant health problem *(CON p. 136)*; and

- There are no small residential alcohol and drug treatment facilities in Connecticut that offer extremely private, discreet and individualized programs exclusively for substance abusing professionals, executives, public officials, and other high-income residents. *(CON p. 52)*

According to the Litchfield Hills Application and testimony offered, National and Connecticut specific statistics support that ten percent (10%) of the population have a problem with dependency on or abuse of illicit drugs or alcohol. Evidence further suggests that this figure is higher among the affluent population.

The Office of National Drug Control Policy published in its Drug Policy Information Clearinghouse (June 2006) for the State of Connecticut the following facts about drug use and availability:

- Cocaine is widely abused in Connecticut;

- Demand for heroin is increasing dramatically in the state and is easily accessible and selling at low prices and high-purity levels;

- MDMA (Ecstasy) is readily available and abused in Connecticut and is a popular drug among college aged residents;

- Prescription drug abuse is also a problem in Connecticut;

- There were a total of 48,218[1] admissions in 2004 to drug/alcohol treatment in Connecticut; and

- Approximately 79,000 residents reported needing, but not receiving, treatment for illicit drug use within the past year. *(CON p.10-18)*

Litchfield Hills has provided evidence of this significant health problem among certain professionals who have high pressure careers, such as physicians, attorneys, and financial services professionals, as follows: substance abuse among physicians may be as high as twelve percent (12%) *(prefile testimony of Mr. Gwozdz)*, eighteen percent (18%) to twenty percent (20%) of attorneys suffer from alcoholism and this rate rises to twenty-five percent (25%) after 20 years of practice *(CON p 136 and pre file testimony of Mr. Gwozdz)*

[1] Note that as referenced in Mr. Gwozdz prefile testimony, according to SAMHSA data for 2008, there were 45,338 admissions for adults 18+

There are no alcohol and substance abuse facilities in Connecticut that are specifically and exclusively oriented toward high profile professionals with substance abuse problems. *(CON p.52 & prefile testimony of Mr. Gwozdz)* These individuals require a small, discreet and very private treatment facility.

The Applicant's proposed center will be very private and intimate and offer substance abuse rehabilitation care with treatment plans that incorporate nationally accepted addiction treatment modalities. It will also focus on its clients' professional situations and backgrounds, individual burdens brought on by unique social backgrounds and family relationships. Given the relatively small size of the proposed facility, significant time will be spent on each client's individual circumstances and treatment will be tailored to their specific situation and needs. *(Prefile testimony of Dr. Sack)*

The Applicant will offer individualized care and appropriate programs that will address the professional and social characteristics of its clients and offer a peer group for clients with specific careers (e.g. physicians, attorneys, senior business executives). *(Prefile testimony of Dr. Sack)*

Litchfield Hills is being proposed by the founders and current leadership team of Employment Options, LLC *(CON p. 51)*. Employment Options is a vocational and residential support and independent living skills provider in Connecticut. Employment Options works collaboratively with the Department of Mental Health and Addition Services, hospitals, physicians, behaviorists, case managers, social workers, conservators and family members *(CON p. 28)*. The services and experience of Employment Options will directly transfer to the work proposed by Litchfield Hills. As important, Litchfield Hills has retained expert consulting services to assist in the establishment and operation of the proposed center. *(Prefile testimony of Dr. Sack)*

The Applicant will employ certified and/or licensed counselors *(CON p. 51)* and will have a very favorable counselor to client ratio.

As asserted in the CON Application, many Connecticut physicians, attorneys and executives must travel outside Connecticut for the alcohol and drug treatment services they require. The proposed Litchfield Hills center will serve clients from throughout the State of Connecticut as well as surrounding states. Connecticut residents who need this type of Center will benefit from a closer proximity to family and after care supports *(CON p. 52)*.

Since the proposed center is a residential service, the hours of operation will be 24 hours per day, 7 days per week, 365 days per year.

Litchfield Hills provided a list of existing providers but distinguishes itself from these providers in that many of the facilities listed are psychiatric facilities and serve patients with complex co-existing psychiatric and substance abuse problems.

The following table shows the projected number of admissions for Connecticut residents to the proposed facility for the first three years of operation:

Number of projected Connecticut Residents admitted for the first three years*

	Year 1	Year 2	Year 3
Connecticut Residents Admitted	89	160	225

Litchfield Hills-Potential Target Population in Connecticut & First 3 Year Admissions

CT Adult Population (2006-2008)[2]	2,673,711
Population with HH income $200K +[3]	213,896
# with drug/alcohol abuse/dependency problem[4]	21,389
# appropriate for residential rehabilitation[5]	3,636
Target population for proposed center[6]	**3,208**
Year 1 Projections (2.5%)	89
Year 2 Projections (5%)	160
Year 3 Projections (7%)	225

In the event that a client is determined not to be appropriate for the level of care delivered at the Litchfield Hills center, such client will be referred to an alternative level of care (e.g. inpatient psychiatric facility/unit, acute care hospital emergency room, detoxification center, specialty center for eating disorder, etc.). All referrals will be done in conjunction with the referring physician or practitioner and the client; and will be based on a client's specific needs and condition. *(Prefile testimony of Dr. Sack)*

Litchfield Hills states that the proposed center will not provide detoxification and therefore will not seek licensure for these services.

The table below summarizes the total projected admissions for the first three years:

Litchfield Hills CT vs. Out of State Admissions (Years 1-3)

	Year 1	Year 2	Year 3
Total Beds	28	28	28
Total Available Bed Days[7]	10,220	10,220	10,220
Projected Total Occupancy[8]	40%	65%	85%
Projected Bed Days[9]	4,088	6,434	8,687
Protected Total Admissions[10]	136	221	290
CT Admissions[11]	80	160	225
Out of State Admissions[12]	56	61	65
% of Admissions from CT	59%	72%	78%

[2] Per U.S. Census Bureau for CT
[3] As per US Census Bureau for CT, 8% of population
[4] As per SAMHSA estimate of 10%
[5] Calculated percent of CT residents that sought residential treatment for substance abuse (17%)
[6] Estimated more conservatively the potential target population to be 15% of total substance abusing population
[7] 28 beds x 365 days
[8] As estimated by Applicant
[9] Percentage of projected total occupancy applied to total available bed days
[10] Based on average 30 day length of stay (i.e. 4088/30days = 136)
[11] Based on capture rates of 2.5, 5, and 7 percent for first 3 years, respectively.
[12] Difference between projected total admissions and projected CT admissions.

Litchfield Hills' decision to establish a 28 bed center was based on the following factors:

- Since the target population is professional and high profile individuals, it is critical that the facility be relatively small and very private;
- A complement of 28 beds will facilitate staffing, conducting small group activities and offering sufficient privacy when needed.

Litchfield Hills provided sufficient documentation to support the proposed capital expenditures and financial viability of the center. More important, it already owns the real estate and its founder shall provide all necessary capital.

There is no State Health Plan in existence at this time.

Litchfield Hills will not have any teaching or research responsibilities.

Litchfield Hills' projected payer mix for the proposed facility is self-pay comprised primarily of households with high income.

Litchfield Hills' staff will provide sufficient technical, financial and managerial competence and expertise to provide efficient and adequate service to the public.

As specifically set forth in its Application and prefile testimony, Litchfield Hills has clearly evidenced the need for a treatment center for affluent, high-profile alcohol and drug abusing/dependent persons. The Litchfield Hills center will serve individuals whose public visibility, wealth and/or public and/or social position make it virtually impossible for them to begin a successful recovery in the existing traditional residential treatment settings. The proposed center will have 28 beds. The population to be served will be adults 18 and over (male and female) with a history of alcohol or drug abuse or dependency, and are high level professionals or persons with a public role. The proposed center will offer substance abuse rehabilitation care with treatment plans that incorporate nationally accepted addiction treatment modalities *(CON p. 51)*. The Center will also focus on its clients' professional situations and backgrounds, individual burdens brought on by unique social backgrounds, and family relationships.

While the Office of Health Care Access approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis, it must be acknowledged that an established unmet need exists in Connecticut for the very services Litchfield Hills seeks to provide. This need was established in the Vista Partners, LLC application, Docket #07-30928-CON, and has been established again in the pending Litchfield Hills application. More important, the need remains unmet, as the Vista Partners CON is expired and Vista affirmatively stated to OHCA that it would not implement its CON *(see OHCA email correspondence from Attorney Kennedy Hudner)*.

We thank you for this opportunity to appear before you today on behalf of Litchfield Hills Retreat, LLC and we respectfully request that you approve this pending CON Application and permit the establishment of the proposed freestanding adult residential substance abuse center in Bethlehem.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: _____

Michele M. Volpe
Juris No. 412124
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FAX TRANSMISSION

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ATTORNEYS AT LAW
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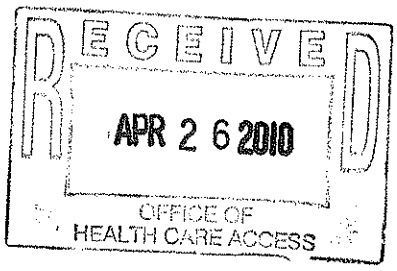
(203) 777-5800 Fax: (203) 777-5806



FAX #: (860) 418-7053
TO: Honorable Cristine Vogel
Office of Health Care Access

DATE: April 26, 2010

PAGES: 6 including this page

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

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Please note that the information contained in this fax is confidential and privileged and is intended only for use by the named receiver. If you have received this fax in error, please call 203-777-5800. Any use of this fax or its contents, including any dissemination or copying, is prohibited. Attorneys receiving this fax in error are directed to review ABA formal ethics opinion no. 92-368.

COMMENTS:

Dear Commissioner Vogel:

Please see the attached Request for Administrative Notice.

Thank you.

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NEW HAVEN, CONNECTICUT 06511
203-777-5800
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Michele M. Volpe
Direct Dial (203) 777-6995

April 26, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
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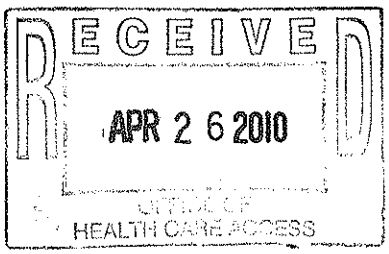

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

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Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Request for Admin Notice) 4.26.10.doc

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING ADULT SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 26, 2010**

REQUEST FOR ADMINISTRATIVE NOTICE

In accordance with Conn. Gen. Stat. § 4-178 and §§ 19a-643-53(d) and (e) of the Rules of Practice of the Office of Health Care Access ("OHCA"), Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC ("Applicant"), hereby requests that OHCA take administrative notice of Docket Number 07-30928-CON, Vista Partners, LLC's CON for the Establishment of an Alcohol and Drug Treatment Center in Sharon, encompassing all information and correspondence submitted to OHCA in reference to that Docket, including but not limited to correspondence from Attorney Kennedy Hudner to OHCA (attached hereto as Exhibit A).

Docket Number 07-30928-CON is an appropriate subject for administrative notice. OHCA has the authority to take notice of judicially cognizable facts and of generally recognized technical or scientific facts that are within the agency's specialized knowledge. Conn. Gen. Stat. § 4-178(6). Such items may include, without limitation, prior decisions and orders of OHCA. OHCA Rules of Practice § 19a-643-53(d).

Docket Number 07-30928-CON has direct bearing on the subject matter of these proceedings. Specifically, in its Final Decision in the Matter of Docket Number 07-30928-CON, OHCA found that a need exists for "small residential alcohol and drug treatment facilities in Connecticut that offer extremely private, discreet and individualized programs for substance

abusing professionals, public officials, and other residents" (See OHCA's Final Decision in DN 07-30928-CON p. 9).

In addition, the email correspondence from Attorney Kennedy Hudner to OHCA dated April 5, 2010, notifying OHCA that Vista Partners, LLC will not be implementing its Certificate of Need authorized by OHCA in Docket Number 07-30928-CON, evidences the fact that this need was never satisfied by Vista Partners, LLC and therefore remains unmet.

Accordingly, the Applicant respectfully requests that OHCA take administrative notice of the entire Vista Partners, LLC CON Application; specifically Docket Number 07-30928-CON and the item attached as Exhibit A. Applicant reserves the right of oral argument in support of this request.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By:_____
Michele M. Volpe
Juris No. 412124
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105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

EXHIBIT A

Roberts, Karen

From: Kennedy Hudner [KHUDNER@murthalaw.com]
Sent: Monday, April 05, 2010 10:14 AM
To: Roberts, Karen
Subject: CON - Vista Partners, LLC
Attachments: Kennedy Hudner.vcf

Dear Karen:

I am replying to your letter dated April 1, 2010 concerning the CON granted to Vista Partners, LLC (No. 07-30928) to establish an alcohol and drug treatment center in Sharon, Ct.

The applicant will not be going forward with this CON. At present, the applicant, Vista Partners, LLC has dissolved. My apologies to you for not notifying you about this sooner.

Very truly yours,

Kennedy Hudner

Kennedy Hudner
Partner
khudner@murthalaw.com

Murtha Cullina LLP
CityPlace I, 185 Asylum Street
Hartford, CT 06103-3469
Direct: 860-240-6029
Direct Fax: 860-240-5829
Mobile: 860-490-6586
Main: 860-240-6000
Main Fax: 860-240-6150

www.murthalaw.com

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CONFIDENTIALITY NOTICE: This message originates from the law firm of Murtha Cullina LLP. The information contained in this e-mail and any files transmitted with it may be a confidential attorney-client communication or may otherwise be privileged and confidential. If the reader of this message, regardless of the address or routing, is not an intended recipient, you are hereby notified that you have received this transmittal in error and any review, use, distribution, dissemination or copying is strictly prohibited. If you have received this message in error, please delete this e-mail and all files transmitted with it from your system and immediately notify Murtha Cullina by sending a reply e-mail to the sender of this message. Thank you.

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FAX #: (860) 418-7053
TO: Honorable Cristine Vogel
Office of Health Care Access

DATE: April 26, 2010

PAGES: 8 including this page

CC: Louis Todisco and Paul Knag
(203) 772 7723

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

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COMMENTS:

Dear Commissioner Vogel:

Please see the attached Objection to Silver Hill Hospital Inc.'s Petition to be Designated an Intervenor With Full Rights of Participation.

Thank you.

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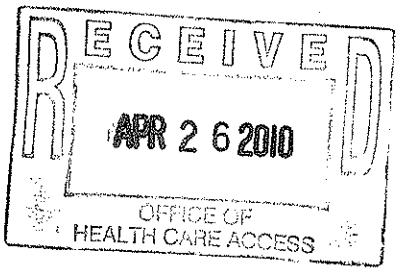

Michele M. Volpe
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April 26, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
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Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

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Thank you.

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Michele M. Volpe

MMV/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Object to Silver Hill Intervene) 4.26.10.doc

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 26, 2010**

OBJECTION TO SILVER HILL HOSPITAL INC.'S PETITION TO BE DESIGNATED AN INTERVENOR WITH FULL RIGHTS OF PARTICIPATION

Pursuant to the Connecticut Uniform Administrative Procedure Act, Conn. Gen. Stat. § 4-166, et seq. (the "UAPA") and § 19a-643-38 et. Seq. of the Regulations of Connecticut State Agencies ("OHCA's Rules of Practice"), the Applicant in the above matter, Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC (the "Applicant"), hereby objects to the petition of Silver Hill Hospital Inc. (the "Petitioner") to be designated as an intervenor with full rights of participation to present evidence, argument and cross examination in this Certificate of Need ("CON") proceeding.

OHCA should deny Petitioner's petition for intervenor status because it fails to demonstrate the elements necessary to qualify for intervenor status. The UAPA and OHCA's Rules of Practice, §§ 19a-643-38 (c) and (d), taken together, provide that Petitioner must prove all of the following in order to be considered for intervenor status:

1. It will be affected by the pending application;

2. It will add evidence or arguments on the issue of the contested case that would otherwise not be available to OHCA;

3. Its participation will be in the interest of justice; and

4. Its participation will not impair the orderly conduct of the proceedings.

If Petitioner is unable to prove any one of the above elements, it may not be considered for intervenor status.[1] Moreover, even if Petitioner could satisfy all of the necessary elements, OHCA must still find that Petitioner's participation as an intervenor would furnish assistance to OHCA in resolving the issue of whether to grant Applicant's pending application.

Petitioner has failed to prove the elements set forth above. First, approval of the pending CON Application to establish a freestanding adult residential substance abuse treatment facility cannot and will not have any legally cognizable effect on Petitioner because the facility proposed by Applicant differs drastically from Petitioner's facility. Petitioner's facility, staff and services, as set forth in its website, consist of "treatment for mood disorders including depression and bipolar disorders, schizophrenia and other psychoses, eating disorders, personality disorders and substance use disorders – with special expertise in treating patients dually-diagnosed with both a psychiatric illness and a substance abuse disorder." Petitioner's website states that its Transitional Living Program "allows patients who have achieved stabilization to continue their treatment in a more residential, home-like setting while continuing to participate in a highly structured, intensive program with full-time psychiatric, nursing and social work staff." By its own description of its facility, Petitioner offers a full-service, clinical approach to a broad spectrum of disorders and a broad spectrum of individuals. The Applicant does not. Petitioner's targeted patient base is markedly broader than Applicant's which will consist of only those clients whose public visibility, wealth or social position make it difficult to begin the road to successful recovery in the existing and known residential treatment facilities such as the Petitioner. The fact that the Petitioner has been offering broad based, highly structured and clinical treatment of many personality and substance abuse disorders to all segments of society since 1931 is one of the main factors which would dissuade Applicant's targeted client base from

[1] OHCA's Rules of Practice §§ 19a-643-38(c) and (d)

seeking treatment at Petitioner's facility. Indeed, the need which Applicant will show is unmet is for those individuals seeking a substantially smaller, much more private setting offering only individualized care and specific medical and clinical programs that directly address the cultural, professional and social characteristics of individuals similarly situated, such as physicians, attorneys, senior business executives and other individuals in the public eye. As important, Applicant's proposed facility will not offer the specific array of medical services as Petitioner does. While Applicant will service patients with co-occurring disorders; Applicant will not accept patients for treatment who suffer from bipolar disorders, schizophrenia and other complex psychoses. Instead, the Applicant proposes only to provide treatment for drug and alcohol abuse among a narrowly defined but statistically significant group of individuals with a substance abuse/dependency diagnosis who have been medically cleared for admission by their treating physician. Indeed, Applicant's targeted group of individuals are those very individuals who will not seek treatment at Petitioner's facility because of the scope and nature of Petitioner's services and patient base. Accordingly, Applicant will not compete with Petitioner and therefore, Petitioner will not be affected by OHCA's grant of the Applicant's pending CON Application.

Secondly, it is disingenuous for Petitioner to now claim that it will add evidence or arguments on the issue of the contested case that would not otherwise be available to OHCA. Despite Petitioner's repeated boasting that it is a "long standing provider of substance abuse services," Petitioner very tellingly chose not to object to a virtually identical CON application which was granted by OHCA absent any opposition whatsoever – that being the CON granted in Docket Number 07-30928-CON on behalf of Vista Partners, LLC (the "Vista CON"). In issuing the Vista CON, OHCA has already made a finding of need that is identical to the need established by the Applicant in its Application. Since the need being advocated by the Applicant

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Similarly, any suggestion that Petitioner's being granted intervenor status will "be in the interest of justice" is without merit as well. Not having even attempted to intervene or object to OHCA's issuance of the Vista CON, it is difficult if not impossible to see how allowing Petitioner intervenor status in the instant proceeding would "be in the interest of justice" or otherwise be of assistance to OHCA in resolving the issue of whether a need exists for Connecticut to have access to the services proposed by the Applicant.

To reiterate, Petitioner's failure to prove any one of the elements set forth above disqualifies it from being considered for intervenor status. The Applicant submits that Petitioner has failed to meet its burden with respect to these elements. Therefore, the Applicant requests that OHCA deny Petitioner's application for intervenor status in its pending CON Application. In the event that Petitioner is granted any participating status in these proceedings, the Applicant respectfully requests that Petitioner not be granted any rights of cross-examination, as Petitioner has provided no evidence or demonstration that it would be properly in position to pose any legitimate inquires beyond those OHCA itself is well-positioned to address based on its administrative expertise.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: _____
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Christopher M. McKeon
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CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 26th day of April, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
Stamford, Connecticut 06901
Facsimile: (203)653-5444

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723

Michele M. Volpe

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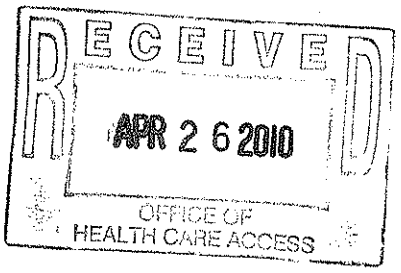

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Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

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Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723

Michele M. Volpe

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, April 27, 2010 10:05 AM
To: Greer, Leslie
Subject: FW: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

Please add to the record.

Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Bettyanne Toole [mailto:bettyanne@bvmlaw.com]
Sent: Monday, April 26, 2010 4:46 PM
To: Lazarus, Steven; Martone, Kim
Cc: michelemvolpe@aol.com; Christopher McKeon; Aimee Onofrio
Subject: RE: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

Steven and Kim: Just as a recap, you should have received the following from us today.

1. Motion to Disqualify the law firm of Robinson & Cole, LLP (sent via fax and Federal Express);
2. Prefiled Testimony of Brian Gwozdz (sent via email, fax and Federal Express);
3. Prefiled Testimony of David Sack, M.D. (sent via email, fax and Federal Express);
4. Request for Administrative Notice(sent via email, fax and Federal Express);
5. Object to the petition of Silver Hill Hospital Inc. to be designated as an intervenor(sent via email, fax and Federal Express);
6. Legal Counsel's Opening and Closing Statement (sent via email, fax and Federal Express).

The originals of these documents, along with the appropriate copies of the same have been sent to you via Federal Express for delivery tomorrow morning.

Thanks very much,
Betty Anne

Betty Anne Toole-Teasley
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Facsimile: (203) 777-5806

This transmittal may be a confidential attorney-client communication or may otherwise be privileged or confidential. If it is not clear that you are

the intended recipient, you are hereby notified that you have received this transmittal in error; any review, dissemination, distribution or copying of this transmittal is strictly prohibited. If you suspect that you have received this communication in error, please notify us immediately by telephone at 1-203-777-5800, or e-mail at bettyanne@bvmlaw.com and immediately delete this message and all its attachments.

IRS CIRCULAR 230 DISCLAIMER: Any tax advice contained in this e-mail is not intended to be used, and cannot be used by any taxpayer, for the purpose of avoiding Federal tax penalties that may be imposed on the taxpayer. Further, to the extent any tax advice contained in this e-mail may have been written to support the promotion or marketing of the transactions or matters discussed in this e-mail, every taxpayer should seek advice based on such taxpayer's particular circumstances from an independent tax advisor.

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, April 27, 2010 10:06 AM
To: Greer, Leslie
Subject: FW: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-315...

Please add to the record.

Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Michelemvolpe@aol.com [mailto:Michelemvolpe@aol.com]
Sent: Monday, April 26, 2010 4:53 PM
To: bettyanne@bvmlaw.com; Lazarus, Steven; Martone, Kim
Cc: cmm@bvmlaw.com; alo@bvmlaw.com
Subject: Re: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-315...

Steve,
When you have a moment will you please send us anything that may have been filed or proposed to be made a part of the record by any other provider. Thank you.

Michele M. Volpe
Bershtein, Volpe & McKeon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

This transmittal may be a confidential attorney-client communication or may otherwise be privileged or confidential. If it is not clear that you are the intended recipient, you are hereby notified that you have received this transmittal in error; any review, dissemination, distribution or copying of this transmittal is strictly prohibited. If you suspect that you have received this communication in error, please notify us immediately by telephone at 1-203-777-5800, or e-mail at bettyanne@bvmlaw.com and immediately delete this message and all its attachments.

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In a message dated 4/26/2010 4:45:55 P.M. Eastern Daylight Time, bettyanne@bvmlaw.com writes:

> Steven and Kim: Just as a recap, you should have received the following from us today.

- Motion to Disqualify the law firm of Robinson & Cole, LLP (sent via fax and Federal Express);
- Prefiled Testimony of Brian Gwozdz (sent via email, fax and Federal Express);
- Prefiled Testimony of David Sack, M.D. (sent via email, fax and Federal Express);
- Request for Administrative Notice(sent via email, fax and Federal Express);
- Object to the petition of Silver Hill Hospital Inc. to be designated as an intervenor(sent via email, fax and Federal Express);
- Legal Counsel's Opening and Closing Statement (sent via email, fax and Federal Express).

The originals of these documents, along with the appropriate copies of the same have been sent to you via Federal Express for delivery tomorrow morning.

Thanks very much,
Betty Anne

Betty Anne Toole-Teasley
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Facsimile: (203) 777-5806

This transmittal may be a confidential attorney-client communication or may otherwise be privileged or confidential. If it is not clear that you are the intended recipient, you are hereby notified that you have received this transmittal in error; any review, dissemination, distribution or copying of this transmittal is strictly prohibited. If you suspect that you have received this communication in error, please notify us immediately by telephone at 1-203-777-5800, or e-mail at bettyanne@bvmlaw.com and immediately delete this message and all its attachments.

IRS CIRCULAR 230 DISCLAIMER: Any tax advice contained in this e-mail is not intended to be used, and cannot be used by any taxpayer, for the purpose of avoiding Federal tax penalties that may be imposed on the taxpayer. Further, to the extent any tax advice contained in this e-mail may have been written to support the promotion or marketing of the transactions or matters discussed in this e-mail, every taxpayer should seek advice based on such taxpayer's particular circumstances from an independent tax advisor.

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

TRANSMISSION OK

TX/RX NO	1510
RECIPIENT ADDRESS	912037775806
DESTINATION ID	
ST. TIME	04/28 09:48
TIME USE	02'59
PAGES SENT	8
RESULT	OK

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

FAX SHEET

TO: MICHELE M. VOLPE

FAX: 203 777-~~5800~~ 5806

AGENCY: BERSHTEIN, VOLPE & MCKEON P.C.

FROM: STEVEN LAZARUS

DATE: 4/28/10 **Time:**

NUMBER OF PAGES: 8
(including transmittal sheet

Comments:

Information for tomorrow's hearing regarding DN: 09-31500
(Employment Options, Inc. d/b/a Litchifield Hills Retreat, LLC)

Please contact me at 860-418-7001 if you have any questions.

PLEASE PHONE Barbara K. Oleiarz IF THERE ARE ANY TRANSMISSION

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

TRANSMISSION OK

TX/RX NO	1508
RECIPIENT ADDRESS	98602405715
DESTINATION ID	
ST. TIME	04/28 09:37
TIME USE	02'35
PAGES SENT	8
RESULT	OK

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

FAX SHEET

TO: LOUIS B. TODISCO / Paul Knag

FAX: 860 240-5715

AGENCY: MURTHA CULLINA LLP

FROM: STEVEN LAZARUS

DATE: 4/28/10 **Time:**

NUMBER OF PAGES: 8
(including transmittal sheet

Comments:

Information for tomorrow's hearing regarding DN: 09-31500
(Employment Options, Inc. d/b/a Litchifield Hills Retreat, LLC)

Please contact me at 860-418-7001 if you have any questions.

PLEASE PHONE Barbara K. Quinn IF THERE ARE ANY TRANSMISSION

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

April 28, 2010

Louis B. Todisco, Esq.
Murtha Cullina, LLP
Two Whitney Avenue
P.O. Box 704
New Haven, CT 06503-0704

RE: Certificate of Need Docket Number 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Establishment of a Free Standing Substance Abuse Facility in Bethlehem, CT
Ruling on Petition for Status filed by Silver Hill Hospital

Dear Attorney Todisco:

Enclosed is the ruling by the Office of Health Care Access on the petition for intervenor status filed by you on behalf of Silver Hill Hospital regarding the public hearing to be held in the matter identified above on April 29, 2010. This ruling will be entered as an exhibit in the Table of Record in this case for the Certificate of Need application filed under Docket Number 09-31500-CON.

If you have any questions concerning this matter, please contact Steven W. Lazarus, Associate Health Care Analyst, at (860) 418-7001.

Sincerely,

Melanie A. Dillon
Hearing Officer

Enclosure

C: Michelle Volpe, Bershtein, Volpe & McKeon P.C

MAD:swl

IN THE MATTER OF:

A Certificate of Need Application by
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Notice to Petitioner; re: Request for Status

Docket Number: 09-31500-CON
April 28, 2010

**RULING ON A PETITION FILED BY
SILVER HILL HOSPITAL
TO BE DESIGNATED AS AN INTERVENOR**

By petition dated April 22, 2010, Silver Hill Hospital ("Petitioner") requested Intervenor status in the public hearing to be held by the Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC ("Applicant") filed under Docket Number: 09-31500-CON. The CON Application is for the establishment of a free standing substance abuse facility in Bethlehem, Connecticut with an associated capital expenditure of $500,000, and was filed pursuant to Section 19a-638 of the Connecticut General Statutes ("C.G.S.").

Pursuant to Section 4-177a, C.G.S., and Section 19a-643-38 of OHCA's Regulations, the Petitioner is hereby designated as an Intervenor with full rights of cross-examination for the hearing scheduled on April 29, at 9:00 am, in OHCA's Hearing Room on the 3rd Floor of 410 Capitol Avenue, Hartford, Connecticut. As an Intervenor with full rights of cross-examination, the Petitioner is allowed to participate as indicated below.

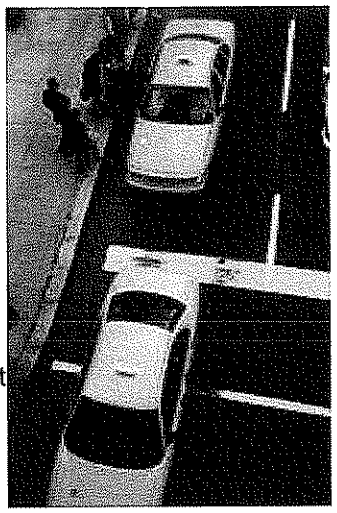
The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 09-31500-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. The Petitioner may be cross-examined by the Applicant and the Petitioner has the right to cross-examine the Applicant.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

4-28-2010
Date

Melanie A. Dillon
Hearing Officer

Directions to the Office of Health Care Access



From I-91 North or South and from East of the River:

In Hartford take I-84 westbound. Exit at Asylum Street, exit 48.

At the signal at the bottom of the ramp, make a gradual right, staying to the left of the fork in the road.

At the first light, take an immediate left onto Broad Street.

Travel on Broad Street to the light at the first four-way intersection; take a right onto Capitol Avenue. OHCA (tan brick building at 410 Capitol Avenue) is two blocks down on the right.

* Pass 410 and enter in the driveway between 410 and 450 Capitol Avenue. Turn right into the parking lot behind the building and proceed to the Security building in the lot. You will be directed to available parking.

From the West:

Take I-84 East to Capitol Avenue, Exit 48B. Bear right on the exit ramp. At the end of the ramp, turn right onto Capitol Avenue. OHCA is 3 blocks down on the right (tan brick building at 410 Capitol Avenue).

Proceed from * above

Directions to Forest and Sisson (Lot C) for visitor shuttle service:

From I-91 (north or south) and from east of the river

In Hartford, take I-84 west. Take Exit 46, Sisson Avenue. At the end of the exit ramp, turn left at the signal light onto Sisson Avenue. Take your first left onto **Capitol Ave. Take your first left onto Forest Street. The parking lot is on your left and is labeled State of Connecticut. A shuttle bus to take you to our offices will either be waiting, or will appear in a few minutes.**

From the West

Take I-84 East to Exit 46, Sisson Avenue. At the end of the exit ramp, turn left at the light onto Sisson Avenue. Take you first left onto **Capitol Avenue. Take your first left onto Forest Street. The parking lot is on your left and is labeled State of Connecticut. A shuttle bus to take you to our offices will either be waiting, or will appear in a few minutes**

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC**

DOCKET NUMBER: **09-31500-CON**

PUBLIC HEARING: **April 29, 2010 at 9:00 a.m.**

PLACE: **410 Capitol Avenue, Third Floor Hearing Room**
Hartford, Connecticut

EXHIBIT	DESCRIPTION
A	Letter from Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC ("Applicant") dated November 18, 2009, enclosing Letter of Intent forms for the establishment of a Free-Standing Mental Health and Substance Abuse Treatment Facility in Bethlehem, received by the Office of Health Care Access ("OHCA") on November 20, 2009.
B	OHCA's request for legal notification in the *Republican American* and notification to Applicant of receipt of the Letter of Intent in the matter of the CON application under Docket Number 09-31500, dated December 7, 2009
C	OHCA's letter to the Applicant dated December 8, 2009, enclosing the Certificate of Need ("CON") application forms under Docket Number 09-31500.
D	Letter from the Applicant dated February 3, 2010, enclosing the CON application under Docket Number 09-31500, received by OHCA on February 5, 2010.
E	Letter from the Applicant to OHCA dated February 11,2 010 enclosing the General Affidavit, received by OHCA on February 16, 2010
F	OHCA's letter to the Applicant dated February 23, 2010, requesting additional information and/or clarification in the matter of the CON application under Docket Number 09-31500.

G	Applicant's responses to OHCA's letter of February 23, 2010, dated March 1, 2010, in the matter of the CON application under Docket Number 09-31500, received by OHCA on March 2, 2010.
H	Letter from Murtha Cullina LLP on behalf of Silver Hill Hospital to OHCA dated March 18, 2010 requesting a hearing in the matter of the CON application under Docket Number: 09-31500, received by OHCA on March 18, 2010.
I	Letter from Robinson & Cole LLP on behalf of High Watch Recovery Center, Inc. to OHCA dated March 22, 2010 requesting a hearing in the matter of the CON application under Docket Number: 09-31500, received by OHCA on March 22, 2010.
J	Letter from Saint Vincent's/Hall-Brooke to OHCA dated March 22, 2010 listing their concerns in the matter of the CON application under Docket Number 09-31500, received by OHCA on March 29, 2010.
K	Designation letter from Commissioner J. Robert Galvin dated April 7, 2010 designating Melanie Dillon as hearing officer in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 7, 2010.
L	Facsimile letter from Bershtein, Volpe & McKeon P.C. noticing their appearance on behalf of the Applicant in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 13, 2010. Hardcopy received on April 15, 2010.
M	OHCA's request for legal notification in the *Republican American* and OHCA's Notice to the Applicant of the public hearing scheduled for April 29, 2010, in the matter of the CON application under Docket Number 09-31500, dated April 14, 2010.
N	OHCA's letter to the Applicant dated April 20, 2010, requesting prefile testimony in the matter of the CON application under Docket Number 09-31500.
O	Petition of Silver Hill Hospital dated April 22, 2010, requesting intervenor status with full rights of participation, along with prefile testimony in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 22, 2010.
P	Facsimile letter from Stonington Institute to OHCA dated April 23, 2010 noting their concerns in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 23, 2010.
Q	Facsimile letter from the Applicant enclosing Prefile Testimony dated April 26, 2010 for Dr. David Sack and Brian Gwozdz in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 26, 2010.

R	Facsimile letter from the Applicant to OHCA dated April 26, 2010 requesting a Motion to Disqualify the law firm of Robinson & Cole LLP from representation of High Watch Recovery Center, Inc. and Motion to Preclude Consideration of any documentation, petition or other request submitted by Robinson & Cole on behalf of High Watch Recovery Center, Inc. in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 26, 2010
S	Facsimile letter from the Applicant dated April 26, 2010 to OHCA requesting Administrative Notice of Docket Number 07-30928 in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 26, 2010.
T	Facsimile letter from the Applicant to OHCA dated April 26, 2010 enclosing Legal Counsel's Opening and Closing Statement in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 26, 2010.
U	Facsimile letter form the Applicant to OHCA dated April 26, 2010 Objecting to Silver Hill Hospital, Inc's. Petition to be designated an intervenor with full rights of participation in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 26, 2010.
V	Email from the Applicant to OHCA dated April 26, 2010 recapping what was sent to OHCA by facsimile in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 26, 2010.
W	OHCA's Ruling on the Petition of Silver Hill Hospital, Inc. to be granted intervenor status in the matter of the CON application under Docket Number 09-31500 dated April 28, 2010.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

AGENDA

PUBLIC HEARING

Certificate of Need Application, Docket Number 09-31500

Employment Options, LLC d/b/a Litchfield Hills Retreat

Establishment of a Free Standing Substance Abuse Facility in Bethlehem, CT

April 29, 2010 at 9:00 a.m.

I. Convening of the Public Hearing

II. Applicant's Direct Testimony (15 minutes)

   a. Intervenor's Cross-Examination of the Applicant
   b. OHCA Questions

III. Intervenor's Direct Testimony (10 minutes)

   a. Applicant's Cross-Examination of the Intervenor
   b. OHCA Questions

IV. Closing Statements

V. Public Hearing Recessed/Closed

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

177 BROAD STREET
STAMFORD, CONNECTICUT 06901
TELEPHONE 203.653.5400
FACSIMILE 203.653.5444
www.murthalaw.com

MURTHA CULLINA

FACSIMILE TRANSMITTAL

Date:	April 28, 2010	Client Code:	
To:	Deputy Commissioner Cristine Vogel Div. of Office of Health Care Access	Facsimile Number: Telephone Number:	860.418.7053
From:	Paul E. Knag, Esq.	Telephone Number:	203.653.5407

Total Number of Pages (including this cover page): 7 Sent by: JLW

RE: DOCKET NO. 09-31500-CON

Dear Commissioner Vogel:

Please see the attached cover letter and Motion to Compel.

Sincerely,
Jessica L. White
Paralegal

RECEIVED
2010 APR 28 A 11:49
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

MURTHA

PAUL E. KNAG
203.653.5407 DIRECT TELEPHONE
203.653.5444 DIRECT FACSIMILE
PKNAG@MURTHALAW.COM

April 28, 2010

Via Facsimile (860) 418-7053
Via email: STEVEN.LAZARUS@CT.GOV
(Original will be hand delivered at hearing.)

Deputy Commissioner Cristine Vogel
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: **Docket No. 09-31500-CON**
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Free Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Silver Hill Hospital, petitioning intervenor, enclosed please find one (1) original and six (6) copies of a Motion to Compel the Appearance, Testimony and Cross-Examination of Michelle Zurko-Smith at the public hearing on April 29, 2010.

Thank you.

Very truly yours,

Paul E. Knag

Enclosures
cc: Michele M. Volpe, Esq. (Bershtein, Volpe & McKeon P.C.)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS DIVISION

IN THE MATTER OF THE APPLICATION OF EMPLOYMENT OPTIONS, INC. D/B/A/ LITCHFIELD HILLS RETREAT, LLC FOR THE ESTABLISHMENT OF A FREE-STANDING MENTAL HEALTH AND SUBSTANCE ABUSE FACILITY IN BETHLEHEM, CONNECTICUT, WITH A TOTAL CAPITAL EXPENDUTRE OF $500,000

DOCKET NO. 09-31500-CON

APRIL 28, 2010

MOTION OF SILVER HILL HOSPITAL, INC. TO COMPEL THE APPEARANCE, TESTIMONY, AND CROSS-EXAMINATION OF MICHELLE ZURKO-SMITH

Silver Hill Hospital, Inc. (the "Silver Hill"), is a psychiatric hospital located in New Canaan, Connecticut. On or about April 21, 2010, Silver Hill submitted a petition to the Department of Public Health, Office of Health Care Access Division ("OHCA") to be designated as an intervenor with full rights of participation in the above referenced Certificate of Need application ("CON") by Employment Options, Inc. d/b/a Litchfield Hills Retreat, LLC (the "Applicant"); the petition is currently pending. Silver Hill by this motion requests that OHCA compel the attendance and testimony of Michelle Zurko-Smith at the public hearing scheduled for April 29, 2010.

Zurko-Smith lists herself as the Applicant. She is CEO and founding member of the corporate Applicant, purportedly the Chief Operating Officer and/or Chief Executive Officer of Litchfield Hills Retreat, LLC ("Litchfield Hills"), the sole owner of the real property upon which the Litchfield Hills facility will be maintained, and the "driving force behind the proposal to establish the Litchfield Hills substance abuse treatment center." In addition, she (either personally or as Applicant's CEO) has financed the Litchfield Hills project to date and she alone intends to finance the remainder of the project from her own personal resources. Presumably, she also prepared the CON, or directed it to be prepared, and provided much, if not all, of the information contained therein.

Despite her preeminent role in the Litchfield Hills project, Zurko-Smith has failed to submit any prefile testimony. Instead, Applicant has filed the testimony of two witnesses, Brian Gwozdz and David Sack, M.D., each of whom made a prefile submission on April 26, 2010. Yet, neither Mr. Gwozdz nor Dr. Sack is even mentioned in Applicant's CON. While the CON designates Zurko-Smith as Applicant's CEO and contains her "resume" and credentials, there is no similar disclosure of Mr. Gwozdz's or Dr. Sack's resume or credentials. Moreover, the testimony provided by these two witnesses is substantially inconsistent with various representations and methodologies contained in Applicant's CON. Without limitation, such discrepancies include the Applicant's intention to obtain licensure and accreditation, the methodology used for determining the public need for the Litchfield

Hills project, the treatment modalities to be employed by the facility (including a discrepancy in the diagnoses to be treated), the target market for services (including a discrepancy in the number of professionals practicing in Connecticut and/or the prevalence of substance abuse among such professionals), and the intended staffing of the facility. Zurko-Smith should be compelled to appear and bear witness to explain such discrepancies. Even more disconcerting, Mr. Gwozdz's and Dr. Sack's prefile testimony was submitted only three (3) days prior to the public hearing, after the deadline for the filing of prefiled testimony by Silver Hill as petitioned intervenor, providing OHCA and/or other interested parties inadequate opportunity for challenge or rebuttal.

Accordingly, failure of Zurko-Smith to appear, give testimony and submit to cross-examination in connection with the April 29, 2010 public hearing would be irreparably prejudicially to the public and serve only to preclude OHCA's complete and educated consideration of Applicant's CON.

Respectfully submitted,

SILVER HILL HOSPITAL, INC.

By _____

Paul E. Knag
Murtha Cullina LLP
177 Broad Street
Stamford, CT 06901
Telephone: (203) 653-5407
Fax: (203) 653-5444
pknag@murthalaw.com

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, CT 06503
Telephone: (203) 772-7718
Fax: (203) 772-7723
ltodisco@murthalaw.com
Its Attorneys

ORDER

The foregoing Motion to Compel having been considered, it is hereby Ordered that:

1. Applicant's CEO, Michelle Zurko-Smith, be compelled to appear, give testimony and submit to cross-examination regarding Applicant's CON.

_____

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Motion to Compel was sent by facsimile and electronic mail, this 28th day of April, 2010, to:

Vincent M. Marino, Esq.
Cohen and Wolf, P.C.
1115 Broad Street
Bridgeport, CT 06604

Michele M. Volpe, Esq.
Bershtein, Volpe & McKeon, P.C.
105 Court Street, Suite 304
New Haven, Connecticut 06511

Paul E. Knag

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

RECEIVED
2010 APR 27 A 11: 22
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

April 26, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
and Federal Express

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of the Prefiled Testimony of Brian Gwozdz.

This Prefiled testimony is being submitted in accordance with Section 19a-643-51(e) of the OHCA Rules of Practices. Mr. Gwozdz will be present at the April 29, 2010 public hearing to adopt his testimony under oath and be available for cross-examination.

Should you require anything further, please feel free to contact me.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Prefiled - Gwozdz) 4.26.10.doc

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING RESIDENTIAL ADULT SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 26, 2010**

PREFILED TESTIMONY OF BRIAN GWOZDZ
ON BEHALF OF
LITCHFIELD HILLS RETREAT, LLC

Good Morning Deputy Commissioner Vogel and members of the OHCA staff. My name is Brian Gwozdz and I am the Acting Director of Litchfield Hills Retreat, LLC ("Litchfield Hills"). I thank you for this opportunity to appear before you today. As stated in our Certificate of Need Application ("CON"), Litchfield Hills respectfully requests that the Office of Health Care Access ("OHCA") approve its pending CON Application and permit the establishment of the proposed freestanding adult substance abuse center in Bethlehem. Our request is based on the following:

1. Clear Public Need for Litchfield Hills

    a. Background

As stated throughout our CON Application, Litchfield Hills will offer a highly specialized treatment program for adults with substance abuse disorders. Unlike any existing providers of substance abuse treatment in Connecticut, Litchfield Hills will be exclusively geared toward individuals whose public visibility, wealth or social position make it difficult to maintain and adhere to a lifestyle that fosters a successful recovery

from substance abuse disorders. These individuals demand a discreet, highly confidential and secluded environment. Socio-economic status should not operate to frustrate or prevent this group of individuals from seeking treatment for substance abuse/dependency in their home state. In recognition of the fact that people with different backgrounds, education and professions often require specific guidance and treatments, Litchfield Hills will offer treatment that is tailored toward this specific population's individualized needs. (See CON Application p. 51)

Litchfield Hills will seek licensure from Connecticut's Department of Public Health as a Facility for the Care or Treatment of Substance Abusive or Dependent Persons and accreditation from the Commission on Accreditation of Rehabilitation Facilities. Litchfield Hills will offer substance abuse rehabilitation care with individualized treatment plans incorporating nationally accepted addiction treatment modalities. The Litchfield Hills treatment plans will be established taking into consideration its clients' professional situations and the individual burdens brought on by their unique social backgrounds and family relationships.

b. Underserved Population

The existing providers of substance abuse treatment in Connecticut are not necessarily tailored to the needs of the specific "high-profile" population Litchfield Hills will serve. This population includes individuals whose public visibility, wealth or social position make it difficult to obtain treatment. The population of "high-profile" Connecticut residents that will benefit from the Litchfield Hills facility is substantial. (See CON Application p. 25)

The need for Litchfield Hills is based on the significant substance and alcohol dependency that exists in Connecticut, particularly among certain high-income individuals such as physicians, attorneys, executives and other high-earners, as well as the fact that there are no small residential alcohol and drug treatment facilities in the state that offer extremely private, discreet and individualized programs sought by this population and proposed by Litchfield Hills. (See CON Application p. 52)

According to a *Time* magazine article (See Exhibit 1), seventy percent (70%) of New York City's drug users are affluent. The article indicates that drug counselors in the United States report increasing numbers of professionals who seek treatment for substance abuse. The article evidences the need for facilities like the one proposed by Litchfield Hills to accommodate this specialized population.

Given that nearly forty percent (40%) of Connecticut's residents work in the fields of management, professional and related occupations (See Exhibit 2), there is undoubtedly a need for a residential treatment facility customized for this population in the state. Note that this percentage does not take into account the population of professional residents who travel outside of the state, for example to New York City, to work, or that population of professionals residing in border states who may need substance abuse treatment.[1]

According to the Department of Public Health, there are presently more than sixteen thousand (16,000) active licensed physicians in Connecticut. According to the state's Department of Labor, as of the first quarter of 2009, there are more than eight thousand (8,000) employed attorneys, four thousand seven hundred fifty (4,750) chief

[1] OHCA Declaratory Ruling 09-31433-DCL permits OHCA to take into consideration out-of-state residents in determining a need for health care services.

executives, and nearly twenty-two thousand (22,000) financial managers, analysts, examiners and other financial specialists. (See Exhibit 3). Again, these figures do not take into account those residents who travel outside of Connecticut for work.

Substance abuse and dependency among physicians is significant. According to the article, *Substance Abuse Among Physicians: What You Need to Know* by Roger S. Cicala, MD (See Exhibit 4), it is conservatively estimated that eight percent (8%) to twelve percent (12%) of physicians will develop a substance abuse problem at some point during their career and that at any given time, as many as seven percent (7%) of practicing physicians are active substance abusers.

The Cicala article states that treatment of physicians has shown to be more successful when it takes place in a facility that has a significant number of other physician patients. The reason for this is because, unless there are other similar patients in the program, the physician in treatment often gets special treatment from other patients and staff, thereby negating some of the benefits of treatment. This principle can be applied across the board to other individuals practicing in various professions.

Similar to physicians, attorneys represent another component within the specialized population that Litchfield Hills is intended to serve. According to the Ohio Lawyers Assistance Program, eighteen percent (18%) to twenty percent (20%) of attorneys suffer from alcoholism. This rate rises to twenty-five percent (25%) after twenty years of practice. (See Exhibit 5) (See also CON Application p.136).

Like physicians and attorneys, "corporate America" is greatly affected by substance abuse/dependency issues. Notwithstanding the highly-educated and career-minded individuals that work in this industry, they are not immune to the abuse of and

dependency on alcohol and drugs. In fact, industry "norms" themselves can be the catalyst for abuse. It is well-documented and written about that those working in the financial services industry are more prone to abusing drugs and alcohol because they are subject to an overwhelming pressure and anxiety about meeting profit goals (See Exhibit 6).

This industry as a whole has the disposable income and access to drugs, drug-using friends and associates. As individuals with management responsibility and power, it is often extremely important for them to be able to receive confidential treatment with similarly situated individuals in a private setting, such as the proposed Litchfield Hills center.

Litchfield Hills would serve this high-profile population comprised of physicians, attorneys, executives and other high-earning individuals by offering a setting where individuals with similar backgrounds and status can obtain treatment without being identified and treated as "special" or "extraordinary" within the facility. This is an important aspect in achieving successful recovery.

c. Connecticut's Population of High-Profile Substance Abusing/Dependent Persons that will Benefit from Establishment of Litchfield Hills

i. Number of Residents with a Substance Abuse Problem

As already stated, the population of professionals and others in high-profile positions is significant in Connecticut. Based on the available statistics, there is a population of approximately 21,389 people in Connecticut suffering from alcoholism and/or drug addiction who may potentially benefit from the establishment of the Litchfield Hills facility (please see below for support of the 21,389 number). This

specific population was considered in determining the need for the Litchfield Hills facility.

The U.S. Census Bureau estimates that for 2006-2008, a population of **2,673,711** adults exists in Connecticut. (See Exhibit 7) The U.S. Census Bureau also reports that for 2008, approximately **8%** of the Connecticut population had a household income of $200,000 or more. (See Exhibit 8) Therefore, by applying this 8% to the total Connecticut population, we estimate that there are **213,896** people in Connecticut with a household income of $200,000 or more. (2,673,711 x 8% = 213,896)

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that approximately (**10%**) of the population have a substance abuse or dependency problem[2]. (See Exhibit 9) By applying this SAMHSA percentage to the 213,896 people in Connecticut with an income of $200,000 or more, we estimate that there are **21,389** professionals or high-profile individuals in the state with a substance abuse problem and a household income of $200,000 or greater. (10% x 213,896 = 21,389). It is this population of 21,389 people that the Litchfield Hills center will provide greater access to for substance abuse and dependency problems.

ii. Projected Volumes.

Out of the **2,673,711**[3] adults in Connecticut, **10%** will have a substance abuse problem (according to SAMHSA). Therefore, the total number of adults in Connecticut with a substance abuse problem (not taking into account household income) is estimated to be **267,371**

[2] Data actually supports a higher percentage than 10% among the affluent community, as referenced herein and on the attached information. For example, 12% for physicians and 18% - 25% for attorneys. Therefore, our projection of 21,389 is conservative.

[3] Based on US Census Bureau data for Connecticut

According to SAMHSA data, in 2008, **45,338**[4] total adults were admitted for substance abuse treatment. (See Exhibit 10) By comparing this number of admissions to the total number of Connecticut adults with a substance abuse problem (267,371), we determined that approximately **17%** of Connecticut's adult population with a substance abuse problem sought treatment. (45,338/267,371=0.17) Therefore, there are approximately 3,636 adults in Connecticut with a household income of $200,000 or more and an alcohol or drug problem who require residential treatment. (21,389 x 17% = 3,636).

To estimate the Litchfield Hills volumes, we conservatively apply **15%** (instead of the 17%) admission rate to the population of **21,389** people that the Litchfield Hills center is intended to serve to estimate the target population for the proposed center. This amounts to **3,208** people. (21,389 x 15% = 3,208)

Admission projections for the first three years are then conservatively estimated at capture rates of 2.5%, 5% and 7% of the projected target population in Connecticut. Therefore, the projected number of admissions in year 1 is 80, in year 2 it is 160, and in year 3 it is 225. (See Exhibit 11)

It is expected that the Connecticut admissions will comprise between 59% and 78% of the total admissions during the first three years of operation. (See Exhibit 11) Projected total occupancy for the proposed Litchfield Hills center has been conservatively estimated at 40% in year 1, 65% in year 2 and 85% in year 3. These occupancy rates are conservative based on the average utilization rates of residential substance abuse centers in Connecticut. According to the National Survey of Substance

[4] Determined by calculating the percentage of population admitted in 2008 18 and older to be 98.6% (100% - 1.4%=98.6%) Then applied 98.6% to total admissions of 45,982 to determine that 45,338 admissions for the population 18 and older (45,982 x 98.6% = 45,338)

Abuse Treatment Services, in 2005, the average utilization rate for residential facilities was 93%. (See Exhibit 12).

The table on the attached Exhibit 11 summarizes the total projected admissions for the first three years and what percentage of the projected admissions is expected to be Connecticut residents.

Litchfield Hills is confident that it can support the projections above, based on the existing need and the potential referrals from existing substance abuse treatment providers in the state that are not tailored to the needs of the specific population. The admission estimates from Connecticut residents noted above are considered conservative. In addition, Litchfield Hills anticipates significant referrals from residents of other states. Upon OHCA approval, Litchfield Hills will expand its marketing activities and ensure that the industry is made aware of the options that it will offer in treating the specialized population of high-profile and professional individuals.

Litchfield Hills recognizes that the bed demand is substantially more than the number of beds proposed. The overall bed need for the target population is 264 beds. This is based on the following assumptions.

- Estimated total target population in the state is 3,208.
- Average length of stay is 30 days.
- Total bed days for total target population = 96,240 (3,208 x 30=96,240)
- Total beds required for above annual bed days is 264 (96,240/365=264)

However, Litchfield Hills firmly believes that the size of its center should be limited to just 28 beds in order to establish the type of individualized, therapeutic environment it desires to offer to the specialized population that it intends to serve. The

decision to establish a 28 bed facility was based in large part on the fact that the target population is made up of professionals and high-profile individuals that demand that the center be small and very private.

d. Need Evidenced by Support Letters

Litchfield Hills is supported by community providers. (See CON Application pp. 116-121) Specifically, community providers have supported the need for the Litchfield Hills center as follows:

> There is a growing need for substance abuse treatment facilities in the state of Connecticut, specifically to treat individuals who are well-known to the public or of prominent social status. It is essential for a successful recovery process for individuals to receive treatment with the utmost privacy. In order to achieve this level of privacy, it may require that these individuals seek treatment out-of-state in a secluded facility.
> **Letter of Support from Tina Scandul, MA of Developmental Disability Counseling Services, LLC (CON Application p. 117)**

> The needs of clients vary and we try to select the most appropriate facility for each individual. One of the concerns that we have had is where to refer people who may have a particular social, wealth or maybe political status issue. Because of this type of concern, their public visibility becomes a real concern for them. Unfortunately, most of these clients eventually sought out facilities long distances away or maybe even out of the state of Connecticut. This is why we are so pleased to hear about this proposed Litchfield Hills Retreat. Such a facility will provide exactly what we would be looking for. We would no longer have to refer clients so far away.
> **Letter of Support from Edward Edgar, LADC of Counseling Center of Waterbury (CON Application p. 118)**

> As the director and a clinician at Transitions I see a diverse client population. Over the years, I have seen and experienced the need for one particular segment of the population. That population happens to be in the public eye and having notoriety with financial means and/or social status that is looking for a residential treatment center that fits their needs. . . I hope that [OHCA] give[s] [Litchfield Hills] a favorable judgment since it is my true belief that there is a need for just such a program to service the above client in the state of Connecticut.
> **Letter of Support from Rick J. Yatsenick, M.S. of Transitions (CON Application p. 119)**

> I am an addiction practitioner located in Woodbury and feel a program such as this would be beneficial when I am presented with clients who need residential programs. . . I hope you consider approval of such a program as it would assist our efforts to effectively deal with addictive disorders among the professional community.
> **Letter of Support from Kevin M. Curry, CAC, ICADC (CON Application p. 120)**

> The shortfall in services is particularly acute for working professionals, business executives and persons who otherwise engage in high profile jobs and whose need of flexible programming and privacy results in their failure to seek needed treatment in existing facilities. The proposed facility in Bethlehem offers a treatment model that draws directly from residential programs in California with a proven track record in serving this target population. As such, the proposed facility offers to meet the need of a segment of the population for whom treatment options are substantially limited. . .
> **Support Letter from Eugene B. Piasetsky, PhD of Neuropsychology & Brain Injury Rehabilitation Services, P.C. (CON Application p. 121)**

Litchfield Hills has received overwhelming support from the provider community, as they clearly recognize the marked absence in treatment options for the high-profile population in the state. This community knows better than anyone that there is a need for a center such as Litchfield Hills, as they have firsthand experience with the issue of referring their high-profile clients to appropriate residential treatment centers close to home. Litchfield Hills is poised to fill the gap in treatment options for this high-profile population.

e. <u>OHCA Found a Need</u>

As you know, OHCA recently recognized the existence of a clear public need for a center such as Litchfield Hills when it granted a CON for a strikingly similar – if not identical – proposal in Docket Number 07-30928-CON on behalf of Vista Partners, LLC ("Vista Partners"). In that Docket, Vista Partners sought approval to establish a private twenty-four bed residential treatment facility in Sharon for high level professionals or

people within the public eye who have a history of alcohol or drug abuse or dependency. Vista Partners proposed to establish this facility at a site that is a mere twenty-nine (29) miles away from the proposed Litchfield Hills site (See Exhibit 13). Despite being granted a CON, Vista Partners did not move forward, and now has no intent to move forward, with establishment of the center. (See Exhibit 14). **Accordingly, the recognized need remains unmet.**

In granting the Vista Partners CON, OHCA expressly found that Vista Partners' proposed high-end residential treatment facility will serve individuals whose public visibility, wealth, public and/or social position make it virtually impossible for them to begin a successful recovery in the existing traditional residential treatment settings. (Final Decision, Docket No. 07-30928-CON p. 2 of 10) OHCA further found that Vista Partner's need was based on the significant health problem in Connecticut posed by substance and alcohol abuse/dependency, specifically among certain professionals (e.g. physicians, attorneys, financial services executives), and the fact that there are no small residential alcohol and drug treatment facilities in the state that offer extremely private, discreet and individualized programs for substance abusing professionals, public officials and other residents. (Final Decision, Final Decision, Docket No. 07-30928-CON p. 2 of 10)

In granting the CON, OHCA relied, in part, on the document provided by Vista Partners to evidence the significant substance abuse/dependency problem among certain professionals who have high pressure careers, such as physicians, attorneys, and financial services professionals. Specifically, OHCA found the following statistics: substance abuse among physicians is about 10%; 18% of attorneys practicing for less than twenty

years, and 20% of attorneys practicing for more than twenty years, suffer from alcoholism[5]; and 10% of financial service professionals have substance abuse problems. (Final Decision, Docket No. 07-30928-CON p. 3 of 10)

In granting a CON to Vista Partners, OHCA found the existence of a clear public need for a high-end, non-medical, residential treatment facility tailored toward high-profile individuals with substance abuse/dependency problems. **Because Vista Partners did not ultimately fulfill this need, it remains unmet.** Litchfield Hills will be competent to satisfy this need and it can do so in a very efficient and cost-effective manner.

2. No Negative Impact on other Substance Abuse Facilities in the State

Litchfield Hills will be different from, and therefore not competitive with, the existing substance abuse treatment facilities in the state. (See CON Application p. 19) Although Litchfield Hills will obtain the same licensure from DPH as many of the existing treatment facilities, it will be significantly different in that it will be a smaller, more private facility offering individualized care and programs that specifically address the professional and social characteristics of its mature clients and offer a peer group for clients with specific careers, such as physicians, attorneys, senior business executives and other individuals in the public eye.

Many of the existing providers of substance abuse treatment in the state offer detoxification services, treatment of behavioral and mood disorders, such as depression and bipolar disorders, schizophrenia and other psychoses, eating disorders, personality disorders and substance abuse disorders. Many of these facilities boast expertise in

[5] Note that Vista Partners actually asserted, as does Litchfield Hills (See Exhibit 5), that between 18% and 20% of attorneys practicing less than 20 years, and 25% of attorneys practicing more than 20 years, suffer from alcoholism.

treating patients who are dually-diagnosed with both a psychiatric illness and a substance abuse disorder. Some of the existing substance abuse treatment providers primarily utilize a twelve-step recovery model in which their core treatment is one of immersion.

Both the full-service, clinical approach and the twelve-step model utilized by existing providers are fundamentally different than the approach that will be employed by Litchfield Hills. Specifically, Litchfield Hills will not provide detoxification or other medical services and instead, it will focus primarily on treating substance abuse. (See CON Application p. 51) Virtually all of Litchfield Hills' beds will be dedicated to culturally similar substance abusing/dependent individuals, which is not true for the existing providers that offer an array of clinical, behavioral health and psychiatric services beyond substance abuse treatment to a broader range of the population.

In contrast to existing providers, the Litchfield Hills program will be structured to provide a supportive and safe setting for adults in the later stages of recovery to make the transition back into the community. Our clients will be able to customize their schedule from a range of clinical options, while allowing them more time to integrate back into the community.

Litchfield Hills will also offer a wider variety of therapy options tailored to the recovering individual in a spa-like retreat environment. For example, in addition to offering a full range of traditional methods, including group and individual therapy, family therapy and relapse prevention counseling, Litchfield Hills will offer a myriad of amenities and alternative practices. These amenities and practices will include equine assisted therapy, massage therapy, reiki, art, music, outdoor recreational activities and other modalities in a manner consistent with substance abuse treatment models. These

therapies, most of which are not employed by existing providers, will shape the core of the Litchfield Hills program. (See CON Application pp. 19 & 53)

Litchfield Hills will be a for-profit, high-end facility catering to an exclusive high-profile population that is presently underserved. Litchfield Hills will not pose competition to the existing providers, as its price point is higher than that of other facilities in the state, which offer "affordable" treatment options. The Litchfield Hills target demographic is different. (See CON Application p. 131) For example, based on information and belief, High Watch Recovery Center charges clients $303 per day of treatment, whereas Litchfield Hills will charge $900 per day. This price variation will ensure that there will be little to no adverse impact on existing providers' admissions.

In fact, Litchfield Hills will complement the existing substance abuse treatment facilities in Connecticut. We view the existing substance abuse providers as potential referral sources for the population that we cater to, as well as a potential referral destination for those individuals that we encounter who are not appropriate for our setting. (See CON Application p. 131)

3. Conclusion

There is a clear public need to justify the establishment of Litchfield Hills. Not only do the numbers support a large population of high-earning professionals and others within the public eye who may need treatment in a state without a treatment center solely and specifically tailored to their unique needs, OHCA found a need for the type of center proposed by Litchfield Hills in granting Vista Partners' CON Application. Because Vista Partners did not implement its proposal and notified OHCA of the same, the need remains unmet.

Litchfield Hills is poised to satisfy the unmet need for a high-end residential substance abuse treatment center tailored to high-profile individuals in Connecticut. Because no truly similar providers of substance abuse treatment exist in this state, establishment of the Litchfield Hills center will have no adverse effect on existing providers. Instead, Litchfield Hills and the existing providers will complement each other in the market by permitting the referral of clients who are better accommodated and treated in this type of treatment center.

Based on the foregoing support evidencing the need for the proposed Litchfield Hills substance abuse treatment center, we ask that OHCA grant our CON Application.

I thank you for this opportunity to appear before you today to provide my testimony in support of the Litchfield Hills CON Application.

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Docs\Prefiled Testimony\Brian Gwozdz\Prefiled Testimony re Need (Gwozdz)(4 26 10).doc

EXHIBIT1

‹ Back to Article Click to Print

TIME IN PARTNERSHIP WITH CNN

Monday, Nov. 06, 1989

Behavior: A Plague Without Boundaries

By Philip Elmer-DeWitt;Jonathan Beaty/Los Angeles and Georgia Harbison/New York

The scene is South Central Los Angeles, but it could as easily be Detroit, Grand Rapids or Kansas City. A young white male driving a 1989 Thunderbird slowly circles one of the worst blocks in the city. He nods toward a group of blacks hanging out at a corner. As his smartly dressed date whirs up her electric window, a clamoring pack of drug dealers surrounds the car. Money is hastily exchanged for a tiny cellophane bag of off-white crystals. The car peels away, fleeing the inner city, headed toward suburban safety. But the driver of the Thunderbird, his supply exhausted, will be back in only three hours, slowly circling the block.

This is not the picture of the crack epidemic portrayed by the nightly news. On TV, crack addicts are almost invariably blacks and Hispanics from the ghetto. In real life, the problem is much broader: the number of white middle- and upper-class crack users may equal -- or even exceed -- the total from poor minority communities. No government studies break down crack use by economic status, but William Hopkins, a leading narcotics expert working for the state of New York, estimates that 70% of New York City's drug users are affluent. Across the U.S., drug counselors report rising numbers of professionals -- doctors, nurses, accountants, professors -- trying to kick crack habits gone out of control. "We've got Wall Street executives who buy crack in the middle of the day and smoke it in the office," says Alan Horowitz, program director at A.C.I., a treatment center in New York City. "We had one air- traffic controller at J.F.K. airport who was smoking crack on his breaks."

Crack, a smokable form of cocaine, is a drug that might have been designed for use on the job. It is easy to conceal, since it burns with virtually no odor, and the gratification is swift: an intense, almost sexual euphoria that lasts only about five minutes and is not accompanied by such telltale side effects as alcohol's slurred speech and heroin's drowsiness.

The problem of crack abuse among the affluent is especially disturbing because it comes at a time when the middle class seemed to be weaning itself from recreational drugs. Between 1985 and 1988, the number of casual drug users in the U.S. dropped from 23 million to 14.5 million, according to the National Institute on Drug Abuse. But according to another federal study, the number of Americans using crack cocaine at least once a week increased by one- third during that period, from under 650,000 to more than 860,000. "The poor people in the ghetto aren't buying all that cocaine," says William Smith, clinical director of California's Phoenix House. "This is a plague that knows no class or racial boundaries."

Psychologists say upwardly mobile Americans who turn to crack share personality traits that may make them vulnerable to the drug's siren call. Dr. Jeffrey Rosecan, director of the Cocaine Abuse Treatment Program at Manhattan's Columbia-Presbyterian Medical Center, sketches a profile of the typical crack user: a man in his 30s or 40s, single or divorced, with a high- pressure job, little inner peace and a history of moderate drug use and heavy drinking. "They're extremists, hard drivers, workaholics," says Rosecan. "With an all-or-nothing personality and a history of drug experimentation, you've got a formula for disaster when this person tries crack."

Crack is not for men only. One of the most striking developments of the past five years is the increase of crack abuse among middle-class women. The American Association for Clinical Chemistry, the organization whose members perform 80% of the drug tests in the U.S., reports that among people who test positive for drugs, the percentage of women jumped from 25% in 1972 to 40% in 1988. Many of them first used cocaine to help lose weight.

The rich have special problems procuring crack. They often have to make their buys in unfamiliar (and unsavory) neighborhoods, where they are prey to all kinds of rip-offs. Street crack is contaminated with an astonishing variety of chemicals, from amphetamines and meat tenderizers to pesticides. To make sure they are not being poisoned, some users are going back to a process popular years ago. They buy cocaine and convert it into a purer form of crack at home. This dangerous process, called free-basing, involves combining cocaine with baking soda and cooking the mixture. The latest trend among well- to-do users is to prepare their free base in microwave ovens.

Initially, a crack addict can continue to function at work. But that first euphoric kick can be followed by depression and paranoia, which the user suppresses by getting high again. So begins a cycle of compulsive binging known as "chasing the high." Five-dollar "nickels" give way to $40 "doves." Soon crack addicts are spending $200 and more every night.

The poor have a built-in defense against runaway crack abuse: they run out of money. The rich have the same limit; it just takes longer to get there. Stories abound of well-heeled users smoking their way through trust funds, savings accounts and charge-card credit lines. Some take out second mortgages and go on to sell jewelry and household items like TVs, VCRs and answering machines.

Having bought their way into addiction, affluent users often try to buy their way out. They can pick and choose from a long menu of treatments, from acupuncture to cocaine-blocking medications like imipramine and desipramine, but there are no quick fixes. In the end, all crack addicts, rich or poor, must put themselves back on their own feet -- a slow process that calls for professional counseling, steady support from family and friends, fearless self-examination and not a little pain.

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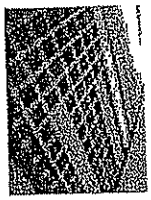
EXHIBIT2

U.S. Census Bureau
American FactFinder



Connecticut
Selected Economic Characteristics: 2006-2008
Data Set: 2006-2008 American Community Survey 3-Year Estimates
Survey: American Community Survey

NOTE. Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

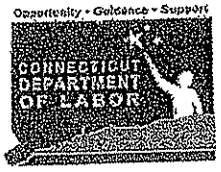
For more information on confidentiality protection, sampling error, nonsampling error, and definitions, see Survey Methodology.

Selected Economic Characteristics	Estimate	Margin of Error	Percent	Margin of Error
EMPLOYMENT STATUS				
Population 16 years and over	2,773,920	+/-1,715	2,773,920	(X)
In labor force	1,888,489	+/-5,447	68.1%	+/-0.2
Civilian labor force	1,881,274	+/-5,572	67.8%	+/-0.2
Employed	1,765,164	+/-5,737	63.6%	+/-0.2
Unemployed	116,110	+/-3,293	4.2%	+/-0.1
Armed Forces	7,215	+/-689	0.3%	+/-0.1
Not in labor force	885,431	+/-5,423	31.9%	+/-0.2
Civilian labor force	1,881,274	+/-5,572	1,881,274	(X)
Percent Unemployed	6.2%	+/-0.2	(X)	(X)
Females 16 years and over	1,440,299	+/-1,439	1,440,299	(X)
In labor force	898,791	+/-4,391	62.4%	+/-0.3
Civilian labor force	898,238	+/-4,382	62.4%	+/-0.3
Employed	843,577	+/-4,633	58.6%	+/-0.3
Own children under 6 years	246,429	+/-2,021	246,429	(X)
All parents in family in labor force	159,193	+/-2,814	64.6%	+/-1.0
Own children 6 to 17 years	535,303	+/-2,623	535,303	(X)
All parents in family in labor force	392,607	+/-4,076	73.3%	+/-0.7
COMMUTING TO WORK				
Workers 16 years and over	1,718,856	+/-5,893	1,718,856	(X)
Car, truck, or van -- drove alone	1,362,603	+/-7,286	79.3%	+/-0.3
Car, truck, or van -- carpooled	142,655	+/-4,149	8.3%	+/-0.2
Public transportation (excluding taxicab)	73,825	+/-2,509	4.3%	+/-0.1
Walked	50,962	+/-2,734	3.0%	+/-0.2
Other means	23,000	+/-1,749	1.3%	+/-0.1
Worked at home	65,811	+/-2,159	3.8%	+/-0.1
Mean travel time to work (minutes)	24.6	+/-0.2	(X)	(X)
OCCUPATION				
Civilian employed population 16 years and over	1,765,164	+/-5,737	1,765,164	(X)
Management, professional, and related occupations	697,360	+/-5,907	39.5%	+/-0.3
Service occupations	287,358	+/-5,019	16.3%	+/-0.3
Sales and office occupations	451,546	+/-5,079	25.6%	+/-0.3
Farming, fishing, and forestry occupations	3,014	+/-662	0.2%	+/-0.1
Construction, extraction, maintenance and repair occupations	143,344	+/-3,130	8.1%	+/-0.2
Production, transportation, and material moving occupations	182,542	+/-3,656	10.3%	+/-0.2
INDUSTRY				

EXHIBIT3

Calendar Year End-2009
Total Active Licenses
From CT DPH

Physical Therapist Assistant	570
Physician Assistant	1690
Physician/Surgeon	16604
Podiatrist	311
Professional Counselor	1650
Psychologist	1821
Radiographer	4053
Registered Nurse	54249
Registered Sanitarian	424
Respiratory Care Practitioner	1707
Speech and Language Pathologist	2363
Sub-Surface Sewage Cleaner	273
Sub-Surface Sewage Installer	2523
Veterinarian	1228
Total	192148



Economy × Workforce × Careers
LABOR MARKET INFORMATION
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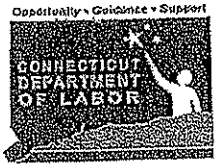
TOTAL ALL INDUSTRIES
STATEWIDE

LEGAL OCCUPATIONS

Occupations	Estimated Employment	Mid-Wage	Average Wage	Entry Level Wage	Wage	Range
LEGAL OCCUPATIONS	14,100	77,070 37.06	96,302 46.30	43,315 20.82	37,455 18.01	>166,400 >80.00
Administrative Law Judges, Adjudicators, and Hearing Officers	200	84,612 40.68	95,089 45.71	74,502 35.81	70,446 33.87	144,173 69.31
Arbitrators, Mediators, and Conciliators	N/A	66,563 32.00	70,619 33.95	42,153 20.27	37,200 17.89	115,717 55.64
Judges, Magistrate Judges, and Magistrates	230	>166,400 >80.00	138,720 66.70	105,138 50.55	60,580 29.13	>166,400 >80.00
Law Clerks	210	48,013 23.08	55,637 26.75	29,250 14.06	27,294 13.13	110,346 53.05
Lawyers	8,090	115,014 55.30	126,521 60.82	67,439 32.42	60,315 29.00	>166,400 >80.00
Legal Support Workers, All Other	N/A	52,783 25.38	53,650 25.80	35,080 16.87	29,026 13.95	77,529 37.27
Paralegals and Legal Assistants	4,670	49,135 23.62	50,541 24.30	34,499 16.58	31,350 15.07	70,232 33.77
Title Examiners, Abstractors, and Searchers	170	49,583 23.84	46,413 22.31	21,647 10.41	18,203 8.75	71,169 34.21

NOTE: The mid-wage is the median wage. The average wage is the mean wage. The entry-level wage is equal to the average of the lower third of reported wages for the occupation. The wage range consists of the 10th and 90th percentiles; 80 percent of workers earn between this wage range, 10 percent earn less while 10 percent earn more.

Reference Date: 1st quarter 2009



Economy & Workforce & Careers
LABOR MARKET INFORMATION
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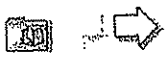
TOTAL ALL INDUSTRIES
STATEWIDE

MANAGEMENT OCCUPATIONS

Occupations	Estimated Employment	Mid-Wage	Average Wage	Entry Level Wage	Wage	Range
MANAGEMENT OCCUPATIONS	N/A	97,398 46.82	109,996 52.88	56,729 27.27	48,441 23.28	>166,400 >80.00
Administrative Services Managers	4,260	76,309 36.68	81,582 39.22	46,124 22.17	39,101 18.80	128,393 61.73
Advertising and Promotions Managers	700	75,692 36.39	89,211 42.89	51,932 24.96	45,658 21.95	156,697 75.34
Chief Executives	4,750	>166,400 >80.00	178,686 85.90	99,796 47.98	88,898 42.74	>166,400 >80.00
Compensation and Benefits Managers	920	79,588 38.26	87,097 41.87	56,172 27.01	50,364 24.22	134,374 64.60
Computer and Information Systems Managers	6,280	111,221 53.47	117,758 56.62	76,289 36.67	71,007 34.14	>166,400 >80.00
Construction Managers	2,550	90,578 43.54	99,250 47.71	62,709 30.15	57,477 27.64	>166,400 >80.00
Education Administrators, All Other	260	88,331 42.47	93,694 45.05	50,060 24.06	37,067 17.82	135,871 65.32
Education Administrators, Elementary and Secondary School	3,150	111,342 N/A	107,062 N/A	79,042 N/A	65,067 N/A	138,027 N/A
Education Administrators, Postsecondary	1,850	97,691 46.97	105,989 50.95	58,236 28.00	50,971 24.51	>166,400 >80.00
Education Administrators, Preschool and Child Care Center/Program	990	41,489 19.95	47,449 22.82	29,326 14.10	25,895 12.45	75,550 36.32
Engineering Managers	3,900	109,976 52.87	118,082 56.77	81,561 39.21	75,075 36.10	>166,400 >80.00
Farm, Ranch, and Other Agricultural Managers	10	73,021 35.10	73,334 35.26	33,363 16.04	28,546 13.72	112,283 53.99
Financial Managers	13,640	101,405 48.75	112,486 54.08	62,517 30.05	56,263 27.05	>166,400 >80.00
Food Service Managers	2,850	48,987 23.55	54,330 26.12	33,677 16.19	31,420 15.11	87,157 41.90
Funeral Directors	310	71,594 34.43	81,824 39.34	46,144 22.18	43,725 21.03	110,715 53.23
General and Operations Managers	29,380	107,841 51.84	124,902 60.05	58,924 28.32	50,920 24.48	>166,400 >80.00
Human Resources Managers, All Other	1,420	100,646 48.39	110,229 52.99	68,669 33.02	61,242 29.45	>166,400 >80.00
Industrial Production Managers	3,050	92,875	94,969	66,180	61,394	132,785

		44.65	45.66	31.81	29.52	63.84
Legislators	500	29,892	33,110	16,656	16,636	56,961
		N/A	N/A	N/A	N/A	N/A



NOTE: The mid-wage is the median wage. The average wage is the mean wage. The entry-level wage is equal to the average of the lower third of reported wages for the occupation. The wage range consists of the 10th and 90th percentiles; 80 percent of workers earn between this wage range, 10 percent earn less while 10 percent earn more.

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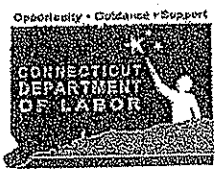

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LABOR MARKET INFORMATION
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TOTAL ALL INDUSTRIES
STATEWIDE

BUSINESS AND FINANCIAL OPERATIONS OCCUPATIONS

Occupations	Estimated Employment	Mid-Wage	Average Wage	Entry Level Wage	Wage	Range
BUSINESS AND FINANCIAL OPERATIONS OCCUPATIONS	84,630	66,170 31.81	73,881 35.52	43,128 20.73	39,141 18.81	113,235 54.44
Accountants and Auditors	17,330	66,504 31.98	73,820 35.49	46,144 22.18	42,562 20.46	108,934 52.38
Appraisers and Assessors of Real Estate	760	66,099 31.77	65,725 31.60	37,593 18.07	32,361 15.56	91,893 44.18
Budget Analysts	1,080	72,980 35.08	73,800 35.48	57,316 27.55	54,806 26.35	99,240 47.71
Business Operations Specialists, All Other	6,650	63,276 30.42	63,438 30.50	35,316 16.98	19,469 9.36	97,560 46.90
Claims Adjusters, Examiners, and Investigators	7,250	60,584 29.12	61,080 29.37	43,806 21.06	40,598 19.52	84,263 40.52
Compensation, Benefits, and Job Analysis Specialists	1,320	62,709 30.16	65,097 31.30	40,639 19.54	36,591 17.59	101,162 48.63
Compliance Officers, Except Agriculture, Construction, Health and Safety, and Transportation	3,370	63,063 30.32	66,939 32.18	39,222 18.85	34,203 16.44	100,828 48.47
Cost Estimators	2,300	65,775 31.62	68,599 32.98	43,543 20.94	40,224 19.34	101,709 48.90
Credit Analysts	900	61,636 29.63	63,883 30.71	43,462 20.90	39,030 18.76	96,265 46.28
Emergency Management Specialists	220	68,669 33.01	67,172 32.29	45,253 21.76	40,740 19.59	94,069 45.22
Employment, Recruitment, and Placement Specialists	3,320	55,180 26.53	65,391 31.44	35,478 17.06	32,645 15.69	102,387 49.22
Financial Analysts	5,980	81,278 39.08	97,762 47.00	53,237 25.60	48,461 23.29	>166,400 >80.00
Financial Examiners	420	87,461 42.05	88,463 42.53	63,245 30.41	57,579 27.69	126,987 61.05
Financial Specialists, All Other	1,540	60,685 29.17	76,552 36.80	40,588 19.51	36,986 17.78	>166,400 >80.00
Human Resources, Training, and Labor Relations Specialists, All Other	1,930	68,113 32.75	68,103 32.75	46,883 22.54	42,784 20.57	98,076 47.16
Insurance Appraisers, Auto Damage	240	56,486 27.16	56,334 27.08	42,774 20.56	39,131 18.81	75,996 36.54
Insurance Underwriters	3,680	63,336 30.45	73,547 35.36	44,120 21.21	41,115 19.77	115,329 55.44

Loan Counselors	370	40,153	45,466	32,260	29,488	66,372
		19.31	21.86	15.51	14.18	31.91
Loan Officers	2,890	61,940	70,946	40,710	36,854	119,023
		29.78	34.11	19.57	17.72	57.22

NOTE: The mid-wage is the median wage. The average wage is the mean wage. The entry-level wage is equal to the average of the lower third of reported wages for the occupation. The wage range consists of the 10th and 90th percentiles; 80 percent of workers earn between this wage range, 10 percent earn less while 10 percent earn more.

Reference Date: 1st quarter 2009

EXHIBIT4

Career Pulse

Substance Abuse Among Physicians: What You Need to Know

Roger S. Cicala, MD

Most physicians are not surprised when told that more than 10% of Americans have a substance abuse problem at some time during their lives.[1] Anyone who has rotated through an emergency department is aware of the magnitude of the problem. However, many are unaware that physicians themselves develop substance abuse problems at least as frequently, and perhaps more frequently, than the population in general.[2,3]

Although the exact rate of substance abuse among physicians is uncertain, even the most conservative estimates are that 8% to 12% of physicians will develop a substance abuse problem at some point during their career.[4,5] At any given time, as many as 7% of practicing physicians—roughly 1 out of every 14—are active substance abusers.[3,5] No group of physicians are immune. The numbers are similar for every specialty, every region of the country, every age range, in urban or rural areas, and in academic medicine versus private practice.

The impact of the problem is severe. Chemical impairment has been shown to be a major risk factor for medical malpractice and negligence lawsuits,[6] the development of physical and psychological illness,[7] and adverse effects on the substance abuser's family.[2] Left untreated, the mortality rate of substance abuse among physicians has been reported as high as 17%.[7]

Despite its high prevalence among physicians, substance abuse is rarely discussed at professional meetings (with the exception of anesthesiology organizations) and receives limited coverage in medical school curricula. In the majority of cases, physicians with substance abuse problems remain undetected by their colleagues for several years before any intervention is made.[7,8]

How does such an endemic problem remain so ignored? Largely because physicians who are abusing drugs or alcohol work hard to keep their problem invisible. The physician abuser often becomes a loner, avoiding colleagues and friends who might notice the effects of abuse. Any suggestion that the person's behavior or performance has changed is first met with explanations and later with simply avoidance or outright anger. The abusing physician will often leave a job (or several jobs) rather than risk being identified as impaired.

The inability or unwillingness of physicians to recognize the signs and symptoms of substance abuse in their colleagues also contributes to the delay in identifying the physician with a substance abuse problem. Almost every physician is familiar with the patients with end-stage alcoholism or drug abuse who haunt emergency departments. However, far fewer physicians consider substance abuse as a possible diagnosis before that end stage is reached. Fewer than 40% of primary care physicians routinely question patients regarding alcohol abuse, and fewer than 20% screen for potential drug abuse.[9] Only a small minority of physicians feel they have a basic knowledge concerning the diagnosis and treatment of substance abuse.[8]

Diagnosing substance abuse in a physician is even more difficult than diagnosing the problem in the general population. Most physician substance abusers continue to function quite well until the problem is far advanced. Because their work provides either the income for drugs or access to drugs, physicians are very likely to protect their performance at work until the disease has neared end stage. The duration of this period varies largely according to the substance(s) involved. Alcoholics can often remain sober during working hours for many years, even though they drink large quantities at night and on weekends. Intravenous opiate or cocaine abusers, on the other hand, may go from experimentation to collapse in a matter of weeks or months.[10]

Nevertheless, signs of substance abuse are usually present to the objective evaluator, and certain risk factors for the problem are well recognized. Given that as many as 10%[5] to 15%[1] of our colleagues develop a substance abuse problem during their careers, each of us should become aware of the signs and symptoms of the

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problem, and know how to contact the appropriate support groups to provide treatment and aftercare to the physician when needed.

CHARACTERISTICS OF SUBSTANCE ABUSE

Unfortunately, the public and far too many physicians continue to think of substance abuse as a bad habit or a moral weakness rather than as a disease.[1,9] All modern medical authorities, however, consider substance abuse to be a neurologic or psychiatric illness that is contributed to by genetic, social, emotional, and psychological problems.[1,5,6,11,12] The individual with a true substance abuse disorder is no more able to control their disease without treatment than a person with severe endogenous depression is able to stop feeling depressed through will power.

While the term "drug addiction" remains in widespread use, it is generally avoided by substance abuse professionals because of its emotional connotations. The terms "substance abuse" or "substance dependence" are preferred for clinical diagnosis. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) defines substance abuse as a maladaptive pattern of use of a chemical substance within a 12 month period that significantly interferes with the person's life as indicated by any 1 of the following[13]:

1. Neglect of work, school, or home obligations
2. Recurrent use of the substance in hazardous situations (eg, driving, operating machinery, or—in the case of a physician—caring for patients)
3. Repeated substance-related legal problems
4. Continued use of the substance despite recurrent social or interpersonal problems associated with its use

A simple summary of the *DSM-IV* criteria for substance abuse is "repeated use of a mood altering chemical, despite adverse consequences from previous use." By such a definition, any individual who receives a second arrest for driving while intoxicated would be automatically be considered to have a substance abuse problem because he or she continued to drink and drive despite having previous adverse consequences.

Physical dependence, that is, the development of withdrawal symptoms when abstaining from the substance, is not necessary to make the diagnosis of substance abuse. Certain substances of abuse—notably the hallucinogens, marijuana, and, to some extent, cocaine—do not result in significant physical withdrawal symptoms even if taken in massive quantities for a prolonged period.[14] Even when abusing substances known to cause withdrawal symptoms, some abusers spend years in exhibiting a binge pattern of abuse and never experience classic withdrawal. Binge abuse—episodes of excessive drug or alcohol use followed by weeks or months of abstinence—is common early in the course of substance abuse.[1,3] A "binge alcoholic," for example, may go weeks or months without a drink to "prove" that they do not have a problem. When they do drink, however, they often drink far more than they had planned and frequently have adverse consequences.

As with most chronic diseases, the long-term course of substance abuse is one of deterioration over time. During the early phases of the disease, however, many individuals have a waxing and waning course as their efforts to control the problem have some short-term success. As the disease progresses, attempts at self control become shorter and less effective, and the effects on the individual, as well as on his or her family, become devastating.[6,10]

The time course of deterioration varies according to the individual and the substance of abuse. Alcohol, benzodiazepine, and marijuana abuse usually show a slow, indolent course. It is often years or even decades before the problem becomes clearly evident; of course, some persons suffer significant effects in a much shorter time. Conversely, intravenous opiate and cocaine abuse (and smoking crack cocaine) usually has a very rapid course; persons abusing these substances often suffer dramatic deterioration within months of their first experimentation.[6,10]

THE ETIOLOGIES OF SUBSTANCE ABUSE

While there is no single "cause and effect" factor for developing substance abuse, several risk factors that predispose individuals to developing the disease are known. Substance abuse has a strong familial association, often affecting multiple family members over several generations. The familial association apparently represents both a genetic predisposition and the influence of environmental factors. Genetically, it has been shown that in comparison to non-abusers, some substance abusers tend to have different central nervous system responses and form different metabolic byproducts after ingesting cocaine, opiates, or alcohol.[14,15] However, substance abusers are also likely to have grown up in dysfunctional homes and to have suffered physical or emotional abuse or family disruption during childhood.

Nearly 90% of substance abusers suffer additional psychiatric disorders.[12] Depressive illness, bipolar illness, and anxiety disorder are often either present in the affected individual or evident in the family history.[12,16] Personality

Table 1. General Factors Associated with Substance Abuse

Depressive or bipolar illness
Divorced or separated marital status
Family history of alcoholism or substance abuse
Family history of psychiatric illness
History of childhood or adolescent abuse
Male gender

Table 2. Physician-Specific Factors Associated with Substance Abuse

Cigarette use > 1 pack per day
High stress or long work hours
History of multiple affairs and/or multiple marriages
History of multiple jobs, especially in multiple communities
Occupational access to controlled substances
Practice in academic medicine
Practice in emergency medicine, anesthesiology, psychiatry
Self-medicating or self-prescribing behavior

disorders also occur more frequently in substance abusers than in the general population.[10] It is not clear, however, whether the psychiatric illness predisposes to substance abuse, results from substance abuse, or whether both the substance abuse and the concurrent psychiatric diagnosis are different manifestations of an underlying pathology. In all likelihood, each of these possibilities exists in various cases. Particularly in physicians, some cases of substance abuse originate as attempts to "self medicate" an underlying depressive or bipolar illness.

There are gender differences in the frequency of substance abuse, which may be even more apparent among physicians than in the general population. Although nearly one third of physicians are female, nearly 90% of physicians referred for substance abuse treatment are male.[3] Compared to their male counterparts, female physicians who develop substance abuse problems are significantly more likely to suffer major depressive illness and less likely to have a personality disorder or to have criminal consequences of their abuse.[17] However, female physicians who do undergo substance abuse treatment are significantly more likely to have suffered permanent physical damage from their substance abuse than are their male counterparts.[18]

Females physicians are also more likely to have initiated substance abuse after a traumatic life event and to have a shorter course between the onset of abuse and the initiation of treatment.[14,15] Conversely, some reports indicate that whereas female physicians are less likely to use illicit substances or to be treated for substance abuse, they are far more likely to take prescribed tranquilizers and opioids than are male physicians.[18] Although taking prescribed medication does not represent substance abuse, the use of such medications while practicing may have significant medicolegal implications in the event of an adverse outcome or malpractice litigation.

ARE CERTAIN PHYSICIANS AT INCREASED RISK?

Minor differences exist in the frequency of abuse in certain medical subspecialties, with emergency medicine, psychiatry, and anesthesiology having slightly higher rates of substance abuse than other specialties.[2] Because this increased incidence is as apparent among residents as among long-term practitioners in these fields, it seems unlikely that the type of practice causes substance abuse.[2] Rather, it may be that persons with a predisposition toward substance abuse are more likely to choose these specialties. Some reports also indicate that physicians in academic medicine have a slightly higher incidence of substance abuse than those in private practice.[19]

Most of the risk factors for physician substance abuse parallel those of the general public (**Table 1**).[1,6,10,16] Although not absolute, the strongest risk factors appear to be a family history of substance abuse and the presence of psychological or psychiatric illness in the individual. There are also certain risk factors that are specific to physicians (**Table 2**).[3,5,6,10] Among the strongest physician-specific predispositions to developing substance abuse are (1) self-treatment with prescription medications, (2) high stress or long hours of practice, and (3) easy or constant access to controlled substances.[3,5,19] It should be noted that all of these risk factors are relative. Physicians with no apparent risk factors do develop substance abuse problems; conversely, a physician with every possible risk factor may never develop such a problem.

IDENTIFYING THE PHYSICIAN WITH A SUBSTANCE ABUSE PROBLEM

As most emergency department physicians can attest, it is fairly simple to detect an individual in the latter stages of substance abuse, after the ravages of the disease have taken their emotional and physical toll. In the vast majority of cases, symptoms of substance abuse are minimal at first and only become evident over time. When symptoms first become evident, they can often be explained by a number of other possible

Table 3. Signs and Symptoms of Substance Abuse in Physicians

Professional activities
Behavior toward staff or patients becomes unpredictable
Closes and locks office door frequently
Frequently at hospital at unusual times or when not on call
Frequently gives others breaks (particularly in anesthesiology)
Frequently late or absent
Increased patient complaints about the physician
Quality of charting or notes deteriorates
Self prescribes or receives personal samples frequently
Spends long hours at office or hospital and may be less productive
Unavailable or behavior is inappropriate when on call
Physical status
Evidence of emotional distress or depression
Frequent medical illness
Multiple accidents or traumatic injuries
Personal hygiene or dress deteriorates
Social/family
Arrests for driving while intoxicated or other legal problems
Children develop problem behaviors
Heavy drinking or intoxication at parties or social functions
Isolated or withdraws from family and social activities
Marital discord or separation
Multiple affairs
Unpredictable personal behavior, including high risk behaviors
Professional history
Employed in positions not appropriate for training and qualifications
Frequent job changes, often with geographic relocations
Unexplained time lapses between jobs
Vague or indefinite letters of reference

Adapted from Talbott GD, Gallegos KV, Angres DH. Impairment and recovery in physicians and other health professionals. In: Graham AW, Schultz TK, Wilford BB, editors. Principles of addiction medicine. 2nd ed. Chevy Chase (MD): American Society of Addiction Medicine; 1998:1267.

causes. Substance abuse is even more difficult to detect in a physician because he or she is aware of the possible symptoms of abuse and makes every effort to conceal them. Additionally, common symptoms, such as daytime somnolence or inability to concentrate, are easily attributed to the high stress or long hours that most physicians experience. Signs of substance abuse in physicians are listed in **Table 3**.

Physicians with substance abuse problems rarely exhibit the obvious symptoms of intoxication, such as slurred speech, pinpoint pupils, or bizarre behavior. Somnolence occurs with certain drugs but is easily explained as exhaustion from being on call or working long hours. Because they have access to sterile, small bore needles, physicians who are intravenous substance abusers will rarely have obvious needle marks (ie, "tracks").

Directly questioning a physician about his or her substance abuse is rarely successful and will often lead to counteraccusations ("you're out to get me" and "you're trying to ruin my practice" are common) or other angry responses. A hallmark of substance abuse is a remarkable denial on the part of the abuser that there is a problem, even as they go to great lengths to hide the symptoms of the problem.[1,8,10] On some levels, this effort may be conscious, but the person involved has often elaborately rationalized and justified the substance abuse so that he or she truly does not believe there is a problem.

The most consistent initial symptoms of substance abuse problems in physicians tend to involve changes in personal relationships and community activities. Increasing isolation is often the most noticeable early sign. Substance abusers find reasons to miss parties, social activities, and even family vacations. Family members and close friends are usually the first to notice the effects but may deny that there is a problem, even to themselves; no one wants to discover that a friend or loved one is a "drug addict." Domestic strife, frequent arguments, and loss of sexual interest are also common early symptoms, although often not apparent to anyone other than the involved domestic partner. One symptom that may be apparent to outsiders is that the children of substance abusers frequently develop behavioral problems.[3]

At-work behavior may differ depending on the substance of abuse. If work provides access to the desired substances, the substance-abusing physician is often a stellar performer, frequently working long hours, even when not on call, in order to remain near the source of supply. Working long hours also makes coworkers likely to attribute some signs of substance abuse to fatigue or stress and allows the abuser to avoid family members and spouses who are more likely to notice such changes.[5,10]

Such individuals often prefer to work alone. Physicians working in areas with access to injectable medications, such as anesthesiologists or emergency department physicians, may frequently give others breaks, while rarely taking breaks themselves. However, intravenous abusers

may need frequent restroom breaks and may lock the doors to their offices. More obvious, but less common, signs include heavy use of "sample" medications for their patients or having samples sent to their home.[10]

Physicians who abuse alcohol or illicit substances obtained away from the workplace often have quite different patterns of behavior. These physicians are often late to work, need to leave early, take long lunch hours or extended breaks during the workday, or are absent from work altogether as they fight the effects of binges and hangovers. Whereas cocaine and amphetamine abuse often causes noticeable personality changes within weeks or months, persons abusing alcohol or tranquilizers often have no apparent signs in the workplace for many years.[7,10]

Mood swings, depression, irritability, and inability to get along with coworkers are frequently seen in substance abusers, even early in the course of the disease. Affected individuals are likely to change jobs rather frequently as a means of avoiding suspicion or comments about their behaviors. The nonchemical problems common in substance abusers, such as numerous extramarital affairs, gambling problems, overspending or other financial difficulties, and behavior problems (particularly inappropriate anger or rage attacks) are often more apparent than the effects of the abused substance.[3]

Unfortunately, physicians are quite adept at hiding their problem from others until the end stage of the substance abuse is reached. Profound consequences, such as death from accidental overdose, criminal charges from self-prescribing or driving while intoxicated, loss of hospital privileges, malpractice suits from practicing while impaired, and suicide from severe depression, are often the first clear sign that a physician might have a substance abuse problem.[3,4,10] It is, therefore, of utmost importance that every physician become aware that ignoring the subtle symptoms in a friend and colleague will actually prevent that person from getting help and may ultimately have tragic consequences. Only a vanishingly small percentage of substance abusers will quit for more than a few months without treatment and aftercare.[1,8]

WHAT TO DO IF YOU SUSPECT A COLLEAGUE HAS A SUBSTANCE ABUSE PROBLEM

Physicians with substance abuse problems are occasionally detected in a way that is so obvious there can be no question the problem exists, such as when a physician is caught diverting medication or is arrested for buying drugs on the street. In most cases, however, enough signs of abuse (Table 3) are present to provide a reasonable degree of suspicion that the physician in question might have a problem but not to clearly prove that they do.

In such cases, it may be tempting for a well-intentioned colleague to privately question or confront the individual about the possibility of substance abuse, but this is rarely effective. As mentioned above, this approach often results in angry denial or counteraccusations. In other cases, the accused physician simply quits the practice and starts over elsewhere. There is also a potential for self harm when a physician with a substance abuse problem feels that he or she is about to be detected but does not believe that he or she will be able to live without the drug of abuse.[3,4]

Instead, the facts that lead to suspicion should be reported to a proper authority or group (eg, the department chair, the institution's physician's wellness committee) that can quietly investigate the situation and take effective action. Many states have a legal requirement that a physician must report any suspicions that a colleague may be practicing while impaired to the proper authorities. Failure to do so could theoretically result in sanctions against the physician who does not make such a report.[3]

Reporting also provides protection for the physician suspected of having a substance abuse problem. The resulting investigation is usually completely confidential and, in most cases, is protected from any outside legal discovery processes under peer review laws. If, however, the problem is not reported until legal issues or questions of competence are raised, the right of the physician to confidentiality may be lost and the problem becomes a matter of public record. Public awareness of the physician's problem may result in rejection of provider status by third party payers and inability to obtain future hospital privileges. Of more immediate concern are medical malpractice suits brought by attorneys and former patients who are well aware that informing a jury the physician was practicing while impaired is likely to result in a positive judgment, no matter what the facts of the case are.

If a peer investigation reveals evidence that a substance abuse problem is likely, it is rarely necessary to involve the state medical board or any legal agencies. Every state medical society has a program or committee dedicated to the identification, treatment, and support of physicians with substance abuse. These programs go under various names, such as "physicians' wellness committee," "physicians' health program," or "impaired physician program." These organizations, which can be located by contacting one's state medical society, are usually empowered by the state medical board to intervene with, and to direct treatment and aftercare of, physicians with substance abuse problems. Typically, as long as the physician remains in compliance with the

wellness committee, no action will be taken by the state medical board, and the interaction remains protected by confidentiality laws.

Once the state physician wellness committee has been contacted and confirms that a problem exists, events generally proceed as follows: First, the committee organizes an intervention for the physician in question. The intervention is a planned confrontation by a small group (usually consisting of a colleague or supervisor, 1 or more addiction treatment professionals, a member of the local physician's wellness committee, and sometimes a family member) who attempt to break through the person's denial and help them see that their problem has become obvious to others. The intervention team presents a treatment option that would allow the physician to return to practice and provide hope that the problem can be solved. In cases in which it remains unclear whether substance abuse is involved, a 4- to 7-day evaluation at a treatment center is arranged.

In most cases, the individual will be immediately escorted to treatment or for evaluation. The potential for self harm at this time is very real; it is for this reason that well-meaning colleagues should not directly confront a physician with a substance abuse problem. By the time the problem has become obvious, the affected person has almost certainly realized that he or she cannot just "quit." Without the hope for successful treatment and a better outcome that is provided by having a planned intervention, the individual may simply become more hopeless and even suicidal.[10]

Although some persons are actually relieved that there is help available, others are unwilling to even consider that they have a problem. The intervention team should plan for the possible refusal, and a very real set of consequences (loss of licensure or job) will usually occur if the physician does not follow the recommendations of the team. Nevertheless, not all interventions are successful, and some people will choose to accept any consequences rather than to address the issue of substance abuse.

Such interventions, although sometimes emotionally traumatic, are necessary. Only a small percentage of physicians with substance abuse problems voluntarily enter treatment on their own.[3] Although accurate statistics are not available concerning the number of physicians who have overcome a substance abuse problem without treatment, figures regarding the general population indicate that fewer than 20% of substance abusers successfully stop for more than a few months without some form of treatment or support.[1,20] Because of high chronic stress levels, relatively easy access to drugs, and the widespread (although erroneous) belief that "self-prescription" is legal and legitimate, some authorities believe that physicians are even less likely than the general population to successfully stop abuse without treatment.[3,21]

SUBSTANCE ABUSE TREATMENT

Unfortunately, even some physicians mistakenly believe that if the individual can overcome the withdrawal syndrome for their drug of abuse, they will be able to stop their substance abuse problem. Although overcoming physical withdrawal is a precursor to successful treatment, it does nothing to eliminate the psychologic cravings and behaviors that are part of substance abuse problems. The relapse rate of persons who are simply detoxified (overcoming physical withdrawal) but do not receive other treatment is greater than 95%.[2]

Treatment of physicians with substance abuse problems differs significantly from the treatment experienced by the general public for several reasons. Routine substance abuse treatment is usually short term (about 1 month) and often takes place in an outpatient setting. Such programs are known to have high relapse rates (greater than 60%) for any given treatment.[22,23] Because motivated individuals will return to treatment—often several times—the eventual success rate is reasonably high.

Nevertheless, such a high relapse rate is not acceptable for a physician who will return to an occupation in which his or her judgment must be impeccable. Since the 1980s, it has been widely recognized that extended treatment, usually lasting 3 to 4 months, significantly lowers the relapse rate of persons recovering from substance abuse.[2,9,10,23] It also has been shown that treatment of physicians is more successful if it takes place in a center that has a significant number of other physician-patients. Unless there are a number of physician-patients in the program, the physician in treatment often gets special treatment from other patients and staff, negating some of the benefits of treatment.[2,19]

Treatment usually begins in a hospital setting. This early phase of treatment focuses on the physical manifestations of substance abuse, such as preventing withdrawal syndrome and overcoming initial drug cravings. Depending upon the substance involved, this phase may take from a few days to 2 weeks. A program of emotional and psychological therapy, behavior modification, and education begins during this part of treatment and continues during an intermediate treatment period that lasts several weeks. Regular participation in self-help recovery programs, such as Alcoholics Anonymous or Narcotics Anonymous, is a major part of the intermediate phase of treatment.

In most centers, the intermediate and late phases of treatment take place in a "residence recovery" setting. Usually, several persons share an apartment or halfway house, where persons further along in the treatment process can provide help and emotional support for newer arrivals. The late phase of treatment often involves a "mirror image" program, whereby recovering physicians work with persons in early recovery, gaining insight into their own disease by observing its effects in others. Family therapy is a significant part of most treatments, helping to heal the numerous effects that substance abuse has on family members.[3,14]

After successfully completing treatment, the vast majority of physicians return to practice. Although the actual process varies from state to state, in most regions, the physician will sign an aftercare contract with the state physician wellness committee. The contract, which lasts from 2 to 5 years, requires attendance at regular aftercare meetings, random drug screens, and participation in appropriate self-help or therapy groups.

Treatment centers experienced in working with physicians report long-term success rates of greater than 70%, but when such a structured aftercare program is undertaken, the success rate increase to approximately 90%.[1,19,22,23] Many of those who do relapse are quickly detected by an aftercare program and return to treatment, after which they eventually enter successful long-term recovery. The majority of relapses occur during the first 2 years after treatment. After 5 years of abstinence, the recovering physician is statistically less likely to suffer a future episode of substance abuse than are physicians in general.[3]

In addition to aiding and monitoring the recovery process, the wellness committee advocates for the physician. In most states, this advocacy is accepted by the state medical board, malpractice insurers, hospitals, and third party payers as evidence of fitness to return to practice. Advocacy goes much further in many states, actively assisting the physician by meeting with partners, colleagues, and hospital staffs, and sometimes negotiating changes in working conditions that may be necessary during early recovery. Although advocacy does not negate or overcome any legal charges that may have been made, it is often considered by judges during plea bargaining or sentencing efforts.

CONCLUSION

The central fact to remember concerning treatment of physicians with substance abuse is that it is usually successful. Treatment centers experienced in working with physicians report long-term success rates of 90% or higher. What cannot be described statistically, however, are the positive effects on the involved physicians and their families. The idea of substance abuse intervention and treatment may be thought of by the abusing physician as the worst thing that could happen. In reality, this is the best thing that could happen to a physician with a substance abuse problem. Although early recovery can be a difficult and emotionally painful process, most recovering physicians are happier and more satisfied than at any time in their lives. Nearly all return to practice, and they (and their coworkers) believe that they are far better physicians after treatment than they ever were before. **HP**

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EXHIBIT 5

SUBSTANCE ABUSE, CHEMICAL DEPENDENCY AND MENTAL HEALTH CONCERNS IN THE LEGAL PROFESSION

OHIO LAWYERS ASSISTANCE PROGRAM, INC.

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Funded By:

The Supreme Court of Ohio
Ohio State Bar Association
Ohio Bar Liability Company

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SUBSTANCE ABUSE, CHEMICAL DEPENDENCY & MENTAL HEALTH CONCERNS IN THE LEGAL PROFESSION

Ohio's integrated program:

The legal professions response to substance abuse, chemical dependency and mental health concerns in Ohio

I. **The Three Components**
Education
Advice and Intervention Assistance
Treatment and After-Care Support

II. **The Organizations**
The Lawyers Assistance Committee of the Ohio State Bar Association
The Ohio Lawyers Assistance Program, Inc. (OLAP)
The Lawyers Support System

III. **Key Rules and Statutes**
Gov. Rule I, Section 3(E)(2)
One hour of instruction to sit for bar examination

Gov. Rule X, Section 3(A)
CLE Requirements

DR 1-103(C)
Confidentiality

R.C. Section 2305.28
Qualified Immunity for Intervention Participant

Gov. Rule V, Section 9(B)
Monitoring

IV. **Funding and Other Support**
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Ohio Bar Liability Insurance Company (OBLIC)
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INTRODUCTION

Since 1990 OLAP has assisted Ohio's judges, lawyers and law students obtain appropriate treatment for substance abuse and chemical dependency. Over 700 men and women have been helped. Recognizing that an impaired lawyer negatively affects nine other people each day, over 6,300 men, women and children have somehow been touched by OLAP.

OLAP and the profession in recent years have observed an increasing number of attorneys who have not only substance abuse problems, but also mental health problems. In addition, OLAP recognized that there are a growing number of attorneys who are suffering from untreated mental health illnesses, and who do not have a substance abuse problem, but need someone to intervene and help them seek appropriate treatment. Such untreated problems not only affect them and their families, but may also affect their clients.

The American Bar Association surveyed attorneys in 1990. Among the startling statistics at that time were that:

1. ⅓ of practicing lawyers suffer from depression, making lawyers 5 to 10 times more likely than other professionals to suffer from a major depressive disorder;

2. 18% - 20% of lawyers suffer from alcoholism, compared with 10% of the rest of Americans. After 20 years of practice, the rate rises to 25%. Alcohol and drug problems cause half the disciplinary cases involving lawyers (*Wall Street Journal*, 11/30/90); and

3. Lawyers are twice as likely as other professionals to commit suicide.

Florida Coastal School of Law Professor Susan Daicoff (formerly at Capital University Law School), who is also a psychologist, has studied this issue. In an article she wrote, which was published in *The Georgetown Journal of Legal Ethics* in Spring. 1998, she states the following:

> . . . "D. INCIDENCE OF SUBSTANCE ABUSE AND DEPRESSION AMONG LAWYERS.
>
> A serious influence complicating and compounding the . . . crisis is the incidence in substance abuse and depression among lawyers. Estimates of the frequency of substance abuse problems, including alcoholism, among lawyers range from three to thirty times that of the general population. About nine to ten percent of the general population in the United States is alcoholic, while empirical studies consistently show that about eighteen percent of lawyers and law students are alcoholic. Similarly, while three to nine percent in the

general population in the United States is clinically depressed, as much as nineteen to twenty percent of practicing attorneys is depressed. A 1986 study found that only about ten percent of entering law students exhibited significant symptoms of psychological problems including depression, anxiety, hostility, paranoia, and obsessive-compulsive symptoms, but this percentage jumped dramatically to thirty-two percent by the end of the first year of law school. By the end of the third year of law school it was forty percent, and two years after graduation it was 17.9%. A 1995 study replicated these findings and found that problems did not significantly abate after the individuals entered the practice of law. Depression, anxiety, social isolation and alienation, hostility, paranoid ideation, and obsessive-compulsive symptoms were more frequent in attorneys than in the general population. Thus, a greater than average percentage of attorneys (as a group) is psychologically impaired in some way. Further, it appears that while the problems often do not appear until the first year of law school, lawyers do not return to their pre-law school level of psychological health after graduation." (pages 555-557)

In one of Professor Daicoff's footnotes, she cites a study by Connie A. Beck which was published in 1995-1996. Ms. Beck's findings are as follows:

	Base Rate		Among Lawyers	
	Male	Female	Male	Female
Depression	8.5%	14.1 %	21%	16%
Anxiety	4%	4%	30%	20%
Obsessive-Compulsive	1.4%-2%	1.4%-2%	21%	15%

Based upon the Ohio bar's experience and the empirical information cited above, OLAP sought and received additional support from The Supreme Court of Ohio to assist those in the profession with mental illness. Professional staff has been added, and additional professional assistance across the state is being secured. The purpose of this publication is to provide you with information, education and resources if you or someone else in the profession is in need of assistance.

DISCLAIMER/PUBLICATION NOTICE

This publication was funded by The Supreme Court of Ohio. However, the opinions expressed in this publication do not necessarily reflect the position of the Court, and no endorsement of the Court should be inferred.

These materials are published as part of the Ohio Lawyers Assistance Program, Inc.'s (OLAP) educational services. The purpose of this publication is to provide Ohio's legal profession with information, education and resources. This publication is not to be used to self-diagnose or to diagnose others. Contact OLAP for further assistance.

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SUBSTANCE ABUSE
IN THE LEGAL PROFESSION

Causes, Prevention, Detection and Treatment Alternatives

I. WHAT ARE SOME FUNCTIONAL DEFINITIONS OF ADDICTION?

A. The inability to stop the use of the substance or behavior in question; the perceived inability to stay stopped.

B. Behavior characterized by:

1. Compulsion: an internal demand beyond intellectual resource or understanding.

2. Loss of control over amount consumed.

3. Continued use or activity despite adverse consequences.

C. Another way of saying it:

1. Psychoactive Substance Dependence (Addiction).

The essential feature of this disorder is a cluster of cognitive, behavioral, and physiological symptoms that indicate that the person has impaired control of psychoactive substances and continues to use the substance(s) despite adverse consequences.

D. A related term:

1. Psychoactive Substance Abuse.

Psychoactive Substance Abuse is a residual category for noting maladaptive patterns of substance use that have never met the criteria for dependence.

II. WHAT ARE THE PRIMARY CLASSIFICATIONS OF SUBSTANCE

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), American Psychiatric Association, 2000) has divided substances into 11 categories:

A. Alcohol - a drug in liquid form.

B. Sedatives, hypnotics and *antianxiety* drugs - sleeping pills and "nerve medication":

Barbituates	**Benzodiazepines**	**Date Rape Drugs**
Seconal	Zolpidem (Ambien)	GHB (Georgia Homeboy, Grievous Bodily Harm)
Pentobarbital (Nembutal)	Flurazepam (Dalmane)	Flunitrazepam (Rohypnol) ("Roofies", "Roffirs", "Rophirs", "Roche", "Forget Me Pill")
Tuinal	Lorazepam (Ativan)	(See: Ecstacy under amphetamines and hallucinogens since it has both properties. It is not classified as a sedative hypnotic.
Phenobarbital (Luminal)	Clorazepate (Tranzene)	
Secobarbital (Amytal)	Chlordiazepoxide (Librium)	
Anembutal	Oxazepam (Serax)	
Butalbital (Fiorinal, Fioricet)	Alprazolam (Xanax)	
	Meprobamate (Equanil, Miltown)	
Butabarbital (Butisol)	Diazepam (Valium)	
Talbutal (Lotusate)	Triaxolam (Halcion)	
Mephobarbital (Mebaral)	Estazolam (ProSam)	
Methohexital (Brevital)	Quazepam (Doral)	
Thiamylal (Surital)	Temazepam (Restoril)	
Thiopental (Pentothal)	Halazepam (Paxipam)	
	Prazepam (Centrax)	
	Midazolam (Versed)	

	Clonazepam (Klonopin)	

Older Sedative Hypnotics (not readily available)
Golutethimide (Doriden)
Noludar
Methaqualone (Quaalude, Soper)
Placidyl

C. Cannabis/marijuana/hashish/hash oil.

D. Cocaine/Crack

E. Amphetamines (Stimulants and Sympathomimetics):

Methamphetamine/"Crank"/"Ice" (smokable)/"Crystal"/"Chalk"/"Fire"/"Glass"
Ritalin (Metadate, Methylini)
Preludin ("Ecstacy")
Aderol
Cylert

F. Hallucinogens:

LSD
Psilocybin and Psilocyn
Mescaline and Peyote
DMT
MDMA ("Ecstacy", "XTC", "Adam", "Essence", "Clarity", "Lover's Speed")

G. Inhalants:

Gasoline, glue, paint thinners, spray paint, cleaners, typewriter correction fluid, spray-can propellants, nitrous oxide ("whip-its"), amyl and butyl nitrate ("poppers," "locker room")

H. Caffeine.

I. Nicotine.

J. Opiates

Thebaine	Loret	Tussionex
Anexsia	Hycodan	Hycomine
Hydrocodone	Oxymorphene	Nalbuphine

Nalonone	Naltrexone	Tylos
Lortab	Hydromorphone	Morphine (Roxanol)
Heroin	Darvon	Codeine
Dilaudid	Demerol	Oxycodone
Meperidine	Percodan	Methadone
Pentazocine	Buprenorphine	Fentanyl
Oxycontin	Duragesic patch (Fentanyl)	
Codeine	Vicoden	Percocet
Lomotil	Paragoric	MSIR
MS-Contin		

K. Phencyclidine (PCP, Hog, Tranq, Angel Dust and PeaCe Pill), Sernyl Arylcyclohexylamine

Ketamine (Ketalar, Ketaject, "Special K", "K", "Vitamin K", "Cut Valiums");
Cyclohexamine
Dizocilpine

III. WHAT DO WE MEAN WHEN WE SAY IT'S A DISEASE?

A. Since 1956, the American Medical Association has considered alcoholism (or chemical dependency) to be a disease, and the American Bar Association's Commission on Lawyers Assistance Programs has adopted this model as well.

B. Alcoholism is a primary, chronic, disease with genetic, psycho-social and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences and distortions in thinking, most notably denial. (American Society of Addiction Medicine (ASAM), National Council on Alcoholism and Drug Dependency (NCADD), 1990).

C. What are the principal characteristics of the disease?

1. Primary Disease

The disease itself causes the drinking or drug use. It is not secondary to some other disease of mental illness, etc.

2. Chronic

There is no cure for the disease, but it can be treated and controlled.

3. Progressive

The disease always gets worse, it does not get better and there is no turning back and beginning all over again as if one never drank or used.

4. Fatal

This is a fatal disease if not controlled. It always leads to premature death and serious health problems even if the death certificate indicates the cause of death to be one of the complications of the disease, e.g., heart problems, liver failure, bleeding ulcers, cancers, etc.

5. Treatable

The disease can be controlled if the drinking or drug use is stopped. It is much like diabetes in the sense that if body chemistry is stabilized by not drinking or using, then the alcoholic may lead a normal life. Recovery rate among the general population who have undergone appropriate treatment is around 70% and among some professional groups (including lawyers) as high as 90%.

D. What are the diagnostic criteria for substance abuse according to the DSM IV-TR (page 199)?

1. A maladaptive pattern of substance abuse leading to clinically significant impairment or distress, as manifested by one (or more) of the following within a 12-month period:

   a. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated absences, poor performance, suspensions from school, neglect of children).

   b. recurrent substance use in situations in which it is physically hazardous (e.g. driving, operating a machine, hunting, boating).

   c. Recurrent substance – related legal problems (e.g. arrests)

   d. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (arguments with spouse, physical fights).

2. The symptoms have never met the criteria for Substance Dependence/Addiction for this class of substance.

E. What are the diagnostic criteria for substance dependence (addiction) according to the DSM IV-TR (page 197)?

1. A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

a. Marked tolerance: need for markedly increased amounts of the substance in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount.

b. Characteristic withdrawal symptoms (increased pulse, respirations, blood pressure, tremors, nausea, vomiting, diarrhea, constipation, sweats). Use of substance to relieve or avoid withdrawal symptoms.

c. Substance is often taken in larger amounts or over a longer period than the person intended.

d. Persistent desire or one or more unsuccessful efforts to cut down or control substance use.

e. A great deal of time spent in activities necessary to get the substance, take the substance, or recover from its effects.

f. Important social, occupational, or recreational activities given up or reduced because of substance use.

g. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

F. Substance Abuse vs. Substance Dependence

a. Unlike the criteria for substance dependence, the criteria for substance abuse do not include tolerance, withdrawal or a pattern of compulsive use and only include the harmful consequences of repeated use. DSM IV-TR, p. 198.

b. Substance abuse is more likely in individuals who have begun to use substances recently. DSM IV-TR, p. 206.

c. Treatment, education and abstinence are critical for one diagnosed with substance abuse for at least three primary reasons:

i. to ensure the safety of the individual, the individual's family and the public;

ii. because the diagnosis of substance abuse indicates that the abuser is, for practical purposes, "out of control" due to "repeated" use in situations where use is inappropriate, harmful and even life threatening. Such "repeated" use may be tantamount to and easily confused with "compulsive" use which indicates dependence;

iii. because substance abuse often evolves into substance dependence. DSM IV-TR, p. 206.

IV. WHAT KIND OF A DISEASE IS IT?

A. It is a genetic and biochemical disease:

Just since 1980, there have been hundreds of studies and scholarly papers (including the discovery of perhaps one of the actual genes) corroborating a genetic or familial predisposition to the disease.

B. Two genetic varieties of the disease:

1. Highly heritable.

a. More likely in the male line.

b. Person can be alcoholic from first use or first drink.

c. Children as young as 8 years of age or younger can be alcoholic or drug dependent.

d. If you have one parent who is an alcoholic/addict, you have a 50% chance of being chemically dependent. If you have two parents who are chemically dependent, you have an 80% chance of becoming an alcoholic and/or an addict.

2. Milieu limited.

a. More likely to come on in 30's or 40's after a more prolonged period of use (average period being 7 years).

b. Can be associated with crisis events in life and inability to control amount used.

C. Biochemistry issues:

1. Brain chemistry affects how one feels.

How do the alcoholics or drug dependents feel that they want to drink for relief? Alcoholics are stimulus augmenters and live in a world that is too loud.

2. Brain Wave Studies.

Low amplitude "P-d" brain waves are too low or are missing. These waves affects cognitive ability to tolerate, interpret, and utilize stress. "Alpha" waves are also deficient or absent.

3. Brain chemistry.

a. Neurotransmitter and Opioid Deficiencies.

Is there something else missing that affects normally feeling good? In alcohol craving rats, there is a serotonin deficiency. Serotonin is a major "feel good" compound in the brain.

The brain has morphine receptor sites because it makes some form of endogenous morphine -- these are the endorphines we produce, e.g., "runner's high." Spinal fluid of alcoholic is deficient in "feel good" endorphines.

Alcoholic rats are deficient in enkephalines as well -- these

are other "feel good" chemicals in the brain.

Some research shows deficiencies in still others like noradrenaline.

b. At first, alcohol makes the alcoholic feel normal.

The alcoholic therefore begins to feel good or normal, like normal people, after he or she has begun to drink and the alcohol has begun to affect the amount of these feel good chemicals in the brain.

But, this is also the point at which the alcohol becomes a double bind because other chemical reactions going on in the alcoholic's chemical system begin to set up the craving process for more and more alcohol.

c. Then, the craving process begins. This craving is the alcoholic's allergic response.

When the alcohol is enough to overcome the normal metabolism of acetaldehyde there is production of dopamine (new gene research involves dopamine receptors) resulting in THIQ which when given to rats will cause them to drink themselves to death. In spinal fluid of an alcoholic, the THIQ is 1000 times greater than normal. Conclusion, craving can be explained biochemically.

D. Psychological Aspects of the Disease:

1. There is no alcoholic personality profile -- the alcoholic personality does not exist.

2. But, there is evidence of poor identification with the parent of the same sex as a result of death, or parent's alcoholism, or parent's work-aholism.

This is the parent from whom we should learn our coping skills at the earliest age. Therefore, the alcoholic may not be learning good stress coping skills while also being genetically and biochemically pre-disposed to stimulus augmentation.

E. Social Aspects of the Disease:

1. Our society promotes and condones drinking and drug use.

2. The 10% to 20% of the general population who are at risk for alcoholism or chemical dependency see advertisements, etc., just like the other 80% to 90% who can handle alcohol in moderation.

3. Additionally, peer pressure to use easily available drugs is rampant among children, youth, and teens -- perhaps the single biggest factor for beginning use.

V. HOW WILL THE DISEASE MANIFEST ITSELF?

A. Home and Family:

1. Heavy drinking/using -- high tolerance.

2. Hide drug/alcohol -- secret use.

3. Broken promises to quit.

4. Behavior excused by family and friends (enablers, hero, scapegoat, mascot and lost child).

5. Mood swings and inconsistency.

6. Fights, arguments, violent outbursts, temper.

7. Drinking or drug use more important than other activities.

8. Children neglected, abused, or in trouble themselves, often with alcohol or drugs.

9. Sexual problems: no sex - rejection; impotence; affairs - change in value system.

10. Withdrawn, isolation and fragmentation of social and family life.

11. Family isolates itself from social supports.

12. Financial problems, e.g., get-rich-quick schemes, trouble with IRS and creditors.

13. Spouse in psychotherapy or taking psychoactive medications.

14. Separation or divorce.

B. Community and Professional:

1. Isolation and withdrawal from service clubs, church involvement, community activities, hobbies, leisure activities, old friends.

2. Withdrawal from bar association work and not completing continuing legal education.

3. Embarrassing behavior at clubs, parties, social functions, fundraisers.

4. Neglect of social commitments.

5. Financial difficulties and inappropriate spending.

6. Legal problems, OMVI, arrest, IRS.

7. Exaggerating work accomplishments and finances.

8. Missed legal deadlines (statute of limitations, motions).

9. Late for/missed court appearances/depositions.

10. Intoxicated after lunch.

C. Office Conduct:

1. Disruption of appointment schedule.

2. Hostile, withdrawn, unreasonable behavior to staff and clients.

3. Office staff assumes responsibility generally taken by attorney.

4. Power struggle within office staff.

5. Decrease in efficiency.

6. Stays late after office hours.

7. Absence from office unexplained or due to illness.

8. Complaints by clients to staff regarding behavior - alcohol on breath, slurred speech.

9. Drinking or drug taking at office.

10. "Locked door syndrome" - mood swings.

11. Experiences blackouts - forgotten phone calls.

12. Gossip regarding behavior changes.

D. Physical Status:

1. Deterioration in personal hygiene.

2. Deterioration in clothing and dressing habits.

3. Accidents.

4. Multiple physical signs and complaints.

5. Frequent visits to physicians/psychologists.

6. Pupil and eye change.

7. Inappropriate tremulousness or sweating.

VI. WHAT ARE THE ULTIMATE "PERSONAL COSTS" OF DOING NOTHING?

A. Loss of physical, emotional, spiritual health for the alcoholic/addict, and usually his or her family.

B. Codependence and Psychologically Damaging Roles in the alcoholic's/addict's family such as

i. the Enabler, who suffers the stress created by continual covering up for alcoholic/addict;
ii. the Hero, who is typically an older child who feels he or she has to excel at everything to save the family reputation; this facade masks internal feelings of inadequacy and anger;
iii. the Mascot, who acts the role of a clown to divert attention from the alcoholic/addict, but suffers repressed hurt and guilt;
iv. the Lost Child, who intensely withdraws into a private fantasy life; internalizing loneliness and feeling unimportant; and
v. the Scapegoat, who tries to take the focus off of the alcoholic/addict by

getting into trouble thereby masking an internal sense of fear.[1]

C. Damage to or loss of marriage.

D. Damage to or loss of parent-child relationships.

E. Loss of friends.

F. Sometimes OMVI's.

G. Sometimes suicide.

VII. WHAT ARE THE ULTIMATE PROFESSIONAL COSTS?

A. If nothing else, loss of real potential.

B. Eventually minor or isolated ethical problems - not yet real neglect because isolated.

C. Eventually it can cause:

1. Actionable misconduct.

2. Patterns of neglect.

3. Competency issues.

4. Loss of professional license, income, etc.

D. Remember, some of the things most likely to cause professional problems are:

1. Marital problems.

2. Financial problems.

3. Bad judgment.

4. Inappropriate disposition.

5. ALCOHOLISM/ADDICTION CAUSES ALL OF THESE.

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[1]Information taken from: *The Family Trap* by Sharon Wegscheider, Johnson Institute, 1976.

VIII. WHY WOULD SOMEONE GENERALLY WANT TO AVOID TREATMENT?

A. The nature of the mechanism of disease activation may involve certain activities that, due to the patient's world view or the law, has the patient:

1. Thinking that the disease is sinful.

2. Thinking that the disease is based on weakness.

3. Thinking that it would only happen to an idiot.

4. Involved in criminal activity.

5. Thinking that it happens only to people who are "psychiatrically disturbed."

6. The perception of going to treatment involves a self-assessment more of wrongness than rightness. Note: Other volitional acts of irresponsibility often go uncondemned by others. When the hypertensive is non-compliant with diet, weight, medication, and smoking there is much more understanding when they enter the hospital than the untreated alcoholic/addict.

IX. WHAT OTHER MECHANISMS ARE ACTIVE THAT HELP THE INDIVIDUAL AVOID TREATMENT?

A. Irrational Beliefs:

1. I can't afford to go to treatment.

2. I'm not that sick.

3. I can quit any time I want.

4. Drinking is not my problem, my wife (my husband) is..., etc.,

5. I'll be branded for life if I go to treatment.

6. I'm not as bad as my partner.

7. My associates drink more than I do!

8. I may be a heavy drinker, but....

9. I may get drunk once in a while, but I'm not an alcoholic.

10. I only use cocaine recreationally.

11. My psychiatrist says I drink because of my anxiety disorder, see he even put me on . . . Valium or Xanax.

12. No way. My dad (my mom) was alcoholic and I'm nothing like him (or her).

13. I think everyone is overreacting.

14. It was 0.22, but the cop was pulling everyone over.

15. I did a lot of drugs experimentally as a kid, but...

16. I promise I'll come in for treatment after we close this deal.

17. Its only marijuana, we all know that its basically harmless.

B. Defense Mechanisms which are normal to all persons can be used by the alcoholic so as to blind himself or herself to reality:

1. Denial - "can't be true" regardless of factual evidence.

2. Minimizing - making something less important.

3. Externalizing - blaming external factors.

4. Rationalizing - giving excuses.

5. Intellectualizing - lengthy intellectual reason and arguments.

6. Displacement - taking it out on others.

7. Active Negativism - refusing to do.

8. Defocusing - wasting time on outside issues.

9. Projection - planning results.

10. Passive Negativism - inaction.

11. Fantasizing - day dreaming.

12. Hopeful Expectation.

13. Manipulating.

14. Undoing.

15. Generalizing.

16. Omnipotent Devaluation.

C. Enablers - Individuals who possess the same irrational beliefs and pathological defense mechanisms as the patient, who nonetheless facilitate the patient's avoidance of treatment.

1. Active Enabling - Purchasing or acquiring the chemical for the individual when he/she is too sick or indisposed to acquire the drug themselves.

2. Passive Enabling - Not acknowledging or exposing the reality of what is going on with the chemically dependent person.

3. Iatrogenic Enabling - The physician who does not diagnose the disease even when obvious or substitutes a second mood altering substance for the primary one. Treating cocaine dependency as a Bipolar illness with Lithium, or Alcoholism as an anxiety disorder with Xanax, Valium or Ativan.

4. Enabling by Omission - The OMVI offender who is referred to a diversion program when the blood alcohol level of record is sufficient to diagnose alcoholism.

X. WHAT CAN BE DONE TO PROMOTE RECOVERY?

A. Speaking to the person - often does not work.

B. Intervention - Collaboration of family, friends and colleagues who identify negative changes in the individual and its impact on relationships and professionalism prompting the impaired individual to seek help. Requires professional assistance - call OLAP.

C. Treatment - Options:

1. Self-help groups (Alcoholics Anonymous [A.A.], Narcotics Anonymous [N.A.], Cocaine Anonymous [C.A.], Al-Anon, Alateen).

2. Intensive outpatient.

3. Residential inpatient.

4. Residential inpatient followed by extended follow-up in halfway house care.

5. Detox-medically managed and monitored detoxification from the substance(s) most often requiring hospitalization.

XI. WHAT MUST BE ACCOMPLISHED AS PART OF ANY RECOVERY PROGRAM REGARDLESS OF THE TECHNIQUE OR TREATMENT MODALITY SELECTED?

A. Self Diagnosis - You cannot treat what the patient does not think he or she has or needs to be treated.

B. Education - Appropriate facts about the disease of addiction lessen the general obstacle or resistance to self diagnosis.

C. Self Treatment - The patient should be empowered with the tools to maintain abstinence and/or avoid relapse.

D. Self Responsibility - The essence of achieving long term remission via dealing with life's problems through a spiritually based self help/support program.

XII. WHAT IS THE "LAWYERS SUPPORT SYSTEM" AFTERCARE PROGRAM?

A. Lawyers Support System (LSS) is a program through which the Ohio Lawyers Assistance Program, Inc. (OLAP) will provide the following services for chemically dependent lawyers who are enrolled:

1. track lawyers through treatment, confirming admission to and successful completion of treatment;

2. assist the treatment provider in structuring aftercare and discharge planning for lawyers receiving treatment;

3. provide assistance for the lawyer's entry into appropriate aftercare and

professional peer support meetings;

4. assist the lawyer in obtaining a primary care physician;

5. establish a random urine drug screening program;

6. track the lawyer's aftercare, peer support, and twelve step meeting attendance;

7. provide assistance to the lawyer in obtaining a local LSS mentor attorney, who is in recovery;

8. provide documentation of compliance by the lawyer to those persons and/or agencies as required;

9. provide advocacy for those lawyers who are compliant with the requirements of the program; and

10. inform OLAP of the status of attendance/compliance.

B. OLAP/LSS will implement the program in the following manner:

1. Upon entrance by the lawyer into treatment, OLAP/LSS will contact the treatment provider requesting a letter documenting admission, progress reports, and documentation of successful completion of treatment. If the lawyer should leave treatment against medical advice or leave treatment before recommended treatment is completed, the treatment provider will be requested to contact OLAP/LSS immediately. The lawyer shall provide OLAP/LSS with a written release to such treatment provider allowing it to inform OLAP/LSS of the lawyer's status at all times.

2. As the lawyer nears the completion of treatment, OLAP/LSS will work with the treatment provider in formulating a discharge and aftercare plan as it relates to the lawyer's obligations as a participant in OLAP/LSS. This would include arranging a visit to the lawyer by a local OLAP/LSS liaison attorney for signing of OLAP/LSS contract.

3. As the lawyer nears the completion of treatment, OLAP/LSS will provide the treatment provider and the lawyer with a list of OLAP-approved aftercare providers and professional peer support groups to be incorporated into the aftercare plan.

4. OLAP/LSS will provide the lawyer with a list of physicians in his or her area who are knowledgeable of chemical dependency and who will provide primary medical care or consultation as required.

5. After the completion of treatment, OLAP/LSS will contact the lawyer on a regular, predetermined basis for monitored submission of any of the following: random urine drug screen, body fluid analysis, and/or breathalyzer test. The urine and/or body fluid test(s) will be forwarded to a National Institute of Alcoholism and Drug Abuse approved laboratory following established legal chain of custody. The results of the tests will be forwarded to OLAP/LSS by the laboratory on a predetermined, timely basis. OLAP/LSS will be notified of any positive test results. Results of breathalyzer tests will be forwarded to OLAP/LSS by the local agency (hospital, treatment center, etc.) that administers the test.

6. Approved aftercare providers will be requested to provide monthly written reports on the lawyer's compliance with attendance.

7. OLAP/LSS will provide the lawyer with the name of a local member of the OLAP/LSS who will act as a mentor attorney. The lawyer will be required to contact the mentor attorney on a weekly basis or other to report his or her progress in recovery. This contact may be made by phone or in person. The mentor attorney will provide OLAP/LSS with status updates on a regular basis.

8. OLAP/LSS will provide documentation of the lawyer's compliance and continuing recovery on a regular basis to any persons or agencies in need of such reports.

9. OLAP/LSS will provide documentation of the lawyer's compliance and continuing recovery, and may, assume an advocacy role in situations when required. This could include appearances with the lawyer before courts, disciplinary proceedings, agencies, employers, potential employers, law partners, etc.

10. OLAP/LSS may take such other actions and impose such additional requirements on the lawyer as it in good faith deems necessary to monitor the lawyer's recovery and to protect and preserve the integrity of the OLAP/LSS.

XIII. WHAT IS THE ROLE OF ALCOHOLICS ANONYMOUS [A.A.] AND OTHER PROGRAMS SUCH AS NARCOTICS ANONYMOUS [N.A.], COCAINE ANONYMOUS [C.A.], AND ALLIED PROGRAMS LIKE ALATEEN AND AL-ANON?

It is not our purpose to try to explain entirely how A.A. works, but it is a grassroots approach to alcoholism treatment that actually works where many times all else has failed. There is no general consensus as to why it works. But, it has had a striking effect on society since its advent in. This particular program addressed living, in the word's fullest sense, without alcohol via a 12-step spiritual program. The program has its roots in the Judeo-Christian ethic. Yet the religious caveats and moralizing are absent, and even an agnostic or atheist can be in the program. What the founders of A.A. discovered is that two or more alcoholics could help each other stay sober and succeed where the individual acting on his own would fail. Thus, while there are strong opinions about A.A., most of which are expressed outside the meetings and outside of the principles on which the program was built, as long as it actually works it must rank as the preeminent approach to the treatment of this particular problem. We would recommend to all of you, if you have not already done so, that you acquaint yourself with the fundamentals of the program.

Further, membership in A.A., N.A., C.A., and Al-Anon, and Alateen (allied programs for the family), has grown by leaps and bounds and the whole family has become part of the treatment and recovery process.

Though acceptance is not complete, there has been a general awakening within society, government, and the medical profession that the problem is treatable, and that A.A. and/or related programs actually work when all else has failed.

As the stigma has faded, industry and business have embraced the concept of early intervention and treatment programs. And, contrary to the experiences of the 50's and 60's, a working relationship has developed between the loosely knit organization of A.A. and a variety of community resources.

XIV. WHAT ARE THE STEPS OF ALCOHOLICS ANONYMOUS?

A. A suggested plan of recovery and relapse prevention.

1. We admitted we were powerless over alcohol (and all other mood altering substances) - that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact

nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics (addicts), and to practice these principles in all our affairs.

B. What, if any, are the guarantees if one chooses to seek help?

1. We are going to know a new freedom and a new happiness.

2. We will not regret the past nor wish to shut the door on it.

3. We will comprehend the word serenity and we will know peace.

4. No matter how far down the scale we have gone, we will see how our experience can benefit others.

5. That feeling of uselessness and self-pity will disappear.

6. We will lose interest in selfish things and gain interest in our fellows.

7. Self seeking will slip away.

8. Our whole attitude and outlook upon life will change.

9. Fear of people and of economic insecurity will leave us.

10. We will intuitively know how to handle situations which used to baffle us.

11. We will suddenly realize that a Higher Power is doing for us what we could not do for ourselves.

"Are these extravagant promises? We think not. They are being fulfilled among us - sometimes quickly, sometimes slowly." Handbook of Alcoholics Anonymous, 1939.

XV. WHAT CAN I DO?

A. Recognize that you have a personal and professional duty to act - to help, whether it is you, yourself, or a colleague or family member who has the disease.

B. The Lawyers Assistance Committee wants to help - and for obvious reasons the earlier the better:

1. Before it reaches even an isolated instance of professional misconduct try to get the person to call the committee.

2. If he or she won't do so - call a member of the committee yourself.

3. We want to help get treatment for the person and restore them to active, healthy and happy lives.

XVI. WHAT IS THE LAWYERS ASSISTANCE COMMITTEE OF THE OHIO STATE BAR ASSOCIATION AND ITS COMPANION ORGANIZATION THE OHIO LAWYERS ASSISTANCE PROGRAM, INC?

The Lawyers Assistance Committee of the Ohio State Bar Association was created in 1977. Its members include representatives of the judiciary, practicing bar, and legal education, many of whom are themselves recovering alcoholics, addicts, or persons recovering from mental health issues, while others are not, but serve only out of a special interest and desire to help.

In an effort to provide even greater service to those who have need of its help, the Lawyers Assistance Committee established the Ohio Lawyers Assistance Program, Inc. (OLAP) in 1991, a non-profit corporation qualified to receive tax deductible contributions under Sec. 501(c)(3) of the Internal Revenue Code., William X. Haase, Esq. (deceased), a retired lawyer with both small and large law firm experience, served as its first full-time Executive Director (1991-1999). Scott R. Mote, J.D., a Columbus attorney, was retained in 1996 as Associate Director to assist in OLAP's expanding workload, and became

Executive Director July 1, 1999. Both Paul A. Caimi, JD, CCDC-I and Stephanie S. Krznarich, MSW, LISW, CCDC-I were retained in early 2002 as Associate Directors to assist in OLAP's continually expanding workload as well as to address mental health concerns in addition to chemical dependency. Through OLAP, the following services are now provided on a full-time basis: (1) confidential advice about individual problems, (2) help in arranging and implementing formal interventions, (3) help in deciding between outpatient and inpatient treatment, and (4) monitoring and aftercare services. Through the so-called Broadbrush Program, OLAP is also presently providing similar services to assist Ohio lawyers who may be suffering from mental health issues other than chemical dependency issues. Any lawyer who feels that OLAP's services may be of help with regard to a lawyer suffering from a mental health issue is encouraged to contact OLAP.

XVII. HOW DO I ACTUALLY CONTACT OLAP?

A. Call OLAP at (1-800-348-4343) or (1-800-618-8606).

B. Anonymity and confidentiality built into procedure.

1. The Lawyers Assistance Committee formulated DR 1-103(C) giving it a privilege for things said to committee members:

Any knowledge obtained by a member of a committee or subcommittee of a bar association, or by a member, employee, or agent of a non-profit corporation established by a bar association, designed to assist lawyers with substance or mental health abuse problems shall be privileged for all purposes under DR 1-103, provided the knowledge was obtained while the member, employee, or agent was performing duties as a member, employee, or agent of the committee, subcommittee, or non-profit corporation.

C. Those seeking advice from the committee or its program and those working through it to carry out interventions are covered by the qualified immunity from a lawsuit in R.C. §2305.28.

D. The following tTreatment centers in the state of Ohio are recommended:

TALBOT HALL AT OSU HOSPITALS EAST
1492 East Broad Street
Columbus, Ohio 43205

(614) 257-3760; 1-800-875-4435

CLEVELAND CLINIC FOUNDATION
9500 Euclid Avenue
Cleveland, Ohio 44195
(216) 444-2200
Assessments: (216) 444-5812; 1-800-223-2273

GLENBEIGH HOSPITAL
2863 State Route 45
P.O. Box 298
Rockcreek, Ohio 44084
(440) 563-3400; 1-800-234-1001

You also can contact your local health department or Ohio Department of Alcohol and Drug Addiction Services (ODADAS) at 614-466-3445 for information.

Please contact OLAP about other treatment options both in and out of state.

XVIII. CONCLUSION.

Lawyers are lousy clients. Likewise, they are difficult patients. The reasons are simple enough: they are trained to deal with and solve problems, and they manage and manipulate people. Thus, it is most difficult for the attorney to seek help since by doing so he or she admits failure as a problem solver. This problem is exacerbated by the fact that the attorney has a tendency to block out the realities of his or her particular situation. Complicating this problem further is the tendency of the attorney's or judge's peers to indulge in a conspiracy of silence, and lighten the normal stresses of our profession. Such efforts accomplish nothing and usually are counterproductive. In a word, covering for good old Joe or Jane is folly or worse!

OLAP works in tandem with local bar lawyers assistance committees, which in turn work with local men and women who are associated with the fellowship of Alcoholics Anonymous and other related organizations in addition to mental health providers. We accept referrals from a judge, a partner or law associate, hospitals, the member himself, and in some cases his or her family.

OLAP hopes that the attorney, judge, law student, or law faculty member will be rehabilitated through hospitalization (if necessary), counseling, psychiatric assistance (if necessary), the application of A.A. principles and mental health support.
NOTE:

These materials on substance abuse originally were edited in 1990 by Prof. Michael Distlehorst, Esq., of the Ethics Institute of Capital University Law School, on behalf of the Lawyer's Assistance Committee of the Ohio State Bar Association, for use in continuing legal education seminars and other programs. The Committee would like to thank the following physicians for advice and consultation in the preparation of various segments of these materials: Dr. Burns Brady, M.D., Dr. Paul Redmond, M.D., and Dr. Craig T. Pratt, M.D.

Revised in December, 1996 by William X. Haase, Esq., Executive Director, and Scott R. Mote, Esq., Associate Director, Ohio Lawyers Assistance Program, Inc.

Revised in July, 2001 by Scott R. Mote, Esq., Executive Director, Ohio Lawyers Assistance Program, Inc.

Revised in May, 2002 by Scott R. Mote, J.D., Executive Director, Stephanie S. Krznarich, LISW, CCDC-I, and Paul A. Caimi, J.D., CCDC-I, Associate Directors, Ohio Lawyers Assistance Program, Inc.

Revised in February, 2003 by Scott R. Mote, J.D., Executive Director, Stephanie S. Krznarich, LISW, CCDC-I, and Paul A. Caimi, J.D., CCDC-I, Associate Directors, Ohio Lawyers Assistance Program, Inc.

EXHIBIT 6

REUTERS

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Wall Street's undertow: drugs and anxiety

Mon Jun 18, 2007 11:45AM EDT

By Tim McLaughlin

NEW YORK (Reuters) - Wall Street's push for record profits is ruining careers, tearing apart families and keeping drug dealers busy, mental health experts say.

While record bonuses make some Wall Street bankers feel invincible, others become emotional wrecks from pressure to perform and some hit rock bottom, experts say.

Harris Stratyner, a psychologist at Caron's New York Recovery Center, said some executives he treats are experimenting with cocaine, opiate-based drugs, Ecstasy and marijuana, as well as abusing alcohol.

"It's like they're chasing a dream. Even when they make tremendous profits, they're still worried," he said.

Alden Cass, a clinical psychologist who counsels Wall Streeters with drug addictions, said drug abuse and high anxiety are undercurrents to the current boom.

"When things are really good, they feel invulnerable," Cass said. "That can lead to adultery, substance abuse, problems with the law."

When it comes to profits, things are really good.

Six of the largest U.S. investment banks -- Goldman Sachs, Lehman Brothers, Citigroup, JPMorgan & Chase Co., Morgan Stanley and Bear Stearns -- combined for $17.6 billion in first-quarter profit this year. That's after shelling out $28.8 billion for pay and benefits, financial statements show.

Those profit and pay figures are more than double those seen in the first quarter of 2000, the last days before the dot-com bubble burst. New York's comptroller estimates Wall Street's 2006 bonuses will generate $1.6 billion in state tax revenue.

COCAINE AND HILLBILLY HEROIN

"To my knowledge, we have not seen an uptick in drug use," Morgan Stanley spokeswoman Jean Marie McFadden said.

The other five firms declined comment or did not return telephone calls.

But Cass said opiate abuse among his clients is rising and they openly talk about being hooked on prescription drugs like OxyContin, known as hillbilly heroin.

"That's what has changed from previous booms on Wall Street," he said.

Cass and Stratyner said their clients sometimes conceal their habits by taking prescription drugs they get for back surgery or sports-related injuries. The Internet has also expanded the black market for drugs.

Wall Street professionals in their 20s use Ritalin and Adderall, prescription drugs used to treat attention-deficit disorder and hyperactivity, to enhance their performance as they grind out 100-hour weeks, Cass said.

Big bonuses and the need to blow off steam have helped invigorate demand for cocaine in Manhattan, according to two junior bankers

who did not want to be named.

J. Rodriguez, convicted of selling drugs to investment bankers and other professionals, said his clients never complained about the p. of cocaine, even as it escalated.

"My customers were all business individuals," Rodriguez said, citing Morgan Stanley bankers as among his clients.

Morgan Stanley said the company has a strong policy against substance abuse and uses random drug testing.

PASSING THE TEST

One hiring manager at a major New York bank said new staff must take a urine test, which is typical for the industry. But he said new hires can choose when to schedule the test during a 45-day period before their start date.

"Our drug test is not so much a test of whether you actually take drugs as it is an intelligence test to see if you can figure out how long it takes to get traces of the drug out of your system," said the manager, who asked not to be named.

The hiring manager said his employer also had a policy of random drug tests for employees but that in several years he had never encountered anyone subjected to such a test.

Drugs are not the only reason for executive meltdowns.

Overwhelming pressure and anxiety to meet profit goals undid star trader David Becker as he rose the Citigroup ladder.

Nine months after becoming global commodities chief, Becker found himself on the fast track to prison. The largest U.S. bank di[illegible]ered in 2004 that Becker and others conspired to overstate profits by $20 million.

[illegible]er, 41, pleaded guilty and is serving a 15-month sentence in federal prison. He declined to comment.

Before he committed his crime, he sought psychiatric help to deal with the pressure of balancing family and career, court papers show.

A metaphor for his life was a painting he owned depicting a man being pulled by all four limbs, Becker's psychiatrist, Dr. Barbara Deutsch, wrote to the judge in the case.

"He felt enormous pressure to make the group's budget at all costs," Deutsch wrote. "He felt identified with this tortured man."

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CHIEF EXECUTIVE

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CEOs Anonymous

Hardly acknowledged, rarely confronted, alcoholism is a stealthy liability that pervades corporate America and puts some of its brightest leaders at risk.

C.J. PRINCE

So far, 2002 has been a rough year for Drew Lewis, former chairman and CEO of Union Pacific Corp. Arrested for drunk driving last July—his second charge—the 70-year-old was sentenced on Jan. 11 to 30 days in jail, which he served in an alcohol treatment center, a $5,000 fine and 40 days of community service. He also had his driver's license revoked for 23 months.

Perhaps more stinging than the particulars of his sentence, though, were the humiliating circumstances of his most recent episode: Lewis reportedly overturned his Lincoln Navigator while pulling out of his own driveway. When officers freed him from the car, he was tested and found to have a blood-alcohol content of 0.30 percent—three times the legal limit in Pennsylvania. CNN reported that, in an apologetic letter to the judge prior to sentencing, Lewis called the incident "a wake-up call I will never forget."

For Lewis' sake, one hopes it's true. Sadly, his long, colorful career, which includes service as Secretary of Transportation under Ronald Reagan, has been peppered with similar reality checks. In 1994, while still CEO of Union Pacific, Lewis was given a five-week pass to an alcohol rehabilitation clinic, and was issued an ultimatum by his board: get help or don't come back. Fourteen months later, he was arrested for driving while under the influence; the story made headlines in papers across the country. Lewis stayed on at Union Pacific until December 1996, when he retired as planned.

To those not familiar with alcoholism, Lewis' lapses in sobriety might look like a case of poor will power or a lack of self-control. And few CEOs could imagine themselves winding up in his shoes. But according to the National Institute on Alcohol Abuse and Alcoholism, one in every 13 adults in the United States abuses alcohol or is an alcoholic. While no similar statistics are available on the number of CEOs diagnosed with the dependency, there's no reason to believe that this disease—like diabetes or hypertension—does not pervade the CEO ranks just as it does any group, according to Dr. James Fearing, president and CEO of Minneapolis-based National Counseling Intervention Services. "It doesn't matter who you are, where you come from, what level you're at in the company, or how much money you have," he says. "It's an equal-opportunity disease."

Fearing estimates that in 2001 alone, his firm, which coordinates executive interventions and counsels companies on workplace addiction, intervened in 25 to 50 C-suite-level cases, primarily in mid- and large-size companies. "Prior to the last three or four years, it might have been upper management, but not top management," he says. "Now we're doing more interventions in the board room."

It's not that executives are drinking more, he adds, but that those around them are more aware of the problem. CEO health has gained greater attention in recent years. And with boards increasingly independent and shareholders more vigilant, CEOs are more likely today to be called on the carpet for any behavior considered unhealthy.

But despite a greater willingness to confront CEOs, the problem is still kept quiet. Stereotypes and misconceptions about alcoholism abound, making it a dirty word inside and outside corporate board rooms. While a CEO might be admired informally for recognizing his or her problem and seeking help for it, Wall Street typically doesn't applaud such candor and self-awareness. Over the years, a small handful of CEOs have gone public with their personal battles, but untold cases remain shuttered away, with boards, employees and CEOs themselves colluding to make addiction in the corner office one of the best-kept secrets in corporate America.

Denial: The CEO's first line of defense

As most recovering alcoholics attest, recovery starts with the addict's acknowledging the problem and admitting he or she needs help—a tall order for CEOs, who may be good at diagnosing problems within their companies, but are typically loathe to admit such weakness in themselves. Corporate culture itself helps to blur the line between social drinker and problem drinker. Five-martini lunches may be passé, but drinking is still prominent, particularly in industries such as advertising, entertainment and hospitality, according to Fearing. CEOs, like other executives, may see it as part of their job to have a few highballs at a business

dinner or to let loose a bit at the company holiday party. Certainly, Southwest Airlines' share price never suffered because of Kelleher's notorious Wild Turkey consumption; in fact, his party-boy image seemed only to endear him to employees and shareholders.

But experts say the stories of Kelleher's drinking were more fable than fact and that if he were consuming as much as he claimed, he'd be in for a rude awakening. For most, the addiction develops gradually, and those afflicted may not notice it until it's already a serious problem. Red McCombs, owner of the Minnesota Vikings and CEO of Red McCombs Enterprises, had his epiphany after 25 years of "moderate social drinking," as he describes it. "I realized it had become a negative issue with me," he says, "and it's quite a depressing thought because you think, 'this couldn't happen to me.'"

He's not alone. Sam Johnson, former CEO of consumer chemical products maker S.C. Johnson & Son, in his recently released autobiographical documentary, *Carnauba: A Son's Memoir*, candidly describes coming to terms with his addiction. During a period of denial in the early '90s, his wife and children pleaded with him to check into the Mayo Clinic to get help. Johnson refused twice before going. "I was struggling with that," he told the *Milwaukee Journal Sentinel* last August. "I was chairman of the Mayo Clinic."

Not surprisingly, the stereotypical images of addiction fail to line up with self-perceptions of successful corporate leaders. "We had one person who thought, 'I only have a substance abuse problem if I end up living in a cardboard box and eating out of dumpsters,'" says Dr. Scott Stacy, director of psychological services at the Professional Renewal Center, a Lawrence, Kans.-based clinic that offers a treatment program for professionals called INSIGHT Executive Consultation Services. "'So since I'm not, therefore, I'm not a drunk.'"

Other negative, albeit less dramatic associations—weakness, helplessness—don't sit well either. "Many CEOs want to be viewed as models of decisiveness and as being as totally together as possible, so it's very difficult for them," says Gene Morrissy, corporate psychologist with management consultancy RHR International. They also tend to hold themselves to inhumanly high standards, in part fueled by the expectations around them, adds Stacy. "There is a misconception that a strong leader has to be in control of everything," he says. "If a CEO's own life becomes unmanageable, the anxiety that goes along with admitting that can be very overwhelming. Some will do anything they can to avoid it."

That includes hiding their habit from others. McCombs managed to get through years of drinking without arousing the suspicion or concern of family, friends or colleagues. "When you become addicted, you become very much aware that you shouldn't show that in public places, so you become more and more of a closet drinker," he explains. "It's something you're trying to hide." But even without pressure from others, McCombs knew he had to quit. "Once you realize you're hooked on a chemical, you have to find a way to get off of it because it's so depressing that it's hard to live with it unless you stay high." After a year of praying for a way out, the answer arrived serendipitously: McCombs became ill with hepatitis and, through his hospitalization, detoxed. He's been sober for 24 years. "I feel like, at age 50, God gave me a new life," he says. "And it really energized me to realize I didn't have to drink anymore."

Intervention and counseling experts say that despite the fact that their performance is monitored, CEOs, isolated by power and position, have a relatively easy time concealing their addictions. "Generally speaking, there aren't a whole lot of people willing to tell them the truth," says Morrissy. "And in a situation like this, they may be even less likely to confront the issue. The CEO then becomes more isolated, which gives him or her more room to engage in that substance abuse."

Clifton Morris, co-founder, chairman and former CEO of AmeriCredit, an auto finance company in Fort Worth, Tex., with $818 million in revenues, sums it up more bluntly. "It's already lonely at the top. How is a CEO going to find anybody to talk to when he's a drunk?"

Morris would know. Though he wasn't a CEO yet, he had very few friends by the time he got sober in 1979. Even after he was fired in 1971 from his position as CFO of Service Corp. International, a Houston-based funeral services company he helped build, Morris still believed he could control his drinking. Eight years later he found himself living at the home of a waitress who served at the gin mill he frequented. By then he was in both physical and financial straits. "I had $13, 48 creditors, two default judgments, I weighed 140 pounds, and my liver weighed 40 pounds," Morris recounts in his thick, southern drawl, "and yellow was not my most becoming color."

Finally, one day, he was talking on the phone with the lawyer handling his third divorce, also a former fraternity brother from his university days. "He said, 'Cliff, you have to check into a hospital.'" The next morning, he did. Since entering Alcoholics Anonymous, Morris hasn't touched alcohol. "And my life has gotten better every single day for 23 years," he says. Morris has always credited AA with his recovery, and he is such a strong believer in its principles that he patterned much of AmeriCredit's corporate culture around them. He keeps a copy of the "Big Book"—a practical guide to AA's 12-step program—on a shelf in his

off in case he should come across someone who needs it.

Morris acknowledges that he had to hit bottom before he could seek help. But he adds that the interventions that have become more common today might have helped. "They weren't even on the map when I got sober," he says. "But they work. Because even if they don't work, they ruin your drinking for sure." Having the spotlight trained on the addiction drags the CEO out of denial. "You'll never have another happy drink," Morris promises.

Executive Interventions: Raising the bottom

That's what intervention specialists hope for when they convene groups to confront addicted professionals. It's also what Fearing of National Counseling Intervention Services calls "raising the bottom" for troubled CEOs. "All interventions are successful in that they break through the conspiracy of silence," he says. But the really successful interventions have to have some muscle behind them. That is, the team confronting the CEO must include colleagues he or she respects and admires, possibly family, and at least one board representative who has the power to unseat the CEO if he or she refuses treatment. The board has to have already considered the financial, operational and other implications of firing the chief, and has to be fully willing to make good on the threat.

That's a more complicated choice in cases where the CEO still seems to be performing well—or when it's not as clear that the situation is likely to worsen. A few years ago, Korn/Ferry International Vice Chairman Peter Crist got a call from a board member of a public company that had begun noticing their CEO was consuming a lot more alcohol than they thought appropriate. "They were struggling with this because, as a player, he was a very good CEO," recalls Crist. "I basically advised them that there was little they could do at that time because there was no performance issue." Over the course of the next year, however, as more incidences of excessive drinking were reported back to Crist, it became clear there was a problem and he recommended that the CEO's closest friend on the board have a private conversation with him, which he did. About four or five months later, Crist learned that after several conversations, the CEO had decided to seek help.

Fearing calls those CEOs who continue to perform well with an addiction the "not-yets." They don't know yet that there's a problem, he says. "But as the progressiveness of the illness takes its course, they will not be able to hide it." For boards, the question becomes, how long should we wait?

In most cases, board members, who may themselves deny the problem exists, are not aware of all the risks involved in quietly hoping that the CEO sobers up and turns himself around. For one thing, a drinking CEO's distraction can lead to decreased productivity among others, says Morrissy. And the accompanying moodiness or unpredictability can inhibit direct reports from consulting with him or her on important decisions. "They don't know which CEO is going to show up on a given day," says Morrissy. "So the CEO who is usually in a bubble is now in a bubble within a bubble."

Add to that the exposure to lawsuits, from clients to shareholders to employees, and the costs start to add up, particularly when it takes only one incident of inappropriate behavior—say, sexual harassment or negligence—to tarnish a company's reputation and cost it millions in damages. During a company holiday party, for example, the senior executive just under the CEO at a mid-sized Minneapolis company drank a few too many and began misbehaving. "He was in the copy room, of all places, and grabbed a woman," recalls Fearing. "He was under the influence at the time, and she won the lawsuit for an awful lot of money."

To avoid that kind of grief, National Counseling Intervention Services advises early confrontation—assuming enough hard evidence is on hand, because without proof, most CEOs won't bite. When the president of one Midwestern company flatly denied having a problem with alcohol at his intervention, Fearing was ready with a list of specific incidents, including a report from the company's banker that the president had been slurring his speech in a meeting, and of the president driving a company car while intoxicated. "So I was able to say, 'Wait, let's look at the facts.' And once I did that, it changed the whole intervention from that point." The president opted for a five-week treatment program and returned to his job.

Seeking treatment: Public or private affair?

Most treatment programs involve at least a four-week stay at a rehabilitation clinic, followed by a plan for ongoing treatment and support, including individual or peer group therapy. The company typically foots the clinic bill—usually sans insurance, lest there be a record of the treatment, says Fearing. Experts estimate the monthly cost at anywhere from $15,000 to $40,000, depending on the facility and length of stay. "That's peanuts compared with how much it costs to bring in a new CEO," says Stacy. "particularly if that CEO is otherwise a very creative, dynamic leader."

Figuring out creative ways to explain the CEO's extended absence is another matter. Usually, the boss will be said to be traveling on business" or vacationing, or both, says Fearing. But the company almost never reveals the truth. "I've gotten calls [from the press] regarding different cases and obviously I can't even acknowledge that I know the person, much less what's involved," he adds.

The secrecy is certainly understandable. Companies and boards have enough to cope with in terms of financial performance ...ut trying to explain away newly revealed liabilities in its leadership. And assuming the CEO returns, they don't want his or ... alcoholism to be a focus. They're also not required by SEC rules to disclose personal illnesses—though they are vaguely directed to reveal information considered "material."

To be sure, Union Pacific's decision to go public with Lewis' leave of absence when he entered treatment in 1994 was considered highly unusual—not to mention risky, given that the $15 billion railroad was right in the middle of a multi-billion-dollar bidding war with Burlington Northern over the acquisition of Santa Fe Pacific Corp. Their motives were never made public, but some speculated that UP's board was attempting to head off rumors or prevent fallout in the event that the truth leaked out some other way. They may even have been influenced by events six months earlier, when a CEO's addiction, previously undisclosed, made headlines when circumstances turned tragic. In May, 1994, Wardell Lazard, 44-year-old founder and CEO of W.R. Lazard & Co., was found dead of an accidental overdose of cocaine and alcohol, and the shocking news was ultimately a fatal blow for the investment bank, which was once the largest minority-owned underwriter in the country.

Board decisions aside, recovering CEOs themselves aren't motivated to tell all, particularly when it seems those who have disclosed are dogged by the label throughout their careers. While no CEO search experts would go on record saying so, at least one admitted he would have to think twice about recommending a recovering alcoholic, however talented, for a top spot—not because he would doubt that candidate's abilities, but because the stereotypes would cloud an otherwise positive story in the following day's financial pages. Tyson Foods CEO John Tyson, who declined to be interviewed, will likely always face questions about his cocaine and alcohol addiction, no matter what other successes—or troubles, more recently—the company trumpets. Sam Johnson, too, has buttoned up, after revealing his story in his documentary; in declining an interview for this piece, his spokesperson said Johnson "feels he's said all he needs to say about this topic."

Some CEOs may remain quiet simply because the principles of AA demand anonymity, even among celebrities. Morris, for example, expressed serious concerns about violating that principle for this article, although he had already told his story in other regional publications. One concern expressed by advocates of anonymity is that addicts will be deterred from seeking help for fear their illness will be disclosed. Others worry that a public figure's relapse, such as Lewis', will raise doubts about the ...am's effectiveness.

...t the public needs to be educated that relapse is a part of recovery," says Professional Renewal Center's Stacy. "It's not a ...ure-all like an antibiotic. And if you're hiding the fact that relapse is a possibility, you're putting unrealistic expectations in people's hearts and minds."

It's a big responsibility to come clean, he adds, but stereotypes fade only when truth is revealed, and, in this case, when more CEOs are willing to risk bad publicity to raise awareness about the disease. "The less mental illness and addiction issues are stigmatized, the better," says Stacy, "and the easier it will be to have people get help without a tremendous amount of shame."

Please send your comments to *CE* at features@chiefexecutive.net.

When It's Time to Get Help

In a culture where deals are made on a handshake but sealed over a clink of glasses or two or three it's hard to tell how much is too much, or too often. Given that it's not a science, what are the signs that one's casual drinking has become an after hours problem?

That depends on whom you ask, and symptoms vary by individual. But "if you're even thinking it might be a problem, then it is," says Dr. Scott Stacy of the Professional Renewal Center. "You may not be dependent on that substance, but it calls for exploration."

Minnesota Vikings owner Red McCombs advises a trial separation. "Just try to stop for a couple of weeks, or even a week," he offers. "If you're addicted, you won't be able to."

AmeriCredit Chairman Clifton Morris, on the other hand, had proven he could sober up for months at a time. Yet without going ...ough the recovery steps of Alcoholics Anonymous and acknowledging his addiction, he always returned to the bottle and hit ...harder than he had before. Which is why he warns CEOs who have a problem that fear of losing their careers or their status isn't a good reason not to get help. "They're going to lose it anyway," he says. "You can't hide that for very long because of the ...rogressive nature of the disease."

Experts agree that alcoholism can and often does progress to tragic ends if left untreated, and they increasingly reject the

"on that one has to hit bottom before getting help. "Many people will die today in the United States based on that old idea," James Fearing, CEO of National Counseling Intervention Services. "We know better than that now."

Of course, not all casual indulgence leads to addiction, and recovering addicts say the key is for CEOs to monitor their own behavior as carefully as they do their companies' financials and to be brutally honest with themselves about what they see. "Most people can drink and don't have any addictive problems. Unfortunately some do," says McCombs. "When you do, it's something you have to take care of or it'll take care of you."

For more information on executive interventions, call National Counseling Intervention Services at 1 800 279 3321 or visit their Web site at www.nationalcounseling.com.

EXHIBIT 7

U.S. Census Bureau
American FactFinder

Connecticut
ACS Demographic and Housing Estimates: 2006-2008
Data Set: **2006-2008 American Community Survey 3-Year Estimates**
Survey: **American Community Survey**

NOTE. Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

For more information on confidentiality protection, sampling error, nonsampling error, and definitions, see Survey Methodology.

ACS Demographic and Housing Estimates	Estimate	Margin of Error	Percent	Margin of Error
SEX AND AGE				
Total population	3,493,006	*****	3,493,006	(X)
Male	1,701,789	+/-690	48.7%	+/-0.1
Female	1,791,217	+/-690	51.3%	+/-0.1
Under 5 years	211,752	+/-327	6.1%	+/-0.1
5 to 9 years	220,450	+/-3,211	6.3%	+/-0.1
10 to 14 years	236,542	+/-3,214	6.8%	+/-0.1
15 to 19 years	250,303	+/-791	7.2%	+/-0.1
20 to 24 years	221,310	+/-659	6.3%	+/-0.1
25 to 34 years	400,908	+/-913	11.5%	+/-0.1
35 to 44 years	525,691	+/-869	15.0%	+/-0.1
45 to 54 years	554,090	+/-767	15.9%	+/-0.1
55 to 59 years	220,106	+/-2,508	6.3%	+/-0.1
60 to 64 years	178,944	+/-2,561	5.1%	+/-0.1
65 to 74 years	229,910	+/-517	6.6%	+/-0.1
75 to 84 years	164,673	+/-1,745	4.7%	+/-0.1
85 years and over	78,327	+/-1,660	2.2%	+/-0.1
Median age (years)	39.1	+/-0.1	(X)	(X)
18 years and over	2,673,711	+/-223	76.6%	+/-0.1
21 years and over	2,523,810	+/-2,354	72.3%	+/-0.1
62 years and over	572,980	+/-2,406	16.4%	+/-0.1
65 years and over	472,910	+/-441	13.5%	+/-0.1
18 years and over	2,673,711	+/-223	2,673,711	(X)
Male	1,282,510	+/-335	48.0%	+/-0.1
Female	1,391,201	+/-318	52.0%	+/-0.1
65 years and over	472,910	+/-441	472,910	(X)
Male	194,583	+/-335	41.1%	+/-0.1
Female	278,327	+/-301	58.9%	+/-0.1
RACE				
Total population	3,493,006	*****	3,493,006	(X)
One race	3,422,833	+/-3,490	98.0%	+/-0.1
Two or more races	70,173	+/-3,490	2.0%	+/-0.1
One race	3,422,833	+/-3,490	98.0%	+/-0.1
White	2,790,080	+/-5,600	79.9%	+/-0.2
Black or African American	327,433	+/-2,881	9.4%	+/-0.1
American Indian and Alaska Native	7,990	+/-834	0.2%	+/-0.1
Cherokee tribal grouping	1,379	+/-471	0.0%	+/-0.1
Chippewa tribal grouping	147	+/-177	0.0%	+/-0.1

Connecticut - ACS Demographic and Housing Estimates: 2006-2008

ACS Demographic and Housing Estimates	Estimate	Margin of Error	Percent	Margin of Error
Navajo tribal grouping	33	+/-51	0.0%	+/-0.1
Sioux tribal grouping	53	+/-52	0.0%	+/-0.1
Asian	116,879	+/-1,341	3.3%	+/-0.1
Asian Indian	40,057	+/-2,261	1.1%	+/-0.1
Chinese	28,342	+/-2,066	0.8%	+/-0.1
Filipino	10,376	+/-1,332	0.3%	+/-0.1
Japanese	3,016	+/-663	0.1%	+/-0.1
Korean	9,016	+/-1,654	0.3%	+/-0.1
Vietnamese	8,443	+/-1,461	0.2%	+/-0.1
Other Asian	17,629	+/-1,946	0.5%	+/-0.1
Native Hawaiian and Other Pacific Islander	1,146	+/-235	0.0%	+/-0.1
Native Hawaiian	632	+/-325	0.0%	+/-0.1
Guamanian or Chamorro	146	+/-109	0.0%	+/-0.1
Samoan	26	+/-44	0.0%	+/-0.1
Other Pacific Islander	342	+/-187	0.0%	+/-0.1
Some other race	179,305	+/-6,429	5.1%	+/-0.2
Two or more races	70,173	+/-3,490	2.0%	+/-0.1
White and Black or African American	21,451	+/-1,972	0.6%	+/-0.1
White and American Indian and Alaska Native	10,587	+/-766	0.3%	+/-0.1
White and Asian	9,530	+/-1,164	0.3%	+/-0.1
Black or African American and American Indian and Alaska Native	4,398	+/-812	0.1%	+/-0.1
Race alone or in combination with one or more other races				
Total population	3,493,006	*****	3,493,006	(X)
White	2,847,338	+/-6,510	81.5%	+/-0.2
Black or African American	364,447	+/-2,573	10.4%	+/-0.1
American Indian and Alaska Native	27,075	+/-1,272	0.8%	+/-0.1
Asian	130,743	+/-1,016	3.7%	+/-0.1
Native Hawaiian and Other Pacific Islander	2,593	+/-588	0.1%	+/-0.1
Some other race	196,878	+/-6,028	5.6%	+/-0.2
HISPANIC OR LATINO AND RACE				
Total population	3,493,006	*****	3,493,006	(X)
Hispanic or Latino (of any race)	405,724	*****	11.6%	*****
Mexican	41,778	+/-3,798	1.2%	+/-0.1
Puerto Rican	222,072	+/-4,286	6.4%	+/-0.1
Cuban	7,521	+/-1,099	0.2%	+/-0.1
Other Hispanic or Latino	134,353	+/-4,995	3.8%	+/-0.1
Not Hispanic or Latino	3,087,282	*****	88.4%	*****
White alone	2,586,459	+/-1,633	74.0%	+/-0.1
Black or African American alone	315,348	+/-2,513	9.0%	+/-0.1
American Indian and Alaska Native alone	6,172	+/-681	0.2%	+/-0.1
Asian alone	115,444	+/-1,356	3.3%	+/-0.1
Native Hawaiian and Other Pacific Islander alone	1,101	+/-225	0.0%	+/-0.1
Some other race alone	14,710	+/-2,086	0.4%	+/-0.1
Two or more races	48,048	+/-2,618	1.4%	+/-0.1
Two races including Some other race	2,927	+/-712	0.1%	+/-0.1
Two races excluding Some other race, and Three or more races	45,121	+/-2,531	1.3%	+/-0.1
Total housing units	1,438,041	+/-227	(X)	(X)

Source: U.S. Census Bureau, 2006-2008 American Community Survey

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

Notes:
·For more information on understanding race and Hispanic origin data, please see the Census 2000 Brief entitled, Overview of Race and Hispanic Origin, issued March 2001, (pdf format)
·While the 2008 American Community Survey (ACS) data generally reflect the November 2007 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in ACS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities. The 2008 Puerto Rico Community Survey (PRCS) data generally reflect the November 2007 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in PRCS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities.
·Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2000 data. Boundaries for urban areas have not been updated since Census 2000. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Explanation of Symbols:

1. An '**' entry in the margin of error column indicates that either no sample observations or too few sample observations were available to compute a standard error and thus the margin of error. A statistical test is not appropriate.
2. An '-' entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution.
3. An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution.
4. An '+' following a median estimate means the median falls in the upper interval of an open-ended distribution.
5. An '***' entry in the margin of error column indicates that the median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
6. An '*****' entry in the margin of error column indicates that the estimate is controlled. A statistical test for sampling variability is not appropriate.
7. An 'N' entry in the estimate and margin of error columns indicates that data for this geographic area cannot be displayed because the number of sample cases is too small.
8. An '(X)' means that the estimate is not applicable or not available.

The letters PDF or symbol indicate a document is in the Portable Document Format (PDF). To view the file you will need the Adobe® Acrobat® Reader, which is available for free from the Adobe web site.

EXHIBIT 8

U.S. Census Bureau
American FactFinder

Connecticut
S1901. Income in the Past 12 Months (In 2008 Inflation-Adjusted Dollars)
Data Set: 2006-2008 American Community Survey 3-Year Estimates
Survey: American Community Survey

NOTE. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see Survey Methodology.

Subject	Households	Margin of Error	Families	Margin of Error	Married-couple families	Margin of Error	Nonfamily households	Margin of Error
Total	1,325,680	+/-2,831	889,222	+/-4,590	675,359	+/-5,509	436,458	+/-4,097
Less than $10,000	5.3%	+/-0.2	3.0%	+/-0.2	0.8%	+/-0.1	10.9%	+/-0.4
$10,000 to $14,999	4.0%	+/-0.2	1.9%	+/-0.1	0.7%	+/-0.1	8.7%	+/-0.4
$15,000 to $24,999	8.0%	+/-0.2	5.1%	+/-0.2	2.9%	+/-0.2	14.4%	+/-0.5
$25,000 to $34,999	7.9%	+/-0.2	6.2%	+/-0.2	4.3%	+/-0.2	11.9%	+/-0.5
$35,000 to $49,999	11.5%	+/-0.2	9.9%	+/-0.3	8.1%	+/-0.3	14.9%	+/-0.5
$50,000 to $74,999	17.6%	+/-0.3	17.3%	+/-0.4	16.5%	+/-0.4	18.0%	+/-0.6
$75,000 to $99,999	14.2%	+/-0.3	16.0%	+/-0.4	17.3%	+/-0.4	9.8%	+/-0.4
$100,000 to $149,999	16.7%	+/-0.3	20.9%	+/-0.4	24.8%	+/-0.4	7.0%	+/-0.3
$150,000 to $199,999	6.8%	+/-0.2	8.9%	+/-0.2	11.0%	+/-0.3	2.1%	+/-0.2
$200,000 or more	8.1%	+/-0.2	10.9%	+/-0.2	13.7%	+/-0.3	2.3%	+/-0.2
Median income (dollars)	68,411	+/-584	84,657	+/-593	99,084	+/-885	39,021	+/-723
Mean income (dollars)	95,430	+/-826	114,065	+/-1,111	132,293	+/-1,408	54,156	+/-851
PERCENT IMPUTED								
Household income in the past 12 months	27.5%	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Family income in the past 12 months	(X)	(X)	27.9%	(X)	(X)	(X)	(X)	(X)
Nonfamily income in the past 12 months	(X)	(X)	(X)	(X)	(X)	(X)	25.1%	(X)

Source: U.S. Census Bureau, 2006-2008 American Community Survey

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

Notes:
·While the 2008 American Community Survey (ACS) data generally reflect the November 2007 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in ACS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities. The 2008 Puerto Rico Community Survey (PRCS) data generally reflect the November 2007 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in PRCS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities.
·Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2000 data. Boundaries for urban areas have not been updated since Census 2000. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Explanation of Symbols:
1. An '**' entry in the margin of error column indicates that either no sample observations or too few sample observations were available to compute a standard error and thus the margin of error. A statistical test is not appropriate.
2. An '-' entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution.
3. An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution.
4. An '+' following a median estimate means the median falls in the upper interval of an open-ended distribution.
5. An '***' entry in the margin of error column indicates that the median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
6. An '*****' entry in the margin of error column indicates that the estimate is controlled. A statistical test for sampling variability is not appropriate.
7. An 'N' entry in the estimate and margin of error columns indicates that data for this geographic area cannot be displayed because the number of sample cases is too small.
8. An '(X)' means that the estimate is not applicable or not available.

EXHIBIT 9

Recognition of Alcohol and Substance Abuse

DAVID J. MERSY, M.D., HealthPartners Spring Lake Park Clinic, Spring Lake Park, Minnesota

Ten percent of the population abuses drugs or alcohol, and 20 percent of patients seen by family physicians have substance-abuse problems, excluding tobacco use. These patients can be identified by relying on regular screening or a high index of suspicion based on "red flags" that can be noted in various clinical situations. The modified CAGE questionnaire is an excellent screening instrument, but several alternatives are available. The best screening test is one that the physician will routinely use well. Laboratory indicators such as gamma-glutamyl transpeptidase, mean corpuscular volume, and carbohydrate-deficient transferrin are nonspecific but can add to the evidence of alcohol abuse. If problem alcohol use is diagnosed, even brief physician advice can be helpful. If the problem has progressed to addiction, referral to an addiction specialist or treatment center is recommended. Special issues arise in dealing with substance abuse in adolescents, elderly patients, and patients with mental illness, but the family physician can play an important role in recognizing this common problem. (Am Fam Physician 2003;67:1529-32,1535-6. **Copyright© 2003 American Academy of Family Physicians.)**

A patient information handout on substance abuse and problem drinking, written by the author of this article, is provided on page 1535.

Members of various family practice departments develop articles for "Problem-Oriented Diagnosis." This is one in a series from the Department of Family and Community Medicine Education at Albany Medical College, Albany, N.Y. Guest editors of the series are Neil C. Mitnick, D.O., and Mary F. Smith, Ph.D.

Substance abuse, defined as the problematic use of alcohol, tobacco, or illicit drugs, has been called the nation's number one health problem.[1] The costs to society are enormous; the National Institute on Alcohol Abuse and Alcoholism estimates that alcohol and drug abuse are associated with 100,000 deaths per year and cost society $100 billion per year.[2]

It is thought that approximately 10 percent of American adults have a problem with drugs or alcohol, and an estimated 20 percent of patients seen by family physicians have substance-abuse problems, excluding tobacco use.[3] Patients who abuse alcohol and drugs are much more likely to develop medical problems than the general population.

Definitions

The American Medical Association recognized alcoholism as a disease in 1956. Early editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) required the presence of tolerance or withdrawal symptoms before a diagnosis of alcohol or drug dependence could be made. In the fourth edition of this publication, the requirements shifted to loss of control and failure to abstain from using the substance despite evidence of the problems it causes.[4] A practical approach for the family physician is to define addiction as the continued use of mood-altering chemicals despite an identified medical or social contraindication. This definition is helpful because physicians do not have to consider the amounts of substances being used or the duration of use.

The distinction between addiction and problem use is particularly important. The problem drinker or drug user may have undiagnosed medical or social problems but not yet have experienced a major loss of control. In full-blown addiction, patients continue using alcohol or drugs despite negative consequences, have a compulsion to continue using alcohol or drugs, and are in denial about the effects on themselves and others.

Approach to the Patient

Patients can present with "red flags" for alcohol and drug problems *(Table 1)*.[5] These warnings can be detected during physical examinations or by screening during consultations for atypical progress of medical problems. Although none of the red flags is pathognomonic for alcohol or drug problems, the presence of even one should raise suspi-

See page 1413 for definitions of strength-of-evidence levels.

See editorial on page 1443.

TABLE 1
"Red Flag" Complaints for Substance-Abuse Problems

Frequent absences from school or work	Gastrointestinal symptoms, such as epigastric distress, diarrhea, or weight changes
History of frequent trauma or accidental injuries	Sexual dysfunction
Depression or anxiety	Sleep disorders
Labile hypertension	

Adapted with permission from Schulz JE, Parran T Jr. Principles of identification and intervention. In: Graham AW, Schultz TK, Wilford BB, eds. Principles of addiction medicine. 2d ed. Chevy Chase, Md.: American Society of Addiction Medicine, 1998:250.

TABLE 2
Physical Findings that Suggest Alcohol and Other Drug Problems

Mild tremor
Odor of alcohol on breath
Enlarged, tender liver
Nasal irritation (suggestive of cocaine insufflation)
Conjunctival irritation (suggestive of exposure to marijuana smoke)
Labile blood pressure, tachycardia (suggestive of alcohol withdrawal)
"Aftershave/mouthwash" syndrome (to mask the odor of alcohol)
Odor of marijuana on clothing
Signs of chronic obstructive pulmonary disease, hepatitis B or C, HIV infection

HIV = human immunodeficiency virus.

Adapted with permission from Schulz JE, Parran T Jr. Principles of identification and intervention. In: Graham AW, Schultz TK, Wilford BB, eds. Principles of addiction medicine. 2d ed. Chevy Chase, Md.: American Society of Addiction Medicine, 1998:251.

cion. In addition to the typical signs, a history of relationship difficulties, poorly explained trauma, or convictions for driving while intoxicated (DWI) should raise suspicion.

A number of physical findings can suggest alcohol or other drug problems *(Table 2)*.[5] Another warning flag pops up when a patient with a chronic disease fails to respond in the expected manner to treatment, such as a patient with diabetes whose glucose level becomes more difficult to control or a patient with hypertension whose blood pressure becomes more difficult to manage despite apparently optimal therapy and supposed compliance.

It is still important to screen all patients for drug and alcohol use when there are no obvious red flags, suspicious physical findings, or atypical features of chronic disease. Screening should be done whenever possible but particularly at the time of the periodic evaluation. In selecting a screening tool, the physician should decide between using a screening test or focusing on the amount of alcohol consumed.

The American Society of Addiction Medicine has developed standards for a positive screen based on the number of drinks ingested per week. Using this standard, a positive screen is considered consumption of more than 14 drinks per week or more than four drinks per occasion for men. For women, a positive screen is more than seven drinks per week or more than three drinks per occasion.[6] The numbers for women are lower because it takes fewer drinks for women to experience the negative consequences of alcohol consumption.[7] If the screen is positive, the physician should take a more extensive history and consider physical examination and laboratory evaluation. The latter can help rule out a false-positive screen and classify the patient as a problem drinker or an alcoholic.

Several other screening tools are available, but the CAGE questionnaire and the conjoint screening test are the most practical for family physicians. CAGE is a mnemonic for a questionnaire that asks about attempts to *C*ut down on drinking, *A*nnoyance with criticisms about drinking, *G*uilt about drinking, and using alcohol as an *E*ye opener.[8,9] The test requires approximately one minute to complete, and although it does not diagnose alcoholism or problem drinking, it should prompt the physician to look further.

The CAGE questionnaire does not differentiate between current and former problems, and it is more accurate in detecting alcoholism than problem drinking. Screening for other substances can be incorporated into the CAGE format by simply including references to them in the questions.[10] The CAGE questionnaire is thought to be 60 to 90 percent sensitive when two or more questions are positive and 40 to 60 percent specific for excluding substance abuse.

> "A key feature of addiction is continued use of the substance despite negative consequences."

Both the CAGE questionnaire and the conjoint screening test perform well as screening tools for substance abuse.

The conjoint screening test is even shorter, involving only two questions: "In the past year, have you ever drunk or used drugs more than you meant to?" and "Have you felt you wanted or needed to cut down on your drinking or drug use in the past year?"[11] When primary care patients were studied, at least one positive response detected current substance-use disorders with nearly 80 percent sensitivity and specificity. As with all screening tests, performance varies with the prevalence of substance abuse in the particular population screened.

It is more important for physicians to pick a screening tool and use it routinely than to try to find the best screening method in each situation. The best method is the one that physicians use on a regular basis. No single screening test can diagnose substance abuse, but a positive screen raises suspicion and should prompt physicians to investigate further.

Laboratory Evaluation

Although many laboratory tests have been used in the evaluation of substance abuse, none is diagnostic. The most useful laboratory tests to confirm alcohol-abuse problems are gamma-glutamyl transpeptidase (GGT), mean corpuscular volume (MCV), and carbohydrate-deficient transferrin (CDT). A urine toxicology screen is the best test to confirm problems with other drugs.

The serum GGT determination is one of the most widely used laboratory tests. This hepatic enzyme is elevated in patients who use alcohol excessively.[12] The test has a higher sensitivity than specificity because other conditions, such as nonalcoholic liver disease, hyperthyroidism, and use of anticonvulsants, can elevate GGT levels.[13]

MCV also has been used as a marker of heavy alcohol consumption. It tends to be less sensitive than measurement of the GGT level, but an elevated MCV level combined with an elevated GGT level should raise suspicion about alcohol abuse.[12]

CDT tests are available to screen for excessive alcohol consumption. It has been estimated that four to seven drinks per day for at least one week can significantly elevate CDT levels in patients with alcoholism.[14]

Special Populations

Recognition of substance abuse in adolescents, geriatric patients, and patients with mental illness provides special challenges.

Drug and alcohol use during adolescence differs from use in adults. The typical acting out of adolescents can be confused with the effects of drug and alcohol use. Adolescents' mistrust of adult authority frequently complicates the detection of substance abuse. A family physician who has interacted with an adolescent over time probably is trusted more than other adult authority figures. The best chance for the physician to detect problems is in the context of routine medical care.[15] Family physicians need to be aware of potential problems and modify the CAGE questionnaire to screen for both drugs and alcohol.

Older patients with alcoholism fall into two groups. The early-onset group had alcoholism earlier in life, while problems in the late-onset group begin after the age of 60.[16] Several studies have evaluated the efficacy of the CAGE questionnaire in elderly patients. While the overall sensitivity and specificity are quite good, this screening tool is not as effective in discriminating between current drinking and a past drinking problem. It is particularly important to modify the CAGE questionnaire to detect drug abuse, because elderly patients are prone to self-medication. The physician must be aware that cognitive impairment can affect the patient's ability to respond accurately to the questions.

The physician should be suspicious of substance abuse in patients with mental disorders. Results from the Epidemiologic Catchment Area study[17] demonstrated that 47 percent of patients with a lifetime diagnosis of schizophrenia or schizophreniform disorder met criteria for some form of substance abuse. In patients with antisocial personality disorder, the percentage was 83.6; in patients with anxiety disorders, the percentage was 23.7; and in patients with affective disorders, the percentage was 32. Suspicion of substance abuse is important not only because

of the prevalence of this disorder, but also because it is very difficult to treat mental illness if concomitant substance abuse is unrecognized.

Treatment

A detailed outline of the treatment of substance abuse is beyond the scope of this article. If problem drinking is identified, even brief physician advice can be helpful.[18] [Evidence level A, randomized controlled trial] These patients have experienced some negative consequences but have not yet experienced a major loss of control. The patient who has been diagnosed with substance abuse should be referred to an addiction-medicine specialist or an inpatient or outpatient treatment center. These steps give the patient a solid start on the recovery process.

If insurance problems or other factors prevent referral, it is possible to detoxify the patient on an outpatient basis. The patient then can be referred to Alcoholics Anonymous or Narcotics Anonymous for sustained follow-up support. Specific medical therapies are available for opioid addiction.

Whatever treatment the patient undergoes, it is important for the family physician to be supportive of the patient and the family in recovery and to be extremely careful about prescribing mood-altering drugs in the future. As a chronic disease, substance abuse tends to relapse. The family physician can play a pivotal role by dealing with the patient and family in a nonjudgmental manner.

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EXHIBIT 10

SAS Output

Substance Abuse Treatment Admissions by Primary Substance of Abuse, According to Sex, Age Group, Race, and Ethnicity

YEAR=2008

STATE: CONNECTICUT		Total	PRIMARY SUBSTANCE												
			Alcohol only	Alcohol with secondary drug	Cocaine (smoked)	Cocaine (other route)	Marijuana	Heroin	Other opiates	PCP	Hallucinogens	Amphetamines	Other stimulants	Tranquilizers	Sedatives
Total	No.	45,982	8,093	8,463	3,642	1,838	4,756	15,238	2,313	406	98	123	9	248	126
	%	100.0	17.6	18.4	7.9	4.0	10.3	33.1	5.0	0.9	0.2	0.3	0.0	0.5	0.3
SEX															
Male	%	71.0	74.1	73.4	56.2	70.8	77.1	71.5	62.2	60.8	68.4	74.0	77.8	56.0	52.4
Female	%	29.0	25.9	26.6	43.7	29.2	22.8	28.5	37.8	39.2	31.6	26.0	22.2	43.5	47.6
Unknown	%	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
AGE AT ADMISSION															
0-11 years	%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0
12-17 years	%	1.4	0.2	0.8	0.1	0.3	9.7	0.2	0.6	2.0	2.0	2.4	33.3	2.0	0.0
18-20 years	%	6.6	1.4	3.9	1.5	6.6	21.3	7.1	7.5	8.6	19.4	14.6	11.1	5.2	4.8
21-25 years	%	15.4	5.9	10.4	7.3	12.0	27.7	19.8	23.1	29.1	26.5	23.6	22.2	18.1	15.1
26-30 years	%	14.0	7.4	11.1	10.7	16.1	18.6	16.4	20.0	36.2	20.4	18.7	22.2	22.2	11.9
31-35 years	%	11.2	8.6	10.7	13.4	15.0	9.4	12.5	12.6	18.2	10.2	13.0	0.0	13.3	11.9
36-40 years	%	13.9	12.5	16.2	20.7	17.8	6.3	14.5	11.4	4.7	7.1	8.9	0.0	8.9	14.3
41-45 years	%	15.5	20.5	20.1	24.6	16.9	3.9	13.1	10.2	1.0	5.1	8.1	0.0	10.9	19.0
46-50 years	%	12.0	20.4	15.9	14.3	10.3	2.0	9.3	7.0	0.0	6.1	7.3	11.1	11.3	12.7
51-55 years	%	6.4	13.8	7.0	5.5	3.9	0.9	4.9	5.5	0.0	2.0	0.0	0.0	4.8	4.8
56-60 years	%	2.5	6.3	3.0	1.1	0.8	0.3	1.7	1.4	0.0	0.0	0.8	0.0	1.6	4.8
61-65 years	%	0.8	2.6	0.7	0.5	0.2	0.0	0.4	0.5	0.0	1.0	1.6	0.0	0.4	0.8
66 years and over	%	0.3	1.4	0.1	0.1	0.0	0.0	0.1	0.1	0.0	0.0	0.8	0.0	0.8	0.0
Unknown	%	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.4	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
RACE															
White	%	65.2	79.8	64.5	48.1	61.7	42.2	66.8	90.4	20.0	54.1	63.4	33.3	83.9	81.7
Black or African-American	%	17.5	8.7	22.8	37.8	19.0	35.7	10.1	2.6	49.0	29.6	8.9	44.4	5.6	7.9
American Indian or Alaska Native	%	0.4	0.3	0.3	0.5	0.5	0.5	0.3	0.5	1.0	1.0	0.8	0.0	0.4	0.0
Asian or Native Hawaiian or Other Pacific Islander	%	0.6	0.5	0.6	1.3	0.3	0.7	0.6	0.5	1.7	0.0	0.8	0.0	1.6	1.6
Other	%	16.0	10.1	11.6	12.2	18.2	20.4	22.0	5.8	28.3	15.3	25.2	22.2	8.1	8.7
Unknown	%	0.3	0.4	0.3	0.1	0.2	0.5	0.1	0.3	0.0	0.0	0.8	0.0	0.4	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ETHNICITY															

→ = 45,338 admissions for CT's 18+ population

SAS Output

Hispanic or Latino	%	18.5	10.7	12.9	13.0	23.6	27.6	25.0	6.6	34.5	23.5	22.0	33.3	9.7	7.1
Not Hispanic or Latino	%	80.8	88.6	86.6	86.6	76.0	70.9	74.6	92.5	65.0	74.5	77.2	66.7	89.1	92.9
Unknown	%	0.7	0.8	0.5	0.4	0.4	1.5	0.4	0.9	0.5	2.0	0.8	0.0	1.2	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Click here to view descriptions of drug categories

-- Quantity is zero

SOURCE: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS).

Based on administrative data reported by States to TEDS through January 6, 2009.

EXHIBIT 11

Litchfield Hills-Potential Target Population in Connecticut & First 3 Year Admissions

CT Adult Population (2006-2008)[1]	2,673,711
Population with HH income $200K +[2]	213,896
# with drug/alcohol abuse/dependency problem[3]	21,389
# appropriate for residential rehabilitation[4]	3,636
Target population for proposed center[5]	**3,208**
Year 1 Projections (2.5%)	89
Year 2 Projections (5%)	160
Year 3 Projections (7%)	225

Litchfield Hills CT vs. Out of State Admissions (Years 1-3)

	Year 1	Year 2	Year 3
Total Beds	28	28	28
Total Available Bed Days[6]	10,220	10,220	10,220
Projected Total Occupancy[7]	40%	65%	85%
Projected Bed Days[8]	4,088	6,434	8,687
Protected Total Admissions[9]	136	221	290
CT Admissions[10]	80	160	225
Out of State Admissions[11]	56	61	65
% of Admissions from CT	59%	72%	78%

[1] Per U.S. Census Bureau for CT
[2] As per US Census Bureau for CT, 8% of population
[3] As per SAMHSA estimate of 10%
[4] Calculated percent of CT residents that sought residential treatment for substance abuse (17%)
[5] Estimated more conservatively the potential target population to be 15% of total substance abusing population
[6] 28 beds x 365 days
[7] As estimated by
[8] Percentage of projected total occupancy applied to total available bed days
[9] Based on average 30 day length of stay (i.e. 4088/30days = 136)
[10] Based on capture rates of 2.5, 5, and 7 percent for first 3 years, respectively.
[11] Difference between projected total admissions and projected CT admissions.

EXHIBIT 12

Type of Care

	Facilities[1]		Clients in Treatment on March 31, 2005				
			All Clients			Clients Under Age 18	
	No.	%	No.	%	Median No. of Clients Per Facility	No.	%
Outpatient	161	75%	19,044	89%	51	672	80%
Regular outpatient	130	60%	7,704	36%	37		
Intensive outpatient	76	35%	1,566	7%	13		
Day treatment/partial hospitalization	40	19%	524	2%	11		
Detoxification	31	14%	367	2%	9		
Methadone	38	18%	8,883	41%	245		
Residential	66	31%	1,826	8%	18	106	13%
Short term	19	9%	470	2%	18		
Long term	48	22%	1,243	6%	17		
Detoxification	8	4%	113	1%	14		
Hospital Inpatient	17	8%	532	3%	16	58	7%
Treatment	11	5%	249	1%	9		
Detoxification	15	7%	383	2%	10		
Total	216		21,502	100%	45	836	100%

[1] Facilities may be included in more than one category.

Opioid Treatment Programs (OTPs)

	No.	%
Facilities with OTPs		
Maintenance only	9	23%
Detoxification only	6	15%
Both maintenance and detoxification	24	62%
Total	39	100%
Clients in Facilities with OTPs	9,340	
Methadone	9,226	
Buprenorphine	114	

Type of Payment Accepted

	Facilities	
	No.	%
Cash or self-payment	199	92%
Private health insurance	151	70%
Medicare	95	44%
Medicaid	161	75%
Other State-financed health insurance	139	64%
Federal military insurance	73	34%
No payment accepted	5	2%
Other type of payment	3	1%
Sliding fee scale	166	77%
Treatment at no charge for clients	136	63%

Facility Capacity and Utilization[1]

	Residential	Hospital Inpatient
No. of facilities	63	8
No. of clients	1,750	489
Designated beds	1,886	536
Utilization rate	93%	91%
Designated beds per facility (average)	30	536

[1] Excludes facilities not reporting both client counts and number of beds, facilities whose client counts were reported by another facility, facilities that included client counts from other facilities, and facilities that did not respond to this question.

Facility Licensing, Approval, Certification, or Accreditation

	Facilities	
	No.	%
Any listed agency/organization	206	95%
State substance abuse agency	120	56%
State mental health department	88	41%
State public health department/board of health	190	88%
Hospital licensing authority	19	9%
JCAHO (Joint Commission on Accreditation of Healthcare Organizations)	87	40%
CARF (Rehabilitation Accreditation Commission)	63	29%
NCQA (National Committee for Quality Assurance)	--	--
COA (Council for Accreditation for Children and Family Services)	12	6%
Other State/Local Agency/Organization	10	5%

Facility Administrative and Funding Characteristics

	Facilities	
	No.	%
Has agreements or contracts with managed care organizations for provision of substance abuse treatment services	164	76%
Receives Federal, State, county, or local government funds for substance abuse treatment programs	173	80%

EXHIBIT 13

Google maps

Directions to 64 Double Hill Rd, Bethlehem, CT 06751
28.7 mi – about **50 mins**

Save trees. Go green!
Download Google Maps on your phone at **google.com/gmm**

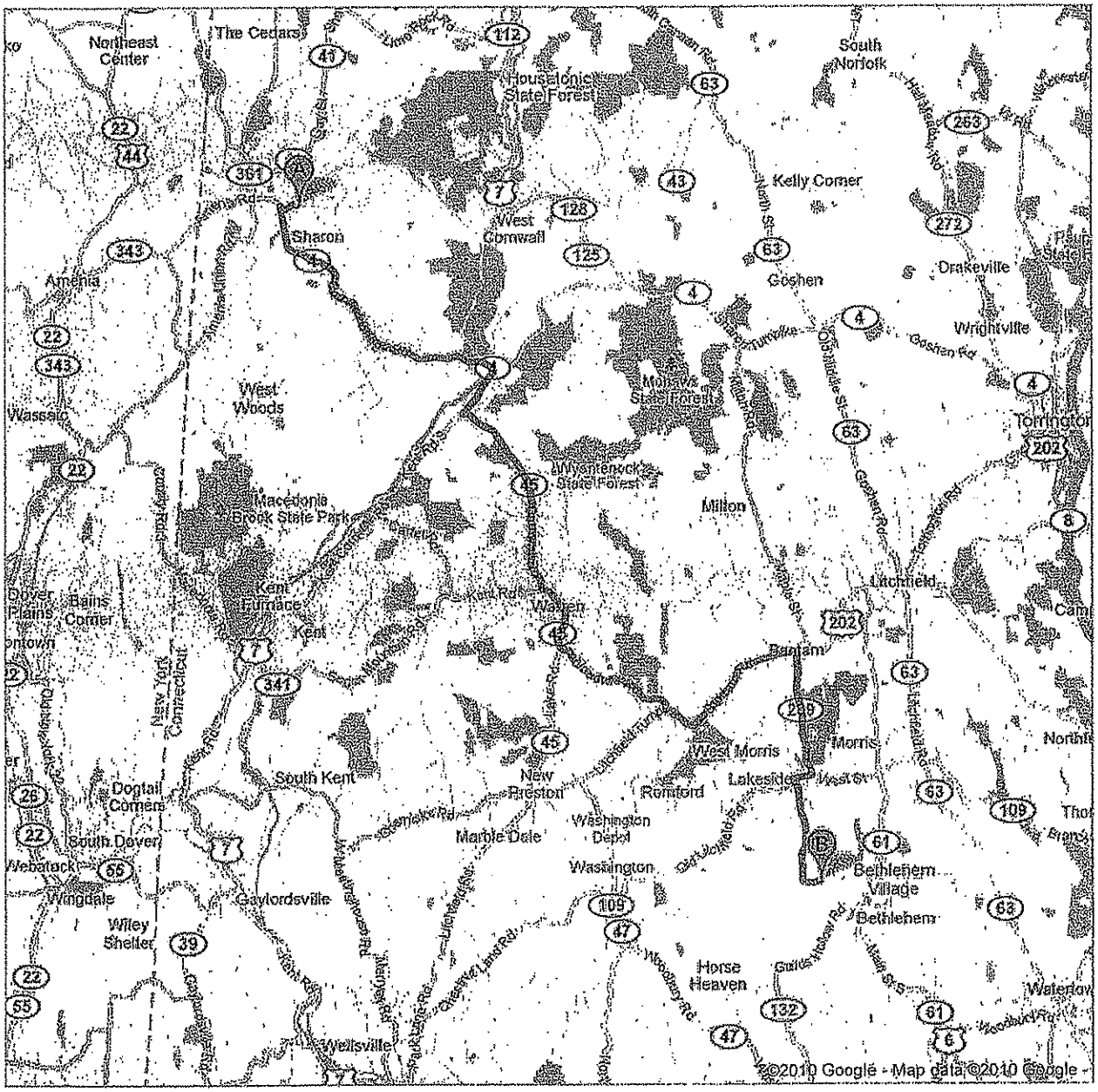

EXHIBIT 14

Roberts, Karen

From: Kennedy Hudner [KHUDNER@murthalaw.com]
Sent: Monday, April 05, 2010 10:14 AM
To: Roberts, Karen
Subject: CON - Vista Partners, LLC
Attachments: Kennedy Hudner.vcf

Dear Karen:

I am replying to your letter dated April 1, 2010 concerning the CON granted to Vista Partners, LLC (No. 07-30928) to establish an alcohol and drug treatment center in Sharon, Ct.

The applicant will not be going forward with this CON. At present, the applicant, Vista Partners, LLC has dissolved. My apologies to you for not notifying you about this sooner.

Very truly yours,

Kennedy Hudner

Kennedy Hudner
Partner
khudner@murthalaw.com

Murtha Cullina LLP
CityPlace I, 185 Asylum Street
Hartford, CT 06103-3469
Direct: 860-240-6029
Direct Fax: 860-240-5829
Mobile: 860-490-6586
Main: 860-240-6000
Main Fax: 860-240-6150

www.murthalaw.com

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BERSHTEIN, VOLPE & McKEON P.C.
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NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

RECEIVED
2010 APR 27 A 11:31
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

April 26, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
and Federal Express

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Request for Administrative Notice.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Request for Admin Notice) 4.26.10.doc

DEPARTMENT OF PUBLIC HEALTH **DIVISION OF OFFICE OF** **HEALTH CARE ACCESS**	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC **D/B/A LITCHFIELD HILLS RETREAT, LLC** **PROPOSAL TO ESTABLISH A** **FREE STANDING ADULT SUBSTANCE** **ABUSE CENTER IN BETHLEHEM**	: : : :	**April 26, 2010**

REQUEST FOR ADMINISTRATIVE NOTICE

In accordance with Conn. Gen. Stat. § 4-178 and §§ 19a-643-53(d) and (e) of the Rules of Practice of the Office of Health Care Access ("OHCA"), Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC ("Applicant"), hereby requests that OHCA take administrative notice of Docket Number 07-30928-CON, Vista Partners, LLC's CON for the Establishment of an Alcohol and Drug Treatment Center in Sharon, encompassing all information and correspondence submitted to OHCA in reference to that Docket, including but not limited to correspondence from Attorney Kennedy Hudner to OHCA (attached hereto as Exhibit A).

Docket Number 07-30928-CON is an appropriate subject for administrative notice. OHCA has the authority to take notice of judicially cognizable facts and of generally recognized technical or scientific facts that are within the agency's specialized knowledge. Conn. Gen. Stat. § 4-178(6). Such items may include, without limitation, prior decisions and orders of OHCA. OHCA Rules of Practice § 19a-643-53(d).

Docket Number 07-30928-CON has direct bearing on the subject matter of these proceedings. Specifically, in its Final Decision in the Matter of Docket Number 07-30928-CON, OHCA found that a need exists for "small residential alcohol and drug treatment facilities in Connecticut that offer extremely private, discreet and individualized programs for substance

abusing professionals, public officials, and other residents" (See OHCA's Final Decision in DN 07-30928-CON p. 9).

In addition, the email correspondence from Attorney Kennedy Hudner to OHCA dated April 5, 2010, notifying OHCA that Vista Partners, LLC will not be implementing its Certificate of Need authorized by OHCA in Docket Number 07-30928-CON, evidences the fact that this need was never satisfied by Vista Partners, LLC and therefore remains unmet.

Accordingly, the Applicant respectfully requests that OHCA take administrative notice of the entire Vista Partners, LLC CON Application; specifically Docket Number 07-30928-CON and the item attached as Exhibit A. Applicant reserves the right of oral argument in support of this request.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By:_____
Michele M. Volpe
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

EXHIBIT A

Roberts, Karen

From: Kennedy Hudner [KHUDNER@murthalaw.com]
Sent: Monday, April 05, 2010 10:14 AM
To: Roberts, Karen
Subject: CON - Vista Partners, LLC
Attachments: Kennedy Hudner.vcf

Dear Karen:

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The applicant will not be going forward with this CON. At present, the applicant, Vista Partners, LLC has dissolved. My apologies to you for not notifying you about this sooner.

Very truly yours,

Kennedy Hudner

Kennedy Hudner
Partner
khudner@murthalaw.com

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Mobile: 860-490-6586
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HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

April 26, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
and Federal Express

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of an Objection to Silver Hill Hospital Inc.'s Petition to be Designated an Intervenor With Full Rights of Participation.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Object to Silver Hill Intervene) 4.26.10.doc

DEPARTMENT OF PUBLIC HEALTH
DIVISION OF OFFICE OF
HEALTH CARE ACCESS : **DOCKET NO. 09-31500-CON**

RECEIVED
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CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

IN RE: EMPLOYMENT OPTIONS, LLC :
D/B/A LITCHFIELD HILLS RETREAT, LLC
PROPOSAL TO ESTABLISH A
FREE STANDING SUBSTANCE
ABUSE CENTER IN BETHLEHEM : **April 26, 2010**

OBJECTION TO SILVER HILL HOSPITAL INC.'S PETITION TO BE DESIGNATED AN INTERVENOR WITH FULL RIGHTS OF PARTICIPATION

Pursuant to the Connecticut Uniform Administrative Procedure Act, Conn. Gen. Stat. § 4-166, et seq. (the "UAPA") and § 19a-643-38 et. Seq. of the Regulations of Connecticut State Agencies ("OHCA's Rules of Practice"), the Applicant in the above matter, Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC (the "Applicant"), hereby objects to the petition of Silver Hill Hospital Inc. (the "Petitioner") to be designated as an intervenor with full rights of participation to present evidence, argument and cross examination in this Certificate of Need ("CON") proceeding.

OHCA should deny Petitioner's petition for intervenor status because it fails to demonstrate the elements necessary to qualify for intervenor status. The UAPA and OHCA's Rules of Practice, §§ 19a-643-38 (c) and (d), taken together, provide that Petitioner must prove all of the following in order to be considered for intervenor status:

1. It will be affected by the pending application;

2. It will add evidence or arguments on the issue of the contested case that would otherwise not be available to OHCA;

3. Its participation will be in the interest of justice; and

4. Its participation will not impair the orderly conduct of the proceedings.

If Petitioner is unable to prove any one of the above elements, it may not be considered for intervenor status.[1] Moreover, even if Petitioner could satisfy all of the necessary elements, OHCA must still find that Petitioner's participation as an intervenor would furnish assistance to OHCA in resolving the issue of whether to grant Applicant's pending application.

Petitioner has failed to prove the elements set forth above. First, approval of the pending CON Application to establish a freestanding adult residential substance abuse treatment facility cannot and will not have any legally cognizable effect on Petitioner because the facility proposed by Applicant differs drastically from Petitioner's facility. Petitioner's facility, staff and services, as set forth in its website, consist of "treatment for mood disorders including depression and bipolar disorders, schizophrenia and other psychoses, eating disorders, personality disorders and substance use disorders – with special expertise in treating patients dually-diagnosed with both a psychiatric illness and a substance abuse disorder." Petitioner's website states that its Transitional Living Program "allows patients who have achieved stabilization to continue their treatment in a more residential, home-like setting while continuing to participate in a highly structured, intensive program with full-time psychiatric, nursing and social work staff." By its own description of its facility, Petitioner offers a full-service, clinical approach to a broad spectrum of disorders and a broad spectrum of individuals. The Applicant does not. Petitioner's targeted patient base is markedly broader than Applicant's which will consist of only those clients whose public visibility, wealth or social position make it difficult to begin the road to successful recovery in the existing and known residential treatment facilities such as the Petitioner. The fact that the Petitioner has been offering broad based, highly structured and clinical treatment of many personality and substance abuse disorders to all segments of society since 1931 is one of the main factors which would dissuade Applicant's targeted client base from

[1] OHCA's Rules of Practice §§ 19a-643-38(c) and (d)

seeking treatment at Petitioner's facility. Indeed, the need which Applicant will show is unmet is for those individuals seeking a substantially smaller, much more private setting offering only individualized care and specific medical and clinical programs that directly address the cultural, professional and social characteristics of individuals similarly situated, such as physicians, attorneys, senior business executives and other individuals in the public eye. As important, Applicant's proposed facility will not offer the specific array of medical services as Petitioner does. While Applicant will service patients with co-occurring disorders; Applicant will not accept patients for treatment who suffer from bipolar disorders, schizophrenia and other complex psychoses. Instead, the Applicant proposes only to provide treatment for drug and alcohol abuse among a narrowly defined but statistically significant group of individuals with a substance abuse/dependency diagnosis who have been medically cleared for admission by their treating physician. Indeed, Applicant's targeted group of individuals are those very individuals who will not seek treatment at Petitioner's facility because of the scope and nature of Petitioner's services and patient base. Accordingly, Applicant will not compete with Petitioner and therefore, Petitioner will not be affected by OHCA's grant of the Applicant's pending CON Application.

Secondly, it is disingenuous for Petitioner to now claim that it will add evidence or arguments on the issue of the contested case that would not otherwise be available to OHCA. Despite Petitioner's repeated boasting that it is a "long standing provider of substance abuse services," Petitioner very tellingly chose not to object to a virtually identical CON application which was granted by OHCA absent any opposition whatsoever – that being the CON granted in Docket Number 07-30928-CON on behalf of Vista Partners, LLC (the "Vista CON"). In issuing the Vista CON, OHCA has already made a finding of need that is identical to the need established by the Applicant in its Application. Since the need being advocated by the Applicant

is identical to that found by OHCA in issuing Vista CON, and since the Petitioner chose not to even seek to offer evidence during the proceedings relating to the Vista CON, there can be no doubt that Petitioner has no evidence to offer that is not otherwise available to OHCA in either Applicant's Application or through administrative notice of all of the evidence which caused OHCA to issue the Vista CON.

Similarly, any suggestion that Petitioner's being granted intervenor status will "be in the interest of justice" is without merit as well. Not having even attempted to intervene or object to OHCA's issuance of the Vista CON, it is difficult if not impossible to see how allowing Petitioner intervenor status in the instant proceeding would "be in the interest of justice" or otherwise be of assistance to OHCA in resolving the issue of whether a need exists for Connecticut to have access to the services proposed by the Applicant.

To reiterate, Petitioner's failure to prove any one of the elements set forth above disqualifies it from being considered for intervenor status. The Applicant submits that Petitioner has failed to meet its burden with respect to these elements. Therefore, the Applicant requests that OHCA deny Petitioner's application for intervenor status in its pending CON Application. In the event that Petitioner is granted any participating status in these proceedings, the Applicant respectfully requests that Petitioner not be granted any rights of cross-examination, as Petitioner has provided no evidence or demonstration that it would be properly in position to pose any legitimate inquires beyond those OHCA itself is well-positioned to address based on its administrative expertise.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By:_____

Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

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CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 26th day of April, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
Stamford, Connecticut 06901
Facsimile: (203)653-5444

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723

Michele M. Volpe

BERSHTEIN, VOLPE & McKEON P.C.
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NEW HAVEN, CONNECTICUT 06511
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CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

April 26, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
and Federal Express

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Legal Counsel's Opening and Closing Statement.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Legal Counsel Opening & Closing Statement) 4.26.10.doc

DEPARTMENT OF PUBLIC HEALTH
DIVISION OF OFFICE OF

RECEIVED
2010 APR 27 A 11: 39
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
	:	
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING RESIDENTIAL ADULT SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 26, 2010**

Legal Counsel's Opening and Closing Statement

My name is Michele Volpe and my firm serves as legal counsel for Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC ("Applicant" or "Litchfield Hills"). We thank you for allowing us to appear before you today.

Litchfield Hills is proposing to establish an alcohol and drug treatment center in Bethlehem, with an associated capital expenditure of $2,500,000. Litchfield Hills will seek licensure from the Department of Public Health to operate a 28 bed, free standing substance abuse facility in accordance with the provisions of the General Statutes of Connecticut Section 19a-493 as a Facility for the Care or Treatment of Substance Abusive or Dependent Persons. *(CON p. 25)*.

The population to be served at Litchfield Hills will primarily include Connecticut residents, as well as individuals from neighboring states, with the following characteristics:

- Adults 18 and over (male and female) (*CON p. 8)*;
- Who have a history of alcohol or drug abuse or dependency (*CON p. 8)*;
- Who have been already been through Detox treatment and/or have been medically cleared by a physician *(CON p.51)*; and
- Who are part of the population of high income professionals, (lawyers and doctors), executives in senior management, and public officials (*CON pp. 51-52)*.

Litchfield Hills is intended to serve individuals whose public visibility, wealth and/or public and/or social position make it difficult for them to continue on the road to a successful recovery in the existing traditional residential treatment settings.

Litchfield Hills based the need for the proposal on the following:

- Substance and alcohol abuse/dependency is a significant health problem in Connecticut *(CON p. 64)*;

- Substance and alcohol abuse/dependency among certain professionals (e.g. physicians, attorneys, financial services executives) is a significant health problem *(CON p. 136)*; and

- There are no small residential alcohol and drug treatment facilities in Connecticut that offer extremely private, discreet and individualized programs exclusively for substance abusing professionals, executives, public officials, and other high-income residents. *(CON p. 52)*

According to the Litchfield Hills Application and testimony offered, National and Connecticut specific statistics support that ten percent (10%) of the population have a problem with dependency on or abuse of illicit drugs or alcohol. Evidence further suggests that this figure is higher among the affluent population.

The Office of National Drug Control Policy published in its Drug Policy Information Clearinghouse (June 2006) for the State of Connecticut the following facts about drug use and availability:

- Cocaine is widely abused in Connecticut;

- Demand for heroin is increasing dramatically in the state and is easily accessible and selling at low prices and high-purity levels;

- MDMA (Ecstasy) is readily available and abused in Connecticut and is a popular drug among college aged residents;

- Prescription drug abuse is also a problem in Connecticut;

- There were a total of 48,218[1] admissions in 2004 to drug/alcohol treatment in Connecticut; and

- Approximately 79,000 residents reported needing, but not receiving, treatment for illicit drug use within the past year. *(CON p.10-18)*

Litchfield Hills has provided evidence of this significant health problem among certain professionals who have high pressure careers, such as physicians, attorneys, and financial services professionals, as follows: substance abuse among physicians may be as high as twelve percent (12%) *(prefile testimony of Mr. Gwozdz)*, eighteen percent (18%) to twenty percent (20%) of attorneys suffer from alcoholism and this rate rises to twenty-five percent (25%) after 20 years of practice *(CON p 136 and pre file testimony of Mr. Gwozdz)*

[1] Note that as referenced in Mr. Gwozdz prefile testimony, according to SAMHSA data for 2008, there were 45,338 admissions for adults 18+

There are no alcohol and substance abuse facilities in Connecticut that are specifically and exclusively oriented toward high profile professionals with substance abuse problems. *(CON p.52 & prefile testimony of Mr. Gwozdz)* These individuals require a small, discreet and very private treatment facility.

The Applicant's proposed center will be very private and intimate and offer substance abuse rehabilitation care with treatment plans that incorporate nationally accepted addiction treatment modalities. It will also focus on its clients' professional situations and backgrounds, individual burdens brought on by unique social backgrounds and family relationships. Given the relatively small size of the proposed facility, significant time will be spent on each client's individual circumstances and treatment will be tailored to their specific situation and needs. *(Prefile testimony of Dr. Sack)*

The Applicant will offer individualized care and appropriate programs that will address the professional and social characteristics of its clients and offer a peer group for clients with specific careers (e.g. physicians, attorneys, senior business executives). *(Prefile testimony of Dr. Sack)*

Litchfield Hills is being proposed by the founders and current leadership team of Employment Options, LLC *(CON p. 51)*. Employment Options is a vocational and residential support and independent living skills provider in Connecticut. Employment Options works collaboratively with the Department of Mental Health and Addition Services, hospitals, physicians, behaviorists, case managers, social workers, conservators and family members *(CON p. 28)*. The services and experience of Employment Options will directly transfer to the work proposed by Litchfield Hills. As important, Litchfield Hills has retained expert consulting services to assist in the establishment and operation of the proposed center. *(Prefile testimony of Dr. Sack)*

The Applicant will employ certified and/or licensed counselors *(CON p. 51)* and will have a very favorable counselor to client ratio.

As asserted in the CON Application, many Connecticut physicians, attorneys and executives must travel outside Connecticut for the alcohol and drug treatment services they require. The proposed Litchfield Hills center will serve clients from throughout the State of Connecticut as well as surrounding states. Connecticut residents who need this type of Center will benefit from a closer proximity to family and after care supports *(CON p. 52)*.

Since the proposed center is a residential service, the hours of operation will be 24 hours per day, 7 days per week, 365 days per year.

Litchfield Hills provided a list of existing providers but distinguishes itself from these providers in that many of the facilities listed are psychiatric facilities and serve patients with complex co-existing psychiatric and substance abuse problems.

The following table shows the projected number of admissions for Connecticut residents to the proposed facility for the first three years of operation:

Number of projected Connecticut Residents admitted for the first three years*

	Year 1	Year 2	Year 3
Connecticut Residents Admitted	89	160	225

Litchfield Hills-Potential Target Population in Connecticut & First 3 Year Admissions

CT Adult Population (2006-2008)[2]	2,673,711
Population with HH income $200K +[3]	213,896
# with drug/alcohol abuse/dependency problem[4]	21,389
# appropriate for residential rehabilitation[5]	3,636
Target population for proposed center[6]	**3,208**
Year 1 Projections (2.5%)	89
Year 2 Projections (5%)	160
Year 3 Projections (7%)	225

In the event that a client is determined not to be appropriate for the level of care delivered at the Litchfield Hills center, such client will be referred to an alternative level of care (e.g. inpatient psychiatric facility/unit, acute care hospital emergency room, detoxification center, specialty center for eating disorder, etc.). All referrals will be done in conjunction with the referring physician or practitioner and the client; and will be based on a client's specific needs and condition. *(Prefile testimony of Dr. Sack)*

Litchfield Hills states that the proposed center will not provide detoxification and therefore will not seek licensure for these services.

The table below summarizes the total projected admissions for the first three years:

Litchfield Hills CT vs. Out of State Admissions (Years 1-3)

	Year 1	Year 2	Year 3
Total Beds	28	28	28
Total Available Bed Days[7]	10,220	10,220	10,220
Projected Total Occupancy[8]	40%	65%	85%
Projected Bed Days[9]	4,088	6,434	8,687
Protected Total Admissions[10]	136	221	290
CT Admissions[11]	80	160	225
Out of State Admissions[12]	56	61	65
% of Admissions from CT	59%	72%	78%

[2] Per U.S. Census Bureau for CT
[3] As per US Census Bureau for CT, 8% of population
[4] As per SAMHSA estimate of 10%
[5] Calculated percent of CT residents that sought residential treatment for substance abuse (17%)
[6] Estimated more conservatively the potential target population to be 15% of total substance abusing population
[7] 28 beds x 365 days
[8] As estimated by Applicant
[9] Percentage of projected total occupancy applied to total available bed days
[10] Based on average 30 day length of stay (i.e. 4088/30days = 136)
[11] Based on capture rates of 2.5, 5, and 7 percent for first 3 years, respectively.
[12] Difference between projected total admissions and projected CT admissions.

Litchfield Hills' decision to establish a 28 bed center was based on the following factors:

- Since the target population is professional and high profile individuals, it is critical that the facility be relatively small and very private;
- A complement of 28 beds will facilitate staffing, conducting small group activities and offering sufficient privacy when needed.

Litchfield Hills provided sufficient documentation to support the proposed capital expenditures and financial viability of the center. More important, it already owns the real estate and its founder shall provide all necessary capital.

There is no State Health Plan in existence at this time.

Litchfield Hills will not have any teaching or research responsibilities.

Litchfield Hills' projected payer mix for the proposed facility is self-pay comprised primarily of households with high income.

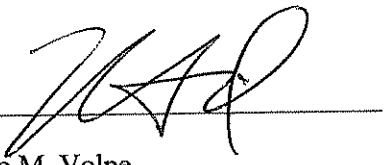
Litchfield Hills' staff will provide sufficient technical, financial and managerial competence and expertise to provide efficient and adequate service to the public.

As specifically set forth in its Application and prefile testimony, Litchfield Hills has clearly evidenced the need for a treatment center for affluent, high-profile alcohol and drug abusing/dependent persons. The Litchfield Hills center will serve individuals whose public visibility, wealth and/or public and/or social position make it virtually impossible for them to begin a successful recovery in the existing traditional residential treatment settings. The proposed center will have 28 beds. The population to be served will be adults 18 and over (male and female) with a history of alcohol or drug abuse or dependency, and are high level professionals or persons with a public role. The proposed center will offer substance abuse rehabilitation care with treatment plans that incorporate nationally accepted addiction treatment modalities *(CON p. 51)*. The Center will also focus on its clients' professional situations and backgrounds, individual burdens brought on by unique social backgrounds, and family relationships.

While the Office of Health Care Access approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis, it must be acknowledged that an established unmet need exists in Connecticut for the very services Litchfield Hills seeks to provide. This need was established in the Vista Partners, LLC application, Docket #07-30928-CON, and has been established again in the pending Litchfield Hills application. More important, the need remains unmet, as the Vista Partners CON is expired and Vista affirmatively stated to OHCA that it would not implement its CON *(see OHCA email correspondence from Attorney Kennedy Hudner)*.

We thank you for this opportunity to appear before you today on behalf of Litchfield Hills Retreat, LLC and we respectfully request that you approve this pending CON Application and permit the establishment of the proposed freestanding adult residential substance abuse center in Bethlehem.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: 

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April 26, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
and Federal Express

RECEIVED
2010 APR 27 A 11: 55
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

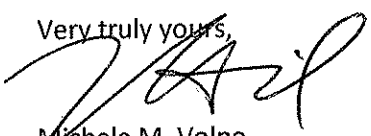
On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of the Prefiled Testimony of David Sack, M.D.

This Prefiled testimony is being submitted in accordance with Section 19a-643-51(e) of the OHCA Rules of Practices. Dr. Sack will be present at the April 29, 2010 public hearing to adopt his testimony under oath and be available for cross-examination.

Should you require anything further, please feel free to contact me.

Thank you.

Very truly yours,



Michele M. Volpe

MMV/bt
Enclosures
F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Prefiled - Sack) 4.26.10.doc

DEPARTMENT OF PUBLIC HEALTH
DIVISION OF OFFICE OF
HEALTH CARE ACCESS : **DOCKET NO. 09-31500-CON**
:
IN RE: EMPLOYMENT OPTIONS, LLC :
D/B/A LITCHFIELD HILLS RETREAT, LLC
PROPOSAL TO ESTABLISH A
FREE STANDING ADULT SUBSTANCE
ABUSE CENTER IN BETHLEHEM : **April 26, 2010**

RECEIVED
2010 APR 27 A 11:5
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

PREFILED TESTIMONY OF EMPLOYMENT OPTIONS, LLC
D/B/A LITCHFIELD HILLS RETREAT, LLC
BY DAVID SACK, M.D.

Good Morning Deputy Commissioner Vogel and members of the OHCA staff. My name is David Sack, M.D. I have been retained as a consultant by Litchfield Hills Retreat, LLC ("Litchfield Hills" or "Center") to assist in the development of its substance abuse treatment program. I thank you for this opportunity to appear before you today in support of Litchfield Hills' pending Certificate of Need ("CON") Application. On behalf of Litchfield Hills, I respectfully request that the Office of Health Care Access ("OHCA") approve its pending CON Application and permit the establishment of the proposed freestanding adult substance abuse center in Bethlehem. Our request is based on the following:

1. Qualification to Testify

In addition to providing consulting services to entities that seek to establish drug and alcohol treatment centers, I currently serve as the Chief Executive Officer of Elements Behavioral Health, Inc., located in Cerritos, California, as well as the Chief

Executive Officer of the Promises Treatment Centers, located in Malibu and West Los Angeles, California.

I am board certified in Psychiatry, Addiction Psychiatry and Addiction Medicine. I have extensive clinical experience in treating substance abusive and dependent persons. In addition, I am well-versed in the establishment and management of specialized residential and outpatient treatment programs. In my capacity as CEO for Promises Treatment Centers and Elements Behavioral Health, as well as my history as a Medical Director for various organizations, I maintain a strong background in the effective management and operation of rehabilitation centers. (See CV attached as Exhibit A).

My background has equipped me to serve as a consultant to entities that desire to establish high-quality substance abuse treatment centers, such as Litchfield Hills. I will lend my experience in the establishment of alcohol and drug abuse treatment facilities to Litchfield Hills to develop clinically appropriate treatment protocols and procedures. I will work hand and hand with the management of Litchfield Hills to develop an effective treatment program in a manner that is consistent with the internationally recognized standards established by the Commission on Accreditation of Rehabilitation Facilities.

2. Background

The founder and CEO of Employment Options LLC ("Employment Options"), Michele Zurko-Smith (sometimes referred to as the "founder"), is the driving force behind the proposal to establish the Litchfield Hills substance abuse treatment center. Employment Options has been providing vocational and residential support and independent living skills training to Connecticut residents for over fifteen (15) years. It has a deeply rooted reputation for quality. In its provision of residential and vocational

services, Employment Options works collaboratively with the Department of Mental Health and Addition Services, hospitals, physicians, behaviorists, case managers, social workers, conservators and family members. (See CON Application p. 28)

3. Litchfield Hills is Professionally Competent to Operate a Substance Abuse Treatment Center

Litchfield Hills is competent to provide high-quality substance abuse treatment services to that portion of the public comprised of "high-profile" individuals that it will be tailored to serve. The proposal to establish the Litchfield Hills substance abuse treatment center is technically, financially and managerially sound (efficient).

Litchfield Hills has the resources necessary to implement a quality substance abuse center. These resources include: (1) the proven track record and history of success of Employment Options; (2) the founder's work and experience with individuals with substance abuse issues; (3) the relatively low cost of the proposal; (4) the founders private funding source for the proposed center; (5) the expert consulting services Litchfield Hills has retained; (6) the internationally-recognized certification it will seek; and (7) the highly trained professionals Litchfield Hills will employ.

a. The Proposal is Managerially and Financially Efficient

Ms. Zurko-Smith has a proven track record in operating Employment Options. She grew the company from an independent contractor model to one that now employs over one hundred sixty (160) people. Employment Options quickly developed into an established and reliable residential and vocational assistance provider in Connecticut. It is now a vendor for the Bureau of Rehabilitation Services, the Department of Developmental Services, the state's Acquired Brain Injury Waiver program and it is contracted with various school districts to assist students with disabilities in career

choices, vocational assessments and job training and placement. (See CON Application p. 51)

Ms. Zurko-Smith's experience and success in establishing and operating Employment Options illustrates her ability and competency to establish and operate the proposed Litchfield Hills center. As a seasoned businesswoman, Ms. Zurko-Smith will lend her talent to Litchfield Hills as its Chief Operating Officer. In addition, Litchfield Hills will hire an experienced individual to serve as Litchfield Hills' Chief Financial Officer who will report to the Chief Executive Officer and oversee the financial operations of Litchfield Hills. (See CON Application p. 30) Keith Arnold, Vice President of Operations for Elements Behavioral Health who is present here today will provide guidance in retaining the Chief Financial Officer for Litchfield Hills, as well as additional members of the senior administrative staff f the Center. A bio for Mr. Arnold is attached to my prefile as Exhibit B.

It is also relevant that the cost to establish the proposed Litchfield Hills center is relatively low compared to other proposals to establish similar treatment facilities. Ms. Zurko-Smith already owns the real estate that will be the site for the proposed center and she will personally fund the project. (See CON Application p. 35) The establishment of Litchfield Hills will benefit the community not only in its provision of needed substance abuse treatment services but also in terms of job creation. (See CON Application p. 49)

Based on these facts, the proposal to establish the Litchfield Hills center is both managerially and financially competent and its establishment will therefore directly benefit the public in an efficient manner.

b. Litchfield Hills is Poised for Entry as a Substance Abuse Treatment Provider

The professional competence of Litchfield Hills to establish a residential substance abuse treatment center can be further evidenced by the fact that Ms. Zurko-Smith and the staff of Employment Options are well-versed on substance abuse issues. Through their work they have encountered numerous individuals with substance abuse and dependency problems. It is this exposure that has prompted Ms. Zurko-Smith to establish the proposed Litchfield Hills substance abuse treatment center.

Specifically, based on the substantial work that Employment Options provides to the population of people with Acquired or Traumatic Brain Injury, Ms. Zurko-Smith and the staff of Employment Options has identified a very high incidence of substance abuse within this population, as well as the population of residents with other disabilities. This correlation has been well documented.

Ms. Zurko-Smith and the Employment Options staff have a great deal of experience working with individuals' substance abuse issues and their respective substance abuse treatment providers. This experience, as well as Ms. Zurko's successful business history, will translate over directly to the work required to establish and successfully operate Litchfield Hills.

c. The Proposal is Technically Efficient

The proposal is technically efficient based on: (1) Litchfield Hills' employment of licensed and trained staff; (2) its Quality Assurance Plan and protocols regarding medical care and coordination; (3) its engagement of an expert consultant; (4) its attainment of DPH licensure; and (5) its compliance with internationally-recognized rehabilitation facility certification requirements.

i. Licensed and Trained Staff

All of the staff employed by Litchfield Hills will be competent, licensed and certified to provide substance abuse treatment, all as required by law and industry standards. Litchfield Hills will hire a Connecticut-licensed alcohol and drug counselor to serve as its Clinical Director responsible for the establishment of treatment programs and clinical protocols and supervision of the treatment staff. (See CON Application pp. 31 & 57) It will operate its treatment programs in accordance with nationally recognized and established treatment plan models.

Litchfield Hills will hire its Clinical Director and treatment staff upon approval from OHCA. Based on the assessment conducted by Litchfield Hills on the number of qualified professionals available in the state to service the clients of the proposed center, we are confident that Litchfield Hills will be able to obtain and retain the needed high-quality professionals. As of the end of 2009, there were more than one thousand (1,000) credentialed substance abuse professionals in Connecticut[1]. This number breaks down to approximately three hundred (300) certified substance abuse counselors and over seven hundred (700) licensed substance abuse counselors. These figures speak to the sizable pool of available talent available to Litchfield Hills. In addition, Litchfield Hills intends to employ other adjunct professionals, such as clinical social workers, to serve its residents.

ii. Quality Assurance Plan

Litchfield Hills will operate in accordance with an established Quality Assurance Plan. (See CON Application pp. 56-59) This Plan: (1) sets forth the Center's mission and objectives; (3) delineates the responsibilities of the management team; (3) ensures the implementation of program services; (4) provides for the development of a Code of

[1] Based on telephone call on April 14, 2010 with the practitioner licensing unit of DPH.

Ethics; (5) establishes protocols for service; and (6) outlines the patient selection criteria. (See CON Application p. 58).

Litchfield Hills will regularly revisit its Quality Assurance Plan. This Plan will be updated and built upon, as needed, to accommodate developments in the field of substance abuse treatment and the needs of the center's patients. Litchfield Hills' adherence to a structured Quality Assurance Plan, and its dedication to the continued development of that Plan, will help to ensure the provision of high-quality substance abuse treatment services to the patients of Litchfield Hills.

iii. Medical Care Coordination

As you heard earlier today, Litchfield Hills will be markedly different in the types of services it will provide and the population that it will serve, compared to the existing substance abuse providers in the state.

Litchfield Hills' clients will be comprised of individuals who have already received detoxification treatment and who have been cleared medically by a referring physician (CON p. 51).

Litchfield Hills Retreat will implement a comprehensive program to meet the needs of individuals with alcohol and drug abuse. It is well recognized that individuals with substance abuse problems often have a co-occurring disorder such as anxiety or depression. This Center will be staff and equipped to deal with this population. As we proceed to licensure will develop a definitive client activity schedule that describes the frequency and duration of each therapeutic modality. The core of our program is that abstinence from psychoactivie substances is best long term solution for individuals with

drug and alcohol problems and that we achieve this goal through the application of a number of evidence based strategies described below.

One such approach that Litchfield Hills will utilize is a self help framework such as the 12 Step Facilitation Therapy. The focus of this treatment is to encourage the individual to accept that they have become powerless over the use of drugs/alcohol and that they need to turn to a higher power for help to overcome their addiction. It relies on participation in peer support groups and a process of mentorship that guides them through the twelve steps, overcoming the guilt and shame caused by their addiction and a commitment to life free of drugs.

Motivational Interviewing. Based on the concept that drug and or alcohol users go through Stages of Change in order to overcome their dependencies. It recognizes that most individuals who have drug problems are ambivalent about continued treatment. It addresses issues of motivation to change and preparedness to take action.

Cognitive Behavioral Therapy. The efficacy of this treatment was first established for depression and anxiety disorders and has been replicated in the treatment of alcohol and drug dependencies. Central to this approach is that the individual with drug misuse has distorted beliefs that underlie their behaviors. Therapy is focused at making the client conscious of these cognitive distortions, and to develop new strategies for responding to these thoughts.

These treatments will be provided in a range of individual and group psychotherapy sessions that reinforce the skills that acquired. In addition, Litchfield Hills Retreat recognizes that a substantial proportion of individuals seeking treatment for alcohol or drug problems experience co-occurring emotional problems that may require

treatment during their stay. These problems may include marital difficulties (including domestic violence), depressive and anxiety disorders, insomnia and other impulse disorders such as gambling. LHR will maintain a licensed professional staff experienced in treating these disorders and may employ a number of modalities including individual and family psychotherapy, biofeedback, meditation, and yoga and exercise therapies.

LHR is a non-medical facility but will support the medical needs of its clients in a number of ways. A comprehensive health survey will be obtained at the time of admissions along with a physical examination by a consulting physician. Only healthy individuals or those with stable medical problems will be admitted for treatment. In those cases where individuals require medication to treat a medical problem, LHR will secure the medications, and provide them to their clients for self-administration according to the schedule indicated by the client's physician. The dose and timing of self administered medications will be observed by LHR staff and recorded in the chart. Clients with medical issues that emerge during their stay at LHR will be referred for treatment to a community physician.

Litchfield Hills' sole focus will be substance abuse/dependency treatment. The staff at Litchfield Hills will ensure that each client will be thoroughly interviewed and assessed prior to acceptance into the Litchfield Hills program. After this assessment, the Clinical Director, in conjunction with the admissions staff, will make an informed decision regarding whether it is appropriate to admit the individual into the Litchfield Hills program in accordance with its licensure and treatment models or whether another, higher level of treatment is required for the individual. (See CON Application p. 53).

In cases where a client is not cleared for admission by the Clinical Director, they will be referred to an alternative facility that offers the specific type of care that is demanded by the individual, whether it is inpatient psychiatric care, detoxification or other specialty care. Any referrals made by the Clinical Director will be coordinated with the client and his or her referring physician.

Once a client is admitted into the Litchfield Hills program, the staff will regularly track the client's progress and response to the established treatment plan. If it becomes apparent that a client requires a higher level of treatment, transfer to another facility will be discussed with the client and his or her treating physician. Once it is decided that a client should be transferred to a different facility, the staff will work with the client's physician in choosing the most appropriate facility and arranging for the transfer.

Based on a thorough admission assessments and continued monitoring, the Litchfield Hills staff will ensure that only appropriate clients enter and remain in its program. The Litchfield Hills staff will work hand and hand with its clients' treating physicians to ensure that all clients are receiving appropriate treatment and will transfer clients to other facilities, as needed. (See CON Application p. 59) It is notable that this referral model is virtually identical to that proposed by Vista Partners LLC, and approved by OHCA, in its proposal to establish and alcohol and drug treatment center in Sharon. (Docket Number 07-30928-CON).

iv. Expert Consultant

Litchfield Hills has retained my services on a consulting basis as another means of ensuring the success of Litchfield Hills and its provision of the quality substance abuse treatment services in accordance with nationally and internationally recognized standards.

I will use my experience to assist in the establishment of appropriate clinical protocols and treatment plans that will be tailored to Litchfield Hills' target population's substance abuse and dependency issues.

My experience in the field of substance abuse treatment will help to ensure that the Litchfield Hills program is developed in accordance with the most current clinical protocols and plans of treatment. In addition, I will assist Litchfield Hills in attaining accreditation from the Commission on Accreditation of Rehabilitation Facilities.

v. DPH Licensure

Litchfield Hills will provide substance abuse treatment services in accordance with its licensure from the Connecticut Department of Public Health as a private freestanding facility for the care or treatment of substance abusive or dependent persons. Accordingly, Litchfield Hills will operate in accordance with the Department's established quality and safety standards regarding such facilities.

vi. CARF Certification

Litchfield Hills's standards of high-quality substance abuse treatment services will be further evidenced by its accreditation from the Commission on Accreditation of Rehabilitation Facilities ("CARF").

CARF is a private, independent, not-for-profit organization that promotes quality rehabilitation services. It does this by establishing standards of quality for organizations to use as guidelines in developing and offering programs or services to consumers. To obtain CARF accreditation, facilities must demonstrate that they substantially meet certain internationally recognized standards applicable to rehabilitation facilities.

Litchfield Hills will seek CARF accreditation and be subject to the CARF guidelines, thereby ensuring the high-quality treatment services. CARF will send professionals in the field to conduct an on-site survey of the Litchfield Hills center to determine the degree to which Litchfield Hills meets the established CARF quality standards. Litchfield Hills recognizes that it is of utmost importance to adhere to the CARF guidelines and obtain accreditation to align the programs and treatment plans with CARF's internationally recognized standards.

To give OHCA an idea as to the types of guidelines that Litchfield Hills will generally be required to adhere to, I have outlined some of the principles that CARF base its standards on. Litchfield Hills will have to satisfactorily demonstrate the following through policy and practice:

- Partnership with the persons served in the development of treatment services and individualized program goals.
- Service design and delivery that focus on the needs of the persons served.
- A service delivery process that uses a multi-disciplinary approach.
- Program accessibility and assignment of qualified staff members to provide behavioral health services.
- A system of accountability that evaluates the outcomes achieved by the persons served as a measure of the success of the behavioral health programs.

In addition, Litchfield Hills will be required to demonstrate conformance to standards highlighting its values and approaches in at least the following areas:

- Organizational leadership
- Corporate compliance (U.S. only)
- Information management and performance management
- Fiscal management (including risk management)
- Human resources
- Communication
- Accessibility
- Health, safety, and transportation
- Information analysis
- Outcomes management
- Rights of the persons served

- Program structure and staffing
- Screening and access to services
- Individual planning
- Transition/recovery support services
- Pharmacotherapy (if applicable)
- Seclusion and restraint (if applicable)
- Records of the persons served
- Quality records review

Litchfield Hills' dedication to employing highly-trained staff, establishing protocols that serve to ensure that Litchfield Hills provides treatment to appropriately admitted clients, its compliance with the state's licensure requirements, its adherence to CARF certification standards, and its willingness to engage a professional in the field, such as me, all lend to the technical efficiency of the proposal.

4. Conclusion

Litchfield Hills is poised to enter into the field of substance abuse treatment; it is professionally competent to establish a center to provide these services to the high-profile population that it intends to serve.

The success of Employment Options and its experience with substance abusing/dependent individuals, the personal financing of the proposed center and the fact that the real estate is already owned by Ms. Zurko-Smith all evidence the managerial and financial efficiency of the proposal, as well as the certainty of implementation.

Furthermore, the technical efficiency of the proposal is evidenced by Litchfield Hills' dedication to engaging experts in the field to establish clinical protocols and treatment plans, hiring only highly-trained and appropriately licensed professionals, adhering to a Quality Assurance Plan and referral protocol, as well as adhering to CARF certification requirements.

Based on the foregoing support evidencing the professional competence of Litchfield Hills, its managers and proposed staff, we ask that OHCA grant Litchfield Hills' pending CON Application to establish and operate the Litchfield Hills residential substance abuse treatment center.

I thank you for this opportunity to appear before you today to provide my testimony in support of the pending CON Application.

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Docs\Prefiled Testimony\Prefiled Testimony (Dr. Sack) (BVM 4.26.10).doc

EXHIBIT A

CURRICULUM VITAE

David A. Sack, MD
19456 Woodlands Lane
Huntington Beach, California, 92648

Telephone: 562-965-3193
Home: 714-969-7093
Fax: 630-982-3688
Email: david.a.sack@gmail.com

Professional Experience:

2008-Present	CEO, Elements Behavioral Health, Inc. CEO, Promises Treatment Centers
2007- 2008	Consultant, clinical trials protocol development primarily in schizophrenia and bipolar disorder.
Center, persistently ill	Attending psychiatrist, La Casa Mental Health Rehabilitation an intensive rehabilitation program for seriously and patients with schizophrenia and schizoaffective disorders.
2006-2007	*Senior Vice President,* Aspen Education Group, Inc., Cerritos California. Executive Director of Eating Disorders Division
2000 - 2005	*Senior Vice President,* National Director of Clinical Research, Comprehensive NeuroScience, Inc., White Plains, NY. Supervised all aspects of clinical trial protocol development and network services specializing in disorders of the central nervous and clinical pharmacology. The network includes a 70 bed Phase I program and 9 Phase II-IV sites.
1994 - 2004	*Principal Investigator* Clinical trials program limited to central nervous system diseases, in Cerritos, CA. Key accomplishments: Successful enrollment, retention and separation from placebo in numerous pivotal trials of antipsychotic medications, mood stabilizers, antidepressants, cognitive and sedative hypnotic medications.
1998 - 2001	*Senior Vice President, Clinical Services* Aspen Education Group, Cerritos, CA Built and managed the operations of the Community Services Division, the largest privately owned network of publicly funded

mental health and substance abuse treatment centers in California, specializing in the treatment of high risk youth.

President and Medical Director
College Health IPA, a managed behavioral health group practice
Cerritos, CA
As medical director developed utilization/managment guidelines and supervised clincal operations. Directly surpervised credentialling and care management. Developed financial models used to negotiate and manage capatiated and risk contracts for behavioral services. Developed a statewide provider network in California. In addition successfully implemented instensive rehabiliation programs and substance abuse treatment programs contracted to County Mental Health Agencies.

1982 - 1999 *Private Practice Experience*
Inpatient and outpatient treatment of patients with mood, anxiety and thought disorders. Developed and supervised ambulatory detoxification and substance abuse treatment programs. Extensive experience with treatment resistant depression including the use of electroconvulsive therapy.
Southern California

1993 - 1999 *Senior Medical, Director*
College Hospital
Cerritos, CA
Responsible for professional affairs, regulatory compliance and managed care contracting. Directly supervised credentialing, peer review and professional conduct, development of policies and procedures, and survey preparation.

1987 - 1993 *Medical, Director*
Los Altos Hospital and Mental Health Center,
Long Beach, CA
Responsible for medical affairs and regulatory compliance. Key Accomplishments: Awarded *Best New Hospital* recognition by national hospital corporation. Implemented specialized programs for Panic disorder and Post-traumatic stress disorder. Authored book on adult victims of sexual abuse. Implemented a successful electroconvulsive therapy program despite a hostile regulatory environment.

1983 - 1987	*Chief, Inpatient Unit* Clinical Psychobiology Branch, National Institute of Mental Health Bethesda, MD Supervised all research trials conducted on an inpatient mental health unit at the Clinical Center, NIH. Conducted independent research in biological rhythms, photobiology, and sleep deprivation.
1994 – 2005	Qualified Medical Examiner, State of California

Education:

1981 - 1983	*Fellowship: Psychopharmacology,* National Institute of Mental Health Bethesda, MD
1979 - 1981	*Residency: Psychiatry,* UCLA Neuropsychiatric Institute Westwood, CA
1978 - 1979	*Internship: Psychiatry,* UCLA Neuropsychiatric Institute Westwood, CA
1978	*M.D.* Rush Medical College Chicago, IL
1974	*B.A. Psychology* Suma Cum Laude, SUNY at Buffalo Buffalo, NY

Licensure and Certifications:

10-31-2006	CA. License# G40374
02-28-2005	DEA License# AS9033983
	Certification: Department of Industrial Relations, Industrial Medical Council; Qualified Medical Evaluator, 1993 to present
	Diplomat: American Society of Addiction Medicine, 2000
	Diplomat: Added Qualification in Addiction Psychiatry, American Board of Psychiatry and Neurology, 1994
	Diplomat: Added Qualification in Geriatric Psychiatry, American Board of Psychiatry and Neurology, 1991

Diplomat: Psychiatry, American Board of Psychiatry and Neurology, January, 1984

Honor: 1978 – Phi Beta Kappa

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RECENT CLINICAL RESEARCH EXPERIENCE

1. "XXX Versus Haloperidol in the Treatment of Schizophrenia and Other Psychotic Disorders".

2. "A Comparative Cost Effectiveness Study of XXX and Usual Care versus Lithium and Usual care in the Treatment of Bipolar Disorder".

3. "XXX Plus XXX Versus XXX Plus Placebo in the Treatment of Major Depression".

4. "Double-Blind, Randomized, Placebo-Controlled Evaluation of the Safety, Tolerability and Parmacokinetics of Dehydoepiandrosterone (DHEA) in Patients with Alzheimer's Disease".

5. "An Open-Label, Multicenter Clinical Trial Evaluating the Safety and Efficacy of XXX Hydrochloride (E2020) in Patients with Alzheimer's Disease".

6. "Strategies for Switching from Conventional Antipsychotic Drugs to XXX".

7. "U-101387G: Double-Blind, Haloperidol-Controlled, Safety and Dose-Finding Study in the treatment of Schizophrenia".

8. "A Phase III Double-Blind Placebo-Controlled Study of XXX in the Treatment of Psychosis".

9. "An Open-label Follow-On Study of the Long-Term Safety of XXX in Patients with Psychosis".

10. "XXX Added to Mood Stabilizers in the Treatment of Bipolar Disorder".

11. "XXX Alone and in Combination with Fluoxetine versus Placebo in Major Depressive Disorder with Psychotic Features".

12. "A Multicenter, Placebo and Active Control, Double-Blind Randomized Study of the Efficacy and Safety of XXX (10 & 20 mg/day) in Schizophrenic and Schizoaffective Patients (3002)".

13. "A Multicenter, Open-Label, Long-Term, Follow-up Safety Study of XXX Tablets in Schizophrenic and Schizoaffective Subjects.

14. "A Prospective, Randomized, International, Parallel-Group Comparison of XXX Vs. XXX in the Reduction of Suicidality in Patients with Schizophrenia and Schizoaffective Disorder Who Are at Risk for Suicide".

15. "A Double-blind, Placebo-Controlled, Parallel- Group Assessment of the XXX Transdermal System in the Reappearance of Symptoms Associated with Major Depression."
16. "A Double-blind, Randomized, Multicenter, Parallel Group design Study to Evaluate the Efficacy and Safety of Two Dose Ranges of XXX in comparison with Placebo and Haloperidol in the Treatment of Schizophrenia."

17. "Protocol XXX, XXX, Placebo, and Paroxetine Comparison in Patients with Major Depressive Disorder."

18. "A Multi-center Placebo–Controlled Double Blind Study Comparing the Safety and Efficacy of XXX and Olanzapine in Subjects with Schizophrenia or Schizoaffective Disorder Needing Inpatient Care".

19. "A 52-week (1 year), Open Extension Study Evaluating The Safety and Efficacy Of Continued Administration of 40-160 mg Daily Of Oral XXX In the Treatment Of Subjects Who Have Participated In Previous XXX Trials" .

20. "XXX in the Management of Behavioral Disturbance and/or Psychosis in Demented Nursing Home Patients."

21. " A Double-Blind Randomized Comparison of the Efficacy and Safety of Short Acting Intramuscular XXX, Short Acting Intramuscular Haloperidol, and Intramuscular Placebo in Patients with Schizophrenia".

22. "The Efficacy of XXX and Adjunctive Lorazepam, as needed, to Treat Acute Behavioral Agitation in Schizophrenia".

23. "A Randomized Double-Blind Study to Evaluate the Anticholinergic Burden in Subjects with Psychosis of Dementia Treated with XXX or Olanzapine".

24. "A Multicenter, Randomized, Double-Blind, Placebo Controlled Study of Three Fixed Doses of XXX in the Treatment of Institutionalized Patients with Psychosis Associated with Dementia of the Alzheimer's Type".

25. "XXX Depot (microspheres) vs. Placebo in the Treatment of Subjects with Schizophrenia or Schizoaffective Disorder".

26. "A Three-Week, Multicenter, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group Safety and Efficacy Study of Extended-Release XXX in Patients With Bipolar Disorder".

27. "The Efficacy and Safety of Flexible Dose Ranges of XXX vs. Placebo or Divalproex Sodium in the Treatment of Manic or Mixed Episodes Associated with Bipolar I Disorder".

28. "A 9-Week, Open-Label, Multicenter, Safety Trial of Flexible Dose Ranges of XXX in the Treatment of manic or Mixed Episodes Associated with Bipolar I Disorder".

29. "A Controlled Trial of Olanzipine versus XXX in the Treatment of Schizophrenic and Schizoaffective Subjects with Prominent Negative Symptoms."

30. "A Multicenter, Randomized, Double-Blind Study of Flexible Doses of XXX vs. Perphenzaine in the Treatment of Patients with Treatment-Resistant Schizophrenia".

31. A Multicenter, Randomized, Double-Blind, Placebo Controlled, 26 Week Study of a Fixed Dose of XXX in the Treatment of Stabilized Patients with Chronic Schizophrenia".

32. "A Multicenter, Randomized, Double-Blind Safety and Tolerability Study of Flexible Doses of XXX and Olanzapine in the Treatment of Patients with Acute Schizophrenia".

33. "A Double-Blind, Placebo and Haloperidol-Controlled, Multicenter Study Evaluating the Safety and Efficacy of XXX in Schizophrenic patients".

34. "A Double-Blind, Placebo and Haloperidol-Controlled, Multicenter Study Evaluating the Safety and Efficacy of XXX in Schizophrenic Patients".

35. "Open Label Trial Exploring A Switching Regimen From Oral Neuroleptics, Other Than Risperidone, To XXX Depot Microspheres".

36. "A Phase III, Open-Label Study of the Safety and Efficacy of XXX in Patients with Major Depressvie Disorder with Psychotic Features Who Have Previously Demonstrated a Rapid Response to either C-1073 or Placebo in Study C-1073-02 or C-1073-03".

37. "A Multicenter, Double-blind, Randomized Comparison of the Efficacy and Safety XXX and Risperidone (RISPERDAL) in the Treatment of Patients with Schizophrenia".

38. "A Multicenter, Double-blind, Randomized Comparison of the Efficacy and Safety of Sustained-release Formulation XXX and Placebo in the Treatment of Patients with Schizophrenia".

39. "A Randomized, Double-Blind, Dose-Ranging Study Of Intramuscular XXX In The Treatment Of Acute Agitation In Patients With A Diagnosis Of Schizophrenia, Schizoaffective, Or Schizophreniform Disorder".

40. "A Double-Blind, Placebo-Controlled Trial To Estimate The Maximum Tolerated Dose (MTD) of XXX In Patients With Schizophrenia or Schizoaffective Disorder, Who Are Poor Metabolizers For The CYP2D6 Enzyme."

41. "A Phase III, Randomized, Double-Blind, Placebo-Controlled, Outpatient Study To Assess The Long-Term Safety And Efficacy Of Two Dose Levels Of XXX In Adult Patients With Primary Insomnia."

42. "A 21-day, double blind, placebo-controlled, parallel-group evaluation of the efficacy and safety of XXX in the treatment of the manic phase of bipolar disorder."

43. "A Randomized, double blind study of this safety and efficacy of XXX plus an atypical Antipsychotic vs. atypical Antipsychotic alone in the treatment of Schizophrenia."

44. "A Multicenter, randomized, parallel group, double blind, Phase III comparison of the efficacy and safety of XXX to placebo, when used as adjunct to mood stabilizers in the maintenance treatment of bipolar I disorder in adult patients."

45. "A Multicenter, open label, flexible dose, parallel-group evaluation of the catarctogenic potential of XXX and Risperidone (Risperdal) in the long term treatment of patients with Schizophrenia or Schizoaffective disorder."

46. A Multicenter, randomized, double blind, placebo controlled study of three fixed doses of XXX in the treatment of patients with acute schizophrenia.

47. "A randomized, double blind, comparison of the efficacy and safety of XXX in Intramuscular formula, Lorazepam or placebo in the treatment of acutely agitated patients diagnosed with bipolar I disorder, manic or mixed."

48. "A randomized, double blind, comparison of the efficacy and safety of XXX in Intramuscular formula, Haloperidol, or placebo in the treatment of acutely agitated patients with a diagnosis of Schizophrenia or Schizoaffective disorder."

49. "A randomized, double blind, dose-ranging study of Intramuscular XXX in the treatment of acute agitation in patients with a diagnosis of schizophrenia, schizoaffective or schizophreniform disorder."

50. "A Multicenter, randomized, double blind, parallel group, placebo controlled, flexible dose study evaluating efficacy, safety and tolerability of once-daily oral XXX (20-40-60-mg) vs. placebo in subjects with major depressive disorder over an eight-week treatment period."

51. "An open label study assessing XXX in subjects with major depressive disorder who discontinued treatment with selective Serotonin Reupdate Inhibitors or a selective Serotonin/Norepinephrine Reuptake Inhibitor due to intolerability."

52. "A randomized, double blind, placebo controlled dose response trial of XXX in the treatment of bipolar I disorder, most recent episode depressed."

53. "A Pharmacokinetics, tolerability and safety of XXX after repeated Intramuscular injection of XXX in the arm or the buttock of subjects with Schizophrenia."

54. "A comparison of steady state Pharmacokinetics of XXX after extended release OROS XXX 15mg and immediate release of Oral Risperidone 8mg b.i.d. in subjects with schizophrenia or schizoaffective disorder."

55. "An open label evaluation of the utility of the XXX Treatment Guidebook during transition of adult patients with schizophrenia or schizoaffective disorder to XXX."

56. "A 12-week, Multicenter, randomized, double blind, placebo-controlled evaluation of XXX as adjunctive therapy in the treatment of cognitive impairment of patients with schizophrenia or schizophrenia disorder."

57. "A randomized, double blind, placebo-controlled and Risperidone-referenced, parallel-group efficacy and safety study of two fixed doses of XXX in the treatment of schizophrenia."

58. "An open label, flexible dose, long term safety and efficacy study of XXX in the treatment of schizophrenia."

59. "A phase III, open-label, fixed dose study to determine the safety of long-term administration of XXX in subjects with chronic insomnia."

60. "A Multicenter, randomized, parallel-group, double blind, phase III comparison of the efficacy and safety of XXX (oral tablets 400mg to 800mg daily in divided doses) to placebo when used as adjunct to mood stabilizers (lithium or divalproex) in the maintenance treatment of bipolar I disorder in adult patients."

61. "A four-week, double blind, Multicenter study comparing the efficacy and safety of XXX to XXX in subjects with schizophrenia or schizoaffective disorder needing inpatient care."

62. "A randomized, double blind, placebo-controlled, dose response of XXX in subjects with schizophrenia who have predominantly negative symptoms."

63. "A Multicenter, double blind, randomized comparison of the efficacy and safety of XXX and Risperidone (RISPERDAL) in the treatment of patients with schizophrenia."

EXHIBIT B

Keith Arnold
Executive Vice President, Elements Behavioral Health

Keith P. Arnold is Vice President of Operations for Elements Behavioral Health and Promises Treatment Centers. He joined the company in August 2008 and is responsible for overseeing and contributing to sales and marketing, corporate branding, referent relations, intake, alumni services, clinical programming, and Internet operations.

Prior to joining Elements, Keith served as Executive Director of Sierra Tucson, a 139-bed dually licensed psychiatric and behavioral health hospital, where he was responsible for leading and directing all aspects of the operation. His 14-year tenure included being the director of marketing, intake, alumni services, and investor relations.

The majority of Keith's career prior to Sierra Tucson was as Director of Client Services for ExecuTrak Systems, an international consulting firm. There he was responsible for sales and marketing, facilitating merger and acquisition integration, strategic planning, rightsizing, quality programs, team building, and business values assessments. He worked with Fortune 100 companies nationally and internationally.

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April 26, 2010
Via Facsimile (860) 418-7053
and Federal Express

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

RECEIVED
2010 APR 27 A 11:59
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Facility in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Motion to Disqualify the law firm of Robinson & Cole LLP.

Thank you.

Very truly yours,

Christopher M. McKeon

CMM/bt
Enclosures

cc: Theodore Tucci, Robinson & Cole LLP

DEPARTMENT OF PUBLIC HEALTH
DIVISION OF OFFICE OF
HEALTH CARE ACCESS : **DOCKET NO. 09-31500-CON**
:
IN RE: EMPLOYMENT OPTIONS, LLC :
D/B/A LITCHFIELD HILLS RETREAT, LLC
PROPOSAL TO ESTABLISH A
FREE STANDING ADULT SUBSTANCE
ABUSE CENTER IN BETHLEHEM : **April 26, 2010**

RECEIVED
2010 APR 27 P 12:00
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

MOTION TO DISQUALIFY ROBINSON & COLE LLP FROM REPRESENTATION OF HIGH WATCH RECOVERY CENTER INC. AND MOTION TO PRECLUDE CONSIDERATION OF ANY DOCUMENTATION, PETITION OR OTHER REQUEST SUBMITTED BY ROBINSON & COLE ON BEHALF OF HIGH WATCH RECOVERY CENTER INC.

Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC ("Applicant"), makes this motion to disqualify the law firm of Robinson & Cole LLP ("R&C") from representing High Watch Recovery Center Inc. ("High Watch"), a potential Intervenor in this matter. The Applicant further moves to preclude from consideration any documentation, petition or other request submitted to the Department of Public Health's Office of Health Care Access Division ("OHCA") by R&C. In support of this Motion, Applicant submits the following:

1. On December 29, 2009, prior to the filing of the Application at issue in this matter, Michele Zurko-Smith, Brian Gwozdz, and Patricia Happy, as representatives of the Applicant, met with R&C Attorneys Ted Tucci and Brian Nichols at R&C's Hartford offices.

2. The purpose of the meeting was to discuss the Application at issue in this matter and the Applicant's possible retaining of R&C in connection therewith.

3. The meeting lasted for approximately one and one-half hours and at the meeting, the Applicant's representatives disclosed virtually every aspect of the substance abuse facility it seeks to establish in its Application.

4. At this meeting, Ms. Zurko-Smith specifically asked Attorney Tucci and Attorney Nichols if all information being communicated to R&C would be held in strict confidence and be subject to the attorney-client privilege.

5. In response to Ms. Zurko-Smith's inquiry, Attorney Tucci and Attorney Nichols assured all present at the meeting that all information disclosed and discussed at the meeting would be kept confidential and was attorney-client privileged.

6. After obtaining such assurance, Applicant's representatives fully disclosed and shared with Attorneys Tucci and Nichols confidential and strategic information regarding the planned facility, and Attorney Tucci and Attorney Nichols rendered and communicated certain impressions, opinions and advice to the Applicant.

7. The Applicant elected not to retain R&C or any attorney for that matter and chose instead to prepare and file its Application on its own which it did on February 5, 2010.

8. On March 22, 2010, R&C, through Attorney Nichols, issued a letter to Commissioner Cristine Vogel on behalf of High Watch as an objector, seeking a hearing on the Applicant's Application and indicating that High Watch will allegedly be adversely impacted if the facility sought by Applicant is established.

9. The Applicant engaged the undersigned's law firm on April 10, 2010 in connection with the hearing on this matter which is now scheduled for April 29, 2010.

10. As a result of R&C's meeting and consultation with Applicant's representatives on December 29, 2009, and R&C's subsequent decision to represent High Watch in direct opposition to Applicant on the very same Application for which Applicant consulted with R&C, R&C's representation of High Watch in this matter would seem to be in direct violation of Rule 1.18 of the Rules of Professional Conduct which provides as follows:

(a) A person who discusses or communicates with a lawyer concerning the possibility of forming a client-lawyer relationship with respect to a matter is a prospective client.

(b) Even when no client-lawyer relationship ensues, a lawyer who has had discussions with a prospective client shall not use or reveal information learned in the consultation, except as Rule 1.9 would permit with respect to information of a former client.

(c) A lawyer subject to subsection (b) shall not represent a client with interests materially adverse to those of a prospective client in the same or a substantially related matter if the lawyer received information from the prospective client that could be significantly harmful to that person in the matter, except as provided in subsection (d). If a lawyer is disqualified from representation under this paragraph, no lawyer in a firm with which that lawyer is associated may knowingly undertake or continue representation in such a matter, except as provided in subsection (d).

(d) When the lawyer has received disqualifying information as defined in subsection (c), representation is permissible if:

(1) both the affected client and the prospective client have given informed consent, confirmed in writing, or

(2) the lawyer who received the information took reasonable measures to avoid exposure to more disqualifying information than was reasonably necessary to determine whether to represent the prospective client; and

(i) the disqualified lawyer is timely screened from any participation in the matter; and

(ii) written notice is promptly given to the prospective client.

11. At no time during or after Applicant's meeting with Attorneys Tucci and Nichols did either inform the Applicant that if R&C was not retained by Applicant, that R&C would or could represent another party to the same proceeding.

12. The Applicant did not and does not consent to R&C's representation of High Watch in this proceeding.

13. R&C's representation of High Watch in this matter in any capacity is unfair and improper and it calls into question the fair and efficient administration of justice in this matter.

The Affidavit of Michele Zurko-Smith, which attests to the foregoing, is attached hereto and submitted herewith.

WHEREFORE, it is respectfully requested that Robinson & Cole LLP be disqualified from representing High Watch Recovery Center Inc. or any other party in opposition to the Applicant in this proceeding because it was and is privy to confidential information communicated to it by the Applicant for the purpose of seeking legal representation in connection with the Application at issue in this proceeding. To the extent that Robinson & Cole LLP has or will submit any documentation, petition or other request on behalf of High Watch prior to the Department of Public Health's Office of Health Care Access Division's ("OHCA") decision on this motion, the Applicant further moves that any such documentation, petition or other request be precluded from consideration by OHCA inasmuch as any such documentation, petition or other request prepared by Robinson & Cole LLP is tainted by the unfair and improper advantage obtained by and through Robinson & Cole LLP's prior consultation with the Applicant as set forth above.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: _____

Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

ORDER

The foregoing motion having been duly heard, it is hereby **GRANTED/DENIED.**

_____
Presiding Officer

CERTIFICATION

This is to certify that a copy of the foregoing was faxed and mailed by first class mail, postage prepaid, this 26th day of April, 2010 to:

Theodore J. Tucci
Robinson & Cole LLP
280 Trumbull Street
Hartford, CT 06103-3597
Facsimile (860) 275 8299

_____
Christopher M. McKeon

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING ADULT SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 26, 2010**

AFFIDAVIT OF MICHELE ZURKO-SMITH

The undersigned, being duly sworn, hereby deposes and says:

1. I am over the age of eighteen years and believe in the obligations of an oath.

2. On December 29, 2009 at approximately 11:00 a.m., as a representative of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC ("Applicant"), I, along with my colleagues, Brian Gwozdz and Patricia Happy, had a meeting at the offices of the law firm of Robinson & Cole LLP ("R&C") located on the 28th floor of 280 Trumbull Street, Hartford, Connecticut, with Attorneys Ted Tucci ("Attorney Tucci") and Brian Nichols ("Attorney Nichols").

3. The purpose of the meeting was to discuss our plans to establish a substance abuse treatment facility in Bethlehem, Connecticut for which we had already filed a Letter of Intent with the State of Connecticut Department of Public Health Division of Office of Health Care Access ("OHCA").

4. At the time of the meeting, we were in the process of preparing an Application for Certificate of Need consistent with the Letter of Intent we had previously filed with OHCA and we were considering retaining R&C to represent Applicant in connection therewith.

5. Our meeting with Attorney Tucci and Attorney Nichols lasted for approximately one and one-half hours and at the meeting, we disclosed every aspect of the substance abuse facility we seek to establish, as well as our theories and analyses as to the need for such a facility, the identity of our consultant's and advisors, the hurdles we had overcome to date in connection with our plans, and the remaining issues and obstacles that stood in the way of our carrying out of our plans to establish a unique substance abuse treatment facility the likes of which do not exist in the State of Connecticut.

6. At this meeting, I specifically and pointedly asked Attorneys Tucci and Nichols if all information being communicated to R&C would be held in confidence.

7. In response to my inquiry, Attorney Tucci assured us that all information disclosed and discussed at the meeting would be kept confidential and was attorney-client privileged.

8. After obtaining such assurance, we fully disclosed and shared with Attorneys Tucci and Nichols confidential and strategic information regarding the planned facility and our Application, and Attorneys Tucci and Nichols rendered and communicated to us certain impressions, opinions and advice.

9. We elected not to retain R&C or any attorney for that matter and chose instead to prepare and file our Application on our own, which we did on February 5, 2010.

10. We were shocked when we learned that R&C was representing High Watch in opposing our Application. We learned that Attorney Nichols issued a letter to OHCA, on behalf of High Watch as an objector, seeking a hearing on our Application and indicating that High Watch will allegedly be adversely impacted if we are permitted to establish the very facility we had described to Attorneys Tucci and Nichols at our December 29, 2009 meeting.

11. At no time during our meeting or afterward did Attorney Tucci or Attorney Nichols indicate that R&C would or could represent another party in this proceeding in the event that we did not retain R&C.

12. We do not and did not consent to R&C's representation of High Watch or any other party or potential party to this proceeding.

13. We feel very strongly that R&C's representation of any party opposing the Application we had consulted R&C about is unfair, unethical and improper and had we known that R&C could or would agree to represent any party in direct opposition to our Application, we would have never disclosed the information we did at our December 29, 2009 meeting.

Michele Zurko-Smith

STATE OF CONNECTICUT)
) ss. New Haven
COUNTY OF NEW HAVEN)

On this the 26th day of April, 2010, before me, the undersigned officer, personally appeared Michele Zurko-Smith, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that he executed the same for the purposes therein contained.

IN WITNESS WHEREOF, I hereunto set my hand.

Commissioner of the Superior Court
~~Notary Public~~ Christopher M. Mason

My Commission Expires:

Greer, Leslie

RECEIVED
2010 APR 28 P 1:21
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

From: Lazarus, Steven
Sent: Wednesday, April 28, 2010 10:25 AM
To: Greer, Leslie; Olejarz, Barbara
Cc: Greci, Laurie; Riggott, Kaila
Subject: FW: Ruling on Petition to be Designated as an Intervenor

Leslie and Barbara,

Please add to the record.

Thank you,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Louis B. Todisco [mailto:LTODISCO@murthalaw.com]
Sent: Wednesday, April 28, 2010 10:06 AM
To: Lazarus, Steven
Cc: michelemvolpe@aol.com; Paul E. Knag
Subject: Ruling on Petition to be Designated as an Intervenor

Mr Lazarus,

We have received the Ruling of the Hearing Officer on the above matter.

The Ruling does not specifically address the right to present evidence. This was requested in the Petition, and proposed testimony of Dr. Sigurd Ackerman was prefiled with the Petition. I note that the Hearing Officer states that the Petitioner may be cross-examined by the Applicant, so it is clear that the right to present evidence was intended, but this should probably be clarified in the Ruling.

Louis Todisco
203-772-7718

Louis B. Todisco
Partner
ltodisco@murthalaw.com

Murtha Cullina LLP
Whitney Grove Square, Two Whitney Avenue
New Haven, CT 06510-1220
Direct: 203-772-7718
Direct Fax: 860-240-5715
Main: 203-772-7700

Main Fax: 203-772-7723

www.murthalaw.com

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From: Lazarus, Steven [mailto:Steven.Lazarus@ct.gov]
Sent: Tuesday, April 27, 2010 7:53 AM
To: Louis B. Todisco
Cc: Roberts, Karen
Subject: Follow up to Pre-File Emai from Monday

Good Morning Lou,

I've attached another copy of the Applicant's pre-file testimony that was emailed to you yesterday under FOI since you office had left me a voice mail stating the you might have been emailed the same 2 files instead of the 2 different files.

Please let me know if you have any additional questions.

Thank you,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

Greer, Leslie

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From: Lazarus, Steven
Sent: Wednesday, April 28, 2010 10:53 AM
To: Greer, Leslie; Olejarz, Barbara
Cc: Greci, Laurie; Riggott, Kaila
Subject: FW: Ruling on Petition to be Designated an Intervenor

Leslie and Barbara,

Please add to the record.

Thank you,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Lazarus, Steven
Sent: Wednesday, April 28, 2010 10:45 AM
To: 'Louis B. Todisco'
Cc: michelemvolpe@aol.com
Subject: RE: Ruling on Petition to be Designated an Intervenor

Not a problem. Have a good day!

Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Louis B. Todisco [mailto:LTODISCO@murthalaw.com]
Sent: Wednesday, April 28, 2010 10:28 AM
To: Lazarus, Steven
Cc: michelemvolpe@aol.com
Subject: RE: Ruling on Petition to be Designated an Intervenor

Mr. Lazarus,

Thank you. I apologize for any inconvenience.

Louis Todisco

Louis B. Todisco
Partner
ltodisco@murthalaw.com

Murtha Cullina LLP
Whitney Grove Square, Two Whitney Avenue
New Haven, CT 06510-1220
Direct: 203-772-7718
Direct Fax: 860-240-5715
Main: 203-772-7700
Main Fax: 203-772-7723

www.murthalaw.com

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From: Lazarus, Steven [mailto:Steven.Lazarus@ct.gov]
Sent: Wednesday, April 28, 2010 10:23 AM
To: Louis B. Todisco
Cc: michelemvolpe@aol.com
Subject: RE: Ruling on Petition to be Designated an Intervenor

Good Morning Attorney Todisco,

You are correct and the tentative Agenda is the appropriate place to see persons allowed to testify.

Sincerely,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Louis B. Todisco [mailto:LTODISCO@murthalaw.com]
Sent: Wednesday, April 28, 2010 10:17 AM
To: Lazarus, Steven
Cc: michelemvolpe@aol.com
Subject: Ruling on Petition to be Designated an Intervenor

Mr. Lazarus,

Since my email on the above subject of a few minutes ago, I note that the Agenda includes time for the Intervenor's Direct Testimony, confirming that the right to present evidence was granted.

Louis Todisco

Louis B. Todisco
Partner
ltodisco@murthalaw.com

Murtha Cullina LLP
Whitney Grove Square, Two Whitney Avenue
New Haven, CT 06510-1220
Direct: 203-772-7718
Direct Fax: 860-240-5715
Main: 203-772-7700
Main Fax: 203-772-7723

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Greer, Leslie

From: Lazarus, Steven
Sent: Wednesday, April 28, 2010 10:21 AM
To: Greer, Leslie; Olejarz, Barbara
Cc: Dillon, Melanie; Greci, Laurie; Riggott, Kaila
Subject: FW: Docket No. 09-31500-CON
Importance: High
Attachments: 4-18-10 Cover Letter re Motion to Compel.pdf; Motion to Compel.pdf

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2010 APR 28 P 1:21
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Leslie and Barbara,

Please add to the record.

Thank you,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Jessica L. White [mailto:jwhite@murthalaw.com]
Sent: Wednesday, April 28, 2010 10:14 AM
To: Lazarus, Steven
Cc: Volpe, Michele M.; Paul E. Knag
Subject: Docket No. 09-31500-CON
Importance: High

Dear Mr. Lazarus:

Please see attached.

Sincerely,

Jessica L. White
Paralegal
jwhite@murthalaw.com

Murtha Cullina LLP
177 Broad Street, 4th Floor
Stamford, CT 06901
Direct: 203-653-5427
Direct Fax: 860-240-5950
Main: 203-653-5400
Main Fax: 203-653-5444

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HEALTH CARE ACCESS

MURTHA

PAUL E. KNAG
203.653.5407 DIRECT TELEPHONE
203.653.5444 DIRECT FACSIMILE
PKNAG@MURTHALAW.COM

April 28, 2010

Via Facsimile (860) 418-7053
Via email: STEVEN.LAZARUS@CT.GOV
(Original will be hand delivered at hearing.)

Deputy Commissioner Cristine Vogel
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: **Docket No. 09-31500-CON**
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Free Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Silver Hill Hospital, petitioning intervenor, enclosed please find one (1) original and six (6) copies of a Motion to Compel the Appearance, Testimony and Cross-Examination of Michelle Zurko-Smith at the public hearing on April 29, 2010.

Thank you.

Very truly yours,

Paul E. Knag

Enclosures
cc: Michele M. Volpe, Esq. (Bershtein, Volpe & McKeon P.C.)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS DIVISION

IN THE MATTER OF THE APPLICATION OF EMPLOYMENT OPTIONS, INC. D/B/A/ LITCHFIELD HILLS RETREAT, LLC FOR THE ESTABLISHMENT OF A FREE-STANDING MENTAL HEALTH AND SUBSTANCE ABUSE FACILITY IN BETHLEHEM, CONNECTICUT, WITH A TOTAL CAPITAL EXPENDUTRE OF $500,000	DOCKET NO. 09-31500-CON APRIL 28, 2010

MOTION OF SILVER HILL HOSPITAL, INC. TO COMPEL THE APPEARANCE, TESTIMONY, AND CROSS-EXAMINATION OF MICHELLE ZURKO-SMITH

Silver Hill Hospital, Inc. (the "Silver Hill"), is a psychiatric hospital located in New Canaan, Connecticut. On or about April 21, 2010, Silver Hill submitted a petition to the Department of Public Health, Office of Health Care Access Division ("OHCA") to be designated as an intervenor with full rights of participation in the above referenced Certificate of Need application ("CON") by Employment Options, Inc. d/b/a Litchfield Hills Retreat, LLC (the "Applicant"); the petition is currently pending. Silver Hill by this motion requests that OHCA compel the attendance and testimony of Michelle Zurko-Smith at the public hearing scheduled for April 29, 2010.

Zurko-Smith lists herself as the Applicant. She is CEO and founding member of the corporate Applicant, purportedly the Chief Operating Officer and/or Chief Executive Officer of Litchfield Hills Retreat, LLC ("Litchfield Hills"), the sole owner of the real property upon which the Litchfield Hills facility will be maintained, and the "driving force behind the proposal to establish the Litchfield Hills substance abuse treatment center." In addition, she (either personally or as Applicant's CEO) has financed the Litchfield Hills project to date and she alone intends to finance the remainder of the project from her own personal resources. Presumably, she also prepared the CON, or directed it to be prepared, and provided much, if not all, of the information contained therein.

Despite her preeminent role in the Litchfield Hills project, Zurko-Smith has failed to submit any prefile testimony. Instead, Applicant has filed the testimony of two witnesses, Brian Gwozdz and David Sack, M.D., each of whom made a prefile submission on April 26, 2010. Yet, neither Mr. Gwozdz nor Dr. Sack is even mentioned in Applicant's CON. While the CON designates Zurko-Smith as Applicant's CEO and contains her "resume" and credentials, there is no similar disclosure of Mr. Gwozdz's or Dr. Sack's resume or credentials. Moreover, the testimony provided by these two witnesses is substantially inconsistent with various representations and methodologies contained in Applicant's CON. Without limitation, such discrepancies include the Applicant's intention to obtain licensure and accreditation, the methodology used for determining the public need for the Litchfield

Hills project, the treatment modalities to be employed by the facility (including a discrepancy in the diagnoses to be treated), the target market for services (including a discrepancy in the number of professionals practicing in Connecticut and/or the prevalence of substance abuse among such professionals), and the intended staffing of the facility. Zurko-Smith should be compelled to appear and bear witness to explain such discrepancies. Even more disconcerting, Mr. Gwozdz's and Dr. Sack's prefile testimony was submitted only three (3) days prior to the public hearing, after the deadline for the filing of prefiled testimony by Silver Hill as petitioned intervenor, providing OHCA and/or other interested parties inadequate opportunity for challenge or rebuttal.

Accordingly, failure of Zurko-Smith to appear, give testimony and submit to cross-examination in connection with the April 29, 2010 public hearing would be irreparably prejudicially to the public and serve only to preclude OHCA's complete and educated consideration of Applicant's CON.

Respectfully submitted,

SILVER HILL HOSPITAL, INC.

By _____

Paul E. Knag
Murtha Cullina LLP
177 Broad Street
Stamford, CT 06901
Telephone: (203) 653-5407
Fax: (203) 653-5444
pknag@murthalaw.com

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, CT 06503
Telephone: (203) 772-7718
Fax: (203) 772-7723
ltodisco@murthalaw.com
Its Attorneys

ORDER

The foregoing Motion to Compel having been considered, it is hereby Ordered that:

1. Applicant's CEO, Michelle Zurko-Smith, be compelled to appear, give testimony and submit to cross-examination regarding Applicant's CON.

_____

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Motion to Compel was sent by facsimile and electronic mail, this 28th day of April, 2010, to:

Vincent M. Marino, Esq.
Cohen and Wolf, P.C.
1115 Broad Street
Bridgeport, CT 06604

Michele M. Volpe, Esq.
Bershtein, Volpe & McKeon, P.C.
105 Court Street, Suite 304
New Haven, Connecticut 06511

Paul E. Knag

Greer, Leslie

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From: Lazarus, Steven
Sent: Wednesday, April 28, 2010 1:14 PM
To: Olejarz, Barbara; Greer, Leslie
Cc: Greci, Laurie; Riggott, Kaila
Subject: FW: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)
Attachments: Objection to Motion to Compel.pdf

Barbara & Leslie,

Please add to the record.

Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Bettyanne Toole [mailto:bettyanne@bvmlaw.com]
Sent: Wednesday, April 28, 2010 1:07 PM
To: Lazarus, Steven; Martone, Kim
Cc: michelemvolpe@aol.com; Christopher McKeon; Aimee Onofrio
Subject: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

Steven and Kim: Attached please find an Objection to Motion to Compel. Thank you.

Betty Anne Toole-Teasley
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Facsimile: (203) 777-5806

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BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

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HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

April 28, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
(Original will be hand delivered at Hearing)

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of an Objection to Silver Hill Hospital Inc.'s Motion to Compel.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Object to Motion to Compel) 4.28.10.doc

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HEALTH CARE ACCESS

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 28, 2010**

OBJECTION TO MOTION TO COMPEL

The Applicant in the above matter, Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC (the "Applicant"), hereby objects to Silver Hill Hospital Inc.'s ("Silver Hill") Motion to Compel. Silver Hill's Motion to Compel is nothing more than an unsubstantiated and unsupported effort to force Applicant to present its Application in a manner dictated by Silver Hill. The Applicant alone determines the manner in which it presents its Application. OHCA has posed completeness questions to the Applicant and Applicant has answered the same. OHCA has the ability to question Applicant and its witnesses at the hearing on the CON Application. There is no authority whatsoever for Silver Hill's claim that Ms. Zurko-Smith should be compelled to testify so that Silver Hill can cross-examine her. Should OHCA grant Silver Hill's Motion to Compel, it will be allowing an intervenor to dictate the manner in which the Applicant presents its case. Such a result is legally unsupported, and it abrogates fundamental concepts of justice and fairness, and it will impair the orderly conduct of the proceedings.

Notwithstanding Silver Hill's misguided effort to compel Ms. Zurko-Smith's testimony, she will be present at the hearing and will offer to be put under oath in order to respond to any inquiries that OHCA may have for her about the CON Application. Any questions as to alleged discrepancies in the CON Application and documentation submitted in support thereof, if any, can and will be addressed through the Applicant's witnesses who have filed prefile testimony

and are subject to cross-examination. To the extent that OHCA wishes further clarification of any information, it alone can inquire of Ms. Zurko-Smith if it so desires.

Silver Hill's Motion contains factual inaccuracies and/or misrepresentations which must be pointed out. First, Ms. Zurko-Smith did not "list herself as the Applicant." The Application clearly provides that Employment Options, LLC is the Applicant. While she is the sole owner of the Applicant, the Application makes clear that the licensure, accreditation, treatment modalities, staffing and implementation of the proposed facility was and will be developed by and through consultants and employees, some of whom have been involved in the CON process, and others who will be retained and/or employed as implementation occurs. Silver Hill's allegations that Ms. Zurko-Smith's failure to offer prefile testimony is "disconcerting" and "serve[s] only to preclude OHCA's complete and educated consideration of Applicant's CON" are unjustified, unsupported and improper.

Secondly, Silver Hill alleges that the Applicant's prefile testimony was submitted after the deadline for filing of same. Silver Hill obviously made this allegation without any inquiry into the Record since if it had conducted any such inquiry, it would have seen OHCA's April 20, 2010 letter to the Applicant (Exhibit N in Table of Record) which clearly and unequivocally stated that the deadline for filing prefile testimony was 4:30 pm on Monday, April 26, 2010 – a deadline which was met by the Applicant.

For these reasons, the Motion to Compel should be summarily denied.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: _____
Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Docs\Silver Hill (Intervenor)\Objection to Motion to Compel.doc

CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 28th day of April, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
Stamford, Connecticut 06901
Facsimile: (203)653-5444

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723

Michele M. Volpe

FAX TRANSMISSION

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET
THIRD FLOOR
NEW HAVEN, CT 06511
(203) 777-5800 Fax: (203) 777-5806

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2010 APR 28 P 1:13
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

FAX #: (860) 418-7053
TO: Honorable Cristine Vogel
Office of Health Care Access

DATE: April 28, 2010

PAGES: 6 including this page

CC: Louis Todisco
(203) 772 7723
Paul Knag
(203) 653 5444

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

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COMMENTS:

Dear Commissioner Vogel:

Please see the attached Objection to Silver Hill Hospital Inc.'s Motion to Compel.

Thank you.

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

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CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

April 28, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
(Original will be hand delivered at Hearing)

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of an Objection to Silver Hill Hospital Inc.'s Motion to Compel.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Object to Motion to Compel) 4.28.10.doc

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 28, 2010**

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2010 APR 28 P 1:13
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OBJECTION TO MOTION TO COMPEL

The Applicant in the above matter, Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC (the "Applicant"), hereby objects to Silver Hill Hospital Inc.'s ("Silver Hill") Motion to Compel. Silver Hill's Motion to Compel is nothing more than an unsubstantiated and unsupported effort to force Applicant to present its Application in a manner dictated by Silver Hill. The Applicant alone determines the manner in which it presents its Application. OHCA has posed completeness questions to the Applicant and Applicant has answered the same. OHCA has the ability to question Applicant and its witnesses at the hearing on the CON Application. There is no authority whatsoever for Silver Hill's claim that Ms. Zurko-Smith should be compelled to testify so that Silver Hill can cross-examine her. Should OHCA grant Silver Hill's Motion to Compel, it will be allowing an intervenor to dictate the manner in which the Applicant presents its case. Such a result is legally unsupported, and it abrogates fundamental concepts of justice and fairness, and it will impair the orderly conduct of the proceedings.

Notwithstanding Silver Hill's misguided effort to compel Ms. Zurko-Smith's testimony, she will be present at the hearing and will offer to be put under oath in order to respond to any inquiries that OHCA may have for her about the CON Application. Any questions as to alleged discrepancies in the CON Application and documentation submitted in support thereof, if any, can and will be addressed through the Applicant's witnesses who have filed prefile testimony

and are subject to cross-examination. To the extent that OHCA wishes further clarification of any information, it alone can inquire of Ms. Zurko-Smith if it so desires.

Silver Hill's Motion contains factual inaccuracies and/or misrepresentations which must be pointed out. First, Ms. Zurko-Smith did not "list herself as the Applicant." The Application clearly provides that Employment Options, LLC is the Applicant. While she is the sole owner of the Applicant, the Application makes clear that the licensure, accreditation, treatment modalities, staffing and implementation of the proposed facility was and will be developed by and through consultants and employees, some of whom have been involved in the CON process, and others who will be retained and/or employed as implementation occurs. Silver Hill's allegations that Ms. Zurko-Smith's failure to offer prefile testimony is "disconcerting" and "serve[s] only to preclude OHCA's complete and educated consideration of Applicant's CON" are unjustified, unsupported and improper.

Secondly, Silver Hill alleges that the Applicant's prefile testimony was submitted after the deadline for filing of same. Silver Hill obviously made this allegation without any inquiry into the Record since if it had conducted any such inquiry, it would have seen OHCA's April 20, 2010 letter to the Applicant (Exhibit N in Table of Record) which clearly and unequivocally stated that the deadline for filing prefile testimony was 4:30 pm on Monday, April 26, 2010 – a deadline which was met by the Applicant.

For these reasons, the Motion to Compel should be summarily denied.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: _____
Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Docs\Silver Hill (Intervenor)\Objection to Motion to Compel.doc

CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 28th day of April, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
Stamford, Connecticut 06901
Facsimile: (203)653-5444

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723

Michele M. Volpe

HIGH WATCH RECOVERY CENTER, INC.
62 Carter Road • P.O. Box 607 • Kent, CT 06757 / 888.493.5368 • 860.927.3772 • Fax 860.927.1840 • www.highwatchrecovery.com

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FACSIMILE TRANSMITTAL SHEET

TO: Steven Lazarus	FROM: Diane Kelli
COMPANY: OCHA	DATE: 4/28/10
FAX NUMBER: 860 - 418-7053	TOTAL NO. OF PAGES INCLUDING COVER: 6
PHONE NUMBER:	**SENDER'S FAX NUMBER : 860-927-1840**

RE: Attached letter to Cristine Vogel

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

(The following documents contain information that belongs to the sender and is legally privileged. The information that follows is intended for use only by the individual(s) listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telephoned, facsimile information is strictly prohibited. If you are receiving this transmission in error, please notify the sender or call High Watch Farm immediately 860-927-3772).

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April 27, 2010

Cristine A. Vogel
Deputy Commissioner
Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: Employment Options, LLC d/b/a Litchfield Hills Retreat
Docket No. 09-31500-CON

Dear Deputy Commissioner Vogel:

I am writing on behalf of High Watch Recovery Center, Inc. ("High Watch") in opposition to the Certificate of Need ("CON") application filed with the Office of Health Care Access ("OHCA") by Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC (the "Applicant") to establish a free-standing substance abuse residential treatment facility in Bethlehem, Connecticut (the "Proposed Facility").

High Watch opposes the CON application submitted by the Applicant on the grounds that (1) no need has been demonstrated for the Proposed Facility and it is not cost-effective, (2) if approved, the Proposed Facility would divert volume from High Watch and other existing providers of substance abuse rehabilitation services, and (3) the treatment model outlined for the Proposed Facility is not clinically sufficient to provide quality care. This letter includes a brief description of High Watch and its mission, and then discusses the above flaws in the Applicant's CON application in more detail.

<u>High Watch</u>

High Watch operates a seventy-eight (78) bed free-standing substance abuse treatment facility in Kent, Connecticut, which is less than thirteen (13) miles from the Proposed Facility.

Founded in 1940 by Bill Wilson, the co-founder of Alcoholics Anonymous, High Watch is the oldest facility in the United States that is dedicated to the Twelve Step Principles of Alcoholics Anonymous. High Watch provides substance abuse treatment through cutting edge programs personalized for the individual patients needs. High Watch is a non-profit, private pay facility and provides a comprehensive array of substance abuse treatment including both traditional counseling and medical therapy for an inclusive fee of $260 per day. Included in this fee are the services of a psychiatrist, psychiatric nurse practitioners, social workers and registered nurses. Attached as Exhibit A to this letter is a brochure that explains High Watch's scope of services in more detail.

No Demand Exists for the Proposed Facility

Contrary to the Applicant's assertions, no demand exists for the Proposed Facility. In fact, the premise behind the Proposed Facility is fundamentally flawed. It assumes that a need exists and that there is a lack of access to substance abuse treatment for those who can most afford it – high net worth, private pay individuals. In response to OHCA's questions regarding demand for the Proposed Facility, the Applicant attempts to establish need by citing to a June 2006 report from the Office of National Drug Control Policy.[1] This report provides data regarding Drug Enforcement Agency drug arrests and incarceration, but provides no support for the existence of an unmet need for substance abuse treatment for wealthy professionals or high profile individuals.

The Applicant has provided certain projections of volume for the first three (3) years of operations for the Proposed Facility.[2] The only support for these projections is the Applicant's statement that they are based on "similar programs that are offer [sic] out of state, the number of

[1] CON Application, p. 9-18.
[2] Id. at p. 23.

professionals in the state, and the ramp up time for advertising the program," in addition to "the number of inquiries generated from [the Applicant's] web site and speaking with professionals in [Connecticut]."[3] The Applicant has provided no data related to existing capacity for substance abuse treatment services in Connecticut,[4] nor has the Applicant provided any data showing existing or future volume for such services.

Existing providers can adequately serve the current and future volume for substance abuse treatment in Connecticut. With respect to High Watch, High Watch has a capacity for 28,470 bed days each year.[5] In 2007, High Watch provided 22,681 bed days, or 79.7% of capacity. In 2008, High Watch provided 20,308 bed days, or 71.3% of capacity. In 2009, High Watch provided 21,795 bed days, or 76.6% of capacity. For the past three (3) years, High Watch's average utilization was 75.9%. High Watch has adequate capacity to serve the volume projected by the Applicant in the first three (3) years of operation.

The Proposed Facility Would Divert Volume from Existing Providers

The Applicant states that its target population is "high level professionals, executives, celebrities, public officials and others who seek a discreet, highly confidential and secluded treatment setting."[6] The Applicant also claims that patients in the target population currently either leave the state to receive services or do not seek treatment.[7] The Applicant provides no data to support this assertion.[8]

As stated above, no basis exists to support the belief that existing facilities are not adequately meeting the treatment needs of high profile private pay patients such as lawyers and

[3] Applicant's Response to Completeness Questions, p. 133.
[4] The Applicant claims that the service are of the Proposed Facility will be the entire state of Connecticut. *See* CON Application, p. 6.
[5] Capacity is calculated by multiplying 78 beds by 365 days per year.
[6] CON Application, p. 25.
[7] Id. at p. 19.
[8] Applicant's Response to Completeness Questions, p. 130.

musicians. To the contrary, High Watch has a long history of providing substance abuse treatment to this population.[9] High Watch, like many existing providers of substance abuse treatment services, upholds the highest standards of confidentiality and serves a broad spectrum of patients, including patients in the Applicant's target population. There is simply no basis to conclude that such patients leave Connecticut to obtain treatment for substance abuse because of a lack of existing capacity to obtain treatment in a confidential manner. Moreover, High Watch provides comprehensive services at a cost that is tens of thousands of dollars less than planned for the Proposed Facility.

In addition, High Watch provides free substance abuse treatment to twenty-six (26) individuals, on average, each year, at a cost of $46,800 per individual. If the Proposed Facility is approved, some of the volume upon which High Watch relies to fund this charity care will likely be diverted to the Proposed Facility. Such a diversion of volume will seriously impair High Watch's ability to continue to provide the same level of charity care to a population of individuals that would not be able to obtain substance abuse treatment otherwise.

The Proposed Facility's Treatment Model is not Clinically Sufficient

If approved, the Proposed Facility will provide substance abuse "education" as well as certain "amenities" such as yoga and massage therapy.[10] The Applicant has provided no evidence that it will provide any defined program of medical treatment at the Proposed Facility. In High Watch's experience, this approach is not clinically sufficient to treat substance abuse disorders. Simply stated, the availability of spa-like accommodations has not been shown to have a positive contribution to the treatment of substance abuse disorders. According to the

[9] I am the co-founder of Connecticut's Lawyer's Concerned for Lawyers program, which was created to provide crisis intervention and referral services for the unique substance abuse and other mental health issues experienced by lawyers.
[10] CON Application, p. 19.

National Institute on Drug Abuse, effective substance abuse treatment is based on a combination of counseling and medical treatment, which is a combination that is not provided by the Proposed Facility.

In addition, the Applicant has stated that the Proposed Facility will target high profile clients who are able to pay the higher price point of the Proposed Facility. There is ample support in clinical literature to indicate that reinforcing the "status" of high profile individuals lends itself to elitism and adds to a patient's substance abuse disorder. High Watch has found that treating a broad spectrum of individuals from a variety of backgrounds and social statuses creates an environment where every patient is able to effectively obtain treatment for his or her substance abuse disorder.

Conclusion

For the above reasons, High Watch respectfully requests that OHCA deny the Applicant's CON application for the Proposed Facility.

Respectfully submitted,

Janina J. Kean, President and CEO

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STAMFORD, CONNECTICUT 06901
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2010 APR 28 P 2:36
CONNECTICUT OFFICE OF
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FACSIMILE TRANSMITTAL

Date:	April 28, 2010	Client Code:	
To:	Deputy Commissioner Cristine Vogel Div. of Office of Health Care Access	Facsimile Number: Telephone Number:	860.418.7053
From:	Paul E. Knag, Esq.	Telephone Number:	203.653.5407

Total Number of Pages (including this cover page): 11 Sent by: JLW

RE: DOCKET NO. 09-31500-CON

Dear Commissioner Vogel:

Please see the attached cover letter and Motion to Strike.

Sincerely,
Jessica L. White
Paralegal

MURTHA

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PAUL E. KNAG
203.653.5407 DIRECT TELEPHONE
203.653.5444 DIRECT FACSIMILE
PKNAG@MURTHALAW.COM

April 28, 2010

Via Facsimile (860) 418-7053
Via email: STEVEN.LAZARUS@CT.GOV
(Original will be hand delivered at hearing.)

Deputy Commissioner Cristine Vogel
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: **Docket No. 09-31500-CON**
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Free Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Silver Hill Hospital, petitioning intervenor, enclosed please find one (1) original and six (6) copies of a Motion to Strike the prefiled testimony of Brian Gwozdz and David Sack, M.D. and to Preclude their proffered testimony at the public hearing on April 29, 2010.

Thank you.

Very truly yours,

Paul E. Knag

Paul E. Knag

Enclosures
cc: Michele M. Volpe, Esq. (Bershtein, Volpe & McKeon P.C.)

RECEIVED
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HEALTH CARE ACCESS

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS DIVISION

IN THE MATTER OF THE APPLICATION OF EMPLOYMENT OPTIONS, INC. D/B/A/ LITCHFIELD HILLS RETREAT, LLC FOR THE ESTABLISHMENT OF A FREE-STANDING MENTAL HEALTH AND SUBSTANCE ABUSE FACILITY IN BETHLEHEM, CONNECTICUT, WITH A TOTAL CAPITAL EXPENDUTRE OF $500,000

DOCKET NO. 09-31500-CON

APRIL 28, 2010

MOTION OF SILVER HILL HOSPITAL, INC. TO STRIKE THE PREFILED TESTIMONY OF BRIAN GWOZDZ AND DAVID SACK, M.D. AND PRECLUDE PROFFERED TESTIMONY AT PUBLIC HEARING

Silver Hill Hospital, Inc. ("Silver Hill") is a psychiatric hospital located in New Canaan, Connecticut. Silver Hill has been granted Intervenor status in this matter by the Department of Public Health, Office of Health Care Access Division ("OHCA"). Silver Hill by this motion requests that OHCA strike the prefiled testimony of Brian Gwozdz and David Sack, M.D., each submitted on or about April 26, 2010, and further preclude their proffered testimony at the public hearing scheduled for April 29, 2010.

OHCA should strike the testimony, because the proffer of the testimony of Mr. Gwozdz and Dr. Sack at this time violates OHCA regulations. OHCA's regulations

specifically provide that: "The direct case of any applicant or petitioner shall consist substantially of the written statement or petition, and the exhibits or other materials annexed thereto unless the presiding officer shall rule otherwise for good cause shown." Reg. Conn. State Agencies (RCSA) § 19a-643-51(d). As set forth below, the proffered testimony of Mr. Gwozdz and Dr. Sack is substantial, expands the need analysis and other analysis set forth in the CON application and exhibits, and is at various times inconsistent with the information in the CON application. It cannot be reasonably said that, given the content, detail and breadth of the testimony and exhibits provided by Mr. Gwozdz and Dr. Sack, the direct case of the Applicant consists substantially of the written statement of the application and materials annexed thereto. This violates the regulation,

Moreover, the Applicant has not even attempted to show "good cause" for its having substantially expanded and modified its certificate of need presentation beyond its application and exhibits. Absent this showing, the testimony should be stricken. OHCA regulations specifically provide for objection to written testimony prior to its admission. RCSA § 19a-643-51(d).

The proffered testimony of Mr. Gwozdz and Dr. Sack also calls into question the assertions within the CON application and the care with which it was prepared.

In support of its arguments, Silver Hill submits the following:

1. The prefiled testimony introduces, at the last minute, new personnel not disclosed in its application. Applicant first submitted its CON application on or about

February 5, 2010. Almost two months later, and just three days before the public hearing on Applicant's CON, Applicant filed the testimony of Mr. Gwozdz and Dr. Sack. Yet, neither witness is even mentioned in Applicant's CON, despite the fact that, at least in Mr. Gwozdz's case, he was acting as Applicant's representative and/or "Acting Director" no later than late December 2009. Moreover, while the CON designates Michele Zurko-Smith as Applicant's CEO and contains her "resume" and credentials, there is no similar disclosure of Mr. Gwozdz's or Dr. Sack's resume or credentials. This key information is a required component of OHCA's CON application process. (*See* CON Application, Sec. 3a). OHCA was not informed of the participation of these individuals or their function with respect to the proposed facility in the application.

2. The prefiled testimony provided by Mr. Gwozdz and Dr. Sack is substantially inconsistent with various representations and methodologies contained in Applicant's CON application regarding need and expands the analysis set forth therein.

Most significantly, the prefiled testimony of Mr. Gwozdz is inconsistent with Applicant's CON with respect to the methodology used to determine the public need for the Litchfield Hills facility The application contained data which supposedly supported a need for services for "high level professionals, executives, celebrities, public officials and others" needing substance abuse treatment whose "public visibility, wealth, fame or social position" demands a confidential treatment facility.

The only reference materials attached to the CON analyzing this segment of the population pertained only to the substance abuse treatment needs of physicians and lawyers. Mr. Gwozdz's testimony introduces an entirely new methodology, implicitly recognizing that the application's need methodology was totally inadequate. He places substantial reliance on several articles and studies not even mentioned in Applicant's CON and introduces data which, while completely flawed, was also not set out in the application. Also, he redefines the target market as persons from households making over $200,000 per year. Not only does Mr. Gwozdz's testimony expand the public need analysis contained in Applicant's CON, but he also relies on the purportedly abandoned and wholly unrelated application of Vista Partners, LLC granted by OHCA for a purportedly similar substance abuse treatment facility; yet, Applicant's CON makes no mention of the Vista Partners application. Applicant has an independent obligation to prove public need to the OHCA and her failure to include the Vista Partners application as part of her public need analysis should preclude consideration of that application.

3. The prefiled testimony provided by Mr. Gwozdz and Dr. Sack is inconsistent with the application in numerous other respects.

Licensure and Accreditation. In the application, when asked to "indicate any ... [Department of Public Health] licensure categories being sought in relation to the proposal," Applicant responds "N/A." (*See* CON Application, Sec. 4c). To the contrary, Gwozdz, in his prefiled testimony, unequivocally states that Litchfield Hills

will seek licensure from Connecticut's Department of Public Health. Dr. Sack, in his prefiled testimony, not only states that Litchfield Hills will seek licensure, but also that it will seek to become accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF"). In fact, Dr. Sack dedicates nearly two whole pages explaining CARF guidelines for accreditation. Yet, Applicant's CON makes no mention of any intent to seek CARF accreditation and the staffing pattern proposed in the CON, which is the basis for the financial projections, would be insufficient to warrant CARF accreditation.

Staffing and Treatment. Yet another example of inconsistent representations pertains to the intended staffing of Litchfield Hills. Dr. Sack's prefiled testimony indicates that Litchfield Hills will employ "adjunct professionals, such a licensed clinical social workers," "treating physician[s]" and otherwise treat substance abuse patients using a "multi-disciplinary approach" pursuant to CARF guidelines. Mr. Gwozdz also refers to himself as "Acting Director" and Michele Zurko-Smith as "Chief Operating Officer." Yet, Applicant's CON states that Ms. Zurko-Smith will be Chief Executive Officer, and indicates an intention to hire only a handful of professionals, including a Chief Financial Officer, Clinical Director (who would be a licensed drug and alcohol counselor) and Treatment Technician. In fact, Applicant's CON distinguishes itself from existing providers by stating that it will provide only conventional substance abuse treatments (i.e., 12-step philosophy), combined with "a myriad of amenities and alternative healing practices." Dr. Sack's testimony is further

inconsistent with the CON in that he states that Litchfield Hills "will be staffed and equipped to deal with [individuals ... hav[ing] a co-occurring disorder such as anxiety or depression." Accordingly, the treatment modalities to be employed by Litchfield Hills (including a discrepancy in the diagnoses to be treated) contemplated by the testimony of both Mr. Gwozdz and Dr. Sack is inconsistent with Applicant's CON.

With these changes, other data in the application would necessarily change, especially the financial projections.

These are but a few examples of inconsistencies between Applicant's CON and the prefiled testimony of Mr. Gwozdz and Dr. Sack.

Summary and Conclusion. Mr. Gwozdz's and Dr. Sack's prefiled testimony was submitted only three (3) days prior to the public hearing, after the deadline for the filing of prefiled testimony by Silver Hill, as petitioned intervenor. As recognized by the regulatory requirement that the Applicant's direct case should consist substantially of the application and exhibits, the Intervenor and OHCA need to be able to rely on the application to evaluate the facts. See RSCA § 19a-643-51(d). An applicant cannot evade the requirements of the application process by saying one thing in the application, and something very different in the prefiled, thereby not properly answering the specific questions in the application. Prefiled testimony is not a proper means for wholesale changes in the application, .

Accordingly, OHCA should strike the prefiled testimony of Mr. Gwozdz and Dr. Sack. The proffer of this testimony violates OHCA regulations. RSCA § 19a-643-

51(d) It should also be stricken, because such testimony is inconsistent with Applicant's CON and was filed just prior to the April 29, 2010 public hearing, resulting in irreparable prejudice to the OHCA, the Intervenor and the public. Moreover, to the extent Mr. Gwozdz or Dr. Sack intends to testify at the public hearing, such testimony should likewise be precluded.

Respectfully submitted,

SILVER HILL HOSPITAL, INC.

By _____

Paul E. Knag
Murtha Cullina LLP
177 Broad Street
Stamford, CT 06901
Telephone: (203) 653-5407
Fax: (203) 653-5444
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Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, CT 06503
Telephone: (203) 772-7718
Fax: (203) 772-7723
ltodisco@murthalaw.com
Its Attorneys

ORDER

The foregoing Motion to Strike and to Preclude having been considered, it is hereby Ordered that:

1. The prefiled testimony of Mr. Gwozdz and Dr. Sack is stricken; and

2. Any testimony proffered by Mr. Gwozdz or Dr. Sack at the April 29, 2010 public hearing is precluded.

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Motion to Strike and to Preclude was sent by facsimile transmission and overnight mail, this 28th day of April, 2010, to:

Vincent M. Marino, Esq.
Cohen and Wolf, P.C.
1115 Broad Street
Bridgeport, CT 06604

Michele M. Volpe, Esq.
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511

Paul E. Knag

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HEALTH CARE ACCESS

PAUL E. KNAG
203.653.5407 DIRECT TELEPHONE
203.653.5444 DIRECT FACSIMILE
PKNAG@MURTHALAW.COM

April 28, 2010

Via Facsimile (860) 418-7053
Via email: STEVEN.LAZARUS@CT.GOV
(Original will be hand delivered at hearing.)

Deputy Commissioner Cristine Vogel
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: **Docket No. 09-31500-CON**
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Free Standing Substance Abuse Center in Bethlehem

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Thank you.

Very truly yours,

Paul E. Knag

Paul E. Knag

Enclosures
cc: Michele M. Volpe, Esq. (Bershtein, Volpe & McKeon P.C.)

Greer, Leslie

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HEALTH CARE ACCESS

From: Lazarus, Steven
Sent: Wednesday, April 28, 2010 2:39 PM
To: Greer, Leslie; Olejarz, Barbara
Cc: Greci, Laurie; Riggott, Kaila
Subject: FW: Docket No. 09-31500-CON
Attachments: Motion to Strike.pdf; 4-28-10 Cover Letter re Motion to Strike.pdf

Leslie and Barbara,

Please add to the record.

Thank you,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Jessica L. White [mailto:jwhite@murthalaw.com]
Sent: Wednesday, April 28, 2010 2:33 PM
To: Lazarus, Steven
Cc: Volpe, Michele M.; Paul E. Knag
Subject: Docket No. 09-31500-CON

Dear Mr. Lazarus:

Please see attached.

Sincerely,

Jessica L. White
Paralegal
jwhite@murthalaw.com

Murtha Cullina LLP
177 Broad Street, 4th Floor
Stamford, CT 06901
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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS DIVISION

IN THE MATTER OF THE APPLICATION OF EMPLOYMENT OPTIONS, INC. D/B/A/ LITCHFIELD HILLS RETREAT, LLC FOR THE ESTABLISHMENT OF A FREE-STANDING MENTAL HEALTH AND SUBSTANCE ABUSE FACILITY IN BETHLEHEM, CONNECTICUT, WITH A TOTAL CAPITAL EXPENDUTRE OF $500,000

DOCKET NO. 09-31500-CON

APRIL 28, 2010

MOTION OF SILVER HILL HOSPITAL, INC. TO STRIKE THE PREFILED TESTIMONY OF BRIAN GWOZDZ AND DAVID SACK, M.D. AND PRECLUDE PROFFERED TESTIMONY AT PUBLIC HEARING

Silver Hill Hospital, Inc. ("Silver Hill") is a psychiatric hospital located in New Canaan, Connecticut. Silver Hill has been granted Intervenor status in this matter by the Department of Public Health, Office of Health Care Access Division ("OHCA"). Silver Hill by this motion requests that OHCA strike the prefiled testimony of Brian Gwozdz and David Sack, M.D., each submitted on or about April 26, 2010, and further preclude their proffered testimony at the public hearing scheduled for April 29, 2010.

OHCA should strike the testimony, because the proffer of the testimony of Mr. Gwozdz and Dr. Sack at this time violates OHCA regulations. OHCA's regulations

specifically provide that: "The direct case of any applicant or petitioner shall consist substantially of the written statement or petition, and the exhibits or other materials annexed thereto unless the presiding officer shall rule otherwise for good cause shown." Reg. Conn. State Agencies (RCSA) § 19a-643-51(d). As set forth below, the proffered testimony of Mr. Gwozdz and Dr. Sack is substantial, expands the need analysis and other analysis set forth in the CON application and exhibits, and is at various times inconsistent with the information in the CON application. It cannot be reasonably said that, given the content, detail and breadth of the testimony and exhibits provided by Mr. Gwozdz and Dr. Sack, the direct case of the Applicant consists substantially of the written statement of the application and materials annexed thereto. This violates the regulation,

Moreover, the Applicant has not even attempted to show "good cause" for its having substantially expanded and modified its certificate of need presentation beyond its application and exhibits. Absent this showing, the testimony should be stricken. OHCA regulations specifically provide for objection to written testimony prior to its admission. RCSA § 19a-643-51(d).

The proffered testimony of Mr. Gwozdz and Dr. Sack also calls into question the assertions within the CON application and the care with which it was prepared.

In support of its arguments, Silver Hill submits the following:

1. The prefiled testimony introduces, at the last minute, new personnel not disclosed in its application. Applicant first submitted its CON application on or about

February 5, 2010. Almost two months later, and just three days before the public hearing on Applicant's CON, Applicant filed the testimony of Mr. Gwozdz and Dr. Sack. Yet, neither witness is even mentioned in Applicant's CON, despite the fact that, at least in Mr. Gwozdz's case, he was acting as Applicant's representative and/or "Acting Director" no later than late December 2009. Moreover, while the CON designates Michele Zurko-Smith as Applicant's CEO and contains her "resume" and credentials, there is no similar disclosure of Mr. Gwozdz's or Dr. Sack's resume or credentials. This key information is a required component of OHCA's CON application process. (*See* CON Application, Sec. 3a). OHCA was not informed of the participation of these individuals or their function with respect to the proposed facility in the application.

2. The prefiled testimony provided by Mr. Gwozdz and Dr. Sack is substantially inconsistent with various representations and methodologies contained in Applicant's CON application regarding need and expands the analysis set forth therein.

Most significantly, the prefiled testimony of Mr. Gwozdz is inconsistent with Applicant's CON with respect to the methodology used to determine the public need for the Litchfield Hills facility The application contained data which supposedly supported a need for services for "high level professionals, executives, celebrities, public officials and others" needing substance abuse treatment whose "public visibility, wealth, fame or social position" demands a confidential treatment facility.

FAX TRANSMISSION

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2010 APR 29 A 8:25
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET
THIRD FLOOR
NEW HAVEN, CT 06511
(203) 777-5800 Fax: (203) 777-5806

FAX #: (860) 418-7053
TO: Honorable Cristine Vogel
Office of Health Care Access

DATE: April 28, 2010

PAGES: 11 including this page

CC: Louis Todisco
(203) 772 7723
Paul Knag
(203) 653 5444

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

CONFIDENTIALITY NOTICE
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COMMENTS:

Dear Commissioner Vogel:

Please see the attached Motion to Strike.

Thank you.

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Faxes\OHCA 4.28.10 (Objection to Motion to Strike).doc

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

RECEIVED
2010 APR 29 A 8:25
CONNECTICUT OFFICE OF HEALTH

Michele M. Volpe
Direct Dial (203) 777-6995

April 28, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
(Original will be hand delivered at Hearing)

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Motion to Strike.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Object to Motion to Strike) 4.28.10.doc

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 28, 2010**

MOTION TO STRIKE

The Applicant in the above matter, Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC (the "Applicant"), respectfully requests that the following be stricken from the Table of Record: (1) the "Facsimile letter from Stonington Institute to OHCA dated April 23, 2010 noting their concerns in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 23, 2010" and (2) the "Letter from Saint Vincent's/Hall-Brooke to OHCA dated March 22, 2010 listing their concerns in the matter of the CON application under Docket Number 09-31500, received by OHCA on March 29, 2010." (collectively referred to herein as the "Letters").

The correspondence submitted by Stonington Institute, as well as the correspondence of Saint Vincent/Hall-Brooke ("Unauthorized Participants") should be stricken from the Record. Allowing the Unauthorized Participants' letters to be part of the Record in this proceeding prejudices the Applicant because: (1) Applicant did not have the opportunity to object to the attempted participation by the Unauthorized Participants; (2) the Unauthorized Participants did not follow the procedure for participation as party intervenor or informal participant in accordance with Section 19a-643-37, 19a-643-38, or 19a-643-39; and (3) the Applicant will not have the opportunity to cross examine the Unauthorized Participants or dispute their self-serving

and ex-parte communications and/or otherwise address the assertions of the Unauthorized Participants.

The Unauthorized Participants had an opportunity to properly request participation in this matter and chose not to. The Applicant submits that the Unauthorized Participants chose not to seek party or informal participation status because they would not have been granted any such rights to participate for the reasons set forth herein.

It is clear that the Unauthorized Participants do not offer a facility that is on par with the center being proposed by the Applicant.

Stonington Institute's April 24, 2010 submission emphasizes its large size and vast array of services. Stonington Institute states that it has well in excess of 45 beds allocated to residential substance abuse, in stark contrast to Applicant's proposed 28 beds. These facts alone distinguish it significantly from the project proposed by Applicant.

By Stonington Institute's own admission it offers detoxification services, ambulatory detoxification and partial hospital services, all of which the Applicant will not provide. As for Stonington Institute's position that OHCA should take into account that it expanded its adult residential substance abuse beds, we offer the following compelling facts:

On December 5, 2007 OHCA granted Vista Partners LLC's ("Vista") CON Application in Docket Number 07-30928-CON to establish a substance abuse treatment center, citing a need for its proposed 24-bed center. Thereafter, on February 2, 2009, OHCA gave Stonington Institute permission to convert its 45 adolescent substance abuse treatment beds to adult beds. (See OHCA CON Determination 08-31228-DTR). OHCA authorized Stonington Institute's request after it had already approved Vista's CON recognizing a need for more residential beds for a certain segment of the population of substance abusers. More important, the approval by OHCA

on behalf of Stonington Institute occurred before OHCA was put on notice that Vista was abandoning its project and would not implement. OHCA was not put on notice of Vista's failure to implement on April 5, 2010.

The foregoing evidences that OHCA recognizes the need for additional adult substance abuse treatment beds in the state, as OHCA granted Stonington Institute's request to add additional adult beds in February of 2009 at a time when OHCA had already approved Vista's project to introduce an additional 24 adult beds. Therefore, the fact of Stonington Institute's conversion of its 45 beds from adolescent to adult has no bearing on the need evidenced in the pending Litchfield Hills proposal.

Accordingly, the only change to date in array of existing residential substance abuse providers in Connecticut that should be afforded any weight by OHCA, and that directly impacts the needs analysis, is the fact that Vista will not implement the OHCA-approved project to establish a 24-bed substance abuse treatment facility. **Therefore, an unmet need still exists in Connecticut.**

Similarly, Saint Vincent/Hall-Brooke's ("Hall-Brooke) facility is not substantially similar to the substance abuse treatment center proposed by Applicant and assertions made in its March 22nd letter to OHCA are simply inaccurate. Like Stonington Institute, Hall-Brooke is a much larger facility than the one proposed by the Applicant. Hall-Brooke's assertion that adequate beds and services are available is unfounded and in contravention of the need that Vista established, and OHCA recognized, in Docket Number 07-30928-CON. Moreover, while Applicant acknowledges that substance abuse is not a problem for only the wealthy, it is this portion of the overall population for which Applicant has established a need and is intended to serve.

Furthermore, Hall-Brooke mistakes Applicant's claims of privacy as claims that related to compliance with state and federal patient confidentiality laws, such as HIPAA. Applicant made clear in its filings before OHCA that the seclusion, privacy and confidentiality of which Applicant boasts is unrelated to its compliance with HIPAA and is instead related to the Applicant's focus on addressing the unique concerns of those "public" individuals who feel compelled, based on the nature of their profession or public role, to limit their visibility while obtaining treatment.

Hall-Brooke acknowledges in its letter to OHCA that it is different from the center proposed by Applicant. Unlike the Applicant's proposed center, Hall-Brooke offers comprehensive acute psychiatric, medical detoxification and dual diagnosis treatment for children, adolescents and adults. Applicant has maintained throughout its CON that it will not provide these types of medical service and it will not treat children or adolescents. Instead, Applicant has emphasized that it will admit only those patients who have gone through a successful detoxification program and who are cleared medically by their physician. In addition, Applicant will implement safeguards to ensure that patients who are not appropriate for treatment offered by Applicant are transferred to more appropriate centers.

Based on the foregoing, and the fact that the Letters submitted by the Unauthorized Participants are not in accordance with the applicable Regulations of Connecticut State Agencies Sections 19a-643-37, 19-643-38, or 19a-643-39, Applicant respectfully requests that OHCA strike from the Table of Record: (1) the "facsimile letter from Stonington Institute to OHCA dated April 23, 2010 noting their concerns in the matter of the Con application under Docket Number 09-31500, received by OHCA on April 23, 2010"; and (2) the "letter from Saint Vincent's/Hall-Brooke to OHCA dated March 22, 2010 listing their concerns in the matter of the

CON application under Docket Number 09-31500, received by OHCA on March 29, 2010."

Copies of the referenced regulations are annexed hereto for your convenience.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By:_____
Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Docs\Motion to Strike.doc

CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 28th day of April, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
Stamford, Connecticut 06901
Facsimile: (203)653-5444

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723

Michele M. Volpe

LEXSTAT REGS CONN STATE AGENCIES 19A-643-37

REGULATIONS OF CONNECTICUT STATE AGENCIES

* THIS DOCUMENT IS CURRENT THROUGH THE 4/6/10 ISSUE OF THE CONN. LAW JOURNAL *

TITLE 19A PUBLIC HEALTH AND WELL-BEING
OFFICE OF HEALTH CARE ACCESS
RULES OF PRACTICE
ARTICLE 2: CONTESTED CASES

PART 1: PARTIES, INTERVENTION AND PARTICIPATION

Regs., Conn. State Agencies § 19a-643-37 (2010)

Sec. 19a-643-37. Application to be designated a party

(a) Filing of petition. Any other person that proposes in a contested case to be designated or admitted as a party, as defined by *section 4-166(8) of the Connecticut General Statutes*, shall file a written petition to be so designated and shall mail copies to all parties not later than five (5) calendar days before the date of the hearing. For good cause shown the presiding officer may waive the five day requirement.

(b) Contents of petition. The petition to be designated a party shall state the name and address of the petitioner. It shall state facts that demonstrate that the petitioner's legal rights duties and privileges shall be specifically affected by the Office's decision in the contested case. It shall state the position of the petitioner concerning the issue of the proceeding, the relief sought by the petitioner, the statutory or other authority therefore, and a summary of any evidence that the petitioner intends to present in the event that the petition is granted.

(c) Designation as party. A presiding officer shall consider all such petitions and will designate or admit as a party in a contested case any person whose legal rights, duties or privileges are required by statute to be determined by the Office or whose legal rights, duties or privileges will be specifically affected by the decision of the Office and any person who is required by law to be a party in the proceedings.

Renumbered from 19a-160-24 to 19a-160-47, see Conn. Law Journal April 13, 1999, effective February 26, 1999.

LEXSTAT REGS CONN STATE AGENCIES 19A-643-37

REGULATIONS OF CONNECTICUT STATE AGENCIES

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TITLE 19A PUBLIC HEALTH AND WELL-BEING
OFFICE OF HEALTH CARE ACCESS
RULES OF PRACTICE
ARTICLE 2: CONTESTED CASES

PART 1: PARTIES, INTERVENTION AND PARTICIPATION

Regs., Conn. State Agencies § 19a-643-38 (2010)

Sec. 19a-643-38. Participation by intervenors

(a) Filing of petition. Any person that proposes to be designated or admitted as an intervenor shall file a written petition to be so designated and shall mail copies to all parties not later than five (5) calendar days before the date of hearing. For good cause shown, the presiding officer may waive the five day requirement.

(b) Contents of request. The request of the proposed intervenor shall state such person's name and address and shall describe the manner in which that person is affected by the contested case. The proposed intervenor shall further state what way and to what extent that person proposes to participate in the hearing, and shall summarize any evidence that person proposes to offer.

(c) Designation as intervenor. The presiding officer will act on behalf of the Office to determine the proposed intervenor's participation in the hearing, taking into account whether or not such participation will furnish assistance to the Office in resolving the issues of the contested case. The presiding officer may grant the request to intervene if the presiding officer finds that the proposed participation as an intervenor will add evidence or arguments on the issue of the contested case that would otherwise not be available to the Office, is in the interest of justice and will not impair the orderly conduct of the proceedings.

(d) Limitation on participation. The intervenor's participation shall be limited to those particular issues, that state of the proceeding and that degree of involvement in the inspection and copying of records, presentation of evidence and argument that the presiding officer shall permit at the time such intervention is allowed, and thereafter by express order upon further application by the said intervenor or upon a finding by the presiding officer that an intervenor's participation must be further restricted so as to promote the orderly conduct of the proceedings.

Renumbered from 19a-160-24 to 19a-160-47, see Conn. Law Journal April 13, 1999, effective February 26, 1999.

LEXSTAT REGS CONN STATE AGENCIES 19A-643-37

REGULATIONS OF CONNECTICUT STATE AGENCIES

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TITLE 19A PUBLIC HEALTH AND WELL-BEING
OFFICE OF HEALTH CARE ACCESS
RULES OF PRACTICE
ARTICLE 2: CONTESTED CASES

PART 1: PARTIES, INTERVENTION AND PARTICIPATION

Regs., Conn. State Agencies § 19a-643-39 (2010)

Sec. 19a-643-39. Participation by informal participants

(a) Request to participate. At any time prior to the commencement of oral testimony in any hearing in a contested case, any person may request that the presiding officer permit that person to present an oral or written statement. Such statements shall be limited to non-expert opinions except as otherwise allowed by the presiding officer, if the presiding officer finds that the parties will not be prejudiced and that the statement may furnish assistance to the Office in resolving the issues of the contested case.

(b) Contents of request. The request shall state such person's name and address, the length of any proposed written statement or the time requested to make any oral statement.

(c) Designation as informal participant. The presiding officer may grant or deny the request and may limit the time such a participant has to make a statement. An informal participant who makes a statement of fact or gives an expert opinion on a central issue in the contested case may be subject to cross-examination or, if the statement is made without authorization from the presiding officer, have the statement stricken from the record, at the discretion of the presiding officer.

Renumbered from 19a-160-24 to 19a-160-47, see Conn. Law Journal April 13, 1999, effective February 26, 1999.

FAX TRANSMISSION

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
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THIRD FLOOR
NEW HAVEN, CT 06511
(203) 777-5800 Fax: (203) 777-5806

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2010 APR 29 A 8:30
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

FAX #: (860) 418-7053
TO: Honorable Cristine Vogel
Office of Health Care Access

DATE: April 28, 2010

PAGES: 5 including this page

CC: Louis Todisco
(203) 772 7723
Paul Knag
(203) 653 5444

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

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COMMENTS:

Dear Commissioner Vogel:

Please see the attached Objection to Motion of Silver Hill Hospital, Inc. to Strike the Prefiled Testimony of Brian Gwozdz and David Sack, M.D. and Preclude Proffered Testimony at Hearing.

Thank you.

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
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HEALTH CARE ACCESS

Christopher M. McKeon
Direct Dial (203) 777-5805

April 28, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
(Original will be hand delivered at Hearing)

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Objection to Motion of Silver Hill Hospital, Inc. to Strike the Prefiled Testimony of Brian Gwozdz and David Sack, M.D. and Preclude Proffered Testimony at Hearing.

Thank you.

Very truly yours,

Christopher M. McKeon

CMM/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 28, 2010**

OBJECTION TO MOTION OF SILVER HILL HOSPITAL, INC. TO STRIKE THE PREFILED TESTIMONY OF BRIAN GWOZDZ AND DAVID SACK, M.D. AND PRECLUDE PROFFERED TESTIMONY AT HEARING

Applicant objects to the Motion of Silver Hill Hospital, Inc. to Strike the Prefiled Testimony of Brian Gwozdz and David Sack, M.D. and Preclude Proffered Testimony at Hearing. Despite Silver Hill's reliance on Section 19a-643-51(d) of the Regulations of Connecticut State Agencies, said Section does not prohibit the filing of prefile testimony which differs slightly from the Application. Specifically, said Section provides that the direct case shall consist "substantially" of the written statement of the written application and the exhibits and other materials annexed thereto. Nothing in Section 19a-643-51(d) prohibits the filing of prefile testimony which explains and/or clarifies the CON application. Indeed, prefile testimony which explains and clarifies an Application is routinely and habitually accepted by OHCA. Moreover, the witnesses will be present at the hearing and available for cross-examination. Again, Silver Hill is erroneously stating that Applicant filed its prefile testimony after the deadline for filing. Said statement is patently false. See Exhibit N of the Table of Record. Silver Hill requested the hearing in this matter and therefore, Applicant must be given the opportunity to present evidence and argument on "all issues to be considered by the Office" in accordance with Section 19a-643-51(a).

Silver Hill's Motion should be summarily denied.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: _____

Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Docs\Silver Hill (Intervenor)\Objection to Motion to Strike and Preclude.doc

CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 28th day of April, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
Stamford, Connecticut 06901
Facsimile: (203)653-5444

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723

~~Michele M. Volpe~~ Christopher M. McKeon

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APR 29 2010
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Greer, Leslie

From: Olejarz, Barbara
Sent: Wednesday, April 28, 2010 4:48 PM
To: Greer, Leslie
Subject: FW: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)
Attachments: Motion to Strike.pdf

Leslie,

I took a copy of the attached for the hearing. Please print out and log it in, scan and distribute

Thanks

Barbara K. Olejarz
Department of Public Health
Offfice of Health Care Access
(860)418-7014
Barbara.Olejarz@ct.gov

From: Lazarus, Steven
Sent: Wednesday, April 28, 2010 4:39 PM
To: melanine.dillon@ct.gov
Cc: Olejarz, Barbara
Subject: FW: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

-FYI-

From: Bettyanne Toole [mailto:bettyanne@bvmlaw.com]
Sent: Wed 4/28/2010 4:32 PM
To: Lazarus, Steven; Martone, Kim
Cc: michelemvolpe@aol.com; Christopher McKeon; Aimee Onofrio
Subject: RE: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

Steven and Kim: Attached please find an Motion to Strike. Thank you.

Betty Anne Toole-Teasley
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
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BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
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203-777-5800
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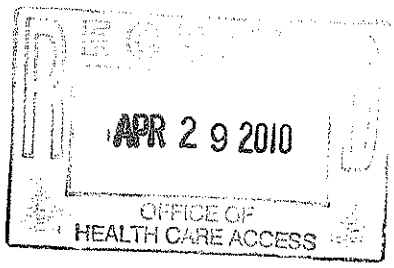


Michele M. Volpe
Direct Dial (203) 777-6995

April 28, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
(Original will be hand delivered at Hearing)

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Motion to Strike.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Object to Motion to Strike) 4.28.10.doc

DEPARTMENT OF PUBLIC HEALTH **DIVISION OF OFFICE OF** **HEALTH CARE ACCESS**	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC **D/B/A LITCHFIELD HILLS RETREAT, LLC** **PROPOSAL TO ESTABLISH A** **FREE STANDING SUBSTANCE** **ABUSE CENTER IN BETHLEHEM**	:	**April 28, 2010**

MOTION TO STRIKE

The Applicant in the above matter, Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC (the "Applicant"), respectfully requests that the following be stricken from the Table of Record: (1) the "Facsimile letter from Stonington Institute to OHCA dated April 23, 2010 noting their concerns in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 23, 2010" and (2) the "Letter from Saint Vincent's/Hall-Brooke to OHCA dated March 22, 2010 listing their concerns in the matter of the CON application under Docket Number 09-31500, received by OHCA on March 29, 2010." (collectively referred to herein as the "Letters").

The correspondence submitted by Stonington Institute, as well as the correspondence of Saint Vincent/Hall-Brooke ("Unauthorized Participants") should be stricken from the Record. Allowing the Unauthorized Participants' letters to be part of the Record in this proceeding prejudices the Applicant because: (1) Applicant did not have the opportunity to object to the attempted participation by the Unauthorized Participants; (2) the Unauthorized Participants did not follow the procedure for participation as party intervenor or informal participant in accordance with Section 19a-643-37, 19a-643-38, or 19a-643-39; and (3) the Applicant will not have the opportunity to cross examine the Unauthorized Participants or dispute their self-serving

and ex-parte communications and/or otherwise address the assertions of the Unauthorized Participants.

The Unauthorized Participants had an opportunity to properly request participation in this matter and chose not to. The Applicant submits that the Unauthorized Participants chose not to seek party or informal participation status because they would not have been granted any such rights to participate for the reasons set forth herein.

It is clear that the Unauthorized Participants do not offer a facility that is on par with the center being proposed by the Applicant.

Stonington Institute's April 24, 2010 submission emphasizes its large size and vast array of services. Stonington Institute states that it has well in excess of 45 beds allocated to residential substance abuse, in stark contrast to Applicant's proposed 28 beds. These facts alone distinguish it significantly from the project proposed by Applicant.

By Stonington Institute's own admission it offers detoxification services, ambulatory detoxification and partial hospital services, all of which the Applicant will not provide. As for Stonington Institute's position that OHCA should take into account that it expanded its adult residential substance abuse beds, we offer the following compelling facts:

On December 5, 2007 OHCA granted Vista Partners LLC's ("Vista") CON Application in Docket Number 07-30928-CON to establish a substance abuse treatment center, citing a need for its proposed 24-bed center. Thereafter, on February 2, 2009, OHCA gave Stonington Institute permission to convert its 45 adolescent substance abuse treatment beds to adult beds. (See OHCA CON Determination 08-31228-DTR). OHCA authorized Stonington Institute's request after it had already approved Vista's CON recognizing a need for more residential beds for a certain segment of the population of substance abusers. More important, the approval by OHCA

on behalf of Stonington Institute occurred before OHCA was put on notice that Vista was abandoning its project and would not implement. OHCA was not put on notice of Vista's failure to implement on April 5, 2010.

The foregoing evidences that OHCA recognizes the need for additional adult substance abuse treatment beds in the state, as OHCA granted Stonington Institute's request to add additional adult beds in February of 2009 at a time when OHCA had already approved Vista's project to introduce an additional 24 adult beds. Therefore, the fact of Stonington Institute's conversion of its 45 beds from adolescent to adult has no bearing on the need evidenced in the pending Litchfield Hills proposal.

Accordingly, the only change to date in array of existing residential substance abuse providers in Connecticut that should be afforded any weight by OHCA, and that directly impacts the needs analysis, is the fact that Vista will not implement the OHCA-approved project to establish a 24-bed substance abuse treatment facility. **Therefore, an unmet need still exists in Connecticut.**

Similarly, Saint Vincent/Hall-Brooke's ("Hall-Brooke) facility is not substantially similar to the substance abuse treatment center proposed by Applicant and assertions made in its March 22nd letter to OHCA are simply inaccurate. Like Stonington Institute, Hall-Brooke is a much larger facility than the one proposed by the Applicant. Hall-Brooke's assertion that adequate beds and services are available is unfounded and in contravention of the need that Vista established, and OHCA recognized, in Docket Number 07-30928-CON. Moreover, while Applicant acknowledges that substance abuse is not a problem for only the wealthy, it is this portion of the overall population for which Applicant has established a need and is intended to serve.

Furthermore, Hall-Brooke mistakes Applicant's claims of privacy as claims that related to compliance with state and federal patient confidentiality laws, such as HIPAA. Applicant made clear in its filings before OHCA that the seclusion, privacy and confidentiality of which Applicant boasts is unrelated to its compliance with HIPAA and is instead related to the Applicant's focus on addressing the unique concerns of those "public" individuals who feel compelled, based on the nature of their profession or public role, to limit their visibility while obtaining treatment.

Hall-Brooke acknowledges in its letter to OHCA that it is different from the center proposed by Applicant. Unlike the Applicant's proposed center, Hall-Brooke offers comprehensive acute psychiatric, medical detoxification and dual diagnosis treatment for children, adolescents and adults. Applicant has maintained throughout its CON that it will not provide these types of medical service and it will not treat children or adolescents. Instead, Applicant has emphasized that it will admit only those patients who have gone through a successful detoxification program and who are cleared medically by their physician. In addition, Applicant will implement safeguards to ensure that patients who are not appropriate for treatment offered by Applicant are transferred to more appropriate centers.

Based on the foregoing, and the fact that the Letters submitted by the Unauthorized Participants are not in accordance with the applicable Regulations of Connecticut State Agencies Sections 19a-643-37, 19-643-38, or 19a-643-39, Applicant respectfully requests that OHCA strike from the Table of Record: (1) the "facsimile letter from Stonington Institute to OHCA dated April 23, 2010 noting their concerns in the matter of the Con application under Docket Number 09-31500, received by OHCA on April 23, 2010"; and (2) the "letter from Saint Vincent's/Hall-Brooke to OHCA dated March 22, 2010 listing their concerns in the matter of the

CON application under Docket Number 09-31500, received by OHCA on March 29, 2010."

Copies of the referenced regulations are annexed hereto for your convenience.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: _____
Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

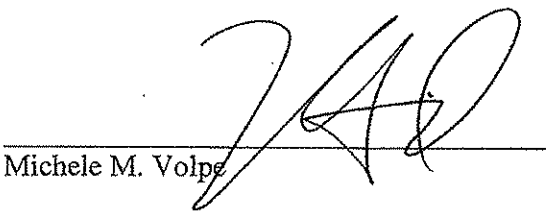
F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Docs\Motion to Strike.doc

CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 28th day of April, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
Stamford, Connecticut 06901
Facsimile: (203)653-5444

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723



Michele M. Volpe

LEXSTAT REGS CONN STATE AGENCIES 19A-643-37

REGULATIONS OF CONNECTICUT STATE AGENCIES

* THIS DOCUMENT IS CURRENT THROUGH THE 4/6/10 ISSUE OF THE CONN. LAW JOURNAL *

TITLE 19A PUBLIC HEALTH AND WELL-BEING
OFFICE OF HEALTH CARE ACCESS
RULES OF PRACTICE
ARTICLE 2: CONTESTED CASES

PART 1: PARTIES, INTERVENTION AND PARTICIPATION

Regs., Conn. State Agencies § 19a-643-37 (2010)

Sec. 19a-643-37. Application to be designated a party

(a) Filing of petition. Any other person that proposes in a contested case to be designated or admitted as a party, as defined by *section 4-166(8) of the Connecticut General Statutes*, shall file a written petition to be so designated and shall mail copies to all parties not later than five (5) calendar days before the date of the hearing. For good cause shown the presiding officer may waive the five day requirement.

(b) Contents of petition. The petition to be designated a party shall state the name and address of the petitioner. It shall state facts that demonstrate that the petitioner's legal rights duties and privileges shall be specifically affected by the Office's decision in the contested case. It shall state the position of the petitioner concerning the issue of the proceeding, the relief sought by the petitioner, the statutory or other authority therefore, and a summary of any evidence that the petitioner intends to present in the event that the petition is granted.

(c) Designation as party. A presiding officer shall consider all such petitions and will designate or admit as a party in a contested case any person whose legal rights, duties or privileges are required by statute to be determined by the Office or whose legal rights, duties or privileges will be specifically affected by the decision of the Office and any person who is required by law to be a party in the proceedings.

Renumbered from 19a-160-24 to 19a-160-47, see Conn. Law Journal April 13, 1999, effective February 26, 1999.

LEXSTAT REGS CONN STATE AGENCIES 19A-643-37

REGULATIONS OF CONNECTICUT STATE AGENCIES

* THIS DOCUMENT IS CURRENT THROUGH THE 4/6/10 ISSUE OF THE CONN. LAW JOURNAL *

TITLE 19A PUBLIC HEALTH AND WELL-BEING
OFFICE OF HEALTH CARE ACCESS
RULES OF PRACTICE
ARTICLE 2: CONTESTED CASES

PART 1: PARTIES, INTERVENTION AND PARTICIPATION

Regs., Conn. State Agencies § 19a-643-38 (2010)

Sec. 19a-643-38. Participation by intervenors

(a) Filing of petition. Any person that proposes to be designated or admitted as an intervenor shall file a written petition to be so designated and shall mail copies to all parties not later than five (5) calendar days before the date of hearing. For good cause shown, the presiding officer may waive the five day requirement.

(b) Contents of request. The request of the proposed intervenor shall state such person's name and address and shall describe the manner in which that person is affected by the contested case. The proposed intervenor shall further state what way and to what extent that person proposes to participate in the hearing, and shall summarize any evidence that person proposes to offer.

(c) Designation as intervenor. The presiding officer will act on behalf of the Office to determine the proposed intervenor's participation in the hearing, taking into account whether or not such participation will furnish assistance to the Office in resolving the issues of the contested case. The presiding officer may grant the request to intervene if the presiding officer finds that the proposed participation as an intervenor will add evidence or arguments on the issue of the contested case that would otherwise not be available to the Office, is in the interest of justice and will not impair the orderly conduct of the proceedings.

(d) Limitation on participation. The intervenor's participation shall be limited to those particular issues, that state of the proceeding and that degree of involvement in the inspection and copying of records, presentation of evidence and argument that the presiding officer shall permit at the time such intervention is allowed, and thereafter by express order upon further application by the said intervenor or upon a finding by the presiding officer that an intervenor's participation must be further restricted so as to promote the orderly conduct of the proceedings.

Renumbered from 19a-160-24 to 19a-160-47, see Conn. Law Journal April 13, 1999, effective February 26, 1999.

LEXSTAT REGS CONN STATE AGENCIES 19A-643-37

REGULATIONS OF CONNECTICUT STATE AGENCIES

* THIS DOCUMENT IS CURRENT THROUGH THE 4/6/10 ISSUE OF THE CONN. LAW JOURNAL *

TITLE 19A PUBLIC HEALTH AND WELL-BEING
OFFICE OF HEALTH CARE ACCESS
RULES OF PRACTICE
ARTICLE 2: CONTESTED CASES

PART 1: PARTIES, INTERVENTION AND PARTICIPATION

Regs., Conn. State Agencies § 19a-643-39 (2010)

Sec. 19a-643-39. Participation by informal participants

(a) Request to participate. At any time prior to the commencement of oral testimony in any hearing in a contested case, any person may request that the presiding officer permit that person to present an oral or written statement. Such statements shall be limited to non-expert opinions except as otherwise allowed by the presiding officer, if the presiding officer finds that the parties will not be prejudiced and that the statement may furnish assistance to the Office in resolving the issues of the contested case.

(b) Contents of request. The request shall state such person's name and address, the length of any proposed written statement or the time requested to make any oral statement.

(c) Designation as informal participant. The presiding officer may grant or deny the request and may limit the time such a participant has to make a statement. An informal participant who makes a statement of fact or gives an expert opinion on a central issue in the contested case may be subject to cross-examination or, if the statement is made without authorization from the presiding officer, have the statement stricken from the record, at the discretion of the presiding officer.

Renumbered from 19a-160-24 to 19a-160-47, see Conn. Law Journal April 13, 1999, effective February 26, 1999.

RECEIVED
APR 29 2010
OFFICE OF
HEALTH CARE ACCESS

Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, April 29, 2010 7:28 AM
To: Olejarz, Barbara; Greer, Leslie; Riggott, Kaila; Greci, Laurie
Subject: FW: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)
Attachments: Objection to Motion to Strike and Preclude.pdf

Leslie and Barbara,

Please add to the record and also note that the email was received at 4:48 pm.

Thank you,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Bettyanne Toole [mailto:bettyanne@bvmlaw.com]
Sent: Wednesday, April 28, 2010 4:48 PM
To: Lazarus, Steven; Martone, Kim
Cc: michelemvolpe@aol.com; Christopher McKeon; Aimee Onofrio
Subject: RE: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

Steven and Kim: Attached please find an Objection to Motion of Silver Hill Hospital, Inc. to Strike the Prefiled Testimony of Brian Gwozdz and David Sack, M.D. and Preclude Proffered Testimony at Hearing. Thank you.

Betty Anne Toole-Teasley
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Facsimile: (203) 777-5806

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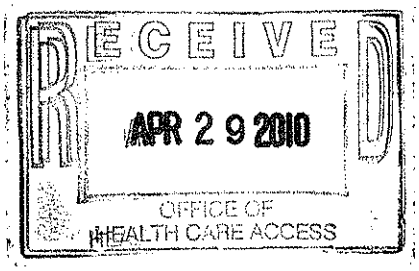
BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806



Christopher M. McKeon
Direct Dial (203) 777-5805

April 28, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
(Original will be hand delivered at Hearing)

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Objection to Motion of Silver Hill Hospital, Inc. to Strike the Prefiled Testimony of Brian Gwozdz and David Sack, M.D. and Preclude Proffered Testimony at Hearing.

Thank you.

Very truly yours,

Christopher M. McKeon

CMM/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

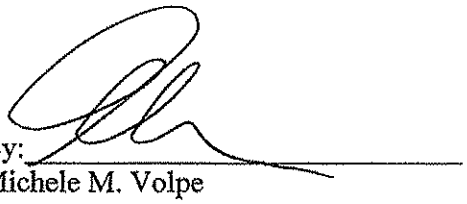
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF OFFICE OF
HEALTH CARE ACCESS : **DOCKET NO. 09-31500-CON**
:
IN RE: EMPLOYMENT OPTIONS, LLC :
D/B/A LITCHFIELD HILLS RETREAT, LLC
PROPOSAL TO ESTABLISH A
FREE STANDING SUBSTANCE
ABUSE CENTER IN BETHLEHEM : **April 28, 2010**

OBJECTION TO MOTION OF SILVER HILL HOSPITAL, INC. TO STRIKE THE PREFILED TESTIMONY OF BRIAN GWOZDZ AND DAVID SACK, M.D. AND PRECLUDE PROFFERED TESTIMONY AT HEARING

Applicant objects to the Motion of Silver Hill Hospital, Inc. to Strike the Prefiled Testimony of Brian Gwozdz and David Sack, M.D. and Preclude Proffered Testimony at Hearing. Despite Silver Hill's reliance on Section 19a-643-51(d) of the Regulations of Connecticut State Agencies, said Section does not prohibit the filing of prefile testimony which differs slightly from the Application. Specifically, said Section provides that the direct case shall consist "substantially" of the written statement of the written application and the exhibits and other materials annexed thereto. Nothing in Section 19a-643-51(d) prohibits the filing of prefile testimony which explains and/or clarifies the CON application. Indeed, prefile testimony which explains and clarifies an Application is routinely and habitually accepted by OHCA. Moreover, the witnesses will be present at the hearing and available for cross-examination. Again, Silver Hill is erroneously stating that Applicant filed its prefile testimony after the deadline for filing. Said statement is patently false. See Exhibit N of the Table of Record. Silver Hill requested the hearing in this matter and therefore, Applicant must be given the opportunity to present evidence and argument on "all issues to be considered by the Office" in accordance with Section 19a-643-51(a).

Silver Hill's Motion should be summarily denied.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: 

Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Docs\Silver Hill (Intervenor)\Objection to Motion to Strike and Preclude.doc

CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 28th day of April, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
Stamford, Connecticut 06901
Facsimile: (203)653-5444

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723

~~Michele M. Volpe~~ Christopher M. McKeen

FAX TRANSMISSION

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET
THIRD FLOOR
NEW HAVEN, CT 06511
(203) 777-5800 Fax: (203) 777-5806

RECEIVED
2010 APR 29 A 8:58
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

FAX #: (860) 418-7053
TO: Honorable Cristine Vogel
Office of Health Care Access

DATE: April 29, 2010

PAGES: **6** including this page

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

CONFIDENTIALITY NOTICE
Please note that the information contained in this fax is confidential and privileged and is intended only for use by the named receiver. If you have received this fax in error, please call 203-777-5800. Any use of this fax or its contents, including any dissemination or copying, is prohibited. Attorneys receiving this fax in error are directed to review ABA formal ethics opinion no. 92-368.

COMMENTS:

Dear Commissioner Vogel:

Please see the attached Motion to Strike.

Thank you.

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Faxes\OHCA 4.29.10 (Motion to Strike - High Watch).doc

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

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2010 APR 29 A 8:58
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

April 29, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Motion to Strike.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Object to Motion to Strike - High Watch) 4.29.10.doc

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 29, 2010**

MOTION TO STRIKE

The Applicant in the above matter, Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC (the "Applicant"), respectfully requests that the "Facsimile letter from High Watch Recovery Center to OHCA dated April 28, 2010 noting their concerns in the matter of the CON Application under Docket Number 09-31500, received by OHCA on April 28, 2010" be stricken from the Table of Record.

The correspondence submitted by High Watch Recovery Center ("Unauthorized Participant") should be stricken from the Record. Allowing the Unauthorized Participant's letter to be part of the Record in this proceeding prejudices the Applicant because: (1) Applicant did not have the opportunity to object to the attempted participation by the Unauthorized Participant; (2) the Unauthorized Participant did not follow the procedure for participation as party intervenor or informal participant in accordance with Section 19a-643-37, 19a-643-38, or 19a-643-39; and (3) the Applicant will not have the opportunity to cross examine the Unauthorized Participant or dispute their self-serving and ex-parte communications and/or otherwise address the assertions of the Unauthorized Participant.

The Unauthorized Participant had an opportunity to properly request participation in this matter and chose not to. The Applicant submits that the Unauthorized Participant chose not to

seek party or informal participation status because it would not have been granted any such rights to participate for the reasons set forth herein.

It is clear that the Unauthorized Participant does not offer a facility that is on par with the center being proposed by the Applicant.

By its own admission, the Unauthorized Participant operates a 78-bed facility, which is in stark contrast to the small, private secluded 28-bed center proposed by the Applicant. In addition, the Unauthorized Participant is dedicated to providing medical treatment to its residents, who stratify a "broad spectrum of individuals from a variety of backgrounds and social statuses." A fundamental component of Applicant's proposal is to provide an environment for similarly situated high-income, publically visible individuals who are concerned about being recognized in a facility such as the one operated by the Unauthorized Participant.

Moreover, the target population of the Applicant's proposed center is much different than the population currently served by the Unauthorized Participant and therefore the Applicant's proposed facility will not affect Unauthorized Participant's admissions. For example, Applicant will charge patients $900 per day compared to Unauthorized Participant charge of $260 per day.

Applicant has maintained throughout its CON that, unlike the Unauthorized Participant, it will not provide the range of medical services that the Unauthorized Participant provides. Instead, Applicant has emphasized that it will admit only those patients who have gone through a successful detoxification program and who are cleared medically by their physician. In addition, Applicant will implement safeguards to ensure that patients who are not appropriate for treatment offered by Applicant are transferred to more appropriate centers. Based on the foregoing differences, Applicant's facility will not target the population currently served by

Unauthorized Participant's facility and it not have any negative impact on the Unauthorized Participant's facility.

Furthermore, Unauthorized Participant mistakes Applicant's claims of privacy as claims that related to compliance with state and federal patient confidentiality laws, such as HIPAA. Applicant made clear in its filings before OHCA that the seclusion, privacy and confidentiality of which Applicant boasts is unrelated to its compliance with HIPAA and is instead related to the Applicant's focus on addressing the unique concerns of those "public" individuals who feel compelled, based on the nature of their profession or public role, to limit their visibility while obtaining treatment.

On December 5, 2007 OHCA granted Vista Partners LLC's ("Vista") CON Application in Docket Number 07-30928-CON to establish a substance abuse treatment center that is strikingly similar to the center proposed by Applicant, citing a need for its proposed 24-bed center. Because Vista never implemented its CON and notified OHCA of its intention not to move forward with its project, the need remains unmet. Accordingly, Unauthorized Participant's assertion that there is no need for the Applicant's proposed center is unfounded.

Based on the foregoing, and the fact that the letter submitted by the Unauthorized Participant is not in accordance with the applicable Regulations of Connecticut State Agencies Sections 19a-643-37, 19-643-38, or 19a-643-39, Applicant respectfully requests that OHCA strike the "Facsimile letter from High Watch Recovery Center to OHCA dated April 28, 2010 noting their concerns in the matter of the CON Application under Docket Number 09-31500, received by OHCA on April 28, 2010" from the Table of Record.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: _____
Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

F:\Doc\10 5051-5100\105056 Zurko-Smith re QHCA\Docs\Motion to Strike (High Watch).doc

RECEIVED
2010 APR 29 A 11:59
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

April 27, 2010

Cristine A. Vogel
Deputy Commissioner
Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: Employment Options, LLC d/b/a Litchfield Hills Retreat
Docket No. 09-31500-CON

Dear Deputy Commissioner Vogel:

I am writing on behalf of High Watch Recovery Center, Inc. ("High Watch") in opposition to the Certificate of Need ("CON") application filed with the Office of Health Care Access ("OHCA") by Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC (the "Applicant") to establish a free-standing substance abuse residential treatment facility in Bethlehem, Connecticut (the "Proposed Facility").

High Watch opposes the CON application submitted by the Applicant on the grounds that (1) no need has been demonstrated for the Proposed Facility and it is not cost-effective, (2) if approved, the Proposed Facility would divert volume from High Watch and other existing providers of substance abuse rehabilitation services, and (3) the treatment model outlined for the Proposed Facility is not clinically sufficient to provide quality care. This letter includes a brief description of High Watch and its mission, and then discusses the above flaws in the Applicant's CON application in more detail.

<u>High Watch</u>

High Watch operates a seventy-eight (78) bed free-standing substance abuse treatment facility in Kent, Connecticut, which is less than thirteen (13) miles from the Proposed Facility.

Founded in 1940 by Bill Wilson, the co-founder of Alcoholics Anonymous, High Watch is the oldest facility in the United States that is dedicated to the Twelve Step Principles of Alcoholics Anonymous. High Watch provides substance abuse treatment through cutting edge programs personalized for the individual patients needs. High Watch is a non-profit, private pay facility and provides a comprehensive array of substance abuse treatment including both traditional counseling and medical therapy for an inclusive fee of $260 per day. Included in this fee are the services of a psychiatrist, psychiatric nurse practitioners, social workers and registered nurses. Attached as Exhibit A to this letter is a brochure that explains High Watch's scope of services in more detail.

No Demand Exists for the Proposed Facility

Contrary to the Applicant's assertions, no demand exists for the Proposed Facility. In fact, the premise behind the Proposed Facility is fundamentally flawed. It assumes that a need exists and that there is a lack of access to substance abuse treatment for those who can most afford it – high net worth, private pay individuals. In response to OHCA's questions regarding demand for the Proposed Facility, the Applicant attempts to establish need by citing to a June 2006 report from the Office of National Drug Control Policy.[1] This report provides data regarding Drug Enforcement Agency drug arrests and incarceration, but provides no support for the existence of an unmet need for substance abuse treatment for wealthy professionals or high profile individuals.

The Applicant has provided certain projections of volume for the first three (3) years of operations for the Proposed Facility.[2] The only support for these projections is the Applicant's statement that they are based on "similar programs that are offer [sic] out of state, the number of

[1] CON Application, p. 9-18.
[2] Id. at p. 23.

professionals in the state, and the ramp up time for advertising the program," in addition to "the number of inquiries generated from [the Applicant's] web site and speaking with professionals in [Connecticut]."[3] The Applicant has provided no data related to existing capacity for substance abuse treatment services in Connecticut,[4] nor has the Applicant provided any data showing existing or future volume for such services.

Existing providers can adequately serve the current and future volume for substance abuse treatment in Connecticut. With respect to High Watch, High Watch has a capacity for 28,470 bed days each year.[5] In 2007, High Watch provided 22,681 bed days, or 79.7% of capacity. In 2008, High Watch provided 20,308 bed days, or 71.3% of capacity. In 2009, High Watch provided 21,795 bed days, or 76.6% of capacity. For the past three (3) years, High Watch's average utilization was 75.9%. High Watch has adequate capacity to serve the volume projected by the Applicant in the first three (3) years of operation.

The Proposed Facility Would Divert Volume from Existing Providers

The Applicant states that its target population is "high level professionals, executives, celebrities, public officials and others who seek a discreet, highly confidential and secluded treatment setting."[6] The Applicant also claims that patients in the target population currently either leave the state to receive services or do not seek treatment.[7] The Applicant provides no data to support this assertion.[8]

As stated above, no basis exists to support the belief that existing facilities are not adequately meeting the treatment needs of high profile private pay patients such as lawyers and

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[3] Applicant's Response to Completeness Questions, p. 133.
[4] The Applicant claims that the service are of the Proposed Facility will be the entire state of Connecticut. *See* CON Application, p. 6.
[5] Capacity is calculated by multiplying 78 beds by 365 days per year.
[6] CON Application, p. 25.
[7] Id. at p. 19.
[8] Applicant's Response to Completeness Questions, p. 130.

musicians. To the contrary, High Watch has a long history of providing substance abuse treatment to this population.[9] High Watch, like many existing providers of substance abuse treatment services, upholds the highest standards of confidentiality and serves a broad spectrum of patients, including patients in the Applicant's target population. There is simply no basis to conclude that such patients leave Connecticut to obtain treatment for substance abuse because of a lack of existing capacity to obtain treatment in a confidential manner. Moreover, High Watch provides comprehensive services at a cost that is tens of thousands of dollars less than planned for the Proposed Facility.

In addition, High Watch provides free substance abuse treatment to twenty-six (26) individuals, on average, each year, at a cost of $46,800 per individual. If the Proposed Facility is approved, some of the volume upon which High Watch relies to fund this charity care will likely be diverted to the Proposed Facility. Such a diversion of volume will seriously impair High Watch's ability to continue to provide the same level of charity care to a population of individuals that would not be able to obtain substance abuse treatment otherwise.

The Proposed Facility's Treatment Model is not Clinically Sufficient

If approved, the Proposed Facility will provide substance abuse "education" as well as certain "amenities" such as yoga and massage therapy.[10] The Applicant has provided no evidence that it will provide any defined program of medical treatment at the Proposed Facility. In High Watch's experience, this approach is not clinically sufficient to treat substance abuse disorders. Simply stated, the availability of spa-like accommodations has not been shown to have a positive contribution to the treatment of substance abuse disorders. According to the

[9] I am the co-founder of Connecticut's Lawyer's Concerned for Lawyers program, which was created to provide crisis intervention and referral services for the unique substance abuse and other mental health issues experienced by lawyers.
[10] CON Application, p. 19.

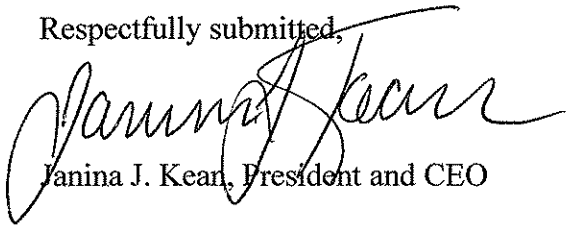
National Institute on Drug Abuse, effective substance abuse treatment is based on a combination of counseling and medical treatment, which is a combination that is not provided by the Proposed Facility.

In addition, the Applicant has stated that the Proposed Facility will target high profile clients who are able to pay the higher price point of the Proposed Facility. There is ample support in clinical literature to indicate that reinforcing the "status" of high profile individuals lends itself to elitism and adds to a patient's substance abuse disorder. High Watch has found that treating a broad spectrum of individuals from a variety of backgrounds and social statuses creates an environment where every patient is able to effectively obtain treatment for his or her substance abuse disorder.

Conclusion

For the above reasons, High Watch respectfully requests that OHCA deny the Applicant's CON application for the Proposed Facility.

Respectfully submitted,



Janina J. Kean, President and CEO

RECEIVED
APR 29 2010
OFFICE OF
HEALTH CARE ACCESS

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: EMPLOYMENT OPTIONS, LLC	:	DOCKET NO. 09-31500-CON
D/B/A LITCHFIELD HILLS RETREAT, LLC	:	
PROPOSAL TO ESTABLISH A	:	
FREE STANDING ADULT SUBSTANCE	:	
ABUSE CENTER IN BETHLEHEM	:	APRIL 29, 2010

OBJECTION TO REQUEST FOR ADMINISTRATIVE NOTICE

The Applicant in this matter, Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, has requested that the Department of Public Health, Office of Health Care Access (OHCA) take administrative notice of Docket Number 07-30928-CON, Vista Partners, LLC's CON for the Establishment of an Alcohol and Drug Treatment Center in Sharon, encompassing all information and correspondence submitted to OHCA in reference to that Docket, including but not limited to correspondence from Attorney Kennedy Hudner to OHCA.

Silver Hill Hospital, Inc., ("Silver Hill") has been designated an Intervenor in this matter. Silver Hill here objects to the Request for Administrative Notice filed by the Applicant. OHCA routinely states in its decisions that cases are decided on a case by case basis and that certificate of need applications do not lend themselves to general applicability. For example, in the Vista Partners, LLC Decision referenced above, OHCA stated:

> The Office of Health Care Access ("OHCA") approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g. the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

Vista Partners, LLC, Docket Number 07-30928-CON, p. 9. Thus, in the Vista Partners LLC matter, the matter of which the Applicant seeks to have notice taken, OHCA has said that CON applications do not lend themselves to general applicability. Accord. Windsor Dispensary Clinic, Inc., Docket Number 07-30999-CON, p. 11.

As it is the consistent position of OHCA that CON applications do not lend themselves to general applicability, and this position was expressed in the application which the Applicant seeks to have noticed, OHCA should not here take administrative notice of the Vista Partners, LLC's CON Application. Rather, in accordance with its consistent position, OHCA should evaluate the present matter on its own merits and on the evidence submitted by the Applicant based on the factors stated above and other factors as determined by OHCA.

For the foregoing reasons, Silver Hill requests that OHCA deny the Applicant's Request to take Administrative Notice.

Respectfully submitted,

SILVER HILL HOSPITAL, INC.

By _____

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ltodisco@murthalaw.com
Its Attorneys

ORDER

The foregoing Objection to Request for Administrative Notice having been heard, it is hereby:

Sustained/Overruled

_____

Hearing Officer

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Petition was hand delivered, this 29 day of April, 2010, to:

Michelle M. Volpe
Bershtein, Volpe & McKeon P.C.re
105 Court Street, 3rd Floor,
New Haven, CT 06511

Paul E. Knag

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
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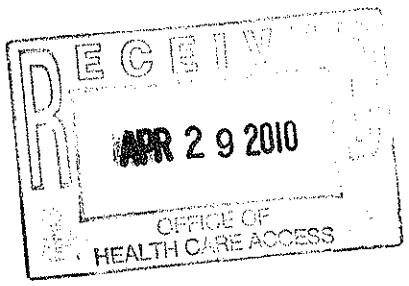

Michele M. Volpe
Direct Dial (203) 777-6995

April 28, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
(Original will be hand delivered at Hearing)

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Motion to Strike.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Object to Motion to Strike) 4.28.10.doc

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 28, 2010**

MOTION TO STRIKE

The Applicant in the above matter, Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC (the "Applicant"), respectfully requests that the following be stricken from the Table of Record: (1) the "Facsimile letter from Stonington Institute to OHCA dated April 23, 2010 noting their concerns in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 23, 2010" and (2) the "Letter from Saint Vincent's/Hall-Brooke to OHCA dated March 22, 2010 listing their concerns in the matter of the CON application under Docket Number 09-31500, received by OHCA on March 29, 2010." (collectively referred to herein as the "Letters").

The correspondence submitted by Stonington Institute, as well as the correspondence of Saint Vincent/Hall-Brooke ("Unauthorized Participants") should be stricken from the Record. Allowing the Unauthorized Participants' letters to be part of the Record in this proceeding prejudices the Applicant because: (1) Applicant did not have the opportunity to object to the attempted participation by the Unauthorized Participants; (2) the Unauthorized Participants did not follow the procedure for participation as party intervenor or informal participant in accordance with Section 19a-643-37, 19a-643-38, or 19a-643-39; and (3) the Applicant will not have the opportunity to cross examine the Unauthorized Participants or dispute their self-serving

and ex-parte communications and/or otherwise address the assertions of the Unauthorized Participants.

The Unauthorized Participants had an opportunity to properly request participation in this matter and chose not to. The Applicant submits that the Unauthorized Participants chose not to seek party or informal participation status because they would not have been granted any such rights to participate for the reasons set forth herein.

It is clear that the Unauthorized Participants do not offer a facility that is on par with the center being proposed by the Applicant.

Stonington Institute's April 24, 2010 submission emphasizes its large size and vast array of services. Stonington Institute states that it has well in excess of 45 beds allocated to residential substance abuse, in stark contrast to Applicant's proposed 28 beds. These facts alone distinguish it significantly from the project proposed by Applicant.

By Stonington Institute's own admission it offers detoxification services, ambulatory detoxification and partial hospital services, all of which the Applicant will not provide. As for Stonington Institute's position that OHCA should take into account that it expanded its adult residential substance abuse beds, we offer the following compelling facts:

On December 5, 2007 OHCA granted Vista Partners LLC's ("Vista") CON Application in Docket Number 07-30928-CON to establish a substance abuse treatment center, citing a need for its proposed 24-bed center. Thereafter, on February 2, 2009, OHCA gave Stonington Institute permission to convert its 45 adolescent substance abuse treatment beds to adult beds. (See OHCA CON Determination 08-31228-DTR). OHCA authorized Stonington Institute's request after it had already approved Vista's CON recognizing a need for more residential beds for a certain segment of the population of substance abusers. More important, the approval by OHCA

on behalf of Stonington Institute occurred before OHCA was put on notice that Vista was abandoning its project and would not implement. OHCA was not put on notice of Vista's failure to implement on April 5, 2010.

The foregoing evidences that OHCA recognizes the need for additional adult substance abuse treatment beds in the state, as OHCA granted Stonington Institute's request to add additional adult beds in February of 2009 at a time when OHCA had already approved Vista's project to introduce an additional 24 adult beds. Therefore, the fact of Stonington Institute's conversion of its 45 beds from adolescent to adult has no bearing on the need evidenced in the pending Litchfield Hills proposal.

Accordingly, the only change to date in array of existing residential substance abuse providers in Connecticut that should be afforded any weight by OHCA, and that directly impacts the needs analysis, is the fact that Vista will not implement the OHCA-approved project to establish a 24-bed substance abuse treatment facility. **Therefore, an unmet need still exists in Connecticut.**

Similarly, Saint Vincent/Hall-Brooke's ("Hall-Brooke) facility is not substantially similar to the substance abuse treatment center proposed by Applicant and assertions made in its March 22nd letter to OHCA are simply inaccurate. Like Stonington Institute, Hall-Brooke is a much larger facility than the one proposed by the Applicant. Hall-Brooke's assertion that adequate beds and services are available is unfounded and in contravention of the need that Vista established, and OHCA recognized, in Docket Number 07-30928-CON. Moreover, while Applicant acknowledges that substance abuse is not a problem for only the wealthy, it is this portion of the overall population for which Applicant has established a need and is intended to serve.

Furthermore, Hall-Brooke mistakes Applicant's claims of privacy as claims that related to compliance with state and federal patient confidentiality laws, such as HIPAA. Applicant made clear in its filings before OHCA that the seclusion, privacy and confidentiality of which Applicant boasts is unrelated to its compliance with HIPAA and is instead related to the Applicant's focus on addressing the unique concerns of those "public" individuals who feel compelled, based on the nature of their profession or public role, to limit their visibility while obtaining treatment.

Hall-Brooke acknowledges in its letter to OHCA that it is different from the center proposed by Applicant. Unlike the Applicant's proposed center, Hall-Brooke offers comprehensive acute psychiatric, medical detoxification and dual diagnosis treatment for children, adolescents and adults. Applicant has maintained throughout its CON that it will not provide these types of medical service and it will not treat children or adolescents. Instead, Applicant has emphasized that it will admit only those patients who have gone through a successful detoxification program and who are cleared medically by their physician. In addition, Applicant will implement safeguards to ensure that patients who are not appropriate for treatment offered by Applicant are transferred to more appropriate centers.

Based on the foregoing, and the fact that the Letters submitted by the Unauthorized Participants are not in accordance with the applicable Regulations of Connecticut State Agencies Sections 19a-643-37, 19-643-38, or 19a-643-39, Applicant respectfully requests that OHCA strike from the Table of Record: (1) the "facsimile letter from Stonington Institute to OHCA dated April 23, 2010 noting their concerns in the matter of the Con application under Docket Number 09-31500, received by OHCA on April 23, 2010"; and (2) the "letter from Saint Vincent's/Hall-Brooke to OHCA dated March 22, 2010 listing their concerns in the matter of the

CON application under Docket Number 09-31500, received by OHCA on March 29, 2010."

Copies of the referenced regulations are annexed hereto for your convenience.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By:_____
Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

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CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 28th day of April, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
Stamford, Connecticut 06901
Facsimile: (203)653-5444

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723

Michele M. Volpe

LEXSTAT REGS CONN STATE AGENCIES 19A-643-37

REGULATIONS OF CONNECTICUT STATE AGENCIES

* THIS DOCUMENT IS CURRENT THROUGH THE 4/6/10 ISSUE OF THE CONN. LAW JOURNAL *

TITLE 19A PUBLIC HEALTH AND WELL-BEING
OFFICE OF HEALTH CARE ACCESS
RULES OF PRACTICE
ARTICLE 2: CONTESTED CASES

PART 1: PARTIES, INTERVENTION AND PARTICIPATION

Regs., Conn. State Agencies § 19a-643-37 (2010)

Sec. 19a-643-37. Application to be designated a party

(a) Filing of petition. Any other person that proposes in a contested case to be designated or admitted as a party, as defined by *section 4-166(8) of the Connecticut General Statutes*, shall file a written petition to be so designated and shall mail copies to all parties not later than five (5) calendar days before the date of the hearing. For good cause shown the presiding officer may waive the five day requirement.

(b) Contents of petition. The petition to be designated a party shall state the name and address of the petitioner. It shall state facts that demonstrate that the petitioner's legal rights duties and privileges shall be specifically affected by the Office's decision in the contested case. It shall state the position of the petitioner concerning the issue of the proceeding, the relief sought by the petitioner, the statutory or other authority therefore, and a summary of any evidence that the petitioner intends to present in the event that the petition is granted.

(c) Designation as party. A presiding officer shall consider all such petitions and will designate or admit as a party in a contested case any person whose legal rights, duties or privileges are required by statute to be determined by the Office or whose legal rights, duties or privileges will be specifically affected by the decision of the Office and any person who is required by law to be a party in the proceedings.

Renumbered from 19a-160-24 to 19a-160-47, see Conn. Law Journal April 13, 1999, effective February 26, 1999.

LEXSTAT REGS CONN STATE AGENCIES 19A-643-37

REGULATIONS OF CONNECTICUT STATE AGENCIES

* THIS DOCUMENT IS CURRENT THROUGH THE 4/6/10 ISSUE OF THE CONN. LAW JOURNAL *

TITLE 19A PUBLIC HEALTH AND WELL-BEING
OFFICE OF HEALTH CARE ACCESS
RULES OF PRACTICE
ARTICLE 2: CONTESTED CASES

PART 1: PARTIES, INTERVENTION AND PARTICIPATION

Regs., Conn. State Agencies § 19a-643-38 (2010)

Sec. 19a-643-38. Participation by intervenors

(a) Filing of petition. Any person that proposes to be designated or admitted as an intervenor shall file a written petition to be so designated and shall mail copies to all parties not later than five (5) calendar days before the date of hearing. For good cause shown, the presiding officer may waive the five day requirement.

(b) Contents of request. The request of the proposed intervenor shall state such person's name and address and shall describe the manner in which that person is affected by the contested case. The proposed intervenor shall further state what way and to what extent that person proposes to participate in the hearing, and shall summarize any evidence that person proposes to offer.

(c) Designation as intervenor. The presiding officer will act on behalf of the Office to determine the proposed intervenor's participation in the hearing, taking into account whether or not such participation will furnish assistance to the Office in resolving the issues of the contested case. The presiding officer may grant the request to intervene if the presiding officer finds that the proposed participation as an intervenor will add evidence or arguments on the issue of the contested case that would otherwise not be available to the Office, is in the interest of justice and will not impair the orderly conduct of the proceedings.

(d) Limitation on participation. The intervenor's participation shall be limited to those particular issues, that state of the proceeding and that degree of involvement in the inspection and copying of records, presentation of evidence and argument that the presiding officer shall permit at the time such intervention is allowed, and thereafter by express order upon further application by the said intervenor or upon a finding by the presiding officer that an intervenor's participation must be further restricted so as to promote the orderly conduct of the proceedings.

Renumbered from 19a-160-24 to 19a-160-47, see Conn. Law Journal April 13, 1999, effective February 26, 1999.

LEXSTAT REGS CONN STATE AGENCIES 19A-643-37

REGULATIONS OF CONNECTICUT STATE AGENCIES

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TITLE 19A PUBLIC HEALTH AND WELL-BEING
OFFICE OF HEALTH CARE ACCESS
RULES OF PRACTICE
ARTICLE 2: CONTESTED CASES

PART 1: PARTIES, INTERVENTION AND PARTICIPATION

Regs., Conn. State Agencies § 19a-643-39 (2010)

Sec. 19a-643-39. Participation by informal participants

(a) Request to participate. At any time prior to the commencement of oral testimony in any hearing in a contested case, any person may request that the presiding officer permit that person to present an oral or written statement. Such statements shall be limited to non-expert opinions except as otherwise allowed by the presiding officer, if the presiding officer finds that the parties will not be prejudiced and that the statement may furnish assistance to the Office in resolving the issues of the contested case.

(b) Contents of request. The request shall state such person's name and address, the length of any proposed written statement or the time requested to make any oral statement.

(c) Designation as informal participant. The presiding officer may grant or deny the request and may limit the time such a participant has to make a statement. An informal participant who makes a statement of fact or gives an expert opinion on a central issue in the contested case may be subject to cross-examination or, if the statement is made without authorization from the presiding officer, have the statement stricken from the record, at the discretion of the presiding officer.

Renumbered from 19a-160-24 to 19a-160-47, see Conn. Law Journal April 13, 1999, effective February 26, 1999.

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
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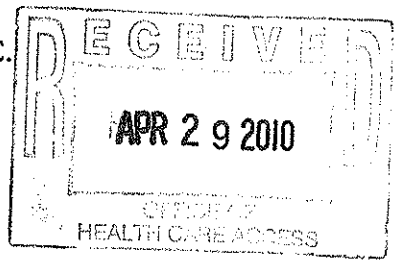


Christopher M. McKeon
Direct Dial (203) 777-5805

April 28, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
(Original will be hand delivered at Hearing)

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Objection to Motion of Silver Hill Hospital, Inc. to Strike the Prefiled Testimony of Brian Gwozdz and David Sack, M.D. and Preclude Proffered Testimony at Hearing.

Thank you.

Very truly yours,

Christopher M. McKeon

CMM/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

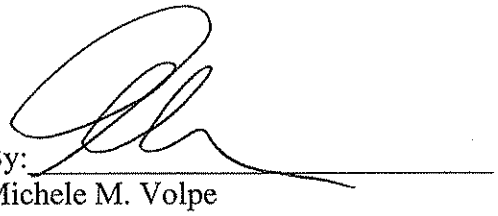
DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**April 28, 2010**

OBJECTION TO MOTION OF SILVER HILL HOSPITAL, INC. TO STRIKE THE PREFILED TESTIMONY OF BRIAN GWOZDZ AND DAVID SACK, M.D. AND PRECLUDE PROFFERED TESTIMONY AT HEARING

Applicant objects to the Motion of Silver Hill Hospital, Inc. to Strike the Prefiled Testimony of Brian Gwozdz and David Sack, M.D. and Preclude Proffered Testimony at Hearing. Despite Silver Hill's reliance on Section 19a-643-51(d) of the Regulations of Connecticut State Agencies, said Section does not prohibit the filing of prefile testimony which differs slightly from the Application. Specifically, said Section provides that the direct case shall consist "substantially" of the written statement of the written application and the exhibits and other materials annexed thereto. Nothing in Section 19a-643-51(d) prohibits the filing of prefile testimony which explains and/or clarifies the CON application. Indeed, prefile testimony which explains and clarifies an Application is routinely and habitually accepted by OHCA. Moreover, the witnesses will be present at the hearing and available for cross-examination. Again, Silver Hill is erroneously stating that Applicant filed its prefile testimony after the deadline for filing. Said statement is patently false. See Exhibit N of the Table of Record. Silver Hill requested the hearing in this matter and therefore, Applicant must be given the opportunity to present evidence and argument on "all issues to be considered by the Office" in accordance with Section 19a-643-51(a).

Silver Hill's Motion should be summarily denied.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC



By: _____

Michele M. Volpe
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Fax No. (203) 777-5806

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CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 28th day of April, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
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Murtha Cullina LLP
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~~Michele M. Volpe~~ Christopher M. McLeod

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203-777-5800
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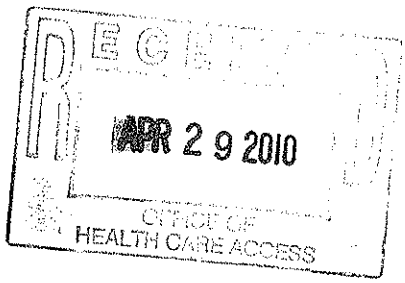

Michele M. Volpe
Direct Dial (203) 777-6995

April 28, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
(Original will be hand delivered at Hearing)

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of an Objection to Silver Hill Hospital Inc.'s Motion to Compel.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

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DEPARTMENT OF PUBLIC HEALTH
DIVISION OF OFFICE OF
HEALTH CARE ACCESS : **DOCKET NO. 09-31500-CON**
:
IN RE: EMPLOYMENT OPTIONS, LLC :
D/B/A LITCHFIELD HILLS RETREAT, LLC
PROPOSAL TO ESTABLISH A
FREE STANDING SUBSTANCE
ABUSE CENTER IN BETHLEHEM : **April 28, 2010**

OBJECTION TO MOTION TO COMPEL

The Applicant in the above matter, Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC (the "Applicant"), hereby objects to Silver Hill Hospital Inc.'s ("Silver Hill") Motion to Compel. Silver Hill's Motion to Compel is nothing more than an unsubstantiated and unsupported effort to force Applicant to present its Application in a manner dictated by Silver Hill. The Applicant alone determines the manner in which it presents its Application. OHCA has posed completeness questions to the Applicant and Applicant has answered the same. OHCA has the ability to question Applicant and its witnesses at the hearing on the CON Application. There is no authority whatsoever for Silver Hill's claim that Ms. Zurko-Smith should be compelled to testify so that Silver Hill can cross-examine her. Should OHCA grant Silver Hill's Motion to Compel, it will be allowing an intervenor to dictate the manner in which the Applicant presents its case. Such a result is legally unsupported, and it abrogates fundamental concepts of justice and fairness, and it will impair the orderly conduct of the proceedings.

Notwithstanding Silver Hill's misguided effort to compel Ms. Zurko-Smith's testimony, she will be present at the hearing and will offer to be put under oath in order to respond to any inquiries that OHCA may have for her about the CON Application. Any questions as to alleged discrepancies in the CON Application and documentation submitted in support thereof, if any, can and will be addressed through the Applicant's witnesses who have filed prefile testimony

and are subject to cross-examination. To the extent that OHCA wishes further clarification of any information, it alone can inquire of Ms. Zurko-Smith if it so desires.

Silver Hill's Motion contains factual inaccuracies and/or misrepresentations which must be pointed out. First, Ms. Zurko-Smith did not "list herself as the Applicant." The Application clearly provides that Employment Options, LLC is the Applicant. While she is the sole owner of the Applicant, the Application makes clear that the licensure, accreditation, treatment modalities, staffing and implementation of the proposed facility was and will be developed by and through consultants and employees, some of whom have been involved in the CON process, and others who will be retained and/or employed as implementation occurs. Silver Hill's allegations that Ms. Zurko-Smith's failure to offer prefile testimony is "disconcerting" and "serve[s] only to preclude OHCA's complete and educated consideration of Applicant's CON" are unjustified, unsupported and improper.

Secondly, Silver Hill alleges that the Applicant's prefile testimony was submitted after the deadline for filing of same. Silver Hill obviously made this allegation without any inquiry into the Record since if it had conducted any such inquiry, it would have seen OHCA's April 20, 2010 letter to the Applicant (Exhibit N in Table of Record) which clearly and unequivocally stated that the deadline for filing prefile testimony was 4:30 pm on Monday, April 26, 2010 – a deadline which was met by the Applicant.

For these reasons, the Motion to Compel should be summarily denied.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By:_____
Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
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Fax No. (203) 777-5806

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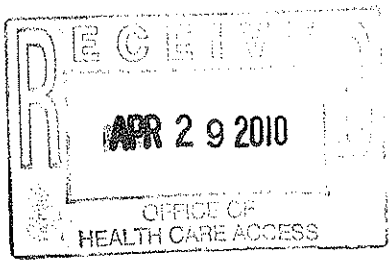
CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 28th day of April, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
Stamford, Connecticut 06901
Facsimile: (203)653-5444

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723

Michele M. Volpe



MURTHA CULLINA

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April 28, 2010

Via Facsimile (860) 418-7053
Via email: STEVEN.LAZARUS@CT.GOV
(Original will be hand delivered at hearing.)

Deputy Commissioner Cristine Vogel
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: **Docket No. 09-31500-CON**
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Free Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Silver Hill Hospital, petitioning intervenor, enclosed please find one (1) original and six (6) copies of a Motion to Compel the Appearance, Testimony and Cross-Examination of Michelle Zurko-Smith at the public hearing on April 29, 2010.

Thank you.

Very truly yours,

Paul E. Knag

Enclosures
cc: Michele M. Volpe, Esq. (Bershtein, Volpe & McKeon P.C.)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS DIVISION

IN THE MATTER OF THE APPLICATION OF EMPLOYMENT OPTIONS, INC. D/B/A/ LITCHFIELD HILLS RETREAT, LLC FOR THE ESTABLISHMENT OF A FREE-STANDING MENTAL HEALTH AND SUBSTANCE ABUSE FACILITY IN BETHLEHEM, CONNECTICUT, WITH A TOTAL CAPITAL EXPENDUTRE OF $500,000	DOCKET NO. 09-31500-CON APRIL 28, 2010

MOTION OF SILVER HILL HOSPITAL, INC. TO COMPEL THE APPEARANCE, TESTIMONY, AND CROSS-EXAMINATION OF MICHELLE ZURKO-SMITH

Silver Hill Hospital, Inc. (the "Silver Hill"), is a psychiatric hospital located in New Canaan, Connecticut. On or about April 21, 2010, Silver Hill submitted a petition to the Department of Public Health, Office of Health Care Access Division ("OHCA") to be designated as an intervenor with full rights of participation in the above referenced Certificate of Need application ("CON") by Employment Options, Inc. d/b/a Litchfield Hills Retreat, LLC (the "Applicant"); the petition is currently pending. Silver Hill by this motion requests that OHCA compel the attendance and testimony of Michelle Zurko-Smith at the public hearing scheduled for April 29, 2010.

Zurko-Smith lists herself as the Applicant. She is CEO and founding member of the corporate Applicant, purportedly the Chief Operating Officer and/or Chief Executive Officer of Litchfield Hills Retreat, LLC ("Litchfield Hills"), the sole owner of the real property upon which the Litchfield Hills facility will be maintained, and the "driving force behind the proposal to establish the Litchfield Hills substance abuse treatment center." In addition, she (either personally or as Applicant's CEO) has financed the Litchfield Hills project to date and she alone intends to finance the remainder of the project from her own personal resources. Presumably, she also prepared the CON, or directed it to be prepared, and provided much, if not all, of the information contained therein.

Despite her preeminent role in the Litchfield Hills project, Zurko-Smith has failed to submit any prefile testimony. Instead, Applicant has filed the testimony of two witnesses, Brian Gwozdz and David Sack, M.D., each of whom made a prefile submission on April 26, 2010. Yet, neither Mr. Gwozdz nor Dr. Sack is even mentioned in Applicant's CON. While the CON designates Zurko-Smith as Applicant's CEO and contains her "resume" and credentials, there is no similar disclosure of Mr. Gwozdz's or Dr. Sack's resume or credentials. Moreover, the testimony provided by these two witnesses is substantially inconsistent with various representations and methodologies contained in Applicant's CON. Without limitation, such discrepancies include the Applicant's intention to obtain licensure and accreditation, the methodology used for determining the public need for the Litchfield

Hills project, the treatment modalities to be employed by the facility (including a discrepancy in the diagnoses to be treated), the target market for services (including a discrepancy in the number of professionals practicing in Connecticut and/or the prevalence of substance abuse among such professionals), and the intended staffing of the facility. Zurko-Smith should be compelled to appear and bear witness to explain such discrepancies. Even more disconcerting, Mr. Gwozdz's and Dr. Sack's prefile testimony was submitted only three (3) days prior to the public hearing, after the deadline for the filing of prefiled testimony by Silver Hill as petitioned intervenor, providing OHCA and/or other interested parties inadequate opportunity for challenge or rebuttal.

Accordingly, failure of Zurko-Smith to appear, give testimony and submit to cross-examination in connection with the April 29, 2010 public hearing would be irreparably prejudicially to the public and serve only to preclude OHCA's complete and educated consideration of Applicant's CON.

Respectfully submitted,

SILVER HILL HOSPITAL, INC.

By _____

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ltodisco@murthalaw.com
Its Attorneys

ORDER

The foregoing Motion to Compel having been considered, it is hereby Ordered that:

1. Applicant's CEO, Michelle Zurko-Smith, be compelled to appear, give testimony and submit to cross-examination regarding Applicant's CON.

_____

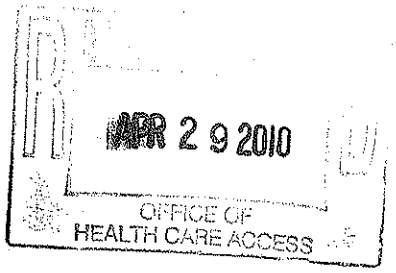
CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Motion to Compel was sent by facsimile and electronic mail, this 28th day of April, 2010, to:

Vincent M. Marino, Esq.
Cohen and Wolf, P.C.
1115 Broad Street
Bridgeport, CT 06604

Michele M. Volpe, Esq.
Bershtein, Volpe & McKeon, P.C.
105 Court Street, Suite 304
New Haven, Connecticut 06511

Paul E. Knag



MURTHA CULLINA

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April 28, 2010

Via Facsimile (860) 418-7053
Via email: STEVEN.LAZARUS@CT.GOV
(Original will be hand delivered at hearing.)

Deputy Commissioner Cristine Vogel
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: **Docket No. 09-31500-CON**
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Free Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Silver Hill Hospital, petitioning intervenor, enclosed please find one (1) original and six (6) copies of a Motion to Strike the prefiled testimony of Brian Gwozdz and David Sack, M.D. and to Preclude their proffered testimony at the public hearing on April 29, 2010.

Thank you.

Very truly yours,

Paul E. Knag

Paul E. Knag

Enclosures
cc: Michele M. Volpe, Esq. (Bershtein, Volpe & McKeon P.C.)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS DIVISION

IN THE MATTER OF THE APPLICATION OF EMPLOYMENT OPTIONS, INC. D/B/A/ LITCHFIELD HILLS RETREAT, LLC FOR THE ESTABLISHMENT OF A FREE-STANDING MENTAL HEALTH AND SUBSTANCE ABUSE FACILITY IN BETHLEHEM, CONNECTICUT, WITH A TOTAL CAPITAL EXPENDUTRE OF $500,000	DOCKET NO. 09-31500-CON APRIL 27, 2010

MOTION OF SILVER HILL HOSPITAL, INC. TO STRIKE THE PREFILED TESTIMONY OF BRIAN GWOZDZ AND DAVID SACK, M.D. AND PRECLUDE PROFFERED TESTIMONY AT PUBLIC HEARING

Silver Hill Hospital, Inc. ("Silver Hill") is a psychiatric hospital located in New Canaan, Connecticut. Silver Hill has been granted Intervenor status in this matter by the Department of Public Health, Office of Health Care Access Division ("OHCA"). Silver Hill by this motion requests that OHCA strike the prefiled testimony of Brian Gwozdz and David Sack, M.D., each submitted on or about April 26, 2010, and further preclude their proffered testimony at the public hearing scheduled for April 29, 2010.

OHCA should strike the testimony, because the proffer of the testimony of Mr. Gwozdz and Dr. Sack at this time violates OHCA regulations. OHCA's regulations

specifically provide that: "The direct case of any applicant or petitioner shall consist substantially of the written statement or petition, and the exhibits or other materials annexed thereto unless the presiding officer shall rule otherwise for good cause shown." Reg. Conn. State Agencies (RCSA) § 19a-643-51(d). As set forth below, the proffered testimony of Mr. Gwozdz and Dr. Sack is substantial, expands the need analysis and other analysis set forth in the CON application and exhibits, and is at various times inconsistent with the information in the CON application. It cannot be reasonably said that, given the content, detail and breadth of the testimony and exhibits provided by Mr. Gwozdz and Dr. Sack, the direct case of the Applicant consists substantially of the written statement of the application and materials annexed thereto. This violates the regulation,

Moreover, the Applicant has not even attempted to show "good cause" for its having substantially expanded and modified its certificate of need presentation beyond its application and exhibits. Absent this showing, the testimony should be stricken. OHCA regulations specifically provide for objection to written testimony prior to its admission. RCSA § 19a-643-51(d).

The proffered testimony of Mr. Gwozdz and Dr. Sack also calls into question the assertions within the CON application and the care with which it was prepared.

In support of its arguments, Silver Hill submits the following:

1. <u>The prefiled testimony introduces, at the last minute, new personnel not disclosed in its application</u>. Applicant first submitted its CON application on or about

February 5, 2010. Almost two months later, and just three days before the public hearing on Applicant's CON, Applicant filed the testimony of Mr. Gwozdz and Dr. Sack. Yet, neither witness is even mentioned in Applicant's CON, despite the fact that, at least in Mr. Gwozdz's case, he was acting as Applicant's representative and/or "Acting Director" no later than late December 2009. Moreover, while the CON designates Michele Zurko-Smith as Applicant's CEO and contains her "resume" and credentials, there is no similar disclosure of Mr. Gwozdz's or Dr. Sack's resume or credentials. This key information is a required component of OHCA's CON application process. (*See* CON Application, Sec. 3a). OHCA was not informed of the participation of these individuals or their function with respect to the proposed facility in the application.

2. The prefiled testimony provided by Mr. Gwozdz and Dr. Sack is substantially inconsistent with various representations and methodologies contained in Applicant's CON application regarding need and expands the analysis set forth therein.

Most significantly, the prefiled testimony of Mr. Gwozdz is inconsistent with Applicant's CON with respect to the methodology used to determine the public need for the Litchfield Hills facility The application contained data which supposedly supported a need for services for "high level professionals, executives, celebrities, public officials and others" needing substance abuse treatment whose "public visibility, wealth, fame or social position" demands a confidential treatment facility.

The only reference materials attached to the CON analyzing this segment of the population pertained only to the substance abuse treatment needs of physicians and lawyers. Mr. Gwozdz's testimony introduces an entirely new methodology, implicitly recognizing that the application's need methodology was totally inadequate. He places substantial reliance on several articles and studies not even mentioned in Applicant's CON and introduces data which, while completely flawed, was also not set out in the application. Also, he redefines the target market as persons from households making over $200,000 per year. Not only does Mr. Gwozdz's testimony expand the public need analysis contained in Applicant's CON, but he also relies on the purportedly abandoned and wholly unrelated application of Vista Partners, LLC granted by OHCA for a purportedly similar substance abuse treatment facility; yet, Applicant's CON makes no mention of the Vista Partners application. Applicant has an independent obligation to prove public need to the OHCA and her failure to include the Vista Partners application as part of her public need analysis should preclude consideration of that application.

3. The prefiled testimony provided by Mr. Gwozdz and Dr. Sack is inconsistent with the application in numerous other respects.

Licensure and Accreditation. In the application, when asked to "indicate any ... [Department of Public Health] licensure categories being sought in relation to the proposal," Applicant responds "N/A." (*See* CON Application, Sec. 4c). To the contrary, Gwozdz, in his prefiled testimony, unequivocally states that Litchfield Hills

will seek licensure from Connecticut's Department of Public Health. Dr. Sack, in his prefiled testimony, not only states that Litchfield Hills will seek licensure, but also that it will seek to become accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF"). In fact, Dr. Sack dedicates nearly two whole pages explaining CARF guidelines for accreditation. Yet, Applicant's CON makes no mention of any intent to seek CARF accreditation and the staffing pattern proposed in the CON, which is the basis for the financial projections, would be insufficient to warrant CARF accreditation.

Staffing and Treatment. Yet another example of inconsistent representations pertains to the intended staffing of Litchfield Hills. Dr. Sack's prefiled testimony indicates that Litchfield Hills will employ "adjunct professionals, such a licensed clinical social workers," "treating physician[s]" and otherwise treat substance abuse patients using a "multi-disciplinary approach" pursuant to CARF guidelines. Mr. Gwozdz also refers to himself as "Acting Director" and Michele Zurko-Smith as "Chief Operating Officer." Yet, Applicant's CON states that Ms. Zurko-Smith will be Chief Executive Officer, and indicates an intention to hire only a handful of professionals, including a Chief Financial Officer, Clinical Director (who would be a licensed drug and alcohol counselor) and Treatment Technician. In fact, Applicant's CON distinguishes itself from existing providers by stating that it will provide only conventional substance abuse treatments (i.e., 12-step philosophy), combined with "a myriad of amenities and alternative healing practices." Dr. Sack's testimony is further

inconsistent with the CON in that he states that Litchfield Hills "will be staffed and equipped to deal with [individuals ... hav[ing] a co-occurring disorder such as anxiety or depression." Accordingly, the treatment modalities to be employed by Litchfield Hills (including a discrepancy in the diagnoses to be treated) contemplated by the testimony of both Mr. Gwozdz and Dr. Sack is inconsistent with Applicant's CON.

With these changes, other data in the application would necessarily change, especially the financial projections.

These are but a few examples of inconsistencies between Applicant's CON and the prefiled testimony of Mr. Gwozdz and Dr. Sack.

Summary and Conclusion. Mr. Gwozdz's and Dr. Sack's prefiled testimony was submitted only three (3) days prior to the public hearing, after the deadline for the filing of prefiled testimony by Silver Hill, as petitioned intervenor. As recognized by the regulatory requirement that the Applicant's direct case should consist substantially of the application and exhibits, the Intervenor and OHCA need to be able to rely on the application to evaluate the facts. See RSCA § 19a-643-51(d). An applicant cannot evade the requirements of the application process by saying one thing in the application, and something very different in the prefiled, thereby not properly answering the specific questions in the application. Prefiled testimony is not a proper means for wholesale changes in the application, .

Accordingly, OHCA should strike the prefiled testimony of Mr. Gwozdz and Dr. Sack. The proffer of this testimony violates OHCA regulations. RSCA § 19a-643-

51(d) It should also be stricken, because such testimony is inconsistent with Applicant's CON and was filed just prior to the April 29, 2010 public hearing, resulting in irreparable prejudice to the OHCA, the Intervenor and the public. Moreover, to the extent Mr. Gwozdz or Dr. Sack intends to testify at the public hearing, such testimony should likewise be precluded.

Respectfully submitted,

SILVER HILL HOSPITAL, INC.

By _____

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Fax: (203) 772-7723
ltodisco@murthalaw.com
Its Attorneys

ORDER

The foregoing Motion to Strike and to Preclude having been considered, it is hereby Ordered that:

1. The prefiled testimony of Mr. Gwozdz and Dr. Sack is stricken; and

2. Any testimony proffered by Mr. Gwozdz or Dr. Sack at the April 29, 2010 public hearing is precluded.

_____

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Motion to Strike and to Preclude was sent by facsimile transmission and overnight mail, this 28th day of April, 2010, to:

Vincent M. Marino, Esq.
Cohen and Wolf, P.C.
1115 Broad Street
Bridgeport, CT 06604

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New Haven, CT 06511

Paul E. Knag

BERSHTEIN, VOLPE & McKEON P.C.
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CONNECTICUT SITING COUNCIL
HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

April 29, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Motion to Strike.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures

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DEPARTMENT OF PUBLIC HEALTH
DIVISION OF OFFICE OF
HEALTH CARE ACCESS : **DOCKET NO. 09-31500-CON**

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CONNECTICUT DEPT. OF PUBLIC
HEALTH CARE ACCESS

IN RE: EMPLOYMENT OPTIONS, LLC :
D/B/A LITCHFIELD HILLS RETREAT, LLC
PROPOSAL TO ESTABLISH A
FREE STANDING SUBSTANCE
ABUSE CENTER IN BETHLEHEM : **April 29, 2010**

MOTION TO STRIKE

The Applicant in the above matter, Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC (the "Applicant"), respectfully requests that the "Facsimile letter from High Watch Recovery Center to OHCA dated April 28, 2010 noting their concerns in the matter of the CON Application under Docket Number 09-31500, received by OHCA on April 28, 2010" be stricken from the Table of Record.

The correspondence submitted by High Watch Recovery Center ("Unauthorized Participant") should be stricken from the Record. Allowing the Unauthorized Participant's letter to be part of the Record in this proceeding prejudices the Applicant because: (1) Applicant did not have the opportunity to object to the attempted participation by the Unauthorized Participant; (2) the Unauthorized Participant did not follow the procedure for participation as party intervenor or informal participant in accordance with Section 19a-643-37, 19a-643-38, or 19a-643-39; and (3) the Applicant will not have the opportunity to cross examine the Unauthorized Participant or dispute their self-serving and ex-parte communications and/or otherwise address the assertions of the Unauthorized Participant.

The Unauthorized Participant had an opportunity to properly request participation in this matter and chose not to. The Applicant submits that the Unauthorized Participant chose not to

seek party or informal participation status because it would not have been granted any such rights to participate for the reasons set forth herein.

It is clear that the Unauthorized Participant does not offer a facility that is on par with the center being proposed by the Applicant.

By its own admission, the Unauthorized Participant operates a 78-bed facility, which is in stark contrast to the small, private secluded 28-bed center proposed by the Applicant. In addition, the Unauthorized Participant is dedicated to providing medical treatment to its residents, who stratify a "broad spectrum of individuals from a variety of backgrounds and social statuses." A fundamental component of Applicant's proposal is to provide an environment for similarly situated high-income, publically visible individuals who are concerned about being recognized in a facility such as the one operated by the Unauthorized Participant.

Moreover, the target population of the Applicant's proposed center is much different than the population currently served by the Unauthorized Participant and therefore the Applicant's proposed facility will not affect Unauthorized Participant's admissions. For example, Applicant will charge patients $900 per day compared to Unauthorized Participant charge of $260 per day.

Applicant has maintained throughout its CON that, unlike the Unauthorized Participant, it will not provide the range of medical services that the Unauthorized Participant provides. Instead, Applicant has emphasized that it will admit only those patients who have gone through a successful detoxification program and who are cleared medically by their physician. In addition, Applicant will implement safeguards to ensure that patients who are not appropriate for treatment offered by Applicant are transferred to more appropriate centers. Based on the foregoing differences, Applicant's facility will not target the population currently served by

Unauthorized Participant's facility and it not have any negative impact on the Unauthorized Participant's facility.

Furthermore, Unauthorized Participant mistakes Applicant's claims of privacy as claims that related to compliance with state and federal patient confidentiality laws, such as HIPAA. Applicant made clear in its filings before OHCA that the seclusion, privacy and confidentiality of which Applicant boasts is unrelated to its compliance with HIPAA and is instead related to the Applicant's focus on addressing the unique concerns of those "public" individuals who feel compelled, based on the nature of their profession or public role, to limit their visibility while obtaining treatment.

On December 5, 2007 OHCA granted Vista Partners LLC's ("Vista") CON Application in Docket Number 07-30928-CON to establish a substance abuse treatment center that is strikingly similar to the center proposed by Applicant, citing a need for its proposed 24-bed center. Because Vista never implemented its CON and notified OHCA of its intention not to move forward with its project, the need remains unmet. Accordingly, Unauthorized Participant's assertion that there is no need for the Applicant's proposed center is unfounded.

Based on the foregoing, and the fact that the letter submitted by the Unauthorized Participant is not in accordance with the applicable Regulations of Connecticut State Agencies Sections 19a-643-37, 19-643-38, or 19a-643-39, Applicant respectfully requests that OHCA strike the "Facsimile letter from High Watch Recovery Center to OHCA dated April 28, 2010 noting their concerns in the matter of the CON Application under Docket Number 09-31500, received by OHCA on April 28, 2010" from the Table of Record.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: _____

Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
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OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicant: Employment Options d/b/a Litchfield Hills Retreat

DN: 09-31500-CON

Hearing Date: April 29, 2010

Time: 9:00 a.m.

Proposal: Establishment of a Free Standing Substance Abuse Facility in Bethlehem, CT

OHCA Exhibit #	Description
F-1	Letter from the Applicant dated April 29, 2010 to OHCA requesting that the letter received from High Watch Recovery Ctr.Be stricken from the record, recived by OHCA on April 29, 2010
2	
3	
4	
5	

Applicant Late File #	Description	Due Date	Rec'd
1	Schedule of Client Activities	May 3, 2010 at noon	_____
2	Organizations chart of staffed positions	May 3, 2010 at noon	_____
3	If needed, updated financial attachment	May 3, 2010 at noon	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____

90416

Table 5.2B – Substance Dependence or Abuse for Specific Substances in the Past Year, by Age Group: Percentages, 2007 and 2008

Past Year Dependence or Abuse	Total (2007)	Total (2008)	Aged 12-17 (2007)	Aged 12-17 (2008)	Aged 18-25 (2007)	Aged 18-25 (2008)	Aged 26+ (2007)	Aged 26+ (2008)
*Low precision; no estimate reported. NOTE: Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). [a] Difference between estimate and 2008 estimate is statistically significant at the 0.05 level. [b] Difference between estimate and 2008 estimate is statistically significant at the 0.01 level. [1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, based on data from original questions not including methamphetamine items added in 2005 and 2006. [2] Estimates in these designated rows do not include data from methamphetamine use items added in 2005 and 2006. [3] Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs. Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2007 and 2008.								
ILLICIT DRUGS[1,2]	2.8	2.8	4.3	4.6	7.9	7.8	1.7	1.7
Marijuana and Hashish	1.6	1.7	3.1	3.4	5.6	5.6	0.7	0.8
Cocaine	0.6	0.6	0.4	0.3	1.4	1.2	0.6	0.5
Heroin	0.1	0.1	0.0	0.1	0.2	0.3	0.1	0.1
Hallucinogens	0.1	0.1	0.5	0.4	0.5	0.6	0.0	0.0
Inhalants	0.1	0.1	0.4	0.4	0.1	0.1	0.0	0.0
Nonmedical Use of Psychotherapeutics[2,3]	0.9	0.9	1.3	1.3	2.1	2.2	0.6	0.6
Pain Relievers	0.7	0.7	0.9	1.0	1.7	1.7	0.5	0.5
Tranquilizers	0.2	0.2	0.2	0.3	0.4	0.4	0.1	0.1
Stimulants[2]	0.2	0.1	0.3	0.3	0.4	0.4	0.1	0.1
Sedatives	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0
ALCOHOL	7.5	7.3	5.4[a]	4.9	16.8	17.2	6.2	6.0
BOTH ILLICIT DRUGS AND ALCOHOL[1,2]	1.3	1.2	2.1	1.9	4.1	4.2	0.7	0.6
ILLICIT DRUGS OR ALCOHOL[1,2]	9.0	8.9	7.7	7.6	20.7	20.8	7.2	7.0

90416

Table 22. *Needing But Not Receiving Treatment for Alcohol Use in Past Year*, by Age Group and State: Estimated Numbers (in Thousands), Annual Averages Based on 2004 and 2005 NSDUHs

State	Total		AGE GROUP (Years)					
			12-17		18-25		26 or Older	
	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval
NOTE: Needing But Not Receiving Treatment refers to respondents classified as needing treatment for alcohol, but not receiving treatment for an alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers). NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach, and the 95 percent prediction (credible) intervals are generated by Markov Chain Monte Carlo techniques. Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005.								
Total	17,787		1,393		5,472		10,923	
Alabama	229	(189 - 278)	20	(15 - 26)	60	(49 - 74)	149	(114 - 195)
Alaska	37	(31 - 44)	4	(3 - 5)	12	(10 - 14)	22	(17 - 28)
Arizona	404	(342 - 474)	35	(27 - 45)	114	(96 - 135)	254	(201 - 320)
Arkansas	139	(117 - 166)	11	(8 - 15)	44	(37 - 53)	84	(65 - 109)
California	2,197	(1,986 - 2,431)	185	(157 - 218)	663	(600 - 732)	1,349	(1,158 - 1,568)
Colorado	334	(283 - 392)	29	(23 - 37)	102	(87 - 119)	203	(160 - 257)
Connecticut	233	(194 - 280)	18	(14 - 23)	70	(60 - 82)	145	(111 - 189)
Delaware	46	(39 - 55)	3	(3 - 4)	17	(14 - 19)	26	(20 - 34)
District of Columbia	43	(36 - 51)	1	(1 - 2)	12	(10 - 14)	30	(23 - 38)
Florida	1,125	(1,015 - 1,247)	76	(65 - 89)	283	(258 - 310)	766	(662 - 884)
Georgia	409	(336 - 498)	32	(23 - 43)	117	(95 - 143)	261	(198 - 343)
Hawaii	66	(55 - 80)	5	(4 - 7)	21	(17 - 25)	40	(30 - 53)
Idaho	86	(73 - 101)	9	(7 - 11)	27	(23 - 32)	50	(39 - 64)
Illinois	848	(774 - 930)	61	(52 - 71)	277	(255 - 301)	510	(442 - 587)
Indiana	385	(329 - 449)	32	(25 - 40)	121	(103 - 142)	232	(184 - 292)
Iowa	209	(179 - 241)	16	(13 - 21)	80	(70 - 92)	112	(89 - 142)
Kansas	186	(159 - 218)	17	(13 - 21)	66	(56 - 77)	103	(81 - 132)
Kentucky	227	(191 - 269)	20	(16 - 26)	63	(52 - 76)	144	(112 - 184)
Louisiana	272	(229 - 324)	20	(16 - 25)	76	(63 - 91)	177	(138 - 224)
Maine	80	(68 - 95)	7	(5 - 9)	22	(19 - 26)	51	(40 - 65)
Maryland	297	(246 - 357)	25	(19 - 32)	85	(70 - 102)	188	(144 - 243)
Massachusetts	408	(345 - 483)	27	(21 - 35)	127	(109 - 148)	254	(198 - 324)

90413

Table 5.19B – Received Substance Use Treatment in the Past Year among Persons Aged 26 or Older, by Demographic Characteristics: Percentages, 2007 and 2008

Demographic Characteristic	Illicit Drugs[1] (2007)	Illicit Drugs[1] (2008)	Alcohol (2007)	Alcohol (2008)	Both Illicit Drugs and Alcohol[1] (2007)	Both Illicit Drugs and Alcohol[1] (2008)	Illicit Drugs or Alcohol[1,2] (2007)	Illicit Drugs or Alcohol[1,2] (2008)
*Low precision; no estimate reported.								
NOTE: Received Substance Use Treatment refers to treatment received in order to reduce or stop illicit drug or alcohol use, or for medical problems associated with illicit drug or alcohol use. It includes treatment received at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail.								
[a] Difference between estimate and 2008 estimate is statistically significant at the 0.05 level.								
[b] Difference between estimate and 2008 estimate is statistically significant at the 0.01 level.								
[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, based on data from original questions not including methamphetamine items added in 2005 and 2006.								
[2] Estimates include persons who received treatment specifically for illicit drugs or alcohol, as well as persons who received treatment but did not specify for what substance(s).								
[3] The Other Employment category includes retired persons, disabled persons, homemakers, students, or other persons not in the labor force.								
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2007 and 2008.								
TOTAL	0.8	0.7	1.0	1.1	0.5	0.4	1.4	1.5
GENDER								
Male	1.2	0.9	1.6	1.6	0.9	0.7	2.2	2.1
Female	0.4	0.5	0.5	0.6	0.2	0.2	0.8	0.9
HISPANIC ORIGIN AND RACE								
Not Hispanic or Latino	0.8	0.8	1.1	1.2	0.5	0.5	1.5	1.6
White	0.7	0.7	1.0	1.1	0.5	0.4	1.4	1.5
Black or African American	1.5	1.3	2.0	1.7	1.1	1.0	2.6	2.4
American Indian or Alaska Native	1.2	1.0	4.0	1.0	1.1	0.7	4.5	2.1
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*
Asian	0.2	*	0.0	0.4	*	*	0.2	0.4
Two or More Races	1.7	1.2	2.1	0.8	0.6	0.6	3.1	1.5
Hispanic or Latino	0.4	0.4	0.5	0.7	0.2	0.2	0.8	1.1
EDUCATION								
< High School	1.2	1.5	1.5	1.6	0.9	1.0	2.3	2.4
High School Graduate	1.0	0.8	1.3	1.2	0.6	0.6	1.8	1.5
Some College	0.8	0.6	1.1	1.4	0.5	0.3	1.4	1.9
College Graduate	0.4	0.2	0.4	0.5	0.2	0.1	0.6	0.6
CURRENT EMPLOYMENT								
Full-Time	0.6	0.6	0.9	1.2	0.4	0.4	1.2	
Part-Time	1.0	0.6	1.1	1.0	0.8	0.4		

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

AGENDA

PUBLIC HEARING

Certificate of Need Application, Docket Number 09-31500

Employment Options, LLC d/b/a Litchfield Hills Retreat

Establishment of a Free Standing Substance Abuse Facility in Bethlehem, CT

April 29, 2010 at 9:00 a.m.

I. Convening of the Public Hearing

II. Applicant's Direct Testimony (15 minutes)

   a. Intervenor's Cross-Examination of the Applicant
   b. OHCA Questions

III. Intervenor's Direct Testimony (10 minutes)

   a. Applicant's Cross-Examination of the Intervenor
   b. OHCA Questions

IV. Closing Statements

V. Public Hearing Recessed/Closed

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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC**

DOCKET NUMBER: **09-31500-CON**

PUBLIC HEARING: **April 29, 2010 at 9:00 a.m.**

PLACE: **410 Capitol Avenue, Third Floor Hearing Room**
Hartford, Connecticut

EXHIBIT	DESCRIPTION
A	Letter from Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC ("Applicant") dated November 18, 2009, enclosing Letter of Intent forms for the establishment of a Free-Standing Mental Health and Substance Abuse Treatment Facility in Bethlehem, received by the Office of Health Care Access ("OHCA") on November 20, 2009.
B	OHCA's request for legal notification in the *Republican American* and notification to Applicant of receipt of the Letter of Intent in the matter of the CON application under Docket Number 09-31500, dated December 7, 2009
C	OHCA's letter to the Applicant dated December 8, 2009, enclosing the Certificate of Need ("CON") application forms under Docket Number 09-31500.
D	Letter from the Applicant dated February 3, 2010, enclosing the CON application under Docket Number 09-31500, received by OHCA on February 5, 2010.
E	Letter from the Applicant to OHCA dated February 11,2 010 enclosing the General Affidavit, received by OHCA on February 16, 2010
F	OHCA's letter to the Applicant dated February 23, 2010, requesting additional information and/or clarification in the matter of the CON application under Docket Number 09-31500.

G	Applicant's responses to OHCA's letter of February 23, 2010, dated March 1, 2010, in the matter of the CON application under Docket Number 09-31500, received by OHCA on March 2, 2010.
H	Letter from Murtha Cullina LLP on behalf of Silver Hill Hospital to OHCA dated March 18, 2010 requesting a hearing in the matter of the CON application under Docket Number: 09-31500, received by OHCA on March 18, 2010.
I	Letter from Robinson & Cole LLP on behalf of High Watch Recovery Center, Inc. to OHCA dated March 22, 2010 requesting a hearing in the matter of the CON application under Docket Number: 09-31500, received by OHCA on March 22, 2010.
J	Letter from Saint Vincent's/Hall-Brooke to OHCA dated March 22, 2010 listing their concerns in the matter of the CON application under Docket Number 09-31500, received by OHCA on March 29, 2010.
K	Designation letter from Commissioner J. Robert Galvin dated April 7, 2010 designating Melanie Dillon as hearing officer in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 7, 2010.
L	Facsimile letter from Bershtein, Volpe & McKeon P.C. noticing their appearance on behalf of the Applicant in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 13, 2010. Hardcopy received on April 15, 2010.
M	OHCA's request for legal notification in the *Republican American* and OHCA's Notice to the Applicant of the public hearing scheduled for April 29, 2010, in the matter of the CON application under Docket Number 09-31500, dated April 14, 2010.
N	OHCA's letter to the Applicant dated April 20, 2010, requesting prefile testimony in the matter of the CON application under Docket Number 09-31500.
O	Petition of Silver Hill Hospital dated April 22, 2010, requesting intervenor status with full rights of participation, along with prefile testimony in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 22, 2010.
P	Facsimile letter from Stonington Institute to OHCA dated April 23, 2010 noting their concerns in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 23, 2010.
Q	Facsimile letter from the Applicant enclosing Prefile Testimony dated April 26, 2010 for Dr. David Sack and Brian Gwozdz in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 26, 2010. Hardcopy received on April 27, 2010.

R	Facsimile letter from the Applicant to OHCA dated April 26, 2010 requesting a Motion to Disqualify the law firm of Robinson & Cole LLP from representation of High Watch Recovery Center, Inc. and Motion to Preclude Consideration of any documentation, petition or other request submitted by Robinson & Cole on behalf of High Watch Recovery Center, Inc. in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 26, 2010. Hardcopy received on April 27, 2010
S	Facsimile letter from the Applicant dated April 26, 2010 to OHCA requesting Administrative Notice of Docket Number 07-30928 in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 26, 2010. Hardcopy received on April 27, 2010.
T	Facsimile letter from the Applicant to OHCA dated April 26, 2010 enclosing Legal Counsel's Opening and Closing Statement in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 26, 2010. Hardcopy received on April 27, 2010.
U	Facsimile letter form the Applicant to OHCA dated April 26, 2010 Objecting to Silver Hill Hospital, Inc's. Petition to be designated an intervenor with full rights of participation in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 26, 2010. Hardcopy received on April 27, 2010.
V	Email from the Applicant to OHCA dated April 26, 2010 recapping what was sent to OHCA by facsimile in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 26, 2010.
W	OHCA's Ruling on the Petition of Silver Hill Hospital, Inc. to be granted intervenor status in the matter of the CON application under Docket Number 09-31500 dated April 28, 2010.
X	E-mail from Murtha Cullina LLP on behalf of Silver Hill Hospital, Inc. to OHCA dated April 28, 2010 requesting a Motion to Compel the Appearance, Testimony and Cross-Examination of Michelle Zurko-Smith in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 28, 2010. Facsimile received on April 28, 2010
Y	E-mail from Murtha Cullina LLP on behalf of Silver Hill Hospital, Inc. to OHCA dated April 28, 2010 regarding OHCA's ruling in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 28, 2010.

Z	E-mail from Murtha Cullina LLP on behalf of Silver Hill Hospital, Inc. to OHCA dated April 28, 2010 regarding clarification of OHCA's ruling in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 28, 2010.
A-1	E-mail from Bershtein, Volpe & McKeon P.C. on behalf of the Applicant to OHCA dated April 28, 2010 objecting to Silver Hill Hospital Inc.'s Motion to Compel in the matter of the CON application under Docket Number 09-31500, received by OHCA on April 28, 2010. Facsimile received on April 28, 2010.
B-1	Email from Murtha Cullina LLP on behalf of Silver Hill Hospital, Inc. to OHCA dated April 28, 2010 requesting a Motion to strike the prefile testimony of Brian Gwozdz and David Sack, M.D. and preclude proffered testimony at the public hearing in the mater of the CON application under Docket Number 09-31500, received by OHCA on April 28, 2010. Facsimile received on April 28, 2010.
C-1	Facsimile letter from High Watch Recovery Center to OHCA dated April 28, 2010 noting their concerns in the matter of the CON Application under Docket Number 09-31500, received by OHCA on April 28, 2010.
D-1	Email from the Applicant to OHCA dated April 28, 2010 requesting a Motion to Strike correspondence submitted by Stonington Institute and Saint Vincent/Hall-Brooke in the matter of the CON Application under Docket Number 09-31500, received by OHCA on April 28, 2010. Facsimile received on April 28, 2010.
E-1	Email from the Applicant to OHCA dated April 28, 2010 objecting to motion of Silver Hill Hospital, Inc. to strike the prefiled testimony of Brian Gwozdz and David Sack, M.D. and preclude proffered testimony at hearing, received by OHCA on April 29, 2010.

PUBLIC HEARING
APPLICANT
SIGN UP SHEET

April 29, 2010
9:00 a.m.

Applicant: Docket Number: 09-31500-CON
Employment Options d/b/a Litchfield Hills Retreat
Establishment of a Free Standing Substance Abuse Facility

in Bethlehem, CT

Name	Phone	Fax	Representing Organization/Self
BMG (BRIAN M. GWOZDZ)	413-519-4237		EMPLOYMENT OPTIONS DBA LITCHFIELD HILLS RETREAT
Michele Zurko-Smith	203-206-8212		Employment Options DBA Litchfield Hills Retreat
Patricia A. Happy	"		Employment Options " "
Keith Arnold	520-488-7278		" " " "
David Sack	562-741-6476		" " " "

Public Hearing
Employment Options d/b/a Litchfield Hills Retreat

Name	Phone	Fax	Representing Organization/Self
ELIZABETH MOORE	203 801-2397	203 966 9336	SILVER HILL HOSPITAL
Sigurd Ackerman	203-801-2215	203-966-9336	Silver Hill Hospital
Heather Porter	203 801 2378	203 801 3455	Silver Hill Hospital
Christopher McKean	203-777-5800	203 777 5806	Counsel for Employment Options
~~Kathleen Steinbach~~	~~860-418-6897~~		~~ATTACH~~
Michele Volpe	203-777-6995	(203) 777-5806	Employment Options / Litchfield Hills
~~Fred O'Brien~~	~~860-245-9121~~	~~860-527-4343~~	~~Here to observe.~~

PUBLIC HEARING
INFORMAL PARTICIPANT
SIGN UP SHEET

April 29, 2010
9:00 a.m.

Applicant: Docket Number: 09-31500-CON
Employment Options d/b/a Litchfield Hills Retreat
Establishment of a Free Standing Substance Abuse Facility

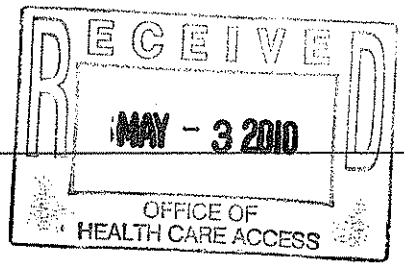
Name	Phone	Fax	Representing Organization/Self
Lauren Siembab	860-418-6897		DMHAS
Frederick O'Brien	860 249 9121	860 527 4343	SELF

PUBLIC HEARING
INTERVENOR
SIGN UP SHEET

April 29, 2010
9:00 a.m.

Applicant: Docket Number: 09-31500-CON
Employment Options d/b/a Litchfield Hills Retreat
Establishment of a Free Standing Substance Abuse Facility

Name	Phone	Fax	Representing Organization/Self
Sigurd Ackerman, M.D.	203 801 2215	203 801 3455	Silver Hill Hospital
Elizabeth Moore	203 801 2297	203 801 3455	" " "
Heather Porter	203 801 2378	203 801 3455	" " "
Paul E. Knag			" " "
Louis B. Toch Esq	203-772-7718	203-772-7723	" " "



Greer, Leslie

From: Lazarus, Steven
Sent: Monday, May 03, 2010 11:44 AM
To: Greer, Leslie; Olejarz, Barbara
Subject: FW: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)
Attachments: Late File (BVM 5.03.10).pdf

Please add to the record. Should be same at the fax received a few minutes ago.

Thank you,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Bettyanne Toole [mailto:bettyanne@bvmlaw.com]
Sent: Monday, May 03, 2010 11:26 AM
To: Lazarus, Steven; Martone, Kim
Cc: michelemvolpe@aol.com; Christopher McKeon; Aimee Onofrio
Subject: Employment Options, LLC dba Litchfield Hills Retreat, LLC (Docket #09-31500-CON)

Steven and Kim: Attached please find the Applicant's Late File. Thank you.

Betty Anne Toole-Teasley
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Facsimile: (203) 777-5806

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BERSHTEIN, VOLPE & McKEON P.C.
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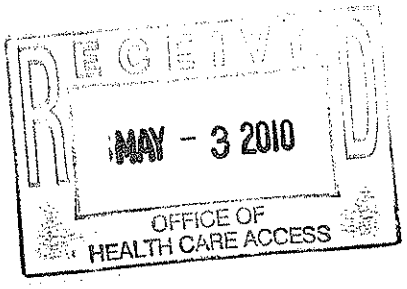
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

Michele M. Volpe
Direct Dial (203) 777-6995

May 3, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
and Federal Express



Deputy Commissioner Cristine Vogel
Hearing Officer Melanie Dillon
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of the Applicant's Late File.

Should you require anything further, please feel free to contact me.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
cc: Michele Zurko-Smith, Brian Gwozdz, David Sack, M.D., Steven Lazarus

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Late File) 5.03.10.doc

Litchfield Hills Retreat, LLC
64 Double Hill Road
Bethlehem, Connecticut

Mailing address: 12 Trefoil Road, Oxford, Connecticut 06478

May 3, 2010
Via Facsimile (860) 418-7053
and Overnight Delivery

Deputy Commissioner Cristine Vogel
Hearing Officer Melanie Dillon
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON; Employment Options, LLC D/B/A Litchfield Hills Retreat, LLC Proposal to Establish a Free Standing Adult Substance Abuse Center in Bethlehem

Dear Deputy Commissioner Vogel and Hearing Officer Dillon:

Pursuant to the Office of Health Care Access' ("OHCA") request for Late File in the matter of Docket Number 09-31500-CON, Litchfield Hills Retreat, LLC ("Litchfield Hills Retreat") is pleased to submit a Schedule of Client Activities, an Organizational Chart of staff positions and an updated Operating Budget.

In accordance with the testimony provided on behalf of Litchfield Hills Retreat at the April 29th public hearing and the proposed staffing set forth in the enclosed Organizational Chart, we have developed a cost estimate for the total salaries, wages, bonuses, benefits and overtime labor costs that will be incurred in operation of our proposed 28-bed center, assuming 90% capacity. This cost estimate for the proposed Litchfield Hills Retreat is enclosed for your review.

As you know, the budget provided in the CON Application at pages 39-46 estimated annual salaries and benefits to be $2,587,762. Based on our updated calculations, we estimate the incurrence of $2,563,200 per year in salaries and benefits – a reduction of $24,562. In addition, the CON Application budget provides for $1,250,897 per year in professional fees and $36,000 for independent contractors, including costs attributable to a physician and other therapists as noted in the CON Application on page 42.

Litchfield Hills Retreat's post-hearing review and analysis of the budget and staffing of the proposed center corroborates our Financial Analysis and clearly illustrates that Litchfield Hills Retreat will be able to provide for all of the proposed services within the budget presented in our CON Application.

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Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

Enclosures

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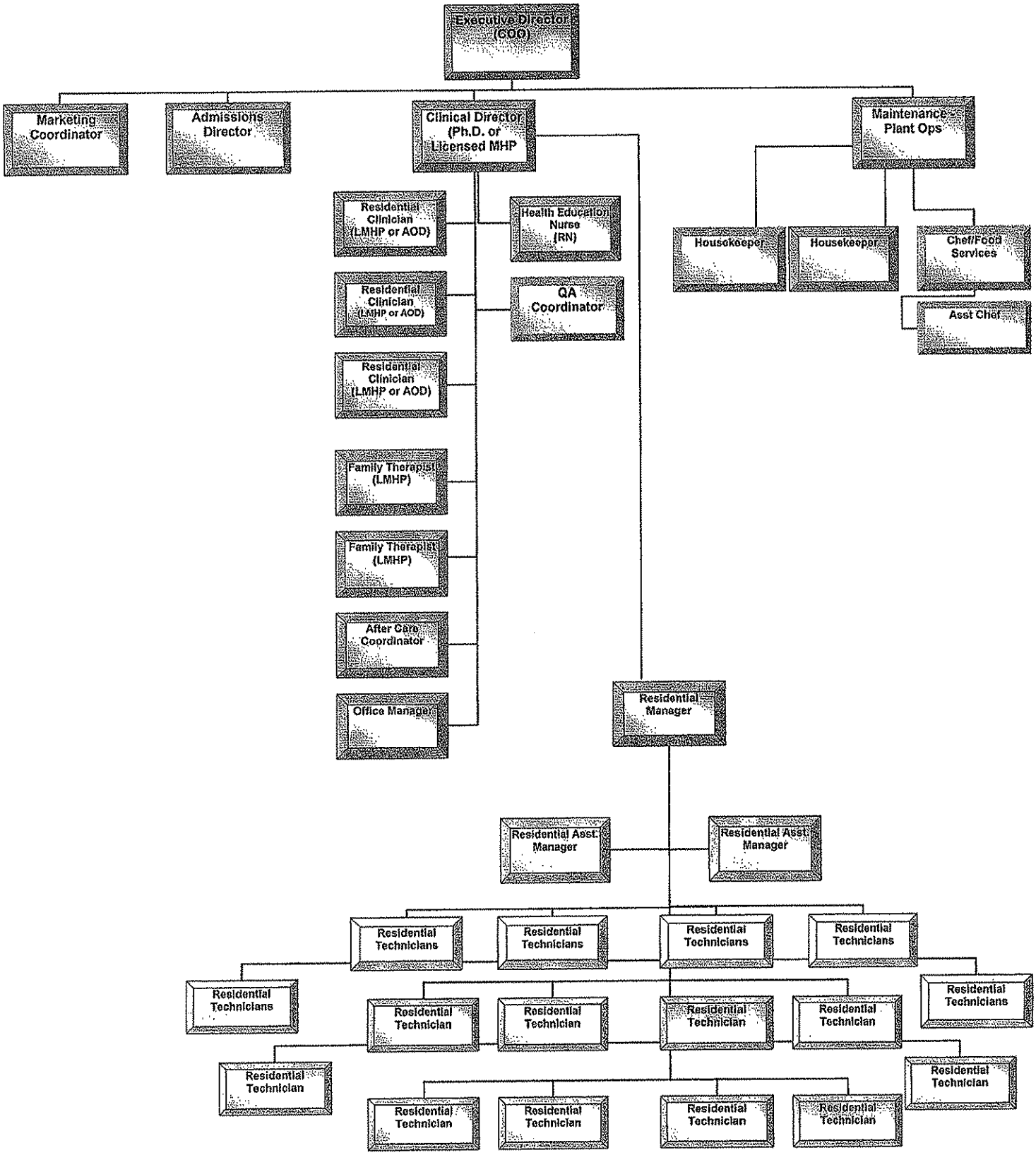

Lithfield Hills Retreat, LLC
Docket Number: 08-31500-CON

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2010 MAY -3 A 11:40
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HEALTH CARE ACCESS

FAX TRANSMISSION

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET
THIRD FLOOR
NEW HAVEN, CT 06511
(203) 777-5800 Fax: (203) 777-5806

FAX #: (860) 418-7053

TO: Honorable Cristine Vogel
Hearing Officer Melanie Dillon
Associate Health Care Analyst Steven Lazarus
Office of Health Care Access

cc: Louis Todisco
(203) 772 7723
Paul Knag
(203) 653 5444

DATE: May 3, 2010

PAGES: 7 including this page

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

CONFIDENTIALITY NOTICE
Please note that the information contained in this fax is confidential and privileged and is intended only for use by the named receiver. If you have received this fax in error, please call 203-777-5800. Any use of this fax or its contents, including any dissemination or copying, is prohibited. Attorneys receiving this fax in error are directed to review ABA formal ethics opinion no. 92-368.

COMMENTS:

Dear Commissioner Vogel:

Please see the attached Late File.

Thank you.

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Faxes\OHCA 5.03.10 (Late File).doc

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Michele M. Volpe
Direct Dial (203) 777-6995

May 3, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
and Federal Express

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MMV/bt
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F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Late File) 5.03.10.doc

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Mailing address: 12 Trefoil Road, Oxford, Connecticut 06478

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Page 278

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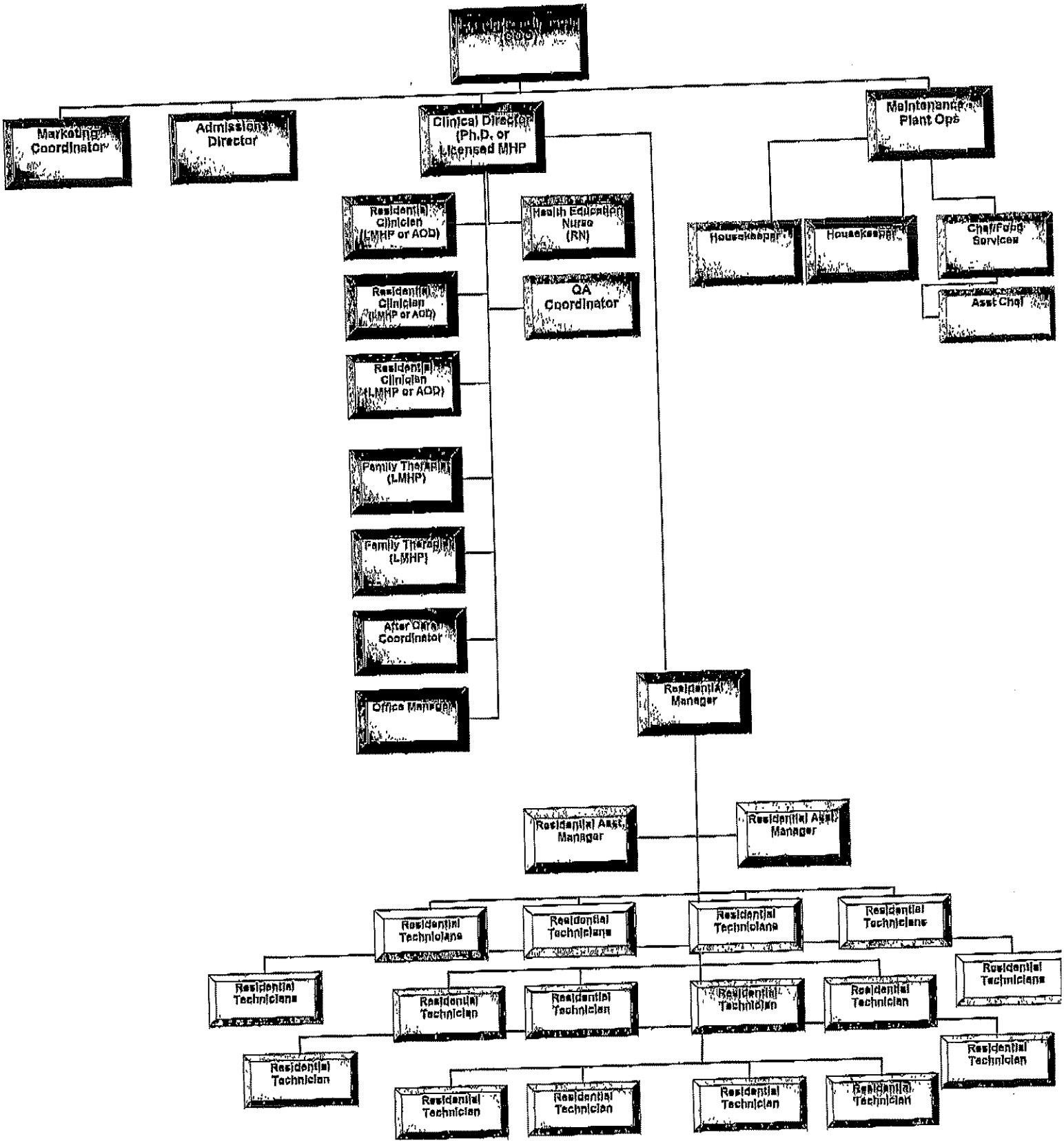

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Michele M. Volpe
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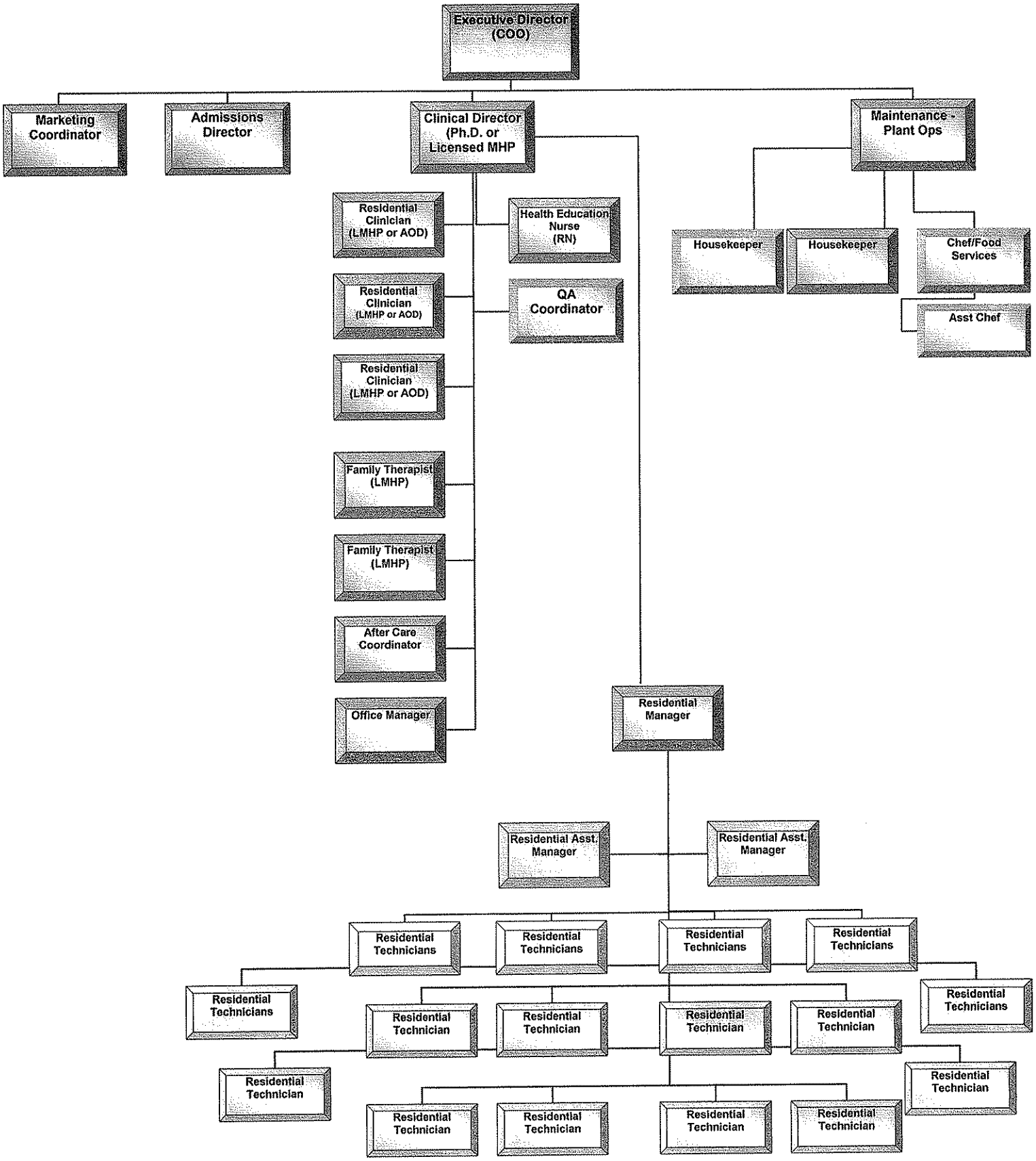
Notes: Service Outing alternates with Equine Assisted Psychotherapy. Individual sessions with Primary Therapists occur 3 times per week during free times. Sessions with Family Therapists occur weekly in addition to the Saturday Family Program. The Alumni Meeting also includes current clients.

Organizational Chart



Lithfield Hills Retreat, LLC
Docket Number: 08-31500-CON

Staffing Build-up assuming a 28 bed program operating at 90% capacity

Position	Salary & Wages	Bonus %	Bonus Dollars	Benefits (13%)	Total
Executive Director (COO)	$ 130,000	30%	$ 39,000	$ 16,900	$ 185,900
Marketing Coordinator	$ 150,000	40%	$ 60,000	$ 19,500	$ 229,500
Admissions Director	$ 90,000	30%	$ 27,000	$ 11,700	$ 128,700
Clinical Director	$ 120,000	15%	$ 18,000	$ 15,600	$ 153,600
Residential Clinician (LMHP or AOD) #1	$ 70,000	15%	$ 10,500	$ 9,100	$ 89,600
Residential Clinician (LMHP or AOD) #2	$ 70,000	15%	$ 10,500	$ 9,100	$ 89,600
Residential Clinician (LMHP or AOD) #3	$ 70,000	15%	$ 10,500	$ 9,100	$ 89,600
Family Therapist (LMHP) #1	$ 70,000	15%	$ 10,500	$ 9,100	$ 89,600
Family Therapist (LMHP) #2	$ 70,000	15%	$ 10,500	$ 9,100	$ 89,600
After Care Coordinator	$ 34,000			$ 4,420	$ 38,420
Office Manager	$ 50,000			$ 6,500	$ 56,500
Health Education Nurse (RN)	$ 60,000			$ 7,800	$ 67,800
QA Coordinator	$ 35,000			$ 4,550	$ 39,550
Residential Manager	$ 50,000			$ 6,500	$ 56,500
Residential Asst. Manager #1	$ 40,000			$ 5,200	$ 45,200
Residential Asst. Manager #2	$ 40,000			$ 5,200	$ 45,200
Residential Technician #1	$ 34,000			$ 4,420	$ 38,420
Residential Technician #2	$ 34,000			$ 4,420	$ 38,420
Residential Technician #3	$ 34,000			$ 4,420	$ 38,420
Residential Technician #4	$ 34,000			$ 4,420	$ 38,420
Residential Technician #5	$ 34,000			$ 4,420	$ 38,420
Residential Technician #6	$ 34,000			$ 4,420	$ 38,420
Residential Technician #7	$ 34,000			$ 4,420	$ 38,420
Residential Technician #8	$ 34,000			$ 4,420	$ 38,420
Residential Technician #9	$ 34,000			$ 4,420	$ 38,420
Residential Technician #10	$ 34,000			$ 4,420	$ 38,420
Residential Technician #11	$ 34,000			$ 4,420	$ 38,420
Residential Technician #12	$ 34,000			$ 4,420	$ 38,420
Residential Technician #13	$ 34,000			$ 4,420	$ 38,420
Residential Technician #14	$ 34,000			$ 4,420	$ 38,420
Residential Technician #15	$ 34,000			$ 4,420	$ 38,420
Residential Technician #16	$ 34,000			$ 4,420	$ 38,420
Maintenance - Plant Ops	$ 70,000	15%	$ 10,500	$ 9,100	$ 89,600
Housekeeper #1	$ 42,000			$ 5,460	$ 47,460
Housekeeper #2	$ 42,000			$ 5,460	$ 47,460
Chef/Food Services	$ 84,000			$ 10,920	$ 94,920
Assistant Chef	$ 49,000			$ 6,370	$ 55,370
Total	$ 1,980,000		$ 207,000	$ 257,400	$ 2,444,400
Overtime (6% of Salaries and Wages)					$ 118,800
Annual Staffing Costs Fully Loaded					**$ 2,563,200**

09-31500

Special notices

ADVERTISERS

Please read your ad on the first day it appears and report any errors in time for the next insertion. The Republican-American is responsible for only one incorrect insertion for any advertisement and then only to the extent of a "make good" insertion. Errors which do not lessen the value of the advertisement will not be corrected by "make good" insertions.

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ANNOUNCEMENT

For the benefit of reader understanding, this newspaper does not accept abbreviations for any words except English standard and industry standard abbreviations. We will not automatically abbreviate and when requested to do so, will follow only standard abbreviations.

Legals/ Public Notices

HARWINTON ZONING COMMISSION

The Harwinton Zoning Commission will hold a public hearing on Monday, April 26, 2010 at 7:00 p.m. in the Town Hall, 100 Bentley Drive, to hear an application submitted by GRJH, Inc. for modifications to previous approval for additional activity, 207 Birge Park Road to include in-service restaurant. Application is on file in the Land Use Office. At such hearing any person or persons may appear and be heard and may be represented by agent or attorney.

Ron Sherlock, Chairman
Zoning Commission
R-A April 16 & 23, 2010

INVITATION TO BID
April 16, 2010

DUE DATE: May 4, 2010
TIME: 2:00 p.m.
LOCATION: University of Connecticut
Capital Projects & Contract Administration
31 LeDoyt Road, Storrs, CT
Attn: Walt Dalla

(Sealed Bids – Faxed Bids will not be accepted)

The University of Connecticut is accepting sealed bids for:

Engineering II Combustion Lab – UCPM Code Remediation
Project Number #901346
UNIVERSITY OF CONNECTICUT
Storrs, CT

Bids must be submitted on the forms supplied and in the manner specified within the Bid Documents. BIDDERS MUST ORDER AND RESERVE A SET OF BID DOCUMENTS PRIOR TO PICK-UP FROM JOSEPH MERRITT & CO., 650 FRANKLIN AVENUE, HARTFORD, CT 06114, PHONE (860) 296-2500 OR FAX (860) 296-0414. BID DOCUMENTS MAY BE PURCHASED FOR THE COST OF PRINTING BY BUSINESS OR PERSONAL CHECK MADE PAYABLE TO JOSEPH MERRITT & CO.

In the bidding of most deferred maintenance, major renovation, and new construction projects, contractors are advised that they must award twenty-five (25%) or more of the values of their awarded contracts to certified SBE's; and, of that amount, twenty five percent (6.25% of the total award) or more must be awarded to SBE's who are also MBE's. The contractors are responsible for ensuring that they and the SBE's they have selected are eligible contractors, and that they meet State requirements.

The University of Connecticut is an Affirmative Action/Equal Opportunity Employer (AA/EOE). Minorities and women are encouraged to bid/apply.
R-A April 16,2010

NOTICE OF ANNUAL TOWN MEETING
TOWN OF SEYMOUR
Thursday, April 22, 2010

The Annual Town Meeting of the Electors and Citizens qualified to vote in the Town meetings of the Town of Seymour, Connecticut, will be held at Seymour Middle School, 21 Mountain Road, Seymour, CT, Thursday, April 22, 2010 @ 7:00 PM.

1. To consider and act upon by vote Move to authorize the issue of notes in anticipation of the receipt of taxes for the Fiscal year commencing July 1, 2010, in an amount not to exceed $2,000,000 to pay current expenses and obligations of the Town, and to authorize the Board of Selectmen, or its designees, to determine, the amount, date, interest rates, maturities, form and other details of the notes, and to bid the Town pursuant to such representations and covenants as deemed necessary or advisable in order to maintain the continued exemption from Federal Income Taxation of interest on the notes, including covenants to pay rebates of investment earnings to the United States in future years.

2. To consider the 2010/2011 Budget as recommended by the Board of Finance. Income $50,728,948.00 Expenses $50,728,948.00. For a Mill Rate of 27.58. This meeting will be adjourned until April 29, 2010 hereupon the town voters will act on the Budgets. This action will occur by machine vote at the Community Center, 20 Pine Street, from 6:00 a.m. - 8:00 p.m.

TOWN REVENUES	BUDGET FY 2010-2011
Town Fees, Assessment & Interest Income	2,213,366.00
State Education Funding &	

INVITATION TO BID
April 16, 2010

DUE DATE: May 5, 2010
TIME: 2:00 p.m.
LOCATION: University of Connecticut
Capital Projects & Contract Administration
31 LeDoyt Road, Storrs, CT
Attn: Walt Dalla

(Sealed Bids – Faxed Bids will not be accepted)

The University of Connecticut is accepting sealed bids for:

Homer Babbidge Window Flashing Repair
Project Number #901399
UNIVERSITY OF CONNECTICUT
Storrs, CT

Bids must be submitted on the forms supplied and in the manner specified within the Bid Documents. BIDDERS MUST ORDER AND RESERVE A SET OF BID DOCUMENTS PRIOR TO PICK-UP FROM JOSEPH MERRITT & CO., 650 FRANKLIN AVENUE, HARTFORD, CT 06114, PHONE (860) 296-2500 OR FAX (860) 296-0414. BID DOCUMENTS MAY BE PURCHASED FOR THE COST OF PRINTING BY BUSINESS OR PERSONAL CHECK MADE PAYABLE TO JOSEPH MERRITT & CO.

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R-A April 16, 2010

INVITATION TO BID
April 16, 2010

DUE DATE: May 6, 2010
TIME: 2:00 p.m.
LOCATION: University of Connecticut
Capital Projects & Contract Administration
31 LeDoyt Road, Storrs, CT
Attn: Walt Dalla

(Sealed Bids – Faxed Bids will not be accepted)

The University of Connecticut is accepting sealed bids for:

Laundry Building Roof Repair
Project Number #201506
UNIVERSITY OF CONNECTICUT
Storrs, CT

Bids must be submitted on the forms supplied and in the manner specified within the Bid Documents. BIDDERS MUST ORDER AND RESERVE A SET OF BID DOCUMENTS PRIOR TO PICK-UP FROM JOSEPH MERRITT & CO., 650 FRANKLIN AVENUE, HARTFORD, CT 06114, PHONE (860) 296-2500 OR FAX (860) 296-0414. BID DOCUMENTS MAY BE PURCHASED FOR THE COST OF PRINTING BY BUSINESS OR PERSONAL CHECK MADE PAYABLE TO JOSEPH MERRITT & CO.

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R-A April 16, 2010

INVITATION TO BID
April 16, 2010

DUE DATE: May 7, 2010
TIME: 2:00 p.m.
LOCATION: University of Connecticut
Capital Projects & Contract Administration
31 LeDoyt Road, Storrs, CT
Attn: Walt Dalla

(Sealed Bids – Faxed Bids will not be accepted)

The University of Connecticut is accepting sealed bids for:

Homer Babbidge Library Plaza Deck Expansion Joint Repair
Project Number #901467
UNIVERSITY OF CONNECTICUT
Storrs, CT

Bids must be submitted on the forms supplied and in the manner specified within the Bid Documents. BIDDERS MUST ORDER AND RESERVE A SET OF BID DOCUMENTS PRIOR TO PICK-UP FROM JOSEPH MERRITT & CO., 650 FRANKLIN AVENUE, HARTFORD, CT 06114, PHONE (860) 296-2500 OR FAX (860) 296-0414. BID DOCUMENTS MAY BE PURCHASED FOR THE COST OF PRINTING BY BUSINESS OR PERSONAL CHECK MADE PAYABLE TO JOSEPH MERRITT & CO.

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R-A April 16, 2010

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INVITATION TO BID

Sealed bids for the SPECIAL EDUCATION OUT OF DISTRICT TRANSPORTATION for the Thomaston Public Schools will be received by the Business Manager at her office on 158 Main Street in Thomaston until 3:00 pm on May 13, 2010.

The superintendent of Schools reserves the right to waive any information and/or to accept or reject any or all bids, or portions of bids.

Bid packages are available in the Superintendent's office Monday through Friday from 8am to 3pm, 158 Main Street Level 6, Thomaston or online at www.thomastonschools.net
R-A April 16, 17 & 18, 2010

LEGAL NOTICE

At the regular meeting on Wednesday, April 14, 2010, the Sharon Planning & Zoning Commission voted unanimously to: Approve the Application of Charles Paley for property at 230 Amenia Road for Restaurant, including outdoor cafe service, bakery or confectionery shop and Retail sales outlet as accessory to the primary use of product production or warehousing on the same site as outlined in section 9.3. P & Q. of the Local Enterprise District special exceptions. The decision will be on file with the Sharon Town Clerk.

Dated at Sharon, Connecticut, this 15th Day of April, 2010

Barclay Prindle, Chairman
Sharon Planning & Zoning Commission
R-A April 16, 2010

Legal Notice

Notice of sales or other disposition, pursuant to Conn. Gen. Stat. 42a-7-210, is hereby given that "Industrial Riggers, Inc." will sell at public auction, to satisfy unpaid storage fees on delinquent accounts, the following property: Misc. equipment for Empire Lighting, Central Electric, Sterling Industries, and Paul Majewicz. Sales to be paid in cash only, at the time of sales. property to be moved off premises same day. Tenants may claim their merchandise up to the time of sale by paying just debts and vacate. Sale to be held on 4/21/10 at 8:00 a.m. at Industrial Riggers, Inc. 300 Chase River Rd. Waterbury, CT. 06704
R-A April 7 through April 21, 2010

LEGAL NOTICE

The Audit of the Northwest Connecticut Convention & Visitors Bureau for the Fiscal Year 2006-2009 has been completed. Anyone wishing further information should call: 860-567-4506 to set up an appointment.

Janet L. Serra, Director
Northwest CT Convention & Visitors Bureau
PO Box 968
Litchfield, CT 06759
R-A April 16, 2010

LEGAL NOTICE

The Torrington Area Health District will hold a public hearing on its 2010-2011 budget on Thursday, April 22, 2010 at 7:00 PM at 350 Main Street, Torrington, CT.

James B. Rokos
Director of Health
R-A April 16, 2010

LEGAL NOTICE
TOWN OF CORNWALL
ADOPTION OF PLAN OF CONSERVATION AND DEVELOPMENT
PLANNING AND ZONING COMMISSION

Pursuant to the provisions of Section 8-23 of the General Statutes, as amended, notice is hereby given that at a regular meeting, April 13, 2010, held in the Cornwall Town Hall, the Cornwall Planning and Zoning Commission made the following decision: By unanimous vote of all regular members, to Adopt the Plan of Conservation of Development, as amended. A copy of the amended Plan is on file in the Office of the Town Clerk for review and placed on the Town of Cornwall website. The Plan of Conservation has been approved with an effective date of May 1, 2010.
Dated this 16th day of April, 2010
Land Use Administrator
Karen Griswold Nelson
R-A April 16, 2010

LEGAL NOTICE

TOWN OF HARWINTON
ZONING BOARD OF APPEALS

MEMORANDUM OF DECISION - VARIANCE

The Zoning Board of Appeals, Town of Harwinton, held a Public Hearing on Wednesday, April 14, 2010, 7:00 p.m., in the Town Hall, 100 Bentley Drive, to hear the application of Chris Johnsiere, 299 Hill Road, requesting a 27.5' side yard variance, Section 5 (CR) Zoning Regulations, for a deck.

Five members of the Board were present.

It was a unanimous vote by the Board to grant the request for variance applied for, hardship being the location of the existing house on the non-conforming narrow lot.

Dated this date, April 15, 2010.

Christine B. Neal, Clerk
HARWINTON ZONING BOARD OF APPEALS
R-A April 17, 2010

LEGAL NOTICE
Town of Kent Zoning Board of Appeals

At a meeting of the Zoning Board of Appeals on April 13, 2010, the following actions were taken:

#03-10 - Justin Money at 24 Maple Street Extension, Map 4 Block 44 Lot 3, seeking relief from Section 5.5 pertaining to the side yard setbacks to permit material storage bins 10' rather than 20' from the north side boundary was denied.

#04-10 - Craig Bibb at 72 Lake Waramaug Road, Map 17 Block 27 Lot 10, seeking relief from Section 5.5 pertaining to the front, side and rear setbacks and Section 10.4.3. pertaining to the Lake Waramaug Watershed District was tabled to the May 11, 2010 meeting.

Dated at Kent, CT, this 16th Day of April, 2010.
Anthony F. Dipentima, Chairman
R-A April 16, 2010

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Legal Notice
Town of Litchfield
Planning and Zoning Commission

Notice is hereby given that at the Litchfield Planning and Zoning Commission meeting held on April 5, 2010 the Commission adopted the following amendments to the Town of Litchfield Subdivision Regulations:

Article V, Section 5.4, Driveways and access ways to add a provision for a shared driveway.

The effective date of these amendments shall be May 1, 2010.

Copies of the amendments are on file at the Land Use Office, Town Hall Annex, 80 Doyle Road, Bantam, CT.

Barbara Putnam
Chairman
R-A April 16, 2010

NOTICE OF PUBLIC HEARING ON CONNECTICUT'S WATER POLLUTION CONTROL FINANCIAL ASSISTANCE PROGRAM FOR STATE FISCAL YEARS 2010 & 2011 CLEAN WATER FUND PROGRAM

In conformance with the provisions of the Municipal Wastewater Treatment Construction Grant Amendments of 1981, Public Law 97-177, the Water Quality Act of 1987, the requirements of Title 40, Part 35 Subpart I, paragraphs 35.2015 and 35.2020, Code of Regulations in the Federal Register, Volume 49, Number 34, February 17, 1984 and pursuant to Sections 22a-439, 22a-439a and 22a-478 of the Connecticut General Statutes and Sections 22a-439-1 and 22a-482-1 (c)(4) of the Regulations of Connecticut State Agencies, the Connecticut Department of Environmental Protection will hold a public hearing to discuss the Federal and State Water Pollution Control Funding Assistance for publicly owned wastewater treatment works (pollution abatement facilities) for State fiscal years 2010 and 2011 (July 1, 2009-June 30, 2011).

The financial assistance program provides grants and loans at various levels to municipalities for planning, design, and construction of wastewater collection and treatment projects. This program uses a priority setting system to rank eligible municipal treatment works projects. The priority system and priority list become the basis for committing available and anticipated state and federal funds. A public hearing on the proposed priorities for Clean Water Fund funding will be held in the Phoenix Auditorium, 5th floor at 79 Elm Street, Hartford, CT on May 11, 2010 at 9:30 am.

The FY10 and FY11 Draft Priority List for the Clean Water Fund program can be found at www.ct.gov/dep/cleanwaterfund.

Interested parties are invited to review and comment on the proposed priority list.
Written statements must be received at the Bureau of Water Protection and Land Reuse, Connecticut Department of Environmental Protection, 79 Elm Street, Hartford, Connecticut 06106-5127 on or before May 17, 2010.

Paul E. Stacey
Director
Bureau of Water Protection and Land Reuse
Planning & Standards Division

Dated: April 13, 2010
R-A April 16, 2010

LEGAL NOTICE

Statute Reference: 19a-638
Applicant: Stay Well 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.
R-A April 16, 2010

NOTICE TO CREDITORS
ESTATE OF KATHRYN V. PITZSCHLER, of Beacon Falls
(10-000056)

The Hon. Peter E. Mariano, Judge of the Court of Probate, District of Waterbury, by decree dated March 11, 2010, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Patricia Alegi, Clerk
The fiduciary is:
ROBERT B. PITZCHLER
c/o ATTY. DANIEL F. SCHOPICK
Shelbox & Schopick
572 White Plains Road
Trumbull, CT 06611
R-A April 16, 2010

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NOTICE TO CREDITORS
ESTATE OF LEON RIELL, of Naugatuck
aka LEON A. RIELL
(10-000079)

The Hon. Peter E. Mariano, Judge of the Court of Probate, District of Naugatuck, by decree dated April 13, 2010, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Patricia Alegi, Clerk
The fiduciary is:
ELISE M. GETER
c/o ATTY. CARLA M. PERUGINI-ERICKSON
PO Box 7209
Prospect, CT 06712
R-A April 16, 2010

PROSPECT PLANNING & ZONING COMMISSION
NOTICE OF PUBLIC HEARING

The Prospect Planning & Zoning Commission will hold a Public Hearing on Wednesday, April 21, 2010 in the lower level conference room of the Prospect Town Hall, 36 Center Street on the following applications:
7:10 p.m. TSC Properties, 170 Scott Road - Change of Zone Designation from RA-1 Acre to Commercial Park District and a text change allowing General Contractors, Service and Equipment as a permitted use within a Commerce Park District.
At this hearing all interested persons will be heard and written correspondence received. The complete file may be reviewed at the Land Use Office in the Prospect Town Hall.
Donald Pomeroy, Chairman
R-A April 9 & 16, 2010

Request for Qualifications
RFQ # 01-9909

The State of Connecticut Judicial Branch, on behalf of the Office of Victim Services (OVS) is soliciting responses to this Request for Qualifications (RFQ) from qualified individuals or institutions to provide assistance on the Sexual Assault Forensic Examiners (SAFE) pilot program.
Interested parties are required to respond to this RFQ by May 7, 2010 before 2:30 p.m. You may Fax or e-mail your response to the individual named in the RFQ. Further information is available in the RFQ documents.

PLEASE CHECK THE JUDICIAL WEB SITE AT:
www.jud.ct.gov/external/news/busopp/Default.htm

JUDICIAL BRANCH
PURCHASING SERVICES
90 WASHINGTON STREET
HARTFORD, CT 06106
An Equal Opportunity/Affirmative Action Employer
R-A April 16, 2010

The University of Connecticut is currently seeking proposals for the following:

1. Landscape Service Contract for the Avery Point Campus. Mandatory pre-proposal meeting 4-28-2010 @ 11:00 AM at the Avery Point Campus
Bid No: PL041610
Opening Date: May 7, 2010 @ 2:00 PM

Interested parties should visit our website at http://www.purchasing.uconn.edu/currentbid/currentbid.html, or call 860-486-2619. Inquiries must be made by Bid Number
R-A April 16, 2010

TOWN OF CORNWALL
BOARD OF FINANCE
NOTICE OF PUBLIC BUDGET HEARING
APRIL 23rd, 2010

The Cornwall Board of Finance will hold a Public Budget Hearing of the electors and citizens of the Town of Cornwall, Connecticut on Friday, April 23, 2010, beginning at 7:30 P.M. at the Cornwall Consolidated School Gathering Room, Cornwall, CT to hear and discuss the following: MUNICIPAL BUDGET FOR THE TOWN OF CORNWALL, CONNECTICUT FOR THE FISCAL YEAR 2010/2011 Copies of the proposed 2010/2011 Municipal Budget are available for inspection in the Finance Office and the Selectmen's Office of the Town Hall, 24 Pine Street, Cornwall, CT Dated at Cornwall, Connecticut, this 8th day of April 2010. Ralph Gold, Chairman, Board of Finance
R-A April 16 & 17, 2010

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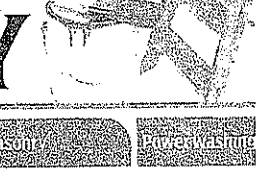
PUBLIC NOTICE
Office of Health Care Access Public Hearing

Statute Reference: 19a-638
Applicants: Town: Docket Number: Proposal:
19a-638
Employment Options d/b/a Litchfield Hills Retreat
Bethlehem
09-31500-CON
Establishment of a Free-Standing Health and Substance Abuse Treatment Facility in Bethlehem, CT with a total capital expenditure of $500,000
Date: April 23, 2010
Time: 9:00 a.m.
Place: Office of Health Care Access, Third Floor Hearing Room, 410 Capitol Avenue Hartford, Connecticut

Any person who wishes to request status in the above listed hearing may file a written petition no later than April 24, 2010 (10 days before the date of the hearing) pursuant to Sections 19-310/39 of OHCA's Regulation. If the request for status is granted the person shall be designated as a Party, an Intervenor or an Participant in the above proceeding. Please check OHCA's website www.ct.gov/ohca for more information or call OHCA directly at 418-7001. The ninety-day review period for the Certificate of Need application will end on May 31, 2010
R-A April 16, 2010

AT YOUR SERVICE DIRECTORY



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ACHEN ASPHALT LLC 860-417-8128
Paving & Land Service. Res/Comm Driveways, repairs, curbing, sealing, drainage, grading, etc. Free Est. achenasphaltpaving.com CT#624251

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K&L LAND SERVICES LLC
Driveways, Parking Lots, Curbing Lic# 579424 - 203-266-6612

Martel Paving & Driveway Sealing
Pave Driveways-Pkg. lots-Drainage
Gravel-Extensions-Repairs
Sealcoat-Hotcrack fill-Free Est.-CT #561045-860-274-3978.

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Driveway Sealing

Daniels Sealcoating & Hot Crack fill Driveways & Sm Parking lots CT #606049
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S & P PAINTING trash and cleanup service. 10-30 yard roll off containers. Same day service. Fully insured VISA/MC. 203-755-4655

AAA TRUCKING & furniture removal, appls, attics/bsmts, cleared. Frenchy 203-758-5912.

CREST RUBBISH REMOVAL 10-30 yard dumpsters Loading avail. Cleanouts estates/bsmts 24/7. Veteran Dirty Deeds Done Dirt Cheap! 203-753-2726

DON * MOVING
203-272-3022 * 203-509-1488

DUMPSTERS
203-759-3040

RANAUDO REFUSE 10-30 yd. Dumpsters, remodeling or cleaning up, 1 item or estates. 203-706-5536

SUPERIOR SERVICE
Basement, Attics, Garage Clean Ups

Home Improvement

EXTERIOR WORKS roofing, Siding, gutters, repairs, power wash. Free Est. CT#571146. 203-723-4675

LA Improvements
No jobs to small! Inside/Outside. 6606383 860-205-2843

Martel LeMay Contracting
Comp. kit./ba Remodeling Additions, Siding, Windws/Drs, Tile installed. 25 yrs exp. Lic#610059 203-982-4833.

NICK'S CONSTRUCTION Stone, brick, fplc, sidewalks, pools, driveways, roofing, painting 2 man. Free, est. 860-274-6629/203-982-3226 CT 600640

RFG BUILDING & REMODELING
Kitchens * baths * additions
CT# 577655 * Bob 203-509-1564

RICH'S HOME IMPROVEMENT
Roofing, siding, sheetrock, painting, Etc. Insured. 4566065 203-757-1717

STRONG CARPENTRY Quality Service Home improvements. bas. kits. lic. ig \small. CT# 616919. 203-266-9990

Lawn Garden Equipment Repair

Landscaping, Power washing, Plumbing, Painting.
Offer a service? Place your Service Directory ad online @ www.rep-am.com

Miscellaneous Services

A SECOND PAIR OF HANDS small household repairs, assemble

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JIM'S MASONRY stonewalls, patios, walkways, bluestone, concrete work, steps, stucco, etc. Free est CT#623100, 203-725-5095

MARIO'S MASONRY Stone, retaining walls, sidewalks, steps, chimney, repairs wet bsmt. Free est. Ins. #661497 203-699-0157/ 271-7517

MASONRY/LANDSCAPING Patios, sidewalk, pavers, bluestone free est #603114 860-417-9659

MERSIN affordable stone brick sidewalk bluestone stairs rpr concr chimney patio 203-565-1260 623967

SONS & FATHER MASONRY
All masonry work & repairs. 30 yrs exp Free est #615751.203-768-7325

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Roofing & Siding. QUALITY GREAT PRICES #638561 203-

Busy Bee Roofing
STRONG SALE
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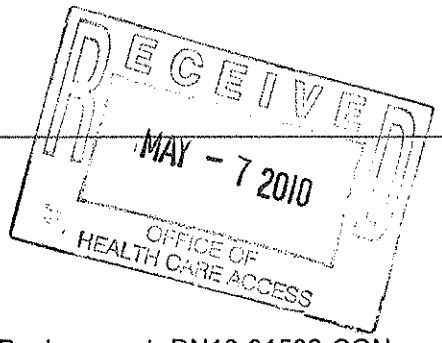
until 5/31/10* 203-206-615

DIDONATO ROOFING Re & Siding. Reasonable
discount. #583058, 203-

M&M REMODELING Go over plywood, repairs, ridge ven #551820. Ins'd. Free est. 86

N & I ROOFING Complete repairs, chimneys, coun flng etc. Reasonable pri est. 888, #603956. 203-7



Greer, Leslie

From: Lazarus, Steven
Sent: Friday, May 07, 2010 8:42 AM
To: 'michael.rosadini@yahoo.com'
Cc: Greer, Leslie
Subject: RE: Lawrence & Memorial- Linear Accelerator Replacement- DN10-31532-CON

If you don't mind, you can put in regular mail that would be fine. No need to overnight it or hand deliver it.

Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Michael Rosadini [mailto:michael.rosadini@yahoo.com]
Sent: Friday, May 07, 2010 7:52 AM
To: Lazarus, Steven
Subject: Re: Lawrence & Memorial- Linear Accelerator Replacement- DN10-31532-CON

And of the disk, is ot needed?

Michael Rosadini M Rosadini Consultants Sent from my Verizon Wireless BlackBerry

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From: "Lazarus, Steven" <Steven.Lazarus@ct.gov>
Date: Fri, 7 May 2010 07:10:11 -0400
To: 'michael.rosadini@yahoo.com'<michael.rosadini@yahoo.com>
Cc: Greer, Leslie<Leslie.Greer@ct.gov>
Subject: RE: Lawrence & Memorial- Linear Accelerator Replacement- DN 10-31532-CON

Thank you Michael. I'll have it added to the record.

Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Michael Rosadini [mailto:michael.rosadini@yahoo.com]
Sent: Thursday, May 06, 2010 5:24 PM
To: Lazarus, Steven
Subject: Lawrence & Memorial- Linear Accelerator Replacement- DN 10-31532-CON

Steven,
This afternoon I delivered the hard copies of the above CON, including filing fee and affidavit.
Attached is the PDF version of the applciation.

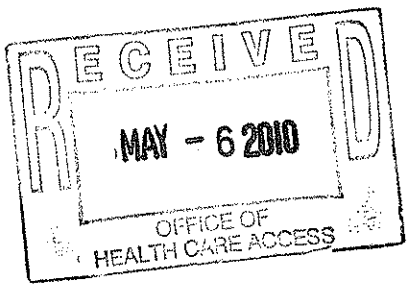
I had a disk made up of this application and inadvertently left it out of the box that I left at OHCA's front desk. If needed, I can deliver that to you tomorrow.

Thanks and let me know if you have any questions
Mike

Michael Rosadini
President
M Rosadini Consultants, LLC
860.539.6055
michael.rosadini@yahoo.com

Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, May 06, 2010 1:44 PM
To: Greer, Leslie
Cc: Greci, Laurie; Martone, Kim; Riggott, Kaila
Subject: FW: Lichfield Hills



Leslie please add this correspondence to Docket No.: 09-31500-CON.

Thank you,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Vogel, Cristine
Sent: Thursday, May 06, 2010 12:28 PM
To: 'Paul E. Knag'
Cc: Volpe, Michele M.; Louis B. Todisco; Lazarus, Steven; Martone, Kim; Dillon, Melanie
Subject: RE: Lichfield Hills

Attorney Knag:
Your request is premature in light of the fact that the proposed decision has not yet been rendered.

Sincerely,
Cristine Vogel

From: Paul E. Knag [mailto:PKNAG@murthalaw.com]
Sent: Thursday, May 06, 2010 11:18 AM
To: Vogel, Cristine
Cc: Volpe, Michele M.; Louis B. Todisco; Lazarus, Steven; Martone, Kim; Dillon, Melanie
Subject: Lichfield Hills

Commisioner,

We are anticipating a proposed decision in this matter shortly. We anticipate that thereafter it will be necessary for you to schedule argument before you.

I represent the Intervenor Silver Hills and Michele Volpe represents the Applicant.

If possible, I am requesting that this be scheduled for May 25 or 26. Michele Volpe is available on either date.

Prior to those dates, I will be on vacation.

Thanks for your consideration.

Paul

Paul E. Knag
Partner
pknag@murthalaw.com

Murtha Cullina LLP
177 Broad Street, 4th Floor
Stamford, CT 06901
Direct: 203-653-5407
Direct Fax: 860-240-5711
Mobile: 203-561-6438
Main: 203-653-5400
Main Fax: 203-653-5444

www.murthalaw.com

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 7, 2010

Michele Zurko-Smith
CEO & Member
Employment Options, LLC
12 Trefoil Road
Oxford, CT 06478

RE: Certificate of Need, Docket Number 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Establishment of a Free-standing Residential Substance Abuse Facility in Bethlehem, Connecticut
Closure of the Public Hearing

Dear Ms. Zurko-Smith:

On May 3, 2010, the Office of Health Care Access ("OHCA") received the information requested by OHCA as a late file submission from the public hearing held in this matter on April 29, 2010. With the receipt of the late file submission, the hearing on the above application is hereby closed.

Sincerely,

Melanie A. Dillon
KM

Melanie A. Dillon
Hearing Officer

MAD:swl

cc: Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.
Paul E. Knag, Esq., Murtha Cullina LLP

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

TRANSMISSION OK

TX/RX NO	1551
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TIME USE	00'37
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RESULT	OK

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

FAX SHEET

TO: Michelle Zurko-Smith

FAX: (203) 267-3813

AGENCY: OHCA / DPH

FROM: Steven Lazarus

DATE: 5/7/10 **TIME:** 1:00 pm

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Closure of Hearing Letter Enclosed

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

(860) 418-7012

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

TRANSMISSION OK

TX/RX NO	1552
RECIPIENT ADDRESS	912037775806
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ST. TIME	05/07 13:05
TIME USE	00'42
PAGES SENT	2
RESULT	OK

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

FAX SHEET

TO: Michelle Volpe

FAX: (203) 777-5806

AGENCY: OHCA/DPH

FROM: Steven Lazarus

DATE: 5/7/10 **TIME:** 1:00 pm

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Closure of Hearing Letter Enclosed

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

(860) 418-7012

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

TRANSMISSION OK

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ST. TIME	05/07 13:07
TIME USE	00'18
PAGES SENT	2
RESULT	OK ✓

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

FAX SHEET

TO: Paul Knag ✓

FAX: (203) 653-5444

AGENCY: OHCA / DPH

FROM: Steven Lazarus

DATE: 5/7/10 **TIME:** 1:00 pm

NUMBER OF PAGES: 2.
(including transmittal sheet

Comments: Closure of Hearing Letter Enclosed

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 7, 2010

IN THE MATTER OF:

An Application for a Certificate of Need filed pursuant to Section 19a-638, C.G.S. by:	Notice of Final Decision Office of Health Care Access Docket Number: 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC	**Establishment of a Free-Standing Residential Substance Abuse Facility in Bethlehem, Connecticut**

To: Michele Zurko-Smith
CEO & Member
Employment Options, LLC
12 Trefoil Road
Oxford, CT 06478

Dear Ms. Zurko-Smith:

Enclosed please find a copy of my Proposed Final Decision rendered in the above referenced matter.

Pursuant to Connecticut General Statutes Section 4-179, each party adversely affected may file exceptions and present briefs with the Deputy Commissioner of Office of Health Care Access, Department of Public Health within fourteen (14) days from the date of this notice. Any request for oral arguments must be received in writing by May 21, 2010. If no timely request is made, the Office of Health Care Access shall assume these rights to be waived and shall render a Final Decision in this matter.

Sincerely,

Melanie A. Dillon, Hearing Officer

MAD:swl

cc: Cristine A. Vogel, Deputy Commissioner, DPH
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.
Paul E. Knag, Esq., Murtha Cullina LLP

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Proposed Final Decision

Applicant:	**Employment Options, Inc. d/b/a Litchfield Hills Retreat, LLC**
Docket Number:	**09-31500-CON**
Project Title:	**Establishment of a Free-Standing Residential Substance Abuse Facility in Bethlehem, Connecticut**
Statutory Reference:	**Section 19a-638 of the Connecticut General Statutes**
Filing Date:	**March 2, 2010**
Hearing Date:	**April 29, 2010**
Decision Date:	**May 7, 2010**
Default Date:	**May 31, 2010**
Staff:	**Steven W. Lazarus Laurie Greci**

Project Description: Employment Options, Inc., d/b/a Litchfield Hills Retreat, LLC ("Applicant"), is proposing to establish a free-standing residential substance abuse facility in Bethlehem, Connecticut, at a total capital cost of $2,500,000.

Nature of Proceedings: On March 2, 2010, the Office of Health Care Access ("OHCA") received a Certificate of Need ("CON") application from the Applicant regarding a proposal to establish a free-standing residential substance abuse facility in Bethlehem, Connecticut, at a total capital cost of $2,500,000.

A notice to the public concerning OHCA's receipt of the Applicant's Letter of Intent was published on December 11, 2009, in the *Waterbury Republican American.*

On March 18, 2010, and March 22, 2010, OHCA received letters from Silver Hill Hospital, Inc., and High Watch Recovery Center, Inc., requesting that a public hearing be held in this matter.

A public hearing regarding the CON application was held on April 29, 2010. On April 14, 2010, the Applicant was notified of the date, time, and place of the hearing. On April 16, 2010, a notice to the public announcing the hearing was published in *Waterbury Republican American.* Commissioner J. Robert Galvin designated Melanie Dillon, Staff Attorney as the hearing officer in this matter on April 7, 2010. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-638, C.G.S.

By petition dated April 22, 2010, Silver Hill Hospital, Inc., requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer approved the Hospital's request for Intervenor status with full rights of cross-examination.

The Hearing Officer heard testimony from the Applicant's and the Intervenor's witnesses and in rendering this proposed final decision, considered the entire record of the proceeding. OHCA's authority to review, approve, modify, or deny this proposal is established by Section 19a-638, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

FINDINGS OF FACT

1. Employment Options, LLC ("EO" or "Applicant") is a private service agency located at 12 Trefoil Road, Oxford, Connecticut. It was established in 1994 and currently employs 138 people. *(November 20, 2009, Letter of Intent, February 5, 2010, and Initial CON Application, page 6)*

2. Michele Zurko-Smith is the Chief Executive Officer and the sole member owner of EO and Litchfield Hills Retreat, LLC. *(November 20, 2009, Letter of Intent, February 5, 2010 and March 2, 2010, Completeness Letter Responses, page 138)*

3. The Applicant contends that EO has a vocational contract with the Bureau of Rehabilitation Services and is also the largest provider of the Acquired Brain Injury Waiver[1] in the State of Connecticut, offering residential support, independent living skills training, as well as vocational services. *(November 20, 2009, Letter of Intent)*

4. The Applicant is proposing to establish Litchfield Hills Retreat, LLC ("LHR"), a 28 bed residential substance abuse treatment facility located at 64 Double Hill Road, Bethlehem,

[1] A Medicaid Waiver program using person centered planning to provide a range of non-medical home, and community based services to maintain adults who have acquired brain injury (not a developmental or degenerative disorder) in the community.

Connecticut. *(February 5, 2010, Initial CON Application, pages 6 &122)*

5. The Applicant proposes to locate its facility on sixty two (62) private acres which will offer privacy while ensuring anonymity, as the current building structure is set back from the rural road and not visible from any direction. Further, the proposed facility will offer private rooms. *(November 20, 2009, Letter of Intent and February 5, 2010, Initial CON Application, page 6)*

6. The Applicant asserts that a 7,500 square foot home is located on the property and that two additional buildings would be built for additional beds, office and program space. *(November 20, 2009, Letter of Intent)*

7. The Applicant limited the number of beds to 28 in order to establish the type of individualized, therapeutic environment it desires to offer the specialized population that it intends to serve. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, Acting Director of Litchfield Hills Retreat, page 148)*

8. The Applicant contends that the proposed facility will treat individuals 18 years of age and older, whose high level of public visibility, wealth, and/or social status makes it difficult for them to begin a successful recovery in the existing residential treatment settings. *(February 5, 2010, Initial CON Application, page 6)*

9. The Applicant claims that the proposed LHR facility will be the first licensed facility in Connecticut for the care and treatment of substance abuse and addictive disorders that is specifically tailored to this population. *(February 5, 2010, Initial CON Application, page 25)*

10. The Applicant asserts that the target population for the proposed LHR facility is currently not being served in the state of Connecticut and that these individuals are either required to travel to other states to receive services or they do not seek treatment. *(February 5, 2010, Initial CON Application, page 19)*

11. The Applicant contends that the only providers that are similar to the proposed facility in terms of level of privacy, upscale amenities, treatment modalities, and price point are located out-of-state and any Connecticut resident seeking this type of upscale residential treatment, including but not limited to the proposed target population, must currently travel elsewhere to receive it. *(March 2, 2010, Completeness Letter Responses, page 130)*

12. Mr. Gwozdz testified that in contrast to the existing providers, LHR's program will be structured to provide a supportive and safe setting for adults in the later stages of recovery to make the transition back into the community. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 153)*

13. LHR asserts that it offers a wide variety of therapy options tailored to the recovering individual in a spa-like retreat environment. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 153)*

14. Mr. Gwozdz testified that LHR will complement the existing substance abuse treatment facilities in Connecticut. LHR views the existing substance abuse providers as potential referral sources for the target population and a potential referral destination for those individuals that are not appropriate for LHR. *(April 26, 2010, Prefile Testimony of Mr. Brian*

Gwozdz, page 154)

15. Mr. Gwozdz testified that the need for LHR is based on the significant substance and alcohol dependency that exists in Connecticut, particularly among certain high-income individuals such as physicians, attorneys, executives and other high-earners. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 143)*

16. LHR proposes to serve this high-profile population comprised of physicians, attorneys, executives and other high-earning individuals by offering a setting where individuals with similar backgrounds and status can obtain treatment without being identified and treated as a "special" or "extraordinary" within the facility. Mr. Gwozdz asserts that this is an important aspect in achieving successful recovery. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz,, page 145)*

17. Mr. Gwozdz testified that the target populations of high-earners are defined as individuals and families earning over $200,000 annually. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, , page 146 and April 29, 2010, Public Hearing Testimony)*

18. According to the U.S. Census Bureau estimates for 2006-2008, approximately 2,673,711 adults reside in Connecticut. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146 and Attached Exhibit 7)*

19. The Applicant testified that Substance Abuse and Mental Health Administration ("SAMHSA") reports that approximately 10% of the population has a substance abuse or dependency problem. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146 and Attached Exhibit 9)*

20. Applying the 10% estimate to Connecticut's total population, the Applicant estimates that without taking household income into account, approximately 267,371 adults in Connecticut have a substance abuse problem. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146 and Attached Exhibit 9)*

21. The Applicant further testified that according to the U.S. Census Bureau, approximately 8% of the Connecticut population has a household income of $200,000 or more. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146 and Exhibit 8)*

22. Accordingly, the Applicant asserts that there are 213,896 households in Connecticut with an annual income of over $200,000. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146)*

23. By applying the SAMHSA percentage of 10% to the estimated 8% of Connecticut's population with an annual income of $200,000 or more, the Applicant estimates that there are 21,389 professional or high profile individuals in Connecticut with a substance abuse problem. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146 and Attached Exhibit 9)*

24. In 2008, SAMHSA reported that 45,338 persons sought treatment for a substance abuse problem in Connecticut. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146 and Attached Exhibit 9)*

25. Accordingly, the Applicant determined that out of the estimated 267,317 persons with a

substance abuse problem in Connecticut, approximately 17% sought treatment (45,338/267,317 = 17%). *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 147 and Attached Exhibit 10)*

26. Mr. Gwozdz testified that the 45,338 figure is for adults that actually sought substance abuse treatment and therefore, it is a conservative figure because it does not take into account those adults that might need treatment but do not seek treatment. *(April 29, 2010, Public Hearing Testimony of Brian Gwozdz)*

27. Moreover, the Applicant utilized a more conservative rate of 15% instead of the 17% referenced in Finding of Fact 25. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 147 and Attached Exhibit 10)*

28. The following table utilizes the information provided above to summarize the potential patient population based on the estimates from the US Census Bureau and SAMHSA information concerning the prevalence of substance abusers that may utilize the services of LHR:

Table I: Projected Number of Potential LHR Clients

Population	Number	Percent of Population	Number of Potential Clients
Adults, 18 years and older	2,673,711	10%	267,317
Households with Income greater than $200,000 annually	267,317	8%	21,390
Adults that seek treatment	21,390	17%*	3,636
Adults that seek treatment	21,390	15%**	**3,209**

(April 26, 2010, Prefiled Testimony of Brian Gwozdz, pages 147, and 233)

29. Relying upon various articles and information from the Department of Labor, the Department of Public Health and the American Medical Association, the Applicant also estimated the potential numbers of lawyers, physicians, chief executives and other high level professionals with a substance abuse problem in Connecticut.

30. The Applicant included in its filing an article entitled, "Addiction and Lawyers: Substance Abuse in the Legal Profession," by Ed Jennett and a copy of a brochure from Lawyers for Lawyers Connecticut, as evidence indicating substance abuse is a problem in the legal profession. *(February 5, 2010, Initial CON Application, pages 81-86)*

31. According to the above article, "Addiction and Lawyers: Substance Abuse in the Legal Profession," it is estimated that 20% of lawyers have a substance abuse problem at sometime in their career. *(March 2, 2010, Completeness Letter Responses, page 136)*

32. Mr. Gwozdz testified that according to the Ohio Lawyers Assistance Program, eighteen (18%) to twenty percent (20%) of attorneys suffer from alcoholism. This rate rises to twenty-five percent (25%) after twenty years of practice. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, Acting Director of Litchfield Hills Retreat, page p. 144 and Attached Exhibit 5)*

33. Mr. Gwozdz testified that according to Connecticut's Department of Labor, as of the first

quarter of 2009, there were more than eight thousand (8,000) employed attorneys, four thousand seven hundred fifty (4,750) chief executives, and nearly twenty-two thousand (22,000) financial managers, analysts, examiners and other financial specialists. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, Acting Director of Litchfield Hills Retreat, page 144 and Attached Exhibit 3)*

34. The Applicants also included in its filing a report from the American Medical Association, "Report 1 of the Council on Scientific Affairs (A-95), Substance Abuse Among Physicians," highlighting the prevalence of substance abuse among physicians based on survey results originally published in the Journal of American Medical Association. *(February 5, 2010, Initial CON Application, pages 87-103)*

35. Mr. Gwozdz testified that according to Connecticut's Department of Public Health, there are presently more than sixteen thousand (16,000) active licensed physicians in Connecticut. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, Acting Director of Litchfield Hills Retreat, page 143 and Attached Exhibit 3)*

36. Mr. Gwozdz testified that it is conservatively estimated that eight percent (8%) to twelve percent (12%) of physicians will develop a substance abuse problem at some point during their career and that at any given time, as many as seven percent (7%) of practicing physicians are active substance abusers. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, Acting Director of Litchfield Hills Retreat, page 144 and Attached Exhibit 4)*

37. The following table summarizes the Applicant's information provided in Findings of Fact 31-37.

Table II: Projected Number of Potential Clients from Target Population

Target Group	Number	Percent of Population	Number of Potential Clients
Active, licensed Physicians	16,000	7%	1,120
Employed Attorneys	8,000	18%	1,440
Chief Executives, Financial Managers, and Other Similar Occupations	26,750	10%	2,675
Total Number of Potential Clients from Target Population			**5,235**

(April 27, 2010, Prefiled Testimony of Brian Gwozdz, pages143-146)

38. The Applicant provided sufficient evidence demonstrating the prevalence of substance abuse among attorneys and physicians.

39. OHCA finds that the Applicant relied upon objective and reliable sources of information and utilized reasonable methodologies to estimate the total number of individuals with a substance abuse problem who may utilize the services provided by LHR.

40. Accordingly, OHCA further finds that the Applicant demonstrated a sufficient need among this relatively small and well-defined population that LHR proposes to serve.

41. The Applicant estimates that its capture rates of those persons from Connecticut seeking

residential treatment to be 2.5%, 5%, and 7% in the first three years of operations. When applied to the number of potential clients of 3,209 (See Finding of Fact 30), the Applicant estimates that it will have 80, 160, and 225 Connecticut admissions in the first three years of operations, respectively. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, pages 147 and 233)*

42. The Applicant assumed that there would be 28 beds available 365 days each year and the length of stay per admission would be 30 days. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, pages 147 and 148)*

43. The Applicant asserts that, according to the research they conducted, a 30 day stay is the national standard for this type of treatment. This data was gathered from other treatments centers and taken from the Office of Applied Studies SAMHSA, 2001 Treatment Episode Data TEDS 5.31.03. *(March 2, 2010, Completeness Letter Responses, page 131)*

44. The Applicants contend that the following table illustrates the utilization of the proposed LHR for the first three years of service:

Table III: Projected Utilization for LHR

LHR, LLC	Projected Utilization		
	Year 1 (Jan. 1-Dec. 31 2011)	**Year 2 (Jan. 1-Dec. 31 2012)**	**Year 3 (Jan. 1-Dec. 31, 2013)**
Total Beds	28	28	28
Total Available Bed Days	10,220	10,220	10,220
Projected Total Occupancy	40%	65%	85%
Projected Bed Days*	4,088	6,643	8,687
Projected Total Admissions (include Out-of-State) **	136	221	290
Connecticut Admission	80	160	225
Out-of-State Admissions***	56	61	65
Total Admission	136	221	290
% of Connecticut Admissions	59%	72%	78%

* The total projected beds was determined by total available beds multiplied the occupancy rate (for example Year 1: 10,220,x.40=4,088)
**The projected total admissions were calculated by taking total bed days divided by an average length of stay of 30 days.
*** Out-of-state admissions were determined by the difference between CT admissions and projected total admissions

(February 5, 2010, Initial CON Application, page 23, March 2, 2010, Completeness Letter Responses, page 130-131, and April 27, 2010, Prefiled Testimony of Brian Gwozdz, Exhibit 11, page 236)

45. The Applicant further testified that its projected total occupancy of 40% in year 1, 65% in year 2 and 85% in year 3 is conservative, particularly in light of the fact that the National Survey of Substance Abuse Treatment Services in 2005 indicated that the average utilization rate for residential facilities was 93%. (*February 5, 2010, Initial CON Application, page 55 and April 26, 2010, Prefiled Testimony of Mr. Gwozdz, page s 147-148 and Attached Exhibit 12*)

46. OHCA finds that based upon the evidence provided, the Applicant's volume projections are reasonable and achievable.

47. The Applicant contends that there is no impact on any existing providers since currently there is no facility in Connecticut that provides the exact services and setting as the proposed facility. *(February 5, 2010, Initial CON Application, page 19)*

48. The Applicant provided a list of 17 locations in the area that offer similar services. *(February 5, 2010, Initial CON Application, pages 21-22)*

49. The Applicant asserts, however, that the proposed facility is markedly different from other similar providers in the area in that the proposed location is extremely private; the building location is not visible from the road; and LHR will offer private rooms and a broad array of treatment methods. *(March 2, 2010, Completeness Letter Responses, page 131)*

50. LHR proposes to offer several amenities and alternative practices such as equine assisted therapy, massage therapy, reiki, art, music, outdoor recreational activities and other modalities in a manner consistent with substance abuse treatment models. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 153)*

51. The Intervenor, Silver Hill Hospital, Inc. ("Silver Hill"), asserts, however, that it is comparable to the proposed facility in that its target population includes the target population of LHR and it has treated many highly visible and/or wealthy patients with great success in its self-pay 4-week residential substance abuse treatment program. *(April 22, 2010, Prefiled Testimony of Dr. Sigurd Ackerman, page 4)*

52. The Intervenor is licensed as a psychiatric hospital and has the ability to deal with detoxification and a variety of physical and psychiatric issues which often accompany drug or alcohol dependence. *(April 22, 2010, Prefiled Testimony of Dr. Sigurd Ackerman, President and Medical Director of Silver Hill Hospital, page 5)*

53. Dr. Ackerman testified that Silver Hill currently operates 52 beds for residential substance abuse/dual disorders treatment. The cost for this self-pay program is $26,000 and private rooms are available at a rate of $49,280. *(April 22, 2010, Prefiled Testimony of Dr. Sigurd Ackerman, page 3)*

54. Dr. Ackerman clarified that all of the rooms in its residential treatment program have two beds; however, an individual can purchase the second bed in the room to make it a private room. *(April 29, 2010, Public Hearing Testimony of Dr. Sigurd Ackerman)*

55. Dr. Ackerman testified that over the last three years, approximately 75 individuals purchased the second bed in the room to convert it to a private room. *(April 29, 2010, Public Hearing Testimony of Dr. Sigurd Ackerman)*

56. The Intervenor asserts that its occupancy rate for residential substance abuse/dual disorders treatment program for FY 2009 and 2010 was 77.7% and 76%, respectively and therefore, there is adequate capacity for such persons at Silver Hill. *(April 22, 2010, Prefiled Testimony of Dr. Sigurd Ackerman, page 3)*

57. The Intervenor asserts that the Applicant failed to prove a need for the proposed service

and that Silver Hill and other facilities in Connecticut have adequate capacity to serve the Applicant's target population. *(April 22, 2010, Prefiled Testimony of Dr. Sigurd Ackerman, page 4)*

58. OHCA finds that the Intervenor merely asserted that there is excess capacity without producing evidence of the same.

59. OHCA also finds that the Intervenor failed to produce evidence that the Applicant's projections with respect to the target population were unreasonable or that the information and data upon which those projections were based were unreliable.

60. Additionally, despite the Intervenor's claims to the contrary, LHR maintains that it will be different, and therefore not competitive with, the existing substance abuse treatment facilities in the state. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 152)*

61. Although, LHR will obtain the same licensure from DPH as many of the existing treatment facilities, it will be significantly different in that it will be a smaller, more private facility offering individualized care and programs that specifically address the professionals and social characteristics of its mature clients and offer a peer group for client with specific careers. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 152)*

62. Dr. Sack testified that LHR has significant differences from Silver Hill in that it will not be a licensed psychiatric hospital and it will be providing community-based residential treatment services in a homelike environment that is relatively non-institutional. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D., Chief Executive Officer of Elements Behavioral Health Inc., and Promises Treatment Centers)*

63. As further clarification, Dr. Sack explained that there are individuals whose acuity is such that they will require detoxification services that would not be available at LHR and who will also need some of the services available at a psychiatric hospital such as Silver Hill. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

64. Dr. Sack also testified that LHR's clients will be comprised of individuals who have already received detoxification treatment and who have been cleared medically by a referring physician. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 249)*

65. Dr. Sack further testified that individuals should be able to choose where they receive their treatment and from whom they receive their treatment. To that end, Dr. Sack maintained that the LHR proposal will offer greater choice in the selection of services for individuals suffering from substance abuse problems. *((April 29, 2010, Public Hearing Testimony of David Sack, M.D)*

66. Based upon the evidence provided, OHCA finds that although LHR may be similar in some respects to existing providers of substance abuse treatment, it is not comparable to many of the existing providers in that it will offer private rooms, several amenities and a broad array of residential treatment services in a homelike, non-institutional environment.

67. Dr. Sack testified that it is well recognized that individuals with substance abuse problems often have a co-occurring disorder such as anxiety or depression and that LHR will be staffed and equipped to deal with this population. *(April 26, 2010, Prefiled Testimony of*

David Sack, M.D., page 249)

68. Although LHR maintains it is a non-medical facility, Dr. Sack testified that it will support the medical needs of its clients through a consulting physician and clients with medical issues that emerge during their stay at LHR will be referred for treatment to a community physician. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 251)*

69. Dr. Sack testified that LHR's sole focus will be substance abuse/dependency treatment. The staff at LHR will ensure that each client will be thoroughly interviewed and assessed prior to acceptance into the program. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 251)*

70. Dr. Sack testified that after the assessment, the Clinical Director, in conjunction with the admissions staff, will make an informed decision regarding whether it is appropriate for the individual to be admitted to the LHR program in accordance with its licensure and treatment models or whether another, higher level of treatment is required for the individual. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 251)*

71. Dr. Sack testified that in cases where a client is not cleared for admission by the Clinical Director, the client will be referred to an alternative facility that offers the specific type of care that is demanded by the individual, whether it is inpatient psychiatric care, detoxification or other specialty care. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 252)*

72. Dr. Sack testified that the Clinical Director will be a licensed Master's level clinician, either a psychologist or a counselor and will be required to have a minimum of three (3) years of experience in drug and alcohol residential treatment programs. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

73. The Clinical Director's primary responsibility would be to design the program, to provide training and supervision to other clinical and non-clinical staff. Responsibilities will also include coordinating admissions and approving appropriateness for the program elements. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

74. LHR will employ licensed master's level therapists to coordinate both the primary therapy and family therapy programs. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

75. LHR will also employ several licensed or certified substance abuse alcohol and drug treatment counselors to provide the psycho-educational programs and individual counseling for drug and alcohol related issues. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

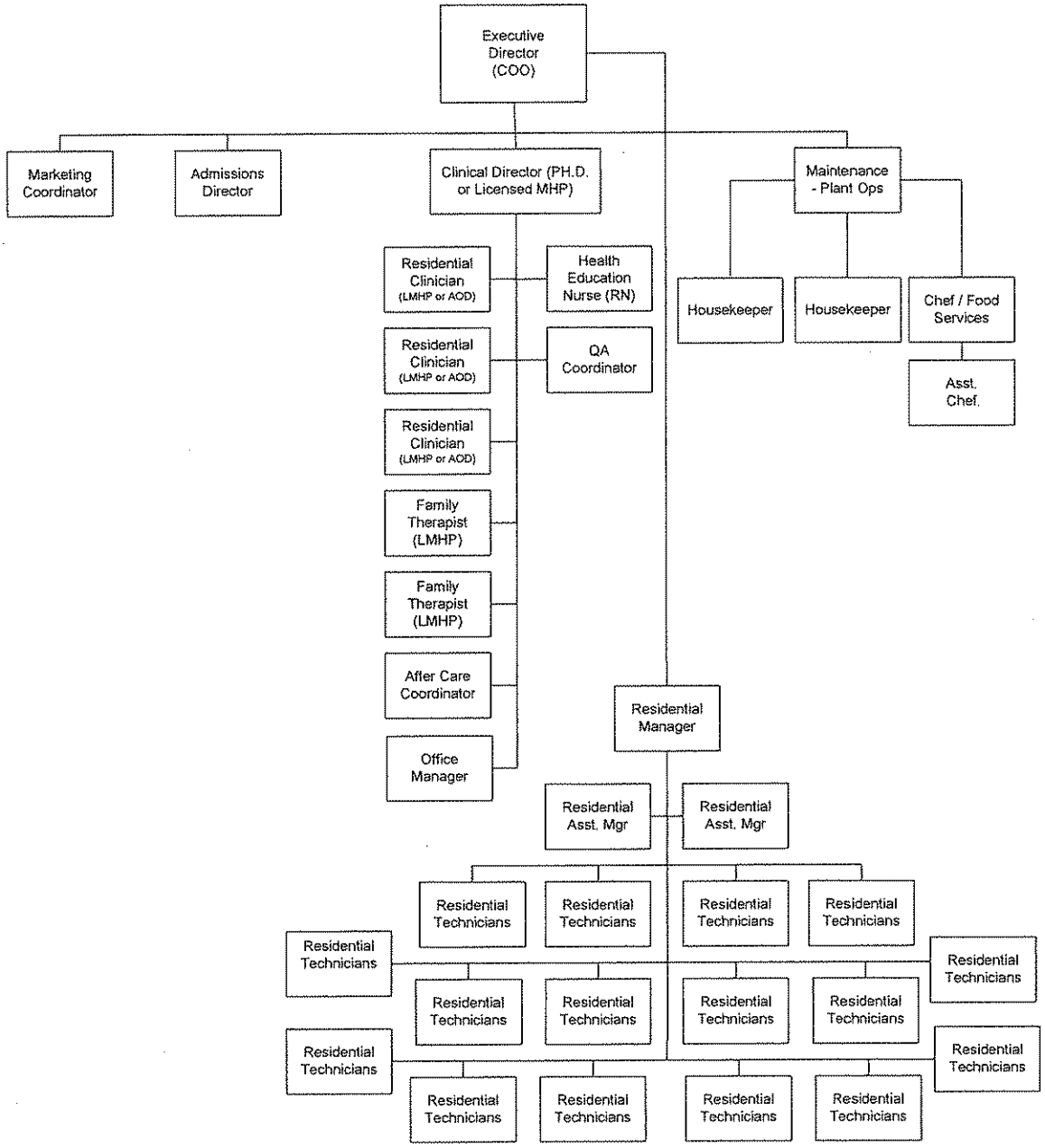
76. Dr. Sack testified that the ratio of counselors to patients will be 1 to 5. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

77. Additionally, LHR will employ several rehabilitation technicians, not necessarily certified or credentialed but experienced to provide direct supervision on a 24-hour basis. Duties may include driving, support services, safety checks, and vital signs monitoring. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

78. Dr. Sack testified that other positions would include a full-time chef to order and prepare foods, grounds keepers, a consulting physician and possibly a consulting psychiatrist. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

79. Dr. Sack testified that the consulting physician would aid in the examination on admissions and review laboratory tests and the consulting psychiatrist would aid in cases where a client's behavior changes or escalates or if they require additional psychiatric consultation. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

80. Upon request from OHCA, the Applicant submitted in the record a chart of organizational positions for the proposed facility.



(May 3, 2010, Applicant's Late File)

81. Dr. Sack also testified that LHR will follow the specific licensure requirements for the State of Connecticut when it is hiring staff. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

82. Dr. Sack testified that as LHR proceeds with licensing, it will develop a definitive client activity schedule that describes the frequency and duration of each therapeutic modality. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 249)*

83. Dr. Sack testified that an example of these activities would include the 12 Step Facilitation Therapy, Motivational Interviewing and Cognitive Behavioral Therapy. These treatments will be provided in a range of individual and group psychotherapy sessions that will reinforce the skill acquired. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 250)*

84. Upon request from OHCA, the Applicant submitted a copy of a tentative program schedule for LHR. It is hereto attached as Exhibit I.

85. OHCA finds that the Applicant has produced evidence demonstrating that it is providing an appropriate level of staffing for the services that it proposes to provide.

86. LHR will obtain licensure from the Department of Public Health as a facility for the care and treatment of substance abusive and dependent persons. *(April 26, 2010, Prefiled Hearing Testimony of David Sack, M.D., page 253)*

87. Additionally, LHR will seek accreditation from the Commission on Accreditation of Rehabilitation Facilities ("CARF"). *(April 26, 2010, Prefiled Hearing Testimony of David Sack, M.D., page 253)*

88. Dr. Sack testified that CARF is a private, independent, not-for-profit organization that promotes quality rehabilitation services. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 253)*

89. Dr. Sack testified that he will assist LHR in attaining accreditation from CARF. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 253)*

90. Dr. Sack testified that in order to obtain CARF accreditation, facilities must demonstrate that they substantially meet certain internationally recognized standards applicable to rehabilitation facilities. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 253)*

91. Dr. Sack testified that LHR has established a Quality Assurance Plan ("QAP") and that adherence to this structured QAP will ensure the provision of high-quality substance abuse treatment services to the patients of LHR. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 255)*

92. Based upon all of the evidence, OHCA finds that LHR is competent to provide efficient and adequate service to the public.

93. The Applicant contends that the proposed capital expenditure associated with this proposal is $500,000, the majority of which is for renovations and furnishing. The

property is currently owned by Michele Zurko-Smith, the CEO of LHR and the current market value of the property is $2 Million. Therefore, the total capital cost associated with this proposal is $2.5 Million. *(February 5, 2010, Initial CON Application, page 35)*

94. The Applicant contends that the proposal will be funded by Ms. Michele Zurko-Smith herself. *(February 5, 2010, Initial CON Application, page 52)*

95. The Applicant submitted Ms. Zurko-Smith's personal 2008 United States tax filings. *(March 2, 2010, Completeness Letter Responses, page 138)*

96. The Applicant contends that proposed service is 100% private pay. *(February 5, 2010, Initial CON Application, page 36)*

97. The Applicant contends that the cost for the proposed services per client will be $50,000.

98. The Applicant projects incremental revenue from operations, total operating expenses and loss/gain from operations associated with the first three years of operating this proposal as follows:

Table IV: Incremental Financial Projections for Operating Years 1 through 3

Description	Year 1	Year 2	Year 3
Incremental Revenue from Operations	$6,450,000	$11,292,000	$14,150,000
Incremental Total Operating Expenses	$5,432,659	$5,622,659	$6,854,000
Incremental (Loss)/Gain from Operations	**$1,017,341**	**$5,669,341**	**$7,296,000**

(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 236 and February 5, 2010, Initial CON Application, page 41)

99. The Applicant contends that Ms. Zurko-Smith as the sole owner of EO, the parent company of LHR, will be responsible for all the costs accrued. *(March 2, 2010, Completeness Letter Responses, page 138)*

100. The Applicant contends that the proposal is cost effective because it is private pay. *(February 5, 2010, Initial CON Application, page 49)*

Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g. the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

Employment Options, LLC ("EO" or "Applicant") is a private service agency that was established in 1994 and currently employs 138 people. Michele Zurko-Smith is the Chief Executive Officer and the sole member owner of EO and Litchfield Hills Retreat, LLC ("LHR"). The Applicant proposes to establish a 28 bed residential substance abuse treatment facility on 62 private acres located at 64 Double Hill Road in Bethlehem, Connecticut.

The Applicant claims that the proposed LHR facility will be the first licensed facility in Connecticut for the care and treatment of substance abuse and addictive disorders that is specifically tailored to treat individuals 18 years of age and older, whose high level of public visibility, wealth, and/or social status makes it difficult for them to begin a successful recovery in the existing residential treatment settings. Specifically, the Applicant claims that it will offer private rooms in a homelike non-institutional environment. The Applicant further claims that it will offer privacy in that its facility is not visible from the road and located on sixty-two acres. LHR proposes to offer several amenities and alternative practices such as equine assisted therapy, massage therapy, reiki, art, music, outdoor recreational activities and other modalities in a manner consistent with substance abuse treatment models.

Utilizing data from the U.S. Census Bureau and SAMHSA, the Applicant determined that there are approximately 3,209 adults in Connecticut with an income of over $200,000 annually with a substance abuse problem who may utilize the services of LHR. (Finding of Facts 18-28). Additionally, utilizing information from various sources such as the Department of Labor and the Department of Public Health and various articles concerning the prevalence of substance abuse among attorneys, physicians and other high earners, the Applicant determined there are approximately 5,235 attorneys, physicians, chief executives and financial executives with a substance abuse problem who may utilize the services of LHR. (Findings of Fact 30-38). OHCA concluded that these numbers were reasonable and based upon reliable sources of information. (Findings of Fact 38-39). Based upon all of the evidence provided, OHCA finds that the Applicant utilized reasonable methodologies to demonstrate a sufficient need among the relatively small well-defined population that LHR proposes to serve. (Finding of Fact 40).

Relying upon the aforementioned numbers, the Applicant provided volume projections for LHR in the first three years of operation. LHR expects to see a total of 136, 221 and 290 patients in years 1, 2 and 3, respectively. (Findings of Fact 44). Moreover, LHR anticipates that its Connecticut admissions for the same three years will be 80, 160 and 225. (Findings of Fact 44). OHCA finds that these projections are reasonable and achievable based upon the evidence provided. (Findingsof Fact 46).

The Intervenor asserted that there is excess capacity for the Applicant's target population without providing evidence of the same. (Findings of Fact 58). Additionally, although the Intervenor claimed that there is no need for the proposal, the Intervenor failed to provide evidence demonstrating that the Applicant's projections concerning its target population were unreasonable or that the information upon which those projections were based was unreliable. (Findings of Fact 59). Finally, even though the Intervenor may offer some services similar to those proposed by the Applicant, LHR provided sufficient evidence differentiating its facility from that of a psychiatric hospital. (Findings of Fact 61-64). Specifically, LHR demonstrated that it is a community rehabilitation facility as opposed to a psychiatric hospital and that it will provide services for individuals that have already received detoxification and who have been medically cleared by a referring physician. (Findings of Fact 64). Furthermore, LHR will provide its services in a relatively non-institutional setting with many amenities and a variety of services for its high end clientele. (Findings of Fact 66). Based upon all of the evidence, OHCA concludes that LHR is a unique facility that will provide services in a setting with certain amenities that are not widely available within the state of Connecticut.

The total capital cost associated with this CON proposal is $2,500,000. (Findings of Fact 93). Ms. Zurko-Smith as the sole owner of EO, the parent company of LHR, will be responsible for all the costs accrued. (Findings of Fact 99). The Applicant projects an incremental gain from operations of $1,017,341, $5,669,341 and $7,296,000, for fiscal years 1-3. (Findings of Fact 98). OHCA concludes based upon the evidence provided that the Applicant's volumes and financial projections upon which they are based appear to be reasonable and achievable.

Order

Based upon the foregoing Findings and Rationale, the Certificate of Need application of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC to establish a Free-Standing Residential Substance Abuse Treatment Facility in Bethlehem, Connecticut, at a total capital cost of $2,500,000, is hereby APPROVED, subject to the following conditions:

1. This authorization shall expire on May 7, 2012. Should the Applicant's proposal not be completed by that date, the Applicant must seek further approval from OHCA to complete the project.

2. The Applicant shall notify OHCA in writing of the commencement date of the proposed facility by no later than one month after the commencement date.

3. Within 30 days of receiving licensure from Connecticut Department of Public Health, the Applicant shall submit a copy of the license to OHCA.

4. Prior to opening its facility, the Applicant shall submit to OHCA a copy of the Certificate of Incorporation for Litchfield Hills Retreat, LLC.

Should the Applicant fail to comply with any of the aforementioned conditions, OHCA reserves the right to take additional action as authorized by law.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

Based upon the foregoing, I respectfully recommend to the Deputy Commissioner that the application of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC to establish a free-standing residential substance abuse treatment facility in Bethlehem, Connecticut, be approved.

5-7-10
Date

Melanie A. Dillon, Esq.
Hearing Officer

MAD:swl/lkg

LITCHFIELD HILLS RETREAT PROGRAM SCHEDULE

(All Information and Times Subject to Change)

	MON	TUES	WED	THU	FRI	SAT	SUN
6:00 AM	*Optional Wake-Up for 7am 12 Step Mtg*	*Optional Wake-Up for 7am 12 Step Mtg*	*Optional Wake-Up for 7am 12 Step Mtg*	*Optional Wake-Up for 7am 12 Step Mtg*	*Optional Wake-Up for 7am 12 Step Mtg*	Sleep-In	Sleep-In
7:00 AM	Wake up	Wake up	Wake up	Wake up	Wake up		
7:30 AM	Daily Reflection	Daily Reflection	Daily Reflection	Daily Reflection	Daily Reflection		
8:00 AM	Breakfast & Chores	Breakfast & Chores	Breakfast & Chores	Breakfast & Chores	Breakfast & Chores	8am Wake up, Daily Reflection, and Chores	8am Wake up, Daily Reflection, and Chores
9:00 AM	**GYM or Trail Walk** *9:00 AM*	**GYM or Trail Walk** *9 to 10:15 am*	**GYM or Trail Walk** *9:00 AM*	**GYM or Trail Walk** *9 to 10:15 am*	**GYM or Trail Walk** *9 to 10:15 am*	9am Breakfast	9am Breakfast
10:00 AM	*to* *10:15 AM*	**or Acupuncture** *9 to 10am*	*to* *10:15 AM*	**or Acupuncture** *9 to 10am*		**10am Big Book Study** *(Clients only)*	9:30 or 9:45 am Leave for AA or CA Mtg
						10am Family Group *(Family only)*	
11:00 AM	11 am to 12:15 pm Insight Oriented Group Psychotherapy	**Step1**	11 am to 12:15 pm Insight Oriented Group Psychotherapy	**Step1**	**Step1**	11:30am **Multi-Family Group** *(Family & Clients)*	
12:00 PM	Lunch	Lunch	Lunch	Lunch	Lunch	1pm Lunch	Lunch
1:30 PM	Meditation	Men's Issues or Women's Issues	VCHC - Service Outing 1:00 PM to 4:00 PM	Mood Regulation Group	**Step1**	**Saturday Family Visiting** *(2pm to 5pm)*	Outing, Massage or Cooking (1pm-5pm)
3:30 PM	Big Book Study	Art Therapy		Psychodrama	Recreational Therapy or Free Time		
5:00 PM	Dinner and Free Time	Dinner and Free Time	Dinner and Free Time	Dinner and Free Time	5:30pm Dinner and Free Time	5:30pm Dinner and Free Time	Dinner and Free Time
6:30 PM	*Depart for 12 Step Mtg or 7pm In-House Book Study*	*Depart for 12 Step Mtg or 7pm In-House Book Study*	***7:30pm Alumni Meeting***	*Depart for 12 Step Mtg or 7pm In-House Book Study*	*Depart for 12 Step Mtg or 7pm In-House Book Study*	Depart for Outside Mtg *(Or 7pm In-House Mtg)*	**Gratitude Group** Free time
9:30 PM	Wrap-Up *(Time may vary)*	Wrap-Up *(Time may vary)*	Wrap-Up *(Time may vary)*	Wrap-Up *(Time may vary)*	Wrap-Up *(Time may vary)*	Wrap-Up *(Time may vary)*	Wrap-Up *(Time may vary)*

Notes: Service Outing alternates with Equine Assisted Psychotherapy. Individual sessions with Primary Therapists occur 3 times per week during free times. Sessions with Family Therapists occur weekly in addition to the Saturday Family Program. The Alumni Meeting also includes current clients.

EXHIBIT I

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

TRANSMISSION OK

TX/RX NO	1561
RECIPIENT ADDRESS	912032673813
DESTINATION ID	
ST. TIME	05/07 14:52
TIME USE	06'31
PAGES SENT	19 ✓
RESULT	OK ✓

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

FAX SHEET

TO: Michelle Zurlo-Smith ✓

FAX: (203) 267-3813

AGENCY: OHCA/DPH

FROM: Steven Lazarus

DATE: 5/7/10 **TIME:** 2:45

NUMBER OF PAGES: 18
(including transmittal sheet

Comments: Proposed Final Decision ~~for~~ Enclosed for DN: 09-31500-CON.

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*** TX REPORT ***
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RESULT	OK

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

FAX SHEET

TO: Paul Knag, Esq.

FAX: (203) 653 5444

AGENCY: OHCA / DPH

FROM: Steven Lazarus

DATE: 5/7/10 **TIME:** 2:45

NUMBER OF PAGES: 18
(including transmittal sheet

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*** TX REPORT ***
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PAGES SENT	19
RESULT	OK

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

FAX SHEET

TO: Michele Volpe, Esq.

FAX: (203) 777-5806

AGENCY: OHCA/DPH

FROM: Steven Lazarus

DATE: 5/7/10 **TIME:** 2:45

NUMBER OF PAGES: 18
(including transmittal sheet

Comments: Proposed Final Decision Enclosed for DN: 09-31500-CON

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FAX TRANSMISSION

BERSHTEIN, VOLPE & McKEON P.C.
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RECEIVED
2010 MAY 19 P 1:38
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

FAX #: (860) 418-7053

TO: Honorable Cristine Vogel
Hearing Officer Melanie Dillon
Associate Health Care Analyst Steven Lazarus
Office of Health Care Access

cc: Louis Todisco
(203) 772 7723
Paul Knag
(203) 653 5444

DATE: May 19, 2010

PAGES: 6 including this page

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

CONFIDENTIALITY NOTICE
Please note that the information contained in this fax is confidential and privileged and is intended only for use by the named receiver. If you have received this fax in error, please call 203-777-5800. Any use of this fax or its contents, including any dissemination or copying, is prohibited. Attorneys receiving this fax in error are directed to review ABA formal ethics opinion no. 92-368.

COMMENTS:

Dear Commissioner Vogel:

Please see the attached.

Thank you.

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Faxes\OHCA 5.03.10 (Late File).doc

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

RECEIVED
2010 MAY 19 P 1:38
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

May 19, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
Via Federal Express

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Motion to Preclude Silver Hill Hospital Inc.'s Filing of Exceptions, Briefs and/or Requesting Oral Argument.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Object to Motion to Preclude) 5.19.10.doc

DEPARTMENT OF PUBLIC HEALTH DIVISION OF OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 09-31500-CON**
IN RE: EMPLOYMENT OPTIONS, LLC D/B/A LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE STANDING SUBSTANCE ABUSE CENTER IN BETHLEHEM	:	**May 19, 2010**

MOTION TO PRECLUDE SILVER HILL HOSPITAL INC.'S FILING OF EXCEPTIONS, BRIEFS AND/OR REQUESTING ORAL ARGUMENT

The Applicant in the above matter, Employment Options, LLC d/b/a/ Litchfield Hills Retreat, LLC (the "Applicant"), respectfully requests that the Silver Hill Hospital, Inc. be precluded from filing Exceptions, Briefs and/or Requesting Oral Argument. A Proposed Final Decision in the above matter was issued on May 7, 2010. Hearing Officer Dillon's transmittal letter also dated May 7, 2010 accurately states that, in accordance with Section 4-179 [1] of the Connecticut General Statutes, any **party** adversely affected by the Proposed Final Decision may file exceptions, present briefs and request oral argument on or before May 21, 2010. The Applicant hereby accepts the Proposed Final Decision and therefore will not be filing any written exceptions or brief nor will it request oral argument.

The Applicant is the only "Party" in this matter (as such term is defined under Section 4-166(8)[2] of the General Statutes and Section 19a-643-10(6)[3] of the Department of Health's

---

[1] Connecticut General Statutes Section 4-179 provides, in relevant part, as follows: When, in an agency proceeding, a majority of the members of the agency who are to render the final decision have not heard the matter or read the record, the decision, if adverse to a **party**, shall not be rendered until a proposed final decision is served upon the **parties**, and an opportunity is afforded to each **party** adversely affected to file exceptions and present briefs and oral argument to the members of the agency who are to render the final decision. (Emphasis supplied).

[2] Connecticut General Statute Section 4-166(8) provides, in relevant part, as follows: " 'Party' means each person (A) whose legal rights, duties or privileges are required by statute to be determined by an agency proceeding **and** who is named or admitted as a party, (B) who is required by law to be a party in an agency proceeding or (C) who is granted status as a party under subsection (a) of section 4-177a" (Emphasis supplied).

Administrative Regulations and Rules of Practice). Since the Applicant accepts the Proposed Final Decision and will not be filing any written exceptions or brief nor will it request oral argument, a Final Decision consistent with the Proposed Final Decision should be rendered forthwith as Section 4-179(d) of the Connecticut General Statutes permits waiver of the provisions at Section 4-179 by the parties and the DPH Division of Office of Health Care Access ("OHCA").

The record reflects that Silver Hill Hospital, Inc. ("Silver Hill") was granted Intervenor status with full rights of cross examination. Silver Hill, however, did not seek nor was it granted "Party" status and therefore the rights specified under Section 4-179 are not available to it. Upon information and belief and based upon statements made by counsel for Silver Hill at the conclusion of the hearing, Silver Hill intends to prepare and file exceptions to the Proposed Final Decision, a brief and/or request oral argument. Simply put, neither the statutes nor the regulations permit Silver Hill, as an Intervenor, to do so. The Applicant respectfully requests that OHCA preclude Silver Hill from filing exceptions to Proposed Final Decision and/or a brief and/or requesting oral argument. To the extent that Silver Hill makes any such filings or request, the Applicant respectfully requests that OHCA not consider the same.

While the statutes and regulations clearly allow only "parties" to file exceptions and briefs and to request oral argument, to the extent that OHCA permits Silver Hill to do so despite Applicant's objection as set forth herein, Applicant respectfully requests the opportunity to file a

---

[3] Department of Health's Administrative Regulations and Rules of Practice Section 19a-643-10(6) provides, in relevant part, as follows: "'Party' means each person whose legal rights, duties or privileges are required by statute to be determined by the Office **and** who is named or admitted as a party or whose legal rights, duties or privileges will be specifically affected by the Office's decision in a contested case **and** who is named or admitted as a party or any person who is required by law to be a party in an Office proceeding." (Emphasis supplied).

rebuttal brief on or before the close of business on Tuesday, May 25, 2010, and we would further request the opportunity to present oral argument in opposition to Silver Hill.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: _____
Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
Tel. No. (203) 777-5800
Fax No. (203) 777-5806

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Docs\Motion to Preclude (re Silver Hill) 5.19.10.doc

CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 19th day of May, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
Stamford, Connecticut 06901
Facsimile: (203)653-5444

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723

Michele M. Volpe

Greer, Leslie

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HEALTH CARE ACCESS

From: Lazarus, Steven
Sent: Wednesday, May 19, 2010 4:05 PM
To: Olejarz, Barbara; Greer, Leslie
Subject: FW: Litchfield Hills Retreat, LLC
Attachments: Intervenor's Request to File Objection.PDF

Please add to the file but not to the legal record, since the hearing was closed as of May 7, 2010.

Thank you,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

From: Louis B. Todisco [mailto:LTODISCO@murthalaw.com]
Sent: Wednesday, May 19, 2010 3:55 PM
To: Lazarus, Steven
Cc: michelemvolpe@aol.com
Subject: FW: Litchfield Hills Retreat, LLC

Steven,

Attached is a request to be permitted to file an objection to the Applicant's Motion to Preclude by the close of business tomorrow.

Lou Todisco

Louis B. Todisco
Partner
ltodisco@murthalaw.com

Murtha Cullina LLP
Whitney Grove Square, Two Whitney Avenue
New Haven, CT 06510-1220
Direct: 203-772-7718
Direct Fax: 860-240-5715
Main: 203-772-7700
Main Fax: 203-772-7723

www.murthalaw.com

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From: Raphaline M. Voccia
Sent: Wednesday, May 19, 2010 3:51 PM
To: Louis B. Todisco
Subject: Litchfield Hills Retreat, LLC

LOUIS B. TODISCO
203.772.7718 DIRECT TELEPHONE
860.240.5715 DIRECT FACSIMILE
LTODISCO@MURTHALAW.COM

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HEALTH CARE ACCESS

May 19, 2010

VIA FACSIMILE (860) 418-7053
VIA E-MAIL: Steven.lazarus@ct.gov
VIA UPS OVERNIGHT MAIL

Honorable Cristine A. Vogel
Deputy Commissioner
Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Free Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

This office received this afternoon the Applicant's Motion to Preclude Silver Hill Hospital, Inc.'s Filing of Exceptions, Briefs and/or Requesting Oral Argument.

On behalf of the Intervenor, Silver Hill Hospital, Inc. I am requesting until the close of business tomorrow, May 20, 2010, to file an objection to this motion. I propose to file the objection by e-mail and facsimile with hard copy to be filed on Friday, May 21, 2010. I note that exceptions, briefs, and a request for oral argument are timely if filed on May 21, 2010.

Sincerely yours,

Louis B. Todisco

Louis B. Todisco

cc: Michele M. Volpe, Esquire

2034485v1

WHITNEY GROVE SQUARE
2 WHITNEY AVENUE, P.O. BOX 704
NEW HAVEN, CONNECTICUT 06503-0704
TELEPHONE 203.772.7700
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www.murthalaw.com

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FACSIMILE TRANSMITTAL

Date:	May 19, 2010	Client Code:	-
To:	Mr. Steven W. Lazarus	Facsimile Number:	860.418.7053
	Office of Health Care Access Div.	Telephone Number:	860.418.7012
From:	Louis B. Todisco	Telephone Number:	203.772.7718

Total Number of Pages (including this cover page): 2 Sent by: Raphaline M. Voccia

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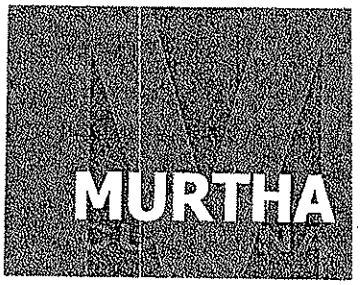

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LOUIS B. TODISCO
203.772.7718 DIRECT TELEPHONE
860.240.5715 DIRECT FACSIMILE
LTODISCO@MURTHALAW.COM

May 19, 2010

VIA FACSIMILE (860) 418-7053
VIA E-MAIL: Steven.lazarus@ct.gov
VIA UPS OVERNIGHT MAIL

Honorable Cristine A. Vogel
Deputy Commissioner
Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Docket No. 09-31500-CON
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Proposal to Establish a Free Standing Substance Abuse Center in Bethlehem

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Sincerely yours,

Louis B. Todisco

Louis B. Todisco

cc: Michele M. Volpe, Esquire

2034485v1

LOUIS B. TODISCO
203.772.7718 DIRECT TELEPHONE
860.240.5715 DIRECT FACSIMILE
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May 19, 2010

VIA FACSIMILE (860) 418-7053
VIA E-MAIL: Steven.lazarus@ct.gov
VIA UPS OVERNIGHT MAIL

Honorable Cristine A. Vogel
Deputy Commissioner
Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

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Sincerely yours,

Louis B. Todisco

Louis B. Todisco

cc: Michele M. Volpe, Esquire

2034485v1

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

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2010 MAY 20 A 11:47
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

May 19, 2010
Via Facsimile (860) 418-7053
Via email: Steven.Lazarus@ct.gov
Via Federal Express

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

On behalf of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, enclosed please find one (1) original and six (6) copies of a Motion to Preclude Silver Hill Hospital Inc.'s Filing of Exceptions, Briefs and/or Requesting Oral Argument.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
cc: Louis Todisco, Murtha Cullina LLP
Paul Knag, Murtha Cullina, LLP

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\OHCA (Object to Motion to Preclude) 5.19.10.doc

DEPARTMENT OF PUBLIC HEALTH
DIVISION OF OFFICE OF
HEALTH CARE ACCESS : **DOCKET NO. 09-31500-CON**
:
IN RE: EMPLOYMENT OPTIONS, LLC :
D/B/A LITCHFIELD HILLS RETREAT, LLC
PROPOSAL TO ESTABLISH A
FREE STANDING SUBSTANCE
ABUSE CENTER IN BETHLEHEM : **May 19, 2010**

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HEALTH CARE ACCESS

MOTION TO PRECLUDE SILVER HILL HOSPITAL INC.'S FILING OF EXCEPTIONS, BRIEFS AND/OR REQUESTING ORAL ARGUMENT

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Administrative Regulations and Rules of Practice). Since the Applicant accepts the Proposed Final Decision and will not be filing any written exceptions or brief nor will it request oral argument, a Final Decision consistent with the Proposed Final Decision should be rendered forthwith as Section 4-179(d) of the Connecticut General Statutes permits waiver of the provisions at Section 4-179 by the parties and the DPH Division of Office of Health Care Access ("OHCA").

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rebuttal brief on or before the close of business on Tuesday, May 25, 2010, and we would further request the opportunity to present oral argument in opposition to Silver Hill.

The Applicant,
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

By: _____
Michele M. Volpe
Christopher M. McKeon
Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor, New Haven, CT 06511
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Fax No. (203) 777-5806

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Docs\Motion to Preclude (re Silver Hill) 5.19.10.doc

CERTIFICATION

This is to certify that a true and correct copy of the foregoing was faxed and mailed by first class mail, postage prepaid, on this 19th day of May, 2010 to:

Paul E. Knag, Esq.
Murtha Cullina LLP
177 Broad Street
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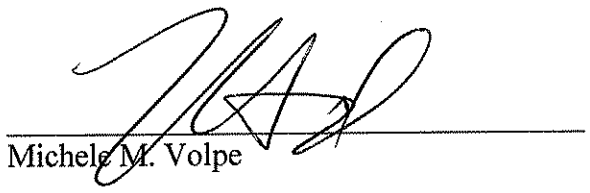
Facsimile: (203)653-5444

Louis B. Todisco, Esq.
Murtha Cullina LLP
Two Whitney Avenue
New Haven, Connecticut 06503
Facsimile: (203)772-7723



Michele M. Volpe

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LOUIS B. TODISCO
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May 20, 2010

VIA HAND DELIVERY

Honorable Cristine A. Vogel
Deputy Commissioner
Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Free Standing Substance Abuse Center in Bethlehem

Dear Commissioner Vogel:

Enclosed is an original and six copies of the Intervenor's Objection to Motion to Preclude Silver Hill Hospital, Inc.'s Filing of Exceptions, Briefs and/or Requesting Oral Argument.

While I had written yesterday that I would file it via facsimile and e-mail today with hard copy filed tomorrow, it was possible to file a hard copy today so I have done so.

Sincerely yours,

Louis B. Todisco

Louis B. Todisco

cc: Michele M. Volpe, Esquire
(via facsimile and hand delivery)

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CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: EMPLOYMENT OPTIONS, LLC. D/B/A/ LITCHFIELD HILLS RETREAT, LLC PROPOSAL TO ESTABLISH A FREE-STANDING SUBSTANCE ABUSE CENTER IN BETHLEHEM,

DOCKET NO. 09-31500-CON

MAY 20, 2010

OBJECTION TO MOTION TO PRECLUDE SILVER HILL HOSPITAL, INC.'S FILING OF EXCEPTIONS, BRIEFS AND/OR REQUESTING ORAL ARGUMENT

The Applicant in this matter has moved that Silver Hill Hospital, Inc. ("Silver Hill"), the Intervenor, be precluded from filing exceptions, briefs and/or requesting oral argument (the "Motion to Preclude"). The basis of the Applicant's Motion is that only a "party" is entitled to file exceptions, present briefs and present oral argument, and Silver Hill is an Intervenor, not a Party.

Based on the discussion at the conclusion of the public hearing on April 29, 2010, Silver Hill intends to file exceptions and a brief and request oral argument on May 21, 2010. Silver Hill requests that the Deputy Commissioner deny the Applicant's Motion to Preclude and review and consider the exceptions and written argument which the Intervenor will file and permit oral argument. There are several reasons why the Motion to Preclude should be denied.

First, the Hearing Officer has ruled in favor of Silver Hill with respect to this issue. At the conclusion of the public hearing on April 29, the Hearing Officer advised the parties that a decision would be served upon all parties to the proceeding and that after the parties had the opportunity to file exceptions, a brief and make oral argument, the

Deputy Commissioner would render a Final Decision. Counsel for the Applicant, Michelle Volpe, then asked the Hearing Officer whether the opportunity to submit exceptions, briefs and oral argument would apply to the Intervenor as well the Applicant. The Hearing Officer said that she believed that the opportunity would be offered to all parties and either the Applicant or the Intervenor could file exceptions. The Hearing Officer said she would check on this, and if the answer was different she would let the parties know.

Subsequently, under cover of letter dated May 7, 2010, the Hearing Officer served a copy of the Proposed Final Decision on both the Applicant and the Intervenor. In the cover letter, the Hearing Officer noted that a party "adversely affected may file exceptions and may present briefs with the Deputy Commissioner . . . within fourteen (14) days of this notice" and that any request for oral argument must be received in writing by May 21, 2010.

There is nothing in the Hearing Officer's letter to indicate that the decision at the hearing -- that is, that the Intervenor would be entitled to file exceptions, a brief and request oral argument -- had changed. The Hearing Officer has not said that it changed. Furthermore, the course of events indicates that the decision has not changed. The Hearing Officer served a copy of the Proposed Final Decision on both the Applicant and the Intervenor. The Applicant was clearly not "adversely affected" by the Proposed Final Decision as it approves the Application in its entirety. Consequently, it could only be the Intervenor which would be adversely affected by the decision. By serving the Proposed Final Decision on the Intervenor, the Hearing Officer has clearly

indicated that her decision that the Intervenor should be able to file exceptions has not changed.

It is true that the Hearing Officer did use the term "party" when discussing the issue of exceptions at the conclusion of the public hearing and in the transmittal letter. However, the Hearing Officer was using this term in a general sense to refer to both the Applicant and the Intervenor. It is clear that the Hearing Officer was addressing counsel for both the Applicant and the Intervenor when she used this term during the discussion at the hearing as to whether the Intervenor would be able to file exceptions. The same is true as to her use of the term party in the May 7, 2010 transmittal letter. Therefore it seems clear that the Hearing Officer intended, and has decided, that the Intervenor be permitted to file exceptions, a brief, and be able to request oral argument.

Second, permitting the Intervenor to do so is consistent with the nature of the rights which OHCA has granted in this proceeding. Silver Hill has been permitted to review documents, present evidence and to cross-examine. Silver Hill appreciates this opportunity. Allowing Silver Hill to comment on the Proposed Final Decision follows from and is consistent with its participation so far in this matter.

Third, respectfully, Silver Hill's participation will add value to decision making process. As a result of its many years of experience in operating substance abuse programs, Silver Hill is familiar with the need for substance abuse services. Silver Hill is in a position to provide information and a perspective which will assist OHCA in evaluating the need analysis in the Proposed Final Decision.

Also, because of its experience and because Silver Hill currently operates substance abuse programs, and the Applicant does not, Silver Hill is in a superior

position to the Applicant to articulate the impact on consumers of health care services and accessibility to substance abuse treatment services which will occur if this Application is approved. Silver Hill pointed out in testimony that granting this application would jeopardize its ability to continue to provide its currently offered services. The potential diversion of patients to the Applicant's program, and the resulting inability to subsidize unprofitable programs and patients with limited means, is squarely encompassed within the statutory requirements that OHCA consider "the impact of such proposal, request or submission on the interest of consumers of health care services," and the contribution (or lack of contribution) "of such proposal, request or submission to the quality, accessibility and cost-effectiveness of health care delivery in the region . . . ." See Conn. Gen. Stat. § 19a-637(a). These statutory criteria were not addressed in the Proposed Final Decision. Silver Hill is in a unique position to articulate considerations directly relevant OHCA's consideration of these statutory criteria through the exception process.

Fourth, OHCA's decision-making process will not in any way be impaired by consideration of Silver Hill's exceptions and argument is support of its exceptions. Oral argument need not be lengthy and OHCA is, of course, able to limit the length of oral argument toward this end. OHCA is not bound to accept Intervenor's arguments, but will have the benefit of the arguments in its decision-making process.

Finally, permitting Silver Hill to participate in the exception process is consistent with OHCA's regulation concerning participation by Intervenors, the practice of other agencies and the law. OHCA's regulation on Intervenors states:

> The presiding officer may grant the request to intervene if the presiding officer finds that the proposed participation as an intervenor will add evidence or arguments on the issue of the contested case that would otherwise not be available to the Office, is in the interest of justice and will not impair the orderly conduct of the proceedings.

Reg. Conn. State Agencies 19a-643-38(c). Permitting Silver Hill to participate by filing exceptions and presenting argument in support of its exceptions will provide argument on the issues in this case that would not be otherwise available and, accordingly, will benefit the decision making process. It is in the interest of justice as the Applicant's proposal would, if approved, have an adverse effect on Silver Hill.

Also, other Connecticut agencies permit Intervenors to file exceptions and briefs and make oral argument. Attached is a March 4, 2010 "Notice of Written Exceptions, Briefs and Oral Arguments" issued by the Department of Public Utility Control evidencing this to be the case. It appears that allowing intervenors to file exceptions, briefs and oral argument has been the long-standing practice of the Department of Public Utility Control. See Metro Mobile CTS, Inc. v. Department of Public Utility Control, 1992 Conn. Super. LEXIS 2316 (1992) (noting in 1992 that the Department of Public Utility Control permitted Metro Mobile which had been admitted as an intervenor to submit written exceptions and present oral argument to the DPUC concerning the draft decision).

Certainly OHCA has the discretion to permit Silver Hill to file exceptions and present argument with respect to the proposed final decision. In the Metro Mobile case cited above, Judge Maloney noted that Section 4-177a of the Connecticut Statutes allows, but does not require, the presiding officer to limit the participation of an

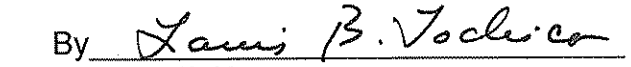
intervenor. See Metro Mobile, supra. OHCA's regulations do not preclude OHCA from permitting an intervenor to participate in the exception process. The Applicant's statement in the Motion to Preclude that "neither the statutes nor the regulations permit Silver Hill, as an Intervenor" to file exceptions, a brief, or to present oral argument is simply wrong.

In summary, permitting Silver Hill to participate in the exception process is contemplated by the Hearing Officer, will allow for a more informed decision-making process, will not impair the orderly conduct of the proceedings and is consistent with Silver Hill's prior participation, OHCA's regulation, the practice of other agencies and the law. The decision of the Hearing Officer to permit Silver Hill to do so was correct.

For the reasons set forth above, Silver Hill should be permitted to file exceptions and provide written and oral argument in support of its exceptions.

Respectfully submitted,

SILVER HILL HOSPITAL, INC.

By 

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Its Attorneys

ORDER

The foregoing Objection to the Motion to Preclude Silver Hill Hospital Inc.'s Filing of Exceptions, Briefs and/or Requesting Oral Argument having been heard, it is hereby SUSTAINED, and the Motion to Preclude Silver Hill Hospital Inc.'s Filing of Exceptions, Briefs and/or Requesting Oral Argument is DENIED.

_____

Deputy Commissioner

DOCKET NO. 09-04-21

DPUC INVESTIGATION INTO
THE SOUTHERN NEW ENGLAND TELEPHONE COMPANY'S
COST OF SERVICE RE: RECIPROCAL COMPENSATION

NOTICE OF WRITTEN EXCEPTIONS, BRIEFS AND ORAL ARGUMENTS
(March 23, 2010) (April 7, 2010)

Pursuant to § 4-179 of the General Statutes of Connecticut, the Department of Public Utility Control (Department) will accept written exceptions and/or briefs from admitted Parties and Intervenors in the docket cited above, concerning the attached draft Decision. Written exceptions and/or briefs concerning the draft Decision may be filed with the Department's Executive Secretary's Office on or before **Tuesday, March 23, 2010, by 4:00 p.m.**

Documents must be filed with the Executive Secretary of the Department in both electronic and paper form. The date and time of filing shall be the date and time the Department first receives a complete electronic version or the paper version and the required number of paper copies. Unless otherwise specified, filings are due by 4:00 p.m. on or before any required date. If a complete electronic version of the filing is submitted through the Department's Web Filing System, only one paper version of the filing is generally required.

If a complete electronic version of the filing is not web filed, submit an original and one copy for all briefs, reply briefs and comments/written exceptions. Each copy shall be collated and secured with the docket number prominently displayed on the first page.

Parties and Intervenors must notify the Department's Executive Secretary's Office, in writing, on or before **Tuesday, March 23, 2010, by 4:00 p.m.**, of their intention to present oral arguments. In the absence of such written notification, the Department will consider the right to oral arguments to have been waived. If a written request is timely received, oral arguments will be heard at the offices of the Department, Ten Franklin Square, New Britain, Connecticut, on **Wednesday, April 7, 2010, at 1:30 p.m.**

The public may call the Department's offices, at (860) 827-1553, option 4 (using a touch tone phone), commencing each day from 7:30 a.m., to be advised as to whether the oral arguments have been cancelled or postponed due to inclement weather.

The Department expects to render a final decision on this matter on **Wednesday, April 14, 2010, at 9:30 a.m.**

Dated at New Britain, Connecticut this 4th day of March, 2010.

DEPARTMENT OF PUBLIC UTILITY CONTROL

Kimberley J. Santopietro
Executive Secretary

By:

Philip L. Dukes

(PMV)

Notice filed with the Secretary of the State on March 4, 2010.

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Objection to the Motion to Preclude Silver Hill Hospital Inc.'s Filing of Exceptions, Briefs and/or Requesting Oral Argument was sent by facsimile and hand delivery, this 20th day of May, 2010, to:

Michelle M. Volpe
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor,
New Haven, CT 06511

Louis B. Todisco

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 20, 2010

Michele Zurko-Smith
CEO & Member
Employment Options, LLC
12 Trefoil Road
Oxford, CT 06478

RE: Certificate of Need, Docket Number 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Establishment of a Free-standing Residential Substance Abuse Facility in Bethlehem, Connecticut
Ruling on Motion to Preclude Silver Hospital Inc.'s Filing of Exeptions, Briefs, and/or Requesting Oral Argument

Dear Ms. Zurko-Smith:

Please be advised that OHCA has received the Applicant's Motion to Preclude Silver Hospital Inc.'s Filing of Exceptions, Briefs, and/or Requesting Oral Argument and the Intervenor's Objection to the same. Pursuant to General Statutes § 4-179, parties adversely affected by the proposed final decision shall have an opportunity to file exceptions and present briefs and oral argument. The Applicant correctly notes that Silver Hill neither sought nor was granted "party" status in the above-referenced matter. Accordingly, Silver Hill is not entitled to the rights granted pursuant to § 4-179.

Based upon the foregoing, the Applicant's Motion to Preclude Silver Hill Hospital Inc.'s Filing of Exceptions, Briefs, and/or Requesting Oral Argument is hereby granted and the Intervenor's Objection to the Motion is overruled.

Sincerely,

Cristine A. Vogel
Deputy Commissioner, DPH

cc: Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.
Paul E. Knag, Esq., Murtha Cullina LLP

****
*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	1606
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RESULT	OK ✓

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

FAX SHEET

TO: Louis Todisco, Esq. ✓

FAX: (203) 772-7723

AGENCY: OHCA / DPH

FROM: Steven Lazarus

DATE: 5/21/10 **TIME:** 8:30

NUMBER OF PAGES: (2)
(including transmittal sheet

Comments:

Ruling Enclosed for DN: 09-31800-con

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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*** TX REPORT ***
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RESULT	OK ✓

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

FAX SHEET

TO: Michele Zurko-Smith ✓

FAX: (203) 267-3813

AGENCY: OHCA/DPH

FROM: Steven Lazarus

DATE: 5/21/10 **TIME:** 8:35 am

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
Ruling Enclosed for DN: 09-~~3156~~ 31500-COU

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RESULT	OK

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

FAX SHEET

TO: Michele Volpe, Esq.

FAX: (203) 777-5806

AGENCY: OHCA/DPH

FROM: Steven Lazarus

DATE: 5/21/10 **TIME:** 8:30

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Ruling Enclosed for Dr.: 09-31500-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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*** TX REPORT ***
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RESULT	OK

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

FAX SHEET

TO: Paul Knag, Esq.

FAX: (703) 653-5444

AGENCY: OHCA / DPH

FROM: Steven Lazarus

DATE: 5/21/10 **TIME:** 8:30

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:

Ruling Enclosed for DN: 09-31500-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 26, 2010

IN THE MATTER OF:

An Application for a Certificate of Need filed pursuant to Section 19a-638, C.G.S. by:	Notice of Final Decision Office of Health Care Access Docket Number: 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC	**Establishment of a Free-Standing Residential Substance Abuse Facility in Bethlehem, Connecticut**

To: Michele Zurko-Smith
CEO & Member
Employment Options, LLC
12 Trefoil Road
Oxford, CT 06478

Dear Ms. Zurko-Smith:

In accordance with the Connecticut General Statutes Section 4-179, the Proposed Final Decision dated May 7, 2010 by Hearing Officer Melanie A. Dillon is hereby adopted as the final decision of the Deputy Commissioner of the Office of Health Care Access, Department of Public Health in this matter. A copy of the Proposed Final Decision is attached hereto and incorporated herein.

Sincerely,

Cristine A. Vogel
Deputy Commissioner

CAV:swl

cc: Melanie A. Dillon, Hearing Officer, OHCA/DPH
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.
Paul E. Knag, Esq., Murtha Cullina LLP

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 7, 2010

IN THE MATTER OF:

An Application for a Certificate of Need filed pursuant to Section 19a-638, C.G.S. by:

Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC

Notice of Final Decision
Office of Health Care Access
Docket Number: 09-31500-CON

Establishment of a Free-Standing Residential Substance Abuse Facility in Bethlehem, Connecticut

To: Michele Zurko-Smith
CEO & Member
Employment Options, LLC
12 Trefoil Road
Oxford, CT 06478

Dear Ms. Zurko-Smith:

Enclosed please find a copy of my Proposed Final Decision rendered in the above referenced matter.

Pursuant to Connecticut General Statutes Section 4-179, each party adversely affected may file exceptions and present briefs with the Deputy Commissioner of Office of Health Care Access, Department of Public Health within fourteen (14) days from the date of this notice. Any request for oral arguments must be received in writing by May 21, 2010. If no timely request is made, the Office of Health Care Access shall assume these rights to be waived and shall render a Final Decision in this matter.

Sincerely,

Melanie A. Dillon, Hearing Officer

MAD:swl

cc: Cristine A. Vogel, Deputy Commissioner, DPH
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.
Paul E. Knag, Esq., Murtha Cullina LLP

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Proposed Final Decision

Applicant:	**Employment Options, Inc. d/b/a Litchfield Hills Retreat, LLC**
Docket Number:	**09-31500-CON**
Project Title:	**Establishment of a Free-Standing Residential Substance Abuse Facility in Bethlehem, Connecticut**
Statutory Reference:	**Section 19a-638 of the Connecticut General Statutes**
Filing Date:	**March 2, 2010**
Hearing Date:	**April 29, 2010**
Decision Date:	**May 7, 2010**
Default Date:	**May 31, 2010**
Staff:	**Steven W. Lazarus Laurie Greci**

Project Description: Employment Options, Inc., d/b/a Litchfield Hills Retreat, LLC ("Applicant"), is proposing to establish a free-standing residential substance abuse facility in Bethlehem, Connecticut, at a total capital cost of $2,500,000.

Nature of Proceedings: On March 2, 2010, the Office of Health Care Access ("OHCA") received a Certificate of Need ("CON") application from the Applicant regarding a proposal to establish a free-standing residential substance abuse facility in Bethlehem, Connecticut, at a total capital cost of $2,500,000.

A notice to the public concerning OHCA's receipt of the Applicant's Letter of Intent was published on December 11, 2009, in the *Waterbury Republican American.*

On March 18, 2010, and March 22, 2010, OHCA received letters from Silver Hill Hospital, Inc., and High Watch Recovery Center, Inc., requesting that a public hearing be held in this matter.

A public hearing regarding the CON application was held on April 29, 2010. On April 14, 2010, the Applicant was notified of the date, time, and place of the hearing. On April 16, 2010, a notice to the public announcing the hearing was published in *Waterbury Republican American.* Commissioner J. Robert Galvin designated Melanie Dillon, Staff Attorney as the hearing officer in this matter on April 7, 2010. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-638, C.G.S.

By petition dated April 22, 2010, Silver Hill Hospital, Inc., requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer approved the Hospital's request for Intervenor status with full rights of cross-examination.

The Hearing Officer heard testimony from the Applicant's and the Intervenor's witnesses and in rendering this proposed final decision, considered the entire record of the proceeding. OHCA's authority to review, approve, modify, or deny this proposal is established by Section 19a-638, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

FINDINGS OF FACT

1. Employment Options, LLC ("EO" or "Applicant") is a private service agency located at 12 Trefoil Road, Oxford, Connecticut. It was established in 1994 and currently employs 138 people. *(November 20, 2009, Letter of Intent, February 5, 2010, and Initial CON Application, page 6)*

2. Michele Zurko-Smith is the Chief Executive Officer and the sole member owner of EO and Litchfield Hills Retreat, LLC. *(November 20, 2009, Letter of Intent, February 5, 2010 and March 2, 2010, Completeness Letter Responses, page 138)*

3. The Applicant contends that EO has a vocational contract with the Bureau of Rehabilitation Services and is also the largest provider of the Acquired Brain Injury Waiver[1] in the State of Connecticut, offering residential support, independent living skills training, as well as vocational services. *(November 20, 2009, Letter of Intent)*

4. The Applicant is proposing to establish Litchfield Hills Retreat, LLC ("LHR"), a 28 bed residential substance abuse treatment facility located at 64 Double Hill Road, Bethlehem,

[1] A Medicaid Waiver program using person centered planning to provide a range of non-medical home, and community based services to maintain adults who have acquired brain injury (not a developmental or degenerative disorder) in the community.

Connecticut. *(February 5, 2010, Initial CON Application, pages 6 &122)*

5. The Applicant proposes to locate its facility on sixty two (62) private acres which will offer privacy while ensuring anonymity, as the current building structure is set back from the rural road and not visible from any direction. Further, the proposed facility will offer private rooms. *(November 20, 2009, Letter of Intent and February 5, 2010, Initial CON Application, page 6)*

6. The Applicant asserts that a 7,500 square foot home is located on the property and that two additional buildings would be built for additional beds, office and program space. *(November 20, 2009, Letter of Intent)*

7. The Applicant limited the number of beds to 28 in order to establish the type of individualized, therapeutic environment it desires to offer the specialized population that it intends to serve. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, Acting Director of Litchfield Hills Retreat, page 148)*

8. The Applicant contends that the proposed facility will treat individuals 18 years of age and older, whose high level of public visibility, wealth, and/or social status makes it difficult for them to begin a successful recovery in the existing residential treatment settings. *(February 5, 2010, Initial CON Application, page 6)*

9. The Applicant claims that the proposed LHR facility will be the first licensed facility in Connecticut for the care and treatment of substance abuse and addictive disorders that is specifically tailored to this population. *(February 5, 2010, Initial CON Application, page 25)*

10. The Applicant asserts that the target population for the proposed LHR facility is currently not being served in the state of Connecticut and that these individuals are either required to travel to other states to receive services or they do not seek treatment. *(February 5, 2010, Initial CON Application, page 19)*

11. The Applicant contends that the only providers that are similar to the proposed facility in terms of level of privacy, upscale amenities, treatment modalities, and price point are located out-of-state and any Connecticut resident seeking this type of upscale residential treatment, including but not limited to the proposed target population, must currently travel elsewhere to receive it. *(March 2, 2010, Completeness Letter Responses, page 130)*

12. Mr. Gwozdz testified that in contrast to the existing providers, LHR's program will be structured to provide a supportive and safe setting for adults in the later stages of recovery to make the transition back into the community. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 153)*

13. LHR asserts that it offers a wide variety of therapy options tailored to the recovering individual in a spa-like retreat environment. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 153)*

14. Mr. Gwozdz testified that LHR will complement the existing substance abuse treatment facilities in Connecticut. LHR views the existing substance abuse providers as potential referral sources for the target population and a potential referral destination for those individuals that are not appropriate for LHR. *(April 26, 2010, Prefile Testimony of Mr. Brian*

Gwozdz, page 154)

15. Mr. Gwozdz testified that the need for LHR is based on the significant substance and alcohol dependency that exists in Connecticut, particularly among certain high-income individuals such as physicians, attorneys, executives and other high-earners. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 143)*

16. LHR proposes to serve this high-profile population comprised of physicians, attorneys, executives and other high-earning individuals by offering a setting where individuals with similar backgrounds and status can obtain treatment without being identified and treated as a "special" or "extraordinary" within the facility. Mr. Gwozdz asserts that this is an important aspect in achieving successful recovery. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz,, page 145)*

17. Mr. Gwozdz testified that the target populations of high-earners are defined as individuals and families earning over $200,000 annually. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, , page 146 and April 29, 2010, Public Hearing Testimony)*

18. According to the U.S. Census Bureau estimates for 2006-2008, approximately 2,673,711 adults reside in Connecticut. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146 and Attached Exhibit 7)*

19. The Applicant testified that Substance Abuse and Mental Health Administration ("SAMHSA") reports that approximately 10% of the population has a substance abuse or dependency problem. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146 and Attached Exhibit 9)*

20. Applying the 10% estimate to Connecticut's total population, the Applicant estimates that without taking household income into account, approximately 267,371 adults in Connecticut have a substance abuse problem. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146 and Attached Exhibit 9)*

21. The Applicant further testified that according to the U.S. Census Bureau, approximately 8% of the Connecticut population has a household income of $200,000 or more. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146 and Exhibit 8)*

22. Accordingly, the Applicant asserts that there are 213,896 households in Connecticut with an annual income of over $200,000. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146)*

23. By applying the SAMHSA percentage of 10% to the estimated 8% of Connecticut's population with an annual income of $200,000 or more, the Applicant estimates that there are 21,389 professional or high profile individuals in Connecticut with a substance abuse problem. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146 and Attached Exhibit 9)*

24. In 2008, SAMHSA reported that 45,338 persons sought treatment for a substance abuse problem in Connecticut. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 146 and Attached Exhibit 9)*

25. Accordingly, the Applicant determined that out of the estimated 267,317 persons with a

substance abuse problem in Connecticut, approximately 17% sought treatment (45,338/267,317 = 17%). *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 147 and Attached Exhibit 10)*

26. Mr. Gwozdz testified that the 45,338 figure is for adults that actually sought substance abuse treatment and therefore, it is a conservative figure because it does not take into account those adults that might need treatment but do not seek treatment. *(April 29, 2010, Public Hearing Testimony of Brian Gwozdz)*

27. Moreover, the Applicant utilized a more conservative rate of 15% instead of the 17% referenced in Finding of Fact 25. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, page 147 and Attached Exhibit 10)*

28. The following table utilizes the information provided above to summarize the potential patient population based on the estimates from the US Census Bureau and SAMHSA information concerning the prevalence of substance abusers that may utilize the services of LHR:

Table I: Projected Number of Potential LHR Clients

Population	Number	Percent of Population	Number of Potential Clients
Adults, 18 years and older	2,673,711	10%	267,317
Households with Income greater than $200,000 annually	267,317	8%	21,390
Adults that seek treatment	21,390	17%*	3,636
Adults that seek treatment	21,390	15%**	**3,209**

(April 26, 2010, Prefiled Testimony of Brian Gwozdz, pages 147, and 233)

29. Relying upon various articles and information from the Department of Labor, the Department of Public Health and the American Medical Association, the Applicant also estimated the potential numbers of lawyers, physicians, chief executives and other high level professionals with a substance abuse problem in Connecticut.

30. The Applicant included in its filing an article entitled, "Addiction and Lawyers: Substance Abuse in the Legal Profession," by Ed Jennett and a copy of a brochure from Lawyers for Lawyers Connecticut, as evidence indicating substance abuse is a problem in the legal profession. *(February 5, 2010, Initial CON Application, pages 81-86)*

31. According to the above article, "Addiction and Lawyers: Substance Abuse in the Legal Profession," it is estimated that 20% of lawyers have a substance abuse problem at sometime in their career. *(March 2, 2010, Completeness Letter Responses, page 136)*

32. Mr. Gwozdz testified that according to the Ohio Lawyers Assistance Program, eighteen (18%) to twenty percent (20%) of attorneys suffer from alcoholism. This rate rises to twenty-five percent (25%) after twenty years of practice. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, Acting Director of Litchfield Hills Retreat, page p. 144 and Attached Exhibit 5)*

33. Mr. Gwozdz testified that according to Connecticut's Department of Labor, as of the first

quarter of 2009, there were more than eight thousand (8,000) employed attorneys, four thousand seven hundred fifty (4,750) chief executives, and nearly twenty-two thousand (22,000) financial managers, analysts, examiners and other financial specialists. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, Acting Director of Litchfield Hills Retreat, page 144 and Attached Exhibit 3)*

34. The Applicants also included in its filing a report from the American Medical Association, "Report 1 of the Council on Scientific Affairs (A-95), Substance Abuse Among Physicians," highlighting the prevalence of substance abuse among physicians based on survey results originally published in the Journal of American Medical Association. *(February 5, 2010, Initial CON Application, pages 87-103)*

35. Mr. Gwozdz testified that according to Connecticut's Department of Public Health, there are presently more than sixteen thousand (16,000) active licensed physicians in Connecticut. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, Acting Director of Litchfield Hills Retreat, page 143 and Attached Exhibit 3)*

36. Mr. Gwozdz testified that it is conservatively estimated that eight percent (8%) to twelve percent (12%) of physicians will develop a substance abuse problem at some point during their career and that at any given time, as many as seven percent (7%) of practicing physicians are active substance abusers. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, Acting Director of Litchfield Hills Retreat, page 144 and Attached Exhibit 4)*

37. The following table summarizes the Applicant's information provided in Findings of Fact 31-37.

Table II: Projected Number of Potential Clients from Target Population

Target Group	Number	Percent of Population	Number of Potential Clients
Active, licensed Physicians	16,000	7%	1,120
Employed Attorneys	8,000	18%	1,440
Chief Executives, Financial Managers, and Other Similar Occupations	26,750	10%	2,675
Total Number of Potential Clients from Target Population			**5,235**

(April 27, 2010, Prefiled Testimony of Brian Gwozdz, pages143-146)

38. The Applicant provided sufficient evidence demonstrating the prevalence of substance abuse among attorneys and physicians.

39. OHCA finds that the Applicant relied upon objective and reliable sources of information and utilized reasonable methodologies to estimate the total number of individuals with a substance abuse problem who may utilize the services provided by LHR.

40. Accordingly, OHCA further finds that the Applicant demonstrated a sufficient need among this relatively small and well-defined population that LHR proposes to serve.

41. The Applicant estimates that its capture rates of those persons from Connecticut seeking

residential treatment to be 2.5%, 5%, and 7% in the first three years of operations. When applied to the number of potential clients of 3,209 (See Finding of Fact 30), the Applicant estimates that it will have 80, 160, and 225 Connecticut admissions in the first three years of operations, respectively. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, pages 147 and 233)*

42. The Applicant assumed that there would be 28 beds available 365 days each year and the length of stay per admission would be 30 days. *(April 26, 2010, Prefiled Testimony of Brian Gwozdz, pages 147 and 148)*

43. The Applicant asserts that, according to the research they conducted, a 30 day stay is the national standard for this type of treatment. This data was gathered from other treatments centers and taken from the Office of Applied Studies SAMHSA, 2001 Treatment Episode Data TEDS 5.31.03. *(March 2, 2010, Completeness Letter Responses, page 131)*

44. The Applicants contend that the following table illustrates the utilization of the proposed LHR for the first three years of service:

Table III: Projected Utilization for LHR

LHR, LLC	Projected Utilization		
	Year 1 (Jan. 1-Dec. 31 2011)	Year 2 (Jan. 1-Dec. 31 2012)	Year 3 (Jan. 1-Dec. 31, 2013)
Total Beds	28	28	28
Total Available Bed Days	10,220	10,220	10,220
Projected Total Occupancy	40%	65%	85%
Projected Bed Days*	4,088	6,643	8,687
Projected Total Admissions (include Out-of-State) **	136	221	290
Connecticut Admission	80	160	225
Out-of-State Admissions***	56	61	65
Total Admission	136	221	290
% of Connecticut Admissions	59%	72%	78%

* The total projected beds was determined by total available beds multiplied the occupancy rate (for example Year 1: 10,220,x.40=4,088)
**The projected total admissions were calculated by taking total bed days divided by an average length of stay of 30 days.
*** Out-of-state admissions were determined by the difference between CT admissions and projected total admissions

(February 5, 2010, Initial CON Application, page 23, March 2, 2010, Completeness Letter Responses, page 130-131, and April 27, 2010, Prefiled Testimony of Brian Gwozdz, Exhibit 11, page 236)

45. The Applicant further testified that its projected total occupancy of 40% in year 1, 65% in year 2 and 85% in year 3 is conservative, particularly in light of the fact that the National Survey of Substance Abuse Treatment Services in 2005 indicated that the average utilization rate for residential facilities was 93%. *(February 5, 2010, Initial CON Application, page 55 and April 26, 2010, Prefiled Testimony of Mr. Gwozdz, page s 147-148 and Attached Exhibit 12)*

46. OHCA finds that based upon the evidence provided, the Applicant's volume projections are reasonable and achievable.

47. The Applicant contends that there is no impact on any existing providers since currently there is no facility in Connecticut that provides the exact services and setting as the proposed facility. *(February 5, 2010, Initial CON Application, page 19)*

48. The Applicant provided a list of 17 locations in the area that offer similar services. *(February 5, 2010, Initial CON Application, pages 21-22)*

49. The Applicant asserts, however, that the proposed facility is markedly different from other similar providers in the area in that the proposed location is extremely private; the building location is not visible from the road; and LHR will offer private rooms and a broad array of treatment methods. *(March 2, 2010, Completeness Letter Responses, page 131)*

50. LHR proposes to offer several amenities and alternative practices such as equine assisted therapy, massage therapy, reiki, art, music, outdoor recreational activities and other modalities in a manner consistent with substance abuse treatment models. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 153)*

51. The Intervenor, Silver Hill Hospital, Inc. ("Silver Hill"), asserts, however, that it is comparable to the proposed facility in that its target population includes the target population of LHR and it has treated many highly visible and/or wealthy patients with great success in its self-pay 4-week residential substance abuse treatment program. *(April 22, 2010, Prefiled Testimony of Dr. Sigurd Ackerman, page 4)*

52. The Intervenor is licensed as a psychiatric hospital and has the ability to deal with detoxification and a variety of physical and psychiatric issues which often accompany drug or alcohol dependence. *(April 22, 2010, Prefiled Testimony of Dr. Sigurd Ackerman, President and Medical Director of Silver Hill Hospital, page 5)*

53. Dr. Ackerman testified that Silver Hill currently operates 52 beds for residential substance abuse/dual disorders treatment. The cost for this self-pay program is $26,000 and private rooms are available at a rate of $49,280. *(April 22, 2010, Prefiled Testimony of Dr. Sigurd Ackerman, page 3)*

54. Dr. Ackerman clarified that all of the rooms in its residential treatment program have two beds; however, an individual can purchase the second bed in the room to make it a private room. *(April 29, 2010, Public Hearing Testimony of Dr. Sigurd Ackerman)*

55. Dr. Ackerman testified that over the last three years, approximately 75 individuals purchased the second bed in the room to convert it to a private room. *(April 29, 2010, Public Hearing Testimony of Dr. Sigurd Ackerman)*

56. The Intervenor asserts that its occupancy rate for residential substance abuse/dual disorders treatment program for FY 2009 and 2010 was 77.7% and 76%, respectively and therefore, there is adequate capacity for such persons at Silver Hill. *(April 22, 2010, Prefiled Testimony of Dr. Sigurd Ackerman, page 3)*

57. The Intervenor asserts that the Applicant failed to prove a need for the proposed service

and that Silver Hill and other facilities in Connecticut have adequate capacity to serve the Applicant's target population. *(April 22, 2010, Prefiled Testimony of Dr. Sigurd Ackerman, page 4)*

58. OHCA finds that the Intervenor merely asserted that there is excess capacity without producing evidence of the same.

59. OHCA also finds that the Intervenor failed to produce evidence that the Applicant's projections with respect to the target population were unreasonable or that the information and data upon which those projections were based were unreliable.

60. Additionally, despite the Intervenor's claims to the contrary, LHR maintains that it will be different, and therefore not competitive with, the existing substance abuse treatment facilities in the state. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 152)*

61. Although, LHR will obtain the same licensure from DPH as many of the existing treatment facilities, it will be significantly different in that it will be a smaller, more private facility offering individualized care and programs that specifically address the professionals and social characteristics of its mature clients and offer a peer group for client with specific careers. *(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 152)*

62. Dr. Sack testified that LHR has significant differences from Silver Hill in that it will not be a licensed psychiatric hospital and it will be providing community-based residential treatment services in a homelike environment that is relatively non-institutional. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D., Chief Executive Officer of Elements Behavioral Health Inc., and Promises Treatment Centers)*

63. As further clarification, Dr. Sack explained that there are individuals whose acuity is such that they will require detoxification services that would not be available at LHR and who will also need some of the services available at a psychiatric hospital such as Silver Hill. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

64. Dr. Sack also testified that LHR's clients will be comprised of individuals who have already received detoxification treatment and who have been cleared medically by a referring physician. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 249)*

65. Dr. Sack further testified that individuals should be able to choose where they receive their treatment and from whom they receive their treatment. To that end, Dr. Sack maintained that the LHR proposal will offer greater choice in the selection of services for individuals suffering from substance abuse problems. *((April 29, 2010, Public Hearing Testimony of David Sack, M.D)*

66. Based upon the evidence provided, OHCA finds that although LHR may be similar in some respects to existing providers of substance abuse treatment, it is not comparable to many of the existing providers in that it will offer private rooms, several amenities and a broad array of residential treatment services in a homelike, non-institutional environment.

67. Dr. Sack testified that it is well recognized that individuals with substance abuse problems often have a co-occurring disorder such as anxiety or depression and that LHR will be staffed and equipped to deal with this population. *(April 26, 2010, Prefiled Testimony of*

David Sack, M.D., page 249)

68. Although LHR maintains it is a non-medical facility, Dr. Sack testified that it will support the medical needs of its clients through a consulting physician and clients with medical issues that emerge during their stay at LHR will be referred for treatment to a community physician. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 251)*

69. Dr. Sack testified that LHR's sole focus will be substance abuse/dependency treatment. The staff at LHR will ensure that each client will be thoroughly interviewed and assessed prior to acceptance into the program. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 251)*

70. Dr. Sack testified that after the assessment, the Clinical Director, in conjunction with the admissions staff, will make an informed decision regarding whether it is appropriate for the individual to be admitted to the LHR program in accordance with its licensure and treatment models or whether another, higher level of treatment is required for the individual. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 251)*

71. Dr. Sack testified that in cases where a client is not cleared for admission by the Clinical Director, the client will be referred to an alternative facility that offers the specific type of care that is demanded by the individual, whether it is inpatient psychiatric care, detoxification or other specialty care. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 252)*

72. Dr. Sack testified that the Clinical Director will be a licensed Master's level clinician, either a psychologist or a counselor and will be required to have a minimum of three (3) years of experience in drug and alcohol residential treatment programs. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

73. The Clinical Director's primary responsibility would be to design the program, to provide training and supervision to other clinical and non-clinical staff. Responsibilities will also include coordinating admissions and approving appropriateness for the program elements. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

74. LHR will employ licensed master's level therapists to coordinate both the primary therapy and family therapy programs. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

75. LHR will also employ several licensed or certified substance abuse alcohol and drug treatment counselors to provide the psycho-educational programs and individual counseling for drug and alcohol related issues. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

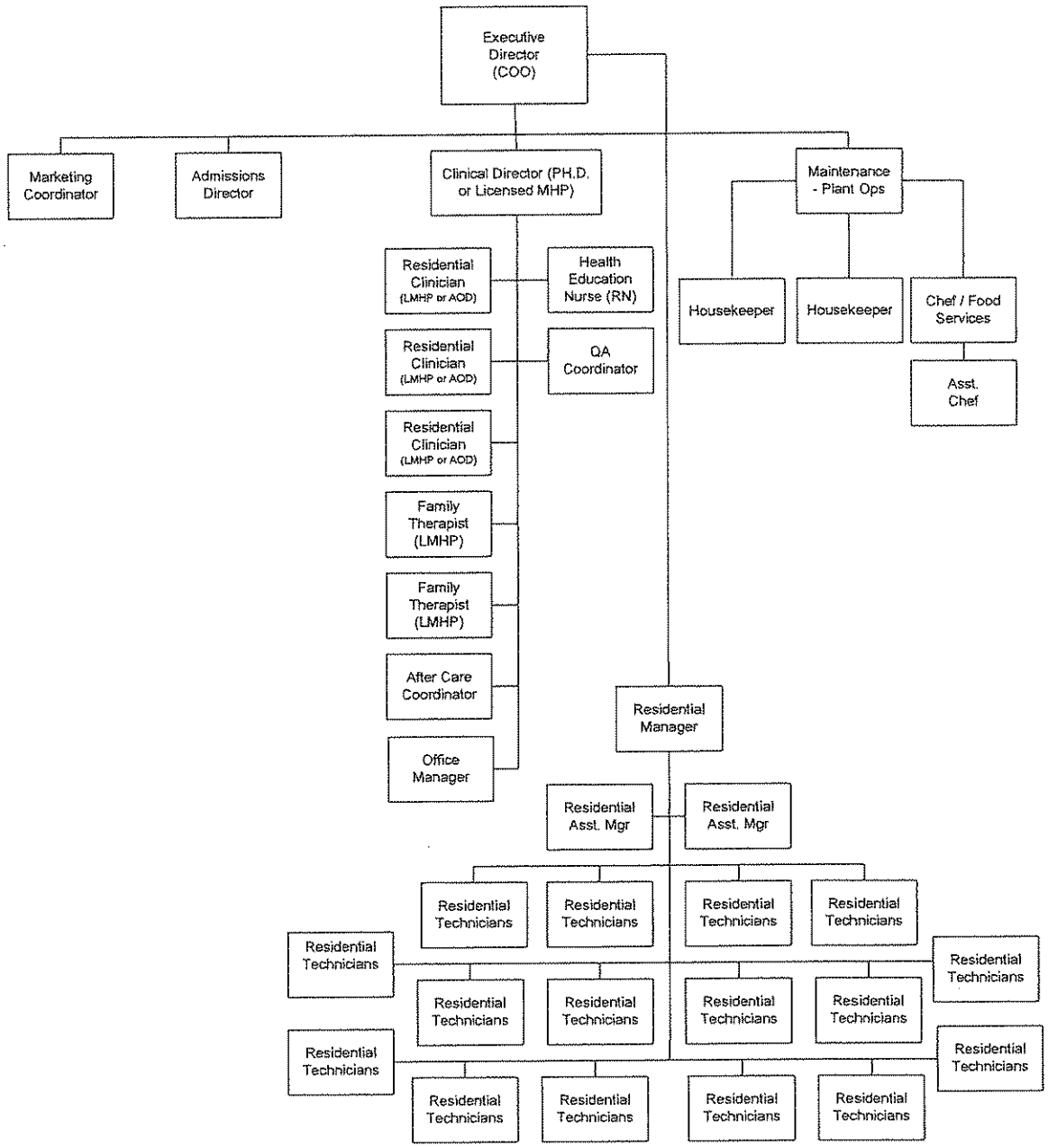
76. Dr. Sack testified that the ratio of counselors to patients will be 1 to 5. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

77. Additionally, LHR will employ several rehabilitation technicians, not necessarily certified or credentialed but experienced to provide direct supervision on a 24-hour basis. Duties may include driving, support services, safety checks, and vital signs monitoring. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

78. Dr. Sack testified that other positions would include a full-time chef to order and prepare foods, grounds keepers, a consulting physician and possibly a consulting psychiatrist. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

79. Dr. Sack testified that the consulting physician would aid in the examination on admissions and review laboratory tests and the consulting psychiatrist would aid in cases where a client's behavior changes or escalates or if they require additional psychiatric consultation. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

80. Upon request from OHCA, the Applicant submitted in the record a chart of organizational positions for the proposed facility.



(May 3, 2010, Applicant's Late File)

81. Dr. Sack also testified that LHR will follow the specific licensure requirements for the State of Connecticut when it is hiring staff. *(April 29, 2010, Public Hearing Testimony of David Sack, M.D.)*

82. Dr. Sack testified that as LHR proceeds with licensing, it will develop a definitive client activity schedule that describes the frequency and duration of each therapeutic modality. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 249)*

83. Dr. Sack testified that an example of these activities would include the 12 Step Facilitation Therapy, Motivational Interviewing and Cognitive Behavioral Therapy. These treatments will be provided in a range of individual and group psychotherapy sessions that will reinforce the skill acquired. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 250)*

84. Upon request from OHCA, the Applicant submitted a copy of a tentative program schedule for LHR. It is hereto attached as Exhibit I.

85. OHCA finds that the Applicant has produced evidence demonstrating that it is providing an appropriate level of staffing for the services that it proposes to provide.

86. LHR will obtain licensure from the Department of Public Health as a facility for the care and treatment of substance abusive and dependent persons. *(April 26, 2010, Prefiled Hearing Testimony of David Sack, M.D., page 253)*

87. Additionally, LHR will seek accreditation from the Commission on Accreditation of Rehabilitation Facilities ("CARF"). *(April 26, 2010, Prefiled Hearing Testimony of David Sack, M.D., page 253)*

88. Dr. Sack testified that CARF is a private, independent, not-for-profit organization that promotes quality rehabilitation services. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 253)*

89. Dr. Sack testified that he will assist LHR in attaining accreditation from CARF. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 253)*

90. Dr. Sack testified that in order to obtain CARF accreditation, facilities must demonstrate that they substantially meet certain internationally recognized standards applicable to rehabilitation facilities. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 253)*

91. Dr. Sack testified that LHR has established a Quality Assurance Plan ("QAP") and that adherence to this structured QAP will ensure the provision of high-quality substance abuse treatment services to the patients of LHR. *(April 26, 2010, Prefiled Testimony of David Sack, M.D., page 255)*

92. Based upon all of the evidence, OHCA finds that LHR is competent to provide efficient and adequate service to the public.

93. The Applicant contends that the proposed capital expenditure associated with this proposal is $500,000, the majority of which is for renovations and furnishing. The

property is currently owned by Michele Zurko-Smith, the CEO of LHR and the current market value of the property is $2 Million. Therefore, the total capital cost associated with this proposal is $2.5 Million. *(February 5, 2010, Initial CON Application, page 35)*

94. The Applicant contends that the proposal will be funded by Ms. Michele Zurko-Smith herself. *(February 5, 2010, Initial CON Application, page 52)*

95. The Applicant submitted Ms. Zurko-Smith's personal 2008 United States tax filings. *(March 2, 2010, Completeness Letter Responses, page 138)*

96. The Applicant contends that proposed service is 100% private pay. *(February 5, 2010, Initial CON Application, page 36)*

97. The Applicant contends that the cost for the proposed services per client will be $50,000.

98. The Applicant projects incremental revenue from operations, total operating expenses and loss/gain from operations associated with the first three years of operating this proposal as follows:

Table IV: Incremental Financial Projections for Operating Years 1 through 3

Description	Year 1	Year 2	Year 3
Incremental Revenue from Operations	$6,450,000	$11,292,000	$14,150,000
Incremental Total Operating Expenses	$5,432,659	$5,622,659	$6,854,000
Incremental (Loss)/Gain from Operations	**$1,017,341**	**$5,669,341**	**$7,296,000**

(April 26, 2010, Prefiled Testimony of Mr. Brian Gwozdz, page 236 and February 5, 2010, Initial CON Application, page 41)

99. The Applicant contends that Ms. Zurko-Smith as the sole owner of EO, the parent company of LHR, will be responsible for all the costs accrued. *(March 2, 2010, Completeness Letter Responses, page 138)*

100. The Applicant contends that the proposal is cost effective because it is private pay. *(February 5, 2010, Initial CON Application, page 49)*

Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g. the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

Employment Options, LLC ("EO" or "Applicant") is a private service agency that was established in 1994 and currently employs 138 people. Michele Zurko-Smith is the Chief Executive Officer and the sole member owner of EO and Litchfield Hills Retreat, LLC ("LHR"). The Applicant proposes to establish a 28 bed residential substance abuse treatment facility on 62 private acres located at 64 Double Hill Road in Bethlehem, Connecticut.

The Applicant claims that the proposed LHR facility will be the first licensed facility in Connecticut for the care and treatment of substance abuse and addictive disorders that is specifically tailored to treat individuals 18 years of age and older, whose high level of public visibility, wealth, and/or social status makes it difficult for them to begin a successful recovery in the existing residential treatment settings. Specifically, the Applicant claims that it will offer private rooms in a homelike non-institutional environment. The Applicant further claims that it will offer privacy in that its facility is not visible from the road and located on sixty-two acres. LHR proposes to offer several amenities and alternative practices such as equine assisted therapy, massage therapy, reiki, art, music, outdoor recreational activities and other modalities in a manner consistent with substance abuse treatment models.

Utilizing data from the U.S. Census Bureau and SAMHSA, the Applicant determined that there are approximately 3,209 adults in Connecticut with an income of over $200,000 annually with a substance abuse problem who may utilize the services of LHR. (Finding of Facts 18-28). Additionally, utilizing information from various sources such as the Department of Labor and the Department of Public Health and various articles concerning the prevalence of substance abuse among attorneys, physicians and other high earners, the Applicant determined there are approximately 5,235 attorneys, physicians, chief executives and financial executives with a substance abuse problem who may utilize the services of LHR. (Findings of Fact 30-38). OHCA concluded that these numbers were reasonable and based upon reliable sources of information. (Findings of Fact 38-39). Based upon all of the evidence provided, OHCA finds that the Applicant utilized reasonable methodologies to demonstrate a sufficient need among the relatively small well-defined population that LHR proposes to serve. (Finding of Fact 40).

Relying upon the aforementioned numbers, the Applicant provided volume projections for LHR in the first three years of operation. LHR expects to see a total of 136, 221 and 290 patients in years 1, 2 and 3, respectively. (Findings of Fact 44). Moreover, LHR anticipates that its Connecticut admissions for the same three years will be 80, 160 and 225. (Findings of Fact 44). OHCA finds that these projections are reasonable and achievable based upon the evidence provided. (Findingsof Fact 46).

The Intervenor asserted that there is excess capacity for the Applicant's target population without providing evidence of the same. (Findings of Fact 58). Additionally, although the Intervenor claimed that there is no need for the proposal, the Intervenor failed to provide evidence demonstrating that the Applicant's projections concerning its target population were unreasonable or that the information upon which those projections were based was unreliable. (Findings of Fact 59). Finally, even though the Intervenor may offer some services similar to those proposed by the Applicant, LHR provided sufficient evidence differentiating its facility from that of a psychiatric hospital. (Findings of Fact 61-64). Specifically, LHR demonstrated that it is a community rehabilitation facility as opposed to a psychiatric hospital and that it will provide services for individuals that have already received detoxification and who have been medically cleared by a referring physician. (Findings of Fact 64). Furthermore, LHR will provide its services in a relatively non-institutional setting with many amenities and a variety of services for its high end clientele. (Findings of Fact 66). Based upon all of the evidence, OHCA concludes that LHR is a unique facility that will provide services in a setting with certain amenities that are not widely available within the state of Connecticut.

The total capital cost associated with this CON proposal is $2,500,000. (Findings of Fact 93). Ms. Zurko-Smith as the sole owner of EO, the parent company of LHR, will be responsible for all the costs accrued. (Findings of Fact 99). The Applicant projects an incremental gain from operations of $1,017,341, $5,669,341 and $7,296,000, for fiscal years 1-3. (Findings of Fact 98). OHCA concludes based upon the evidence provided that the Applicant's volumes and financial projections upon which they are based appear to be reasonable and achievable.

Order

Based upon the foregoing Findings and Rationale, the Certificate of Need application of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC to establish a Free-Standing Residential Substance Abuse Treatment Facility in Bethlehem, Connecticut, at a total capital cost of $2,500,000, is hereby APPROVED, subject to the following conditions:

1. This authorization shall expire on May 7, 2012. Should the Applicant's proposal not be completed by that date, the Applicant must seek further approval from OHCA to complete the project.

2. The Applicant shall notify OHCA in writing of the commencement date of the proposed facility by no later than one month after the commencement date.

3. Within 30 days of receiving licensure from Connecticut Department of Public Health, the Applicant shall submit a copy of the license to OHCA.

4. Prior to opening its facility, the Applicant shall submit to OHCA a copy of the Certificate of Incorporation for Litchfield Hills Retreat, LLC.

Should the Applicant fail to comply with any of the aforementioned conditions, OHCA reserves the right to take additional action as authorized by law.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

Based upon the foregoing, I respectfully recommend to the Deputy Commissioner that the application of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC to establish a free-standing residential substance abuse treatment facility in Bethlehem, Connecticut, be approved.

5-7-10
Date

Melanie A. Dillon, Esq.
Hearing Officer

MAD:swl/lkg

LITCHFIELD HILLS RETREAT PROGRAM SCHEDULE

(All Information and Times Subject to Change)

	MON	TUES	WED	THU	FRI	SAT	SUN
6:00 AM	*Optional Wake-Up for 7am 12 Step Mtg*	*Optional Wake-Up for 7am 12 Step Mtg*	*Optional Wake-Up for 7am 12 Step Mtg*	*Optional Wake-Up for 7am 12 Step Mtg*	*Optional Wake-Up for 7am 12 Step Mtg*	Sleep-In	Sleep-In
7:00 AM	Wake up	Wake up	Wake up	Wake up	Wake up		
7:30 AM	Daily Reflection	Daily Reflection	Daily Reflection	Daily Reflection	Daily Reflection		
8:00 AM	Breakfast & Chores	Breakfast & Chores	Breakfast & Chores	Breakfast & Chores	Breakfast & Chores	8am Wake up, Daily Reflection, and Chores	8am Wake up, Daily Reflection, and Chores
9:00 AM	**GYM or Trail Walk** *9:00 AM*	**GYM or Trail Walk** *9 to 10:15 am*	**GYM or Trail Walk** *9:00 AM*	**GYM or Trail Walk** *9 to 10:15 am*	**GYM or Trail Walk** *9 to 10:15 am*	9am Breakfast	9am Breakfast
10:00 AM	*to 10:15 AM*	**or Acupuncture** *9 to 10am*	*to 10:15 AM*	**or Acupuncture** *9 to 10am*		**10am Big Book Study** *(Clients only)*	9:30 or 9:45 am Leave for AA or CA Mtg
						10am Family Group *(Family only)*	
11:00 AM	11 am to 12:15 pm Insight Oriented Group Psychotherapy	**Step1**	11 am to 12:15 pm Insight Oriented Group Psychotherapy	**Step1**	**Step1**	**11:30am Multi-Family Group** *(Family & Clients)*	
12:00 PM	Lunch	Lunch	Lunch	Lunch	Lunch	1pm Lunch	Lunch
1:30 PM	Meditation	Men's Issues or Women's Issues	VCHC - Service Outing 1:00 PM to 4:00 PM	Mood Regulation Group	**Step1**		Outing, Massage or Cooking (1pm-5pm)
3:30 PM	Big Book Study	Art Therapy		Psychodrama	Recreational Therapy or Free Time	**Saturday Family Visiting** *(2pm to 5pm)*	
5:00 PM	Dinner and Free Time	Dinner and Free Time	Dinner and Free Time	Dinner and Free Time	5:30pm Dinner and Free Time	5:30pm Dinner and Free Time	Dinner and Free Time
6:30 PM	*Depart for 12 Step Mtg or 7pm In-House Book Study*	*Depart for 12 Step Mtg or 7pm In-House Book Study*	***7:30pm Alumni Meeting***	*Depart for 12 Step Mtg or 7pm In-House Book Study*	*Depart for 12 Step Mtg or 7pm In-House Book Study*	Depart for Outside Mtg *(Or 7pm In-House Mtg)*	**Gratitude Group** Free time
9:30 PM	Wrap-Up *(Time may vary)*	Wrap-Up *(Time may vary)*	Wrap-Up *(Time may vary)*	Wrap-Up *(Time may vary)*	Wrap-Up *(Time may vary)*	Wrap-Up *(Time may vary)*	Wrap-Up *(Time may vary)*

Notes: Service Outing alternates with Equine Assisted Psychotherapy. Individual sessions with Primary Therapists occur 3 times per week during free times. Sessions with Family Therapists occur weekly in addition to the Saturday Family Program. The Alumni Meeting also includes current clients.

EXHIBIT 1

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

TRANSMISSION OK

TX/RX NO	1619
RECIPIENT ADDRESS	912032673813 ✓
DESTINATION ID	
ST. TIME	05/26 15:24
TIME USE	13'08
PAGES SENT	20
RESULT	OK ✓

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

FAX SHEET

TO: Michèle Zurico-Smith ✓

FAX: (203) 267-3813

AGENCY: OHCA / DPH

FROM: Steven Lazarus

DATE: 5/26/10 **TIME:** 3:15

NUMBER OF PAGES: 20
(including transmittal sheet

Comments:
Final Decision Enclosed for Docket # 09-315 re CONN

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

TRANSMISSION OK

TX/RX NO	1620
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ST. TIME	05/26 15:38
TIME USE	12'52
PAGES SENT	20
RESULT	OK

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

FAX SHEET

TO: Michele Volpe, Esq.

FAX: (203) 777-5806

AGENCY: OHCA / DPH

FROM: Steven Lazarus

DATE: 5/26/10 **TIME:** 3:15

NUMBER OF PAGES: 20
(including transmittal sheet

Comments: Final Decision Enclosed for DN: 09-31500-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

TRANSMISSION OK

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TIME USE	05'19
PAGES SENT	20
RESULT	OK

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

FAX SHEET

TO: Paul Knag, Esq.

FAX: (203) 653-5444

AGENCY: OHCA / DPH

FROM: Steven Lazarus

DATE: 5/26/10 **TIME:** 3:15

NUMBER OF PAGES: 20
(including transmittal sheet

Comments: Final Decision Enclosed for 09-31500-CON.

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2010 MAY 28 P 12:57
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

FAX TRANSMISSION

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET
THIRD FLOOR
NEW HAVEN, CT 06511
(203) 777-5800 Fax: (203) 777-5806

FAX #: (860) 418-7053
TO: Honorable Cristine Vogel
Office of Health Care Access

DATE: May 28, 2010

PAGES: 5 including this page

FROM: Michele M. Volpe

MATTER #: 105056

SUBJECT:

Re: Docket No. 09-31500-CON
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Proposal to Establish a Fee Standing Substance Abuse Facility in Bethlehem

CONFIDENTIALITY NOTICE
Please note that the information contained in this fax is confidential and privileged and is intended only for use by the named receiver. If you have received this fax in error, please call 203-777-5800. Any use of this fax or its contents, including any dissemination or copying, is prohibited. Attorneys receiving this fax in error are directed to review ABA formal ethics opinion no. 92-368.

COMMENTS:

Dear Commissioner Vogel:

Please see the attached.

Thank you.

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

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2010 MAY 28 P 12:57
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HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

May 28, 2010
Via Facsimile (860) 418-7053
and USPS 1st Class Mail

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC D/B/A Litchfield Hills Retreat, LLC
Proposal to Establish a Free Standing Residential Adult
Substance Abuse Center in Bethlehem

Dear Deputy Commissioner Vogel:

Pursuant to condition #4 of the Office of Health Care Access' Final Order in the above referenced Docket, enclosed please find the Articles of Organization of Litchfield Hills Retreat, LLC and the Secretary of the State's Acceptance of Business Filing of the same.

Thank you.

Very truly yours,

Michele M. Volpe

Enclosures
cc: Michele Zurko-Smith, Litchfield Hills Retreat, LLC

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\Ltr to OHCA re Articles of Org (5.28.10).docx

ARTICLES OF ORGANIZATION

DOMESTIC LIMITED LIABILITY COMPANY

Office of the Secretary of the State
30 Trinity Street / P.O. Box 150470 / Hartford, CT 06115-0470 / Rev. 11/06/2001
See reverse for instructions

Space For Office Use Only — Filing Fee: $60.00

1. NAME OF THE LIMITED LIABILITY COMPANY:
Litchfield Hills Retreat, LLC

2. NATURE OF BUSINESS TO BE TRANSACTED OR THE PURPOSES TO BE PROMOTED OR CARRIED OUT: to own, operate and manage a holistic spa and retreat and to do any and all other activities related or incidental thereto.

3. PRINCIPAL OFFICE ADDRESS: (Provide complete address. See instructions for further details.)
91 Willenbrock Road, Unit 3A, Oxford, CT 06478

4. APPOINTMENT OF STATUTORY AGENT FOR SERVICE OF PROCESS:

Name of agent:	Business address: (P.O. Box is not acceptable)
Jeffrey W. Tuccio	**235 Wakelee Avenue** **Ansonia, CT 06401**
	Residence address: (P.O. Box is not acceptable) **30 Somerset Lane** **Milford, CT 06460**

Acceptance of appointment

Signature of agent – Jeffrey W. Tuccio

5. MANAGEMENT:

(Place a check mark next to the following statement *only* if it applies)

The management of the limited liability company shall be vested in one or more managers.

6. MANAGER(S) OR MEMBER(S) INFORMATION

Name	Title	Residence Address	Business Address
Michele Zurko-Smith	Member	12 Trefoil Drive Oxford, CT 06478	91 Willenbrock Road, Unit 3A Oxford, CT 06478

7. EXECUTION:

Dated this 31st day of March, 2009

Michele Zurko-Smith — Print or type name of organizer

Signature

Reference an 8 ½ x 11 attachment if additional space is required

P:\PAUL\LLC\LITCHFIELD HILLS RETREAT LLC ART ORG.DOC

SECRETARY OF THE STATE
30 TRINITY STREET
P.O. BOX 150470
HARTFORD, CT 06115-0470

APRIL 2,2009

JEFFREY W TUCCIO
LYONS TUCCIO & TUCCIO LLC
235 WAKELEE AVE
ANSONIA, CT 06401

RE: Acceptance of Business Filing

This letter is to confirm the acceptance of the following business filing:

Business Name:
LITCHFIELD HILLS RETREAT, LLC

Work Order Number: 2009080887-001
Business Filing Number: 0003899751
Type of Request: ARTICLES OF ORGANIZATION
File Date/Time: APR 01 2009 08:30 AM
Effective Date/Time:
Work Order Payment Received: 170.00
Payment Received: 85.00
Credit on Account: .00
Customer Id: 001684117
Business Id: 0967487

JAMES AUGERI
Commercial Recording Division
860-509-6048
WWW.CONCORD.SOTS.CT.GOV

BUSINESS FILING REPORT

WORK ORDER NUMBER:2009080887-001
BUSINESS FILING NUMBER: 0003899751

BUSINESS NAME:

LITCHFIELD HILLS RETREAT, LLC

BUSINESS LOCATION:

91 WILLENBROCK ROAD, UNIT 3A
OXFORD,CT 06478

MEMBER INFORMATION FOR ONE MEMBER:

NAME:MICHELE ZURKO-SMITH
TITLE:MEMBER

** END OF REPORT **

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

RECEIVED
2010 JUN -1 P 12:00
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Michele M. Volpe
Direct Dial (203) 777-6995

May 28, 2010
Via Facsimile (860) 418-7053
and USPS 1st Class Mail

Deputy Commissioner Cristine Vogel
Department of Public Health
Division of Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 09-31500-CON
Employment Options, LLC D/B/A Litchfield Hills Retreat, LLC
Proposal to Establish a Free Standing Residential Adult Substance Abuse Center in Bethlehem

Dear Deputy Commissioner Vogel:

Pursuant to condition #4 of the Office of Health Care Access' Final Order in the above referenced Docket, enclosed please find the Articles of Organization of Litchfield Hills Retreat, LLC and the Secretary of the State's Acceptance of Business Filing of the same.

Thank you.

Very truly yours,

Michele M. Volpe

Enclosures
cc: Michele Zurko-Smith, Litchfield Hills Retreat, LLC

F:\Doc\10 5051-5100\105056 Zurko-Smith re OHCA\Letters\Ltr to OHCA re Articles of Org (5.28.10).docx

ARTICLES OF ORGANIZATION

DOMESTIC LIMITED LIABILITY COMPANY

Office of the Secretary of the State
30 Trinity Street / P.O. Box 150470 / Hartford, CT 06115-0470 / Rev. 11/06/2001
See reverse for instructions

RECEIVED
2010 JUN -1 P 12:00
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Space For Office Use Only **Filing Fee: $60.00**

1. NAME OF THE LIMITED LIABILITY COMPANY:
Litchfield Hills Retreat, LLC

2. NATURE OF BUSINESS TO BE TRANSACTED OR THE PURPOSES TO BE PROMOTED OR CARRIED OUT: to own, operate and manage a holistic spa and retreat and to do any and all other activities related or incidental thereto.

3. PRINCIPAL OFFICE ADDRESS: (Provide complete address. See instructions for further details.)
91 Willenbrock Road, Unit 3A, Oxford, CT 06478

4. APPOINTMENT OF STATUTORY AGENT FOR SERVICE OF PROCESS:

Name of agent:	Business address: (P.O. Box is not acceptable)
Jeffrey W. Tuccio	**235 Wakelee Avenue** **Ansonia, CT 06401**
	Residence address: (P.O. Box is not acceptable) **30 Somerset Lane** **Milford, CT 06460**

Acceptance of appointment

Signature of agent – Jeffrey W. Tuccio

5. MANAGEMENT:
(Place a check mark next to the following statement ***only*** if it applies)

_____The management of the limited liability company shall be vested in one or more managers.

6. MANAGER(S) OR MEMBER(S) INFORMATION

Name	Title	Residence Address	Business Address
Michele Zurko-Smith	Member	**12 Trefoil Drive** **Oxford, CT 06478**	91 Willenbrock Road, Unit 3A Oxford, CT 06478

7. EXECUTION:
Dated this 31st day of March, 2009

Michele Zurko-Smith	
Print or type name of organizer	Signature

Reference an 8 ½ x 11 attachment if additional space is required

F:\PAULA\LLC\LITCHFIELD.HILLS.RETREAT.LLC.ART.ORG.DOC

SECRETARY OF THE STATE
30 TRINITY STREET
P.O. BOX 150470
HARTFORD, CT 06115-0470

APRIL 2,2009

JEFFREY W TUCCIO
LYONS TUCCIO & TUCCIO LLC
235 WAKELEE AVE
ANSONIA, CT 06401

RE: Acceptance of Business Filing

This letter is to confirm the acceptance of the following business filing:

Business Name:
LITCHFIELD HILLS RETREAT, LLC

Work Order Number: 2009080887-001
Business Filing Number: 0003899751
Type of Request: ARTICLES OF ORGANIZATION
File Date/Time: APR 01 2009 08:30 AM
Effective Date/Time:
Work Order Payment Received: 170.00
Payment Received: 85.00
Credit on Account: .00
Customer Id: 001684117
Business Id: 0967487

JAMES AUGERI
Commercial Recording Division
860-509-6048
WWW.CONCORD.SOTS.CT.GOV

BUSINESS FILING REPORT

WORK ORDER NUMBER:2009080887-001
BUSINESS FILING NUMBER: 0003899751

BUSINESS NAME:

LITCHFIELD HILLS RETREAT, LLC

BUSINESS LOCATION:

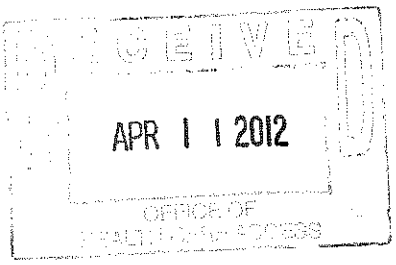
91 WILLENBROCK ROAD, UNIT 3A
OXFORD,CT 06478

MEMBER INFORMATION FOR ONE MEMBER:

NAME:MICHELE ZURKO-SMITH
TITLE:MEMBER

** END OF REPORT **

April 11, 2012



VIA HAND DELIVERY

Kimberly R. Martone, Director of Operations
Office of Health Care Access
410 Capital Avenue, MS #13HCA
P. O. Box 340308
Hartford, CT 06106

Re: Litchfield Hills Retreat, LLC
Establishment of a Free-Standing Residential Substance Abuse Facility in Bethlehem, Connecticut
Docket No. 09-31500

Dear Ms. Martone,

Enclose please find an original and three (3) copies of a Form for Modification of a Previously Authorized Certificate of Need requesting a one-year extension of the CON expiration deadline for the Litchfield Hills Retreat project. The Final Decision in this matter was issued on May 26, 2010, and in accordance with Section 19a-639b(a) of the Connecticut General Statutes, the CON is set to expire on May 26, 2012. In consideration of the good faith efforts towards project completion detailed in the attached Modification Request, Litchfield Hills Retreat, LLC respectfully requests an extension of the CON through May 26, 2013.

Please feel free to contact me with any questions.

Sincerely,

Michele L. Zurko-Smith
Sole Member
Litchfield Hills Retreat, LLC

/mlz

cc: Jennifer L. Groves, Esq.

RECEIVED
APR 11 2012
OFFICE OF HEALTH CARE ACCESS

State of Connecticut
Office of Health Care Access
Form for Modification of a Previously Authorized Certificate of Need

All persons who are requesting a modification to a previously authorized Certificate of Need must complete this form. Completed forms should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	**Litchfield Hills Retreat, LLC**[1]	
Doing Business As	**Litchfield Hills Retreat**	
Name of Parent Corporation	**N/A**	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	**91 Willenbrock Road Unit 3A Oxford, CT 06478**	
Petitioner type (e.g., P for profit and NP for Not for Profit)	**Profit**	
Name of Contact person, including title	**Michele Zurko-Smith, Member**	

[1] The CON in Docket No. 09-31500-CON was issued to Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC, of 12 Trefoil Road, Oxford, Connecticut. However, the Applicant proposed that Litchfield Hills Retreat, LLC, a separate legal entity, would own and operate the facility. Condition No. 4 of the Final Decision requires that the Applicant provide OHCA with a Certificate of Incorporation for Litchfield Hills Retreat, LLC prior to opening the facility. Litchfield Hills Retreat, LLC was registered with the Secretary of State of Connecticut on April 1, 2009, as a domestic limited liability company. A copy of the Articles of Organization for Litchfield Hills Retreat, LLC, and evidence of filing of same with the Secretary of State, are attached as Exhibit A.

Contact person's street mailing address	**91 Willenbrock Road Unit 3A Oxford, CT 06478**	
Contact person's phone, fax and e-mail address	**(203) 206.8212 (Tel.) (203) 267-3813 (Fax) mlzurko@aol.com**	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Title of Previously Authorized Project and Associated Docket Number(s):

Establishment of a Free-Standing Residential Substance Abuse Facility in Bethlehem, Connecticut – Docket No. 09-31500-CON

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

64 Double Hill Road, Bethlehem, CT 06751

c. Type of Modification Request:

☐ Change in the Scope of the Authorized Certificate of Need Project

☒ Extension of CON Expiration Date

☐ Change in a CON Order Condition *(other than to extend expiration date)*

☐ Other – Describe: _____

SECTION III. IF REQUESTING A CHANGE IN THE SCOPE OF AUTHORIZED PROJECT:

a. Provide a one page description of the requested change in the scope of a previously authorized Certificate of Need project and provide a detailed rationale for such change:

SECTION IV. IF REQUESTING AN EXTENSION OF THE CON EXPIRATION DATE:

a. Certificate of Need expiration date per CON Final Decision: **May 26, 2012**[2]

b. Requested revised CON expiration date: **May 26, 2013**

[2] While Condition No. 1 of the Proposed Final Decision references an expiration date of May 7, 2012, the Final Decision was issued on May 26, 2010, and in accordance with Section 19a-639b(a) of the Connecticut General Statutes, the CON is valid for two years, or until May 26, 2012.

c. Rationale for increased time to fully complete and implement the authorized project:

The CON issued to Employment Options d/b/a Litchfield Hills Retreat, LLC ("Employment Options") in Docket No. 09-31500-CON authorizes the establishment of a 28-bed residential substance abuse treatment facility in Bethlehem. The facility will be located on property owned by Michelle Zurko-Smith, the President and CEO of Employment Options and sole member of Litchfield Hills Retreat, LLC ("Litchfield Hills Retreat"). Litchfield Hills Retreat will be the licensed operator of the facility.

As set forth in the CON Application and testified to at the public hearing on this matter, this project is being completed in phases. The first phase, which is near completion, involves operationalizing eight beds in the existing 7,500 square foot house located on the property. The second phase involves construction of two additional buildings on the property to house the remaining 20 beds. Due to unforeseen issues with land use and other local approvals, there have been delays in completing both phases of the project. While all such issues have been resolved, additional time is required to bring the initial eight beds online and to complete construction of the new buildings. For this reason, and in consideration of Ms. Zurko-Smith's good faith efforts and progress towards project completion, the Applicant is requesting a one-year extension of the CON expiration deadline.

By way of background, when the CON for this project was authorized in May of 2010, the Town of Bethlehem had in place a nine-month moratorium on the establishment of residential substance abuse facility, which was set to expire. Throughout the summer of 2010, the Town of Bethlehem held public hearings around the possible extension of this moratorium and/or the passage of an ordinance that would restrict the development of such facilities. Ms. Zurko-Smith submitted (or attempted to submit) various applications and plans for approval and was met with delays. The moratorium was not extended and no prohibitive ordinances were passed, however, the conduct of the Town of Bethlehem in connection with approval of the Litchfield Hills Retreat project led Ms. Zurko-Smith to file a federal lawsuit alleging, among other things, that the Town of Bethlehem violated both the Americans With Disabilities Act and the Fair Housing Act (*see* Zurko-Smith v. Town of Bethlehem, Docket No. 09CV 1667 (WWE)).

Despite the uncertainty of approval from the Town of Bethlehem, Ms. Zurko-Smith began work on Phase I, which involved operationalizing eight beds in the existing house at 64 Double Hill Road. The house was fitted out for the eight beds, as well as necessary administrative and program space. Litchfield Hills Retreat filed an Initial Licensure Application with the Department of Public Health ("DPH") for a Facility for the Care or Treatment of Substance Abusive or Dependent Persons. A representative of the Division of Building & Fire Safety inspected and approved the facility to open, subject to local Fire Marshal approval. The Fire Marshal withheld approval unless and until Litchfield Hills Retreat put sprinklers in the house. The sprinklers were installed in 2011, and Litchfield Hills Retreat obtained Fire Marshal approval and a Certificate of Occupancy (see Exhibit B attached). Ms. Zurko-Smith has been advised that, subject to providing DPH with updated insurance certificates, the name of the facility's Clinical Director and a few remaining items, and possibly subject to a re-visit by the Division of Building & Fire

Safety, the license will be issued. Litchfield Hills Retreat anticipates opening the eight beds within the next several months.

Litchfield Hills Retreat has also been planning for the construction of two additional buildings, which will allow it to open the remaining 20 approved beds for patients. The uncertainty of Town of Bethlehem approval, the federal litigation and the delay in bringing the first 8 beds online has resulted in delays in this process as well. Plans for the new buildings were submitted to the Town of Bethlehem for approval and were reviewed on multiple occasions with the local Building Official and Fire Marshall. Foundation permits were issued in August of 2011 (see Exhibit C attached) and building permits were issued in October of 2011 (see Exhibit D attached). The commencement of construction was thereafter put on hold in consideration of the upcoming winter and anticipated bad weather. Litchfield Hills Retreat has also received various approvals from the Torrington Area Health District relative to the septic system on the property (see Exhibit E attached).

Now that all necessary local approvals have been obtained, Litchfield Hills Retreat is prepared to begin construction. The foundations have been staked. Litchfield Hills Retreat anticipates that it will take one year to construct the new buildings, prepare the new buildings for patients, relocate administrative/clinical staff, and bring the 20 beds online. Based on the foregoing, Litchfield Hills Retreat is requesting a 12-month extension of the CON expiration deadline, through May 26, 2013.

SECTION V. IF REQUESTING A CHANGE IN A CON FINAL DECISION CONDITION *(other than extension of the CON expiration date)*

a. Identify the CON Condition that you are requesting to be revised or vacated.

_____

b. Provide the rationale for such requested change:

_____

_____

_____

_____

_____

SECTION VI. OTHER

a. Submit a completed CON Modification Affidavit.

See attached.

b. Identify any other pertinent changes to the findings of facts upon which the original CON authorization was based as a result of this requested modification.

N/A

c. Identify what has been accomplished to date in terms of full project implementation.

See Section IV.c. above.

CON MODIFICATION AFFIDAVIT

Applicant: **Litchfield Hills Retreat, LLC**

Project Title: **Establishment of a Free-Standing Residential Substance Abuse Facility in Bethlehem, Connecticut**

I, **Michele Zurko-Smith**, **CEO/Sole Member** of **Litchfield Hills Retreat, LLC** being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge.

.

Signature _____ Date 4-11-2012

Subscribed and sworn to before me on April 11, 2012

Deborah L Allen
Notary Public/Commissioner of Superior Court

My commission expires: 10/31/2013

EXHIBIT A

ARTICLES OF ORGANIZATION

DOMESTIC LIMITED LIABILITY COMPANY

Office of the Secretary of the State
30 Trinity Street / P.O. Box 150470 / Hartford, CT 06115-0470 / Rev. 11/06/2001
See reverse for instructions

Space For Office Use Only	Filing Fee: $60.00

1. NAME OF THE LIMITED LIABILITY COMPANY:
Litchfield Hills Retreat, LLC

2. NATURE OF BUSINESS TO BE TRANSACTED OR THE PURPOSES TO BE PROMOTED OR CARRIED OUT: to own, operate and manage a holistic spa and retreat and to do any and all other activities related or incidental thereto.

3. PRINCIPAL OFFICE ADDRESS: (Provide complete address. See instructions for further details.)
91 Willenbrock Road, Unit 3A, Oxford, CT 06478

4. APPOINTMENT OF STATUTORY AGENT FOR SERVICE OF PROCESS:

Name of agent:	Business address: (P.O. Box is not acceptable)
Jeffrey W. Tuccio	**235 Wakelee Avenue** **Ansonia, CT 06401**
	Residence address: (P.O. Box is not acceptable) **30 Somerset Lane** **Milford, CT 06460**

Acceptance of appointment

Signature of agent – Jeffrey W. Tuccio

5. MANAGEMENT:
(Place a check mark next to the following statement ***only*** if it applies)

_____The management of the limited liability company shall be vested in one or more managers.

6. MANAGER(S) OR MEMBER(S) INFORMATION

Name	Title	Residence Address	Business Address
Michele Zurko-Smith	**Member**	**12 Trefoil Drive** **Oxford, CT 06478**	**91 Willenbrock Road, Unit 3A** **Oxford, CT 06478**

7. EXECUTION:
Dated this 31st day of March, 2009

Michele Zurko-Smith	
Print or type name of organizer	Signature

Reference an 8 ½ x 11 attachment if additional space is required

F:\PAULA\LLC\LITCHFIELD.HILLS.RETREAT.LLC.ART.ORG.DOC

Business Inquiry

HOME HELP

Business Inquiry Details

Business Name:	**LITCHFIELD HILLS RETREAT, LLC**	Business Id:	**0967487**
Business Address:	**91 WILLENBROCK ROAD, UNIT 3A, OXFORD, CT, 06478**	Mailing Address:	**91 WILLENBROCK ROAD, UNIT 3A, OXFORD, CT, 06478**
Citizenship/State Inc:	**Domestic/CT**	Last Report Year:	**2010**
Business Type:	**Domestic Limited Liability Company**	Business Status:	**Active**
Date Inc/Register:	**Apr 01, 2009**		

Principals

Name/Title:	Business Address:	Residence Address:
MICHELE ZURKO-SMITH MEMBER	12 TREFOIL DRIVE, OXFORD, CT, 06478	91 WILLENBROCK ROAD, UNIT 3A, OXFORD, CT, 06478

Business Summary

Agent Name:	**JEFFREY W. TUCCIO**
Agent Business Address:	**235 WAKELEE AVENUE, ANSONIA, CT, 06401**
Agent Residence Address:	**30 SOMERSET LANE, MILFORD, CT, 06460**

View Filing History View Name History View Shares

Back

EXHIBIT B

Attn: K. Kass,

Town of Bethlehem
Office of the Building Official
Certificate of Occupancy

Property Owner; Michele Zurko Smith

Address; 64 Double Hill Road, Bethlehem CT

Permit Number; 2171...(and others subsequently)

Date; July 21, 2011

This is to certify that a Certificate of Occupancy be issued for the Litchfield Hills Retreat (Building # 1) construction to existing home at the 64 Double Hill Road, Bethlehem property of Michele Zurko Smith.

The construction under permit 2171 dated March 4, 2011 (and others subsequently) has been approved and conforms to the building codes of the State of Connecticut and those of the Town of Bethlehem.

Stipulations:

- Facility will become a Public Water Supply when population reaches 25 or greater (per TAHD)
- Annual Fire Marshal inspections required, per Connecticut State General Statutes

Approved for Use: R4

Note:

1. Edition of the building code under which the permit was issued; IBC 2003, 2003-IBC Portion of the 2005 & 2009 Amendments of state Building Code State of Connecticut and 2005 NEC-70
2. 2005 Connecticut Fire Safety Code with 2009 State of Connecticut Fire Safety Code Amendments
3. Sprinkler system installed throughout Building # 1, NFPA 13 R

Building Official, Roger D. Natusch

Roger D. Natusch

Town of Bethlehem 36 Main Street South, P.O.Box16, Bethlehem CT 0675
Telephone 203-266-5703 Fax 203-266-7670

cc. Selectmen Firemarshal M. Lynch, TAHD

EXHIBIT C

August 10, 2011
Permit # 2300
Building # 2
Litchfield Hills Retreat LLC
64 Double Hill Road
Rockfall Company 860-790-6291

INSPECTION RECORD

TOWN OF BETHLEHEM

~~Building~~ Extension 2/15/12

C.O. _____

	Inspector	Date	Remarks
Building Footings* 10/11/11 #2383			
Drains and Waterproofing* 10/11/11 2384			
Structural (Rough)* 10/11/11 2384			
Insulation* 10/11/11 2384			
Plumbing (Underground)			
Plumbing (test)			
Heating			
Air Conditioning			
Rough Wiring			
Electric Service			
~~Demolition~~ Stake at	RWW	10-18-11	OK
Fireplace / Hearth / Smokeshelf			

Final Inspection Approved _____ Date _____

Certificate of Occupancy or Use _____ Date _____

[redacted]

August 10, 2011
Permit # 2301
Building #~~3~~ (3)
Litchfield Hills Retreat LLC
64 Double Hill Road
Rockfall Company 860-790-6291

INSPECTION RECORD

TOWN OF BETHLEHEM

Extension 2/15/12

C.O. _____

foundation only	Inspector	Date	Remarks
Building Footings * #2384			
Drains and Waterproofing * #2384			
Structural (Rough) * 2384			
Insulation * 2384			
Plumbing (Underground)			
Plumbing (test)			
Heating			
Air Conditioning			
Rough Wiring			
Electric Service			
~~Demolition~~ Stake out	RAS	10-18-11	
Fireplace / Hearth / Smokeshelf			

Final Inspection Approved _____ Date _____

Certificate of Occupancy or Use _____ Date _____

[redacted]

EXHIBIT D

Town of Bethlehem
Office of the Fire Marshal
36 Main Street South
Bethlehem CT 06751

October 6, 2011

Mr. Henry Racki
Rockfall Company
57 Carriage Drive
Durham, CT 06422

Re: 64 Double Hill Road, Bethlehem CT

The Fire Marshal and the Building Official have reviewed all of the revisions of the Building Code and Fire Code corrections you and your Engineers have submitted to the original prints submitted to our office, over the last few months. These reviews were completed today. All of the information and prints provided substantially meet both the Connecticut State Building Code and State Fire Code.

The additional deck ramps blue prints shall be submitted for review and approval prior to construction, an additional building permit will be needed at that time.

Please stop by the office and submit an application for the building permit for this project.

If you should have any questions please contact the office.

Sincerely,

David P. Hardt
Fire Marshal

Roger D. Natusch
Building Official

Cc: Michael Lynch, Esq.

TOWN OF BETHLEHEM
APPLICATION

PLANNING APPROACH	PERMIT NO.	C. OF
DATE:	No 2383	DATE:

PERMISSION IS HEREBY GRANTED TO: **OWNER**

OWNER: LITCHFIELD HILLS RETREAT LLC

ADDRESS: 64 DOUBLE HILL RD BETHLEHEM CT

TO ERECT A: RESIDENCE BUILDING #2

LOCATION: 64 DOUBLE Hill Rd

BUILDING, STREET AND SIDE LOT LINES TO BE AS CERTIFIED ON PLOT PLAN ON FILE

APPLICANT

COMPANY NAME: THE ROCKFALL COMPANY LLC — LICENSE # 0000-352

NAME: Henry RACKI — CELL PHONE # 860-790-6291

ADDRESS: PO BOX 66 ROCKFALL CT 06481

APPROVED BY: _____ BUILDING OFFICIAL — DATE: 10/11/11

TYPE OF WORK	EST. COST	FEES	CONTRACTOR'S SIGNATURE
FOUNDATION			
STRUCTURAL			
PLUMBING			
HEATING			
AIR CONDITIONING			
ELECTRIC WIRING			
ELECTRIC SERVICE			
DEMOLITION			
TOTAL COST	$	$ 5529.92	TOTAL FEES

See enclosed

DESCRIPTION OF WORK

USE GROUP	TYPE WATER PROOFING	FOOTING DRAINS REQUIRED YES ☐ NO ☐	SIZE _____ x _____		FOUNDATION SIZE	FOOTING SIZE
TYPE CONSTR.	AREA SQ. FT		NO. ROOMS	GARAGE SIZE _____ x _____		NO. FAMILIES
	CEILING HEIGHTS	CELLAR	1ST	2ND	WOOD DECK SIZE _____ x _____	WINGS _____ x _____
TUBS	SHOWER STALLS	LAV.	SINKS	CLOSETS	LAUNDRY ROOM	MISCELLANEOUS
TYPE INSTALL		BOILER MAKE	SIZE		BURNER NAME	NO. ZONES
MAKE	SIZE		NO. ZONES			
NO. OUTLETS	NO. CIRCUITS		SUB-PANELS			
☐ TEMP ☐ NEW	AMPS		OUTSIDE DISCONNECT ☐ YES ☐ NO		GROUNDING WATER MAIN ☐ YES ☐ NO	

SEE PLANS

pd ck# 10818

INSPECTIONS REQUIRED

TEL (203) 266-5703

BEFORE POURING FOOTING
BEFORE BACKFILL
FRAMING
ELECTRICAL (INCLUDING SERVICE)
MECHANICAL
INSULATION
FIREPLACE/HEARTH/SMOKE
ON COMPLETION (FOR C.O.)

ADDITIONAL REMARKS:

CERTIFICATION: I hereby certify that [ ] I am the owner of record of the named property or [ ] the proposed work is authorized by the owner of record and/or I have been authorized to make this application as an authorized agent, and we agree to conform to all applicable laws, regulations and ordinances. All information contained within is true and accurate to the best of my knowledge and belief.

Signature (in ink)

PERMITS ARE NOT VALID IF CONSTRUCTION WORK IS NOT STARTED WITHIN SIX MONTHS FROM DATE PERMIT IS ISSUED. ALL WORK TO BE DONE ACCORDING TO THE REGULATIONS OF THE TOWN OF BETHLEHEM AND APPLICABLE STATE REGULATIONS. NO CHANGES WILL BE MADE TO APPROVED PLOT PLANS, BUILDING PLANS OR SPECIFICATIONS UNLESS AUTHORIZED BY THE BUILDING OFFICIAL.

THIS APPLICATION VOID UNLESS PROPERLY COMPLETED

WHITE – BUILDING INSPECTION COPY • CANARY – ASSESSOR'S COPY • PINK – TAX COLLECTOR COPY

TOWN OF BETHLEHEM
APPLICATION

PLANNING APPROACH	PERMIT NO.	C. OF
DATE:	№ 2364	DATE:

PERMISSION IS HEREBY GRANTED TO: **OWNER**

OWNER: LITCHFIELD HILLS RETREAT LLC

ADDRESS: 64 DOUBLE HILL RD BETHLEHEM CT

TO ERECT A: RESIDENCE BUILDING 03'

LOCATION: 64 DOUBLE HILL RD

BUILDING, STREET AND SIDE LOT LINES TO BE AS CERTIFIED ON PLOT PLAN ON FILE

APPLICANT

COMPANY NAME: THE ROCKFALL COMPANY LLC — LICENSE # 000 352

NAME: HENRY RACH. JR — PHONE # 860 [illegible] 6291

ADDRESS: PO BOX 56 ROCKFALL CT 06481

APPROVED BY: Ryan D Roland — BUILDING OFFICIAL — DATE: 10/11/11

TYPE OF WORK	EST. COST	FEES	CONTRACTOR'S SIGNATURE
FOUNDATION			
STRUCTURAL			
PLUMBING			
HEATING			
AIR CONDITIONING			
ELECTRIC WIRING			
ELECTRIC SERVICE			
DEMOLITION			
TOTAL COST	$	$ 5529.43	TOTAL FEES

DESCRIPTION OF WORK

USE GROUP	TYPE WATER PROOFING	FOOTING DRAINS REQUIRED YES ☐ NO ☐	SIZE ___ x ___	FOUNDATION SIZE	FOOTING SIZE
TYPE CONSTR.	AREA SQ. FT		NO. ROOMS	GARAGE SIZE ___ x ___	NO. FAMILIES
	CEILING HEIGHTS	CELLAR	1ST	2ND	WOOD DECK SIZE ___ x ___ / WINGS ___ x ___
TUBS	SHOWER STALLS	LAV.	SINKS	CLOSETS	LAUNDRY ROOM / MISCELLANEOUS
TYPE INSTALL	BOILER MAKE	SIZE	BURNER NAME	NO. ZONES	
MAKE	SIZE	NO. ZONES			
NO. OUTLETS	NO. CIRCUITS	SUB-PANELS			
☐ TEMP ☐ NEW	AMPS	OUTSIDE DISCONNECT ☐ YES ☐ NO	GROUNDING WATER MAIN ☐ YES ☐ NO		

SEE PLANS

pd ck 10519

INSPECTIONS REQUIRED

TEL (203) 266-5703

BEFORE POURING FOOTING
BEFORE BACKFILL
FRAMING
ELECTRICAL (INCLUDING SERVICE)
MECHANICAL
INSULATION
FIREPLACE/HEARTH/SMOKE
ON COMPLETION (FOR C.O.)

ADDITIONAL REMARKS:

CERTIFICATION: I hereby certify that [ ] I am the owner of record of the named property or [ ] the proposed work is authorized by the owner of record and/or I have been authorized to make this application as an authorized agent, and we agree to conform to all applicable laws, regulations and ordinances. All information contained within is true and accurate to the best of my knowledge and belief.

Signature (in ink)

PERMITS ARE NOT VALID IF CONSTRUCTION WORK IS NOT STARTED WITHIN SIX MONTHS FROM DATE PERMIT IS ISSUED. ALL WORK TO BE DONE ACCORDING TO THE REGULATIONS OF THE TOWN OF BETHLEHEM AND APPLICABLE STATE REGULATIONS. NO CHANGES WILL BE MADE TO APPROVED PLOT PLANS, BUILDING PLANS OR SPECIFICATIONS UNLESS AUTHORIZED BY THE BUILDING OFFICIAL.

THIS APPLICATION VOID UNLESS PROPERLY COMPLETED

WHITE – BUILDING INSPECTION COPY • CANARY – ASSESSOR'S COPY • PINK – APPLICANT'S COPY

Smith 64 Double Hill Road (#2) #3 same
Phase I

3523 sq. ft.		x 112.01	= 3948.35
Ed. fee	+	x .26	= 1026.57
C/O	+		= 30.00
Sprinkler review (1-100 spr)			= 275.00
Plan review			= 250.00
	Total		5529.92

~~10/7/11 Plans to be submitted~~
waiting on decking & handicamp

[redacted]

EXHIBIT E

TORRINGTON AREA HEALTH DISTRICT

350 Main Street • Suite A • Torrington, Connecticut 06790
Phone (860) 489-0436 • Fax (860) 496-8243 • E-mail info@tahd.org • Web Address www.tahd.org

"Promoting Health & Preventing Disease Since 1967"

PAID $250
5-20-11
CK 7886

APPLICATION & APPROVAL FOR A NEW SEPTIC SYSTEM

Notes: This Approval Expires 12 Months From Date Of Issuance.
This Is Only A Plan Approval - Not A Permit To Construct - Installer Must Obtain A Separate Permit Prior To Any Work.

STREET ADDRESS OF PLAN 164 Double Hill Rd TOWN Bethlehem

SUBDIVISION NAME Bldg. #2 LOT # _____

ENGINEER NAME Berkshire Engineering & Surveying, LLC PHONE 860-567-8007

ENGINEER STREET ADDRESS 143 Bantam Lake Rd TOWN Bantam ZIP 06750

OWNER Michele Zurko-Smith PHONE 203-206-8212

MAILING ADDRESS 116 Main St N. TOWN Bethlehem ZIP _____

RESIDENTIAL STRUCTURE:

NUMBER OF BEDROOMS _____ TOILETS / SINKS IN BASEMENT – YES ( ) NO ( ) GARBAGE GRINDER YES ( ) NO ( )

JACUZZI OR WHIRLPOOL _____ CAPACITY IN GALLONS _____

* SIZE OF (FUTURE?) SWIMMING POOL – ABOVE GROUND _____ BELOW GROUND _____
(* If future pool location is known at the time of the application it should be shown on design plan.)

COMMERCIAL OR NON-RESIDENTIAL:

SQUARE FOOTAGE OF BUILDING 3525 (x2) INTENDED USE Social Rehab

NUMBER OF EMPLOYEES _____

DESIGN FLOW _____ Bldg. #2

TOILETS / SINKS IN BASEMENT - YES ( ) NO (X)

A COPY OF ANY EASEMENTS OR DEED RESTRICTIONS MUST BE ATTACHED

CLOSEST PUBLIC WATER LINE _____

UNDERGROUND STORAGE TANKS? YES ( ) NO (X)

- This application must be accompanied by the fee of **$250.00**, two (2) sets of engineered plans showing the map, block and lot numbers and one (1) set of returnable building plans. (Returned Check Fee **$25**)
- The applicant understands that the results of any tests conducted by or on behalf of the Torrington Area Health District are public information. The responsibility for the proper maintenance and operation of this septic system is entirely the owner's.

APPLICANT SIGNATURE Vincent Marino, Esq DATE 5.20.11 PHONE 203-550-13
Cohen and Wolf, P.C., 1115 Broad St., Bridgeport, CT 06477

FOR HEALTH DISTRICT USE ONLY

APPLICATION # 133604 REVIEWED BY Ross APPROVAL DATE 6.1.11

The Torrington Area Health District is an equal opportunity provider.

Rev. 3-22-

TORRINGTON AREA HEALTH DISTRICT

350 Main Street • Suite A • Torrington, Connecticut 06790
Phone (860) 489-0436 • Fax (860) 496-8243 • E-mail info@tahd.org • Web Address www.tahd.org
"Promoting Health & Preventing Disease Since 1967"

paid 5/24/11 CK# 117306

APPLICATION & APPROVAL FOR A NEW SEPTIC SYSTEM

Notes: This Approval Expires 2 Months From Date Of Issuance
This is ONLY A Plan Approval And A Permit To Construct/Install Must Obtain A Separate Permit Prior To Any Work

STREET ADDRESS OF PLAN 64 Double Hill Road TOWN Bethlehem

SUBDIVISION NAME Bldg #3 LOT # _____

ENGINEER NAME Berkshire Engineering + Surveying PHONE 860-567-8007

ENGINEER STREET ADDRESS 143 Bantam Lake TOWN Bantam ZIP 06750

OWNER Michele Zurko-Smith PHONE 203-206-8212

MAILING ADDRESS 116 Main St North TOWN Bethlehem ZIP _____

RESIDENTIAL STRUCTURE:

NUMBER OF BEDROOMS _____ TOILETS / SINKS IN BASEMENT – YES ( ) NO ( ) GARBAGE GRINDER YES ( ) NO ( )

JACUZZI OR WHIRLPOOL _____ CAPACITY IN GALLONS _____

* SIZE OF (FUTURE?) SWIMMING POOL – ABOVE GROUNG _____ BELOW GROUND _____
(* If future pool location is known at the time of the application it should be shown on design plan.)

COMMERCIAL OR NON-RESIDENTIAL:

SQUARE FOOTAGE OF BUILDING 3525 INTENDED USE Social Rehab

NUMBER OF EMPLOYEES _____

DESIGN FLOW _____

TOILETS / SINKS IN BASEMENT - YES ( ) NO (X)

A COPY OF ANY EASEMENTS OR DEED RESTRICTIONS MUST BE ATTACHED

CLOSEST PUBLIC WATER LINE _____

UNDERGROUND STORAGE TANKS? YES ( ) NO (X)

TOWN OF BETHLEHEM
DATE RECEIVED 6/2/2011 E
BUILDING _____
FIRE _____
APPROVED DATE _____

- This application must be accompanied by the fee of **$250.00**, two (2) sets of engineered plans showing the map, block and lot numbers and one (1) set of returnable building plans. (Returned Check Fee **$25**)
- The applicant understands that the results of any tests conducted by or on behalf of the Torrington Area Health District are public information. The responsibility for the proper maintenance and operation of this septic system is entirely the owner's.

APPLICANT SIGNATURE _____ **DATE** 5-20-11 **PHONE** 203-556-1391

Vincent Marino, Esq., Cohen and Wolf, P.C., 115 Broad St., Bridgeport, CT 06604

FOR HEALTH DISTRICT USE ONLY

APPLICATION # 13268 REVIEWED BY Ross APPROVAL DATE 6.3.11

The Torrington Area Health District is an equal opportunity provider.

TAHD Fax:8604968243 Jun 6 2011 11:14 P.04

Torrington Area Health District
350 Main St. - Suite A
Torrington, Ct 06790

Permit #

13364

T A H D Is A Equal Opportunity Provider

Design Review For Subsurface Sewage Disposal System

Lot #	Street #	Street Name	Town	Subdivision
64	Double Hill Road		Bethlehem	**Building 2**

Owner	Owner Address	Town	State	Zip
Michele Zurko Smith	116 Main Street North	Bethlehem	Ct.	06751

Builder	Builder Address	Town	State	Zip
Berkshire Engineering & Engineer	143 Bantam Lake Rd.	Bantam	C T	06750

This Approval Indicates That The Proposal Has Been Reviewed By The Health District And Is In Compliance With Applicable Regulations As Contained In The Public Health Code For This Project.

Plan Date: May 18, 2011 Plan prepared by Dennis Mcmorrow

Plan Approval Date: June 1, 2011 # Of Bedrooms: 8 (1-bed)

Septic System Type	Tank Size	Field Sq Ft.	Legnth Of Septic System
4 Ft. Wide Trenches	1500	1200 Ft.sq.	200'

☒ Approved ☐ Plan Revision Required ☒ Required ☐ Not Required
(2) Perk Tests In Fill By Engineer

This Is Not A Permit To Construct A Subsurface Sewage Disposal System. The Permit To Construct Will Be Issued To The Licensed Septic System Installer Prior To Actual Construction. This Plan Approval Is Subject To Specific And General Conditions As Shown On Both Sides Of This Form. Please Read Them Carefully.

☒ Engineer Design	☒ Field Staking By Engineer	☐ Engineer Supervision
☒ Percolation Test In Fill	☒ Select Fill Required	☐ As-built Installer
☒ Engineer As Built Required	☐ Curtain Drain	☐ As Below

Design Based Upon Ten Single Bed Rooms And Three Daily Employees.
10 (75 Gal/bed) = 750 G/d
3 Staff @ 20g/p = 60
Total Gal/day For Bldg. 2 = 810gal/day.

Approved By: _____ Director Of Health

_____ Sanitarian

Torrington Area Health District
350 Main St. - Suite A
Torrington, Ct 06790

Permit # **13368**

T A H D Is A Equal Opportunity Provider

Design Review For Subsurface Sewage Disposal System

Lot #	Street #	Street Name	Town	Subdivision
	64	Double Hill Road	Bethlehem	**Building 3**

Owner	Owner Address	Town	State	Zip
Michele Zurko Smith	116 Main Street North	Bethlehem	Ct.	06751

Builder	Builder Address

Engineer	Engineer Address	Town	State	Zip
Berkshire Engineering &	143 Bantam Lake Rd.	Bantam	C T	06750

This Approval Indicates That The Proposal Has Been Reviewed By The Health District And Is In Compliance With Applicable Regulations As Contained In The Public Health Code For This Project.

Plan Date: May 18, 2011 Plan prepared by Dennis Mcmorrow

Plan Approval Date: June 3, 2011 # Of Bedrooms: 8(1 Bed)

Septic System Type	Tank Size	Field Sq Ft.	Legnth Of Septic System
4 Ft. Wide Trenches	1500	1200	200'

☒ Approved ☐ Plan Revision Required ☒ Required ☐ Not Required
(2) Perk Tests In Fill By Engineer

This Is Not A Permit To Construct A Subsurface Sewage Disposal System. The Permit To Construct Will Be Issued To The Licensed Septic System Installer Prior To Actual Construction. This Plan Approval Is Subject To Specific And General Conditions As Shown On Both Sides Of This Form. Please Read Them Carefully.

☒ Engineer Design	☒ Field Staking By Engineer	☐ Engineer Supervision
☒ Percolation Test In Fill	☒ Select Fill Required	☐ As-built Installer
☒ Engineer As Built Required	☐ Curtain Drain	☐ As Below

Design Is Based Upon Ten Single- Bed Rooms And Three Transient Employees.
10(75 Gal/bed) = 750 Gal/day.
3 Stakk @ 20 Gal/person = 60 Gal.
Therefore, Total Gal/day For Bldg. #3 = 810.

Approved By: _____ Director Of Health

Richard Rowe Sanitarian

Torrington Area Health District
350 Main St. - Suite A
Torrington, Ct. 06790

Permit to Construct
A Subsurface Sewage Disposal System
Fee : $125.00

13364
Permit # | Date Issued | Expires

☒ **New Septic System** ☐ **Repair Septic System** ☐ **Dep System**

64 Double Hill Road | Bethlehem | **Building 2**
Street # | Street Name | Town | Lot # | Subdivision

Michele Zurko Smith | 203-206-8212
Owner | Telephone

Licensed Installer | License # | Installer Tel#

Installer street | **Installer mail town** | **zip**

Berkshire Engineering & Surv | 860-567-8007
Engineer | Engineer Telephone

Specific Conditions:

☒ Engineer Design	☒ Select Fill Required	☐ As Below
☒ Percolation Test in Fill	☐ Curtain Drain	☒ In Place Sieve test Required
☒ Engineer As Built Required	☐ Engineer Supervision	
☒ Field Staking by Engineer	☐ As-Built Installer	

(3) Perk Tests in Fill by Engineer
◉ Required ○ Not Required

Variances Granted
○ Yes ○ No
If Yes, see notes !

Notes

DESIGN BASED UPON TEN SINGLE BED ROOMS AND THREE DAILY EMPLOYEES.
10 (75 GAL/BED) = 750 G/D
3 STAFF @ 20G/P = 60
TOTAL GAL/DAY FOR BLDG. 2 = 810GAL/DAY.

A Permit To Construct:

81 Number of Bedrooms
1500 Gallon septic tank
1200 Ft.sq. Square feet of subsurface disposal system
200' Linear feet of subsurface disposal system
4 Ft. Wide Trenches Septic system type
May 18, 2011 Plan design dated
Dennis Mcmorrow Designed by
June 1, 2011 Health District approved date
Richard Rossi Approving Sanitarian

Installer signature _____

Sanitarian _____

TAHD IS AN EQUAL OPPORTUNITY PROVIDER

Torrington Area Health District
350 Main St. - Suite A
Torrington, Ct. 06790

Permit to Construct
A Subsurface Sewage Disposal System
Fee : $125.00

13368
Permit # | Date Issued | Expires

☒ **New Septic System** ☐ **Repair Septic System** ☐ **Dep System**

64 Double Hill Road | Bethlehem | **Building 3**
Street # | Street Name | Town | Lot # | Subdivision

Michele Zurko Smith | 203-206-8212
Owner | Telephone

Licensed Installer | License # | Installer Tel#

Installer street | **Installer mail town** | **zip**

Berkshire Engineering & Surv | 860-567-8007
Engineer | Engineer Telephone

Specific Conditions:

☒ Engineer Design	☒ Select Fill Required	☐ As Below
☒ Percolation Test in Fill	☐ Curtain Drain	☒ In Place Sieve test Required
☒ Engineer As Built Required	☐ Engineer Supervision	
☒ Field Staking by Engineer	☐ As-Built Installer	

(3) Perk Tests in Fill by Engineer
◉ Required ○ Not Required

Variances Granted
○ Yes ◉ No
If Yes, see notes !

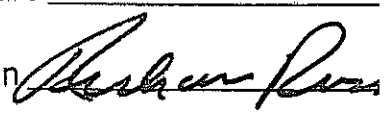
Notes

DESIGN IS BASED UPON TEN SINGLE- BED ROOMS AND THREE TRANSIENT EMPLOYEES.
10(75 GAL/BED) = 750 GAL/DAY.
3 STAKK @ 20 GAL/PERSON = 60 GAL.
THEREFORE, TOTAL GAL/DAY FOR BLDG. #3 = 810.

A Permit To Construct:

81 Number of Bedrooms
1500 Gallon septic tank
1200 Square feet of subsurface disposal system
200' Linear feet of subsurface disposal system
4 Ft. Wide Trenches Septic system type
May 18, 2011 Plan design dated
Dennis Mcmorrow Designed by
June 3, 2011 Health District approved date
Richard Rossi Approving Sanitarian

Installer signature _____

Sanitarian 

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TORRINGTON AREA HEALTH DISTRICT

350 Main Street ♦ Suite A ♦ Torrington, Connecticut 06790
Phone (860) 489-0436 ♦ Fax (860) 496-8243 ♦ E-mail info@tahd.org ♦ Web Address www.tahd.org

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Morris
Norfolk
Plymouth
Salisbury
Thomaston
Torrington
Warren
Watertown
Winsted

9-28-11

Building Department
Town Hall
Bethlehem, CT.

On September 27, 2011, a review was made by this department of the floor plans of the three buildings either existing or proposed for the property located at 64 Double Hill Road, Bethlehem, CT. Noted was the fact that each building would have its own kitchenette area instead of a centralized facility. We find this proposal satisfactory as it meets the criteria for the septic system designs previously approved. Any future changes to this three kitchenette arrangement may void the septic system approvals presently in place.
Please contact this office should you have any questions.

Richard Rossi

Torrington Area Health District

The Torrington Area Health District is an equal opportunity provider and employer and operates in accordance with USDA policy which prohibits discrimination. Complaints of discrimination may be filed with the USDA Secretary of Agriculture, Office of Civil Rights, Washington, DC 20250-9410 or call 202-720-5964.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

June 29, 2012

VIA FACSIMILE ONLY

Michele Zurko-Smith
Member
Litchfield Hills Retreat, LLC
91 Willenbrock Road
Unit 3A
Oxford, CT 06478

RE: Certificate of Need Determination; Report Number 12-31771-DTR
Request for Time Extension for the Duration of Certificate of Need;
Final Decision Rendered Under Docket No.: 09-31500-CON

Dear Ms. Zurko-Smith:

On April 1, 2012, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA"), received your request to extend the expiration date from May 26, 2012 to May 26, 2013 for the project approved by the Certificate of Need ("CON") final decision approved under Docket No.: 09-31500-CON authorizing Litchfield Hills Retreat, LLC ("Applicant") to establish a Free-Standing Residential Substance Abuse Treatment Facility in Bethlehem.

The Applicant submitted sufficient documentation to establish that it has nearly completed the first phase of the proposal which involved operationalizing eight beds in the existing 7,500 square foot house located on the property. The second phase involves construction of two additional buildings on the property to house the remaining 20 beds. The Applicant is requesting a one-year time extension to complete the second phase of the proposal.

All necessary local approvals have been obtained by the Applicant and the Applicant is ready to begin construction. The Applicant provided copies of various approvals it received for phase two of the proposal, such as the Fire Marshall approval for the existing building and the foundation and building permits for the new building construction.

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 34038
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

As required by General Statutes 19a-639b (b), OHCA noticed this request on its website for 30 days, which ended June 3, 2012. During the posting period, OHCA did not receive any written comments or requests for a public hearing.

Based upon a review of the factors outlined above, OHCA determines that the Applicant's request for the time extension for the Certificate of Need approval (under Docket No.: 09-31500-CON) is reasonably necessary to expeditiously complete the project and the request is hereby **granted**, pursuant to the provisions set forth in General Statutes §19a-638b (b). OHCA extends the Certificate of Need duration date to June 30, 2013. If you have any questions regard this correspondence, please contact Steven W. Lazarus at (860) 418-7012.

Sincerely,

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

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

TRANSMISSION OK

TX/RX NO	2968
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: MICHELE ZURKO-SMITH

FAX: 203 267-3813

AGENCY: LITCHFIELD HILLS RETREAT, LLC

FROM: STEVEN LAZARUS

DATE: 6/29/12 **Time:** 3:50 p.m

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:

Certificate of Need Determination; Report Number 12-31771-DTR

Request for Time Extension for the Duration of Certificate of Need

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION PROBLEMS.