

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

**RECEIVED**

2008 SEP 23 A 11: 2b

CONNECTICUT OFFICE OF  
HEALTH CARE ACCESS

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by the Applicant(s), pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

#### **SECTION I. APPLICANT INFORMATION**

If this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

|                                                                                                                                           | Applicant One                                                                    | Applicant Two |
|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------|
| Full legal name                                                                                                                           | Jewish Family Services of Greater Hartford                                       |               |
| Doing Business As                                                                                                                         |                                                                                  |               |
| Name of Parent Corporation                                                                                                                |                                                                                  |               |
| Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)             | 333 Bloomfield Ave.<br>Suite A<br>W Hartford CT 06117                            |               |
| Identify Applicant Status:<br>P for Profit or<br>NP for Nonprofit                                                                         | NP                                                                               |               |
| Does the Applicant have Tax Exempt Status?                                                                                                | Yes                                                                              | Yes No        |
| Contact Person, including Title/Position:<br>This Individual will be the Applicant Designee to receive all correspondence in this matter. | Joan Margolis, Director of Operations and Community Programs                     |               |
| Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)                      | Jewish Family Services<br>333 Bloomfield Ave.<br>Suite A<br>W Hartford, CT 06117 |               |
| Contact Person Telephone Number                                                                                                           | 860-236-1927                                                                     |               |
| Contact Person Fax Number                                                                                                                 | 860-570-1593                                                                     |               |

|                               |                           |  |
|-------------------------------|---------------------------|--|
| Contact Person e-mail Address | jmargolis@jfshartford.org |  |
|-------------------------------|---------------------------|--|

## SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Farmington Valley Satellite Office

b. Project Proposal: Mental Health Services

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:

|                                                |                                                      |                                                            |
|------------------------------------------------|------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> New (F, S, Fnc)       | <input type="checkbox"/> Additional (F, S, Fnc)      | <input type="checkbox"/> Replacement                       |
| <input type="checkbox"/> Expansion (F, S, Fnc) | <input type="checkbox"/> Relocation                  | <input checked="" type="checkbox"/> Termination of Service |
| <input type="checkbox"/> Reduction             | <input type="checkbox"/> 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:

|                                                                                    |
|------------------------------------------------------------------------------------|
| <input type="checkbox"/> New equipment acquisition and operation                   |
| <input type="checkbox"/> Replacement equipment with disposal of existing equipment |
| <input type="checkbox"/> Major medical equipment                                   |
| <input type="checkbox"/> Change in ownership or control                            |

f. Location of proposal, identifying Street Address, Town and Zip Code:

The Chai Center, 166 West Main Street, Avon, CT  
06002

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

Avon, Farmington, Canton, New Hartford, Granby, E. Granby, Simsbury, Collinsville

h. Estimated starting date for the project: 7-16-08

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: \$ 0

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

|                                                               |  |
|---------------------------------------------------------------|--|
| Major Medical Equipment Purchases*                            |  |
| Medical Equipment Purchases*                                  |  |
| Non-Medical Equipment Purchases*                              |  |
| Land/Building Purchases                                       |  |
| Construction/Renovation                                       |  |
| Other (Non-Construction) Specify: _____                       |  |
| <b>Total Capital Expenditure</b>                              |  |
| 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              |  |
| <b>Total Capital Cost</b>                                     |  |
| <b>Total Project Cost</b>                                     |  |
| 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):

|                                                     |                                          |                                            |
|-----------------------------------------------------|------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Applicant's Equity         | <input type="checkbox"/> Capital Lease   | <input type="checkbox"/> Conventional Loan |
| <input type="checkbox"/> Charitable Contributions   | <input type="checkbox"/> Operating Lease | <input type="checkbox"/> CHEFA Financing   |
| <input type="checkbox"/> Funded Depreciation        | <input type="checkbox"/> Grant Funding   |                                            |
| <input type="checkbox"/> Other (specify) <u>N/A</u> |                                          |                                            |

#### 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.

The Clinic is a licensed outpatient mental health facility. Individual and family counseling provided by a licensed clinical social worker is the type of service.

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

Proposal is to cease offering the above service.

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

No one is currently served. The target population was people seeking behavior health therapy, but this service was not sought at the location in question.

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

None

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

Private practices.

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

The termination of this service will have no effect, as only a dozen clients were served at the location in 3 years. Presently no clients are being served at the location.

7. Who will be responsible for providing the service?

N/A

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

N/A.

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0382

**Psychiatric Outpatient Clinic for Adults**

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

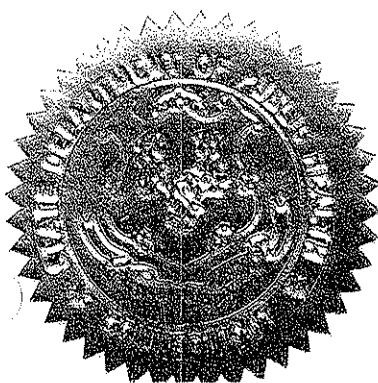
Jewish Family Services Of Greater Hartford of West Hartford, CT, d/b/a Jewish Family Services Of Greater Hartford, Farmington Office is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

**Jewish Family Services Of Greater Hartford, Farmington Office** is located at 166 West Main Street, Avon, CT 06001 with:

Anne M. Danagher as Executive Director  
Janice Rothstein as Director

This license expires **March 31, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, June 10, 2005. INITIAL



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

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

**AFFIDAVIT**

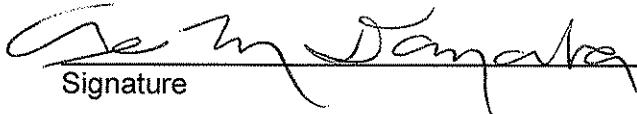
**To be completed by each Applicant**

Applicant: Jewish Family Services of Greater Hartford

Project Title: Farmington Valley Satellite Office

I, Anne M. Danaher, Executive Director  
(Name) (Position – CEO or CFO)

of Jewish Family Services of Greater Hartford 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 Jewish Family Services of Greater Hartford complies with the appropriate and (Facility Name) applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

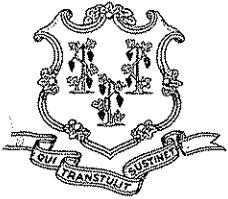
Signature 9-22-08  
Date

Subscribed and sworn to before me on September 22, 2008

Patricia W. Weiner  
Notary Public/Commissioner of Superior Court

**PATRICIA W. WEINER**  
**NOTARY PUBLIC**

My commission expires: MY COMMISSION EXPIRES JUNE 30, 2011



# STATE OF CONNECTICUT

## OFFICE OF HEALTH CARE ACCESS

M. JODI RELL  
GOVERNOR

CRISTINE A. VOGEL  
COMMISSIONER

October 7, 2008

Joan Margolis  
Director of Operations and Community Programs  
Jewish Family Services of Greater Hartford  
333 Bloomfield Avenue, Suite A  
West Hartford, CT 06117

Re: Letter of Intent; Docket Number: 08-31245  
Jewish Family Services of Greater Hartford  
Termination of a Psychiatric Outpatient Clinic for Adults at 166 West Main Street  
in Avon

Dear Ms. Margolis:

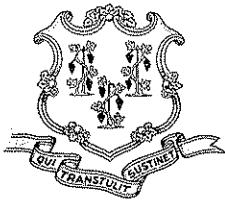
On September 23, 2008, the Office of Health Care Access (“OHCA”) received the Letter of Intent (“LOI”) Form of Jewish Family Services of Greater Hartford (“Applicant”) for the termination of a psychiatric outpatient clinic for adults at 166 West Main Street in Avon, with no capital expenditure.

A notice to the public regarding OHCA’s receipt of a LOI was published by *The Hartford Courant* 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  
Certificate of Need Supervisor

KRM:lmg



M. JODI RELL  
GOVERNOR

# STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL  
COMMISSIONER

October 7, 2008

Requisition # HCA09-045  
Email: [Publicnotices@courant.com](mailto:Publicnotices@courant.com)

The Hartford Courant  
285 Broad Street  
Hartford, CT 06115

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 **Saturday, October 11, 2008**.

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad, acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Paolo Fiducia at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone  
Certificate of Need Supervisor

Attachment

KRM:PF:lmg

c: Sandy Salus, OHCA

*An Affirmative Action / Equal Opportunity Employer*

410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308

Telephone: (860) 418-7001 • Toll free (800) 797-9688

Fax: (860) 418-7053

**PLEASE INSERT THE FOLLOWING:**

Statute Reference: 19a-638  
Applicants: Jewish Family Services of Greater Hartford  
Town: Avon  
Docket Number: 08-31245-LOI  
Proposal: Termination of a psychiatric outpatient clinic for adults at  
166 West Main Street  
Capital Expenditure: \$0

The Applicant may file its Certificate of Need application between November 22, 2008 and January 21, 2009. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

## Greer, Leslie

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sent: Wednesday, October 08, 2008 4:57 AM

----IMA4bcae30.48ec/pop.state.ct.us  
Content-Type: text/plain; charset=us-ascii

Your message was successfully relayed to a system that does not support delivery confirmations.  
Unless the delivery fails, this will be the only delivery notification.

----IMA4bcae30.48ec/pop.state.ct.us  
Content-Type: message/delivery-status

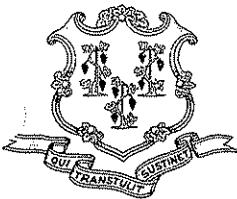
Reporting-MTA: pop.state.ct.us  
Final-Recipient: rfc8222;lgreer04@hotmail.com  
Action: relayed  
Status: 2.0.0

----IMA4bcae30.48ec/pop.state.ct.us  
Content-Type: message/rfc822

Received: from doit-mstwmms1 [159.247.5.80] by pop.state.ct.us with ESMTP  
(SMTPD-9.23) id AE0E01E0; Wed, 08 Oct 2008 08:56:46 -0400  
Received: from 159.247.77.53 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall  
v0.0.0)); Wed, 08 Oct 2008 09:03:49 -0400  
X-Server-Uuid: AAF81055-C3E5-43F1-82D3-EBCFC44FF42A  
X-MimeOLE: Produced By Microsoft Exchange V6.5  
Content-class: urn:content-classes:message  
Return-Receipt-To: "Greer, Leslie" <Leslie.Greer@ct.gov>  
MIME-Version: 1.0  
Disposition-Notification-To: "Greer, Leslie" <Leslie.Greer@ct.gov>  
Subject: FW: RALLY  
Date: Wed, 8 Oct 2008 08:54:57 -0400  
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B101B7D920@DOIT-EX401.exec.ds.state.ct.us>  
X-MS-Has-Attach: yes  
X-MS-TNEF-Correlator:  
Thread-Topic: RALLY  
Thread-Index: Ackon20sDf4xV69BQE+Se2bE2ih/IQABzIjAAABUI3AAAGqX4AAI2sKwAAEAlA=

From: "Greer, Leslie" <Leslie.Greer@ct.gov>  
To: lgreer04@hotmail.com  
X-WSS-ID: 64F2703F2C4581189-01-01  
Content-Type: multipart/mixed;  
boundary="----=\_NextPart\_001\_01C92945.110F47ED"

----IMA4bcae30.48ec/pop.state.ct.us--



# STATE OF CONNECTICUT

## OFFICE OF HEALTH CARE ACCESS

M. JODI RELL  
GOVERNOR

CRISTINE A. VOGEL  
COMMISSIONER

October 8, 2008

Joan Margolis  
Director of Operation and Community Programs  
Jewish Family Services of Greater Hartford  
333 Bloomfield Avenue  
Suite A  
West Hartford, CT 06117

RE: Certificate of Need Application Forms  
Docket Number: 08-31245-CON  
Proposal to Terminate Psychiatric Services at the Behavioral Health Outpatient  
Clinic in Avon

Dear Ms. Margolis:

Enclosed are the application forms for Jewish Family Services of Greater Hartford's Certificate of Need ("CON") proposal for the termination of psychiatric services at the behavioral health outpatient clinic in Avon with no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between November 22, 2008, and January 21, 2009.

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 the submission, each in 3-ring binders.

- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.
- Submit an electronic copy of the documents in MS Word format with financial attachments and other data, as appropriate, in MS Excel format.

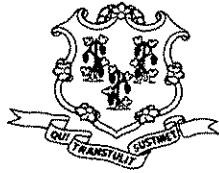
The OHCA analyst assigned to the CON application is Paolo Fiducia. Please feel free to contact him at (860) 418-7035, if you have any questions.

Sincerely,



Kimberly Martone  
Certificate of Need Supervisor

Enclosure



## State of Connecticut Office of Health Care Access Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than November 22, 2008, and may be submitted no later than January 21, 2009. The Analyst assigned to your application is Paolo Fiducia and may be reached at the Office of Health Care Access at (860) 418-7001.

**Docket Number:** 08-31245-CON

**Applicant(s) Name:** Jewish Family Services of Greater Hartford

**Contact Person:** Joan Margolis

**Contact Title:** Director of Operation and Community Programs  
Jewish Family Services of Greater Hartford

**Contact Address:** 333 Bloomfield Ave  
Suite A  
West Hartford, CT 06117

**Project Location:** Avon

**Project Name:** Terminate Psychiatric Services at our Behavioral Health  
Outpatient Clinic in Avon

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

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

### **1. Expansion of Existing or New Service**

What services are currently offered at your facility? Please list.

### **2. State Health Plan**

No questions at this time.

### **3. Applicant's Long Range Plan**

Is this application consistent with your long-range plan?

Yes       No

If "No" is checked, please provide an explanation.

### **4. Clear Public Need**

A. Regarding this termination of services in Avon, please answer the following:

- i) Explain in detail the Applicant's rationale for this termination of services. Identify the process undertaken by the Applicant in making the decision to terminate.
- ii) When did the Applicant start offering Psychiatric Services at Avon?
- iii) Did the Applicant seek CON authorization to start offering Psychiatric Outpatient Services for Adults at the Avon location?
- iv) When did the Applicant decide to terminate psychiatric services at Avon?
- v) When did the Applicant return its "Psychiatric Outpatient Clinic for Adults" license to the Department of Public Health?
- vi) When was the Department of Mental Health and Addiction Services notified of the termination of the program at Avon and their role in the provision of this service?
- vii) Provide a list of all the Jewish Family Services of Greater Hartford's facilities, location of each facility, types of services offered and available capacity for each service offered.
- viii) Did the Applicant determine there was no or insufficient public need for the continuation of this program?

- ix) Was the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?
- x) Did this termination require the vote of the Board of Directors of the Applicant? If so, please provide a copy of the minutes (excerpted for other unrelated business) for the meeting(s) at which this termination was discussed and voted on.

B. Provide or answer the following:

- i) Provide a detailed description of the specific service components (i.e. description of the programs, age groups) that are available and provided at the Avon location. Identify what the hours of operation are for the service location.
- ii) List the service area towns. Provide a rationale for choosing the selected towns.
- iii) Provide the units of service (i.e. clinic visits) for the past three fiscal or calendar years by patient town of origin, for the Avon service location.
- iv) Provide the units of service (i.e. number of admissions) for the past three fiscal or calendar years by patient town of origin, for the Avon service location.
- v) Discuss any scheduling backlogs that did exist at the Avon service location.
- vi) Were there any waiting lists in place at the Avon service location? If so, identify the number of patients on the waiting list.
- vii) Describe the pattern of referrals to the Avon service location that did exist.
- viii) Please provide a report that lists, by year, for FYs 2005, 2006, and 2007, to date, the following: average daily census; number of clients on the last day of the month; the number of clients admitted during the month; and the number of clients discharges during the month.

C. Regarding the impact on the patient and provider community of the termination of services at the Avon service location, provide the following information:

- i) Explain the procedures that the Applicant followed in terminating these services and transferring patients to other community providers.
- ii) Discuss how the services described above will continue to be made available to the patients that had previously utilized the Avon service locations. List any special populations that utilized the services and explain how these clients will continue to access this service after the Avon service location closed.
- iii) Provide the information as outlined in the following table concerning the existing providers services in the Avon service area:

Specify days of the week and start and end time for each day.

<sup>2</sup> Number of clients served by Provider for the most recent 12 month period, if known.

- iv) Did your facility contact any other providers in the Avon service area to see if they were willing and able to absorb the patient population base for displaced patients? Please provide a detailed explanation, including any written agreements or memorandum of understanding between the Applicant and any other facilities as related to the proposal.
- v) What was the effect of the termination of the Avon service location on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?
- vi) Did this termination of services create any barriers to access in the region? If so, please discuss such barriers, as they now exist.
- vii) Provide information and supporting documentation addressing the issue of transportation for the Avon patients.

D. Did your proposal remedy any of the following barriers to access?  
Please provide an explanation.

|                                            |                                                 |
|--------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Cultural          | <input type="checkbox"/> Transportation         |
| <input type="checkbox"/> Geographic        | <input type="checkbox"/> Economic               |
| <input type="checkbox"/> None of the above | <input type="checkbox"/> Other (Identify) _____ |

If you checked other than None of the above, please provide an explanation.

E. Provide copies of any of the following plans, studies or reports related to your proposal:

|                                                                                                                                        |                                                |
|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Epidemiological studies                                                                                       | <input type="checkbox"/> Needs assessments     |
| <input type="checkbox"/> Public information reports                                                                                    | <input type="checkbox"/> Market share analysis |
| <input type="checkbox"/> Other (Identify) _____                                                                                        |                                                |
| <input type="checkbox"/> None: <i>explain</i> why no reports, studies or market share analysis was undertaken related to the proposal: |                                                |

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## 5. Quality Measures

A. Provide or answer the following:

- i) Provide a copy of the State of Connecticut Department of Public Health license(s) currently held by Jewish Family Services of Greater Hartford in Avon.
- ii) Are there any unique characteristics of your patient/physician mix?

Yes       No

If you checked "Yes," please provide an explanation.

B. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief

Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.

**Note:** For physicians, please provide a list of hospitals where the physicians have admitting privileges.

C. Provide a copy of the most recent inspection reports and/or certificate for your facility:

|                                               |                                                                                         |
|-----------------------------------------------|-----------------------------------------------------------------------------------------|
| <input type="checkbox"/> DPH                  | <input type="checkbox"/> JCAHO                                                          |
| <input type="checkbox"/> Fire Marshall Report | <input type="checkbox"/> Other States Health Dept. Reports (new out-of-state providers) |
| <input type="checkbox"/> AAAHC                | <input type="checkbox"/> AAAASF                                                         |
| <input type="checkbox"/> Other: _____         |                                                                                         |

**Note:** Above referenced acronyms are defined below.<sup>1</sup>

## 6. Improvements to Productivity and Containment of Costs

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

|                                                                                                                        |                                            |
|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Energy conservation                                                                           | <input type="checkbox"/> Group purchasing  |
| <input type="checkbox"/> Reengineering                                                                                 | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.) |                                            |
| <input type="checkbox"/> Other (identify) _____                                                                        |                                            |

## 7. Miscellaneous

A. Provide or answer the following:

i) Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

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

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

Yes       No

If you checked "Yes," please provide an explanation.

## 8. Financial Information

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

Corporation (Inc.)     Limited Liability Company (LLC)  
 Partnership             Professional Corporation (PC)  
 Joint Venture             Other (Specify):

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

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

## 9. Revenue, Expense and Volume Projections

A) Provide the following financial information for the Avon service location:

i) Please submit an audited or unaudited Balance Sheet and Income Statement or Statement of Operations for the two most recently completed fiscal years. These statements should be externally prepared and submitted on the preparer's letterhead.

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

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

|           |  | Provider's Payer Mix |
|-----------|--|----------------------|
| Medicare* |  |                      |

|                                               |               |
|-----------------------------------------------|---------------|
| Medicaid* (includes other medical assistance) |               |
| TriCare (CHAMPUS)                             |               |
| <b>Total Government Payers</b>                |               |
| Commercial Insurers*                          |               |
| Self-Pay                                      |               |
| Workers Compensation                          |               |
| <b>Total Non-Government Payers</b>            |               |
| Uncompensated Care                            |               |
| <b>Total Payer Mix</b>                        | <b>100.0%</b> |

\*Includes managed care activity.

D. Provide the following for the financial and statistical projections for the Avon service location:

- i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached, Financial Attachment I.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.
- ii) Please complete the enclosed, OHCA's **Financial Attachment II.**
- iii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).
- iv) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

## GENERAL AFFIDAVIT

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

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

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

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

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Signature

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Date

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

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

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

| Please provide <b>three</b> 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  | Projected Incremental Total Incremental Expenses | Incremental Revenue | Allowances/ Deductions | Charity Care | Bad Debt | Net Revenue |
|                                                                                                                                                                        |                          |                          | (1) | (2)                                              | (3)                 | (4)                    | (5)          | (6)      | (7)         |
| Total Facility by Payer Category:                                                                                                                                      |                          |                          |     |                                                  |                     |                        |              |          |             |
| Medicare                                                                                                                                                               |                          |                          |     |                                                  | \$0                 |                        |              |          | \$0         |
| Medicaid                                                                                                                                                               |                          |                          |     |                                                  | \$0                 |                        |              |          | \$0         |
| CHAMPUS/TriCare                                                                                                                                                        |                          |                          |     |                                                  | \$0                 |                        |              |          | \$0         |
| <b>Total Governmental</b>                                                                                                                                              |                          |                          |     |                                                  | 0                   | \$0                    | \$0          | \$0      | \$0         |
| Commercial Insurers                                                                                                                                                    |                          |                          |     |                                                  |                     |                        |              |          | \$0         |
| Uninsured                                                                                                                                                              |                          |                          |     |                                                  |                     |                        |              |          | \$0         |
| <b>Total NonGovernment</b>                                                                                                                                             |                          |                          |     |                                                  | \$0                 | 7                      | \$0          | \$0      | \$0         |
| <b>Total All Payers</b>                                                                                                                                                |                          |                          |     |                                                  | \$0                 | 7                      | \$0          | \$0      | \$0         |

13. B (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.

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

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**From:** HC Public Notice [HCPublicNotice@courant.com]  
**Sent:** Thursday, October 09, 2008 10:13 AM  
**To:** Greer, Leslie  
**Subject:** RE: Legal Ad 08-31245

Leslie,

Here is the notice that I have scheduled for tomorrow, 10/10 for a total of \$158.56.  
Ad# 2236522.

## NOTICE

**Statute Reference:** 19a-638

**Applicants:** Jewish Family Services of Greater Hartford

**Town:** Avon

**Docket Number:** 08-31245-LOI

**Proposal:** Termination of a psychiatric outpatient clinic for adults at 166 West Main Street

**Capital Expenditure:** \$0

The Applicant may file its Certificate of Need application between November 22, 2008 and January 21, 2009. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

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**From:** Greer, Leslie [mailto:[Leslie.Greer@ct.gov](mailto:Leslie.Greer@ct.gov)]  
**Sent:** Wednesday, October 08, 2008 8:19 AM  
**To:** [publicnotices@courant.com](mailto:publicnotices@courant.com)  
**Subject:** Legal Ad 08-31245

Legal Ad,

Please run the attached public notice in your newspaper no later than Saturday, October 11, 2008. Please notify me that you have received this request.

Thank you,

*Leslie M. Greer*  
Office of Health Care Access  
State of Connecticut  
410 Capitol Avenue  
Hartford, CT 06134  
Phone: (860) 418-7001  
Fax: (860) 418-7053  
Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)