STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

JOHN G. ROWLAND
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 29, 2004

Ms. Susan Zee
Administrator
Sage Rehab, Inc.
701 Cottage Grove Road
Suite E 130
Bloomfield, CT 06002

Re: Letter of Intent, Docket Number 04-30317-LOI
Sage Rehab, Inc.
Comprehensive Outpatient Rehabilitation Facility
Notice of Letter of Intent

Dear Ms. Zee:

On June 18, 2004, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Sage Rehab, Inc. ("Applicant") for the Comprehensive Outpatient Rehabilitation Facility, at a total capital expenditure of $0.

A notice to the public regarding OHCA's receipt of a LOI was published in the *Hartford Courant* pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes as amended by Section 1 of Public Act 03-17. Enclosed for your information is a copy of the notice to the public

Sincerely,

Susan Cole England

Susan Cole England
Certificate of Need Supervisor

SCE:KM:bko

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

JOHN G. ROWLAND
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 29, 2004

Purchase Order # HCA05-006
FAX: 241-3866
Account # 700309

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 Thursday, July 1, 2004.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

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

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Susan Cole England

Susan Cole England
Certificate of Need Supervisor

Attachment

SCE:KM:bko

c: Kathy Howe, OHCA

The Hartford Courant
Docket Number 04-30317

Letter of Intent
June 29, 2004

PLEASE INSERT THE FOLLOWING:

Pursuant to Section 19a-638 of the Connecticut General Statutes as amended by Section 1 of Public Act 03-17, the Office of Health Care Access ("OHCA") has received a Letter of Intent to file the following Certificate of Need application:

Applicant:	Sage Rehab, Inc.
Town:	Bloomfield
Docket Number:	04-30317
Proposal:	Comprehensive Outpatient Rehabilitation Facility
Total Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between August 17, 2004 and October 16, 2004. Interested persons are invited to submit written comments to OHCA regarding the Letter of Intent or the Certificate of Need application, when it is submitted by the Applicant. Such comments should be directed to:

Cristine A. Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
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 may be obtained from OHCA at the standard copy charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant. A copy of the Certificate of Need application may then be obtained from OHCA at the standard copy charge.

Confirmation Report – Memory Send

Time : Jun-29-2004 15:01
Tel line : 8604187053
Name : OFFICE OF HEALTHCARE

Job number	:	932
Date	:	Jun-29 14:58
To	:	92413866
Document pages	:	002
Start time	:	Jun-29 14:58
End time	:	Jun-29 15:01
Pages sent	:	002
Status	:	OK

Job number : 932 *** SEND SUCCESSFUL ***

JOHN G. ROWLAND
GOVERNOR

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

June 29, 2004

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Sincerely,

Susan Cole England

Susan Cole England
Certificate of Need Supervisor

Attachment

SCE:KM:bko

c: Kathy Howe, OHCA

An 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

Sage Rehab, Inc.
701 Cottage Grove Road, Suite E 130, Bloomfield, CT 06002 www.sagerehab.org
Phone: 860-286-0838 Fax: 860-286-0109

FACSIMILE TRANSMITTAL SHEET

TO: Commissioner Cristine Vogel
FROM: Susan Zee, Administrator
COMPANY:
DATE: 06-17-04
FAX NUMBER: 860-418-7053
TOTAL NO. OF PAGES INCLUDING COVER: 10
PHONE NUMBER:
SENDER'S PHONE NUMBER: 860-286-0838
RE:
SENDER'S FAX NUMBER: 860-286-0109

☑ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY

NOTES/COMMENTS:

Please see the attached letter of intent. The original is being sent by mail.

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

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form 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 there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	Sage Rehab, Inc.	
Doing Business As		
Name of Parent Corporation	Not applicable	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	701 Cottage Grove Rd. Suite E130, Bloomfield, CT 06002	
Applicant type (e.g., profit/non-profit)	Non-profit	
Contact person, including title or position	Susan Zee, Administrator	
Contact person's street mailing address	701 Cottage Grove Rd. Suite E130, Bloomfield, CT 06002	
Contact person's phone #, fax # and e-mail address	Phone: 860-286-0838 Fax: 860-286-0109 szee@sagerehab.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Comprehensive Outpatient Rehabilitation Facility

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☒ New (F, S, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Service Termination

☐ Bed Addition ☐ Bed Reduction ☐ Change in Ownership/Control

☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☐ Project expenditure/cost cost greater than $ 1,000,000

☐ Equipment Acquisition greater than $ 400,000

☐ New ☐ Replacement ☐ Major Medical

☐ Imaging ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address):

701 Cottage Grove Road, Suite E 130, Bloomfield, CT 06002

d. List all the municipalities this project is intended to serve:

Greater Hartford Area

e. Estimated starting date for the project: July 1, 2004.

f. Type of project: **14** **(Fill in the appropriate number(s) from page 7 of this form)**

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
Not Applicable				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $ Not applicable

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	$
Fair Market Value of Leased Equipment	
Total Capital Cost	$

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
Not applicable				

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

☐ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan

☐ Charitable Contributions ☐ CHEFA Financing ☐ Grant Funding

☐ Funded Depreciation ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment.

- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.
- ☐ The cost of the equipment is not to exceed $2,000,000.
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant: Sage Rehab, Inc.

Project Title: Comprehensive Outpatient Rehabilitation Facility

I, Layth Haddad (Name), President/CEO (Position – CEO or CFO)

of Sage Rehab, Inc. being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that Sage Rehab, Inc. complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature June 17, 2004 Date

Subscribed and sworn to before me on the 17th day of June, 2004, in the county of Hartford, Connecticut.

Notary Public/Commissioner of Superior Court

My commission expires: 04-30-2005.

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

PROJECT DESCRIPTION

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

Sage Rehab, Inc. was formed by a group of dedicated team of professionals who identified a growing need in the Greater Hartford community for comprehensive outpatient rehabilitation services. Unlike other outpatient facilities, we specialize in providing comprehensive outpatient rehabilitation incorporating traditional and state-of-the-art techniques, including a range of assistive tools and technology. Our services include:

- Assistive Technology Assessments and Training
- Case Management
- Cognitive Therapy
- Massage Therapy
- Neuropsychology
- Occupational Therapy
- Orthotics Clinic
- Physiatry
- Physical Therapy
- Psychology
- Speech-Language Pathology
- Vocational Counseling
- Wheelchair Clinic

Services proposed to be provided to Medicare beneficiaries include physical therapy, psychology, occupational therapy, and speech-language pathology, all under the supervision of a Board-certified physiatrist.

Currently we serve individuals of all ages diagnosed with a variety of diagnoses, including: brain injury; stroke; neurological and neuromuscular disorders; and developmental disabilities. The targeted population served through a Comprehensive Outpatient Rehabilitation Facility will include individuals who are Medicare beneficiaries requiring the services listed above.

We focus on treating complex, medically involved patients who require special care beyond that provided by typical outpatient facilities. The paucity of comprehensive rehabilitation services, provided under the supervision of a physiatrist has been clearly identified by the patient population that we have been serving. For patients discharged from inpatient facilities and patients who have long-term deficits or permanent disabilities, comprehensive rehabilitation services are required to aid them in increasing their independence. The comprehensiveness of our services allows patients to avoid the difficulties associated with coordinating care at different locations when they require multiple services. This comprehensiveness also fosters better care, since it is coordinated and efficient. With the typical profile of our patients, our service delivery

model is recognized as the optimum manner for effective treatment on an outpatient level.

The services are provided by clinicians and therapists licenses by the Department of Public Health for their respective disciplines, and under the supervision of a licensed, Board-certified physiatrist.

Most of the services are reimbursed by third-payers. The designated CMS intermediary has approved our application to become a Comprehensive Outpatient Rehabilitation Facility pending a site survey by the Department of Public Health. It is the intent that with approval by the Office of Health Care Access we will be able to provide services to Medicare beneficiaries, and thus be reimbursed accordingly for the services provided.