MURTHA CULLINA LLP
ATTORNEYS AT LAW

177 BROAD STREET
STAMFORD, CONNECTICUT 06901

TELEPHONE (203) 653-5400
FACSIMILE (203) 653-5444
www.murthalaw.com

FACSIMILE TRANSMITTAL

Date:	September 25, 2008	Client Code:	
To:	Ms. Cristine A. Vogel	Facsimile Number:	+1 (860) 418-7053
	State of Connecticut, Office of Health Care Access	Telephone Number:	+1 (860) 418-7005
From:	Elizabeth M. Newirth	Telephone Number:	(203) 653-5411

Total Number of Pages (including this cover page): 2 Sent by: Jennifer M. Caulfield

MESSAGE:

Please see the attached correspondence regarding a change of Applicant's Designee from that identified in the Letter of Intent on Form 2030 which we submitted on behalf of our client, Formé Rehabilitation of CT, Inc.

RECEIVED
2008 SEP 25 P 3:48
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

IF THERE ARE ANY PROBLEMS RECEIVING THIS TELECOPY PLEASE CONTACT OUR FAX/MAIL CENTER AT (203) 653-5400, IMMEDIATELY.

MURTHA CULLINA LLP
ATTORNEYS AT LAW

177 BROAD STREET
STAMFORD, CONNECTICUT 06901
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ELIZABETH M. NEUWIRTH
(203) 653-5411 DIRECT TELEPHONE
(203) 653-5444 DIRECT FACSIMILE
ENEUWIRTH@MURTHALAW.COM

September 25, 2008

VIA FAX: (860) 418-7053

Ms. Cristine A. Vogel, Commissioner
Office of Health Care Access (OHCA)
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Change of Applicant's Designee for Letter of Intent on Form 2030 for Certificate of Need Application for Establishment of Multi-Specialty Rehabilitation Services Program in Norwalk

Dear Ms. Vogel:

Yesterday, on behalf of our client Formé Rehabilitation of CT, Inc., I submitted to your office a Letter of Intent on Form 2030 ("LOI") via fax. In the LOI, I am named as the Applicant's Designee for purposes of receiving all correspondence in this matter. It has since come to my attention that your office desires that the contact person not be an attorney for the entity but rather an internal person. Accordingly, please list the following as the contact person:

Mr. Peter Montpelier
c/o Formé Rehabilitation & Sports Medicine
1075 Central Park Avenue
Scarsdale, NY 10583
Tel. No.: (914) 723-4900 x1
Fax No.: (914) 723-7893
Email: peter@formezone.com

I would ask that you please kindly continue to copy me on all such correspondence.

Thanking you for your cooperation, I am,

Very truly yours,

Elizabeth Neuwirth/jmc

Elizabeth M. Neuwirth

MURTHA CULLINA LLP
ATTORNEYS AT LAW

177 BROAD STREET
STAMFORD, CONNECTICUT 06901

TELEPHONE (203) 653-5400
FACSIMILE (203) 653-5444
www.murthalaw.com

FACSIMILE TRANSMITTAL

Date:	September 24, 2008	Client Code:	-
To:	Ms. Cristine A. Vogel	Facsimile Number:	+1 (860) 418-7053
	State of Connecticut, Office of Health Care Access	Telephone Number:	+1 (860) 418-7005
From:	Elizabeth M. Neuwirth	Telephone Number:	(203) 653-5411

Total Number of Pages (including this cover page): 11 Sent by: Jennifer M. Caulfield

MESSAGE:

Please see the attached Letter of Intent on Form 2030 which we respectfully request be filed on behalf of our client, Formé Rehabilitation of CT, Inc.

**IF THERE ARE ANY PROBLEMS RECEIVING THIS TELECOPY
PLEASE CONTACT OUR FAX/MAIL CENTER AT (203) 653-5400, IMMEDIATELY.**

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. PETITIONER INFORMATION

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

	Petitioner	Petitioner
Full Legal Name	Formé Rehabilitation of CT, Inc.	
Doing Business As	———	
Name of Parent Corporation	N/A	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	1075 Central Park Ave. Scarsdale, NY 10583	
What is the Petitioner's Status: P for profit and NP for non-profit	P	
Does the Applicant have Tax-Exempt Status?	Yes No X	
Contact Person, including Title/Position: This individual will be the Applicant's Designee to receive all correspondence in this matter.	Elizabeth Neuwirth, Esq.	

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	Murtha Cullina LLP 177 Broad Street Stamford, CT 06901	
Contact Person's Telephone Number	(203) 653-5411	
Contact Person's Fax Number	(203) 653-5444	
Contact Person's E-Mail Address	eneuwirth@murthalaw.com	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Project Title: Multi-Specialty Rehabilitation Services Program

b. Project Proposal: Open a Multi-Specialty Rehabilitation Services Program

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)* Multi-Specialty ☐ 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:

i.Park 7, 761 Main Avenue, Norwalk, CT 06859

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

We anticipate that our primary service area would include these towns: Norwalk; Wilton; Westport; New Canaan; Weston; Georgetown; Ridgefield; Redding; and Easton. Our secondary service area would include: Southport; Fairfield; Aspetuck; Cannondale; North Wilton; Long Ridge; and Springdale. However, for custom-crafted and fitted pediatric prosthetics and orthotics, the service area may reach to Danbury, Bethel, Monroe, Shelton, Stratford, Bridgeport, and Milford.

h. Estimated starting date for the project: January 1, 2008

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. EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ 78,420

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

Medical Equipment Purchases	$78,240
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building Asset Purchases	
Construction/Renovations	
Other (Non-Construction) – Specify:	
Total Capital Expenditure	
Medical Equipment – Fair Market Value of Leases	
Major 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	**$78,240**
Capitalized Financing Costs (Informational Purpose Only)	

*Provide an itemized list of all 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 copy of the vendor contract or quotation for the medical equipment.

e. Check each applicable financing method or funding source to be used for the proposal:

X Petitioner's Equity ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing

☐ Funded Depreciation ☐ Grant Funding ☐ Other (specify): _____

SECTION IV. PROPOSAL 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" sheet(s) of paper. At a minimum, each of the following elements need to be addressed, if applicable.

(1) Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health 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?

DESCRIPTION OF PROPOSED MULTI-SPECIALTY REHABILITATION SERVICES PROGRAM

(1) Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

N/A

(2) Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable?

Rehabilitation services (*i.e.*, physical therapy; speech and language pathology; cognitive therapies; occupational therapy) from the pediatric population to adults. Applicant (or an affiliate) will also be enrolled as a supplier of durable medical equipment under the Medicare and Medicaid programs and through private payer contracts. Based on interviews with local pediatricians, orthopedists and personnel at two local hospitals, applicant believes that individuals in the service area with complex therapy needs are currently traveling excessive distances in order to get adequate physical and occupational rehabilitation services, and specialized custom orthotics. In addition, there is a pronounced need for services for children and adolescents, especially those with multiple impairments or complex presentations (such as those with autism spectrum disorders). The applicant does not believe that a DPH license will be required.

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

There are a growing number of children and young adults who are diagnosed with autism-spectrum disorders and whose skills and deficits vary widely. Many of these young people have difficulties in tolerating interpersonal experiences or complex stimuli; some appear socially and physically awkward; some are non-verbal. There are few opportunities for these children to enjoy and master physical activities commensurate with their special needs.

To meet this need, in addition to the general rehabilitation services described above, applicant intends to offer a multi-specialty program aimed at children and young adults with autism-spectrum disorders and other special needs. This program is already in operation at applicant's New York location. Called FormèKids, this program combines customized aerobic exercise, age-appropriate resistance training, and movement-based activities as well as physical and occupational therapy and community outreach. A medical director who is a board-certified pediatrician will provide consultation to the program, which will be directed by a licensed physical or occupational therapist. The program provides a non-competitive atmosphere in which health professionals focus on improving each child's physical and mental health status and psychosocial skills. Obesity prevention through exercise and improved nutritional choices are also addressed. The program is designed for youngsters who have motor and coordination deficits, decreased ability to plan and organize actions, and poor sensory integration. Games exploring creativity and body expression are emphasized. FormèKids will be staffed by a certified adaptive physical education teacher with at least a bachelor's degree, physical therapists, occupational therapists, a registered dietician, and certified personal trainers.

Although parents are not required to workout with their children, we encourage them to be actively involved in their child's program. Children enrolled in the program participate in monthly group "fun talks" with staff professionals.

A comprehensive sports medicine/athlete development program will also be offered. Called FASST, this program combines the services of a physical and occupational therapist, athletic trainer and strength coach. FASST will serve children from age 8 through collegiate level athletes. This program provides a competitive atmosphere in which health professionals focus on improving the strength and speed of the area's student-athletes. Injury prevention and rehabilitation will also be available. This program is generally provided on a self-pay basis, and a number of "scholarships" will be made available to talented child and young adult athletes.

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

School-based programs are overburdened by the costs of serving the increasing number of identified children requiring individualized education plans, and often do not adequately serve the needs of this population.

Within a twenty (20) mile radius of Applicant's proposed location, the wait for an appointment for a child needing multi-disciplinary therapy services for autism-spectrum disorder is a minimum of ten (10) days, with the longest wait time at possible service providers being twenty-one (21) days. This represents a significant backlog in the Primary Service Area.

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

While there are many physical and occupational therapy providers in the service area, there are currently no facilities that offer an integrated, multidisciplinary approach to pediatric and adolescent clients with the cognitive, perceptual and motor impairments that we target. The area hospital and pediatricians have indicated that they lack adequate resources to which to refer pediatric and adolescent patients.

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

The Facility would, we believe, make available badly needed services to the increasing number of children and adolescents identified as having autism-spectrum disorders and a range of developmental / cognitive / sensory disabilities.

(7) Who will be responsible for providing the service(s)?

The following will be responsible for providing the proposed services: physical therapists; speech and language pathologists; licensed professionals trained in cognitive therapy; occupational therapists; social workers; psychologists; and physicians.

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

Payments are anticipated under Medicare, Medicaid, and private payors with whom Applicant will seek to contract. Some individuals will be self pay.

SECTION VI. AFFIDAVIT

Petitioner: Formé Rehabilitation of CT, Inc.

Project Title: Multi-Specialty Rehabilitation Services

I, GINA CAPPELLI (Name), PRESIDENT (Position – CEO or CFO)

of Formé Rehabilitation of CT, Inc. (Organization Name), 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 Formé Rehabilitation of CT, Inc. (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.

Gina Cappelli
Signature

9/24/08
Date

Subscribed and sworn to before me on 9/24/08

Joseph C. Landi
Notary Public / Commissioner of Superior Court

My commission expires: 5/26/2010

Notary Public
State of New York
JOSEPH C. LANDI
01LA6007666
05/26/2010

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2008 SEP 25 A 8:28
CONNECTICUT
HEALTH CARE
OFFICE OF
ACCESS

Form 2030
Revised 7/06

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 29, 2008

Peter Montpelier
Forme Rehabilitation & Sports Medicine
1075 Central Park Avenue
Scarsdale, NY 10583

Re: Letter of Intent, Docket Number 08-31239
Forme Rehabilitation & Sports Medicine
Establishment of Multi-Specialty Rehabilitation Services Program
Notice of Letter of Intent

Dear Mr. Montpelier:

On September 25, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Forme Rehabilitation & Sports Medicine ("Applicant") for the establishment of a Multi-Specialty Rehabilitation Services program in Norwalk, with a capital expenditure of $78,240.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Hour Publishing* 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:af:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 29, 2008

Requisition # HCA09-041
Email: OBIT@The Hour.com
Attention: David

The Hour Publishing Company
P.O. Box 790
Norwalk, CT 06852-0790

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, October 4, 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 Alexis Fedorjaczenko at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:AF:lmg

c: Sandy Salus, OHCA

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Forme Rehabilitation & Sports Medicine
Town:	Norwalk
Docket Number:	08-31239-LOI
Proposal:	Establishment of Multi-Specialty Rehabilitation Services Program in Norwalk
Capital Expenditure:	$78,240

The Applicant may file its Certificate of Need application between November 24, 2008 and January 23, 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

Sent: Monday, September 29, 2008 9:26 AM

----IMA6f80f8b.48e1/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.

----IMA6f80f8b.48e1/pop.state.ct.us
Content-Type: message/delivery-status

Reporting-MTA: pop.state.ct.us
Final-Recipient: rfc8222;obit@THEHOUR.COM
Action: relayed
Status: 2.0.0

----IMA6f80f8b.48e1/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 AF7F041C; Mon, 29 Sep 2008 13:25:19 -0400
Received: from 159.247.77.53 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall v6.0.0)); Mon, 29 Sep 2008 13:32:28 -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: Legal Ad 08-31239-LOI
Date: Mon, 29 Sep 2008 13:23:41 -0400
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B101B7D8F2@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach: yes
X-MS-TNEF-Correlator:
Thread-Topic: Legal Ad 08-31239-LOI
Thread-Index: AckiWB2bscDh85nGSzmK8ReYuoQhrg==
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
To: obit@THEHOUR.COM
X-WSS-ID: 64FFCEA62C4227339-01-01
Content-Type: multipart/mixed;
boundary="----_=_NextPart_001_01C92258.1DF7D77A"

----IMA6f80f8b.48e1/pop.state.ct.us--

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 29, 2008

Mr. Peter Montpelier
c/o Formé Rehabilitation & Sports Medicine
1075 Central Park Avenue
Scarsdale, NY 10583

RE: Certificate of Need Application Forms; Docket Number: 08-31239-CON
Formé Rehabilitation of CT, Inc.
Establishment of Multi-Specialty Rehabilitation Services Program in Norwalk

Dear Mr. Montpelier:

Enclosed are the application forms for Formé Rehabilitation of CT, Inc.'s Certificate of Need ("CON") proposal for the establishment of multi-specialty rehabilitation services program in Norwalk with an associated capital expenditure of $78,240. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between November 24, 2008 and January 23, 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 CON analyst assigned to the CON application is Alexis Fedorjaczenko. Please feel free to contact her at (860) 418-7001 if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosure

Cc: Elizabeth Neuwirth, Esq.,Murtha Cullina LLP

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 24, 2008 and may be submitted no later than January 23, 2009. The Analyst assigned to your application is Alexis Fedorjaczenko. She may be reached at the Office of Health Care Access at (860) 418-7067.

Docket Number:	08-31239-CON
Applicant(s) Name:	Formé Rehabilitation of CT, Inc.
Contact Person:	Peter Montpellier Formé Rehabilitation & Sports Medicine
Contact Address:	1075 Central Park Avenue Scarsdale, NY 10583
Project Location:	Norwalk
Project Name:	Establishment of Multi-Specialty Rehabilitation Services Program in Norwalk
Type of proposal:	Section(s) 19a-638
Est. Capital Expenditure:	$78,240

1. Expansion of Existing or New Service

What services are currently offered by your organization that the proposed expansion or new service will augment or replace? Please describe the Applicant's current and proposed range of services, and indicate where services are currently provided.

Augment:

Replace:

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. Explain how it was determined there was a need for the proposal in Norwalk.

i) Provide the following information:

a) Describe the population to be served, including the number of individuals to receive the proposed service. Include demographic Information as appropriate.

b) Primary and secondary service area ("PSA" and "SSA") towns

c) Scheduling backlogs in service area.

d) Travel distance from the proposed site to service area towns.

e) Hours of operation of the proposed service.

ii) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation used to develop the projections.**

iii) Provide the information as outlined in the following table concerning the existing providers current operations in the Applicant's PSA & SSA towns:

Primary Service Area:

Name of Provider	Similar Services Provided? (Y/N) (List the services)	Affiliated Physicians

Secondary Service Area:

Name of Provider	Similar Services Provided? (Y/N) (List the services)	Affiliated Physicians

iv) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

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

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

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

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

☐ Epidemiological studies
☐ Public information reports
☐ Market share analysis
☐ Other (Identify)
☐ None, *Explain* why no reports, studies or market share analysis was undertaken related to the proposal:

D. Provide a copy of any of needs assessment that was conducted related to the proposal. If a needs assessment was not conducted, explain why not.

5. Quality Measures

A. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

- ☐ American College of Cardiology
- ☐ National Association of Child Bearing Centers
- ☐ Report of the Inter-Council for Radiation Oncology
- ☐ National Committee for Quality Assurance
- ☐ American College of Obstetricians & Gynecologists
- ☐ American College of Radiology
- ☐ Public Health Code & Federal Corollary
- ☐ American College of Surgeons
- ☐ Substance Abuse Society and Mental Health Services Administration
- ☐ Other, Specify:

B. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

C. 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.*

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

- ☐ DPH
- ☐ Fire Marshall Report
- ☐ AAAHC
- ☐ Other:
- ☐ JCAHO
- ☐ Other States Health Dept. Reports
- ☐ (New Out-of-State Providers) AAAASF

Note: Above referenced acronyms are defined below. [1]

[1] 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.

E. Provide a copy of the following (as applicable):

- ☐ A copy of the related Quality Assurance plan
- ☐ Protocols for service (new service only)
- ☐ Patient Selection Criteria/Intake form

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?

- ☐ Energy conservation
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ None of the above
- ☐ Other (identify):
- ☐ Group purchasing
- ☐ Reengineering

7. Miscellaneous

A. 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.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

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

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

8. Financial Information

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

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

B. Provide the following financial information:

i) Please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Identify the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

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

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

* Provide an itemized list of all non-medical equipment.

10. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:
Source and amount:

Operating Funds Source/Entity Name Available Funds	$_____
Contributions	$_____
Funded depreciation	$_____
Other	$_____

☐ Grant:

Amount of grant	
Funding institution/ entity	

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	
CON Proposed debt financing	
Interest rate	%
Monthly payment	
Term	Years
Debt service reserve fund	

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	
CON Proposed lease financing	
Fair market value of leased assets at lease inception	
Interest rate	%
Monthly payment	
Term	Years

☐ Other financing alternatives:

Amount	
Source (e.g., donated assets, etc.)	

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution,
   ii. Letter of interest from CHEFA,
   iii. Amortization schedule (if not level amortization payments),
   iv. Lease agreement.

12. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the proposed service based on Gross Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following for the financial and statistical projections:

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 provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal **by payer. See attached, 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.). ***Note:*** *Include consideration of The Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development of the financial projections.*

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.

v) Provide a copy of the rate schedule for the proposed service.

vi) Describe how this proposal is cost effective.

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
Description	Actual Results	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected 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
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes				$0			$0			$0
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

*Volume Statistics:

*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

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

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

GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

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

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000, or capital expenditure exceeding $3,000,000 for major medical equipment, or CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.** _____ 19a-638 and 19a-639. **Fee Required.** 2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section. 3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000 4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ $ 1,000.00 b. Additional Fee: (Capital Expenditure Assessment)_____ $_____.00 (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ $_____.00 d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE: _____	$_____.00

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