GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

Fax

To: Kimberly Martone
Certificate of Need Supervisor
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134-0308

From: Nancy M. Hamson
Planning Director
Greenwich Hospital
5 Perryridge Road
Greenwich, CT 06830

Fax: 860-418-7053 **Pages:** 11 (including cover)

Phone: **Date:** December 3, 2008

Re: **cc:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

• **Comments:**

Please confirm that you have received this fax. Thank you for your attention to this matter.

GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

December 1, 2008

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

Dear Commissioner Vogel:

Enclosed please find an original Letter of Intent as well as six hard copies from Greenwich Hospital to provide outpatient physical medicine services at 2015 W. Main Street in Stamford, CT.

Thank you in advance for your consideration of this project. If you have any questions, please call me at (203) 863-3909.

Sincerely,

Nancy M. Hamson

Nancy M. Hamson
Director of Planning

CC: Frank A. Corvino, Greenwich Hospital

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

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

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	Greenwich Hospital	
Doing Business As	Greenwich Hospital	
Name of Parent Corporation	Greenwich Health Care Services, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	5 Perryridge Road Greenwich, CT 06830	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Nancy Hamson Director of Planning	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	5 Perryridge Road Room 3-3307 Greenwich CT 06830	
Contact Person Telephone Number	203-863-3909	
Contact Person Fax Number	203-863-4784	
Contact Person e-mail Address	nancyh@greenhosp.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Establishment of Outpatient Physical and Occupational Medicine Services in Stamford CT

b. Project Proposal: Establishment of Outpatient Physical and Occupational Medicine Services in Stamford CT

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)* PT, OT, Physiatry 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:

2015 West Main Street, Stamford CT 06902

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

Greenwich and Stamford

h. Estimated starting date for the project: April 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
NA				

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $1,297,027

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

Medical Equipment (Purchase)	$62,678
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	$92,618
Land/Building (Purchase)	
Construction/Renovation	$1,141,731
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$1,297,027**
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	$1,297,027

- Provide an itemized list of all medical and non-medical equipment to be purchased and leased.

Please see Attachment 1

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

NA				

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

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

- ☒ Applicant's Equity
- ☐ Capital Lease
- ☐ Conventional Loan
- ☐ Charitable Contributions
- ☐ Operating Lease
- ☐ CHEFA Financing
- ☐ Funded Depreciation
- ☐ Grant Funding
- ☐ Other *(specify)* _____

SECTION IV. PROJECT DESCRIPTION

In paragraph format, please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

Please see Attachment 2

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

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

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

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

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

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

7. Who will be responsible for providing the service?

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

AFFIDAVIT

To be completed by each Applicant

Applicant: Greenwich Hospital

Project Title: Establishment of Outpatient Physical and Occupational Medicine Services in Stamford CT

I, Frank A. Corvino (Name), President/CEO (Position – CEO or CFO)

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

Signature Dec. 1, 2008 Date

Subscribed and sworn to before me on December 1, 2008

Notary Public/Commissioner of Superior Court

SHEILA G. VENTO
NOTARY PUBLIC
MY COMMISSION EXPIRES MAR. 31, 2012

My commission expires:

Form 2030
Revised 10/2007

ATTACHMENT 1

Item

Exercise bicycle
Platform Mat
Treatment Table
Traction Package
Parallel Bars
Staircase
Heating Therapy Unit
Chilling Unit
Iontophoresis (4)
Gel Warmers (6)
Combination Carts (3)
Cardio Machine
Treadmill
Hand Evaluation Kit
Fluidotherapy Unit
Physical Therapy Only Ultrasound
Cart
Hand Therapy Table
MEDX Laser/Phototherapy System
Akron Treatment Table
Reception Chairs
Staff Desks
End Tables
Coffee Tables
Alarm System
PC/Monitors
Small Exercise Equipment (balls, straps, etc)
Overhead Pulleys
Weights
Exercise Mats
Mobile Intercom
Anatomical Charts

ATTACHMENT 2

Greenwich Hospital is a progressive medical center offering a wide range of medical, surgical, diagnostic and preventive programs. A member of the Yale New Haven Health System, Greenwich Hospital is a community teaching hospital, affiliated with the Yale University School of Medicine. Greenwich Hospital is committed to providing the highest quality of care to the communities it serves. Greenwich Hospital's Department of Public Health License is presented in Appendix I. With this Letter of Intent, Greenwich Hospital is seeking approval for it's establishment of outpatient physical and occupational medicine services in Stamford CT.

Greenwich Hospital provides Physical and Occupational Therapy as well as Physiatry services at the site located at 2015 W. Main Street in Stamford, CT. The Physical Therapists provide care for a variety of diagnoses including orthopedic and neurologic. This includes specific diagnoses such as low back pain, balance disorders, post surgical rehabilitation etc. The Occupational Therapists provide care focused on hand and upper extremity disorders. This includes both repetitive and traumatic type injuries. The Physiatrists provide medical management of Physical Medicine and Rehabilitation needs. They evaluate new patients, prescribe medications and necessary therapies, and services such as acupuncture and trigger point injections. State-of-the-art care is provided through the use of modalities and equipment such as ultrasound, electric stimulation, cold laser treatment, treadmills, bicycles, parallel bars and training stairs to provide the patient with relief of pain, swelling and to help increase overall functional abilities. Greenwich Hospital is the legal entity that is providing the services. Services are provided by Hospital employed clinicians who are licensed in the state of Connecticut in their respective disciplines. These services are the same as those currently (and historically) provided at Greenwich Hospital's main campus located at 5 Perryridge Road in Greenwich, CT.

Rehabilitation services at Greenwich Hospital reflect the latest in technological and therapeutic advances. Over the past several years, volume for outpatient physical and occupational medicine services had increased greatly at the Hospital's main campus. As a result, the service was at capacity in its physical space on the Hospital's main campus and feasible opportunities to increase the size of the physical space it occupied had been exhausted. Given the continued increase in demand without the ability to physically accommodate the higher demand, wait times for patients had grown. Ideally, patients should be scheduled within a day or two of requesting an appointment. The department would regularly reach waiting times of two to three weeks. Given the strong emphasis at Greenwich Hospital on service excellence and high quality care, changes needed to be made to how care was delivered for outpatient physical and occupational medicine services at Greenwich Hospital.

Patients who require outpatient physical and occupational medicine services generally come for treatment several times a week for multiple weeks. Out of convenience, patients often choose a therapy location that is close to their home. Creating that convenience and easy accessibility was a goal in choosing the current location of 2015 West Main Street in Stamford CT. Greenwich Hospital serves a majority of its patients from Greenwich and Stamford who benefit from the easy access of the site and its close proximity to their homes. Decanting volume from the main campus to the 2015 West Main Street location frees up capacity at the main campus and decreases the waiting times for patients. This, in turn, enables Greenwich Hospital to provide the high quality, service excellence focused care that best meets the needs of its patients.

The addition of Greenwich Hospital's outpatient physical and occupational medicine services in Stamford CT enhances the State of Connecticut health care delivery system. The Tully Center in Stamford is a similar provider in the geographic area. Greenwich Hospital provides the service under its acute care hospital license and no impact on Greenwich Hospital's payer sources is anticipated. Greenwich Hospital provides patients with state-of-the-art, easily accessible, excellent quality care when they need it, as soon as they need it.

APPENDIX 1

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0045

General Hospital

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

Greenwich Hospital of Greenwich, CT, d/b/a Greenwich Hospital is hereby licensed to maintain and operate a General Hospital.

Greenwich Hospital is located at 5 Perryridge Road, Greenwich, CT 06830

The maximum number of beds shall not exceed at any time:
32 Bassinets
174 General Hospital beds

This license expires **September 30, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2007. RENEWAL.

Satellites
The Endoscopy Center Of Greenwich Hospital, 500 West Putnam Avenue, Greenwich, CT

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

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

X

Form 2030
Revised 10/2007

GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

December 1, 2008

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

Dear Commissioner Vogel:

Enclosed please find an original Letter of Intent as well as six hard copies from Greenwich Hospital to provide outpatient physical medicine services at 2015 W. Main Street in Stamford, CT.

Thank you in advance for your consideration of this project. If you have any questions, please call me at (203) 863-3909.

Sincerely,

Nancy M. Hamson

Nancy M. Hamson
Director of Planning

CC: Frank A. Corvino, Greenwich Hospital

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

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

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	Greenwich Hospital	
Doing Business As	Greenwich Hospital	
Name of Parent Corporation	Greenwich Health Care Services, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	5 Perryridge Road Greenwich, CT 06830	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Nancy Hamson Director of Planning	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	5 Perryridge Road Room 3-3307 Greenwich CT 06830	
Contact Person Telephone Number	203-863-3909	
Contact Person Fax Number	203-863-4784	
Contact Person e-mail Address	nancyh@greenhosp.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Establishment of Outpatient Physical and Occupational Medicine Services in Stamford CT

b. Project Proposal: Establishment of Outpatient Physical and Occupational Medicine Services in Stamford CT

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)* PT, OT, Physiatry 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:

2015 West Main Street, Stamford CT 06902

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

Greenwich and Stamford

h. Estimated starting date for the project: April 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
NA				

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $1,297,027

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

Medical Equipment (Purchase)	$62,678
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	$92,618
Land/Building (Purchase)	
Construction/Renovation	$1,141,731
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$1,297,027**
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	$1,297,027

- Provide an itemized list of all medical and non-medical equipment to be purchased and leased.

Please see Attachment 1

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

NA				

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

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

- ☒ Applicant's Equity
- ☐ Capital Lease
- ☐ Conventional Loan
- ☐ Charitable Contributions
- ☐ Operating Lease
- ☐ CHEFA Financing
- ☐ Funded Depreciation
- ☐ Grant Funding
- ☐ Other *(specify)* _____

SECTION IV. PROJECT DESCRIPTION

In paragraph format, please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

Please see Attachment 2

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

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

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

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

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

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

7. Who will be responsible for providing the service?

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

AFFIDAVIT

To be completed by each Applicant

Applicant: Greenwich Hospital

Project Title: Establishment of Outpatient Physical and Occupational Medicine Services in Stamford CT

I, Frank A. Corvino (Name), President/CEO (Position – CEO or CFO)

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

Signature Date: Dec. 1, 2008

Subscribed and sworn to before me on December 1, 2008

Notary Public/Commissioner of Superior Court

SHEILA G. VENTO
NOTARY PUBLIC
MY COMMISSION EXPIRES MAR. 31, 2012

My commission expires:

ATTACHMENT 1

Item

Exercise bicycle
Platform Mat
Treatment Table
Traction Package
Parallel Bars
Staircase
Heating Therapy Unit
Chilling Unit
Iontophoresis (4)
Gel Warmers (6)
Combination Carts (3)
Cardio Machine
Treadmill
Hand Evaluation Kit
Fluidotherapy Unit
Physical Therapy Only Ultrasound
Cart
Hand Therapy Table
MEDX Laser/Phototherapy System
Akron Treatment Table
Reception Chairs
Staff Desks
End Tables
Coffee Tables
Alarm System
PC/Monitors
Small Exercise Equipment (balls, straps, etc)
Overhead Pulleys
Weights
Exercise Mats
Mobile Intercom
Anatomical Charts

ATTACHMENT 2

Greenwich Hospital is a progressive medical center offering a wide range of medical, surgical, diagnostic and preventive programs. A member of the Yale New Haven Health System, Greenwich Hospital is a community teaching hospital, affiliated with the Yale University School of Medicine. Greenwich Hospital is committed to providing the highest quality of care to the communities it serves. Greenwich Hospital's Department of Public Health License is presented in Appendix I. With this Letter of Intent, Greenwich Hospital is seeking approval for it's establishment of outpatient physical and occupational medicine services in Stamford CT.

Greenwich Hospital provides Physical and Occupational Therapy as well as Physiatry services at the site located at 2015 W. Main Street in Stamford, CT. The Physical Therapists provide care for a variety of diagnoses including orthopedic and neurologic. This includes specific diagnoses such as low back pain, balance disorders, post surgical rehabilitation etc. The Occupational Therapists provide care focused on hand and upper extremity disorders. This includes both repetitive and traumatic type injuries. The Physiatrists provide medical management of Physical Medicine and Rehabilitation needs. They evaluate new patients, prescribe medications and necessary therapies, and services such as acupuncture and trigger point injections. State-of-the-art care is provided through the use of modalities and equipment such as ultrasound, electric stimulation, cold laser treatment, treadmills, bicycles, parallel bars and training stairs to provide the patient with relief of pain, swelling and to help increase overall functional abilities. Greenwich Hospital is the legal entity that is providing the services. Services are provided by Hospital employed clinicians who are licensed in the state of Connecticut in their respective disciplines. These services are the same as those currently (and historically) provided at Greenwich Hospital's main campus located at 5 Perryridge Road in Greenwich, CT.

Rehabilitation services at Greenwich Hospital reflect the latest in technological and therapeutic advances. Over the past several years, volume for outpatient physical and occupational medicine services had increased greatly at the Hospital's main campus. As a result, the service was at capacity in its physical space on the Hospital's main campus and feasible opportunities to increase the size of the physical space it occupied had been exhausted. Given the continued increase in demand without the ability to physically accommodate the higher demand, wait times for patients had grown. Ideally, patients should be scheduled within a day or two of requesting an appointment. The department would regularly reach waiting times of two to three weeks. Given the strong emphasis at Greenwich Hospital on service excellence and high quality care, changes needed to be made to how care was delivered for outpatient physical and occupational medicine services at Greenwich Hospital.

Patients who require outpatient physical and occupational medicine services generally come for treatment several times a week for multiple weeks. Out of convenience, patients often choose a therapy location that is close to their home. Creating that convenience and easy accessibility was a goal in choosing the current location of 2015 West Main Street in Stamford CT. Greenwich Hospital serves a majority of its patients from Greenwich and Stamford who benefit from the easy access of the site and its close proximity to their homes. Decanting volume from the main campus to the 2015 West Main Street location frees up capacity at the main campus and decreases the waiting times for patients. This, in turn, enables Greenwich Hospital to provide the high quality, service excellence focused care that best meets the needs of its patients.

The addition of Greenwich Hospital's outpatient physical and occupational medicine services in Stamford CT enhances the State of Connecticut health care delivery system. The Tully Center in Stamford is a similar provider in the geographic area. Greenwich Hospital provides the service under its acute care hospital license and no impact on Greenwich Hospital's payer sources is anticipated. Greenwich Hospital provides patients with state-of-the-art, easily accessible, excellent quality care when they need it, as soon as they need it.

APPENDIX 1

10/03/2007 15:22 FAX ☑002

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0045

General Hospital

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

Greenwich Hospital of Greenwich, CT, d/b/a Greenwich Hospital is hereby licensed to maintain and operate a General Hospital.

Greenwich Hospital is located at 5 Perryridge Road, Greenwich, CT 06830

The maximum number of beds shall not exceed at any time:
32 Bassinets
174 General Hospital beds

This license expires **September 30, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2007. RENEWAL.

Satellites
The Endoscopy Center Of Greenwich Hospital, 500 West Putnam Avenue, Greenwich, CT

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

X

Form 2030
Revised 10/2007

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 10, 2008

Nancy Hamson
Director of Planning
Greenwich Hospital
5 Perry Road
Greenwich, CT 06830

RE: Certificate of Need Application Forms, Docket Number 08-31283-CON
Greenwich Hospital
Establishment and Operation of Outpatient Physical Therapy and Occupational Medicine Services in Stamford

Dear Ms. Hamson:

Enclosed are the application forms for Greenwich Hospital's Certificate of Need ("CON") proposal to establish outpatient physical therapy and occupational medicine services at 2015 West Main Street in Stamford, Connecticut, at a estimated total capital expenditure of $1,297,027. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between January 30, 2009, and March 31, 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 eight (8) hard copies of each submission in **3-ring binders**.
- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.

- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Steven W. Lazarus. Please contact him at (860) 418-7012, if you have questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

of _____ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☐ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

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

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than January 30, 2009 and may be submitted no later than March 31, 2009. The Analysts assigned to your application is Steven W. Lazarus. He may be reached at the Office of Health Care Access at (860) 418-7012.

Docket Number:	**08-31283-CON**
Applicant Name:	**Greenwich Hospital**
Contact Person:	**Nancy Hamson**
Contact Title:	**Director of Planning**
Contact Address:	**Greenwich Hospital** **5 Perryridge Road** **Greenwich, CT 06830**
Project Location:	**Stamford**
Project Name:	**Establishment and Operation of Outpatient Physical Therapy and Occupational Medicine Services in Stamford**
Type of proposal:	**Sections 19a-639, C.G.S.**

Est. Capital Expenditure: $1,297,027

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

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 proposed Outpatient Physical and Occupational Medicine Services in Stamford.

B. Has Greenwich Hospital ("Hospital") conducted a needs assessment for the proposed services in Stamford? If so, provide a copy.

C. Provide a list of the service area towns for the proposed service in Stamford.

D. Provide the methodology used to delineate the service areas, and/or the rationale used to choose the proposed service area towns.

E. Describe the population to be served with the proposed outpatient physical and occupational medicine services. (i.e. conditions, diseases etc.)

F. Discuss in detail the outpatient physical and occupational medicine services currently provided at the Hospital or any other Hospital location.

G. The impact of this proposal on the Hospital's outpatient physical and occupational medicine services on hospital campus.

H. Where has the Hospital and/or Hospital affiliated physicians referred patients requiring outpatient physical and occupational medicine services prior to offering the proposed services in Stamford?

I. Provide the date the Hospital began operating the proposed services in Stamford.

J. Please provide the existing outpatient physical and occupational medicine services historical volume at the Hospital's main campus, in Stamford and the projected volume by location (Hospital's main campus and the proposed service in Stamford) for the proposed services in Stamford, in the following table:

	Actual Exam Volume By Location (Last 3 Completed FYs)			**CFY Volume* By Location**	**Projected Exam Volume By Location (First 3 Full Operational FYs)****		
	FY 2006	**FY 2007**	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**
Outpatient Physical Theraphy	Hospital: Stamford:	Hospital: Stamford	Hospital: Stamford	Hospital: Stamford	Hospital: Stamford	Hospital: Stamford	Hospital: Stamford
Occupational Medicine	Hospital: Stamford :	Hospital: Stamford	Hospital: Stamford	Hospital: Stamford	Hospital: Stamford	Hospital: Stamford	Hospital: Stamford

Notes: *Please report the annualized number of exams, identifying the respective number of months of recorded activity in your response.

If the first year of operation of the proposed service site is only a partial year, the Hospital must provide the first partial year and then the first three full FYs. **Include all assumptions used in the derivation/calculation of your projections.

K. Provide FY 2008 and year-to-date volume for outpatient physical and occupational medicine services at the Hospital by patient town of origin.

L. Does the Hospital offer other services other than the proposed services at this location in Stamford?

M. Are there Hospital affiliated physicians located at this location in Stamford? If yes, provide the names of the physicians and practices and their specialties.

N. Hours of operation of the proposed services in Stamford.

O. Hours of operation for the Hospital's outpatient physical and occupational medicine services located at the main campus.

P. Provide the information as outlined in the following table concerning the existing providers' (in the Hospital total service area) currently in operation:

Name of Provider Street, Town, Zip Code	**Similar Services Provided? (Y/N) List**	**Affiliated Physicians (Name, Practice)**

Note: Include all hospitals, outpatient centers, and physician offices.

Q. List the nearest provider of outpatient physical and occupational medicine services.

i) Please provide the number of Hospital patients referred to this provider for the proposed services during FY 2008 and year-to-date.

R. What will be the effect of your proposal on existing providers of the same services (i.e. patient volume, quality of care, etc.)?

S. 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.

T. 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:

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 Committee for Quality Assurance	☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers	☐ American College of Obstetricians & Gynecologists	☐ American College of Surgeons
☐ Report of the Inter-Council for Radiation Oncology	☐ American College of Radiology	☐ Substance Society Abuse 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	☐	JCAHO
☐	Fire Marshall Report	☐	Other States Health Dept. Reports (new out-of-state providers)
☐	AAAHC	☐	AAAASF
☐	Other: _____		

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

E. Provide a copy of the related sections of the Quality Assurance plan to the proposal and the corresponding sections of the latest annual evaluation report of the Hospital's Quality Assurance Committee.

F. 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 ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify) _____

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

[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.

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

C. Provide a copy of the State of Connecticut Department of Public Health license currently held.

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): _____

B. Provide the following financial information:

i) Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant may reference that filing for this proposal.

ii) Provide the total current assets balance as of the date of submission of this application.

iii) Provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date.

iv) Please describe the billing structure in detail and name of 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. Construction Information

A. Provide a detailed description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide the following breakdown of the new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			
Other (Specify)_____			
Total Construction/Renov. Cost			

D. Explain how the proposed new construction or renovations will affect the delivery of patient care.

E. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

11. Land/ Building Purchase

A. If the CON involves any land/building purchase, please answer all of the following that apply:

Please submit a copy of the Real Estate Property Appraisal.	$_____
What is the useful life of the building?	_____ Years
Please submit a schedule of depreciation for the purchased building as an attachment.	

For multiple items, please attach a separate sheet for each item in the above format.

12. 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:

1) 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:
   i. Letter of interest from the lending institution,
   ii. Amortization schedule (if not level amortization payments),
   iii. Lease agreement,
   iv. Vendor quote.

13. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current and projected payer mix for the outpatient physical and occupational medicine services and **proposed services, based on Gross Patient Revenue** in the following reporting format:

Total Facility Description	Current Payer Mix at the Hospital	Year 1 Projected Payer Mix at Stamford Location	Year 2 Projected Payer Mix at Stamford Location	Year 3 Projected Payer Mix at Stamford Location
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total 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. 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 Financial Attachment I.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicants audited financial statements.

ii) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Please complete CON 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) Provide a discussion on reimbursement for the proposed services.

vii) Describe how this proposal is cost effective.

Greenwich Hospital

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

Greenwich Hospital

13. C (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				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.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 16, 2008

Nancy Hamson
Director of Planning
Greenwich Hospital
5 Perryridge Road, Room 3-3307
Greenwich, CT 06830

Re: Letter of Intent, Docket Number 08-31283
Greenwich Hospital
Establishment and Operation of Physical Therapy and Occupational Medicine Services in Stamford, CT
Notice of Letter of Intent

Dear Ms. Hamson:

On December 3, 2008 the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Greenwich Hospital ("Applicant") for the establishment and operation of physical therapy and occupational medicine services in Stamford, with a total capital expenditure of $1,1297,027.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Greenwich Times and Stamford Advocate* 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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 16, 2008

Requisition # HCA09-085
Email: legal.notices@scni.com

The Advocate
75 Tresser Blvd.
Stamford, CT 06903

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 no later than **Saturday, December 20, 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 **Steven Lazarus** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:SWL:lmg

c: Sandy Salus, OHCA

The Advocate
Docket Number: 08-31283

Letter of Intent
December 16, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicants:	Greenwich Hospital
Town:	Stamford
Docket Number:	08-31283-LOI
Proposal:	Establishment and Operation of Physical Therapy and Occupational Medicine Services
Capital Expenditure:	$1,297,027

The Applicant may file their Certificate of Need application between January 30, 2009 and March 31, 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 at OHCA or on OHCA's website at www.ct.gov/OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicants.

Greer, Leslie

Sent: Tuesday, December 16, 2008 9:46 AM

----IMAeb4bf0c.4947/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.

----IMAeb4bf0c.4947/pop.state.ct.us
Content-Type: message/delivery-status

Reporting-MTA: pop.state.ct.us
Final-Recipient: rfc8222;legal.notices@scni.com
Action: relayed
Status: 2.0.0

----IMAeb4bf0c.4947/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 AF080DBC; Tue, 16 Dec 2008 09:45:28 -0500
Received: from 159.247.77.53 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall v6.0.0)); Tue, 16 Dec 2008 09:52:07 -0500
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 08-31283 (2)
Date: Tue, 16 Dec 2008 09:42:38 -0500
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B101B7DA3B@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach: yes
X-MS-TNEF-Correlator:
Thread-Topic: Legal Ad 08-31283 (2)
Thread-Index: AclfjIqNsZ5MC5JEQoiLvm0gSKOCmQ==
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
To: legal.notices@scni.com
X-WSS-ID: 65591F1D30S2046096-01-01
Content-Type: multipart/mixed;
boundary="----_=_NextPart_001_01C95F8C.8AAC2782"

----IMAeb4bf0c.4947/pop.state.ct.us--

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 16, 2008

Requisition # HCA09-084
Email: legal.notices@scni.com

Greenwich Times
20 East Elm Street
Greenwich, CT 06830

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 no later than **Saturday, December 20, 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 **Steven Lazarus** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:SWL:lmg

c: Sandy Salus, OHCA

Greenwich Times
Docket Number: 08-31283

Letter of Intent
December 16, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicants:	Greenwich Hospital
Town:	Stamford
Docket Number:	08-31283-LOI
Proposal:	Establishment and Operation of Physical Therapy and Occupational Medicine Services
Capital Expenditure:	$1,297,027

The Applicant may file their Certificate of Need application between January 30, 2009 and March 31, 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 at OHCA or on OHCA's website at www.ct.gov/OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicants.

Greer, Leslie

Sent: Tuesday, December 16, 2008 9:34 AM

----IMAeb4bc3f.4947/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.

----IMAeb4bc3f.4947/pop.state.ct.us
Content-Type: message/delivery-status

Reporting-MTA: pop.state.ct.us
Final-Recipient: rfc8222;legal.notices@scni.com
Action: relayed
Status: 2.0.0

----IMAeb4bc3f.4947/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 AC3C1148; Tue, 16 Dec 2008 09:33:32 -0500
Received: from 159.247.77.53 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall v6.0.0)); Tue, 16 Dec 2008 09:40:10 -0500
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 08-31283
Date: Tue, 16 Dec 2008 09:30:40 -0500
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B101B7DA3A@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach: yes
X-MS-TNEF-Correlator:
Thread-Topic: Legal Ad 08-31283
Thread-Index: AcIfit6vayoQLPrkT/6K63/AlVm/fw==
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
To: legal.notices@scni.com
X-WSS-ID: 65596240305/2044723-01-01
Content-Type: multipart/mixed;
boundary="----_=_NextPart_001_01C95F8A.DEDA6121"

----IMAeb4bc3f.4947/pop.state.ct.us--

Greer, Leslie

From: Rose Trapasso [Rose.Trapasso@scni.com] on behalf of legals [legals@scni.com]
Sent: Tuesday, December 16, 2008 12:00 PM
To: Greer, Leslie
Subject: RE: Legal Ad 08-31283 (2)

Hi Leslie I put the notice in both papers on the same order and requisition both number in the PO field. You get a better price for both papers on same order. Thank you, Rose

---

From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Tuesday, December 16, 2008 11:51 AM
To: legals
Subject: RE: Legal Ad 08-31283 (2)

Yes, and different requisition numbers for billing.

From: Rose Trapasso [mailto:Rose.Trapasso@scni.com] **On Behalf Of** legals
Sent: Tuesday, December 16, 2008 11:31 AM
To: Greer, Leslie
Subject: RE: Legal Ad 08-31283 (2)

Hello Leslie, this ad is all set for both The Advocate and Greenwich Time for Sat. 12/20. The previous email was the same except you put in p.s. both papers. Correct? Thank you, Rose

---

From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Tuesday, December 16, 2008 9:43 AM
To: legals
Subject: Legal Ad 08-31283 (2)

Legal Ad,
Please run the attached public notice in your newspaper no later than December 20, 2008; please notify me that you have received this request.
(P.S. this public notice is to appear in both The Advocate & Greenwich Times)

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

The ADVOCATE
Greenwich Time

9 Riverbend Drive South
Building 9A
P.O. Box 4910
Stamford, CT 06907-0910
tel: 203/316-2004
fax: 203/964-2302
legal.notices@scni.com

STATE OF CONNECTICUT SS.Stamford, Connecticut
COUNTY OF FAIRFIELD

LEGAL NOTICE
Statute Reference: 19a-638
Applicants: Greenwich Hospital
Town: Stamford
Docket Number: 08-31283-LOI
Proposal: Establishment and Operation of Physical Therapy and Occupational Medicine Services
Capital Expenditure: $1,297,027

The Applicant may file their Certificate of Need application between January 30, 2009 and March 31, 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 at OHCA or on OHCA's website at www.ct.gov/OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicants.

I Rose Trapasso
Being duly sworn, depose and say that I am a Representative in the employ of SOUTHERN CONNECTICUT NEWSPAPERS, INC. publisher of The Advocate and Greenwich Time, that a Classified Advertisment

Legal Notice

was published in The Advocate, the Greenwich Time and/~~or~~ on the Internet 12-20-08

Subscribed and sworn to before me on this 29th Day of December 2008

Pamela R. Henderson
Notary Public
My commission expires on _____

PAMELA R. HENDERSON
NOTARY PUBLIC
MY COMMISSION EXPIRES MAY 31, 2012