



**GREENWICH  
HOSPITAL**  
YALE NEW HAVEN HEALTH

**RECEIVED**

2008 DEC -3 A 10:09

**Fax**

CONNECTICUT OFFICE OF  
HEALTH CARE ACCESS

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**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

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

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

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**Re:** **cc:**

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

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**• Comments:**

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

RECEIVED

2008 DEC -3 A 10:09

CONNECTICUT OFFICE OF  
HEALTH CARE ACCESS



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

Page 3 of 9

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: _____	
<b>Total Capital Expenditure</b>	<b>\$1,297,027</b>
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV))	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
<b>Total Capital Cost</b>	
Capitalized Financing Costs (Informational Purpose Only)	
<b>Total Capital Expenditure with Cap. Fin. Costs</b>	<b>\$1,297,027</b>

- 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

- 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
- 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?

Page 6 of 9

**AFFIDAVIT****To be completed by each Applicant**Applicant: Greenwich HospitalProject Title: Establishment of Outpatient Physical and Occupational Medicine Services in Stamford CTI, Frank A. Corvino, President/CEO  
(Name) (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 complies with the appropriate and (Facility Name) applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.



Signature

Dec. 1, 2008

Date

Subscribed and sworn to before me on

December 1, 2008  
Notary Public/Commissioner of Superior CourtSHEILA 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 its 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.

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## APPENDIX 1

10/08/2007 15:22 FAX

GI002

## 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:

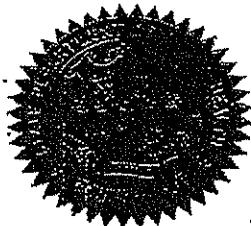
- 32 Bassinets
- 174 General Hospital beds

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



2008 DEC -4 A 11:23

CONNECTICUT OFFICE OF  
HEALTH CARE ACCESS

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

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	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  
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### 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  
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 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:

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 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

- Estimated Total Project Expenditure/Cost: \$1,297,027
- Please provide the following tentative capital expenditure/costs related to the proposal:

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Non-Medical Equipment (Lease (FMV))*	
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<b>Total Capital Cost</b>	
Capitalized Financing Costs (Informational Purpose Only)	
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- Provide an itemized list of all medical and non-medical equipment to be purchased and leased.

Please see Attachment 1

- 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

- 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
- Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

- 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) \_\_\_\_\_

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



Signature

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: \_\_\_\_\_

## 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  
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## ATTACHMENT 2

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## APPENDIX 1

10/03/2007 15:22 FAX

002

### STATE OF CONNECTICUT

#### Department of Public Health

##### LICENSE

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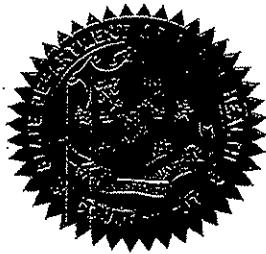
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174 General Hospital beds

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

##### Satellites

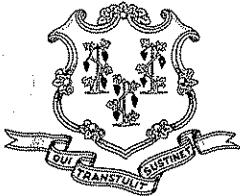
The Endoscopy Center Of Greenwich Hospital, 500 West Putnam Avenue, Greenwich, CT



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

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

X



M. JODI RELL  
GOVERNOR

STATE OF CONNECTICUT  
OFFICE OF HEALTH CARE ACCESS

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.

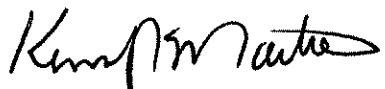
When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. **Failure to observe these requirements will require follow-up work on your part to correct the filing.**

- 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

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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
<b>Outpatient Physical Therapy</b>	Hospital: Stamford:	Hospital: Stamford	Hospital: Stamford	Hospital: Stamford	Hospital: Stamford	Hospital: Stamford
<b>Occupational Medicine</b>	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:

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 were 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:

<input type="checkbox"/> American College of Cardiology	<input type="checkbox"/> National Committee for Quality Assurance	<input type="checkbox"/> Public Health Code & Federal Corollary
<input type="checkbox"/> National Association of Child Bearing Centers	<input type="checkbox"/> American College of Obstetricians & Gynecologists	<input type="checkbox"/> American College of Surgeons
<input type="checkbox"/> Report of the Inter-Council for Radiation Oncology	<input type="checkbox"/> American College of Radiology	<input type="checkbox"/> 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:

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

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

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

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

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:	
<b>Total Capital Expenditure</b>	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV))	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
<b>Total Capital Cost</b>	
Capitalized Financing Costs (Informational Purpose Only)	
<b>Total Capital Expenditure with Cap. Fin. Costs</b>	

\* 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				
<b>Total Government Payers</b>				
Commercial Insurers*				
Uninsured				
Workers Compensation				
<b>Total Non-Government Payers</b>				
<b>Total Payer Mix</b>	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.**

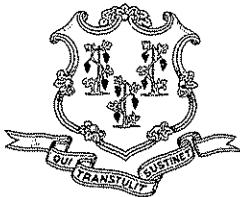
- iii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.). *Note: Include consideration of the Deficit Reduction Act of 2005 and the reduction of Medicaid and 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.

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

**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:

<u>Total Facility:</u> 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
<b>NET PATIENT REVENUE</b>										
Non-Government				\$0						\$0
Medicare				\$0						\$0
Medicaid and Other Medical Assistance				\$0						\$0
Other Government				\$0						\$0
<b>Total Net Patient Patient Revenue</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Other Operating Revenue</b>										
Revenue from Operations				\$0						\$0
										\$0
<b>OPERATING EXPENSES</b>										
Salaries and Fringe Benefits				\$0						\$0
Professional / Contracted Services				\$0						\$0
Supplies and Drugs				\$0						\$0
Bad Debts				\$0						\$0
Other Operating Expense				\$0						\$0
<b>Subtotal</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
Depreciation/Amortization										
Interest Expense										
Lease Expense										
<b>Total Operating Expense</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
Gain/(Loss) from Operations				\$0						\$0
Plus: Non-Operating Revenue										
Revenue Over/(Under) Expense										
<b>FTEs</b>				<b>0</b>						<b>0</b>

\*Volume Statistics:  
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and projected 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

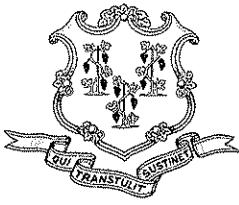
KRM:lmg

*An Affirmative Action / Equal Opportunity Employer*

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

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

Fax: (860) 418-7053



# 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](mailto: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**.

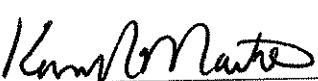
Please provide the following **within 30 days** of publication:

- 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

*An Affirmative Action / Equal Opportunity Employer*

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

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

Fax: (860) 418-7053

**PLEASE INSERT THE FOLLOWING:**

Statute Reference: 19a-638  
Applicants: 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](http://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

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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: rfc822;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>

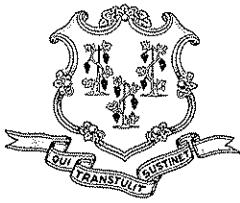
To: legal.notices@scni.com

X-WSS-ID: 65591F1D3052046096-01-01

Content-Type: multipart/mixed;

boundary="----=\_NextPart\_001\_01C95F8C.8AAC2782"

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



M. JODI RELL  
GOVERNOR

# STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL  
COMMISSIONER

December 16, 2008

Requisition # HCA09-084  
Email: [legal.notices@scni.com](mailto: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**.

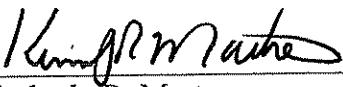
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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

  
\_\_\_\_\_  
Kimberly R. Martone  
Certificate of Need Supervisor

Attachment

KRM:SWL:img

c: Sandy Salus, OHCA

*An Affirmative Action / Equal Opportunity Employer*

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

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

Fax: (860) 418-7053

**PLEASE INSERT THE FOLLOWING:**

Statute Reference: 19a-638  
Applicants: 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](http://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

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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: rfc822;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: Ac1fit6vayoQLPrkT/6K63/AlVm/fw==

From: "Greer, Leslie" <Leslie.Greer@ct.gov>

To: legal.notices@scni.com

X-WSS-ID: 6559624030S2044723-01-01

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](http://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 Occupa-  
tional Medicine  
Services  
Capital Expenditure:  
\$1,297,027  
The Applicant may  
file their Certificate of  
Need application be-  
tween January 30,  
2009 and March 31,  
2009. Interested per-  
sons are invited to  
submit written com-  
ments to Christine 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 web-  
site at  
[www.ct.gov/OHCA](http://www.ct.gov/OHCA).  
A copy of the Letter  
of Intent or a copy of  
Certificate of Need  
Application, when  
filed, may be ob-  
tained 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 Giapasso  
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 Advertisement

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 29<sup>th</sup>  
Day of December 2008

Pamela R. Henderson  
Notary Public  
My commission expires on \_\_\_\_\_

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