Geoffrey Cole
President and CEO

Norwalk
Hospital

Norwalk,
Connecticut 06856

June 1, 2009

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

Re: Sale of Norwalk Health Care, Inc.

Dear Commissioner Vogel:

Attached is a Letter of Intent for the sale of Norwalk Health Care, Inc. which conducts business as Honey Hill Rehabilitation & Skilled Nursing Center. Norwalk Health Care, Inc. is a non-stock, tax exempt subsidiary of Norwalk Hospital's parent corporation, Norwalk Health Services Corporation.

The proposed sale will result in selling all of Norwalk Health Care, Inc.'s rights, title, and interest in the facility to Hunter Management, LLC, an Illinois limited liability company.

If you have any questions, please do not hesitate to contact me at (203) 852-2212.

Sincerely,

Geoffrey F. Cole
President and CEO
Norwalk Hospital Association

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	Norwalk Health Care, Inc.	
Doing Business As	Norwalk Health Care, Inc.	
Name of Parent Corporation	Norwalk Health Services Corporation	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	34 Maple Street Norwalk, CT 06856	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Dan DeBarba Chief Operating Officer	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Norwalk Health Care, Inc. 34 Maple Street Norwalk, CT 06856	
Contact Person Telephone Number	(203) 852-3273	
Contact Person Fax Number	(203) 852-3436	
Contact Person e-mail Address	Dan.DeBarba@Norwalkhealth.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Sale of Skilled Nursing Facility

b. Project Proposal:

Norwalk Health Care, Inc. (the "Applicant") is a non-stock tax-exempt 150-bed skilled nursing facility located at 34 Midrocks Drive in Norwalk, Connecticut. The skilled nursing facility conducts business under the name of Honey Hill Rehabilitation & Skilled Nursing Center ("Honey Hill"). The proposed project will result in the Applicant selling all of its rights, title and interest in the Facility to Hunter Management, LLC, an Illinois limited liability company (the "Purchaser"). The Purchaser has agreed to purchase Honey Hill for Seven Million Eight Hundred Seventy-Five Thousand Dollars ($7,875,000).

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity
☐ Trauma Center ☐ Transplantation Programs
☐ Rehabilitation *(specify type)* _____
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Inpatient *(specify)* _____

Outpatient Service(s):

☐ Ambulatory Surgery Center ☐ Primary Care ☐ Oncology
☐ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care
☐ Rehabilitation *(specify type)* _____ ☐ Central Services Facility
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Outpatient *(specify)* _____

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
☐ Cineangiography Equipment ☐ New Technology: _____

Non-Clinical:

☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations
☒ Change in Ownership or Control ☐ Land and/or Building Acquisitions
☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☒ Yes ☐ No

If you checked "Yes" above, please check the appropriate box below:

☐ 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:

34 Midrocks Drive, Norwalk, CT 06851

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

Norwalk, New Canaan, Weston, Westport, Wilton, Darien, Easton, Trumbull, Bridgeport, Southport and Stamford.

h. Estimated starting date for the project:

Immediately upon regulatory approval.

i. If the proposal includes change in the number of beds provide the following information:

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $0

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

Major Medical Equipment Purchases*
Medical Equipment Purchases*
Non-Medical Equipment Purchases*
Land/Building Purchases
Construction/Renovation
Other (Non-Construction) Specify:_____
Total Capital Expenditure
Major Medical Equipment – Fair Market Value of Leases Medical
Equipment – Fair Market Value of Leases
Non-Medical Equipment – Fair Market Value of Leases*
Fair Market Value of Space – Capital Leases Only
Total Capital Cost
Total Project Cost
Capitalized Financing Costs (Informational Purpose Only)

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

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☐ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

   ☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

   ☐ Non Substantive

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

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

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

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

☐ 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.

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: Norwalk Health Care, Inc.

Project Title: Sale of Skilled Nursing Facility

I, Geoffrey Cole, President and CEO of Norwalk Health Care, Inc. 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 Norwalk Health Care, Inc. complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Geoffrey Cole — 5/29/09

Signature — Date

Subscribed and sworn to before me on 5-29-09

[illegible] M. [illegible] Juris No.: 408121

Notary Public/Commissioner of Superior Court

My commission expires: _____

Responses to Questions in Section V

Project Description

Norwalk Health Care, Inc. (the "Applicant") is a non-stock tax-exempt 150-bed skilled nursing facility located at 34 Midrocks Drive in Norwalk, Connecticut. The skilled nursing facility conducts business under the name of Honey Hill Rehabilitation & Skilled Nursing Center ("Honey Hill") The proposed project will result in the Applicant selling all of its rights, title and interest in the Facility to Hunter Management, LLC, an Illinois limited liability company (the "Purchaser"). The Purchaser has agreed to purchase Honey Hill for Seven Million Eight Hundred Seventy-Five Thousand Dollars ($7,875,000).

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.

   Honey Hill currently provides residents with a full range of long and short-term skilled nursing home services including sub-acute medical and rehabilitation, and dementia services as well as social activities and dietary planning. In addition, Honey Hill also offers wound care management, physical therapy, occupational therapy, speech therapy, recreational therapy, intravenous therapy, hospice care, respite care and total parenteral nutrition. A copy of the facility's license is attached hereto as Exhibit A.

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

   The parties do not anticipate any interruptions or changes of service as a result of the Purchaser assuming ownership of Honey Hill. However, the Purchaser may expand on certain programmatic offerings as it deems appropriate. Because Honey Hill's current license is non-transferable, the Purchaser is currently seeking to obtain its own license from DPH so that the facility may continue to be operated as a Chronic and Convalescent Nursing Home as defined in the applicable DPH statutes and regulations.

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

   Honey Hill's current population of residents from Norwalk and the surrounding towns who require both long and short-term nursing home care will continue to be served after the proposed sale and change of ownership takes place.

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

   The proposed sale and change of ownership will enable the facility to continue serving its current populations.

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

The following facilities offer skilled nursing home services within a 10 mile radius of Honey Hill: Marathon Healthcare Center, Westport Health Care Center, Cambridge Manor, Wilton Meadows Health Care, Lourdes Health Care Center (serving retired nuns), Notre Dame Convalescent Home and Waveny Care Center.

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

   The effect of this proposal should be neutral because the proposed project will not result in the addition or reduction of any skilled nursing home beds within the State of Connecticut.

7. Who will be responsible for providing the service?

   The current Medical Director, Director of Patient Care Services, Assistant Director of Patient Care Services, Admissions Director, Director of Dining Services, Director of Financial Services, Director of Human Resources, Maintenance & Housekeeping Supervisor, MDS Coordinators, Director of Recreation, Director of Rehabilitation Services, Director of Social Services, Director of Staff Development and Nursing Unit Managers for Honey Hill are all expected to remain in their present positions after the change of ownership. It is also expected that most, if not all, of the facility's current licensed and unlicensed staff will be offered employment with the Purchaser. Management services for Honey Hill will be provided by Purchaser.

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

   The primary payers for nursing home services at Honey Hill are Medicaid and Medicare. In addition, there are an immaterial number of commercial patients. It is not anticipated that any change in payers will occur as a result of this transaction.

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 2116-C

Chronic and Convalescent Nursing Home

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

Norwalk Health Care Inc of Norwalk, CT, d/b/a Honey Hill Rehabilitation And Nursing Center is hereby licensed to maintain and operate a Chronic and Convalescent Nursing Home.

Honey Hill Rehabilitation And Nursing Center is located at 34 Midrocks Road, Norwalk, CT 06851 with:

Eric B. Einstein MD as Medical Director
Arthur E. Santilli as Administrator
*Deborah A. Quare RN as Director of Nurses

The maximum number of beds shall not exceed at any time:

150 Chronic and Convalescent Nursing Home beds

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

Dated at Hartford, Connecticut, July 1, 2007.

Waiver Sec. 19-13-D8v(b)(2)(A) Exp: N/A

License revised to reflect:
*Change of Director of Nurses effective 06/09/08.

J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA,
Commissioner

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 12, 2009

Daniel DeBarba
Chief Operating Officer
Norwalk Health Care, Inc.
34 Maple Street
Norwalk, CT 06856

Re: Letter of Intent, Docket Number 09-31383-LOI
Service Termination regarding Honey Hill Rehabilitation and Skilled Nursing Center by Norwalk Health Care, Inc., with the Reestablishment of the Skilled Nursing Center by Hunter Management, LLC
Notice of Letter of Intent

Dear Mr. DeBarba:

On June 3, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Norwalk Health Care, Inc. ("Applicant") for the service termination regarding Honey Hill Rehabilitation and Skilled Nursing Center in Norwalk by Norwalk Health Care, Inc. and the Reestablishment of the Skilled Nursing Center by Hunter Management, LLC, with a total capital expenditure of $7,785,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Hour* pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Director of Operations

KRM:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 12, 2009

Requisition # HCA09-148
Email: OBIT@The Hour.com
Attention: David

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

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Thursday, June 18, 2009.**

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 Jack Huber or Paolo Fiducia at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:JH:PF:lmg

c: Sandy Salus, OHCA

Norwalk Health Care, Inc.
Docket Number: 09-31383

Letter of Intent
June 12, 2009

PLEASE INSERT THE FOLLOWING:

Statute References:	19a-638 & 19a-639
Applicant:	Norwalk Health Care, Inc.
Town:	Norwalk
Docket Number:	09-31383-LOI
Proposal:	Service Termination regarding the Honey Hill Rehabilitation and Skilled Nursing Center in Norwalk by Norwalk Health Care, Inc., with the Reestablishment of the Skilled Nursing Center by Hunter Management, LLC
Capital Expenditure:	$7,875,000

The Applicant may file its Certificate of Need application between August 2, 2009 and October 1, 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 the 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: Monday, June 15, 2009 1:27 PM

----IMA7e88452.4a36/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.

----IMA7e88452.4a36/pop.state.ct.us
Content-Type: message/delivery-status

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

----IMA7e88452.4a36/pop.state.ct.us
Content-Type: message/rfc822

Received: from doit-mstwmms1 [159.247.5.80] by pop.state.ct.us with ESMTP
(SMTPD-10.02) id A44F0C9C; Mon, 15 Jun 2009 13:26:39 -0400
Received: from 159.247.77.55 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall v6.0.0)); Mon, 15 Jun 2009 13:35:08 -0400
X-Server-Uuid: AAF81055-C3E5-43F1-82D3-EBCFC44FF42A
X-MimeOLE: Produced By Microsoft Exchange V6.5
Content-class: urn:content-classes:message
Return-Receipt-To: "Greer, Leslie" <Leslie.Greer@ct.gov>
MIME-Version: 1.0
Disposition-Notification-To: "Greer, Leslie" <Leslie.Greer@ct.gov>
Subject: Legal Ad 09-31383-LOI
Date: Mon, 15 Jun 2009 13:24:09 -0400
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B1028AD74B@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach:
X-MS-TNEF-Correlator:
Thread-Topic: Legal Ad 09-31383-LOI
Thread-Index: Acnt3hc0UbCCBIJFRbChQTGf/DM6/w==
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
To: obit@THEHOUR.COM
X-WSS-ID: 662859C625S2110350-01-01
Content-Type: multipart/mixed;
boundary="----_=_NextPart_001_01C9EDDE.17C70413"

----IMA7e88452.4a36/pop.state.ct.us--

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 12, 2009

via fax and email only

Daniel DeBarba
Chief Operating Officer
Norwalk Health Care, Inc.
34 Maple Street
Norwalk, CT 06856

RE: Certificate of Need Application Forms, Docket Number: 09-31383-CON
Norwalk Health Care, Inc.
Service Termination regarding the Honey Hill Rehabilitation and Skilled Nursing Center in Norwalk by Norwalk Health Care Inc., with the Reestablishment of the Skilled Nursing Center by Hunter Management, LLC.

Dear Mr. DeBarba:

Enclosed are the application forms for Norwalk Health Care, Inc.'s Certificate of Need ("CON") proposal for the service termination regarding the Honey Hill Rehabilitation and Skilled Nursing Center in Norwalk by Norwalk Health Care Inc., with the reestablishment of the skilled nursing center by Hunter Management, LLC., at an associated capital expenditure of $7,875,000. According to the parameters stated in Sections 19a-638 and 19a-639 of the Connecticut General Statutes, the CON application may be filed between August 2, 2009, and October 1, 2009.

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

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and six (6) hard copies of 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 OHCA analysts assigned to the CON application are Paolo Fiducia and Jack Huber. Please contact either analyst at (860) 418-7001 if you have questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

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 a response of "Not Applicable" may be an acceptable answer. Your Certificate of Need application will be eligible for submission no earlier than August 2, 2009, and may be submitted no later than October 1, 2009. The OHCA analysts assigned to your application are Paolo Fiducia and Jack Huber. Either analyst may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	09-31383-CON
Applicant Name:	Norwalk Health Care, Inc.
Contact Person:	Daniel DeBarba
Contact Title:	Chief Operating Officer
Contact Address:	Norwalk Health Care, Inc. 34 Maple Street Norwalk, CT 06856
Project Location:	Norwalk
Project Name:	Service Termination Regarding Honey Hill Rehabilitation and Skilled Nursing Center by Norwalk Health Care Inc. with the Reestablishment of the Skilled Nursing Center by Hunter Management, LLC.
Proposal Type:	Sections 19a-638 and/or 19a-639, C.G.S.
Estimated Total Capital Expenditure:	$7,875,000

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

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

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

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

GENERAL AFFIDAVIT

Applicant: Norwalk Health Care, Inc.

Project Title: Service Termination regarding the Hill Rehabilitation and Skilled Nursing Center in Norwalk by Norwalk Health Care Inc., with the Reestablishment of the Skilled Nursing Center by Hunter Management, LLC.

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

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

_____ _____
Signature Date

Subscribed and sworn to before me on _____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

GENERAL AFFIDAVIT

Applicant: Hunter Management, LLC

Project Title: Service Termination regarding the Hill Rehabilitation and Skilled Nursing Center in Norwalk by Norwalk Health Care Inc., with the Reestablishment of the Skilled Nursing Center by Hunter Management, LLC.

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

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

_____ _____
Signature Date

Subscribed and sworn to before me on _____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

GENERAL AFFIDAVIT

Applicant: Honey Hill Rehabilitation and Skilled Nursing Center

Project Title: Service Termination regarding the Hill Rehabilitation and Skilled Nursing Center in Norwalk by Norwalk Health Care Inc., with the Reestablishment of the Skilled Nursing Center by Hunter Management, LLC.

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

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

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

Questions Specific to the Proposal:

1. Provide a description of each of the legal entities involved in the proposed sales transaction, which represents the termination of long term care services at the Honey Hill Rehabilitation and Skilled Nursing Center by Norwalk Health Care, Inc. and the reestablishment of those services by Hunter Management, LLC:

   A. Honey Hill Rehabilitation and Skilled Nursing Center ("Nursing Center")
   B. Norwalk Health Care, Inc. ("Applicant" or "seller").
   C. Hunter Management, LLC (or "buyer").

2. Describe the process undertaken and the conclusions reached by the Applicant for the sale of the Nursing Center from Norwalk Health Care, Inc. to Hunter Management.

3. How was Hunter Management, LLC selected by the Applicant as the buyer of the Nursing Center?

4. How is the acquisition of the Nursing Center consistent with the long range plans of Hunter Management, LLC? Please explain.

5. When did the Nursing Center open and has the Nursing Center always operated as a subsidiary of Norwalk Health Care, Inc.?

6. Provide a description of the services and programs offered at the Nursing Center.

7. Discuss how the aforementioned services and programs will continue to be made available to Nursing Home residents and/or other individuals that utilize the Nursing Center services and programs after the sale transaction takes place.

8. List the service area towns of the Nursing Center. Provide a rationale for choosing the selected towns.

9. Identify the name and location of the other chronic and convalescent nursing home facilities within the Nursing center's service area.

10. Provide the service utilization for each of the Nursing Center's services /programs for the past three fiscal years ("FYs") or calendar years ("CYs"), current FY or CY and projected for the next three FYs or CYs.

11. Explain the steps the Applicant is taking in terminating its involvement with Nursing Center services and in transferring the Nursing Center's services to Hunter Management.

12. Provide copies of all written agreements or memorandums of understanding between the seller and buyer. If a final version is not available, provide a draft with an estimated date by which the final documents will be available.

13. Provide the following information for the seller and buyer:

    A. Legal chart of corporate structure, prior to and after the proposal transaction.
    B. The most recent annual report of each entity.
    C. Board of Directors or governing body resolutions approving the proposal (i.e. a copy of the minutes [excerpted for other unrelated business] for the meeting(s) at which this termination was discussed and votes were taken)

14. Provide a narrative describing the current and proposed relationship between the following entities:

    A. Norwalk Health Care, Inc. and Nursing Center
    B. Hunter Management and the Nursing Center

General Financial Information

15. Indicate type of ownership (check off all that apply)

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

A. Does the Applicant have Tax Exempt Status? If yes, provide documentation.

B. Provide audited financial statements for the most recently completed fiscal year for the Nursing Center, NHC and HM. If audited financial statements do not exist, in lieu of audited financial statements, provide other documentation of the Applicant's financial viability (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.) These numbers should correspond to the actuals reported in Financial Attachment.

Capital Expenditures and Financial Information

16. Submit a final version of all capital expenditures and costs associated with the proposal:

Table 1. Total Project Cost Itemization

Item Description	Amount
Medical Equipment Purchase	$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase	
Construction/Renovation	
Other Non-Construction (Specify)	
Subtotal: Total Capital Expenditure	**$**
Medical Equipment Lease (Fair Market Value)	$
Imaging Equipment Lease (Fair Market Value)	
Non-Medical Equipment Lease (Fair Market Value)	
Fair Market Value of Space (Capital Leases Only)	
Subtotal: Total Capital Cost	**$**
Total Project Cost (Total Cap. Expenditures + Total Cap. Costs)	**$**
Capitalized Financing Costs (For Informational Purpose Only)	$
Total Project Cost with Capitalized Finance Costs	**$**

17. Provide the current and projected patient population mix with the CON proposal for the proposed program.

Patient Population Mix	**Current FY____**	**Year 1 FY____**	**Year 2 FY____**	**Year 3 FY____**
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Other (specify):				
Total Government				
Commercial Insurers*				
Uninsured**				
Workers Compensation				
Other (specify):				
Total Non-Government				
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.
** Includes uninsured only; add additional payers as appropriate, i.e., self-pay, co-payments received from insured patients.

17. Provide the basis for the patient population mix for the proposed service.

18. Justify why the proposed patient population mix is reasonable.

Financial Attachments

19. Provide a summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. Complete **Financial Attachment I**. (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years after project completion.

20. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. Complete **Financial Attachment II.** The projections must include the first three full fiscal years after project completion at a minimum.

21. List all assumptions utilized in developing both Financial Attachment I and II (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

22. Provide documentation to support the proposed rates and units of service for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service.

23. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

24. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

Other Review Criteria

25. State Health Plan - No questions at this time.

26. Submit a list of **all** key professional, administrative, clinical, and direct service personnel related to the proposal. Provide a copy of their Curriculum Vitae.

27. Provide a copy of any inspection reports and/or certificates for your facility that are relevant to the proposal, along with a narrative explanation.

28. Explain how this proposal contributes to the quality of health care delivery in the region.

29. In the past year has your facility undertaken any of the following activities to improve productivity and contain costs? Check off the applicable activities.

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

30. Will this proposal result in any change to your teaching or research responsibilities? If yes, provide an explanation.

31. Do the following 19a-637 C.G.S. criteria relate to your proposal? Specify each criterion that applies to this proposal and explain how this is so. Provide supporting documentation.

    A. Voluntary efforts to improve productivity and contain costs.
    B. Change to your teaching or research responsibilities.
    C. Special characteristics of your patient/physician mix.

32. Provide a copy of the State of Connecticut, Department of Public Health license currently held and indicate any additional licensure categories HM may be seeking.

13. B 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 Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
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.

13. B 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 Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
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.

13. B 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 Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
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.

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 Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses: _____										
Total Facility by 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

****
*** TX REPORT ***
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OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: DANIEL DEBARBA

FAX: (203) 852-3436

AGENCY: NORWALK HEALTH CARE, INC.

FROM: JACK HUBER

DATE: 6/15/2009 **Time:** ~7:30 am

NUMBER OF PAGES: 17
(including transmittal sheet)

Comments: Please find with this transmission:
CON Application Forms for the Proposal to
Sale Honey Hill Rehab. & Nursing Center
DN: 09-31383

PLEASE PHONE Jack A. Huber at (860) 418-7034

Dear Mr. DeBarba – Please find attached the CON materials necessary to complete your CON application for the above referenced proposal. If you have any questions feel free to contact me or Paolo Fiducia by e-mail of telephone at (860) 418-7001. Regards, Jack Huber

Jack Huber
Health care Analyst

Greer, Leslie

From: obit Classified [classified@thehour.com]
Sent: Monday, June 15, 2009 4:55 PM
To: Greer, Leslie
Subject: RE: Legal Ad 09-31383-LOI

Leslie,

You are all set for tomorrow.
Thanks
Jocelyn at The Hour
203-354-1100

-----Original Message-----
From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Mon 6/15/2009 1:24 PM
To: obit Classified
Subject: Legal Ad 09-31383-LOI

Legal Ad,

Please run the attached legal ad in your newspaper by June 16, 2009.
Please notify me when this has been completed.

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>