LOUIS B. TODISCO
203.772.7718 DIRECT TELEPHONE
860.240.5715 DIRECT FACSIMILE
LTODISCO@MURTHALAW.COM

August 10, 2009

VIA HAND DELIVERY

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

Re: Letter of Intent for: Proposal to Establish an Outpatient Rehabilitation Center in South Windsor, CT

Dear Commissioner Vogel:

Enclosed for filing please find an original and six copies of Select Physical Therapy's Letter of Intent for its Proposal to Establish an Outpatient Rehabilitation Center in South Windsor, CT.

Please forward to me the appropriate application forms and instructions for this proposal.

If you have any questions or if or you require any additional information, please call me at (203) 772-7718.

Sincerely yours,

Louis B. Todisco

Louis B. Todisco

Enclosures

cc: Melanie B. Zinn, Select Medical Corporation
Douglas Bowie, ATC, Regional Director

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	PTSMA, Inc.	
Doing Business As	Select Physical Therapy	
Name of Parent Corporation	Select Medical Corporation	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	PTSMA/Select Medical Corp 4714 Gettysburg Road Mechanicsburg, PA 17055 Attn: Melanie Zinn	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes No x	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Louis B. Todisco Counsel	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Murtha Cullina LLP 2 Whitney Avenue P.O. Box 704 New Haven, CT 06503-0704	
Contact Person Telephone Number	(203) 772-7718	

Contact Person Fax Number	(203) 772-7723	
Contact Person e-mail Address	ltodisco@murthalaw.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Proposal to Establish an Outpatient Rehabilitation Center in South Windsor, CT 06074.

b. Project Proposal: Select Physical Therapy is seeking to establish an outpatient rehabilitation center at 25 Oakland Road in South Windsor, 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)* Physical Therapy ☐ 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:

25 Oakland Road, South Windsor, Ct 06074

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

South Windsor, Windsor, East Windsor, Ellington, Vernon, Manchester, East Hartford.

h. Estimated starting date for the project: Upon approval of CON.

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: $37,500.00

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases* (Physical therapy equipment)	$15,000.00
Non-Medical Equipment Purchases* (Computer and phone)	$9,000.00
Land/Building Purchases (Lease hold improvements)	$7,500.00
Construction/Renovation	
Other (Non-Construction) Specify: Sinage	$6,000.00
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

Please see attached.

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: PTSMA, Inc. d/b/a Select Physical Therapy

Project Title: Proposal to Establish an Outpatient Rehabilitation Center in South Windsor, CT

I, Douglas Bowie, ATC (Name), Regional Director (Position – CEO or CFO)

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

Signature 8·10·09 Date

Subscribed and sworn to before me on 8-10-09

Notary Public/Commissioner of Superior Court

EMILY C. COMEAU
NOTARY PUBLIC
MY COMMISSION EXPIRES JULY 31, 2011

My commission expires:

RECEIVED
2009 AUG 10 P 2:29
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

PTSMA, Inc. d/b/a Select Physical Therapy
Proposal to Acquire an Outpatient Rehabilitation Center in South Windsor, CT

PTSMA, Inc. d/b/a Select Physical Therapy ("Applicant") is a wholly-owned subsidiary of Select Physical Therapy Holdings, Inc. which is in turn a wholly-owned subsidiary of Select Medical Corporation. In 2007, the Applicant acquired thirty-two ("32") outpatient rehabilitation centers from HealthSouth Corporation. Select Physical Therapy offers comprehensive outpatient rehabilitation care including physical and occupational therapy, care for sports injuries and conditions and work-related and non work-related injuries. The Applicant would provide these services at the location which is the subject of this Letter of Intent.

The target population for the Applicant's services includes any persons with injuries or illnesses that are appropriate for treatment in an outpatient rehabilitation facility from young pediatric/adolescent patients through older geriatric patients. The types of injuries can include, but are not limited to, orthopedic injuries, congenital and developmental diseases and conditions, neurological injuries or conditions, vestibular injuries or conditions.

The Applicant is seeking to establish a new location at 25 Oakland Road, South Windsor, CT. The Applicant would offer the services outlined above at this location. There is an existing outpatient rehabilitation center at this location. The Applicant is not buying the existing provider. Rather, the existing provider will cease to provide services at this location, and the Applicant will lease space from the owner of the facility and begin to provide services at this location.

There are other similar providers in the anticipated service area. However, the Applicant believes that there is ample need for the services to be offered at this location. As noted, there is an existing outpatient rehabilitation center at this location. The existence of a provider at this location and the small number of other providers in South Windsor and East Windsor, support the need for the services to be provided at this location. The Applicant believes that it will be able to meet this need.

This proposal will have a positive effect on the health care delivery system in Connecticut. This office will offer much needed rehabilitation services for all age ranges (pediatric, adolescent, active adult and geriatric) as well as orthopedic screenings, orthotic services, cane and crutch fitting and wellness programs.

Select Physical Therapy is not licensed by the Department of Public Health. However, personnel who provide services will include licensed persons such as physical therapists, occupational therapists, physical therapy assistants and athletic trainers.

The Applicant will be responsible for providing the services to be offered at this location through appropriately licensed employees.

There will be no anticipated payer changes once this project becomes operational. The payers that are pertinent to this facility location include, but are not limited to the Centers for Medicare and Medicaid Services, Aetna, Cigna, United Healthcare, Anthem Blue Cross Blue Shield, Tricare, Champus, Workers Compensation Insurance Carriers and others.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 17, 2009

via fax and email only

Melanie Zinn
Manager of Regulatory Affairs
Select Medical Corporation
4714 Gettsberg Road
Mechanicsburg, PA 17055

RE: Certificate of Need Application Forms; Docket Number: 09-31432-CON
PTSMA, Inc. d/b/a Select Physical Therapy
Establish an Outpatient Rehabilitation Center in South Windsor

Dear Ms. Zinn:

Enclosed are the application forms for PTSMA, Inc. d/b/a Select Physical Therapy's Certificate of Need ("CON") proposal for the establishment of an outpatient rehabilitation center in South Windsor, Connecticut, at a capital expenditure of $37,500. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between October 9, 2009, and December 8, 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 analyst assigned to the CON application is Jack A. Huber. Please contact him at (860) 418-7034 if you have questions.

Sincerely,

Harold M. Oberg
CON 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 October 9, 2009, and may be submitted no later than December 8, 2009. The OHCA Analyst assigned to your application is Jack A. Huber. He may be reached at the Office of Health Care Access at (860) 418-7034.

Docket Number:	09-31432-CON
Applicant Name:	PTSMA, Inc. d/b/a Select Physical Therapy
Contact Person:	Melanie Zinn
Contact Title:	Manager of Regulatory Affairs
Contact Address:	Select Medical Corporation 4714 Gettysberg Road Mechanicsburg, PA 17055
Project Location:	South Windsor
Project Name:	Establish an Outpatient Rehabilitation Center in South Windsor
Proposal Type:	Section 19a-638, C.G.S.
Estimated Total Capital Expenditure:	$37,500

New Service Application

1. Project Description and Need

A. Provide a narrative detailing the proposal.

B. Provide the following regarding the proposal's location:

i) The rationale for choosing the proposed service location;

ii) The service area towns and the basis for their selection;

iii) The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

iv) How and where the proposed patient population is currently being served;

v) All existing providers (name, address, services provided) of the proposed service in the towns listed above and in nearby towns; and

vi) The effect of the proposal on existing providers.

2. Projected Volume

A. Complete the following table for the first three fiscal years ("FY") of the proposed service.

Table 1: Projected Volume

	Projected Volume (First 3 Full Operational FYs)**			
	FY****	FY****	FY****	FY****
Service type***				
Total				

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Identify each service/procedure type and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

B. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

C. Provide historical volumes for three full years and the current year to date for any of the Applicant's existing services that support the need to implement the proposed service.

D. Provide a copy of any articles, studies, or reports that support the statements made in this application justifying need for the proposal, along with a brief explanation regarding the relevance of the selected articles.

3. Quality Measures

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

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

C. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services

D. Identify the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

4. Organizational and Financial Information

A. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

B. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☐ No

C. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

D. Financial Statements

i) If the Applicant is a Connecticut hospital: 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 hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii) If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

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

Table 2: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
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 ***	
Total Capital Cost	**$**
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.
** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross sq. feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.
*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

F. List all funding or financing sources for the proposal, and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges received to date; letter of interest or approval from a lending institution.

5. Revenues, Expenses, and Patient Population Projections

a. Patient Population Mix

i. Provide the current and projected patient population mix (based on the number of patients, not on revenue) for the proposed program.

Table 3: Patient Population Mix

	Current** FY ***	Year 1 FY ***	Year 2 FY ***	Year 3 FY ***
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix				

* Includes managed care activity.
** New programs may leave the "current" column blank.
*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

ii. Provide the basis for/assumptions used to project the patient population mix.

b. Financial Attachments I & II

i. 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 of the project.

ii. 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 of the project.

iii. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iv. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

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

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

vii. Describe how this proposal is cost effective.

6. Other Review Criteria

A. Describe the proposal's relationship to the Applicant's long-range plans. Provide supporting documentation.

B. Specify whether any of the following apply to the proposal. If so, provide an explanation and supporting documentation.
   i) Voluntary efforts to improve productivity and contain costs;
   ii) Changes to the Applicant's teaching or research responsibilities; and/or
   iii) Special characteristics of the Applicant's patient or physician mix.

GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

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

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

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

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

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

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	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovernment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	0469
RECIPIENT ADDRESS	917174129842
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ST. TIME	08/17 10:31
TIME USE	02'20
PAGES SENT	13
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: MS. MELANIE ZINN

FAX: (717) 412-9842

AGENCY: SELECT MEDICAL CORPORATION

FROM: JACK HUBER

DATE: 8/17/2009 **Time:** ~10:30 am

NUMBER OF PAGES: 13
(including transmittal sheet)

Comments: Transmitted: Application Forms
Docket Number: 09-31432-CON
PTSMA, Inc. d/b/a Select Physical Therapy
O/P Rehabilitaion Center in South Windsor, CT

Cc: Louis B. Todisco, Esq., Legal Counsel, Murtha Cullina, LLP

PLEASE PHONE Jack A. Huber at (860) 418-7034
IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	0470
RECIPIENT ADDRESS	912037727723
DESTINATION ID	
ST. TIME	08/17 10:37
TIME USE	20'22
PAGES SENT	13
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STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: LOUIS B. TODISCO, ESQ.

FAX: (203) 772-7723

AGENCY: MURTHA CULLINA, LLP

FROM: JACK HUBER

DATE: 8/17/2009 **Time:** ~10:35 am

NUMBER OF PAGES: 13
(including transmittal sheet)

Comments: Transmitted: Application Forms
Docket Number: 09-31432-CON
PTSMA, Inc. d/b/a Select Physical Therapy
O/P Rehabilitaion Center in South Windsor, CT

Cc: Ms. Melanie Zinn, Mgr., Reg. Affairs, Select Medical Coporation

PLEASE PHONE Jack A. Huber at (860) 418-7034
IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 17, 2009

Melanie Zinn
Manager of Regulatory Affairs
PTSMA, Inc. d/b/a Select Physical Therapy
4714 Gettysburg Road
Mechanicsburg, PA 17055

Re: Letter of Intent; Docket Number: 09-31432
PTSMA, Inc. d/b/a Select Physical Therapy
Establish an Outpatient Rehabilitation Center in South Windsor
Notice of Letter of Intent

Dear Ms. Zinn:

On August 10, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of PTSMA, Inc. d/b/a Select Physical Therapy ("Applicant") to establish an Outpatient Rehabilitation Center in South Windsor with a total capital expenditure of $37,500.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Journal Inquirer* 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
Director of Operations

KRM:lmg

cc: Louis B. Todisco, Esq., Murtha Cullina LLP

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 17, 2009

Requisition # HCA010-009
Email: Legals@JournalInquirer.com

Journal Inquirer
306 Progress Drive
Manchester, CT 06040

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Friday, August 21, 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 at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:JAH:lmg

c: Marie Dempsey, OHCA

Journal Inquirer
Docket Number: 09-31432-LOI

Letter of Intent
August 17, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	PTSMA, Inc. d/b/a/ Select Physical Therapy
Town:	South Windsor
Docket Number:	09-31432-LOI
Proposal:	Establish an Outpatient Rehabilitation Center in South Windsor
Capital Expenditure:	$37,500

The Applicant may file its Certificate of Need application between October 9, 2009 and December 8, 2009. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT, 06134-0308.

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

Greer, Leslie

From: legals@journalinquirer.com
Sent: Tuesday, August 18, 2009 10:55 AM
To: Greer, Leslie
Subject: RE: Legal Ad 09-~~31342~~ 31432

Leslie,
Your legal ad is all set to run in the August 19, 2009 edition of the Journal Inquirer. We will forward invoice for $110.18 to you along with Affidavit of Publication and tear sheet as requested.
Thank you,
Tom
Classified Dept.

---- Original Message ----
From: Leslie.Greer@ct.gov
To: legals@journalinquirer.com
Subject: Legal Ad 09-31342
Date: Mon, 17 Aug 2009 15:48:24 -0400

>Legal Ad,
>
>Please run the attached public notice in your newspaper by Friday
>August 21, 2009. Please notify me by email 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>
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>P Please consider the environment before printing this message
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