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

March 30, 2010

VIA HAND DELIVERY

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

Re: Letter of Intent, Proposal of PTSMA, Inc. to Acquire an Outpatient Rehabilitation Center in Southington, CT

Dear Deputy Commissioner Vogel:

This firm represents PTSMA, Inc.

This Letter of Intent is being filed by two applicants, PTSMA, Inc. and Orthopedic Physical Therapy, LLC. Orthopedic Physical Therapy, LLC currently operates an outpatient rehabilitation center at 98 Main Street, Southington, CT. The proposal described in the Letter of Intent is for PTSMA, Inc. to acquire the assets of Orthopedic Physical Therapy, LLC and to continue to operate the outpatient rehabilitation center at this location.

I have enclosed an original and six copies of the Letter of Intent signed by representatives of PTSMA, Inc. and Orthopedic Physical Therapy, LLC. Please forward to us 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

Enclosure

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.	Orthopedic Physical Therapy, LLC
Doing Business As	Select Physical Therapy	
Name of Parent Corporation	Select Medical Corporation	No Parent Company
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 B. Laughman	98 Main Street Southington, CT 06489 Mail to: Michael Daley 389 Jinnyhill Road Cheshire, CT 06410
Identify Applicant Status: P for Profit or NP for Nonprofit	P	P
Does the Applicant have Tax Exempt Status?	Yes No x	Yes No x
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Louis B. Todisco Counsel	Michael Daley Manager
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	389 Jinnyhill Road Cheshire, CT 06410

Contact Person Telephone Number	(203) 772-7718	(860) 621-7389
Contact Person Fax Number	(203) 772-7723	(860) 621-2586
Contact Person e-mail Address	ltodisco@murthalaw.com	Mdaley7810@oal.com

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Proposal of PTSMA, Inc. to Acquire an Outpatient Rehabilitation Center in Southington, CT 06489.

b. Project Proposal: PTSMA, Inc. is seeking to acquire an outpatient rehabilitation center at 98 Main Street in Southington, 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:

98 Main Street, Southington, CT 06489

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

PTSMA expects that this project will serve, as it does currently, persons who live or work in the Town of Southington, and surrounding towns including Cheshire, Plainville, Bristol, New Britain, Berlin, Meriden and Wolcott.

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: $33,000.00

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases* (Physical therapy equipment)	$30,000.00
Non-Medical Equipment Purchases* (Computer and phone)	$3,000.00
Land/Building Purchases (Lease hold improvements)	
Construction/Renovation	
Other (Non-Construction) Specify: Sinage	
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 (PTSMA, Inc.) ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing

☐ Funded Depreciation ☐ Grant Funding

☐ Other *(specify)* _____

SECTION IV. PROJECT DESCRIPTION

Please see pages 5a and 5b following.

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?

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

There are two Applicants in this matter. PTSMA, Inc. d/b/a Select Physical Therapy ("PTSMA") and Orthopedic Physical Therapy, LLC ("OPT").

PTSMA 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.

OPT is a limited liability company which provides physical therapy services at two sites in Southington, Connecticut, including 98 Main Street, Southington, the location which is the subject of this Letter of Intent.

PTSMA is seeking to purchase the assets of OPT utilized at its 98 Main Street location, enter into a lease of these premises and to continue rehabilitation services to patients at this location.

The target population for PTSMA's services will be the same as OPT's target population and 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, and vestibular injuries or conditions.

PTSMA's service area will include the Town of Southington and contiguous towns, including Cheshire, Plainville, Bristol, New Britain, Berlin, Meriden and Wolcott. PTSMA's patients would include persons who live or work in the service area. There are other similar providers in the service area. However, PTSMA believes that there is ample need for the services to be offered at this location. OPT is currently providing the services to be offered by PTSMA to patients at this location. Also, PTSMA, independently, has a substantial presence in the Town of Southington at this time, because PTSMA provides sports medicine services to the Southington school system.

This proposal will have a positive effect on the health care delivery system in Connecticut. This office will continue to 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.

PTSMA 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.

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

PTSMA does not anticipate 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.

AFFIDAVIT

To be completed by each Applicant

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

Project Title: Proposal to Acquire an Outpatient Rehabilitation Center in Southington, CT

I, Mark Gombotz, 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 3/30/10 Date

Subscribed and sworn to before me on 3/30/10 Southington CT 06489

Notary Public/Commissioner of Superior Court

My commission expires:

MANJULA IYER
NOTARY PUBLIC
STATE OF CONNECTICUT
MY COMM. EXP. 10/31/2014

AFFIDAVIT

To be completed by each Applicant

Applicant: Orthopedic Physical Therapy, LLC

Project Title: Proposal of PTSMA, Inc. to acquire an Outpatient Rehabilitation Center in Southington, CT

I, Michael Daley (Name), Manager (Position – CEO or CFO)

of Orthopedic Physical Therapy, LLC 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 Orthopedic Physical Therapy, LLC (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 3/30/10 Date

Subscribed and sworn to before me on 3/30/10 Southington, CT 06489

Manjula Iyer

Notary Public/Commissioner of Superior Court

MANJULA IYER
NOTARY PUBLIC
STATE OF CONNECTICUT
MY COMM. EXP. 10/31/2014

My commission expires:

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

April 13, 2010

Facsimile Only

Michael Daley
Orthopedic Physical Therapy, LLC
389 Jinnyhill Road
Cheshire, CT 06410

Re: Letter of Intent; Docket Number: 10-31580
Orthopedic Physical Therapy, LLC and PTSMA, Inc.
Orthopedic Physical Therapy, LLC to Transfer Ownership of Outpatient Physical Therapy Services Located at 98 Main Street, Southington, to PTSMA, Inc. d/b/a/ Select Physical Therapy

Dear Mr. Daley,

On March 31, 2010, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Orthopedic Physical Therapy, LLC ("Applicant") for Orthopedic Physical Therapy, LLC to transfer ownership of Outpatient Physical Therapy Services located at 98 Main Street, Southington, to PTSMA, Inc. d/b/a/ Select Physical Therapy, with a total capital expenditure for $33,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Herald* 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

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

April 13, 2010 Requisition # 30994

The Herald
One Herald Square
New Britain, CT 06050

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, April 16, 2010.**

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 Laurie Greci or Olga Armah at 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:LKG:OA:lmg

c: Danielle Pare, DPH

The Herald
Docket Number: 10-31580

Letter of Intent
April 13, 2010

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Orthopedic Physical Therapy, LLC
Town:	Southington
Docket Number:	10-31580-LOI
Proposal:	Orthopedic Physical Therapy, LLC to Transfer Ownership of Outpatient Physical Therapy Services Located at 98 Main Street, Southington, to PTSMA, Inc. d/b/a/ Select Physical Therapy
Capital Expenditure:	$33,000

The Applicant may file its Certificate of Need application between May 30, 2010 and July 29, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner Office of Health Care Access, Division of Department of Public Health, 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.

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

TRANSMISSION OK

TX/RX NO	1449
RECIPIENT ADDRESS	912037727723
DESTINATION ID	
ST. TIME	04/13 13:10
TIME USE	06'35
PAGES SENT	4
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: LOUIS B. TODISCO, ESQ.

FAX: (203) 772-7723

AGENCY: MURTHA CULLINA LLP

FROM: LAURIE GRECI

DATE: 4/13/10 **TIME:**

NUMBER OF PAGES: 4
(including transmittal sheet

Comments: Docket 10-31580

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

TRANSMISSION OK

TX/RX NO	1450
RECIPIENT ADDRESS	98606212586
DESTINATION ID	
ST. TIME	04/13 13:18
TIME USE	00'55
PAGES SENT	4
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: MICHAEL DALEY

FAX: (860) 621-2586

AGENCY: ORTHOPEDIC PHYSICAL THERAPY, LLC

FROM: LAURIE GRECI

DATE: 4/13/10 **TIME:**

NUMBER OF PAGES: 4
(including transmittal sheet

Comments: Docket 10-31580

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: ads [ads@graystoneadv.com]
Sent: Tuesday, April 13, 2010 10:06 AM
To: Greer, Leslie
Subject: Re: Legal Ad 10-31580

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061
E-mail: ads@graystoneadv.com
http://www.graystoneadv.com/

On 4/13/10 9:10 AM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

> To Whom It May Concern,
> Please run the attached public notice in The Herald by April 16, 2010. For billing please refer to requisition 30994, if you have any questions feel free to call me.
>
> Thank you,
>
> Leslie M. Greer
> Office of Health Care Access
> A Division of Department of Public Health
> State of Connecticut
> 410 Capitol Avenue, MS#13HCA
> Hartford, CT 06134
> Phone: (860) 418-7001
> Fax: (860) 418-7053
> *Website:* www.ct.gov/ohca <http://www.ct.gov/ohca>
> Please consider the environment before printing this message

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 15, 2010

via fax and email only

Melanie Laughman
PTSMA , Inc.
4714 Gettysbury Road
Mechanicsburg, PA 17055

Michael Daley
Manager
Orthopedic Physical Therapy, LLC
389 Jinnyhill Road
Cheshire, CT 06410

RE: Certificate of Need Application Forms, Docket Number 10-31580-CON
PTSMA , Inc. and Orthopedic Physical Therapy, LLC
PTSMA, Inc. proposes to acquire the assets of Orthopedic Physical Therapy, LLC and continue to operate the outpatient rehabilitation center located at 98 Main Street, Southington.

Dear Ms. Laughman and Mr. Daley:

Enclosed are the application forms for PTSMA , Inc.'s Certificate of Need ("CON") proposal for the PTSMA, Inc. proposes to acquire the assets of Orthopedic Physical Therapy, LLC and continue to operate the outpatient rehabilitation center located at 98 Main Street, Southington. with an associated capital expenditure of $33,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between May 30, 2010, and July 29, 2010.

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 analysts assigned to the CON application are Laurie Greci and Olga Armah. Please contact them at (860) 418-7001 if you have questions.

Sincerely,

Kaila Riggott

Kaila Riggott
Certificate of Need Supervisor

Attachments

C: Michael Daley, Manager, Orthopedic Physical Therapy, LLC
Louis B. Todisco, Murtha Cullina, LLP

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: _____

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 May 30, 2010, and may be submitted no later than July 29, 2010. The Analyst assigned to your application is Laurie Greci and Steven Lazarus. They may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	10-31580-CON
Applicants' Names:	PTSMA , Inc. Orthopedic Physical Therapy, LLC
Contact Person:	Michael Daley
Contact Title:	Manager Orthopedic Physical Therapy, LLC
Contact Address:	389 Jinnyhill Road Cheshire, CT 06410
Project Location:	Southington
Project Name:	Orthopedic Physical Therapy, LLC Proposes to Transfer Ownership of Outpatient Physical Therapy Services Located at 98 Main Street, Southington, to PTSMA, Inc. d/b/a/ Select Physical Therapy
Type proposal:	Section 19a-638, C.G.S.
Est. Capital Expenditure:	$33,000

1. Project Description and Need

a. Provide a narrative detailing the proposal.

b. Explain how each Applicant determined need for the proposal and discuss the benefits of this proposal for each Applicant (discuss each Applicant separately in separate paragraphs).

c. Provide a history and timeline of the proposal (e.g., When did discussions begin between the Applicants? What have the Applicants accomplished so far?).

d. List any changes to the clinical services offered by the Applicants that result from this proposal, and provide an explanation.

e. Describe the existing population served by the facility changing ownership or control, and how the proposal will impact these populations. Include demographic information as appropriate.

f. Describe the transition plan and how the Applicants will ensure continuity of services. Provide a copy of a transition plan, if available.

g. List all existing providers (name, address, services provided) of the services involved in this proposal in the towns served by the facility changing ownership or control, and in nearby towns.

h. Describe the effect of this proposal on existing providers.

i. For each Applicant (and any new entities to be created as a result of the proposal), provide the following prior to and after this proposal:

   i. Legal chart of corporate or entity structure including all affiliates.
   ii. List of owners and the % ownership and shares of each.

j. Provide copies of all signed written agreements or memorandum of understanding, including all exhibits/attachments, between the Applicants related to the proposal. Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

2. Actual and Projected Volume

a. Provide volumes for the most recently completed FY by town.

b. Complete the following tables for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal, for the facility/services changing ownership or control.

Table 1: Historical, Current, and Projected Volume

	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational Ys)**		
	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****
Service***							
Total							

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

** 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 separately and add lines as necessary.

**** Fill in years. In a footnote, identify the period covered by the Applicants' FY (e.g. July 1-June 30, calendar year, etc.).

c. Explain any increases and/or decreases in volume seen in the tables above.

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

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

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 square 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. Patient Population Projections

a. 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.

** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

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

6. Financial Attachments I & II

a. 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.

c. 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.

d. 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.).

e. 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).

f. Identify the entity that will be billing for the proposed service(s).

g. As a result of the proposal, will there be any change to existing reimbursement contracts between the Applicants and payers (e.g. Medicare, Medicaid, commercial)? Explain.

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

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

j. Describe how this proposal is cost effective.

7. 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.

6 a. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and if applicable, volume statistics without, incremental to and with the proposal in the following reporting format:

Total Facility:	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
Description	Actual Results	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected With Project
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes				$0			$0			$0
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

*Volume Statistics:

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

6. b.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 _____ FY Projected Incremental Total Incremental Expenses:	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
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		$0				$0	$0	$0
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0	0	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	0	$0	$0	$0	$0	$0	$0	$0

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 CT Services
Type of Unit Description: CT Scan
# of Months in Operation 3

Year 1 **FY Projected Incremental** Total Incremental Expenses: **$53,513** **Total Facility by Payer Category:**	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9	
Medicare		$1,000	42	$42,000	$28,467	$0	$0	$13,533	$17,838	($4,305)	
Medicaid		$1,000	3	$3,000	$1,963	$0	$0	$1,037	$1,274	($237)	
CHAMPUS/TriCare		$1,000	0	$0	$0	$0	$0	$0	$0	$0	
Total Governmental		$1,000	45	$45,000	$30,430	$0	$0	$14,570	$19,112	($4,542)	
Commericial Insurers		$1,000	79	$79,000	$42,229	$2,000	$0	$34,771	$33,552	$1,219	
Uninsured		$1,000	2	$2,000	$900	$1,050	$0	$50	$849	($799)	
Total NonGovenrment		$1,000	81	$81,000	$43,129	$3,050	$0	$34,821	$34,401	$420	
Total All Payers		$1,000	126	$126,000	$73,559	$3,050	$0	$49,391	$53,513	***($4,122)***	($4,122)

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

FAX SHEET

TO: Michael Daley

FAX: (860) 621 2586

AGENCY: Orthopedic Physical Therapy LLC

FROM: Laurie Greci

DATE: 4/15/10 **TIME:** 2:45

NUMBER OF PAGES: 13
(including transmittal sheet

Comments: CON Application and Forms

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Atty. louis Todisco

FAX: 203 772 7723

AGENCY: Murtha Cullina

FROM: Laura Greci

DATE: 4/15/10 **TIME:** 2:45

NUMBER OF PAGES: 13
(including transmittal sheet

Comments: CON Application for PTSMA et al

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10-31580

NEW BRITAIN HERALD Classifieds PLACING 860-2

www.NewBritainHerald.com

BUSINESS HOURS: MONDAY-FRIDAY 8:00 AM - 5:00 PM

LEGALS

LEGAL NOTICE
ZONING BOARD OF APPEALS COMMISSION

In accordance with the State of Connecticut General Statutes and the Town of Berlin Zoning Regulations, Public hearings will be held on Tuesday, April 27, 2010 at 7:00 p.m. in the Berlin Town Hall, Council Chambers, 240 Kensington Road to hear the following:

#2010-04-08

547 Norton Road
David & Mary Beth Uryga, Applicants, request a side yard variance of 9.3 feet where 30 feet is required for an addition, at 547 Norton Road, Map 15-3, Block 69, Lot 34N, per Section V.A.10 of the Berlin Zoning Regulations. The property is owned by David & Mary Beth Uryga, and the zone is R-43.

#2010-04-09

171 Overhill Drive
Claire Meyer, Applicant, requests a side yard variance of 5.7 feet where 10 feet is required for an addition, at 171 Overhill Drive, Map 10-3, Block 100, Lot K63, per Section V.B.5 of the Berlin Zoning Regulations. The property is owned by Robert H.A. Meyer, and the zone is R-11.

Lorraine E. Clark, Secretary
Zoning Board of Appeals

LEGAL NOTICE
Accepting bids to satisfy artificer's lien on a 2003 Mustang in as-is condition. Morande Ford, 250 Webster Square Road, Berlin, CT. Contact Jim Leva or Greg Frascatore 860-828-3546.

LEGAL NOTICE

Statute Reference: 19a-638

Applicant: Orthopedic Physical Therapy, LLC

Town: Southington

Docket Number: 10-31580-LOI

Proposal: Orthopedic Physical Therapy, LLC to Transfer Ownership of Outpatient Physical Therapy Services Located at 98 Main Street, Southington, to PTSMA, Inc. d/b/a/ Select Physical Therapy

Capital Expenditure: $33,000

The Applicant may file its Certificate of Need application between May 30, 2010 and July 29, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner Office of Health Care Access, Division of Department of Public Health, 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.

110 LOST & FOUND

LOST PUPPY - Brittany Spaniel, butterscotch & white. 7 mos. **REWARD!** Miller St area of New Britain. 860-604-2639.

it's true, your junk can be someone else's treasure. Prove it to yourself by running a low-cost, high-result Tag Sale ad of your own this weekend. Call Classified at 229-8687.

210 ROOMS FOR RENT

New Britain- A clean Lrg 1 br, share kitchen. Free prkg. $125/wk. Sec. 860-224-0551.

NEW BRITAIN: Room to rent, heat included.860-997-0611 or 706-790-1017

230 APARTMENTS UNFURNISHED

1, 2, 3 & 4 BR apts avail in **Meriden, New Britain & Bristol.** 203-440-3120

NEW BRITAIN: 1 & 2 BR apts. Small quiet bldg, off-st. parking, immed. occup. Free ht/hw. $750 & up. 860-584-1654.

NEW BRITAIN - 2 BR, $650. Free mo rent. Pkg, laundry, super. (860) 348-9534.

NEW BRITAIN: 2 br apt., remodeled, w/garage. Close to Rt.9 & 84. 860-229-6788

it's true, your junk can be someone else's treasure. Prove it to yourself by running a low-cost, high-result Tag Sale ad of your own this weekend. Call Classified at 229-8687.

it's true, your junk can be someone else's treasure. Prove it to yourself by running a low-cost, high-result Tag Sale ad of your own this weekend. Call Classified at 229-8687.

230 APARTMENTS UNFURNISHED

NEW BRITAIN - 3 BR, avail for lease. Awkassociates.com 860-747-1144.

NEW BRITAIN - (3) 1 BR's. **$560** + util, **$630** + util, **$695** inc ht/hw. 860-841-9886.

NEW BRITAIN - 3 BR, 3rd FL, cold flat, no pets. $750. No sec dep req'd.860-348-0353.

NEW BRITAIN: 4 rooms, 120 Clinic Dr. w/heat & gas. $750/mo. 860-229-5569, 860-604-0133.

New Britain: 5 rm, 2 br, Near CCSU. 860-221-4832 days, 860-225-4832, eves.

NEW BRITAIN
5 RM, 3rd FL, stove & fridge, no pets. 860-229-6421

230 APARTMENTS UNFURNISHED

NEW BRITAIN-Dwntwn. Studio, $525. 1 BR, $625. Super, lndry, nr bsline. 348-9534.

New Britain- Lg 1 BR apt., 2nd flr, Parking. Sec. dep. $600. No pets.860-224-0551.

230 APARTMENTS UNFURNISHED

PUBLISHER'S NOTICE

All real estate advertised in this newspaper is subject to the Federal Fair Housing Act of 1968 revised March 12, 1989 which makes it illegal to advertise any preference, limitation, or discrimination based on race, color, religion, national origin, gender, handicap, or familial status or intention to make any such preference, limitation, or discrimination. It is also subject to Connecticut Public Act 80449 and the New Haven Ordinance to stop discrimination against families/single parents with children. All residential property advertised in this newspaper is subject to the Connecticut General Statutes Sections 46a-64c which prohibits the making, printing, or publishing or cause to be made printed or published any notice, statement, or advertisement with respect to the sale or rental of a dwelling that indicates any preference, limitation, or discrimination based on race, creed, color, national origin, gender, marital status, age, lawful source of income, familial status, physical or mental disability, or sexual orientation or an intention to make any such preference, limitation, or discrimination.
This newspaper will not knowingly accept any advertising for real estate or for the sale or rental of residential property which is in violation of these laws.

230 APARTMENTS UNFURNISHED

NEW BRITAIN- $625 mo. Includes heat and hot water! 1 br unit. Off street parking, laundry facility, close to major hwys and bus line. Sec. dep. req'd. Sorry No Dogs, cats with deposit. For info; 203-639-8271.

NEW BRITAIN
Large & beautiful
2 bedrms
fully applianced
only $748, no utilities
credit & criminal ck required
860-225-3600

NEWBRITAIN/PLAINVILLE- 2 BR dplx, $900+util. 860-833-9674/ 860-593-2424

PLAINVILLE - Effic. C/A, lndry fac. Sec bldg. Lighted off-st pkg. 1 yr lease. 1 mo sec.No pets. $600.628-8949.

245 HOUSES FOR RENT

NEW BRITAIN; 143 Heather Lane. 4 BR, for rent or auction to buy. 860-543-3284.

350 MOBIL

Bristol: 2br db master br, $ 860-747-6681

645 GENER HELP

PIZZA COOK:- Apply in p Pizza, 96 Mill

It's true, can be son treasure. yourself a low-cost Tag ad of y this w Call Cla 229-1

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If you have a put a Heralc to work fo

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Clay R. Pollan's THAT DAILY PUZZLER SCRAM

Edited by Ray &

Rearrange letters of the four scrambled words below to form four simple words.

TINKET

SOISA

DUGLI

CARCDO

4/16/10