

Table of Contents:

Question Number/Appendix	Page Number/Tab Index
1	
2	
3	
4	
5	
6	
7 A	
7 B	
7 C	
7 D	
7 E	
7 F	
7 G	
7 H	
8 A	
8 B	
9	
10 A	
10 B	
10 C	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20 A	
20 B	
21	
22	
23	
24	
25	
26	
27 A	
27 B	
27 C	
27 D	
27 E	
28	

Question Number/Appendix

Appendix A

Appendix B

Appendix C

Appendix D

Appendix E

Appendix F

Appendix G

Page Number/Tab Index

PROJECT DESCRIPTION AND CONTACT INFORMATION

1.) Please provide below an Executive Summary of the proposal.

Visiting Physician Services, Inc. proposes to obtain a license to provide physician house calls to RI's elderly, homebound, and the population who do not have access to medical care resulting in a significant reduction of medical costs throughout the health care system.

By treating individuals at home, various medical conditions can be addressed before they become serious in nature thereby reducing visits to the emergency room or admission to a hospital. On average, the cost to the health care system for a visiting physician house call would be approximately \$150 as opposed to an average emergency room visit at a cost of \$1,500 not including the cost of ambulance services. Additionally, home visits would allow the physician to observe individuals in their own environment thereby facilitating a more accurate assessment of their needs and functional abilities.

It is our belief that this proposal provides a dual benefit: Provision of medical care to an underserved population and a significant reduction in medical costs to an overburdened health care system.

2.)

Capital Cost	\$100,000	From responses to Questions 10 and 11
Operating Cost	\$250,000	For the first full year after implementation, from response to Question 18
Date of Proposal Implementation	OCTOBER, 2012	Month and year

3.) Please provide the following information:

Information of the applicant:

Name:	VISITING PHYSICIAN SERVICES, INC.	Telephone #:	401-728-6500
Address:	334 EAST AVENUE PAWTUCKET, RI	Zip Code:	02860

Information of the facility (if different from applicant):

Name:		Telephone #:	
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Address:		Zip Code:	
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Information of the Chief Executive Officer:

Name:	MICHAEL BIGNEY	Telephone #:	401-728-6500
Address:	334 EAST AVENUE PAWTUCKET, RI	Zip Code:	02860
E-Mail:	mbigney@nursingplacement.com	Fax #:	401-728-6509

Information for the person to contact regarding this proposal:

Name:	STEPHANIE RYAN	Telephone #:	401-728-6500
Address:	334 EAST AVENUE PAWTUCKET, RI	Zip Code:	02860
E-Mail:	sryan@nursingplacement.com	Fax #:	401-728-6509

4.) Select the category that best describes the facility named in Question 3.

- | | |
|---|---|
| <input type="checkbox"/> Freestanding ambulatory surgical center | <input type="checkbox"/> Home Care Provider |
| <input checked="" type="checkbox"/> Home Nursing Care Provider | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Hospice Provider | |
| <input type="checkbox"/> Inpatient rehabilitation center (including drug/alcohol treatment centers) | |
| <input type="checkbox"/> Multi-practice physician ambulatory surgery center | |
| <input type="checkbox"/> Multi-practice podiatry ambulatory surgery center | |
| <input type="checkbox"/> Nursing facility | <input type="checkbox"/> Other (specify): _____ |

5.) Please select each and every category that describes this proposal.

- A. ___ construction, development or establishment of a new healthcare facility;
- B. ___ a capital expenditure for:
 - 1. ___ health care equipment in excess of \$2,250,000;
 - 2. ___ construction or renovation of a health care facility in excess of \$5,250,000;
 - 3. ___ an acquisition by or on behalf of a health care facility or HMO by lease or donation;
 - 4. ___ acquisition of an existing health care facility, if the services or the bed capacity of the facility will be changed;
- C. ___ any capital expenditure which results in an increase in bed capacity of a hospital and inpatient rehabilitation centers (including drug and/or alcohol abuse treatment centers);
- D. ___ any capital expenditure which results in an increase in bed capacity of a nursing facility in excess of 10 beds or 10% of facility's licensed bed capacity, whichever ever is greater, and for which the related capital expenditures do not exceed \$2,000,000
- E. ___ the offering of a new health service with annualized costs in excess of \$1,500,000;
- F. ___ predevelopment activities not part of a proposal, but which cost in excess of \$5,250,000;
- G. ___ establishment of an additional inpatient premise of an existing inpatient health care facility;
- H. ___ tertiary or specialty care services: full body MRI, CT, cardiac catheterization, positron emission tomography, linear accelerators, open heart surgery, organ transplantation, and neonatal intensive care services. Or, expansion of an existing tertiary or specialty care service involving capital and/or operating expenses for additional equipment or facilities;

HEALTH PLANNING AND PUBLIC NEED

6.) Please discuss the relationship of this proposal to any state health plans that may have been formulated by the state agency, including the Health Care Planning and Accountability Advisory Council, and any state plans for categorically defined programs. In your response, please identify all such priorities and how the proposal supports these priorities.

VISITING PHYSICIAN SERVICES IS UNAWARE OF ANY SIMILAR MEDICAL MODEL CURRENTLY BEING OFFERED IN RHODE ISLAND.

7.) On a separate sheet of paper, please discuss the proposal and present the demonstration of the public need for this proposal. Description of the public need must include at least the following elements:

- A. Please identify the documented availability and accessibility problems, if any, of all existing facilities, equipments and services available in the state similar to the one proposed herein:

Name of Facility/Service Provider	List similar type of Service/Equipment	Documented Availability Problems (Y/N)	Documented Accessibility Problems (Y/N)	Distance from Applicant (in miles)

- B. Please discuss the extent to which the proposed service or equipment, if implemented, will not result in any unnecessary duplication of similar existing services or equipment, including those identified in (A) above.
- C. Please identify the cities and towns that comprise the primary and secondary service area of the facility. Identify the size of the population to be served by this proposal and (if applicable) the projected changes in the size of this population.
- D. Please identify the health needs of the population in (C) relative to this proposal.
- E. Please identify utilization data for the past three years (if existing service) and as projected through the next three years, after implementation, for each separate area of service affected by this proposal. Please identify the units of service used.

Actual (last 3 years)	FY 2012	FY 2013	FY 2014
Hours of Operation			
Utilization (#)			
Throughput Possible (#)			
Utilization Rate (%)			

QUESTION NO: 7

Visiting Physician Services, Inc. has done considerable research regarding the impact of providing physician house calls to the elderly, homebound, and others in need. It is the Company's position that there is both a significant public need and positive impact from this proposal, both in the care to the individual and in the savings to the medical system. First, by treating individuals at home a condition that might otherwise go untreated and go unattended or which becomes a serious condition because it was not treated, requires an emergency call and visit to the hospital. Second, the Company's research indicates that there is considerable reduction in costs by treating an individual before a condition becomes an emergency.

A. Visiting Physician Services, Inc. is unaware of any similar services being offered in the State of Rhode Island. Accordingly, we believe that this will be the first of its kind in the State.

B. As indicated above, being unaware of any similar existing services being provided in the State of Rhode Island, it would be the opinion of Visiting Physicians Services, Inc that there will be no duplication.

C. It is the intention of Visiting Physicians Services, Inc. to serve the entire State of Rhode Island. It is the nature of the service being provided, home physician house calls that allows the service to be provided to the entire State.

D. The research of Visiting Physicians Services, Inc. has indicated that there is a significant need and benefit for home physician house call visits. Often times, the elderly and/or homebound, either because of their lack of mobility or simply because of choice, will not obtain needed medical attention, but wait until a situation becomes an emergency. At the emergency stage, both an ambulance and an emergency room visit are required. Research has shown that by providing routine visits to an individual at home, many medical conditions can be otherwise timely treated, thereby avoiding both the emergency room visit and the costs associated therewith. The average cost of an emergency room visit and the needed ambulance to transport the individual to a hospital is on average Two Thousand and 00/100 (\$2,000.00) Dollars. With the average

cost of a physicians visit being One Hundred Fifty and 00/100 (\$150.00) Dollars per visit, the savings can be dramatic.

E. As Visiting Physician Services, Inc. is unaware of any similar services being offered in the State of Rhode Island, we do not believe that there is data that can be presented at this time.

F. As has previously been stated, it is the position of Visiting Physician Services, Inc. that this proposal is the first of its kind in the State of Rhode Island. Thus, Visiting Physician Services, Inc. would be of the position that one hundred (100%) percent of the need will be currently met by this proposal.

G. Visiting Physician Services, Inc. is unaware of alternative proposals that have been previously presented. Thus, at this time, Visiting Physician Services, Inc. does not believe that there are other entities with whom a collaborative effort could be formed.

H. For the many reasons stated herein, being predominantly, the improved care to the elderly and homebound and the associated significant savings and costs to the medical system, Visiting Physician Services, Inc. believes that this proposal is a justified one which should be granted a license by the State of Rhode Island.

Projected	FY 2012	FY 2013	FY 2014
Hours of Operation	MON-FRI 8AM TO 4PM	MON-FRI 8AM TO 4PM	MON-FRI 8AM TO 4PM
Utilization			
Throughput Possible			
Utilization Rate (%)			

- F. Please identify what portion of the need for the services proposed in this project is not currently being satisfied, and what portion of that unmet need would be satisfied by approval and implementation of this proposal.
- G. Please identify and evaluate alternative proposals to satisfy the unmet need identified in (F) above, including developing a collaborative approach with existing providers of similar services.
- H. Please provide a justification for the instant proposal and the scope thereof as opposed to the alternative proposals identified in (G) above.

HEALTH DISPARITIES AND CHARITY CARE

- 8.) The RI Department of Health defines health disparities as inequalities in health status, disease incidence, disease prevalence, morbidity, or mortality rates between populations as impacted by access to services, quality of services, and environmental triggers. Disparately affected populations may be described by race & ethnicity, age, disability status, level of education, gender, geographic location, income, or sexual orientation.
 - A. Please describe all health disparities in the applicant's service area. Provide all appropriate documentation to substantiate your response including any assessments and data that describe the health disparities.
 - B. Discuss the impact of the proposal on reducing and/or eliminating health disparities in the applicant's service area.
- 9.) Please provide a copy of the applicant's charity care policies and procedures and charity care application form.

PLEASE SEE ATTACHMENT 'A'

QUESTION NO: 8

As has been identified in this proposal, the research of Visiting Physician Services, Inc. has indicated that there is both a significant unmet and unknown benefit generated by providing physician house call visits. Previously within this proposal, Visiting Physician Services, Inc. has identified the obvious benefits by providing physician house call visits to the elderly, homebound, or others that may otherwise either not seek treatment or wait until a situation becomes an emergency. Clearly, there is a significant benefit in treating an individual before a situation becomes an emergency. Second, as previously stated, Visiting Physician Services, Inc. believes that this proposal would provide a significant benefit in the reduction of costs to the medical system.

Additionally and not yet discussed, are the unknown, but documented, benefits associated with physician house call visits. Visiting Physician Services, Inc., in doing its research, also has learned that Doctors have found a significant benefit merely in visiting a patient's home. In visiting a patient at home, a Doctor is able to view the living conditions of that patient. Often checking what type of food that individual might have in their home and seeing how the individual is attending to their medication can bring significant benefits. The visiting physician can see if an individual's refrigerator might be empty allowing the physician to take steps to ensure that the patient receives proper food. Additionally, if the individual is having difficulty taking their medications, the visiting physician can assist in establishing a plan that allows the patient to do so on a more regimented basis. Medication taken properly is a significant benefit.

VISITING PHYSICIAN SERVICES, INC.

CHARITY CARE POLICY

It shall be the policy of Visiting Physician Services, Inc. to provide physician house calls to all individuals regardless of ability to pay.

Visiting Physician Services, Inc, shall allocate resources to identify charity cases and provide uncompensated care based upon the information submitted at the time of application for charity care by the patient or the patient's representative.

Uninsured individuals shall be defined as patients of Visiting Physician Services, Inc. who are without third party insurance coverage for medical services.

ELIGIBILITY CRITERIA:

1. Charity care must be secondary to all other financial resources available to the patient. Insured patients may be eligible for charity care if their family income is two hundred (200%) percent or less of the Federal Poverty Guidelines and they meet all other criteria.
2. Determination of eligibility for charity care shall be reviewed regardless of the source of referral and without discrimination as to race, color, creed, national origin, age, handicap status or marital status.
3. Patient must be a Rhode Island resident.

ELIGIBILITY DETERMINATION:

1. Charity eligibility shall be determined once application has been received and reviewed.
2. Cases for consideration may be requested by a patient, family member, physician, hospital personnel, or recognized social agency who may be aware of the financial need of a patient.

APPLICATION PROCESS

1. Persons requesting assistance shall be given a Charity Care Application form. The patient shall authorize Visiting Physician Services, Inc. to make inquiries of employers or other institutions for the purpose of verifying information provided by the patient and/or family applying for assistance.
2. All applications and supporting documentation shall be treated with proper regard for patient confidentiality.
3. Visiting Physician Services, Inc. reserves the right to request additional information before making an eligibility determination.

VISITING PHYSICIAN SERVICES, INC.

CHARITY CARE APPLICATION

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

NAME OF EMPLOYER: _____

PHONE NUMBER OF EMPLOYER: _____

DO YOU HAVE HEALTH INSURANCE : YES ___ NO ___

PLEASE PROVIDE A BRIEF EXPLANATION BELOW WHY YOU ARE
APPLYING FOR CHARITY CARE:

DO YOU HAVE A COMMUNITY SOCIAL WORKER: YES ___ NO ___

IF YES, PLEASE PROVIDE THEIR NAME AND PHONE NUMBER:

Please Note:

4. Determination of eligibility for charity care shall be applied regardless of the source of referral and without discrimination as to race, color, creed, national origin, age, handicap status or marital status.
5. Patient must be a Rhode Island resident.

APPLICANT SIGNATURE

DATE

FINANCIAL ANALYSIS

10.) A) Please itemize the capital costs of this proposal. Present all amounts in thousands (e.g., \$112,527=\$113). If the proposal is going to be implemented in phases, identify capital costs by each phase.

CAPITAL EXPENDITURES		
	Amount	Percent of Total
Survey/Studies	\$	%
Fees/Permits	\$1,000	3%
Architect	\$	%
"Soft" Construction Costs	\$1,000	3%
Site Preparation	\$	%
Demolition	\$	%
Renovation	\$5,000	12%
New Construction	\$	%
Contingency	\$	%
"Hard" Construction Costs	\$5,000	12%
Furnishings	\$	%
Movable Equipment	\$20,000	49%
Fixed Equipment	\$10,000	24%
"Equipment" Costs	\$30,000	73%
Capitalized Interest	\$	%
Bond Costs/Insurance	\$	%
Debt Services Reserve ¹	\$	%
Accounting/Legal	\$5,000	12%
Financing Fees	\$	%
"Financing" Costs	\$5,000	12%
Land	\$	%
Other (specify _____)	\$	%
"Other" Costs	\$	%
TOTAL CAPITAL COSTS	\$41,000	100%

¹ Should not exceed the first full year's annual debt payment.

B.) Please provide a detailed description of how the contingency cost in (A) above was determined.

C.) Given the above projection of the total capital expenditure of the proposal, please provide an analysis of this proposed cost. This analysis must address the following considerations:

- i. The financial plan for acquiring the necessary funds for all capital and operating expenses and income associated with the full implementation of this proposal, for the period of 6 months prior to, during and for three (3) years after this proposal is fully implemented, assuming approval.
- ii. The relationship of the cost of this proposal to the total value of your facility's physical plant, equipment and health care services for capital and operating costs.
- iii. A forecast for inflation of the estimated total capital cost of the proposal for the time period between initial submission of the application and full implementation of the proposal, assuming approval, including an assessment of how such inflation would impact the implementation of this proposal.

11.) Please indicate the financing mix for the capital cost of this proposal. **NOTE:** the Health Services Council's policy requires a minimum 20% equity investment in CON projects (33% equity minimum for equipment-related proposals).

Source	Amount	Percent	Interest Rate	Terms (Yrs.)	List source(s) of funds (and amount if multiple sources)
Equity*	\$41,000	100%			
Debt**	\$	%	%		
Lease**	\$	%	%		
TOTAL	\$41,000	100%			

* Equity means non-debt funds contributed towards the capital cost of an acquisition or project which are free and clear of any repayment obligation or liens against assets, and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged (R23-15-CON).

** If debt and/or lease financing is indicated, please complete Appendix F.

12.) Will a fundraising drive be conducted to help finance this approval? Yes ___ No X

13.) Has a feasibility study been conducted of fundraising potential? Yes ___ No X

- If the response to Question 13 is 'Yes', please provide a copy of the feasibility study.

14.) Will the applicant apply for state and/or federal capital funding? Yes ___ No X

- If the response to Question 14 is 'Yes', please provide the source: _____, amount: _____, and the expected date of receipt of those monies: _____.

15.) Please calculate the yearly amount of depreciation and amortization to be expensed.

Depreciation/Amortization Schedule - Straight Line Method					
	Improvements	Equipment		Amortization	Total
		Fixed	Movable		
Total Cost	\$5,000	\$10,000	\$20,000	\$6,000	\$ *1*
(-) Salvage Value	\$0	\$0	\$0	\$0	\$0
(=) Amount Expensed	\$.333	\$1,429	\$2,857	\$1,200	\$5,819
(/) Average Life (Yrs.)	15	7	7	5	
(=) Annual Depreciation	\$.333	\$1,429	\$2,857	\$1,200	\$ *2*

1 Must equal the total capital cost (Question 10 above) less the cost of land and less the cost of any assets to be acquired through lease financing

2 Must equal the incremental “depreciation/amortization” expense, column -5-, in Question 18 (below).

16.) For the first full operating year of the proposal (identified in Question 18 below), please identify the total number of FTEs (full time equivalents) and the associated payroll expense (including fringe benefits) required to staff this proposal. Please follow all instructions and present the payroll in thousands (e.g., \$42,575=\$43).

Personnel	Existing		Additions/(Reductions)		New Totals	
	# of FTEs	Payroll W/Fringes	# of FTEs	Payroll W/Fringes	# of FTEs	Payroll W/Fringes
Medical Director		\$	0	\$0	0	\$0
Physicians		\$	1.75	\$190,000	1.75	\$190,000
Administrator		\$.25	\$0	.25	\$0
RNs		\$	0	\$0	0	\$0
LPNs		\$	0	\$0	0	\$0
Nursing Aides		\$	0	\$0	0	\$0
PTs		\$	0	\$0	0	\$0
OTs		\$	0	\$0	0	\$0
Speech Therapists		\$	0	\$0	0	\$0
Clerical		\$	1	\$45,000	1	\$45,000
Housekeeping		\$	0	\$0	0	\$0
Other: (specify)		\$	1	\$45,000	1	\$45,000
TOTAL		\$	4	\$ *1*	4	\$280,000

1 Must equal the incremental “payroll w/fringes” expense in column -5-, Question 18 (below).

INSTRUCTIONS:

- “FTEs” Full time equivalents, are the equivalent of one employee working full time (i.e., 2,080 hours per year)
- “Additions” are NEW hires;
- “Reductions” are staffing economies achieved through attrition, layoffs, etc. It does **NOT** report the reallocation of personnel to other departments.

17.) Please describe the plan for the recruitment and training of personnel.

18.) Please complete the following pro-forma income statement for each unit of service. Present all dollar amounts in thousands (e.g., \$112,527=\$113). Be certain that the information is accurate and supported by other tables in this worksheet (i.e., “depreciation” from Question 15 above, “payroll” from Question 16 above). If this proposal involved more than two separate “units of service” (e.g., pt. days, CT scans, outpatient visits, etc.), insert additional units as required.

PRO-FORMA P & L STATEMENT FOR WHOLE FACILITY					
	Actual Previous Year 2011__ (1)	Budgeted Current Year 2012__ (2)	<-- FIRST FULL OPERATING YEAR 2013>		
			CON Denied (3)	CON Approved (4)	Incremental Difference *1* (5)
REVENUES:					
Net Patient Revenue	\$	\$312,000	\$	\$395,000	\$ 395,000 *2*
Other:	\$	\$	\$	\$	\$
Total Revenue	\$	\$312,000	\$	\$395,000	\$395,000
EXPENSES:	\$	\$	\$	\$	\$
Payroll w/Fringes	\$	\$240,000	\$	\$280,000	\$ 280,000 *3*
Bad Debt	\$	\$3,000	\$	\$4,000	\$ 4,000 *4*
Supplies	\$	\$10,000	\$	\$12,000	\$12,000
Office Expenses	\$	\$10,000	\$	\$10,000	\$10,000
Utilities	\$	\$4,000	\$	\$4,000	\$4,000
Insurance	\$	\$12,000	\$	\$15,000	\$15,000
Interest	\$	\$0	\$	\$	\$ 0 *5*
Depreciation/Amortization	\$	\$5,800	\$	\$5,800	\$ 5,800 *6*
Leasehold Expenses	\$	\$9,000	\$	\$9,000	\$9,000
Other: (ADVERTISING)	\$	\$60,000	\$	\$50,000	\$50,000

Total Expenses	\$	\$353,800	\$	\$389,800	\$389,800 *7*
OPERATING PROFIT:	\$	\$-41,800	\$	\$5,200	\$5,200

For each service to be affected by this proposal, please identify each service and provide: the utilization, average net revenue per unit of services and the average expense per unit of service.

Service Type:	VISITING PHYSICIAN SERVICES				
Service (#s):					
Net Revenue Per Unit *8*	\$0	\$.125	\$0	\$.131	\$.131
Expense Per Unit	\$0	\$.142	\$0	\$.130	\$.130
Service Type:					
Service (#s):					
Net Revenue Per Unit *8*	\$	\$	\$	\$	\$
Expense Per Unit	\$	\$	\$	\$	\$

INSTRUCTIONS: Present all dollar amounts (except unit revenue and expense) in thousands.

- *1* The Incremental Difference (column -5-) represents the actual revenue and expenses associated with this CON. It does not include any already incurred allocated or overhead expenses. It is column -4- less column -3-.
- *2* Net Patient Revenue (column -5-) equals the different units of service times their respective unit reimbursement.
- *3* Payroll with fringe benefits (column -5-) equals that identified in Question 16 above.
- *4* Bad Debt is the same as that identified in column -4-.
- *5* Interest Expense equals the first full year's interest paid on debt.
- *6* Depreciation equals a full year's depreciation (Question 15 above), not the half year booked in the year of purchase.
- *7* Total Expense (column -5-) equals the operating expense of this proposal and is defined as the sum of the different units of service;
- *8* Net Revenue per unit (of service) is the actual average net reimbursement received from providing each unit of service; it is NOT the charge for that service.

19.) Please provide an analysis and description of the impact of the proposed new institutional health service or new health equipment, if approved, on the charges and anticipated reimbursements in any and all affected areas of the facility. Include in this analysis consideration of such impacts on individual units of service and on an aggregate basis by individual class of payer. Such description should include, at a minimum, the projected charge and reimbursement information requested above for the first full year after implementation, by payor source, and shall present alternate projections assuming (a) the proposal is not approved, and (b) the proposal is approved. If no additional (incremental) utilization is projected, please indicate this and complete this table reflecting the total utilization of the facility in the first full fiscal year.

Projected First Full Operating Year: FY 2013									
Payor Mix	Implemented			Not Implemented			Difference		
	Projected Utilization		Total Revenue	Projected Utilization		Total Revenue	Projected Utilization		Total Revenue
	#	%	\$	#	%	\$	#	%	\$
Medicare	1000	33	150,000				1000	33	150,000
RI Medicaid	750	25	75,000				750	25	75,000
Non-RI Medicaid									
RiteCare									
Blue Cross	125	4	15,000				125	4	15,000
Commercial	200	7	28,000				200	7	28,000
HMO's	350	12	42,000				350	12	42,000
Self Pay	515	17	85,000				515	17	85,000
Charity Care	60	2	\$0			\$0	60	2	\$0
Other: _____									
TOTAL	3,000	100	395,000				3,000	100	395,000

20.) Please provide the following: N/A

A. Please provide audited financial statements for the most recent year available.

B. Please discuss the impact of approval or denial of the proposal on the future viability of the (1) applicant and (2) providers of health services to a significant proportion of the population served or proposed to be served by the applicant.

21.) Please identify the derivable operating efficiencies, if any, (i.e., economies of scale or substitution of capital for personnel) which may result in lower total or unit costs as a result of this proposal.

22.) Please describe on a separate sheet of paper all energy considerations incorporated in this proposal.

23.) Please comment on the affordability of the proposal, specifically addressing the relative ability of the people of the state to pay for or incur the cost of the proposal, at the time, place and under the circumstances proposed. Additionally, please include in your discussion the consideration of the state's economy.

QUALITY, CONTINUITY OF CARE, AND RELATIONSHIP TO THE HEALTH CARE SYSTEM

24.) **A) If the applicant is an existing facility: N/A**

Please identify and describe any outstanding cited health care facility licensure or certification deficiencies, citations or accreditation problems as may have been cited by appropriate authority. Please describe when and in what manner this licensure deficiency, citation or accreditation problem will be corrected.

B) If the applicant is a proposed new health care facility:

Please describe the quality assurance programs and/or activities which will relate to this proposal including both inter and intra-facility programs and/or activities and patient health outcomes analysis whether mandated by state or federal government or voluntarily assumed. In the absence of such programs and/or activities, please provide a full explanation of the reasons for such absence.

Visiting Physician Services will implement quality assurance policies and procedures as they pertain to patient care and outcomes. Outcome statistics will be tracked and reported to the Governing body on a quarterly basis.

C) If this proposal involves construction or renovation: N/A

Please describe your facility's plan for any temporary move of a facility or service necessitated by the proposed construction or renovation. Please describe your plans for ensuring, to the extent possible, continuation of services while the construction and renovation take place. Please include in this description your facility's plan for ensuring that patients will be protected from the noise, dust, etc. of construction.

25.) Please discuss the impact of the proposal on the community to be served and the people of the neighborhoods close to the health care facility who are impacted by the proposal. N/A

26.) Please discuss the impact of the proposal on service linkages with other health care facilities/providers and on achieving continuity of patient care.

Visiting Physician Services will refer patients to other health care facilities and providers on an as needed basis.

27.) Please address the following:

- A. How the applicant will ensure full and open communication with their patients' primary care providers for the purposes of coordination of care;

Visiting Physician Services shall provide a written report of findings, care provided and any recommendations to a patient's Primary Care Physician (PCP) provided the patient has a PCP.

- B. Discuss the extent to which preventive services delivered in a primary care setting could prevent overuse of the proposed facility, medical equipment, or service and identify all such preventative services;

By providing physician house calls, medical conditions can be addressed before they become serious thereby reducing the need for emergency room visits and/or hospitalization resulting in significant cost savings to an overburdened health care system.

- C. Describe how the applicant will make investments, parallel to the proposal, to expand supportive primary care in the applicant's service area.

Once licensure has been obtained, Visiting Physician Services will add additional physicians and medically equipped vehicles in strategic areas throughout RI should the need arise.

- D. Describe how the applicant will use capitalization, collaboration and partnerships with community health centers and private primary care practices to reduce inappropriate Emergency Room use.

Visiting Physician Services will refer patients to other health care facilities, providers and social service agencies on an as needed basis.

- E. Identify unmet primary care needs in your service area, including "health professionals shortages", if any (information available at Office of Primary Care and Rural Health at <http://www.health.ri.gov/disease/primarycare/hpsa-professionals.php>).

Unmet primary care needs include elderly and homebound individuals who often do not seek out medical attention until it becomes an emergent situation. Additionally, the Office of Primary Care and Rural Health published a report in November, 2011 which indicates that people living in the non-metropolitan regions of Rhode Island have limited access to health care providers and inadequate public transportation. These are the populations Visiting Physician Services proposes to serve.

- 28.) Please discuss the relationship of the services proposed to be provided to the existing health care system of the state.

Currently there is no other medical model in the state of RI similar to this proposal. It is our belief that this proposal will provide a dual benefit: Provision of medical care to underserved populations throughout the state and a significant reduction in medical costs to the state and federal government as well as private insurers.

Select and complete the Appendixes applicable to this application:

Appendix	Check off:	Required for:
A		Accelerated review applications
B		Applications involving provision of services to inpatients
C		Nursing Home applications
D	X	All applications
E		Applications with healthcare equipment costs in excess of \$1,000,000 and any tertiary/specialty care equipment
F		Applications with debt or lease financing
G	X	All applications

Appendix A

Request for Expeditious Review

- 1.) Name of applicant: _____
- 2.) Indicate why an expeditious review of this application is being requested by marking at least one of the following with an 'X'.
 - _____ a. for emergency needs documented in writing by the state fire marshal or other lawful authority with similar jurisdiction over the relevant subject matter;
 - _____ b. for the purpose of eliminating or preventing fire and/or safety hazards certified by the state fire marshal or other lawful authority with similar jurisdiction of the relevant subject matter as adversely affecting the lives and health of patients or staff;
 - _____ c. for compliance with accreditation standards failure to comply with which will jeopardize receipt of federal or state reimbursement;
 - _____ d. for such an immediate and documented public health urgency as may be determined to exist by the Director of Health with the advice of the Health Services Council.
- 3.) For each response with an 'X' beside it in Question 2 above, furnish documentation as indicated:
 - 2.a: a written communication from the State Fire Marshal or other lawful authority with similar jurisdiction over the relevant subject matter setting forth the particular emergency needs cited and the measures required to meet the emergency;
 - 2.b: documentation from the State Fire Marshal or other lawful authority with similar jurisdiction of the relevant subject matter certifying that particular fire and/or safety hazards currently exist which adversely affect the life and health of patients or staff and outlining the measures which must be taken in order to alleviate these hazards;
 - 2.c: a written communication from the accrediting agency naming specific deficiencies and required remedies for situations failure of compliance with which will jeopardize receipt of federal or state reimbursement;
 - 2.d: a complete description and documentation of the immediate and documented public health urgency, which, in the applicant's opinion, necessitates an expeditious review.

Appendix B

Provision of Health Services to Inpatients

1. Are there similar programmatic alternatives to the provision of institutional health services as proposed herein which are superior in terms of:
 - a. Cost Yes No
 - b. Efficiency Yes No
 - c. Appropriateness Yes No
2. For each No response in Question 1, discuss your finding that there are no programmatic alternatives superior to this proposal separately for each such finding.
3. For each Yes response in Question 1, identify the superior programmatic alternative to this proposal, and explain why that superior alternative was rejected in favor of this proposal separately for each such finding..
4. In the absence of proposed institutional health services proposed herein, will patients encounter serious problems in obtaining care of the type proposed in terms of:
 - a. Availability Yes No
 - b. Accessibility Yes No
 - c. Cost Yes No
5. For each Yes response in Question 4, please justify and provide supporting evidence separately for availability, accessibility and cost.

Appendix C

Nursing Home Proposals

1. Provide the current patient census at the facility by payer source in the table below.
Date of Census ___/___/___, Licensed bed capacity_____.

Payor	Number of Patients	Percent of Total
Medicare		%
RI Medicaid		%
Non-RI Medicaid		%
Private Pay		%
Veterans		%
Other: (specify _____)		%
TOTAL:		100%

2. Please complete the following Medicaid per diem worksheet for the facility.

Expense	COSTS		REIMBURSEMENT		MAXIMUM RATE	
	Current FY 20__	First FY 20__ Project Approved (proposed)	Current FY 20__	First FY 20__ Project Approved (proposed)	Current FY 20__	First FY 20__ Project Approved (proposed)
Pass Through Cost Center						
Fair Rental Cost Center						
Direct Labor Cost Center						
Other Operating Expenses						
TOTAL:						

3. Pursuant to Section 5.8 of the Rules and Regulations for Licensing of Nursing Facilities (R23-17-NF), please demonstrate that the applicant or proposed license holder shall have sufficient resources to operate the nursing facility at licensed capacity for thirty (30) days, evidenced by an unencumbered line of credit, a joint escrow account established with the Department, or a performance bond secured in favor of the state or a similar form of security satisfactory to the Department, if applicable.

4. Complete the following itemization of projected utilization and net patient revenue for the first full operating year.

Payors	Implemented	Not Implemented	Incremental Difference
MEDICAID			
Per Diem Revenue			
Patient Days			
Total Revenue			
MEDICARE			
Per Diem Revenue			
Patient Days			
Total Revenue			
COMMERCIAL			
Per Diem Revenue			
Patient Days			
Total Revenue			
PRIVATE PAY			
Per Diem Revenue			
Patient Days			
Total Revenue			
VETERANS			
Per Diem Revenue			
Patient Days			
Total Revenue			
Other			
Per Diem Revenue			
Patient Days			
Total Revenue			
TOTAL PATIENT REVENUE			
TOTAL PATIENT DAYS			

5. Based on the format below, please provide a summary of the applicant's administrative and operational policies and procedures to provide individualized and resident-centered care, services, and accommodations, and a sense of peace, safety, and community, and clearly identify how the proposal would advance these areas:

- a. Resident's physical environment:
 - i. Accommodations for privacy vs. congregate and common areas;
 - ii. Choice and autonomy in personal space, fixtures, furniture;
 - iii. Access to and involvement in decentralized services, such as, community kitchen(s), laundry, activities;

- iv. Access to outdoors and outdoor activities (e.g., sunrooms, patios, gardens and gardening);
- b. Resident-centered systems of care:
 - i. Security systems and care delivery systems to foster autonomy, choice, and negotiated risk;
 - ii. Individualized daily/nightly scheduling (e.g., daily rhythm, going to bed, waking);
 - iii. Dining flexibility (e.g., time, access to dining style and menu choice);
 - iv. Lifestyle/activities flexibility;
- c. Workforce administration:
 - i. How do staffing schedules and assignments ensure consistent delivery of resident services and foster relationship building?
 - ii. Administrative status strategies for dealing with licensed staff turn-over (e.g. Registered nurses, Licenses Practical nurses, Nursing Assistants)

Appendix D

All applications must be accompanied by responses to the questions posed herein.

1. Provide a description and schematic drawing of the contemplated construction or renovation or new use of an existing structure and complete the Change in Space Form. N/A
2. Please provide a letter stating that a preliminary review by a Licensed architect indicates that the proposal is in full compliance with the current edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities" and identify the sections of the guidelines used for review. Please include the name of the consulting architect, and their RI Registration (license) number and RI Certification of Authorization number. N/A
3. Provide assurance and/or evidence of compliance with all applicable federal, state and municipal fire, safety, use, occupancy, or other health facility licensure requirements. N/A
4. Does the construction, renovation or use of space described herein corrects any fire and life safety, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), U.S. Department of Health and Human Services (DHHS) or other code compliance problems: Yes _____ No X
 - o If Yes, include specific reference to the code(s). For each code deficiency, provide a complete description of the deficiency and the corrective action being proposed, including considerations of alternatives such as seeking waivers, variances or equivalencies.
5. Describe all the alternatives to construction or renovation which were considered in planning this proposal and explain why these alternatives were rejected. **Visiting Physician Services will be seeing client in their home and will travel throughout the state in a medically equipped van.**
6. Attach evidence of site control, a fee simple, or such other estate or interest in the site including necessary easements and rights of way sufficient to assure use and possession for the purpose of the construction of the project. N/A
7. If zoning approval is required, attach evidence of application for zoning approval. N/A
8. If this proposal involves new construction or expansion of patient occupancy, attach evidence from the appropriate state and/or municipal authority of an approved plan for water supply and sewage disposal. N/A
9. Provide an estimated date of contract award for this construction project, assuming approval within a 120-day cycle. N/A
10. Assuming this proposal is approved, provide an estimated date (month/year) that the service will be actually offered or a change in service will be implemented. If this service will be phased in, describe what will be done in each phase. **OCTOBER, 2012**

Appendix G

Ownership Information

All applications must be accompanied by responses to the questions posed herein.

1. List all officers, members of the board of directors, trustees, stockholders, partners and other individuals who have an equity or otherwise controlling interest in the applicant. For each individual, provide their home and business address, principal occupation, position with respect to the applicant, and amount, if any, of the percentage of stock, share of partnership, or other equity interest that they hold.
2. For each individual listed in response to Question 1 above, list all (if any) other health care facilities or entities within or outside Rhode Island in which he or she is an officer, director, trustee, shareholder, partner, or in which he or she owns any equity or otherwise controlling interest. For each individual, please identify: A) the relationship to the facility and amount of interest held, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, and F) any professional accreditation (e.g. JACHO, CHAP, etc.).
3. If any individual listed in response to Question 1 above, has any business relationship with the applicant, including but not limited to: supply company, mortgage company, or other lending institution, insurance or professional services, please identify each such individual and the nature of each relationship.
4. Have any individuals listed in response to Question 1 above been convicted of any state or federal criminal violation within the past 20 years? Yes ___ No X_.
 - If response is 'Yes', please identify each person involved, the date and nature of each offense and the legal outcome of each incident.
5. Please provide organization chart for the applicant, identifying all "parent" entities with direct or indirect ownership in or control of the applicant, all "sister" legal entities also owned or controlled by the parent(s), and all subsidiary entities owned by the applicant. Please provide a brief narrative clearly explaining the relationship of these entities, the percent ownership the principals have in each (if applicable), and the role of each and every legal entity that will have control over the applicant.
6. Please list all licensed healthcare facilities (in Rhode Island or elsewhere) owned, operated or controlled by any of the entities identified in response to Question 5 above (applicant and/or its principals). For each facility, please identify: A) the entity, applicant or principal involved, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, and F) any professional accreditation (e.g. JACHO, CHAP, etc.).

7. Have any of the facilities identified in Question 5 or 6 above had: A) federal conditions of participation out of compliance, B) decertification actions, or C) any actions towards revocation of any state license? Yes ___ No X
- If response is 'Yes', please identify the facility involved, the nature of each incident, and the resolution of each incident.
8. Have any of the facilities owned, operated or managed by the applicant and/or any of the entities identified in Question 5 or 6 above during the last 5-years had bankruptcies and/or were placed in receiverships? Yes ___ No X
- If response is 'Yes', please identify the facility and its current status.
9. For applications involving establishment of a new entity or involving out of state entities, please provide the following documents:
- Certificate and Articles of Incorporation and By-Laws (for corporations)
 - Certificate of Partnership and Partnership Agreement (for partnerships)
 - Certificate of Organization and Operating Agreement (for limited liability corporations)

Appendix G
Ownership Information

1) Michael Bigney **Business Address:**
10 Linden Drive 334 East Avenue
Providence, RI 02906 Pawtucket, RI 02860

Occupation – CPA –Owner of Nursing Placement, Inc. (Home Nursing Care Provider)

Administrator for applicant - - - will own 34% of stock

Maria Barros **Business Address:**
60 Capwell Avenue 334 East Avenue
Pawtucket, RI 02860 Pawtucket, RI 02860

Occupation – RN - - - Owner of Nursing Placement, Inc. (Home Nursing Care Provider)

Director of Clinical Operations for applicant - - - will own 33% of stock

Stephanie Ryan **Business Address:**
258 Bellman Avenue 334 East Avenue
Warwick, RI 02886 Pawtucket, RI 02860

Occupation – RN – Direct of Operations – Nursing Placement, Inc. - - - will own 33% of stock.

2) Michael Bigney

1) Nursing Placement, Inc. – 75% ownership interest – Home Nursing Care Provider – 334 East Avenue Pawtucket, RI 02860 - - - State License # HNC02300 - - - No Medicare Provider Number - - - CHAP Accreditation.

2) Nursing Placement Home Health Care Services, Inc. - - - 100% ownership interest – Home Nursing Care Provider – 334 East Avenue Pawtucket, RI 02860 - - - State License # HNC02299 - - - Medicare Provider Number - 41-7055 - - - CHAP Accreditation.

3) Hospice of Nursing Placement, Inc. – Non-Profit Entity – no ownership interest, but manage operations of entity – Hospice Provider – 334 East Avenue Pawtucket, RI 02860 - - - State License # HSP01616 - - - Medicare Provider Number - 41-1508 - - - CHAP Accreditation.

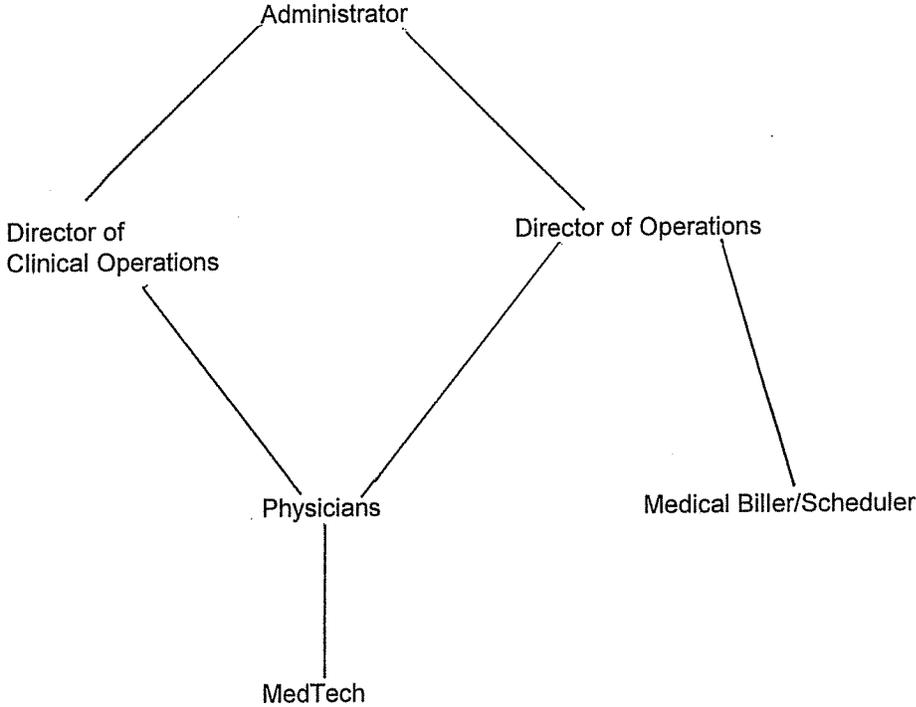
Maria Barros

1) Nursing Placement, Inc. – 25% ownership interest – Home Nursing Care Provider – 334 East Avenue Pawtucket, RI 02860 - - - State License # HNC02300 - - - No Medicare Provider Number - - - CHAP Accreditation.

2) Hospice of Nursing Placement, Inc. – Non-Profit Entity – no ownership interest, but manage operations of entity – Hospice Provider – 334 East Avenue Pawtucket, RI 02860 - - - State License # HSP01616 - - - Medicare Provider Number - 41-1508 - - - CHAP Accreditation.

- 3) Business Relationships – Michael Bigney and Maria Barros (Bigney & Barros Properties, LLC) own the office building located at 334 East Avenue Pawtucket, RI 02860. The applicant will pay rent to Bigney & Barros Properties, LLC.
- 4) No convictions of any state or federal criminal violations within the past twenty years for any of the owners of the applicant.
- 5) Organizational Chart - - - See attached
- 6) Please refer to Question #2.

**Visiting Physician Services
Organizational Chart**



MICHAEL A BIGNEY
LISA & MICHAEL BIGNEY TRUST
10 LINDEN DR
PROVIDENCE, RI 02906

1214

80-568/1012

6/11/2012
Date

Pay to the Order of Rhode ISLAND General Treasurer \$ 500 ⁰⁰
Five Hundred 00/100 Dollars  Security Features Details on Back.



UMB Bank, N.A.
Warsaw, MO

For Visiting Physician Society, Inc. Michael A. Bigny MP

⑆ 10 20568 ⑆ ⑆ 214 ⑆ 77 ⑆ 1633259217 ⑆

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- 5. Unless otherwise stated all authorized shares are deemed to have a nominal or par value of \$0.01 per share.
- 4. The corporation has the purpose of engaging in any lawful business, and shall have perpetual existence until dissolved or terminated in accordance with Chapter 7-1.2.

3. The address of the initial registered office of the corporation is:

One Ship Street
 Providence RI 02903
 (Street Address, not P.O. Box) and the name of its initial registered agent at
 (City/Town) (Zip Code)
 Stephen M. Litwin, Esquire
 (Name of Agent)

(b) If more than one class: Total number of shares of each class
 limitations, or restrictions of them, which are permitted by the provisions of Chapter 7-1.2 of the General Laws, 1956, as amended, in respect of any class or classes of shares of the corporation and the fixing of which by the articles of association is desired, and an express grant of the authority as it may then be desired to grant to the board of directors to fix by vote or votes any of them that may be desired but which is not fixed by the articles:

2. The total number of shares which the corporation has the authority to issue is:

(a) If only one class: Total number of shares 2,000

or

(This is a close corporation pursuant to §7-1.2-1701 of the General Laws, 1956, as amended.) (Strike if inapplicable.)

1. The name of the corporation is Visiting Physician Services, Inc.

The undersigned acting as incorporator(s) of a corporation under Chapter 7-1.2 of the General Laws of Rhode Island, 1956, as amended, adopt(s) the following Articles of Incorporation for such corporation:

ARTICLES OF INCORPORATION
BUSINESS CORPORATION

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
 Office of the Secretary of State
 Division of Business Services
 148 W. River Street
 Providence, Rhode Island 02904-2615
 www.sos.ri.gov



Filing and License Fee: \$230.00 minimum

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6. Additional provisions, if any, not inconsistent with Chapter 7-1.2 which the incorporators elect to have set forth in these Articles of Incorporation:

Multiple horizontal lines for providing additional provisions.

7. The name and address of each incorporator is:

Name

Address

Stephen M Litwin

One Ship Street, Providence, RI 02903

Horizontal lines for name and address information.

8. These Articles of Incorporation shall be effective upon filing unless a specified date is provided which shall be no later than the 90th day after the date of this filing upon filing

Under penalty of perjury, I/we declare and affirm that I/we have examined these Articles of Incorporation, including any accompanying attachments, and that all statements contained herein are true and correct.

Stephen M. Litwin

Date: March 1, 2012

Signature of each Incorporator

Horizontal lines for signatures.