State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted 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. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner	Petitioner
Full Legal Name	BACK & NECK PAIN CENTER OF GREENWICH, PC	
Doing Business As	SAME	
Name of Parent Corporation	SAME	
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	100 MELROSE AVE SUITE 101 GREENWICH, CT 06830	
What is the Petitioner's Status: P for profit and NP for Nonprofit	P	
Contact Person, including Title/Position: This Individual will be the Petitioner's Designee to receive all correspondence in this matter.	ADRIAN M MARCUS, DC PRESIDENT	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	100 MELROSE AVE SUITE 101 GREENWICH, CT 06830	

Contact Person's Telephone Number	203-629-0202
Contact Person's Fax Number	203-629-0765
Contact Person's e-mail Address	BACKDOC007@HOTMAIL.COM

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title: MEDICARE OUT PATIENT REHABILITATION SERVICES - PHYSICAL & OCCUPATIONAL THERAPY

b. Location of proposal, identifying Street Address, Town and Zip Code: 100 MELROSE AVE, STE 101, GREENWICH, CT 06830

c. List each town this project is intended to serve: GREENWICH, STAMFORD, NEW CANAAN, DARIEN, NORWALK, WEST PORT RYE, NY & PORCHESTER, NY

d. Estimated starting date for the project: NOV 01, 2006

e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in the boxes that apply)

E	P		E	P		E	P	
☐	☐	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
☐	☐	Behavioral Health Provider	☐	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Hospital Affiliate	☐	☒	Other (specify): MEDICARE OUT PATIENT REHAB - PHYSICAL & OCCUPATIONAL THERAPY			

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ 13,000

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

Medical Equipment Purchases	1,000
Major Medical Equipment Purchases	0
Non-Medical Equipment Purchases*	0
Land/Building/Asset Purchases	0
Construction/Renovation	0
Other (Non-Construction) Specify: CONSULTANT	12,000
Total Capital Expenditure	1,000
Medical Equipment - Fair Market Value of Leases	
Major 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	13,000
Capitalized Financing Costs (Informational Purpose Only)	0

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

Major Medical and/or Imaging Equipment Acquisition: 0

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide copy of the vendor contract or quotation for the medical equipment.

c. Check each applicable financing method or funding source to be used for the proposal:

☒	Petitioner's Equity	☐	Capital Lease	☐	Conventional Loan
☐	Charitable Contributions	☐	Operating Lease	☐	CHEFA Financing
☐	Funded Depreciation	☐	Grant Funding	☐	Other (specify): _____

SECTION IV. PROPOSAL DESCRIPTION

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 elements need to be addressed, if applicable.

1. Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

2. Identify the types of services that are 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 the entity that will be providing the service(s).

5. Identify the entity that will be responsible for the billing of the service(s) relating to this proposal.

6. Identify the entity that owns/leases or will own/lease the physical space of the proposed equipment/service?

7. If there is more than one entity involved in this proposal, please provide copies of any and all existing or proposed contracts or written agreements entered between the two entities that relate to the proposal.

8. Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal.

9. Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable.

10. Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal.

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

PROPOSAL DESCRIPTION

1. Therapy services permitted by the State Practice Act are provided now. However, medicare patients can not be treated until we are certified as a Rehabilitation Agency.
2. Physical and Occupational therapy are proposed. During the certification process, we will employ a licensed Physical Therapist and an Occupational Therapist at a later date.
3. Patients come to our office generally from Greenwich, Stamford, New Canaan, Darien, Norwalk, Westport, Rye, NY and Port Chester, NY.
4. Back and Neck Center of Greenwich, PC will provide the services.
5. Same as #4.
6. Same as #4.
7. Only one entity will provide the services.
8. Only the one entity is involved with this proposal.
9. Adrian M. Marcus, DC is the sole owner of the provider.
10. Same as #8.
11. Medicare is the current payer of this service. However, when we become certified, we anticipate potential new sources of referral and payment.

SECTION V. AFFIDAVIT

To be completed by each Petitioner

Petitioner: ADRIAN M. MARCUS, DC

Project Title: MEDICARE OUTPATIENT REHABILITATION SERVICES

I, ADRIAN M. MARCUS, DC, PRESIDENT/CEO
(Name) (Position – CEO or CFO)

of BACK & PAIN CENTER OF GREENWICH, PC being duly sworn, depose and state that the
(Organization Name)

information provided in this CON Determination form is true and accurate to the best of my knowledge, and that BACK & PAIN CENTER OF GREENWICH, PC complies with the appropriate
(Facility Name)

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.

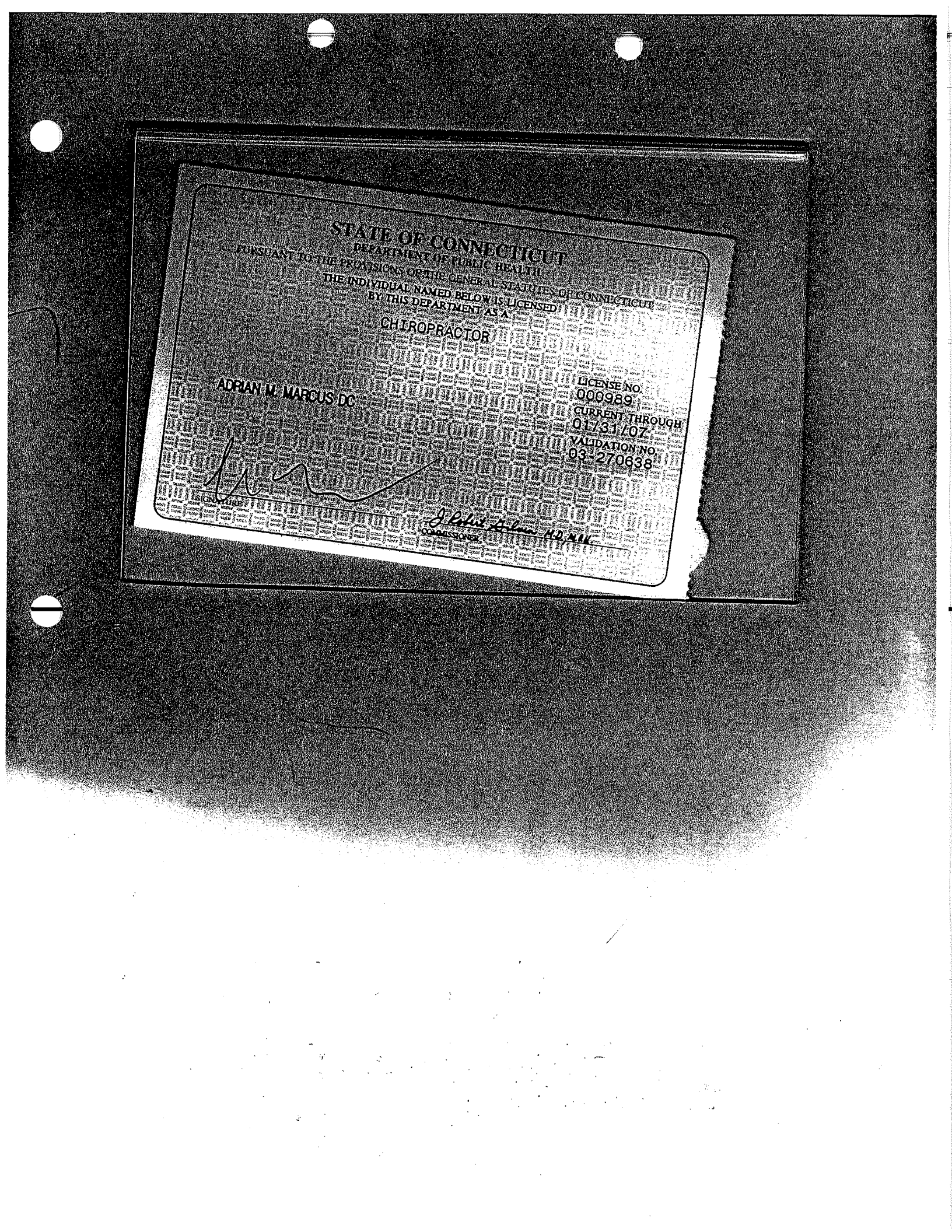
Signature

9/23/06
Date

Subscribed and sworn to before me on 9/23/06

Mariela Vaillant
Notary Public/Commissioner of Superior Court

My commission expires: MARIELA VAILLANT
Notary Public
STATE OF CONNECTICUT
My Commission Expires Nov. 30, 2008



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
PURSUANT TO THE PROVISIONS OF THE GENERAL STATUTES OF CONNECTICUT
THE INDIVIDUAL NAMED BELOW IS LICENSED
BY THIS DEPARTMENT AS A
CHIROPRACTOR
ADRIAN M. MARCUS DC
LICENSE NO.
000989
CURRENT THROUGH
01/31/07
VALIDATION NO.
03-270638
SIGNATURE
J. Robert Galvin M.D. M.P.H.
COMMISSIONER