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?

SECTION V. AFFIDAVIT

To be completed by each Petitioner

Petitioner: ADRIAN M. MARCOS, DC

Project Title: MEDICARE OUTPATIENT REHABILITATION SERVICES

I, ADRIAN M. MARCOS, 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

4/17/07
Date

RECEIVED
2007 APR 20 A 11:55
OFFICE OF HEALTH CARE ACCESS

Subscribed and sworn to before me on 4/17/07

Notary Public/Commissioner of Superior Court

MARIELA VAILLANT
Notary Public
STATE OF CONNECTICUT
My Commission Expires Nov. 30, 2009

My commission expires:

Dr. Adrian Marcus
100 Melrose Ave. Suite 101
Greenwich, CT 06830
Tel. (203) 629-0202
Fax. (203) 629-0765

Back & Neck Pain Center of Greenwich

Fax

To: Kimberly Martone
Fax: 860 418 7053
Phone:
Re:

From:
Pages:
Date:
CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

• Comments:

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.

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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.

Dr. Adrian M. Marcus

100 Melrose Avenue, Suite 101
Greenwich, Connecticut 06830

Telephone (203) 629-0202
Facsimile (203) 629-0765

PROPOSAL DESCRIPTION

At the present time, there are no Medicare certified Outpatient Rehabilitation facilities in the Fairfield County area that offer integrated chiropractic and physical therapy services.

The Back & Neck Pain Center of Greenwich, P.C. is an established chiropractic practice, serving the residents of Greenwich and its surrounding communities.

The Back & Neck Pain Center of Greenwich, P.C. proposes to expand its services to include physical therapy and eventually occupational therapy.

The integration of physical therapy will offer the following patient benefits:

1. Expanded rehabilitation. Chiropractic adjustments and rehabilitation exercises go hand in hand, creating a synergistic effect that is usually greater than the effect of either therapy alone.

2. Second professional opinion. Patients gain the benefit of a second opinion from a professional in another discipline.

3. Convenience. Patients will be able to get this opinion conveniently without having to travel to another office.

4. More one-on-one time. Patients will receive more time for active rehabilitative care.

5. Lasting results from treatment. Chiropractic treatment, in the absence of appropriate rehabilitative care, may be ongoing and the results limited without active rehabilitation.

According to the Connecticut Opinion of the Attorney General: "Sound reasoning suggests that the use of physical therapy in the practice of chiropractic complements, rather than detracts from each respective field of practice" (07/10/81).

We strongly believe that by providing integrated services, it will enable us to offer a more complete and lasting service that will ultimately improve outcomes from patient care.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 11, 2007

Adrian Marcus, D.C.
President
Back and Neck Pain Center of Greenwich, P.C.
100 Melrose Avenue, Suite 101
Greenwich, CT 06830

RE: Certificate of Need Application Forms, Docket Number 07-30960-CON
Back and Neck Pain Center of Greenwich, P.C.
Proposal to Become a Medicare-Certified Outpatient Rehabilitation Service Provider

Dear Dr. Marcus:

Enclosed are the application forms for Back and Neck Pain Center of Greenwich, PC's Certificate of Need ("CON") proposal for the Proposal to Become a Medicare-Certified Outpatient Rehabilitation Service Provider with an associated capital expenditure of $13,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between June 19, 2007, and August 18, 2007.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and three (3) hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests a copy of the submission be in MS Word format and the scanned copy be in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Laurie K. Greci. Please feel free to contact him/her at (860) 418-7001, if you have any questions.

Sincerely,

Kimberly Martone /sa
Kimberly Martone
Certificate of Need Supervisor

Enclosures

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, "Not Applicable" may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than June 19, 2007, and must be submitted no later than August 18, 2007. The Analyst assigned to your application is Laurie K. Greci and you may reach her at the Office of Health Care Access at (860) 418-7001.

Docket Number: 07-30960-CON

Applicant's Name: Back and Neck Pain Center of Greenwich, P.C.

Contact Person: Adrian Marcus D.C.
Contact Title: President
Back and Neck Pain Center of Greenwich, P.C.
Contact Address: 100 Melrose Avenue, Suite 101
Greenwich, CT 06830

Project Location: Greenwich

Project Name: Proposal to Become a Medicare-Certified Outpatient Rehabilitation Service Provider

Type proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: $13,000

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

4. Clear Public Need

Note: Sections 19a-634 and 19a-637 of the Connecticut General Statutes specifically mandate that OHCA consider the availability, scope and need for services for the residents of Connecticut. Therefore, OHCA does not consider out-of-state volume in its evaluation of need for the proposed service.

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:
   a) Primary service area towns (PSA).
   b) Secondary service area towns (SSA).
   c) If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town.
   d) If new facility/service, the population to be served, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate.
   e) Scheduling backlogs in service area.
   f) Travel distance from proposed site to service area towns.
   g) Hours of operation of existing/proposed service.

ii) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

iii) Identify the existing providers of the proposed service in your service area and provide the information as outlined in the following table concerning the existing providers' (in the Applicant(s) PSA & SSA) current operations:

Primary Service Area:

Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians

Secondary Service Area:

Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians

iv) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

B. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

C. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

☐ None: *explain* why no reports, studies or market share analysis was undertaken related to the proposal:

_____

_____

_____

5. Quality Measures

A. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

B. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

☐ American College of Cardiology	☐ National Committee for Quality Assurance	☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers	☐ American College of Obstetricians & Gynecologists	☐ American College of Surgeons
☐ Report of the Inter-Council for Radiation Oncology	☐ American College of Radiology	☐ Substance Society Abuse and Mental Health Services Administration

☐Other: Specify _____

C. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

D. Submit a list of all key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.
Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

E. Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐	DPH	☐	JCAHO
☐	Fire Marshall Report	☐	Other States Health Dept. Reports (new out-of-state providers)
☐	AAAHC	☐	AAAASF
☐	Other: _____		

Note: Above referenced acronyms are defined below. [1]

F. Provide a copy of the following (as applicable):

- ☐ A copy of the related Quality Assurance plan
- ☐ Protocols for service (new service only)
- ☐ Patient Selection Criteria/Intake form

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

☐	Energy conservation	☐	Group purchasing
☐	Reengineering	☐	None of the above

- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ Other (identify)_____

7. Miscellaneous

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐	Yes	☐	No

If you checked "Yes," please provide an explanation.

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[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

8. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

i) Please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Identify the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

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

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

* Provide an itemized list of all non-medical equipment.

10. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$_____ _____
Contributions	$_____
Funded depreciation	$_____
Other	$_____

☐ Grant:

Amount of grant	$_____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	$ _____
CON Proposed debt financing	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years
Debt service reserve fund	$ _____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	$ _____
CON Proposed lease financing	$ _____
Fair market value of leased assets at lease inception	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years

☐ Other financing alternatives:

Amount	$ _____
Source (e.g., donated assets, etc.)	_____

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution,
   ii. Letter of interest from CHEFA,
   iii. Amortization schedule (if not level amortization payments),
   iv. Lease agreement.

11. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following for the financial and statistical projections:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached. Note:** that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).
Note: Include consideration of the Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development in the financial projections.

iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

iv) Provide a copy of the rate schedule for the proposed service.

v) Provide copies of your charity care policy and sliding fee scale.

vi) Describe how this proposal is cost effective.

11. C (i). 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: / **Description**	FY Actual Results	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project	FY Projected W/out Project	FY Projected Incremental	FY 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.

11. C. ii) 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									
Year 1 (20__) **FY Projected Incremental**	(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 Incremental Expenses:										
Total Facility by Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

11. C ii) 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	(1)	(2) Rate	(3) Units	(4) Gross	(5) Allowances/	(6) Charity	(7) Bad	(8) Net	(9) Operating	(10) Gain/(Loss)
Total Incremental Expenses:	**$53,513**			Revenue Col. 2 * Col. 3	Deductions	Care	Debt	Revenue Col.4 - Col.5	Expenses Col. 1 Total *	from Operations Col. 8 - Col. 9
Total Facility by Payer Category:								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
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)***

EXAMPLE

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: _____