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	Marianne Urbanski	
Doing Business As	Dr Marianne Urbanski	
Name of Parent Corporation	Dr Marianne Urbanski	
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	546. S. Broad St Suite 3A Meriden CT 06450	
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.	Dr Marianne Urbanski	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	Same as above	

Contact Person's Telephone Number	203-630-1312	
Contact Person's Fax Number	203-235-6673	
Contact Person's e-mail Address	docfloss@docfloss.com	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title: Install ICAT

b. Location of proposal, identifying Street Address, Town and Zip Code: 546 S. Broad St. Meriden CT 06450

c. List each town this project is intended to serve: Meriden

d. Estimated starting date for the project: Nov. 16, 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): Private Office			

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ 180,000

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

Medical Equipment Purchases	180,000
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building/Asset Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
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	
Capitalized Financing Costs (Informational Purpose Only)	

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

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
ICAT Scan	ICAT		1	180,000

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. dental services
2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable? X ray imaging
3. Identify the current population served and the target population to be served.
4. Identify the entity that will be providing the service(s). Dr. Urbanski
5. Identify the entity that will be responsible for the billing of the service(s) relating to this proposal. Dr. Urbanski
6. Identify the entity that owns/leases or will own/lease the physical space of the proposed equipment/service? Dr. Urbanski
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. no
8. Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal. n/A
9. Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable. n/A
10. Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal. n/A
11. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational? no changes
Current clients are payers

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

DENTIST

LICENSE NO.
007003
CURRENT THROUGH
05/31/07
VALIDATION NO.
03-309363

MARIANNE URBANSKI DMD

SIGNATURE

J Robert Galvin M.D., M.P.H.
COMMISSIONER

SECTION V. AFFIDAVIT

To be completed by each Petitioner

Petitioner: Marianne Urbanski

Project Title: Owner

I, Marianne Urbanski, CEO
(Name) (Position – CEO or CFO)

of Dr Marianne Urbanski 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 Dr Urbanski 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 10/23/06
Date

Subscribed and sworn to before me on October 23, 2006

Notary Public/Commissioner of Superior Court

LEILA G. GRABER
NOTARY PUBLIC
MY COMMISSION EXPIRES MAY 31, 2011

My commission expires:

Form 2020
Revised 7/06

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 13, 2006

Marianne Urbanski, DMD
Chief Executive Officer
546 South Broad St., Suite 3A
Meriden, CT 06450

Re: Letter of Intent, Docket Number 06-30852
Dr. Marianne Urbanski
Proposal to Acquire i-CAT Cone Beam 3-D Dental System
Notice of Letter of Intent

Dear Dr. Urbanski:

On October 30, 2006, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Dr. Marianne Urbanski ("Applicant") to acquire i-CAT Cone Beam 3-D Dental System, at a total capital expenditure of $180,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Record Journal* pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:LKG:bko

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 13, 2006

Requisition # HCA07-095
FAX #: (203) 317-2233

Record Journal
11 Crown Street, Box 915
Meriden, CT 06450-0915

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 Sunday, December 17, 2006.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

If there are any questions regarding this legal notice, please contact Laurie Greci at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:LKG:bko

c: Sandy Salus, OHCA

The Record Journal
Docket Number 06-30852

Letter of Intent
December 13, 2006

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Dr. Marianne Urbanski
Town:	Meriden
Docket Number:	06-30852-LOI
Proposal:	Acquire i-CAT Cone Beam 3-D Dental System
Total Capital Expenditure:	$180,000

The Applicant may file its Certificate of Need application between December 29, 2006 and February 27, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at 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	1598
RECIPIENT ADDRESS	912033172233
DESTINATION ID	
ST. TIME	12/13 14:51
TIME USE	00'45
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 13, 2006

Marianne Urbanski, DMD
546 South Broad Street, Suite 3A
Meriden, CT 06450

RE: Certificate of Need Application Forms, Docket Number 06-30852-CON
Dr. Marianne Urbanski
Acquisition of a i-CAT Cone Beam 3-D Dental Imaging System

Dear Dr. Urbanski:

Enclosed are the application forms for Dr. Marianne Urbanski's Certificate of Need ("CON") proposal for the Proposal to Acquire i-CAT Cone Beam 3-D Dental System with an associated capital expenditure of $180,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between December 29, 2006, and February 27, 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 her at (860) 418-7001 if you have any questions.

Sincerely,

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 December 29, 2006, and may be submitted no later than February 27, 2007. The Analyst assigned to your application is Laurie Greci and she may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 06-30852-CON

Applicant's Name: Marianne Urbanski, DMD

Contact Person: Marianne Urbanski, DMD
Contact Title: Chief Executive Officer
Contact Address: 546 South Broad Street, Suite 3A
Meriden, CT

Project Location: Meriden

Project Name: ~~Acquisition of an i-CAT Cone Beam 3-D Dental Imaging~~ System

Type proposal: Section 19a-639, C.G.S.

Est. Capital Expenditure: $180,000

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

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

B. Provide the following information on the proposed service area:
   i) A list of the primary service area towns.
   ii) A list of the secondary service area towns.
   iii) Information or documentation that supporting the towns listed in each service area.

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.

H. 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 and SSA) current operations:

Description of Service[1]	Provider Name, Street Address, Town and Zip Code	Hours and Days of Operation[2]	Current Utilization[3]

[1] If proposal concerns imaging equipment, provide a description of the equipment used by the Provider, if known (i.e., for MRI scanners, include Tesla strength, and whether or not the scanner is considered to be "open" or "closed", for CT scanners, include the number of "slices".); list one piece of equipment per line.
[2] Specify days of the week and start and end time for each day.
[3] Number of scans performed on specified scanner by Provider for the most recent 12 month period, if known.

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

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

K. Provide the information as outlined in the following table concerning the existing providers' (in the Applicant(s) PSA & SSA) current operations:

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

☐ Cultural
☐ Geographic
☐ None of the Above
☐ Transportation
☐ Economic
☐
☐ Other, Specify: _____

If you checked other than "None of the Above", please provide an explanation

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

- ☐ Epidemiological studies
- ☐ Public information reports
- ☐ Other (Identify)
- ☐ Needs assessments
- ☐ Market share analysis

☐ 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 Association of Child Bearing Centers
- ☐ Report of the Inter-Council for Radiation Oncology
- ☐ National Committee for Quality Assurance
- ☐ American College of Obstetricians & Gynecologists
- ☐ American College of Radiology
- ☐ Public Health Code & Federal Corollary
- ☐ American College of Surgeons
- ☐ Substance Abuse Society 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
- ☐ Fire Marshall Report
- ☐ AAAHC
- ☐ Other:
- ☐ JCAHO
- ☐ Other States Health Dept. Reports (New Out-of-State Providers)
- ☐ AAAASF

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
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ None of the above
- ☐ Other (identify):
- ☐ Group purchasing
- ☐ Reengineering

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.

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.

[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.

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.)
- ☐ Partnership
- ☐ Joint Venture
- ☐ Other (Specify):
- ☐ Limited Liability Company (LLC)
- ☐ Professional Corporation (PC)

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 form, Financial Attachment I.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) Please complete the enclosed form, OHCA's **Financial Attachment II.**

iii) 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.).

iv) 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.

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

vi) Describe how this proposal is cost effective.

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: _____

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:	**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.

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 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:				Revenue Col. 2 * Col. 3	Deductions	Care	Debt	Revenue Col.4 - Col.5 -Col.6 - Col.7	Expenses Col. 1 Total * Col. 4 / Col. 4 Total	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	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