State of Connecticut
Office of Health Care Access
Letter of Intent Form
Form 2030

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by the Applicant(s), pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	Terence S. Jackson D.M.D., M.A.	Jack DeGrado D.M.D.
Doing Business As	Periodontics & Implant Denistry Center, LLC	Stamford Dental Group, LLC
Name of Parent Corporation	Same	Same
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	47 Oak St. 2nd Floor Stamford, Ct 06905	47 Oak St. 2nd Floor Stamford, Ct 06905
Identify Applicant Status: P for Profit or NP for Nonprofit	P	P
Does the Applicant have Tax Exempt Status?	No	No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Terence Jackson Manager	Jack DeGrado Manager
JackContact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	47 Oak St. 2nd Floor Stamford, Ct 06905	47 Oak St. 2nd Floor Stamford, Ct 06905
Contact Person Telephone Number	203-252-2252	
Contact Person Fax Number	203-504-6270	
Contact Person e-mail Address	terrysj@aol.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Installation of i-CAT 3-D Cone Beam Dental Imaging Unit

b. Project Proposal: Complete any/all required site preparations to facilitate installation of i-CAT imaging system & install iCAT imaging system.

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity
☐ Trauma Center ☐ Transplantation Programs
☐ Rehabilitation *(specify type)* _____
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Inpatient *(specify)* _____

Outpatient Service(s):

☐ Ambulatory Surgery Center ☐ Primary Care ☐ Oncology
☐ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care
☐ Rehabilitation *(specify type)* _____ ☐ Central Services Facility
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Outpatient *(specify)* _____

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
☐ Cineangiography Equipment ☒ New Technology: i-CAT 3-D Cone Beam Dental CT

Non-Clinical:

☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations
☐ Change in Ownership or Control ☐ Land and/or Building Acquisitions
☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☒ Yes ☐ No

If you checked "Yes" above, please check the appropriate box below:

☐ New (F, S, Fnc) ☒ Additional (F, S, Fnc) ☐ Replacement
☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Termination of Service
☐ Reduction ☐ Change in Ownership/Control

e. Will the Capital Expenditure/Cost of the proposal exceed $3,000,000, pursuant to Section 19a-639, C.G.S.?

☐ Yes ☒ No

If you checked "Yes" above, please check the boxes below, as appropriate:

☐ New equipment acquisition and operation

☐ Replacement equipment with disposal of existing equipment

☐ Major medical equipment

☐ Change in ownership or control

f. Location of proposal, identifying Street Address, Town and Zip Code:

47 Oak St. Stamford, Ct. 06905

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

Stamford, Ct.

h. Estimated starting date for the project: August 2008

i. If the proposal includes change in the number of beds provide the following information:

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $184,198.94

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases* **Dental I-CAT Machine**	169,999
Land/Building Purchases	
Construction/Renovation **Room Preparation**	4,000
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**173,999**
Major Medical Equipment – Fair Market Value of Leases Medical	
Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	
Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

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

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☒ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

   ☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

   ☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
3-D Cone Beam Dent. CT	i-CAT	17-19	1	184,198.94

Note: Provide a copy of the vendor contract or quotation for each major medical/imaging equipment.

e. Type of financing or funding source (more than one can be checked):

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

SECTION IV. PROJECT DESCRIPTION

In paragraph format, please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

1 List the types of services currently being provided.

All service provided are dental in nature and include everything from diagnostic to therapeutic treatment. They may be as simple as a filling or as complex as a full mouth rehabilitation with bilateral sinus elevation surgery and implants.

2. List the types of services being proposed and what DPH licensure categories will be sought, if applicable.

The services being proposed are diagnostic in nature. The I-CAT 3-D Cone Beam Dental CT unit will be used to obtain information for treatment planning and diagnosis. In addition, it will provided real-time images to aid in sinus elevation surgery and implant placement.

3. Identify the current population served and the target population to be served.

The target population will consist of any patient in need of a sinus elevation surgery, implant placement, wisdom tooth extraction, tempromandibular dysfunction, oral pathology, craniofacial abnormities, or full mouth rehabilitation. Including, but not limited to Stamford, Greenwich, Darien, New Canaan, Norwalk, Westport, and Fairfield.

4. Identify the unmet need and describe how this project will fulfill that need.

There are currently no I-CAT 3-D Cone Beam Dental CT machines in the Stamford area. The acquisition of an I-CAT could service the Stamford community. Currently, if a patient needs a dental CT scan they have to schedule an appointment at a local radiology facility. The appointment often takes 1-2 weeks to get and then it takes another 2 weeks to receive the report.

5. Are there any similar existing service providers in the proposed geographic area?

Yes and no. There are no I-CAT machines currently in use in the aforementioned geographic area, but a similar scan may be obtained.

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.

There should no effect on the health care delivery system in the State of Connecticut. The patient will benefit significantly and will no longer have to wait 2-4 weeks for diagnostic imagine.

7. Who will be responsible for providing the service?

Certified staff from Dr. Jackson and Dr. DeGrado's office will be trained to take I-CAT images.

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

The service will be paid for by the patients and the patient's insurance company. The patients will be referred by Drs Jackson and DeGrado and any outside referrals seeking I-CAT imaging for diagnosis and treatment planning.

AFFIDAVIT

To be completed by each Applicant

Applicant: Terence Jackson

Project Title: Installation of i-CAT 3-D Cone Beam Dental Imaging Unit

I, Terence Jackson (Name), CEO (Position – CEO or CFO)

of Periodontics & Implant Dentistry being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that Periodontics & Implant (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature 4-21-08 Date

Subscribed and sworn to before me on 4/21/08

Notary Public/Commissioner of Superior Court

My commission expires: _____

ELIJAH M BURTON
Notary Public
State of Connecticut
My Commission Expires September 30, 2012

RECEIVED
2008 APR 22 A 11:13
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Form 2030
Revised 10/2007

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 30, 2008

Terence S. Jackson, DMD, MA
Periodontics & Implant Dentistry Center, LLC
47 Oak Street, Second Floor
Stamford, CT 06905

RE: Certificate of Need Application Forms, Docket Number 08-31143-CON
Terence S. Jackson, DMD, MA d/b/a Periodontics & Implant Dentistry Center, LLC and Jack DeGrado, WMD d/b/a Stamford Dental Group, LLC
Installation of i-CAT 3-D Cone Beam Dental Imaging Unit in Stamford

Dear Mr. Jackson:

Enclosed are the application forms for Terence S. Jackson, DMD, MA d/b/a Periodontics & Implant Dentistry Center, LLC and Jack DeGrado, WMD d/b/a Stamford Dental Group, LLC's Certificate of Need ("CON") proposal for the Installation of i-CAT 3-D Cone Beam Dental Imaging Unit in Stamford with an associated capital expenditure of $173,999. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes, the CON application may be filed between June 21, 2008, and August 20, 2008.

When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. **Failure to observe these requirements will require follow-up work on your part to correct the filing.**

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and six (6) hard copies of each submission in 3-ring binders.
- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.
- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Alexis Fedorjaczenko. Please contact her at (860) 418-7067 if you have 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 June 21, 2008, and may be submitted no later than August 20 2008. The Analyst assigned to your application is Alexis Fedorjaczenko. She may be reached Office of Health Care Access at (860) 418-7067.

Docket Number: 08-31143-CON

Applicant's Name: Terence S. Jackson, DMD, MA d/b/a Periodontics & Implant Dentistry Center, LLC and Jack DeGrado, WMD d/b/a Stamford Dental Group, LLC

Contact Person: Terence Jackson

Contact Title: Manager

Contact Address: 47 Oak Street, Second Floor
Stamford, CT 06905

Project Location: Stamford

Project Name: Installation of i-CAT 3-D Cone Beam Dental Imaging Unit

Proposal type: Section 19a-639, C.G.S.

Est. Capital Expenditure: $173,999

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.

i) Provide the following information:
   a) List the primary service area (PSA) towns. Provide a rationale for choosing the selected PSA towns.
   b) List the secondary service area (SSA) towns. Provide a rationale for choosing the selected SSA towns.
   c) The units of service for the past three fiscal years and the current fiscal year- to-date by service area town *for each Applicant.*
   d) The units of service for the past three fiscal years and the current fiscal year- to-date by service type f*or each Applicant.*
   e) Describe the population to be served, including the number of individuals to receive the proposed service. Include demographic Information as appropriate.
   f) Scheduling backlogs in service area.
   g) Travel distance from the proposed site to service area towns.
   h) Hours of operation of existing and the proposed service.

ii) Identify the existing providers of the proposed service in your service area.

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

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

v) 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

* List the services

Secondary Service Area:

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

* List the services

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
- ☐ Public information reports
- ☐ Needs assessments
- ☐ Market share analysis
- ☐ Other (Identify)
- ☐ **None, (If none, *explain* why no needs assessment, 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
- ☐ JCAHO
- ☐ Other States Health Dept. Reports
- ☐ (New Out-of-State Providers) 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
☐ 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.

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.

D. Provide a copy of the written agreement or memorandum of understanding between the Applicants related to the proposal.

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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.

Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

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 the current payer mix and the projected payer mix for the first three fiscal years with the CON proposal for the Total Facility based on Gross Patient Revenue in the following reporting format:

Payer	Current Payer Mix	FY_____ (Year 1) Projected Payer Mix	FY_____ (Year 2) Projected Payer Mix	FY_____ (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**	**100**	**100**	**100**

*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, Financial Attachment I.
Note: *The actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.*

ii) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal by payer. See attached, 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.).
Note: *Include consideration of The Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development of the financial projections.*

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.

12. Project Specific Questions - Imaging:

1. Provide the information as outlined in the following table concerning the existing providers' in the Applicants' PSA current operations:

Description of Service[1]	Provider Name and Location	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.
[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.

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: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000, or capital expenditure exceeding $3,000,000 for major medical equipment, or CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.** _____ 19a-638 and 19a-639. **Fee Required.** 2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section. 3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000 4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	$ 1,000.00 $_____.00 $_____.00
SECTION B TOTAL FEE DUE: _____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

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
	Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
Description	Results	W/out Project	Incremental	With Project	W/out Project	Incremental	With Project	W/out Project	Incremental	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.

Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description

Type of Unit Description:

# of Months in Operation

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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 30, 2008

Terence Jackson, DMD
Periodontics & Implant Dentistry Center, LLC
47 Oak Street, Second Floor
Stamford, CT 06905

Re: Letter of Intent, Docket Number 08-31143
Terence S. Jackson d/b/a Periodontics & Implant Dentistry Center, LLC and
Jack DeGrado, WMD d/b/a Stamford Dental Group, LLC
Installation of i-CAT 3-D Cone Beam Dental Imaging Unit
Notice of Letter of Intent

Dear Mr. Jackson:

On April 22, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Middlesex Hospital ("Applicant") for the installation of i-CAT 3-D Cone Beam Dental Imaging unit in Stamford, with a capital expenditure of $173,999.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Advocate* pursuant to Section 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:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 30, 2008

Requisition # HCA08-192
Email: legal.notices@scni.com

The Advocate
75 Tresser Blvd.
Stamford, CT 06903

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 **Monday, May 5, 2008.**

Please provide the following within **30 days of publication:**

- Proof of publication (copy of legal ad acceptable) showing published date along with the invoice.

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

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:AGF:lmg

c: Sandy Salus, OHCA

The Advocate
Docket Number 08-31143

Letter of Intent
April 30, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Terence S. Jackson, DMD, MA d/b/a Periodontics & Implant Dentistry Center, LLC and Jack DeGrado, WMD d/b/a Stamford Dental Group, LLC
Town:	Stamford
Docket Number:	08-31143-LOI
Proposal:	Installation of i-CAT 3-D Cone Beam Dental Imaging unit
Total Capital Expenditure:	$173,999

The Applicant may file its Certificate of Need application between June 21, 2008 and August 20, 2008. 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.

Greer, Leslie

From: Ginia Hines [Ginia.Hines@scni.com]
Sent: Wednesday, April 30, 2008 3:12 PM
To: Greer, Leslie
Subject: RE: Legal Ad 08-31143

All set.

Thanks
Ginia Hines

From: Greer, Leslie
Sent: Wednesday, April 30, 2008 3:08 PM
To: legals
Subject: Legal Ad 08-31143

<<File: 08-31143 LOI Advocate.doc>>
Legal Ad,

Please run the attached Public Notice in your newspaper no later than May 5, 2008. Please notify me that you have received this request.

Thank you,

Leslie M. Greer

Office of Health Care Access

State of Connecticut

410 Capitol Avenue

Hartford, CT 06134

Phone: (860) 418-7001

Fax: (860) 418-7053

Website: www.ct.gov/ohca