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CONNECTICUT OFFICE OF HEALTH CARE ACCESS

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	Jeffrey T. Kozlowski, D.D.S.	
Doing Business As	Kozlowski Orthodontics, P.C.	
Name of Parent Corporation	N/A	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	190 Hempstead Street New London, CT 06320	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	No	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Jeffrey T. Kozlowski, D.D.S. President/Owner	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	190 Hempstead Street New London, CT 06320	
Contact Person Telephone Number	860.287.2688 cell 860.442.4421 office	
Contact Person Fax Number	866.837.6409	
Contact Person e-mail Address	orthokoz@gmail.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Kodak 9000 Dental 3D (Localized field of view)

b. Project Proposal: To add on a localized field of view (3.8 cm x 5 cm) dental 3D sensor to my existing Kodak 9000 digital panoramic/cephalometric x-ray machine.

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

Inpatient Service(s): Not Applicable

Outpatient Service(s): Not Applicable

Imaging:

- ☐ MRI
- X CT Scanner
- ☐ PET Scanner
- ☐ CT Simulator
- ☐ PET/CT Scanner
- ☐ Linear Accelerator
- ☐ Cineangiography Equipment
- ☐ New Technology: _____

Non-Clinical: Not Applicable

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

X Yes ☐ No

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

- ☐ New (F, S, Fnc)
- X 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 X 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:

190 Hempstead Street, New London, CT 06320

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

This project is intended to serve patients referred to Kozlowski Orthodontics, P.C. for evaluation of tooth and root positioning, impacted and missing teeth, presence and location of supernumerary (extra) teeth, and spacing between roots of teeth.

h. Estimated starting date for the project: Immediately following approval of CON.

i. If the proposal includes change in the number of beds provide the following: **Not Applicable**

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $40,555

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	$40,555
Non-Medical Equipment Purchases*	$0
Land/Building Purchases	$0
Construction/Renovation	$0
Other (Non-Construction) Specify:_____	$0
Total Capital Expenditure	**$40,555**
Major Medical Equipment – Fair Market Value of Leases Medical	$0
Equipment – Fair Market Value of Leases	$0
Non-Medical Equipment – Fair Market Value of Leases*	$0
Fair Market Value of Space – Capital Leases Only	$0
Total Capital Cost	**$40,555**
Total Project Cost	**$40,555**
Capitalized Financing Costs (Informational Purpose Only)	$0

* 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.

Not Applicable

d. Major Medical and/or Imaging Equipment Acquisition: to view the Kodak 9000 3D unit please log on to the following website

http://www.my90003d.com/site.html#/uk/concept/

Equipment Type	Name	Model	Number of Units	Cost per unit
Extraoral Dental Imaging System Sensor Upgrade	Kodak	9000 3D	One (1)	$40,555

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):

X 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 are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

SEE ATTACHED

2. List the types of services 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 any unmet need and describe how this project will fulfill that need.

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

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

7. Who will be responsible for providing the service?

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

AFFIDAVIT

To be completed by each Applicant

Applicant: **Jeffrey T. Kozlowski, D.D.S., 190 Hempstead Street, New London, 06320**

Project Title: **Kodak 9000 Dental 3D (Localized field of view)**

I, Jeffrey T. Kozlowski, D.D.S., (Name) President (Position – CEO or CFO)

of Kozlowski Orthodontics, P.C. 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 Kozlowski Orthodontics, P.C. complies with the appropriate and (Facility Name)

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 11·18·08 Date

Subscribed and sworn to before me on November 18, 2008

Notary Public/Commissioner of Superior Court

My commission expires: 6/30/11

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HEALTH CARE ACCESS

Form 2030
Revised 10/2007

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The goal of the proposed project, "Kodak 9000 Dental 3D (Localized field of view)", is to provide state-of-the-art, low radiation, localized dental, in-office diagnostic capabilities for the sole purpose of treating patients referred to Kozlowski Orthodontics, P.C. Kozlowski Orthodontics P.C. would like to upgrade its existing Kodak 9000 digital panoramic/ceplalometric dental x-ray machine by adding a localized dental 3D radiographic field of view measuring a mere **3.8cm x 5cm**. The upgrade is to be placed into service at 190 Hempstead Street, New London, CT, in the same location as the existing dental x-ray machine.

Currently, Kozlowski Orthodontics P.C. is providing treatment to our patients within the field of orthodontics and dentofacial orthopedics, however, we are doing so without the benefit of in-office, localized, three dimensional imaging. In my 10 year career, I have never referred a patient for a medical, full-head CT scan to determine tooth and root positioning. However, there have been many indications for the use of localized, dental 3D imaging that would have improved my diagnostic information and hence improve the ability to accurately and effectively treatment plan my patients. The addition of localized field of view dental 3D imaging will enable our practice to provide better diagnostic and treatment planning capabilities to our patients, as well as, enable us to provide state-of-the-art clinical care with respect to emerging dental technology. Kozlowski Orthodontics, P.C. will not require additional DPH licensure to utilize these new dental diagnostic technologies.

With the advancement of 3D radiographic technologies, this type of localized dental technology will enable orthodontists to provide improved care to their patients. The Kodak 9000 3D localized radiographic field of view will allow the orthodontist to gain a three dimensional view of various dental and orthodontic issues that are virtually impossible to diagnose and treatment plan with traditional two dimensional radiography. These issues include (but are not limited to):

- Determination of tooth and root positioning for orthodontic movement of teeth minimizing the risk of morbidity to adjacent teeth and bone,
- Localization of impacted teeth and determination of their 3D relationship to the roots of adjacent teeth, thus enabling the orthodontist to determine the best direction to move the impacted tooth,
- Localization of supernumerary (extra) teeth to minimize the scope of surgery required by an oral surgeon to localize and remove these teeth,
- Accurate 3D measurement of tooth size of unerupted teeth to assist in the determination of a patient's crowding/spacing and tooth size relationships allowing the orthodontist to provide treatment with fewer tooth extractions
- Evaluation of bone volume surrounding the teeth to ensure that orthodontic movement of teeth maintains a healthy tooth-bone relationship before, during and after treatment

kozlowskiorthodontics

Both the current population served and the target population is limited to the patients referred to Kozlowski Orthodontics, P.C. for the evaluation of tooth and root positioning. The unmet need within the current and target populations is the patients' desire to have access to the advancements in dental technology that are readily available to patients of other states where localized dental, three dimensional imaging technology has already been embraced. This project will fulfill that need by providing our patients with low radiation, in-office, localized dental 3D radiographic imaging technology that is not currently available in our office or in the greater medical/dental community.

It is not anticipated that this proposal will have a negative effect on the greater health care delivery system in the State of Connecticut as it is limited to dental technologies exclusively for the patients referred to Kozlowski Orthodontics. It will, however, have a profound effect on the quality of the diagnostic and treatment planning capabilities provided to the patients of Kozlowski Orthodontics, as well as, improve the quality of care we are able to provide our patients.

The responsibility of providing the dental imaging services will be assigned to the doctor and staff of Kozlowski Orthodontics, P.C. There are no current payers of this service as no service currently exists for dental localized field of view 3D imaging in our office. Any anticipated payer changes when the project becomes operational will be limited exclusively to the patients of Kozlowski Orthodontics, P.C. As imaging needs are based on diagnostic and treatment planning needs, payers will be limited to patients referred to Kozlowski Orthodontics, P.C. who required these types of diagnostic capabilities.

In summary, it is the contention of Kozlowski Orthodontics, P.C. that the upgrade/addition to the Kodak 9000 3D localized field of view, three dimensional radiographic imaging to our practice is necessary for us to continue providing state-of-the-art care to our patients with regards to diagnosis and treatment planning of orthodontic procedures. This is consistent with the determination and use of dental, localized field of view 3D radiographic technology seen in other states where practitioners have open access to the purchase and use of this technology.

Respectfully submitted,

11.18.08

Jeffrey T. Kozlowski, D.D.S.

PracticeWorks

THIS DOCUMENT IS ONE PART OF A MULTI-PART AGREEMENT

PURCHASE AGREEMENT

This Purchase Agreement (the "Contract") is a binding and enforceable agreement effective as of the date (the "Effective Date") of our receipt of a signed and dated copy of this Agreement that has not been changed or modified in any way by you other than by identifying the products to be purchased or subscribed for in the space below, by and between PracticeWorks Systems, LLC ("PracticeWorks", "we", "us", "our"), a Georgia limited liability company with principal offices located at 1765 The Exchange, Atlanta, Georgia 30339, and the customer identified below ("Customer", "you", "your"):

Customer: Dr. Jeff Kozlowski,
Address: 190 hempstead st
New london, ct 06320

eMail: jkozlowski01@snet.net
Phone: 8604424421
Fax:

Proposal Valid Until: 5/19/2008
Sales Representative: Chris Miner
Phone: 800.944.6385

The Terms and Conditions below, together with the Products and Services Guide, the KODAK RVG® Sensors Product Protection (if applicable), the KODAK 8000 Digital Panoramic System and KODAK 8000C Digital Panoramic and Cephalometric System Product Protection (if applicable), Addendum A hereto (the Business Associates Agreement) and any exhibits or attachments we and you agree to comprise the parts of this Contract. This Contract constitutes the entire agreement between you and us as to the subject matter hereof and supersedes all prior or contemporaneous agreements, negotiations, representations and proposals, written or oral. By signing below, you are agreeing to the entire Contract and acknowledge that you have received and read the Products and Services Guide, the KODAK RVG Sensors Product Protection (if applicable), the KODAK 8000 Digital Panoramic System and KODAK 8000C Digital Panoramic and Cephalometric System Product Protection (if applicable), Addendum A and any attached exhibits.

We offer to sell you and you agree to purchase the products described below pursuant to the terms of this Contract. Chris Miner

Qnt	Sku	Description	MSRP	Cash
1	K9-K9000C	Kodak 9000 Panoramic & Cephalometric Unit	$ 84,500.00	$ 65,000.00
1	K9-9000C-INST	Kodak 9000C Installation	$ 2,650.00	$ 2,650.00
1	K9-9000-TRAIN	Training for Kodak 9000/C System	$ 795.00	$ 795.00
1	Canon YSi Bundle	Cannon Rebel XS. Dental Kit.	$3500	0
		With option to upgrade To 3D for Balance of $109,000 - 65,445 = 40,555		
		*SUB TOTAL:	$ 87,945.00	$ 68,445.00

ADVANTAGE PLAN - DETAIL

0	RVG Sensor	KODAK RVG 5 Year Advantage Plan	$ -
0	8000/8000C Unit	KODAK 8000 / 8000C Advantage Plan	$ -
0	CR 7400 Unit	KODAK CR 7400 Advantage Plan	$ -

SALES ORDER - LOB SUMMARY

Practice Management: $	-	Aftermarket: $	-	Mo. Advantage Plan: $	-	Total Discounts: $	(19,500.00)
Digital Radiography: $	68,445.00	Imaging: $	-	Mo. Software Support: $	-	Deposit Due: $	34,222.50

PAYMENTS

Name On Check :
Requested Ship Date for this Order:
Thank you for your payment o paid by check number .

AMEX [redacted] Zip 06333

Applicable Sales Tax is not included in the total price on this order. You agree that your credit card or ACH may be charged the balance of the purchase price for the products described above, well as for sales tax and shipping, less the deposit, when the order is shipped, unless otherwise set forth in Section 2 of the Terms and Conditions below. In addition you agree that your credit or ACH may be debited monthly for the Advantage Plan, Monthly Support Maintenance Fee and any Subscription Fee set forth above.

By signing below, you agree to pay the fees described above for the products set forth in this Contract, you agree to the Terms and Conditions below and you represent that you are the duly authorized representative of the Customer, all effective as of the Effective Date.

Customer:
Signature:
Title:
Date: 5·19·08
Print: Jeff Kozlowski

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 1, 2008

Jeffrey T. Kozlowski, D.D.S.
President/Owner
Kozloweki Orthodontics, P.C.
190 Hempstead Street
New London, CT 06320

RE: Certificate of Need Application Forms; Docket Number: 08-31278-CON
Kozloweki Orthodontics, P.C.
Acquisition of Kodak 9000 Dental 3D

Dear Mr. Kozlowski:

Enclosed are the application forms for Kozloweki Orthodontics, P.C.'s Certificate of Need ("CON") proposal for the Acquisition of a Kodak 9000 Dental 3D system with an estimated total capital expenditure of $40,555. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between January 24, 2009, and March 25, 2009.

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 (5) 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 CON analyst assigned to the CON application is Alexis Fedorjaczenko. Please contact her at (860) 418-7067 if you have any questions.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Enclosure

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 January 24, 2009, and may be submitted no later than March 25, 2009. The Analyst assigned to your application is Alexis Fedorjaczenko. She may be reached Office of Health Care Access at (860) 418-7067.

Docket Number: 08-31278-CON

Applicant's Name: Jeffrey T. Kozlowski, D.D.S. d/b/a Kozlowski Orthodontics, P.C.

Contact Person: Jeffrey T. Kozlowski, D.D.S.

Contact Title: President/Owner

Contact Address: 190 Hempstead Street
New London, CT 06320

Project Location: New London

Project Name: Acquisition of Kodak 9000 Dental 3D

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

Est. Capital Expenditure: $40,555

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** *for 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) Complete the following table regarding capacity of the proposed equipment:

a.	Avg. # of hours/day the equipment will operate	
b.	# Days/Week the equipment will be operational	
c.	# Weeks/Year the equipment will be operational	
d.	Targeted utilization as % of capacity (indicate a % and provide rationale for choosing that %, below)	
e.	Annual total capacity for scans in hours (a * b * c * d)	
f.	Average scan time in hours	
g.	Annual capacity: # scans/machine (e * f)	
h.	Projected actual # of scans in the first year of operation	
i.	% Total Capacity (h / g)	

vi) Provide the information as outlined in the following table concerning the existing providers in the Applicant(s) PSA & SSA:

Provider Name and Location	Affiliated Physicians	Description of Service (1)	Similar Services Provided? (Y/N) (2)	Hours & Days of Operation (3)	Current Utilization (4)

1. If proposal concerns imaging equipment, provide a description of the equipment used by the Provider, if known.
2. List the sernoces
3. Specify days of the week and start and end time for each day.
4. Number of scans performed on specified scanner by Provider for the most recent 12-month period, if known.

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 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 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.

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.

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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.

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.

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.) ☐ 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 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.

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.

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

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)

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: _____

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 1, 2008

Jeffrey Kozlowski, DDS
President/Owner
Kozlowski Orthodontics, P.C.
190 Hempstead Street
New London, CT 06320

Re: Letter of Intent, Docket Number 08-31278
Kozlowski Orthodontics, P.C.
Acquisition of Kodak 9000 Dental 3D
Notice of Letter of Intent

Dear Mr. Kozlowski:

On November 25, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Kozlowski Orthodontics, P.C. ("Applicant") for the acquisition of a Kodak 9000 Dental 3D in New London, with a capital expenditure of $40,555.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Day* 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

December 1, 2008

Requisition # HCA08-076
Email: Legal@Theday.com

The Day
47 Eugene O'Neil Drive
Box 1231
New London, CT 06360

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 **Friday, December 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

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Kozlowski Orthodontics, P.C.
Town:	New London
Docket Number:	08-31278-LOI
Proposal:	Acquisition of a Kodak 9000 Dental 3D
Capital Expenditure:	$40,555

The Applicant may file its Certificate of Need application between January 24, 2009 and March 25, 2009. 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

ent: Monday, December 01, 2008 10:04 AM

----IMAf1c4321.4934/pop.state.ct.us
Content-Type: text/plain; charset=us-ascii

Your message was successfully relayed to a system that does not support delivery confirmations.
Unless the delivery fails, this will be the only delivery notification.

----IMAf1c4321.4934/pop.state.ct.us
Content-Type: message/delivery-status

Reporting-MTA: pop.state.ct.us
Final-Recipient: rfc8222;Legal@theday.com
Action: relayed
Status: 2.0.0

----IMAf1c4321.4934/pop.state.ct.us
Content-Type: message/rfc822

Received: from doit-mstwmms1 [159.247.5.80] by pop.state.ct.us with ESMTP
(SMTPD-9.23) id A31F0400; Mon, 01 Dec 2008 15:03:43 -0500
eceived: from 159.247.77.53 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall v6.0.0)); Mon, 01 Dec 2008 15:10:28 -0500
X-Server-Uuid: AAF81055-C3E5-43F1-82D3-EBCFC44FF42A
x-mimeole: Produced By Microsoft Exchange V6.5
Content-class: urn:content-classes:message
Return-Receipt-To: "Greer, Leslie" <Leslie.Greer@ct.gov>
MIME-Version: 1.0
Disposition-Notification-To: "Greer, Leslie" <Leslie.Greer@ct.gov>
Subject: Legal Ad 08-31278
Date: Mon, 1 Dec 2008 15:00:35 -0500
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B101B7D9F9@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach: yes
X-MS-TNEF-Correlator:
Thread-Topic: Legal Ad 08-31278
Thread-Index: AclT73jn6AWkAqc/S5qgoxdlSxvHRA==
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
To: Legal@theday.com
X-WSS-ID: 652A9B3E30S1372645-02-01
Content-Type: multipart/mixed;
boundary="----_=_NextPart_001_01C953EF.792C5E03"

----IMAf1c4321.4934/pop.state.ct.us--

Greer, Leslie

From: Foley, Melanie [M.Foley@theday.com]
Sent: Monday, December 01, 2008 3:22 PM
To: Greer, Leslie
Subject: Document1
Attachments: Doc1.doc

Good afternoon Leslie,

Here is the legal ad for 12/2. If you have any questions feel free to contact me.

Melanie

Melanie Foley

Legal, Obituary & Milestone
Advertising Representative
The Day & The Times Community News Group
Phone (860) 701-4219
Fax (860) 442-5443
www.theday.com

The Day

47 Eugene O'Neill Drive
New London, CT 06320
860-442-2200
www.theday.com

Receipt

Account Number: D1640
Order Number: d00164341

Salesperson: Melanie Foley | **Printed on:** 12/1/2008
Telephone: 860-701-4219 ext 4219 | **Fax:** (860) 442-5443
Email: m.foley@theday.com

CT OFFICE OF HEALTH CARE
ACCESS MS#13HCA
PO BOX 340308
HARTFORD, CT 06134
860-418-7001

Title: The Day | **Class:** Public Notices 010
Start date: 12/2/2008 | **Stop date:** 12/2/2008 |
Insertions: 1 | **Lines:** 0 ag

Title: Day Website | **Class:** Public Notices 010
Start date: 12/2/2008 | **Stop date:** 12/2/2008 |
Insertions: 1 | **Lines:** 0 ag

A preview of your ad will appear between the two solid lines.

7082

PUBLIC NOTICE

Statute Reference: 19a-639
Applicant: Kozlowski Orthodontics, P.C.
Town: New London
Docket Number: 08-31278-LOI
Proposal: Acquisition of a Kodak 9000 Dental 3D
Capital Expenditure: $40,555

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Payment Information

Total Order Price: $155.00
Payment Type: | Exp: