



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

RECEIVED

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CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

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	McAraw, Cantner & Cantner, LLC	
Doing Business As	Professional LLC	
Name of Parent Corporation	Same	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	97 Elm Street Old Saybrook, CT 06475	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes	No <input checked="" type="checkbox"/> Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	I.L. Cantner, II, D.M.D. Partner	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	97 Elm Street Old Saybrook, CT 06475	
Contact Person Telephone Number	860-388-4439	
Contact Person Fax Number	860-388-4493	
Contact Person e-mail Address	ilcantner@comcast.net	

SECTION II. GENERAL APPLICATION INFORMATION

- a. Project Title: Gendex GXCB-500 Dental 3D
- b. Project Proposal: To add a Gendex GXCB-500 combination panoramic x-ray/medium field of view cone-beam scanner
- c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s): Not Applicable

Outpatient Service(s): Not Applicable

Imaging:

☐ MRI

☐ CT Simulator

☐ Cineangiography Equipment

☒ CT Scanner

☐ PET/CT Scanner

☐ New Technology: _____

☐ PET Scanner

☐ Linear Accelerator

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.?

☒ Yes

☐ No

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

☐ New (F, S, Fnc)

☐ Expansion (F, S, Fnc)

☐ Reduction

☒ Additional (F, S, Fnc)

☐ Relocation

☐ Change in Ownership/Control

☐ Replacement

☐ Termination of Service

- 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:

97 Elm Street, Old Saybrook, CT 06475

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

Waterford, East Lyme, Old Saybrook,
Westbrook, Clinton & Madison

This project is intended to solely serve patients referred to _____ for the evaluation and/or treatment of _____.

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

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

Not Applicable

ii. **SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION**

a. Estimated Total Project Expenditure/Cost: **\$124,000**

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

Major Medical Equipment Purchases*	\$124,000
Medical Equipment Purchases*	N/A
Non-Medical Equipment Purchases*	N/A
Land/Building Purchases	N/A
Construction/Renovation	N/A
Other (Non-Construction) Specify: _____	\$124,000
Total Capital Expenditure	
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	\$124,000
Total Capital Cost	\$124,000
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.

Not Applicable

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
Extraoral Dental Imaging System (panoramic + cone-beam scanner)	Gendex	GXCB-500	One (1)	\$124,000

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):

- | | | |
|---|--|--|
| <input type="checkbox"/> Applicant's Equity | <input type="checkbox"/> Capital Lease | <input type="checkbox"/> Conventional Loan |
| <input type="checkbox"/> Charitable Contributions | <input type="checkbox"/> Operating Lease | <input type="checkbox"/> CHEFA Financing |
| <input type="checkbox"/> Funded Depreciation | <input type="checkbox"/> Grant Funding | |
| <input checked="" type="checkbox"/> Other (specify) <u>Henry Schein Financial</u> | | |

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. See Attached

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.
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: I.L. CaNTNER, II, D.M.D.Project Title: Gendex GXCB-500 Dental 3DI, I.L. Cantner, II, D.M.D., Partner
(Name) (Position – CEO or CFO)of McAraw, Cantner & Cantner 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 McAraw, Cantner & Cantner 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 _____ Date 1/4/10
Subscribed and sworn to before me on January 4, 2010
Patricia A. Greco
 Notary Public/Commissioner of Superior Court
My commission expires: 8-31-2012

Section IV. Project Description

IV.1:

Currently, McAraw, Cantner & Cantner Dental, LLC is providing treatment to our patients in the field of periodontics and implants. We are doing so without the benefit of in-office, localized, three dimensional imaging. This type of technology would provide increased diagnostic information that would improve the ability to accurately and effectively establish treatment plans for our patients. The diagnostic and treatment planning tools greatly surpass those that currently exist with conventional two-dimensional imaging. This technology would not require any additional licensing from the DPH.

IV.2:

The advancement in technology that is Dental Cone Beam Scanning has allowed dentists as a whole the ability to increase patient care due to our ability to better diagnose and plan for said patients. The Gendex GXCB-500 medium field of view allows for dentists to gain three dimensional views that can reveal critical anatomical views currently not available through traditional two dimensional imaging. In our case, being able to accurately measure the distances to nerve canals and sinus floors without magnification or distortion as well as measure the thicknesses and densities of bone will allow for better planning and therefore safer procedures with surgical predictability. Additionally, for cases that do not require three-dimensional imaging, the Gendex GXCB-500 can take a traditional two-dimensional panoramic x-ray.

IV.3,4:

The current population and target population is limited to McAraw, Cantner & Cantner Dental, LLC existing and future patient base and those patients referred to McAraw, Cantner & Cantner Dental, LLC. There exists a need within the aforementioned patient base for the same access to **all** of the advancements in dental technology that is currently available to patients in all other states. Cone Beam three-dimensional imaging has already been embraced across the country as standard of care due to its diagnostic capabilities. This project seeks to fulfill said need by providing our patients with a low radiation, in-office, localized dental CT radiographic imaging technology that is not currently available in our office. There exists only one provider of this technology in the greater medical/dental community but said provider is another dental practitioner who is not utilizing this technology as an imaging center.

IV.5:

Currently, one practitioner has received approval for localized 3D imaging. Said practitioner is not accepting referrals solely for the application of imaging.

IV.6:

It is not anticipated that this proposal will have a negative effect on the health care delivery system in the State of Connecticut. To the contrary, the reduced amount of radiation compared to a traditional medical CT as well as the reduced cost of each scan, the addition of this type of technology will have a positive effect on the health care delivery system. In addition, the quality of the diagnostic and treatment planning capabilities provided to our patients will increase the quality of care and the access to information for our patients.

IV.7:

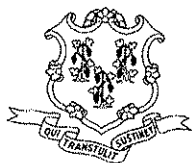
The responsibility of providing the dental imaging services will be assigned to the doctor and staff of McAraw, Cantner & Cantner Dental, LLC.

IV.8:

There are no current payers for this service as no such service currently exists within our office. Any anticipated changes when the service commences will be limited solely to the patients of McAraw, Cantner & Cantner Dental, LLC. As imaging needs are based exclusively to the patients of McAraw, Cantner & Cantner Dental, LLC, payers will be limited to said patient base and any future patients referred to McAraw, Cantner & Cantner Dental, LLC.

Summary:

In summary, the addition of medium field of view, Dental Cone Beam CT imaging is necessary to our ability to continue to provide state-of-the-art care to our patients in regards to diagnostic and treatment planning. It is important to consider that this technology is currently being utilized across the country by general dentists and specialists alike where practitioners have open access to this technology. It is quickly becoming standard of care for a wide array of dental procedures. This technology will be used only in cases in which two-dimensional imaging would not provide sufficient information. Currently in these situations the only options we have are to use two-dimensional imaging, or to send our patients out for high-cost, high-dose medical CT's that are approximately 100 times more radiation and provide thicker slices, and less dental-specific data than the Gendex GXCB-500. The GXCB-500 scans both arches while exposing the patient to a mere 36 microsieverts of radiation (less than half the effective dose of a digital full mouth series and a fraction of the approximate 3000 microsieverts of a traditional medical CT.)



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

January 12, 2010

Via: E-mail

I.L. Centner, II, DMD
Partner
McAraw, Centner & Centner, LLC
97 Elm Street
Old Saybrook, CT 06475

RE: Certificate of Need Application Forms; Docket Number: 10-31515-CON
McAraw, Centner & Centner, LLC
Acquisition of a Cone-Beam Computed Tomography Scanner in Old Saybrook

Dear Dr. Centner:

Enclosed are the application forms for McAraw, Centner & Centner, LLC's Certificate of Need ("CON") proposal for the acquisition of a cone-beam computed tomography scanner to be located in Old Saybrook, Connecticut, at an estimated total capital expenditure of \$124,000. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes, the CON application may be filed between March 7, 2010, and May 6, 2010.

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.

An Equal Opportunity Employer
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688
Fax: (860) 418-7053

- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

The OHCA analyst assigned to this CON application is Jack A. Huber. Please feel free to contact him at (860) 418-7034, if you have questions.

Sincerely,



Kaila Riggott
Planning Specialist

Enclosures

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

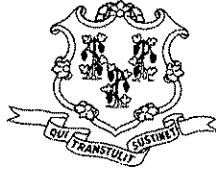
My commission expires: _____

OFFICE OF HEALTH CARE ACCESS
REQUEST FOR NEW CERTIFICATE OF NEED
FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">DATE</th> <th style="width: 10%; text-align: center;">INITIAL</th> </tr> </thead> <tbody> <tr> <td>1. Check logged (Front desk)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>2. Check rec'd (Clerical/Cert.)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>3. Check correct (Superv.)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>4. Check logged (Clerical/Cert.)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		DATE	INITIAL	1. Check logged (Front desk)	_____	_____	2. Check rec'd (Clerical/Cert.)	_____	_____	3. Check correct (Superv.)	_____	_____	4. Check logged (Clerical/Cert.)	_____	_____
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3. Check correct (Superv.)	_____	_____														
4. Check logged (Clerical/Cert.)	_____	_____														

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
<p>1. Check statute reference as applicable to CON application (see statute for detail):</p> <p>_____ 19a-638. Additional function or service, change of ownership, service termination. No Fee Required.</p> <p>_____ 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.</p> <p>_____ 19a-638 and 19a-639. Fee Required.</p> <p>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.</p> <p>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</p> <p>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 <u>OR</u> if both 19a-638 and 19a-639 are checked):</p> <p style="margin-left: 20px;">a. Base fee: _____</p> <p style="margin-left: 20px;">b. Additional Fee: (Capital Expenditure Assessment) _____</p> <p style="margin-left: 40px;">(To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) (\$ _____ x .0005)</p> <p style="margin-left: 20px;">c. Sum of base fee plus additional fee: (Lines A4a + A4b) _____</p> <p style="margin-left: 20px;">d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).</p>	<div style="text-align: right;">\$ 1,000.00</div> <div style="text-align: right;">\$ _____ .00</div> <div style="text-align: right;">\$ _____ .00</div>
SECTION B TOTAL FEE DUE: _____	\$ _____ .00

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



**State of Connecticut
Department of Public Health
Office of Health Care Access
Certificate of Need Application**

Please complete all questions. If any question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. Your Certificate of Need application will be eligible for submission no earlier than March 7, 2010 and may be submitted no later than May 6, 2010. The OHCA analyst assigned to this application is Jack A. Huber. He may be reached at the Office of Health Care Access at (860) 418-7034.

Docket Number: 10-31515-CON

Applicant Name: McAraw, Centner & Centner, LLC

Contact Person: I.L. Centner, II, DMD

Contact Title: Partner

Contact Address: 97 Elm Street
Old Saybrook, CT 06905

Project Location: Old Saybrook

Project Name: Acquisition of a Cone-Beam Computed Tomography
Scanner in Old Saybrook

Proposal Type: Section 19a-639 of the Connecticut General Statutes

**Estimated Total
Capital Expenditure:** \$124,000

Imaging Application

1. Project Description and Need

- a. Provide a narrative detailing the proposal.
- b. Provide the Manufacturer, Model, Number of slices/tesla strength of the proposed scanner (as appropriate to each piece of equipment).
- c. List each of the Applicant's sites and the imaging modalities and other services currently offered by location.
- d. Complete **Table 1** for each scanner (of the type proposed) currently operated by the Applicant at each of the Applicant's sites.

Table 1: Existing Scanners Operated by the Applicant

Provider Name Street Address Town, Zip Code	Description of Service *	Hours/Days of Operation **	Utilization ***

* Include equipment strength (e.g. slices, tesla strength), whether scanner is open or closed (for MRI)

** Days of the week scanner is operational, and start and end time for each day; and

*** Number of scans performed on each scanner for the most recent 12-month period (identify period).

- e. Provide the following regarding the proposal's location:
 - i. The rationale for locating the proposed equipment at the proposed site;
 - ii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;
 - iii. How and where the proposed patient population is currently being served;
 - iv. Describe the unique/specialized diagnostic and treatment planning needs of the patient population that require use of the proposed 3-D imaging equipment.
 - v. Does the Applicant expect referrals from other dentists/orthodontists for the proposed service? If yes, quantify and document.
 - vi. All existing and CON approved providers (name, address) of the proposed service in the towns listed above and in nearby towns;
 - vii. The effect of the proposal on existing providers; and

- viii. If the proposal involves a new site of service, identify the service area towns and the basis for their selection.

2. Actual and Projected Volume

- a. Complete the following table for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal. Report the total number of patients for each year, and provide a breakdown of the target population for the proposed Cone Beam Scanner by diagnoses.

Table 2: Historical, Current, and Projected Volume, by Diagnoses

	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**		
	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****
Diagnoses***							
Total							

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.

*** Identify each type of diagnoses and add lines as necessary.

**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

- b. Provide a breakdown, by town, of the volumes provided in Table 2 for the most recently completed full FY.
- c. Explain any increases and/or decreases in volume seen in the tables above.
- d. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.
- e. Provide a copy of any articles, studies, or reports that support the need to acquire the proposed scanner, along with a brief explanation regarding the relevance of each selected article.

3. Quality Measures

- a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.
- b. Explain how this proposal contributes to the quality of health care delivery in the region.

- c. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services

4. Organizational and Financial Information

- a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).
- b. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☐ No
- c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.
- d. Financial Statements
- i. If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.
- ii. If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)
- e. Submit a final version of all capital expenditures/costs as follows:

Table 3: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	\$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
Total Capital Expenditure	\$
Medical Equipment Lease (Fair Market Value) ***	\$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost	\$
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	\$

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

- f. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges received to date; letter of interest or approval from a lending institution.

5. Patient Population Projections

- a. Provide the current and projected patient population mix (based on the number of patients, not on revenue) with the CON proposal for the proposed scanner.

Table 4: Patient Population Mix

	Current** FY ***	Year 1 FY ***	Year 2 FY ***	Year 3 FY ***
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix				

* Includes managed care activity.

** New programs may leave the "current" column blank.

*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

- b. Provide the basis for/assumptions used to project the patient population mix.

6. Financial Attachments I & II

- a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.
- b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

- c. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).
- d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).
- e. Describe the billing for the proposed service. Provide the name of the insurance companies that reimburse for the proposed service(s).
- f. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.
- g. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.
- h. Describe how this proposal is cost effective.

7. Other Review Criteria

- a. Describe the proposal's relationship to the Applicant's long-range plans. Provide supporting documentation.
- b. Specify whether any of the following apply to the proposal. If so, provide an explanation and supporting documentation.
 - i. Voluntary efforts to improve productivity and contain costs;
 - ii. Changes to the Applicant's teaching or research responsibilities; and/or
 - iii. Special characteristics of the Applicant's patient or physician mix.

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:

<u>Total Facility:</u>									
<u>Description</u>	<u>FY Actual Results</u>	<u>FY Projected W/out Project</u>	<u>FY Projected Incremental</u>	<u>FY Projected With Project</u>	<u>FY Projected W/out Project</u>	<u>FY Projected Incremental</u>	<u>FY Projected With Project</u>	<u>FY Projected W/out Project</u>	<u>FY Projected With Project</u>
Revenue from Operations									
Non-Operating Revenue									
Total Revenue:	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total Operating Expenses									
Income before provision for income taxes	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Provision for income taxes									
Net Income	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Retained earnings, beginning of year									
Retained earnings, end of year	\$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.

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*** TX REPORT ***

TRANSMISSION OK

TX/RX NO 1132
RECIPIENT ADDRESS 918603884493
DESTINATION ID
ST. TIME 01/12 17:40
TIME USE 05'28
PAGES SENT 13
RESULT OK



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

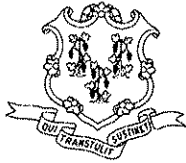
TO: I.L. CANTNER, D.M.D.
FAX: (860) 388-4493
AGENCY: MCARAW, CANTNER & CANTNER, LLC
FROM: JACK HUBER
DATE: 1/12/2010 Time: ~4:30 pm
NUMBER OF PAGES: 11
(including transmittal sheet)

Comments: Transmission: CON Forms
Docket Number: 10-31515-CON
Proposal Seeking Cone-Beam CT Scanner

**PLEASE PHONE Jack A. Huber at (860) 418-7034
IF THERE ARE ANY TRANSMISSION PROBLEMS.**

Phone: (860) 418-7001

Fax: (860) 418-7053



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

January 14, 2010

I.L. Cantner, DMD
McAraw, Cantner & Cantner, LLC
97 Elm Street
Old Saybrook, CT 06475

Facsimile Only

Re: Letter of Intent; Docket Number: 10-31515-LOI
McAraw, Canter & Cantner, LLC
Acquisition of a Cone Beam CT Scanner in Old Saybrook
Notice of Letter of Intent

Dear Dr. Cantner,

On January 6, 2010, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of McAraw, Cantner & Cantner, LLC ("Applicant") for the acquisition of a cone beam computed tomography scanner in Old Saybrook, with a total capital expenditure of \$124,000.

A notice to the public regarding OHCA's receipt of a LOI was published by *The Day Publishing Company* pursuant to Section 19a-639 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim Martone".

Kimberly R. Martone
Director of Operations

KRM:lmg



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

January 14, 2010

Requisition # 30064

The Day Publishing Company
47 Eugene O'Neill Drive
Box 1231
New London, CT 06320

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, January 18, 2010**.

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 Jack Huber at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim Martone", written over a horizontal line.

Kimberly R. Martone
Director of Operations

Attachment

KRM:JAH:lmg

c: Danielle Pare, DPH

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	McAraw, Cantner & Cantner, LLC
Town:	Old Saybrook
Docket Number:	10-31515-LOI
Proposal:	Acquisition of a Cone Beam CT Scanner in Old Saybrook
Capital Expenditure:	\$124,000

The Applicant may file its Certificate of Need application between March 7, 2010 and May 6, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner, Department of Public Health, Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available at OHCA or on OHCA's website at www.ct.gov/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 1149
RECIPIENT ADDRESS 98603884493
DESTINATION ID
ST. TIME 01/15 12:26
TIME USE 01'16
PAGES SENT 4
RESULT OK



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: I.L. CANTNER, DMD
FAX: (860) 388-4493
AGENCY: MCARAW, CANTNER & CANTNER, LLC
FROM: JACK HUBER
1/15/10
DATE: _____ TIME: _____
NUMBER OF PAGES: 4
(including transmittal sheet)

Comments: Docket 10-31515-LOI

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: ads [ads@graystoneadv.com]
Sent: Thursday, January 14, 2010 1:28 PM
To: Greer, Leslie
Subject: Re: Legal Ad Requisition 30064

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061
E-mail: ads@graystoneadv.com
<http://www.graystoneadv.com/>

On 1/14/10 1:18 PM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

To Whom It May Concern,
Please run the attached public notice in The Day Publishing newspaper by 1/18/10.

The requisition # is 30064

Feel free to call me with any questions regarding this request.

Thank you,

Leslie M. Greer x
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7001
Fax: (860) 418-7053
Website: www.ct.gov/ohca <<http://www.ct.gov/ohca>>



Please consider the environment before printing this message