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	Paul M. Ciuci, DMD, MD	Fedele N. Volpe, DMD
Doing Business As	Oral & Maxillofacial Surgeons of Milford & Derby	Oral & Maxillofacial Surgeons of Milford & Derby
Name of Parent Corporation	Oral & Maxillofacial Surgeons of Milford & Derby	Oral & Maxillofacial Surgeons of Milford & Derby
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	One Golden Hill Milford, CT 06460	One Golden Hill Milford, CT 06460
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.	Paul M. Ciuci, DMD, MD Partner	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	One Golden Hill Milford, CT 06460	
Contact Person Telephone Number	(203)-874-1664 Office (203)-889-8409 Cell	

Contact Person Fax Number	(203)-877-2027	
Contact Person e-mail Address	PCiuci@CTOMFS.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Cone Beam CT Scanner

b. Project Proposal: Addition of CBCT to Oral & Maxillofacial Surgeons of Milford & Derby.

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

Inpatient Service(s): Not Applicable.

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)* Office of Oral & Maxillofacial Surgeons of Milford & Derby.

Imaging:

- ☐ MRI
- ☒ 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.?

☒ 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:

676 New Haven Avenue, Derby, CT 06418

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

This project is intended to serve the established referral base of Oral & Maxillofacial Surgeons of Milford & Derby for evaluation of the maxillofacial region as it pertains to dentoalveolar structures, congenital and development deformities, and maxillofacial pathology.

h. Estimated starting date for the project: Following approval of Certificate of Need.

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

Not Applicable.

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: $ 189,999

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

Major Medical Equipment Purchases*	0.00
Medical Equipment Purchases*	$179,999
Non-Medical Equipment Purchases*	5,000
Land/Building Purchases	0.00
Construction/Renovation	$5,000
Other (Non-Construction) Specify:_____	0.00
Total Capital Expenditure	**$189,999**
Major Medical Equipment – Fair Market Value of Leases Medical	0.00
Equipment – Fair Market Value of Leases	0.00
Non-Medical Equipment – Fair Market Value of Leases*	0.00
Fair Market Value of Space – Capital Leases Only	0.00
Total Capital Cost	**$189,999**
Total Project Cost	**$189,999**
Capitalized Financing Costs (Informational Purpose Only)	0.00

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

Medical Equipment Purchase: Imaging Sciences International i-Cat CBCT and Panoramic X-ray Option.

Non-Medical Equipment Purchase: Additional Computers and monitors for use with CBCT.

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
Cone Beam CT Scanner	Imaging Sciences International	i-CAT	One (1)	$169,999
Digital Panoramic Option	Imaging Sciences International	i-CAT	One (1)	$10,000

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):

- ☐ Applicant's Equity
- ☐ Capital Lease
- ☒ Conventional Loan
- ☐ Charitable Contributions
- ☒ Operating Lease
- ☐ CHEFA Financing
- ☐ Funded Depreciation
- ☐ Grant Funding

SECTION IV. PROJECT DESCRIPTION

See page 8 & 9.

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.

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: Paul M. Ciuci DMD, MD, One Golden Hill Street , Milford CT, 06460

Project Title: **Cone Beam CT Scanner**

I, Paul M. Ciuci DMD, MD (Name), Secretary (Position)

of Oral & Maxillofacial Surgeons of Milford & Derby 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 Oral & Maxillofacial Surgeons of Milford & Derby (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 12/22/2009
Date

Subscribed and sworn to before me on Dec 22, 2009

Leonard G. Barbieri
Notary Public/~~Commissioner~~ of ~~Superior Court~~

My commission expires: 9/3/13

RECEIVED
2010 JAN -8 A 11:26
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Form 2030
Revised 10/2007

AFFIDAVIT

To be completed by each Applicant

Applicant: Fedele N. Volpe, DMD, One Golden Hill Street , Milford CT, 06460

Project Title: **Cone Beam CT Scanner**

I, Fedele N. Volpe, DMD, President
(Name) (Position)

of Oral & Maxillofacial Surgeons of Milford & Derby 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 Oral & Maxillofacial Surgeons of Milford & Derby complies with
(Facility Name)
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 12/23/09
Date

Subscribed and sworn to before me on Dec 23, 2009

Gennaro A. Barbieri
Notary Public/~~Commissioner of Superior Court~~

My commission expires: 9/30/2013

Ms. Christine A. Vogel
Office of Health Care Access
410 Capitol Ave, MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

To Ms. Christine Vogel,

Oral & Maxillofacial Surgeons of Milford and Derby is a traditional oral surgical practice providing comprehensive care. Our practice is experienced in treating diseases of the oral cavity and the facial skeleton. We have been providing surgical care for the past 50 years which includes surgical extraction of teeth, wisdom tooth extractions, oral pathology, facial trauma, reconstruction of cleft lip and palate defects, facial trauma reconstruction, orthognathic surgery and surgical treatment of obstructive sleep apnea. (Please find the attached DPH licenses). As we bring our practice into the 21st century we are looking to upgrade our office located at 676 New Haven Ave, in Derby, with the addition of low radiation, dental digital imaging, more specifically i-CAT cone beam CT technology.

Knowing both the physical and radiographic anatomy is essential to treat pathologic conditions of the oral cavity and maxillofacial region. Prior to treatment the majority of our patients under go conventional x-ray imaging with film processing. The addition of an i-CAT Cone Beam CT scanner will replace our current film based panoramic x-ray machine and will give us superior imaging capability, a decrease dosage of radiation to our patients and an environmentally friendly solution to film processing. The use of cone beam technology will improve treatment outcome by knowing the specific three dimensional location of vital structures of maxillofacial region. In the past we have referred patients to established practices with collimated, in office cone beam CT scans to determine specific surgical anatomy. The use of cone beam technology as compared with a traditional CT scan reduces our patient's exposure of radiation by almost a factor of 100 and significantly reduces artifact and scatter caused by the intra-oral metals in filling and crowns. No additional DPH licenses will be required for our practitioners or office with addition of an i-CAT Cone Beam CT scanner.

The current population served by Oral & Maxillofacial Surgeons of Milford & Derby is our established referral base in the surrounding towns. Our patients both children and adults are referred to our practice from the area general dentists, orthodontists, endodontists, pediatric dentists and primary care physicians. We also receive referrals from the emergency departments of several local hospitals at which we have operating privileges. Our target population is the same as our established or current patient population. The addition of digital cone beam technology will allows us to better serve patients referred to our practice.

Our office currently has intra oral x-rays (non-digital) as well as a film, non-digital, panoramic x-ray. Converting our office from traditional film x-rays to digital x-rays will decrease the radiation delivered to our patients. We can utilize the 2 dimensional radiographs of the i-CAT for the majority of patients and only when 3 dimension information is needed utilize the full scan. An in-office cone beam CT scanner will allow limited, 3 dimensional views of procedure related surgical anatomy. In-office CT technology will allow us to become a state of the art practice utilizing CT guided surgery. The use of digital technology will free our office of toxic, hazardous chemicals of traditional film developing decreasing our environmental impact.

To our knowledge there are a select few in-office cone beam CT scanners in the state of Connecticut. These premier practices as well as practices in other states can offer their patients a higher level of care. There are no other dental offices in our area utilizing in office cone beam technology. Implementation of in-office cone beam CT scans will improve the health care delivery system in Connecticut by providing patients an advanced level of care and improved access to care.

In the past Oral & Maxillofacial surgeons have been using 2-dimensional images to treat 3 dimensional patients. With the use of multiple x-rays, geometry and linear measurements the surgeon would guesstimate the surgical anatomy. This is a disservice to our patients which present unanticipated anatomy at the time of surgery and can compromise care. Collimated field of view cone beam CT scans allow the surgeon to see precise surgical anatomy in 3-dimesnions eliminating guess work. 3 Dimensional cone beam imaging will allow us to exact a surgical plan not offered by our existing 2 dimensional imaging.

This technology will be used specifically to:

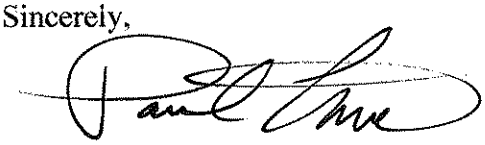
- Locate impacted and retained teeth to accurately plan surgical approaches.
- Determine exact position of the vital nerves in wisdom tooth surgery, jaw reconstructive surgery, trauma and implant surgery to reduce unsettling paresthesia.
- Locates3 dimensional position of sinuses involved in tooth surgery, implant placement and trauma surgery to decrease sinus complications.
- It allows for planning reconstruction of jaw defects from cleft lip and palate patients, trauma and cancer survivors.
- Allows for 3 dimensional treatment planning for corrective jaw surgery for congenital malformations and obstructive sleep apnea.
- Precise imaging of the Temporomandibular joint and related structures for patients who suffer with Temporomandibular Joint Disorders (TMD).
- Utilize CT guided surgical applications in cancer reconstruction and implant surgery.

The dedicated and experienced team at Oral & Maxillofacial Surgeons of Milford & Derby are eager to adopt new technology. Our surgeons, surgical assistants and staff will be responsible for providing this advanced imaging technology. Upon installation of our i-CAT all members of our surgical team will undergo in office, hands on training to provide superior dental imaging for our patients.

In our office there are no current payers for this service because in-office 3D imaging is not available to our patients. Once utilization of cone beam technology takes place the patients referred to our practice who require advanced imaging will be the responsible payers.

Oral & Maxillofacial Surgeons of Milford & Derby know there is no other viable in-office, low radiation, limited view, 3 Dimensional technologies that will offer our patients unparalleled imaging. The addition of an i-CAT cone beam CT scanner will allow us to enter the digital age and provide state of the art surgical treatment for our patients.

Sincerely,



Paul M. Ciuci DMD, MD

HENRY SCHEIN®

DENTAL

135 Duryea Road, Melville, New York 11747
(800) 645-6594

EQUIPMENT ORDER NO. # 20091217144849578

*** Equipment Expansion ***

Date: 12/29/2009	Acct No: 2038741664		Install Date:
Field Sales Consultant	Number	Equipment Specialist: Chris Anderson	Number: CHA
Installation Address: 676 New Haven Ave			
City: Derby		State: CT	Zip: 06418
Office Phone: 203-734-2523		Home Phone:	
New Acct:		Existing Acct:	

Sold To: Dr Paul Ciuci			
Address: 676 New Haven Ave			
City: Derby	State: CT	Zip: 06418	
Deliver To:			
Phone: 203-734-2523	Fax:		

Henry Schein Dental
5 Barnes Industrial Road South
Wallingford | CT | 06492
Phone: (860) 539-8944 | Fax: (203) 413-6488

Qty	Manufacturer	Code Number	Description	Amount	Extension
1	IMGSCI	773-9571	i-Cat 3D System 1719	$169,999.00	$169,999.00
1	IMGSCI	773-7354	Digital Panoramic Option	$10,000.00	$10,000.00
			Includes Free 2nd year warranty		
			Includes Invivo Imaging Software		
			HSFS		
			90 Days Deferred - $1.00 Buyout		
			60 Months 1-3 = $0.00		
			60 Months 4-63 = $4,174.15		
			Note: Payment estimate good until 1/2/2010.		
			Note: Based on a finance amount of $196,522.92.		
			Note: All payments are subject to credit approval and verification.		
			_____ Initial here to have your HSFS Partner advance your		
			deposit to Henry Schein Dental.		
			(Your monthly payment may differ.)		

Payment Terms: Minimum 10% deposit to initiate order with balance to be paid on delivery of equipment or _____, whichever occurs first.

☑ Henry Schein Financial Services (HSFS) ☐ Cash /Bank Financing

SSN* _____ SSN* _____

DOB _____ Bank Name _____

Credit Card # _____ Bank Officer _____

Expiration _____ Bank Phone _____

THIS ORDER IS SUBJECT TO THE TERMS AND CONDITIONS APPEARING ON THE REVERSE SIDE HEREOF, AND ANY SUPPLEMENTAL TERMS AND CONDITIONS THAT WE PROVIDE WITH ANY PRODUCT PURCHASED HEREUNDER AND PURCHASER AGREES TO BE BOUND THEREBY.

X _____ _____ X _____ _____
Purchaser's Signature Date Equipment Specialist Date

_____ _____ _____
Prices are in effect until Acceptance by Henry Schein Dental Date

Sub Total	$179,999.00
Other	
S & H	$5,399.98
6.00% Sales Tax	$11,123.94
Total	$196,522.92
Deposit	$0.00
Balance Due	$196,522.92
HSFS Estimated Monthly Payment	

☐ Privileges Member

* SSN (Required for orders over $5000)

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
PURSUANT TO THE PROVISIONS OF THE GENERAL STATUTES OF CONNECTICUT

THE INDIVIDUAL NAMED BELOW IS LICENSED
BY THIS DEPARTMENT AS A

DENTIST

PAUL MICHAEL CIUCI

LICENSE NO.
009672
CURRENT THROUGH
09/30/10
VALIDATION NO.
03-883535

SIGNATURE

J Robert Galvin MD, MPH, MBA
COMMISSIONER

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
PURSUANT TO THE PROVISIONS OF THE GENERAL STATUTES OF CONNECTICUT

THE INDIVIDUAL NAMED BELOW IS LICENSED
BY THIS DEPARTMENT AS A

PHYSICIAN/SURGEON

PAUL MICHAEL CIUCI

LICENSE NO.
045907
CURRENT THROUGH
09/30/10
VALIDATION NO.
03-883556

SIGNATURE

J Robert Galvin MD, MPH, MBA
COMMISSIONER

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
PURSUANT TO THE PROVISIONS OF THE GENERAL STATUTES OF CONNECTICUT

THE INDIVIDUAL NAMED BELOW IS LICENSED
BY THIS DEPARTMENT AS A

DENTAL ANES/CONSCIOUS SEDATION PERMITEE

PAUL MICHAEL CIUCI

LICENSE NO.
008439
CURRENT THROUGH
07/31/10
VALIDATION NO.
03-883536

SIGNATURE

J Robert Galvin MD, MPH, MBA
COMMISSIONER

CIUCI, PAUL M DMD
ORAL AND MAXILLOFACIAL SURGEONS
OF MILFORD AND DERBY
ONE GOLDEN HILL STREET
MILFORD, CT 06460-0000-000

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
BC7464326	08-31-2010	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	08-20-2007

CIUCI, PAUL M DMD
ORAL AND MAXILLOFACIAL SURGEONS
OF MILFORD AND DERBY
ONE GOLDEN HILL STREET
MILFORD, CT 06460-0000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
BC7464326	08-31-2010	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	08-20-2007

CIUCI, PAUL M DMD
ORAL AND MAXILLOFACIAL SURGEONS
OF MILFORD AND DERBY
ONE GOLDEN HILL STREET
MILFORD, CT 06460-0000

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Form DEA-223 (4/07)

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

PURSUANT TO THE PROVISIONS OF THE GENERAL STATUTES OF CONNECTICUT
THE INDIVIDUAL NAMED BELOW IS LICENSED
BY THIS DEPARTMENT AS A:

DENTIST

LICENSE NO.
006602
CURRENT THROUGH
02/28/10
VALIDATION NO.
03-775672

FEDELE N. VOLPE DMD

SIGNATURE

J. Robert Galvin, MD, MPH&A
COMMISSIONER

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
AV1722796	05-31-2011	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	05-08-2008

VOLPE, FEDELE N DMD
1 GOLDEN HILL
MILFORD, CT 06460-0000

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (4/07)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

December 21, 2009

FEDELE N. VOLPE, DMD
1 GOLDEN HILL
MILFORD, CT 06460

DUPLICATE LICENSE

This is to certify that the records of the Connecticut Department of Public Health indicate that the above mentioned individual has been issued Connecticut Dental Anes/Conscious Sedation Permitee license number 006602. This license is current through 04/30/2010.

Sincerely,

J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA
Commissioner

Should you wish to validate the authenticity of this document, please visit the Department's website at https://www.clicense.ct.gov.

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
P.O. Box 340308 Hartford, CT 06134-0308
Affirmative Action / Equal Employment Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

January 19, 2010 Via: Fax & E-mail

Paul M. Ciuci, DMD, MD
Partner
Oral & Maxillofacial Surgeons of Milford & Derby
One Golden Hill
Milford, CT 06460

RE: Certificate of Need Application Forms; Docket Number: 10-31515-CON
Oral & Maxillofacial Surgeons of Milford & Derby
Acquisition of a Cone-Beam Computed Tomography Scanner in Derby

Dear Dr. Ciuci:

Enclosed are the application forms for Oral & Maxillofacial Surgeons of Milford & Derby's Certificate of Need ("CON") proposal for the acquisition of a cone-beam computed tomography scanner to be located in Derby, Connecticut, at an estimated total capital expenditure of $189,999. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes, the CON application may be filed between March 9, 2010, and May 8, 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 five (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 OHCA analyst assigned to this CON application is Alexis Fedorjaczenko. Please feel free to contact her at (860) 418-7067, if you have questions.

Sincerely,

Kaila Riggott

Kaila Riggott
Planning Specialist

Enclosure

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 9, 2010 and may be submitted no later than May 8, 2010. The OHCA analyst assigned to this application is Alexis Fedorjaczenko. She may be reached at the Office of Health Care Access at (860) 418-7067.

Docket Number:	10-31516-CON
Applicant Name:	Oral & Maxillofaxial Surgeons of Milford & Derby
Contact Person:	Paul M. Ciuci, DMD, MD Fedele N. Volpe, DMD
Contact Title:	Partner
Contact Address:	One Golden Hill Milford, CT 06460
Project Location:	Derby, CT
Project Name:	Acquisition of a Cone-Beam Computed Tomography Scanner in Derby
Proposal Type:	Section 19a-639 of the Connecticut General Statues
Estimated Total Capital Expenditure:	$189,999

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.

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: _____

Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and if applicable, volume statistics without, incremental to and with the proposal in the following reporting format:

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

*Volume Statistics:

*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

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

****
*** TX REPORT ***
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Paul Ciuci

FAX: 203.877.2027.

AGENCY:

FROM: Alexis Fedunjaczenko

DATE: 1/19/10 **TIME:** 12:30

NUMBER OF PAGES: 12
(including transmittal sheet

Comments:

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

January 20, 2010 VIA Facsimile Only

Paul Ciuci, DMD, MD
Oral & Maxillofacial Surgeons of Milford & Derby
676 New Haven Avenue
Derby, CT 06418

Re: Letter of Intent, Docket Number 10-31516
Acquisition of a Cone Beam CT Scanner
Notice of Letter of Intent

Dear Dr. Ciuci,

On January 8, 2010, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Oral & Maxillofacial Surgeons of Milford & Derby ("Applicant") for the acquisition of a Cone Beam CT Scanner in Derby, with a total capital expenditure of $189,999.

A notice to the public regarding OHCA's receipt of a LOI was published in *The New Haven Register* 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
Director of Operations

KRM:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

January 20, 2010 Requisition # 30110

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Sunday, January 24, 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 Alexis Fedorjaczenko at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:AF:lmg

c: Danielle Pare, DPH

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

New Haven Register
Docket 10-31516

Letter of Intent
January 20, 2010

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Oral & Maxillofacial Surgeons of Milford & Derby
Town:	Derby
Docket Number:	10-31516-LOI
Proposal:	Acquisition of a Cone Beam CT Scanner
Capital Expenditure:	$189,999

The Applicant may file its Certificate of Need application between March 9, 2010 and May 8, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner Office of Health Care Access Division of Department of Public Health, 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 Applicants.

Greer, Leslie

From: ads [ads@graystoneadv.com]
Sent: Wednesday, January 20, 2010 2:45 PM
To: Greer, Leslie
Subject: Re: Legal Notice Requisition 30110

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 1/20/10 2:17 PM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

> To Whom It May Concern,
> Please run the attached public notice in the New Haven Register by 1/24/10. Please refer to ***requisition 30110*** for billing purposes, if you have any questions feel free to call me.
>
> Thank you,
>
> Leslie M. Greer
> 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

****
*** TX REPORT ***
****

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

FAX SHEET

TO: PAUL CIUCI, DMD, MD

FAX: (203) 877-2027

AGENCY: ORAL & MAXILLOFACIAL SURGEONS OF MILFORD & DERBY

FROM: ALEXIS FEDORJACZENKO

DATE: 1/21/10 **TIME:**

NUMBER OF PAGES: 4
(including transmittal sheet

Comments: Docket 10-31516

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.