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	Joel D. Davidson	
Doing Business As	Joel D. Davidson, D.M.D.	
Name of Parent Corporation	None	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	630 Tolland Stage Road PO Box 887 Tolland, CT 06084	
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.	Joel D Davidson, D.M.D.	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	630 Tolland Stage Road PO Box 887 Tolland, CT 06084	
Contact Person Telephone Number	860-872-8551	
Contact Person Fax Number	860-871-8364	
Contact Person e-mail Address	jddavidson@mail.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Gendex GXCB-500 HD Dental 3D

b. Project Proposal: To add a Gendex GXCB-500 HD 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	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:

630 Tolland Stage Road Tolland, CT 06084

g. List each town this project is intended to serve: Patients of Dr. Joel Davidson coming mainly from Tolland, CT and surrounding towns of Tolland County.

This project is intended to solely serve patients referred to Dr. Joel Davidson for the evaluation and/or treatment of periodontics, endodontics, oral surgery and implants.

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: $126,000

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	$126,000
Non-Medical Equipment Purchases*	N/A
Land/Building Purchases	N/A
Construction/Renovation	N/A
Other (Non-Construction) Specify:_____	N/A
Total Capital Expenditure	**$126,000**
Major Medical Equipment – Fair Market Value of Leases Medical	N/A
Equipment – Fair Market Value of Leases	N/A
Non-Medical Equipment – Fair Market Value of Leases*	N/A
Fair Market Value of Space – Capital Leases Only	N/A
Total Capital Cost	**$126,000**
Total Project Cost	**$126,000**
Capitalized Financing Costs (Informational Purpose Only)	N/A

* 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 HD	One (1)	$126,000

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):

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. **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: Joel D. Davidson, D.M.D.

Project Title: Joel D. Davidson, D.M.D. – Gendex GXCB 500 HD

I, Joel D. Davidson, D.M.D (Name) Owner (Position)

of _Tolland, CT_____ 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 _Joel D. Davidson, D.M.D._____ 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 3/6/10 Date

Subscribed and sworn to before me on March 6th 2010

Notary Public/Commissioner of Superior Court

My commission expires: LISA IRWIN NOTARY PUBLIC MY COMMISSION EXPIRES FEB. 28, 2014

JOEL D. DAVIDSON, D.M.D.

FAMILY DENTISTRY

630 Tolland Stage Road
P.O. Box 887
Tolland, CT 06084
Telephone (860) 872-8551
Fax (860) 871-8364

Section IV. Project Description

IV. 1:
Currently Joel D. Davidson, D.M.D. is providing treatment to his patients in the field of diagnosis, periodontics, oral surgery, endodontics and implants. I am 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 my 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 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 HD 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. Also, being able to 3D visualize and measure roots of teeth will lead to more successful root canals. Additionally, for cases that do not require three-dimensional imaging, the Gendex GXCB-500 HD can take a traditional two-dimensional panoramic x-ray.

IV. 3,4:
The current population and target population is limited to Dr. Joel D Davidson's existing and future patient base and those patients referred to Dr. Davidson. 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.

JOEL D. DAVIDSON, D.M.D.

FAMILY DENTISTRY

630 Tolland Stage Road
P.O. Box 887
Tolland, CT 06084
Telephone (860) 872-8551
Fax (860) 871-8364

IV. 5:
There is not a provider of these services in Tolland County or Eastern Connecticut.

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 Joel D. Davidson. D.M.D. 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 Joel D. Davidson, D.M.D. As imaging needs are based exclusively to the patients of Dr. Davidson payers will be limited to said patient base and any future patients referred to Dr. Davidson

Summary:
In summary, the addition of medium field of view, dental 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 dentist and specialists alike where practitioners have open access to this technology and 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 HD. The GXCB-500 HD 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.)

HENRY SCHEIN®

EQUIPMENT ORDER NO. # **20100306004152046**

DENTAL

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

***** Equipment Expansion *****

Date: 3/6/2010	Acct No: 8608728551		Install Date:
Field Sales Consultant: Mike Gantos	Number: CT14	Equipment Specialist: Chris Anderson	Number: CHA
Installation Address: 630 Tolland Stage Road			
City: Tolland		State: CT	Zip: 06082
Office Phone: 860-872-8551		Home Phone:	
New Acct:		Existing Acct:	
Henry Schein Dental			
5 Barnes Industrial Road South			
Wallingford		CT	06492
Phone: (860) 539-8944		Fax: (203) 413-6488	

Sold To: Dr Joel Davidson		
Address: 630 Tolland Stage Road		
City:. Tolland	State: CT	Zip: 06082
Deliver To:		
Phone: 860-872-8551	Fax: 860-871-8364	

Qty	Manufacturer	Code Number	Description	Amount	Extension
1	GENDEX	717-2928	Cone Beam 3D Imaging Sys HD	$126,000.00	$126,000.00
1	GENDEX	717-5535	2010 CB500 2nd Year Warranty		
1	GENDEX	717-4448	Q2 CB500 PromoInvivo Soft		

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	$126,000.00
Other	
S & H	$3,780.01
6.00% Sales Tax	$7,786.80
Total	$137,566.81
Deposit	$13,756.69
Balance Due	$123,810.12
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

LICENSE NO.
004523
CURRENT THROUGH
12/31/10
VALIDATION NO.
03-985748

JOEL D. DAVIDSON, DMD

SIGNATURE

J Robert Galvin, MD, MPH, MBA

COMMISSIONER

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

March 16, 2010

Via: Fax & E-mail

Joel D. Davidson, D.M.D.
630 Tolland Stage Road
P.O. Box 887
Tolland, CT 06084

RE: Certificate of Need Application Forms; Docket Number: 10-31564-CON
Joel D. Davidsion, D.M.D.
Acquisition of a Cone-Beam Computed Tomography Scanner in Tolland, Connecticut

Dear Dr. Davidsion:

Enclosed are the application forms for Joel D. Davidson, D.M.D.'s Certificate of Need ("CON") proposal for the acquisition of a cone-beam computed tomography scanner to be located in Tolland, Connecticut, at an estimated total capital expenditure of $126,000. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes, the CON application may be filed between May 8, 2010, and July 7, 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.

Enclosure

- 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 Steven W. Lazarus. Please feel free to contact him at (860) 418-7012, if you have questions.

Sincerely,

Kaila Riggott

Kaila Riggott
Planning Specialist

GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

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

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

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

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 May 8, 2010 and may be submitted no later than July 7, 2010. The OHCA analyst assigned to this application is Steven W. Lazarus. He may be reached at the Office of Health Care Access at (860) 418-7012.

Docket Number:	10-31564-CON
Applicant Name:	Joel D. Davidson, D.M.D.
Contact Person:	Joel D. Davidson, D.M.D.
Contact Title:	Owner
Contact Address:	P.O. Box 887 630 Tolland Stage Road Tolland, CT 06084
Project Location:	Tolland, Connecticut
Project Name:	Acquisition of a Cone-Beam Computed Tomography Scanner
Proposal Type:	Section 19a-639 of the Connecticut General Statues
Estimated Total Capital Expenditure:	$126,000

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.

Financial Attachment II

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

Type of Service Description										
Type of Unit Description:										
# of Months in Operation										
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

Finanical Attachment I

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

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

*Volume Statistics:

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

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

TRANSMISSION OK

TX/RX NO	1361
RECIPIENT ADDRESS	98608718364
DESTINATION ID	
ST. TIME	03/16 12:35
TIME USE	02'24
PAGES SENT	13
RESULT	OK

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

FAX SHEET

TO: Joel D. Davidson, DMD

FAX: (860)871-8364

AGENCY:

FROM: OHCA - Steven Lazarus

DATE: 3/16/10 **TIME:** 12:30 pm

NUMBER OF PAGES:
(including transmittal sheet

Comments: Con Application Material Enclosed. An electronic copy of this material will be emailed to you shortly.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, March 16, 2010 3:56 PM
To: jddavidson@mail.com
Cc: Greer, Leslie; Riggott, Kaila
Subject: CON Application Material for DN: 10-31564-LOI Enclosed
Attachments: 10-31564 FA I.xls; 10-31564 Affidavit-General.doc; 10-31564 Application.doc; 10-31564 CONFEE.doc; 10-31564 Cover Letter.doc; 10-31564 FA II.xls

Dear Dr. Davidson,

Attached is the electronic copy of the CON application material faxed to you earlier today. Please feel free to contact me if you have any questions.

Sincerely,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)

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

March 18, 2010 Facsimile Only

Joel D. Davidson, D.M.D.
630 Tolland Stage Road
Tolland, CT 06084

Re: Letter of Intent; Docket Number: 10-31564
Joel D. Davidson, D.M.D.
Acquisition of a Cone Beam Dental CT Scanner

Dear Dr. Davidson,

On March 9, 2010, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Joel D. Davidson, D.M.D. ("Applicant") for the acquisition of a cone beam dental CT scanner in Tolland, with a total capital expenditure of $126,000.

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

March 18, 2010 Requisition # 31564

Journal Inquirer
306 Progress Drive
Manchester, CT 06040

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, March 22, 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 Steven Lazarus at 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:SWL:lmg

c: Danielle Pare, DPH

Journal Inquirer
Docket Number: 10-31564

Letter of Intent
March 18, 2010

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Joel D. Davidson, D.M.D.
Town:	Tolland
Docket Number:	10-31564-LOI
Proposal:	Acquisition of a Cone Beam Dental CT Scanner
Capital Expenditure:	$126,000

The Applicant may file its Certificate of Need application between May 8, 2010 and July 7, 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 Applicant.

Greer, Leslie

From: ads [ads@graystoneadv.com]
Sent: Thursday, March 18, 2010 4:36 PM
To: Greer, Leslie
Subject: Re: Legal Notice 10-31564

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 3/18/10 4:27 PM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

> To Whom It May Concern,
> Please run the attached public notice in the Journal Inquirer by March 22, 2010. Please refer to requisition 31564 for billing purposes.
>
> 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 ***
****

TRANSMISSION OK

TX/RX NO	1367
RECIPIENT ADDRESS	98608718364
DESTINATION ID	
ST. TIME	03/18 16:06
TIME USE	00'31
PAGES SENT	4
RESULT	OK

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

FAX SHEET

TO: JOEL D. DAVIDSON, D.M.D.

FAX: (860) 871-8364

AGENCY:

FROM: STEVEN LAZARUS

DATE: 3/18/10 **TIME:**

NUMBER OF PAGES: 4
(including transmittal sheet

Comments: Docket 10-31564

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.