Application Checklist

Instructions:

1. **Please check each box below, as appropriate; and**
2. **The completed checklist *must* be submitted as the first page of the CON application.**

☐ **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

For OHCA Use Only:

Docket No.: _____ Check No.: _____
OHCA Verified by:_____ Date: _____

☐ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)***

☐ **Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.**

☐ **Attached are completed Financial Attachments I and II.**

☐ **Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.**

Note: A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to ohca@ct.gov.

Important: For CON applications(less than 50 pages) filed electronically through email, the signed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.

☐ **The following have been submitted on a CD**

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

AFFIDAVIT

Applicant: _____

Project Title: _____

_____

I, _____, _____
(Individual's Name) (Position Title – CEO or CFO)

of _____ being duly sworn, depose and state that
(Hospital or Facility Name)

_____'s information submitted in this Certificate of
(Hospital or Facility Name)

Need Application is accurate and correct to the best of my knowledge.

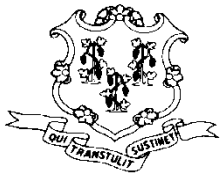
_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____



State of Connecticut
Office of Health Care Access
Certificate of Need Application

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number:

Applicant:

Applicant's Facility ID*:

Contact Person:

Contact Person's Title:

Contact Person's Address:

Contact Person's Phone Number:

Contact Person's Fax Number:

Contact Person's Email Address:

Project Town:

Project Name:

Statute Reference: Section 19a-638, C.G.S.

Estimated Total Capital Expenditure:

*Please provide either the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier.

1. Project Description: Increase in Licensed Bed Capacity

a. Please provide a narrative detailing the proposal, which chronicles the history of the service earmarked for an increase in licensed beds and provides a rationale for the proposed licensed bed increase.

b. Provide in table format the proposed number of (1) licensed, (2) available (3) and staffed beds for each unit/location involved in this proposal.

TABLE 1
PROPOSED BEDS

Unit/Location	Licensed*	Available**	Staffed***

*The number of licensed beds and new born bassinets listed on the hospital's Connecticut Department of Public Health (DPH) license on the last day of the fiscal year.
**The number of beds in service in nursing units that could be occupied by patients during the fiscal year
***The number of beds with sufficient staff occupied by patients during the fiscal year.

c. Provide letters that have been received in support of the proposal.

2. Clear Public Need

a. Explain why there is a clear public need for the proposal. Provide evidence that demonstrates this need.

b. Provide the following regarding the proposal's location:

i. The rationale for choosing the proposed service location;

ii. The service area towns, the corresponding patient volume and the basis for their selection;

TABLE 2
UTILIZATION BY TOWN

Fiscal Year*		
Town**	**Discharges*****	**Reason for Inclusion********

*Complete for the most recently completed fiscal year (FY) - label and identify the period covered (e.g., July 1-June 30, calendar year, etc.)
**List the official name of town; do not use village or borough names.
***Provide the number of discharges, by service area town.
****Provide basis for the selected towns.

iii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

iv. How and where the proposed patient population is currently being served;

v. All existing providers (name, facility ID, address) in the service area towns listed above and in nearby towns;

TABLE 3
EXISTING SERVICE PROVIDERS

Facility Name	Facility ID*	Facility Address

*Please provide either the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

vi. Describe existing referral patterns in the area to be served by the proposal; and

vii. The effect of the proposal on existing providers, explaining how current referral patterns will be affected by the proposal.

c. Provide the following regarding the proposed increase in licensed beds:

i. Explain the specific rationale for the increase in beds at each unit/location, including:

(1) The calculation or other methods by which the proposed increases were determined, clearly identifying all underlying assumptions used;
(2) The patient population that will be served; and
(3) The benefits of each proposed increase.

ii. For the last three complete FYs, the current FY-to-date, and the first three full years of the proposal, provide the following by service (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric) as relevant to the proposal:

a. Occupancy rate;
b. Average daily census; and
c. Variability in census including peak census.

d. Provide a copy of any articles, studies, or reports that support the statements made in this application justifying need for the proposal, along with a brief explanation regarding the relevance of the selected articles.

e. Explain why the proposal will not result in an unnecessary duplication of existing or approved health care services.

3. Historical & Projected Volume

a. For each service involved in this proposal, provide the number of discharges by town for the most recently completed fiscal year ("FY").

TABLE 4
DISCHARGES BY SERVICE AND TOWN

Town***	Fiscal Year*					
	Service**					
	Medical/Surgical	Maternity	Psychiatric	Rehabilitation	Pediatric	Total****
Total						

*Label and identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).
**Provide the number of discharges for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric) by patient town.
***List the official name of town; do not use village or borough names.
****Total should match town discharge total in Table 2.

b. In table format, provide historical volumes (three **full** years and the current year-to-date) for the number of discharges and patient days by service.

TABLE 5A
HISTORICAL AND CURRENT DISCHARGES

Service*	Actual Volume (Last 3 Completed FYs)			
	FY**	FY**	FY**	CFY***
Medical/Surgical				
Maternity				
Psychiatric				
Rehabilitation				
Pediatric				
Total				

*Provide the number of discharges for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric).
**Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).
***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.

TABLE 5B
HISTORICAL AND CURRENT PATIENT DAYS

Service*	Actual Volume (Last 3 Completed FYs)			
	FY**	FY**	FY**	CFY***
Medical/Surgical				
Maternity				
Psychiatric				
Rehabilitation				
Pediatric				
Total				

*Provide the number of patient days for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric).
**Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).
***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.

c. Explain any increases and/or decreases in volume seen in the table above.

d. Complete the following tables for the first three **full** fiscal years ("FY"), for the projected number of discharges and patient days by service (if the first year is a partial year, include that as well).

TABLE 6A
PROJECTED DISCHARGES BY SERVICE

Service*	Projected Volume			
	FY**	FY**	FY**	FY**
Medical/Surgical				
Maternity				
Psychiatric				
Rehabilitation				
Pediatric				
Total				

*Provide the number of discharges for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric).
**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. In a footnote, identify the period covered by the Applicant's fiscal year FY (e.g. July 1-June 30, calendar year, etc.).

TABLE 6B
PROJECTED PATIENT DAYS BY SERVICE

Service*	Projected Volume			
	FY**	FY**	FY**	FY**
Medical/Surgical				
Maternity				
Psychiatric				
Rehabilitation				
Pediatric				
Total				

*Provide the number of patient days for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric).
**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. In a footnote, identify the period covered by the Applicant's fiscal year FY (e.g. July 1-June 30, calendar year, etc.).

e. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

4. 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 the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to, (1) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (2) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program.

c. Identify the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

5. 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.

d. Financial Statements

i. <u>If the Applicant is a Connecticut hospital:</u> 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. <u>If the Applicant is not a Connecticut hospital (other health care facilities):</u> 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 7
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	Cost
Equipment (Medical, Non-medical Imaging) Land/Building Purchase* Construction/Renovation** Land/Building Purchase* Other (specify)	
Total Capital Expenditure (TCE)	
Lease (Medical, Non-medical Imaging)***	
Total Capital Cost (TCO)	
Total Project Cost (TCE+TCO)	

*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 and funds received to date; letter of interest or approval from a lending institution.

g. Demonstrate how this proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant.

6. Patient Population Mix: Current and Projected

a. Provide the current and projected number of discharges (and corresponding percentages) by patient population mix; including, but not limited to, access to services by Medicaid recipients and indigent persons for the proposed program.

TABLE 8
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Most Recently Completed FY**		Projected					
			FY**		FY**		FY**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*								
Medicaid*								
CHAMPUS & TriCare								
Total Government								
Commercial Insurers								
Uninsured								
Workers Compensation								
Total Non-Government								
Total Payer Mix								

*Includes managed care activity.
**Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.
Note: The patient population mix should be based on patient volumes, not patient revenues.

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

c. For the Medicaid population only, provide the assumptions and actual calculation used to determine the projected patient volume.

d. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation for good cause for doing so. *Note: good cause shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers*.

7. Financial Attachment I

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 the assumptions utilized in developing **Financial Attachment I** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

c. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation of the proposed licensed bed increase.

d. Describe how this proposal is cost effective.