Supplemental CON Application Form

Establishment of an Outpatient Surgical Facility

Conn. Gen. Stat. § 19-638(a)(6)

Applicant:

Project Name:

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 Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 of the Connecticut General Statutes, and that all facts contained in this Certificate of Need application are true 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: _____

1. Project Description: Outpatient Surgical Facility

a. Report the number of proposed operating rooms (ORs). Identify the number to be equipped and utilized and the number to be built and shelled for future use.

b. Provide the number of physicians and their specialties that will utilize the new outpatient surgical facility.

2. Clear Public Need

a. List all existing providers of the proposed service in the service area towns (i.e., listed in the Main Application) and in nearby towns. In Table A (below), provide the existing provider's name, address and, if available, the number of ORs utilized.

TABLE A
EXISTING SERVICE PROVIDERS

Facility Name	Facility Address	Number of Operating Rooms

b. If application is for a new outpatient surgical facility affiliated with a hospital, complete Table B and Table C (below).

For Table B:

i. Provide the number of operating rooms at the hospital that are uniquely equipped to perform the types of surgeries included in the proposal.

ii. Provide a breakout by available, utilized and not utilized (e.g., shelled) ORs.

iii. Provide the maximum number of surgical cases (of the type included in the proposal) that can optimally be performed at the hospital for one year and provide an explanation of the criteria or basis used to estimate the number.

iv. Report the number of surgical cases for the most recently **completed** fiscal.

TABLE B
AFFILIATED HOSPITAL OPERATING ROOM CAPACITY

Specialty	Number of Operating Rooms			Maximum Surgical Case Capacity	Surgical Cases Most Recently Completed FY____
	Available	Utilized	Not Utilized		

For Table C:

v. Complete Table C (below) for all surgical volume at the affiliated hospital. Provide data for the past three historical fiscal years and current fiscal year-to-date (indicate months included).

TABLE C
AFFILIATED HOSPITAL HISTORICAL OPERATING ROOM UTILIZATION

	FY ____	FY ____	FY ____	CFY ____*
Total number of surgical cases performed				
Annual increase in surgical cases performed				
Number of operating rooms				
Avg. annual number of surgical cases per room				
Total number of surgical case hours				
Number of hours available per year				
Percentage of Total Hours Utilized	**%**	**%**	**%**	**%**

***CFY Months include _____**

3. Projected Volume

a. Provide the calculations used to determine the proposed number of operating rooms (relate this to the projected volumes, including information such as the estimated number of procedures per room). Include relevant documentation to support these estimates.

b. Complete Table D and Table E (below) for the first three projected FYs of the proposal and adhere to the following:

i. If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs;

ii. Identify the number of surgical cases for each specialty/operating room – add lines as necessary;

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

iv. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume.

TABLE D
PROJECTED SURGICAL VOLUME BY SPECIALTY (E.G., ORTHOPEDIC)

Specialty	Projected Surgical Case Volume			
	Partial FY ____*	FY ____	FY ____	FY ____
Total				

*Months include _____

TABLE E
PROJECTED SURGICAL VOLUME BY OPERATING ROOM

Operating room	Projected Surgical Case Volume			
	Partial FY ____*	FY ____	FY ____	FY ____
Total				

*Months include _____

c. Complete Table F (below) for the first three projected FYs of the proposal and adhere to the following:

i. If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs.

TABLE F
PROJECTED OPERATING ROOM UTILIZATION

	Partial FY ____*	**FY ____**	**FY ____**	**FY ____**
Total number of surgical cases performed Annual increase in surgical cases performed Number of operating rooms Avg. annual number of surgical cases per room Total number of surgical case hours Number of hours available per year				
Percentage of Total Hours Utilized	**%**	**%**	**%**	**%**

***Months include _____**

4. Other

a. For a hospital applicant, describe any impact the proposal will have on the distribution of inpatient/outpatient surgical volume.

b. For non-hospital Applicants only, provide transfer agreements with hospitals in close proximity to the proposed facility.