Supplemental CON Application Form

**Increase in Licensed Bed Capacity**

Conn. Gen. Stat. § 638(a)(12)

**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: Increase in Licensed Bed Capacity**
2. Provide information the existing/proposed allocation of beds for each unit/location involved in this proposal. In completing Table A and Table B below, please adhere to the following:
	* 1. The licensed bed column should represent the number of licensed beds and newborn bassinets listed on the hospital’s Connecticut Department of Public Health (DPH) license on the last day of the fiscal year;
		2. available beds should represent the number of beds in service in nursing units that could be occupied by patients during the fiscal year; and
		3. staffed beds should represent the number of beds with sufficient staff occupied by patients during the fiscal year.

**Table A**

Existing beds

|  |  |  |  |
| --- | --- | --- | --- |
| **Unit/Location** | **Licensed** | **Available** | **Staffed** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Table B**

proposed beds

|  |  |  |  |
| --- | --- | --- | --- |
| **Unit/Location** | **Licensed** | **Available** | **Staffed** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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

the calculation or other methods by which the proposed increases were determined, clearly identifying all underlying assumptions used;

the patient population that will be served; and

the benefits of each proposed increase.

* 1. 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:

Occupancy rate;

Average daily census; and

Variability in census including peak census.

1. **Historical & Projected Volume**
2. Provide the number of discharges by town for the most recently **completed** fiscal year. In completing the Table C below, please adhere to the following:
	* 1. Label and identify the period covered and define the Applicant’s FY (e.g., July 1-June 30, calendar year, etc.); and
		2. Provide the number of discharges for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric);
		3. List the official name of town (i.e., use **ONLY** [official town names](http://ctstatelibrary.org/cttowns/counties)); do not use village or borough names; and
		4. Table totals should match OHS Tables 4 and 7 from the CON Main form.

**Table C**

DISCHARGES BY SERVICE AND TOWN

|  |  |
| --- | --- |
| **Official Town Name** | **FY\_\_\_\_** |
| **Medical/Surgical** | **Maternity** | **Psychiatric** | **Rehabilitation** | **Pediatric** | **Total** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |

* 1. Provide historical volumes (three **full** fiscal years and the current year-to-date) for the number of discharges and patient days by service. In completing the Table D and Table E below, please adhere to the following:
		1. Provide the number of discharges/patient days for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation and Pediatric);
		2. Fill in years. In a footnote, identify the period covered by the Applicant’s FY (e.g., July 1-June 30, calendar year, etc.);
		3. 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 D**

Historical and Current **Discharges**

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

**\*Months include \_\_\_\_\_\_\_\_\_**

**Table E**

Historical and Current **PATIENT DAYS**

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

**\*Months include \_\_\_\_\_\_\_\_\_**

* 1. Explain any increases and/or decreases in volume seen in Tables D and E, above.
	2. Complete Table F and Table G 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 F

Projected DISCHARGES by Service

|  |  |
| --- | --- |
| **Service\*** | **Projected Volume** |
| **Partial FY \_\_\_\_\*** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
| Medical/Surgical |  |  |  |  |
| Maternity |  |  |  |  |
| Psychiatric |  |  |  |  |
| Rehabilitation |  |  |  |  |
| Pediatric |  |  |  |  |
| **Total** |  |  |  |  |

**\*Months include \_\_\_\_\_\_\_\_\_**

# TABLE G

Projected pATIENT DAYS by Service

|  |  |
| --- | --- |
| **Service\*** | **Projected Volume** |
| **Partial FY \_\_\_\_\*** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
| Medical/Surgical |  |  |  |  |
| Maternity |  |  |  |  |
| Psychiatric |  |  |  |  |
| Rehabilitation |  |  |  |  |
| Pediatric |  |  |  |  |
| **Total** |  |  |  |  |

**\*Months include \_\_\_\_\_\_\_\_\_**

* 1. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service/patient day volume; explain any increases and/or decreases in volume reported in OHS Tables F and G.