

Supplemental CON Application Form
Increase of Two or More Operating Rooms
Conn. Gen. Stat. § 19a-638(a)(14)

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: Hospital/Outpatient Surgical Facility Operating Room Increase

- a. Report the number of existing operating rooms (ORs), identifying the number that are equipped and utilized and the number that were built/shelled for future use.
- b. Report the number of proposed operating rooms, identifying the number to be equipped and utilized and the number to be built and shelled for future use.

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. Provide the facility name, address, and if available, the number of operating rooms utilized.

TABLE A
EXISTING SERVICE PROVIDERS

Facility Name	Facility Address	Number of Operating Rooms

- b. Provide the calculations used to determine the proposed number of ORs (relate this to the projected volumes, including information such as the estimated number of procedures per room) and include relevant documentation to support these estimates.
- c. Complete Table B (below). Provide the number of operating rooms by specialty at the OSF or hospital that are uniquely equipped to perform the types of surgeries included in the proposal:
 - i. Provide a breakout by available, utilized and not utilized (e.g., shelled) ORs;
 - ii. Provide the maximum number of surgical cases (of the type included in the proposal) that can optimally be performed at the OSF or hospital for one year and provide an explanation of the criteria or basis used to estimate the number; and
 - iii. Report the number of surgical cases for the most recently **completed** fiscal year.

TABLE B
OPERATING ROOM CAPACITY

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

3. Actual and Projected Volume

- a. Complete Table C and Table D (below). In **Table C**, report the units of service by specialty (e.g., thoracic, orthopedic, etc.), and in **Table D**, report the units of service by each existing and proposed operating room. Complete the tables as follows:
 - i. For current fiscal year (CFY) periods 6 months or greater, report annualized volume, identify the months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the months covered.
 - ii. If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs.
 - iii. Identify the number of surgical cases for each specialty - add lines as necessary.
 - iv. Fill in fiscal years. In a footnote, identify the period covered by the applicant's FY (e.g., July 1-June 30, calendar year, etc.).

TABLE C
HISTORICAL SURGICAL VOLUME BY SPECIALTY

Specialty	Actual Surgical Case Volume (Last 3 Completed FYs)				Projected Surgical Case Volume (First 3 Full Operational FYs)			
	FY ____	FY ____	FY ____	CFY ____*	Partial FY ____**	FY ____	FY ____	FY ____
Total								

*CFY Months include _____

**Partial FY Months include _____

TABLE D
HISTORICAL SURGICAL VOLUME BY OPERATING ROOM

Operating Room	Actual Surgical Case Volume (Last 3 Completed FYs)				Projected Surgical Case Volume (First 3 Full Operational FYs)			
	FY ____	FY ____	FY ____	CFY ____ *	Partial FY ____ **	FY ____	FY ____	FY ____
Total								

*CFY Months include _____

**Partial FY Months include _____

- b. 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.
- c. Provide a discussion on any shift of surgical procedures from existing operating rooms to the proposed operating rooms.
- d. Complete Table E (below) for all surgical case volume at the OSF or hospital. Categorize surgical volume by specialty and include the corresponding number of surgical case hours for the past three fiscal years and current fiscal year to-date. **Note: totals should match those provided in Tables C and D above.**

TABLE E
PROCEDURE TIME BY SPECIALTY (E.G., THORACIC, ORTHOPEDIC, ETC.)

Specialty	FY ____		FY ____		FY ____		CFY ____ *	
	Surgical Case Volume	Surgical Case Hours						
Total								

*CFY Months include _____

e. Complete Table F (below) for all OSF or hospital surgical volume for the past three historical years and current fiscal year-to-date. *Note: totals should match those provided in the tables above.*

TABLE F
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	%	%	%	%

*Months include _____

f. Complete Table G (below) for all OSF or hospital surgical volume 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 G
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.