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.

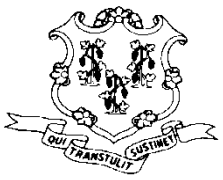
_____ _____
Signature Date

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: Acquisition of Equipment

a. Please provide a narrative detailing the proposal.

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

c. Provide the Manufacturer, Model, Number of slices/tesla strength of the proposed scanner (as appropriate to each piece of equipment).

d. List each of the Applicant's sites and the imaging modalities and other services currently offered by location.

2. Clear Public Need

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

b. Complete **Table 1** for each piece of equipment of the type proposed currently operated by the Applicant at each of the Applicant's sites.

TABLE 1
EXISTING EQUIPMENT OPERATED BY THE APPLICANT

Provider Name/Address	Service*	Days/Hours of Operation **	Utilization***

*Include equipment strength (e.g. slices, tesla strength), whether the unit is open or closed (for MRI)
**Days of the week unit is operational, and start and end time for each day
***Number of scans/exams performed on each unit for the most recent 12-month period (identify period).

c. 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. Identify the name and location (name, facility ID, address, service, hours of operation) of existing providers in the service area and within close proximity, provide the utilization of these services for the most recently completed year;

TABLE 2
EXISTING SERVICE PROVIDERS

Facility Name	Facility ID*	Facility Address	Service	Utilization**	Days/Hours of Operation

*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.
**Number of scans/exams performed on each unit for the most recent 12-month period (identify period).

v. The effect of the proposal on existing providers; and

vi. If the proposal involves a new site of service, identify the service area towns and the basis for their selection.

TABLE 3
APPLICANT'S SERVICE AREA

Town	Reason for Inclusion

Note: Provide basis for the selected towns.

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

3. Actual and Projected Volume

a. Complete the following tables for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal, for each of the Applicant's existing and proposed pieces of equipment (of the type proposed, at the proposed location only). In Table 4a, report the units of service by piece of equipment, and in Table 4b, report the units of service by type of exam (e.g. if specializing in orthopedic, neurosurgery, or if there are scans that can be performed on the proposed scanner that the Applicant is unable to perform on its existing scanners).

TABLE 4A

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY EQUIPMENT UNIT

Equipment* **	**Actual Volume (Last 3 Completed FYs)**			**CFY Volume***	**Projected Volume (First 3 Full Operational FYs)****		
	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****
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 scanner separately and add lines as necessary. Also break out inpatient/outpatient/ED volumes if applicable.
****Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

TABLE 4B

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY TYPE OF SCAN/EXAM

Service* **	**Actual Volume (Last 3 Completed FYs)**			**CFY Volume***	**Projected Volume (First 3 Full Operational FYs)****		
	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****
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 scan/exam (e.g. orthopedic, neurosurgery or if there are scans/exams that can be performed on the proposed piece of equipment that the Applicant is unable to perform on its existing equipment) 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 detailed explanation of all assumptions used in the derivation/ calculation of the projected volume by scanner and scan type.

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

d. Provide a breakdown, by town, of the volumes provided in Table 4a for the most recently completed FY.

TABLE 5
Utilization by Town

Town	Equipment*	Utilization FY XX**

*Identify each scanner separately and add lines as necessary. Also, break out inpatient/outpatient/ED volumes if applicable and include equipment strength (e.g. slices, tesla strength), whether the unit is open or closed (for MRI).
**Fill in year

e. Describe existing referral patterns in the area to be served by the proposal.

f. Explain how the existing referral patterns will be affected by the proposal.

g. 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 the selected articles.

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.

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 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 6
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

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 volume (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 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Most Recently Completed FY**		Projected					
			FY**		FY**		FY**	
	Volume	%	Volume	%	Volume	%	Volume	%
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 <u>full</u> 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. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

d. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

e. Describe how this proposal is cost effective.