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.

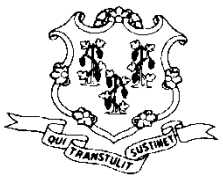
_____ _____
Signature Date

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: Outpatient Surgical Facility Operating Room Increase

a. Please provide a narrative detailing the proposal.

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

c. Report the number of existing operating rooms, identifying the number that are equipped and utilized and the number that were built and shelled for future use.

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

b. 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), and include any documentation to support these estimates.

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

i. The rationale for choosing the proposed service location;

ii. The service area towns and the basis for their selection;

TABLE 1
APPLICANT'S SERVICE AREA

Towns	

Note: 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 and associated information) of the proposed service in the towns listed above and in nearby towns in the format presented in Table 2 as follows:

TABLE 2
EXISTING SERVICE PROVIDERS AND OPERATING ROOM CAPACITY

Facility Name	Facility ID*	Facility Address	Number of Operating Rooms				Estimated Capacity for Proposal		Current Utilization[7]
			Available[1]	Utilized[2]	Not Utilized[3]	Equipped for Proposal[4]	Min[5]	Max[6]	

*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.
[1]Include used, equipped, and shell space.
[2]Include those actually used to perform surgeries.
[3]Include those not used and those that are equipped or are only shell space.
[4]Include those rooms that are uniquely equipped to perform the types of surgeries included in the proposal.
[5]Minimum number of surgical cases to be performed in a single operating room for one year. Provide an explanation of the criteria or basis used to estimate the number.
[6]Maximum number of surgical cases of the type included in the proposal that can optimally be performed in a single operating room in one year. Provide an explanation of the criteria or basis used to estimate the number.
[7]Report the number of surgical cases for the most current 12 month period and identify the period covered

vi. The effect of the proposal on existing providers.

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

e. Attach a copy of any articles, studies, or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles.

3. Actual and Projected Volume

a. Provide total volumes for the most recently completed full fiscal year by town.

TABLE 3
UTILIZATION BY TOWN

Town	Utilization FY XX*

Note: Provide basis for the selected towns.
*Fill in year and identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.). Provide the number of patient volume for the most recently completed fiscal year by service area town.

b. Complete the following tables for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal for the outpatient surgical case volume of each of the Applicants and physicians involved in the proposal. In Table 4A, report the units of service by specialty (e.g., thoracic, orthopedic, etc.), and in Table 4B, report the units of service by each existing and proposed operating room. Add lines as necessary.

TABLE 4A
HISTORICAL SURGICAL VOLUME BY SPECIALTY (E.G., THORACIC, ORTHOPEDIC, ETC.)

	Actual Surgical Case Volume (Last 3 Completed FYs)			CFY Volume*	Projected Surgical Case Volume (First 3 Full Operational FYs)**		
Specialty* **	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 the number of surgical cases for each specialty - 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.).

TABLE 4B
HISTORICAL SURGICAL VOLUME BY OPERATING ROOM

Operating Room***	Actual Surgical Case Volume (Last 3 Completed FYs)			CFY Volume*	Projected Surgical Case 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 operating room by location and any other identifier, 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.).

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

d. Provide a detailed description of all assumptions used in the derivation/calculation of the projected volumes.

e. Provide a discussion on any shift of surgical procedures from existing operating rooms to the proposed operating rooms.

f. For hospital Applicants, provide inpatient volume in the formats presented in Tables 4A and 4B and describe any impact the proposal will have on the inpatient surgery volumes of the Applicant(s).

g. Using the following table, categorize the outpatient surgical procedures that have been performed by the Applicant during the past three fiscal years and report the total time required to perform the surgical cases by specialty. Note: totals should match information provided in Table 4A.

TABLE 5
PROCEDURE TIME BY SPECIALTY (E.G., THORACIC, ORTHOPEDIC, ETC.)

Specialty**	FY ***		FY ***		FY ***	
	Surgical Case Volume*	Total Time	Surgical Case Volume*	Total Time	Surgical Case Volume*	Total Time
Total*						

*Ensure that the totals in this table correspond to the totals in Table 4a, or provide an explanation for why they do not.
**Identify each specialty category, and add lines as necessary.
***Fill in years. In a footnote, identify the period covered by each Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

h. Using the total number of procedures performed and the total number of minutes as reported above, report the Applicants' historical operating room utilization for outpatient surgical procedures as presented in Table 6.

TABLE 6
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	**%**	**%**	**%**	**%**

*Fill in years. For current fiscal year, report annualized volume, identifying the number of actual months covered and the method of annualizing if different from above.

i. Use the format presented in Table 7 to identify the number of outpatient surgical cases actually performed and projected to be performed by the proposal's physicians, by facility:

TABLE 7
ACTUAL/PROJECTED NUMBER OF SURGICAL CASES BY FACILITY

Facility Name	Physician Name	Specialty*	Actual by Fiscal Year				Projected by Fiscal Year		
			FY**	FY**	FY**	CFY**	FY**	FY**	FY**

*Identify each specialty category, 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.). 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.

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.

d. <u>For non-hospital Applicants only</u>, provide transfer agreements with hospitals closest to the proposed facility.

5. Organizational and Financial Information

a. Identify the Applicants' ownership type(s) (e.g. Corporation, PC, LLC, etc.).

b. Provide copies of Articles of incorporation, Articles of Organization, or Partnership Agreements (all that are appropriate) **related to the proposal.**

c. Do the Applicants have non-profit status?
☐ Yes (Provide documentation) ☐ No

d. 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.

e. Provide copies of all signed written agreements or memorandum of understanding including all exhibits/attachment etc., between the Applicants **related to the proposal.**

f. Identify the current and proposed percentage of ownership.

g. Identify and discuss any changes in legal status, or changes in membership or independence of the Applicants' board of directors or governing body that occur as a result of the proposal.

h. 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.)

i. Submit a final version of all capital expenditures/costs as follows:

TABLE 8
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.

j. 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.

k. Provide a copy of the Applicant's charity care policy and sliding fee scale applicable to the proposal.

l. 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 9
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 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. Identify the entity that will be billing for the proposed service(s).

d. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

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

f. Describe how this proposal is cost effective.