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 singed 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:

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:

1. **Project Description: Outpatient Surgical Facility**

   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 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;

      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. Complete the following table concerning the existing providers in the towns listed above and also in nearby towns; and

Table 1: Utilization and Capacity of Existing Providers

Provider Name Street Address Town, Zip Code	Number of Operating Rooms				Estimated Capacity for Proposal		Current Utilization [7]
	Available [1]	Utilized [2]	Not Utilized [3]	Equipped for Proposal [4]	Minimum [5]	Maximum [6]	

				Total			

[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 surgeries 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 surgeries 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 procedures 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. Projected Volume

a. Complete the following tables for the first three projected FYs of the proposal, for the outpatient surgical volume of each of the Applicants and physicians involved in the proposal. In Table 2a, report the units of service by service or procedure type, and in Table 2b, report the units of service by each existing and proposed operating room. Add lines as necessary.

Table 2a: Projected Outpatient Surgical Volume, by Procedure Type

	Projected Volume (First 3 Full Operational FYs)*		
	FY ***	FY ***	FY ***
Service or procedure type**			
Total			

* 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 service/procedure type 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.).

Table 2b: Projected Outpatient Surgical Volume, by Operating room

	Projected Volume (First 3 Full Operational FYs)*		
	FY ***	FY ***	FY ***
Operating room**			
Total			

* 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.).

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

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 contributes to the quality of health care delivery in the region.

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 Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

b. Descive the proposed ownership structure for the outpatient surgical facility.

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

d. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☐ No

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. Provide 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.)

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

Table 3: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
Total Capital Expenditure (TCE)	**$**
Medical Equipment Lease (Fair Market Value) ***	$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost (TCC)	**$**
Total Project Cost (TCE + TCC)	**$**
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$

* 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.

h. 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.

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

j. Demonstrate how this proposal will affect the financial strength of the state's health care system.

6. Patient Population Mix: Current and Projected

a. Provide the current and projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed program.

Table 4: Patient Population Mix

	Current FY *****	**Year 1 FY *****	**Year 2 FY *****	**Year 3 FY *****
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix				

* Includes managed care activity.
** New programs may leave the "current" column blank.
*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

b. Provide the basis for/assumptions used to project the patient population mix.

7. Financial Attachments I & II

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 a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three <u>full</u> fiscal years of the project.

c. Provide the assumptions utilized in developing **<u>both</u> Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

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

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

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

h. Describe how this proposal is cost effective.