Supplemental CON Application Form

**Establishment of an Outpatient Surgical Facility**

Conn. Gen. Stat. § 19-638(a)(6)

**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: Outpatient Surgical Facility**
	1. Report the number of proposed operating rooms (ORs). Identify the number to be equipped and utilized and the number to be built and shelled for future use.
	2. Provide the number of physicians and their specialties that will utilize the new outpatient surgical facility.
2. **Clear Public Need**
	1. List all existing providers of the proposed service in the service area towns (i.e., listed in the Main Application) and in nearby towns. In Table A (below), provide the existing provider’s name, address and, if available, the number of ORs utilized.

**Table A**

Existing Service providers

|  |  |  |
| --- | --- | --- |
| **Facility Name** | **Facility Address** | **Number of Operating Rooms** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

* 1. If application is for a new outpatient surgical facility affiliated with a hospital, complete Table B and Table C (below).

**For Table B:**

* + 1. Provide the number of operating rooms at the hospital that are uniquely equipped to perform the types of surgeries included in the proposal.
		2. Provide a breakout by available, utilized and not utilized (e.g., shelled) ORs.
		3. Provide the maximum number of surgical cases (of the type included in the proposal) that can optimally be performed at the hospital for one year and provide an explanation of the criteria or basis used to estimate the number.
		4. Report the number of surgical cases for the most recently **completed** fiscal.

**Table B**

Affiliated Hospital Operating Room capacity

|  |  |  |  |
| --- | --- | --- | --- |
| **Specialty** | **Number of Operating Rooms** | **Maximum Surgical Case Capacity** | **Surgical CasesMost RecentlyCompleted FY\_\_\_\_** |
| **Available** | **Utilized** | **Not Utilized** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**For Table C:**

* + 1. Complete Table C (below) for all surgical volume at the affiliated hospital. Provide data for the past three historical fiscal years and current fiscal year-to-date (indicate months included).

**Table C**

Affiliated Hospital 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** | **%** | **%** | **%** | **%** |

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

1. **Projected Volume**
	1. 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). Include relevant documentation to support these estimates.
	2. Complete Table D and Table E (below) for the first three projected FYs of the proposal and adhere to the following:
		1. If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs;
		2. Identify the number of surgical cases for each specialty/operating room – add lines as necessary;
		3. Fill in years. In a footnote, identify the period covered by the applicant’s FY (e.g., July 1-June 30, calendar year, etc.);
		4. 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.

**Table D**

**Projected Surgical Volume by Specialty (e.g., orthopedic)**

|  |  |
| --- | --- |
| **Specialty** | **Projected Surgical Case Volume** |
| **Partial FY \_\_\_\_\*** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Total** |  |  |  |  |

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

**Table E**

**Projected Surgical Volume by Operating Room**

|  |  |
| --- | --- |
| **Operating room** | **Projected Surgical Case Volume** |
| **Partial FY \_\_\_\_\*** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Total** |  |  |  |  |

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

* 1. Complete Table F (below) for the first three projected FYs of the proposal and adhere to the following:
		1. 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 F**

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 \_\_\_\_\_\_\_\_\_**

1. **Other**
	1. For a hospital applicant, describe any impact the proposal will have on the distribution of inpatient/outpatient surgical volume.
	2. For non-hospital Applicants only, provide transfer agreements with hospitals in close proximity to the proposed facility.