

## 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](mailto: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

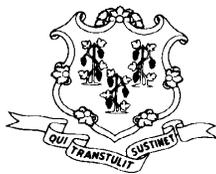
\_\_\_\_\_  
Date

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:**

**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 and Need: Change of Ownership or Control**

- a. Please provide a narrative detailing the proposal.
- b. Explain how each Applicant determined need for the proposal and discuss the benefits of this proposal for each Applicant (discuss each Applicant separately in separate paragraphs).
- c. Provide a history and timeline of the proposal (e.g., When did discussions begin between the Applicants? What have the Applicants accomplished so far?).
- d. List any changes to the clinical services offered by the Applicants that result from this proposal, and provide an explanation.
- e. Describe the existing population served by the facility changing ownership or control, and how the proposal will impact these populations. Include demographic information as appropriate.
- f. Describe the transition plan and how the Applicants will ensure continuity of services. Provide a copy of a transition plan, if available.
- g. For each Applicant (and any new entities to be created as a result of the proposal), provide the following prior to and after this proposal:
  - i. Legal chart of corporate or entity structure including all affiliates.
  - ii. List of owners and the % ownership and shares of each.
- h. Provide copies of all signed written agreements or memorandum of understanding, including all exhibits/attachments, between the Applicants related to the proposal. Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

## **2. 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.

## **3. 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 2: Proposed Capital Expenditures/Costs**

Medical Equipment Purchase	\$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
<b>Total Capital Expenditure (TCE)</b>	<b>\$</b>
Medical Equipment Lease (Fair Market Value) ***	\$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
<b>Total Capital Cost (TCC)</b>	<b>\$</b>
<b>Total Project Cost (TCE + TCC)</b>	<b>\$</b>
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.

- 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 affect the financial strength of the state's health care system.

**4. 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 3: Patient Population Mix**

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

\* 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.

**5. 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 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. As a result of the proposal, will there be any change to existing reimbursement contracts between the Applicants and payers (e.g. Medicare, Medicaid, commercial)? Explain.
- e. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.
- f. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.
- g. Describe how this proposal is cost effective.