

Supplemental CON Application Form

**Increase in Licensed Bed Capacity**

Conn. Gen. Stat. § 638(a)(12)

**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 the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Subscribed and sworn to before me on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public/Commissioner of Superior Court

My commission expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Project Description: Increase in Licensed Bed Capacity**
	1. Provide information for each unit/location involved in this proposal in the table below.

**Table A**

proposed beds

|  |  |  |  |
| --- | --- | --- | --- |
| **Unit/Location** | **Licensed\*** | **Available\*\*** | **Staffed\*\*\*** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

\* The number of licensed beds and newborn bassinets listed on the hospital’s Connecticut Department of Public

Health (DPH) license on the last day of the fiscal year.

\*\* The number of beds in service in nursing units that could be occupied by patients during the fiscal year

\*\*\* The number of beds with sufficient staff occupied by patients during the fiscal year.

* 1. Explain the specific rationale for the increase in beds at each unit/location, including:
		1. The calculation or other methods by which the proposed increases were determined, clearly identifying all underlying assumptions used;
		2. The patient population that will be served; and
		3. The benefits of each proposed increase.
	2. For the last three complete FYs, the current FY-to-date, and the first three full years of the proposal, provide the following by service (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric) as relevant to the proposal:

Occupancy rate;

Average daily census; and

Variability in census including peak census.

1. **Historical & Projected Volume**
	1. Provide the number of discharges by town for the most recently completed fiscal year

**Table B**

DISCHARGES BY SERVICE AND TOWN

|  |  |
| --- | --- |
| **Town\*\*\*** | **Fiscal Year\*** |
| **Service\*\*** |
| **Medical/Surgical** | **Maternity** | **Psychiatric** | **Rehabilitation** | **Pediatric** | **Total\*\*\*\*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |

\* Label and identify the period covered by the Applicant’s FY (e.g., July 1-June 30, calendar year, etc.).

\*\* Provide the number of discharges for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and

 Pediatric) by patient town.

\*\*\* List the official name of town; do not use village or borough names.

\*\*\*\*Total should match town discharge total in Main Form, Table 8.

* 1. Provide historical volumes (three **full** years and the current year-to-date) for the number of discharges and patient days by service.

**Table C**

Historical and Current Discharges

|  |  |
| --- | --- |
| **Service\*** | **Actual Volume****(Last 3 Completed FYs)** |
| **FY\*\*** | **FY\*\*** | **FY\*\*** | **CFY\*\*\*** |
| Medical/Surgical |  |  |  |  |
| Maternity |  |  |  |  |
| Psychiatric |  |  |  |  |
| Rehabilitation |  |  |  |  |
| Pediatric |  |  |  |  |
| **Total** |  |  |  |  |

\* Provide the number of discharges for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation,

and Pediatric).

\*\* 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.

**Table D**

Historical and Current PATIENT DAYS

|  |  |
| --- | --- |
| **Service\*** | **Actual Volume****(Last 3 Completed FYs)** |
| **FY\*\*** | **FY\*\*** | **FY\*\*** | **CFY\*\*\*** |
| Medical/Surgical |  |  |  |  |
| Maternity |  |  |  |  |
| Psychiatric |  |  |  |  |
| Rehabilitation |  |  |  |  |
| Pediatric |  |  |  |  |
| **Total** |  |  |  |  |

\* Provide the number of patient days for each service listed (Medical/Surgical, Maternity, Psychiatric,

Rehabilitation, and Pediatric).

\*\* 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.

* 1. Explain any increases and/or decreases in volume seen in the table above.
	2. Complete the following tables for the first three **full** fiscal years (“FY”), for the projected number of discharges and patient days by service (if the first year is a partial year, include that as well).

# TABLE E

Projected DISCHARGES by Service

|  |  |
| --- | --- |
| **Service\*** | **Projected Volume** |
| **FY\*\*** | **FY\*\*** | **FY\*\*** | **FY\*\*** |
| Medical/Surgical |  |  |  |  |
| Maternity |  |  |  |  |
| Psychiatric |  |  |  |  |
| Rehabilitation |  |  |  |  |
| Pediatric |  |  |  |  |
| **Total** |  |  |  |  |

\* Provide the number of discharges for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation,

and Pediatric).

\*\* 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. In a footnote, identify the period covered by the Applicant’s fiscal year FY (e.g. July 1-June 30, calendar year, etc.).

# TABLE F

Projected pATIENT DAYS by Service

|  |  |
| --- | --- |
| **Service\*** | **Projected Volume** |
| **FY\*\*** | **FY\*\*** | **FY\*\*** | **FY\*\*** |
| Medical/Surgical |  |  |  |  |
| Maternity |  |  |  |  |
| Psychiatric |  |  |  |  |
| Rehabilitation |  |  |  |  |
| Pediatric |  |  |  |  |
| **Total** |  |  |  |  |

\* Provide the number of patient days for each service listed (Medical/Surgical, Maternity, Psychiatric,

Rehabilitation, and Pediatric).

\*\* 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. In a footnote, identify the period covered by the Applicant’s fiscal year FY (e.g. July

1-June 30, calendar year, etc.).

* 1. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.