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

a. 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.

b. Explain the specific rationale for the increase in beds at each unit/location, including:

   i. The calculation or other methods by which the proposed increases were determined, clearly identifying all underlying assumptions used;
   ii. The patient population that will be served; and
   iii. The benefits of each proposed increase.

c. 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:
   i. Occupancy rate;
   ii. Average daily census; and
   iii. Variability in census including peak census.

2. Historical & Projected Volume

a. 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.

b. 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.

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

d. 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.).

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