

Budget Review Regulations For Short-Term Acute Care Hospitals Not Exempt From Annual Budget Review

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Sec. 19a-160-100. General purpose

Sections 19a-160-100 to 19a-160-118, inclusive apply to the commission's review of operating and capital expenditure budgets of short-term acute care hospitals under section 19a-156, General Statutes which are not exempt from annual budget review pursuant to section 19a-157, General Statutes.

The purpose of sections 19a-160-100 to 19a-160-118 inclusive is to provide the hospital industry, the public, and other interested parties with descriptive statements of the procedures that the Connecticut commission on hospitals and health care (the commission) will employ in its review and approval of hospital budgets.

The regulations establish and equitably apply presumptively reasonable tests of the financial requirements for each hospital which will be sufficiently informative to permit hospitals to identify in their budgetary processes items which might not be considered presumptively reasonable so that they may be reviewed in greater depth internally by the hospital prior to budget submission. If, after such a review, a hospital nonetheless believes that unusual circumstances exist, it should be prepared to submit additional explanatory material.

The commission recognizes that much of the data used to determine reasonableness will not be available at the time that budgets are submitted owing to the fact that they are developed from material included in the budget submissions. The commission will endeavor to quantify and promulgate the data as soon as possible after the receipt of the budgets.

Nothing in sections 19a-160-100 to 19a-160-118, inclusive should be interpreted as preventing the commission from reviewing any financial requirement in carrying out its mandate under Connecticut laws.

Unless otherwise specified in these regulations, all financial and statistical data submitted to the commission in compliance with these regulations must be prepared in accordance with the following principles:

- (a) **Consistency:** Consistency refers to continued uniformity during a period and from one period to another in methods of accounting, mainly, but not only, in valuation bases and methods of accrual. Any change in accounting procedure which results in lack of consistency and which is material in nature, must be brought to the attention of the commission by way of a cover letter which will accompany the hospital's budget submission and shall include both a description and analysis of the impact such accounting procedure change has on the data submitted. A change is material if it warrants identification in the audited financial statements of the hospital.
- (b) **Depreciation policies:** Straight line depreciation must be used in the reporting of depreciation relating to all assets. The estimated useful life of a depreciable asset is its normal operating or service life. Useful lives of hospital assets shall be based on the most recent American Hospital Association useful life guidelines.
- (c) **Related organization:** Auxiliaries, guilds, fund raising groups and other related organizations frequently assist hospitals. For reporting purposes the finances of these organizations shall be separated from or combined with reports of the hospital in accordance with the American Institute of Certified Public Accountants 1978 exposure draft of a proposed statement of position on modification of reporting principles relating to

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hospital related organizations and funds held in trust by others.
(Effective August 23, 1984.)

Sec. 19a-160-101. Definitions

- (a) The definitions provided by sec. 19a-145, General Statutes and by sec. 19a-160-112 and sec. 19a-160-48(a) through (f) and (i) through (t), of the regulations of Connecticut state agencies, shall govern the interpretation and application of sections 19a-160-100 to 19a-160-118, inclusive.
- (b) Except as otherwise required by the context, the following definitions shall apply to the deliberations of this commission concerning all matters arising under chapter 368c, as applicable.
- (1) Adjusted discharges: Inpatient discharges adjusted to reflect all patient service volumes, including outpatient volumes.
 - (2) Adjusted patient days: Inpatient patient days adjusted to reflect all patient service volumes, including outpatient volumes.
 - (3) Authorized budget: The operating and capital expenditures fiscal plan approved by the commission on hospitals and health care.
 - (4) Authorized budgeted expenses: The net operating budgeted expenses of a hospital that serve as the basis for the commission patient revenue authorization.
 - (5) Bad debts: The uncollectable accounts receivable of the hospital relating to patients from whom reimbursement was expected at the time service was rendered. Bad debts are distinguished from free care, i.e., care for which the hospital does not expect to receive full reimbursement at the time it is provided.
 - (6) Base period: The year prior to the budget year. It is also referred to as the current year.
 - (7) Building and building equipment: Roofs, walls, and attachments to buildings such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. Building equipment is equipment affixed to buildings, not subject to transfer or movement and is used for general purposes rather than specific departmental functions.
 - (8) Board-designated funds: Unrestricted funds available for specific purposes or projects.
 - (9) Budget year: The fiscal period beginning October 1 following the base period.
 - (10) BY: Budget year.
 - (11) Capital expenditures: Expenditures for items which at the time of acquisition have an estimated useful life of at least three years and a purchase price of at least \$500. Such items shall include, but not be limited to the following:
 - (A) Land, buildings, fixed equipment, major movable equipment and any attendant improvements thereto.
 - (B) The total cost of all studies, surveys, designs, plans, working drawings, specifications, and other activities essential to acquisition, improvement expansion or replacement of the plant or equipment in question when such total cost, in aggregate, exceeds \$100,000.
 - (C) Leased assets. Purchase price for leased assets shall be the fair market value at the time of lease.
 - (D) Maintenance expenditures capitalized in accordance with generally accepted accounting principles.
 - (E) Donated Assets. Donations of property and equipment which under generally accepted accounting principles are capitalized at fair market value at the date of contribution.

In addition, capital expenditures shall include expenditures of at least \$1,200 for

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- groups of related items with an expected life of more than three years which are capitalized under generally accepted accounting principles.
- (12) Cluster: A group of cost centers.
 - (13) Contractual allowances: The difference between gross revenue from patients for services rendered and amounts received (or to be received) from third party payors. Contractual allowances are to be distinguished from uncollectable accounts receivable of the hospital, bad debts and free care. For purposes of this definition any allowed differentials are to be considered contractual allowances.
 - (14) Cost center: An expense classification which identifies the salary, nonsalary and depreciation expenses of a specific department or function. In addition, cost centers may be established to identify specific categories of expense such as interest, malpractice, leases, building and building equipment depreciation.
 - (15) Current year: The year prior to the budget year. Also referred to as the base period.
 - (16) CY: Current year.
 - (17) Endowment funds: Funds in which a donor has stipulated, as a condition of his gift, that the principal amount of the fund is to be maintained inviolate and in perpetuity, and that only income from investments of the fund may be expended, (See also term endowments).
 - (18) Expense recoveries: Adjustments made to expenses, based on the income received due to rebates, refunds, and gifts or grants.
 - (19) Factor prices: The difference in salary costs experienced by an individual hospital due to the economic conditions in the geographic area of the hospital compared to those economic conditions which affect all hospitals in Connecticut.
 - (20) Financial requirements: The total monetary elements required by a hospital to implement its authorized operating and capital expenditures budgets.
 - (21) Fixed expenses: Expenses whose magnitude does not vary with volumes.
 - (22) Free care: The difference between the amount of expected reimbursement from charity patients, as defined by hospital board policy, for hospital services rendered, and the amount of the hospital's published charges for such services. Courtesy discounts, contractual allowances, and charges for health care services provided to employees are not included under the definition of free care.
 - (23) Funded depreciation reserves: Patient revenues related to depreciation expense and specifically set aside for the replacement of capital assets [FN1].
 - (24) Funding of depreciation: The assignment of all or a portion of patient revenue related to depreciation expense to a fund to be held in reserve for the purpose of providing funds for future replacement of depreciable assets.
 - (25) Gross revenue from patients: Total patient charges for patient care services.
 - (25a) Health promotion/disease prevention program: A planned, organized initiative designed to avert illness and support behavior conducive to health through health education and other interventions.
 - (26) Inflation factor: The estimated rate of increase or decrease in a hospital's expenses due to anticipated economic conditions in the budget year.
 - (27) Leased asset: See capital expenditure.
 - (28) Major movable equipment: Equipment which usually has a relatively fixed location in the building but is capable of being moved and generally has a function related to a specific cost center.
 - (29) Non-operating revenue: Unrestricted revenue not directly derived from patient care, related patient services, or the sale of related goods and services. Non-operating revenue is further classified as revenue derived from either philanthropic or non-philanthropic sources.
 - (30) Net expense: Gross expenses less expense recoveries which are reported as

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- credits to expense.
- (31) Net patient revenue: Gross revenues from patients less contractual allowances.
 - (32) New or additional debt: Increased financial requirements which result from new or additional borrowing.
 - (33) New or additional program: Any new service or additional function which the hospital is not presently providing.
 - (34) Operating expense: The expenses necessary to maintain the functions of the hospital net of any expense recoveries.
 - (35) Other operating revenues: Revenue from non-patient goods and services. Such revenue is normal to the operation of a hospital but should be accounted for separately from patient revenues. Revenue from gifts, grants or subsidies specified by donor for research, educational or other programs, and, therefore, revenues restricted by the donor or grantor for operating purposes, are considered other operating revenue.
 - (36) Plant replacement and expansion funds: Funds donated for renewal or replacement of plant.
 - (37) Presumptively reasonable budget: The operating or capital expenditures budget of a hospital which meets the criteria set forth in these regulations.
 - (38) Price change: The increase/decrease in gross revenue from patients attributable to a change in total charges per unit of service. With respect to price changes, units of service for the following revenue centers shall be:
 - Adult medical/surgical - Patient days
 - Intensive care/coronary care - Patient days
 - Psychiatric inpatient - Patient days
 - Maternity - Patient days
 - Newborn - Patient days
 - Rehabilitation - Patient days
 - Pediatrics - Patient days
 - Ambulatory surgery - Visits or man minutes
 - Home Care - Visits
 - Outpatient care/clinic services - Visits
 - Private referred - Visits
 - Outpatient psychiatric care - Visits
 - Long-term care - Patient days
 - Alcohol and drug treatment - Patient days
 - Other psychiatric services - Patient days
 - Operating room - Man minutes
 - Recovery room - Occupancy minutes
 - Delivery room - Number of deliveries
 - Diagnostic radiology - RVU'S (Relative Value Units)
 - Physical medicine - Treatment minutes
 - Respiratory therapy - Treatment hours
 - Intravenous therapy - Number of 1000 cc equivalent
 - Pharmacy - Adjusted patient days
 - Medical & surgical supplies - Adjusted patient days
 - Emergency room - Visits
 - Laboratory - RVU'S
 - Anesthesiology - Minutes (salary); or cases (fee)
 - Radioisotopes - RVU'S
 - Radiation therapy - RVU'S
 - Speech and hearing - Treatments
 - ECG - Exams

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EEG - Exams
 Pulmonary function - RVU'S
 Psychiatric/psychological services - Treatments
 Organ retrieval - Number of organs
 Renal dialysis - Treatments
 Occupational/recreational therapy - Treatments
 Routine special services - Patient days
 Diagnostic cardiology - RVU'S
 C.T. Scan - RVU'S

A hospital will be allowed to utilize units or individual procedures other than those specified above, providing the following provisions are met:

- (A) Requests for alternate units or individual procedures must be submitted to the commission 30 days prior to the budget submission;
- (B) All requests must include a description of the alternate statistic proposed and an explanation as to why the proposed statistic is more appropriate.

The commission must respond to requests for use of alternate statistics within 15 days of submission of the request. If the commission agrees on the use of alternate statistics, the hospital will not be allowed to change the units from one year to the next unless prior approval to change is granted by the commission. If the commission does not agree to the hospital's request to use an alternate statistic, the commission shall provide the hospital with its reasons for rejecting the alternate statistic.

- (39) Projected actual budget: A hospital's prediction of the total operating expenses, revenues, and volumes for the base period.
- (40) Proxies: Surrogates of actual hospital expense categories.
- (41) Repayment of debt: Retirement of principal indebtedness.
- (42) Restricted funds: Funds restricted by donors for specific purposes. The term refers to specific purpose and endowment funds.
- (42a) Relative value unit (RVU): A precisely specified quantity with an assigned or calculated numerical weight which reflects the relationship between this quantity and other quantities of like kind.
- (43) Specific purpose funds: Funds restricted externally by a donor, or otherwise, for a specific purpose or project. Board-designated funds do not constitute specific purpose funds.
- (44) Screens: Financial measurements or statistical ratios developed by the commission to determine presumptively reasonable financial requirements.
- (45) Term endowments: Donated funds which by the terms of the gift become available either for any purpose designated by the governing board or for a specific purpose designated by the donor upon the happening of an event or upon the passage of a stated period of time.
- (46) Third party payors: A governmental agency or private corporation that is liable to pay all or a part of the cost of hospitalization or ambulatory service because of statute or a contractual agreement.
- (47) Unrestricted funds: Funds which bear no external restrictions as to use or purpose; i.e., funds which can be used for any purpose as distinguished from funds restricted externally for specific operating purposes, for plant replacement and expansion, or for endowment.
- (48) Variable expenses: Expenses whose magnitude varies with volume.
- (49) Volume: The patient days, admissions, out-patient visits, patient revenues, or other quantitative measures of services rendered by the hospital.
- (50) Volume incentive: A positive or negative adjustment pursuant to section 19a-160-104 of these regulations to recognize the hospital's ability to contain or reduce health care costs through effective utilization of hospital services.

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- (51) Working capital: Current assets (excluding funds committed for the retirement of long term debt) minus current liabilities (excluding the current portion of long term debt). All amounts due to or from other funds are considered as current assets or current liabilities. (The current portion of long term debt is excluded from this definition because it is treated separately in reviewing financial requirements). (Effective December 17, 1984.)

Sec. 19a-160-102. Proposed operating and capital expenditures budgets

- (a) Scope. The procedures herein set forth for the annual review of operating and capital expenditures budgets shall govern only non-governmental short-term acute care hospitals and World War II Veterans' Memorial Hospital.
- (b) Date of filing. Each hospital shall file an original and eight copies of its proposed operating and capital expenditures budget no later than 90 days prior to the commencement of the budget year. The budget year shall represent the fiscal year beginning October 1 and ending the following September 30.
- (c) Special components for budget filing. In addition to the requirements identified in section 19a-160-59(d), (e), and (f), the applicant's proposed budget shall include as special components the following information:
- (1) Notwithstanding the provisions of section 19a-160-59(d)(5), hospitals shall file current fiscal year operating and capital expenditure data based on a minimum of twenty-four weeks' actual experience and a remaining period estimate of anticipated experience for the current year;
 - (2) A cost finding and allocation report which shows gross revenue from patients for each revenue producing cost center along with the operating expenses for each such cost center with a schedule showing the allocation of total costs from the non-revenue producing cost centers to the revenue producing cost centers. In lieu of the foregoing, hospitals may submit an estimated cost finding for the budget year based upon percentages of indirect expenses allocated to revenue producing departments for the last completed fiscal year.
 - (3) Comments from the professional standards review organization(s) regarding the volume of current year and budget year admissions, patient days, outpatient services (visits) and ancillary services.
 - (4) Comments from the health systems agencies regarding the hospital's proposed capital expenditures and compliance with the health system's plan;
 - (5) Identification of expenses relating to teaching, research, and community service programs as well as the amount of patient revenues realized or requested to finance such programs;
 - (6) Statements which address each of the criteria identified in section 19a-153, G.S., as defined in article 3, section 19a-160-48, not addressed in the above as each may relate to the hospital's proposed budget;
 - (7) Any supplemental information necessary to support the hospital's request for financial requirements not considered presumptively reasonable by these regulations.

(Effective August 23, 1984.)

Sec. 19a-160-103. General approach--operating budget

- (a) An overall test of reasonableness will be applied to the total net patient revenue budget of each hospital as described in section 19a-160-104. Where budgeted revenues satisfy required conditions for such approval, as described in section 19a-160-104, the commission will approve the net patient revenue budget without further analysis. Such approval will not imply approval of each individual financial requirement for the purpose of establishing its reasonableness for subsequent review. Where budgeted net revenues do

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- not satisfy such requirements, the commission may modify the budget of the hospital.
- (b) It is not the intent of the commission that the overall test of reasonableness be considered as a budgetary floor for each hospital in the state. Therefore, should a hospital not meet the overall test of reasonableness, it will be subject to all the budget review screens set forth in these regulations. Should the hospital not be able to satisfy the test of overall reasonableness, the commission may authorize a net patient revenue budget less than it would have received had it qualified initially for the overall test of reasonableness.
- (c) Hospital budgets which do not meet the overall test of reasonableness will be subject to the following:
- (1) Analysis of the hospital's expense budget base. The expense budget base will be determined pursuant to subsection B below unless the hospital's CY projected actual expenses are adjusted by applying the unit cost screens described in section 19a-160-105; in such case the expense budget base will be equal to the lower of:
 - (A) The hospital's projected CY actual net operating expenses, less expenses not considered presumptively reasonable by applying the screens described in section 19a-160-105, or,
 - (B) The hospital's net operating expenses which served as the basis for its authorized budget for the current year (CY) adjusted for:
 - (i) Presumptively reasonable differences in volumes between those approved in the CY budget and CY projected actual volumes (as described in section 19a-160-105) and updated inflation levels (as described in section 19a-160-107(f)).
 - (ii) The effects of extraordinary items as described in section 19a-160-104.
 - (2) An analysis of net BY expenses compared with the expense budget base. This analysis will include, but not be limited to, the following factors:
 - (A) Volume and intensity changes from CY to BY, section 19a-160-108.
 - (B) Inflation, section 19a-160-107.
 - (C) Funding of depreciation, section 19a-160-109.
 - (D) Nonvolume related changes, section 19a-160-111.
- (d) Where a hospital's total budgeted expenses are less than the presumptively reasonable total BY expense budget as determined in subdivisions (1) and (2) of subsection (c) of this section, the commission will accept the budgeted expenses as a presumptively reasonable financial requirement. Where the overall expense budget is greater than the presumptively reasonable BY expense budget, the commission in its preliminary decision will provide the hospital with a statement of the items not considered presumptively reasonable.
- The determination by the commission in its preliminary decision that a proposed financial requirement, or a portion thereof, is presumptively reasonable, will neither be binding upon the commission in any further review of the hospital's budget nor excuse the hospital from the requirement that it justify said financial requirement as a necessary one in any such further review. Such justification shall be presented in a manner consistent with the provisions of these regulations.
- (e) Additional reasonableness tests and other evaluations will be applied to the following budgeted financial requirements and sources of funds as described in the indicated sections of these regulations.
- (1) Free care and settlement allowances, section 19a-160-113.
 - (2) Working capital and bad debts, section 19a-160-112.
 - (3) Capital expenditures, section 19a-160-115.

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- (4) Non-operating revenue, section 19a-160-114.
- (5) Net financial effects of differences between CY projected actual and CY budgeted volumes, section 19a-160-105.
- (6) Interest and operating leases, section 19a-160-110.
- (f) After approval of a hospital's revenue budget the hospital will file, in a form and manner acceptable to the commission, a schedule of charges to be effective for the budget year. This schedule is to be accompanied by: a schedule by revenue producing cost center comparing fully allocated costs with gross patient revenues which served as the basis for the authorized budget. In lieu of the foregoing, hospitals may submit an estimated cost finding for the budget year based upon percentages of indirect expenses allocated to revenue producing departments for the last completed fiscal year. (Effective August 23, 1984.)

Sec. 19a-160-104. Overall test of reasonableness

- (a) The commission will find that the hospital's requested net patient revenues in the budget year are presumptively reasonable if the following conditions are met:
 - (1) That net patient revenues for the BY do not exceed the net patient revenues which served as the basis for the current year budget updated for volume and inflation changes by more than the hospital's inflation factor plus two percent plus or minus any volume incentive adjustment.
 - (2) That the proposed percent increase due to price in the BY over the current year authorization does not exceed the hospital's inflation factor as determined in sec. 19a-160-107 of these regulations.
 - (3) That the percent increase in net operating expenses in the BY over the net expenses which served as the basis for the authorized budget in the current year updated for volume and inflation changes, does not exceed the percentage determined in subdivision (1) of this section.
 - (4) That the hospital project not decrease in gross patient revenues in the BY over the current year's authorized gross revenues due to aggregate reductions in the number of discharges, patient days or procedures and the commission agrees with projected CY volumes.
 - (5) In addition to the above, the commission will allow extraordinary items which serve to reduce or increase net patient revenues, net expenses or prices vis-a-vis those of the current year and which might unduly distort year-to-year comparisons.
As examples:
 - (A) If a hospital's current year authorized budget included start-up costs in anticipation of higher volumes, then higher BY volumes should require less than presumptively reasonable increases in expense and revenues;
 - (B) If current year hospital costs are shifted to other providers (e.g. physicians), then BY hospital patient revenue requirements should be commensurately less;
 - (C) If significant changes in non-operating revenues, fund transfers, allowances, etc. are experienced, they should not be used to defray unreasonable increases in other financial requirements.
 - (D) If a carry over of gains/losses from variations in volumes occurs, such carryover should result in lower/greater BY revenue requirements (see sec. 19a-160-116).
 - (E) Justified changes in contractual allowances.
 - (F) If a hospital proposes to initiate a health promotion/disease prevention program which can not be financed through non-patient revenues, then the operating expenses attendant [FN1] to the program will be authorized

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as an extraordinary adjustment to the overall reasonableness test if the hospital demonstrates to the satisfaction of the commission that the proposal meets the following criteria:

- (i) There is evidence that the problem to which the program is addressed is of sufficient magnitude to warrant priority and intervention.
 - (ii) The objective(s) of the program is quantified in terms of the desired achievement of the target population within a specified timeframe.
 - (iii) There is evidence that the method of intervention or modality selected is appropriate to and effective for the target population.
 - (iv) The program is coordinated with other related health promotion/disease prevention efforts in the community.
 - (v) Competent staff and adequate resources are available to implement the program.
 - (vi) The proposal is consistent with the goals and objectives of the state health plan and health systems plan.
 - (vii) A methodology is proposed to evaluate the extent to which the desired outcome is achieved.
 - (viii) The program is cost effective and affordable.
- (6) That the hospital's request satisfies the criteria identified in section 19a-153, G.S.
- (b) The screens and presumptively reasonableness tests described in sections 19a-160-105 to 19a-160-114, inclusive, will not apply to hospitals whose operating budget is approved pursuant to this section. Capital budgets will be reviewed for the hospitals as described in section 19a-160-115.
- (c) At the election of the hospital at the time of its budget submission in any fiscal year, a plus or minus adjustment shall be made pursuant to subsections (a)(1) and (a)(3) to recognize the difference between the hospital's CY authorized budget and the CY authorized budget adjusted for volume. A plus adjustment shall be made whenever the adjusted budget is less than the authorized budget. Conversely, a minus adjustment shall be applied when the adjusted budget exceeds the authorized budget. The plus or minus adjustment shall represent 25% of the percentage difference between the authorized budget adjusted for volume and the original authorization.
- (d) Denial or modification of budget: The commission may modify or deny a budget which is not presumptively reasonable. Such modification shall be in accordance with the criteria set forth in section 19a-153, G.S., and the commission's budget review regulations as issued pursuant to sec. 19a-156(b), G.S., which shall include, but not be limited to, modifications based on the factors set forth in sections 19a-160-105 to 19a-160-115, inclusive.
(Effective August 23, 1984.)

Sec. 19a-160-105. Presumptively reasonable CY (budget base)

- (a) Unless a hospital's net patient revenue budget is approved per sec. 19a-160-104 (overall test of reasonableness) or the hospital was exempt from the budget review process for the current year, the commission will calculate a presumptively reasonable expense budget base pursuant to (2) below unless the hospital's projected actual expenses are adjusted by applying the unit cost screens described in section 19a-160-105; in such case the expense budget base will be equal to the lower of:
- (1) The hospital's projected CY actual net operating expenses, less expenses not considered presumptively reasonable by applying screens as described in subsection (b) of this section, or
 - (2) The hospital's net expense which served as the basis for the authorized budget

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- for the current year adjusted for:
- (A) Differences in volumes between the CY authorized budget and the CY projected actual (as described in subsection (c) of this section).
 - (B) The effects of extraordinary items (as described in section 19a-160-104).
 - (C) Changes due to inflation as described in section 19a-160-107(f).
- (b) The following screens will apply to subdivision (1) of subsection (a) of this section.
- (1) The screens shall apply to projected CY actual net expense, for the departments and/or cost centers listed in subsection (d) of this section, except for:
 - (A) Depreciation on building and building equipment.
 - (B) Interest expense.
 - (C) Malpractice insurance premiums.
 - (D) Physicians' compensation.
 - (2) Prior to the calculation of screens, employee benefits costs shall be allocated to all cost centers other than employee benefits based on each center's percentage of total non-physician and physician employee compensation (excluding physician fees).
 - (3) The screens will be computed on the CY projected actual unit expenses on two levels. The first level screen will be applied in the following cost center clusters (as detailed in subsection (d) of this section) using the units of service indicated:
 - (A) Routine services - patient days.
 - (B) Special services - adjusted discharges.
 - (C) General services - adjusted patient days.
 - (4) In establishing presumptively reasonable limits per unit for each cluster, hospitals will be grouped as set forth in subsection (e) of this section.
 - (5) CY projected actual non-physician compensation including employees benefits, will be adjusted for factor prices. The remaining non-physician costs will be added to the adjusted compensation amount. The resultant sum will be divided by the appropriate unit of service identified in (3), above, to derive unit cost. Unit costs within each cluster for each hospital will be calculated. For each cluster the unit costs will be ranked from high to low within a group. The presumptive reasonable unit cost limits will be established at 105 percent of the median unit costs in each ranking, and in this regard the commission shall take into consideration teaching and research expenses.
 - (6) Where a hospital's CY projected actual non-physician unit costs adjusted for factor price for a given cluster fall below 105 percent of the median unit cost for hospitals in its group, the commission will conclude that said costs are presumptively reasonable.
 - (7) Where a hospital's CY projected actual non-physician unit costs adjusted for factor prices for a given cluster exceed 105 percent of the median unit costs of hospitals in its group, a second level screen will be applied to each cost center within that cluster.
 - (8) The units of service to be used in developing and applying second level screens will be as set forth in subsection (d) below.
 - (9)(A) When a hospital is found to have exceeded both the first and second level screens, the commission shall determine, pursuant to the second level screen, the amount of excess expense for each cost center in the cluster. Excess expense in each cost center is the amount of expense in excess of 105 percent of the median. The aggregate of such amounts in excess will then serve to reduce a hospital's projected actual CY net operating expense as provided in section 19a-160-105(a)(1) of these regulations.

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- (B) The amount of excess expense identified pursuant to the second level screen shall be calculated in terms of the hospital's own dollars. This shall be accomplished by multiplying the cost in excess of the screen by the quotient of the hospital's projected/actual non-physician costs, unadjusted for factor price, divided by the hospital's non-physician costs as adjusted for factor price.
- (c) The following volume adjustments will apply to subdivision (2) of subsection (a) of this section.
- (1) Gross budgeted expenses (before expense recoveries) which served as the basis for the CY authorized revenues, will be adjusted to exclude depreciation, interest, malpractice premiums, and physicians' salaries, all of which are assumed to be totally fixed. All other gross expenses are assumed to be 50 percent fixed and 50 percent variable with volumes for purposes of presumptive reasonableness.
- (2) The net authorized budgeted expense as derived in subdivision (1) of this subsection will be increased or decreased to reflect appropriate volume changes and to reflect change in expense recoveries as reported by the hospital for the CY projected actual versus the authorized level. For this purpose, volume changes are defined as changes in gross patient revenues excluding changes due to price.
- (3) CY projected actual expenses for depreciation, interest, malpractice premiums, and physicians' salaries will be evaluated independently, and reasonable levels of increases or decreases in these expenses over CY authorized levels shall be added to or subtracted from the above expenses adjusted for volume as determined in subdivision (2) of this subsection.
- (d) First level screens shall be applied to the routine, special and general services clusters listed below. Second level screens shall be applied to the individual cost centers listed under these clusters.
- (1) Routine services:
- (A) Adult medical and surgical;
- (B) Intensive and coronary care;
- (C) Psychiatric inpatient;
- (D) Maternity;
- (E) Newborn; well and sick.
- (2) Special services:
- (A) Operating and recovery room;
- (B) Delivery room (deliveries);
- (C) Diagnostic radiology;
- (D) Laboratory;
- (E) Physical medicine;
- (F) Respiratory therapy;
- (G) Intravenous therapy;
- (H) Pharmacy and medical supplies: For the purposes of comparability, all non-salary costs (excluding leases, departmental depreciation, expense recoveries, and physician compensation) in routine services plus operating, recovery and delivery rooms and routine special services shall be reclassified to the pharmacy and medical supplies unit cost center designation;
- (I) Emergency room (emergency room visits);
- (J) Radioisotope.

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- (3) General services:
 - (A) General administration;
 - (B) General accounting and other administrative departments (including but not limited to general accounting, patient billing and collection, admitting inpatient and out-patient, automatic data processing, communication, personnel, public relations and purchasing);
 - (C) Dietary and pay cafeteria;
 - (D) Housekeeping;
 - (E) Laundry and linen;
 - (F) Operation of plant and repairs and maintenance;
 - (G) Medical records;
 - (H) Social services.

The units identified in subsection (b)(3) above will be used for second level screens with the exception of routine service cost centers where the patient days of each cost center will be used, the delivery room where the number of deliveries will be used, and emergency room where the number of emergency room visits will be used.

- (e) Grouping for screening unit costs.

Group A
St. Francis
St. Raphael
Bridgeport

Group B
Norwalk
Waterbury
New Britain
St. Vincent's
Mt. Sinai
St. Mary's
Danbury
Middlesex
Stamford
Lawrence & Memorial

Group C
Greenwich
Manchester
Griffin
Meriden-Wallingford
Bristol
Park City
St. Joseph
Backus
Day Kimball
Charlotte Hungerford
Windham

Group D
Milford
Rockville
Sharon
World War II
Johnson
New Milford
Bradley
Winsted

For purposes of calculating unit costs for hospitals in Group C, above, Newington Children's Hospital will be excluded from the group in order to eliminate the effect of its high unit costs on screens applied to the other Group C hospitals. For purposes of establishing Newington's budget base, Newington's unit cost will be either:

- (1) Evaluated in light of unit costs from comparable children's hospitals, if available, or;
- (2) Adjusted by eliminating costs which are unique to a children's hospital and the remaining unit costs compared to 105% of the Group C hospital's median unit costs.

(Effective August 23, 1984.)

Sec. 19a-160-106. Budget base selection

- (a) For purposes of the commission's preliminary decision for hospitals which did not receive *Current with materials published in Connecticut Law Journal through 09/01/2009*

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- an exemption from the budget review process in the current year, the presumptively reasonable budget base shall be determined pursuant to subdivision (1) below unless the hospital's projected actual expenses are adjusted by applying the unit cost screens described in section 19a-160-105; in such case the expense budget base will be equal to the lower of:
- (1) Net expenses which served as a basis for the authorized budget in the base period adjusted for volume variations, as described in subsection 19a-160-105(c), inflation changes as described in subsection 19a-160-107(f), and extraordinary items described in subsection 19a-160-104(a)(5); or
 - (2) Estimated actual expenses adjusted pursuant to the evaluation of unit cost screens and for the effects of any extraordinary item.
- (b) For purposes of the commission's preliminary decision for hospitals which did receive an exemption from the budget review process in the current year but did not receive an exemption from the budget review process in the most recently completed fiscal year, the presumptively reasonable budget base shall be the lower of:
- (1) The expenses which served as the basis for the exemption and the authorized summary budget for the current year; or,
 - (2) The estimated actual expenses for the current year adjusted pursuant to the evaluation of unit cost screens and for the effects of any extraordinary items; or,
 - (3) The base period expense per equivalent admission specified in sec. 19a-160-137(c)(2) of the commission's regulations multiplied by the number of actual equivalent admissions as defined in sec. 19a-160-132, for the most recently completed fiscal year and the resultant product then adjusted by the hospital's inflation and volume index as defined in sec. 19a-160-131(e), for the current year.
- (c) For purposes of the commission's preliminary decision for hospitals which did receive an exemption from the budget review process in the current year and the most recently completed fiscal year, the presumptively reasonable budget base shall be the lower of:
- (1) The expenses which served as the basis for the exemption and the authorized summary budget for the current year; or,
 - (2) The estimated actual expenses for the current year adjusted pursuant to the evaluation of unit cost screens and for the effects of any extraordinary items; or,
 - (3) The base period expense per equivalent admission specified in sec. 19a-160-137(b)(2) of the Commission's regulations multiplied by the hospital's inflation and volume index as defined in sec. 19a-160-131, of the Commission's regulations for the most recently completed fiscal year and the resultant product then multiplied by the number of actual equivalent admissions, as defined in such regulations, for the most recently completed fiscal year. The amount so derived will be then adjusted by the hospital's inflation and volume index as previously referenced for the current year.
- (d) Should the hospital contest the preliminary decision of the commission the hospital will be required to justify its projected actual expenses in light of its CY authorized expenses, adjusted for volume, as well as its performance in relation to the unit cost screens.
- (1) Should a hospital wish to contest the use of its authorized expenses adjusted for volume, inflation ((a)(1) above) and extraordinary items as a presumptively reasonable budget base in the commission's preliminary decision, the hospital will be required to explain and justify all significant differences (i.e., increases and decreases) between this base and its projected actual expenses by the following categories of expense:
 - (A) volume;
 - (B) inflation;
 - (C) non-volume.

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- (2) Should a hospital wish to contest the use of its projected actual expenses adjusted by unit cost screens, ((a)(2) above) as a presumptively reasonable budget base, the hospital will be required to explain and justify its performance in relation to the unit cost screens.

(Effective August 23, 1984.)

Sec. 19a-160-107. Inflation factor

- (a) The commission views inflation as a broad economic force whose magnitude is beyond the control of the hospital industry. Accordingly, in reviewing hospital budgets it is necessary that the Commission recognize the probable impact of this economic force upon industry costs only to the extent that is generated by factors external to the industry.
- (b) A predictive model will be used to forecast inflation rates in various cost categories. The hospital inflation factor will consist of a composite index to predict the impact of inflation on the cost of hospital services based on consistent proxies of actual hospital expense categories which are, to the extent practicable, external to the hospital industry but comparable thereto. This index will be based on relevant inflation and deflation factors in applicable sectors of the non-hospital economy and will be used to prepare a statistical screen for the comparison of changes in hospital costs.
- (c) Budget year inflation forecasts used by the commission for each expense category shall be based on the most current forecasts of hospital inflation available from the firm preparing forecasts under contract with the federal health care financing administration where consistent with (b) above and shall be issued by the commission and forwarded to the hospitals on or before April 15 of each year. In any hearing held by the commission pursuant to section 19a-160-106 of these regulations, a hospital may contest these forecasts.
- (d) The components, or expense categories of the index, will then be weighed in terms of the proportionate contribution of each component to the total hospital CY projected actual budget to derive that hospital's presumptively reasonable inflation factor.
- (e) The budgeted percentage increase in a hospital's total costs owing to inflation will be considered presumptively reasonable to the extent that it does not exceed its inflation factor. Costs not directly related to changes in the economy, such as approved new programs or services, depreciation, interest, and leased equipment shall be considered separately.
- (f) Each hospital's inflation factor prepared in accordance with subsections (b), (c), (d), and (e) above, shall be updated by the commission during the course of the fiscal year for which it is applied. The commission shall update the current year inflation forecasts by April 15 and forward such updated current year inflation forecasts to the hospitals. Each hospital's current year inflation factor shall then be recalculated using the updated current year inflation forecast weighted in terms of the proportionate contribution of each expense component to the hospital's total CY projected actual gross expenses. The variations between each hospital's original current year inflation factor index and each hospital's updated current year inflation factor shall then be calculated and applied against each hospital's current year authorized net expenses subject to inflation, adjusted for volume changes in accordance with subsection 19a-160-105(c) of these regulations. Notwithstanding the other provisions of this section, for purposes of determining the presumptively reasonable CY budget base pursuant to sec. 19a-160-105 of these regulations, the commission shall adjust the hospital's CY authorized expense and revenue bases upward or downward by the amount of 100% of the dollar variation in non-salary expenses due to inflation and 75% of the dollar variation in salary expenses due to inflation. In any hearing held by the commission pursuant to sec. 19a-160-117 of these

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- regulations the hospital may contest said updated predictive forecast.
- (g) On January 15th the commission shall publish actual composite indices for the prior year based on the actual inflation forecasts and results as determined by the firm preparing forecasts under contract with the federal health care finance administration. Each hospital's inflation factor for the prior fiscal year shall then be recalculated using actual inflation results, weighted by each hospital's prior year actual gross expense components, and then compared to each hospital's most current inflation factor for the prior year and the difference calculated. Each hospital's prior year authorized net expenses subject to inflation shall be increased or decreased by this difference, except for the 75% restriction on the salary adjustment, as described above, and the result added to or subtracted from each hospital's current year authorized net revenue, as appropriate.
- (Effective August 23, 1984.)

Sec. 19a-160-108. Changes due to volume (BY v CY)

Changes in expense due to changes in volumes will be calculated as follows:

- (1) The budget base before expense recoveries, developed pursuant to section 19a-160-106, will be adjusted to exclude depreciation, interest, malpractice premiums and physicians' salaries, all of which are assumed to be totally fixed expenses.
- (2) The adjusted budget base as derived in subdivision (1) of this section will then be increased or decreased to reflect presumptively reasonable variable expenses attendant to volume changes from current year projected actual levels to budget year levels. For this purpose, volume changes are defined as changes in gross patient revenues excluding changes due to price. Presumptively reasonable expenses will be assumed to be 50 percent variable with changes in volume. In lieu of this formula the commission may consider an expense analysis which a hospital may propose for revenue producing departments (including allocated overhead) relating to budgeted volume changes in each department.

(Effective August 23, 1984.)

Sec. 19a-160-109. Funding of depreciation

- (a) Proposed funding of depreciation will be analyzed in relation to existing funds available, such as plant expansion and replacement funds, as well as the hospital's reserve for depreciation.
- (b) For reporting purposes, the hospital is required to establish two separate and distinct funds, one relating to funded major moveable equipment depreciation and one relating to building and building equipment funded depreciation. In the event that the hospital has already established separate funds for major moveable equipment funded depreciation and building and building equipment funded depreciation, the separation of total funded depreciation will be reported on this basis. In the absence of such established separate funds, the establishment of these funds shall be made based upon the percentage relationship of accumulated depreciation attributable to major moveable equipment and building and building equipment to the total of such accumulated depreciation as reported by the hospital for the fiscal year ended September 30, 1980 unless otherwise allowed by the commission. As part of all budget data submissions to the commission pursuant to sec. 19a-156, the hospital is also required to report changes in the balances of these funds as well as the source and application of all monies donated or designated for capital purposes and all monies generated through patient revenues which relate to depreciation expense in the hospital's budget.
- (c) Changes in depreciation from current year authorized levels to budgeted levels will be deemed presumptively reasonable only if such changes are directly associated with certificates of need approved by the commission or items included in the amount of

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approved capital budgets. Changes in depreciation expense associated with capital expenditures not approved under a certificate of need or as part of the amount of a commission authorized capital budget will not be considered presumptively reasonable. (Effective August 23, 1984.)

Sec. 19a-160-110. Interest, operating leases

- (a) Increases and decreases in interest expense from current year authorized levels to budgeted levels will be deemed presumptively reasonable only if such changes are directly associated with any of the following:
- (1) Approved certificates of need
 - (2) Approved capital budgets
 - (3) Increases and decreases in interest rates paid on borrowing levels included in the current year's authorized budget
- (b) Changes in operating lease expense from current year authorized levels to budgeted levels will be deemed presumptively reasonable only if such changes are either:
- (1) Directly associated with the amount of an approved capital budget or approved certificate of need, or
 - (2) Not in excess of current year authorized operating lease expense (not including multi-year fixed payment leases) multiplied by the hospital's budget year authorized inflation factor.
- (Effective August 23, 1984.)

Sec. 19a-160-111. Non-volume

- (a) Where a hospital has budgeted for expense increases that are not volume related, the commission will evaluate such net expense increases in light of the hospital's unit cost performance, first in the cost cluster first level screen and then in the second level cost center screens in which additional expenses are proposed. A hospital's unit costs will then be compared to costs of the same cluster and cost centers in other hospitals. For purposes of this section, hospitals will be grouped in the same manner as set forth in 19a-160-105, subsection (e) and non-physician compensation will be adjusted for factor price.
- (b) For hospitals whose cost cluster first level screen performance is in excess of 95 percent of the median, in the absence of evidence to the contrary, the hospital should finance additional expenses not already covered by the volume adjustments through productivity improvements. Therefore, unit costs of hospitals in excess of 95 percent of the first level cluster screen median will not be considered presumptively reasonable. For hospitals with cost center below 95 percent of the first level cluster screen median, additional costs will be considered presumptively reasonable in cost centers within that cluster whose costs are less than 95 percent of the median of the cost center provided the additional proposed cost does not exceed 50 percent of the difference between the hospital's cost in that cost center and 95 percent of the median of the cost center. For example, if the hospital is below 95 percent of the cluster median for general services and the hospital is at 70 percent of the median in the dietary cost center, and the cost difference in the dietary cost center between 70 percent of the median and 95 percent of the median is \$20,000, the commission will consider an increase in costs in that cost center up to \$10,000 presumptively reasonable.
- (c) Should a hospital not pass the cost center screen, it will be required to justify all its non-volume requests in the cost center. A hospital shall be required to justify why increases up to the amount by which it failed the cost center screen cannot be financed through improvements in internal efficiencies.
- (d) The commission will give special consideration to health promotion/disease prevention programs, as defined in section 19a-160-101 if the hospital demonstrates to the

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commission's satisfaction that the proposal meet the criteria listed in subparagraph 19a-160-104(a)(5)(F) of these regulations.
(Effective August 23, 1984.)

Sec. 19a-160-112. Working capital and bad debts

The commission recognizes that differing accounts receivable write off policies (bad debt policies) will have an effect on a hospital's working capital requirement. For example, a hospital with a policy which requires that uncollected receivables be charged to bad debts after six months will require a greater working capita] requirement than the hospital with a two month write off policy. In recognition of this fact and to ensure equity in the evaluation of budget requests for all hospitals, the commission considers it necessary to evaluate working capital and bad debts, net of recoveries, in aggregate.

- (a) The commission will consider that a hospital's working capital and bad debts, net of recoveries are presumptively reasonable where a hospital's percent of proposed BY working capital and bad debts, net of recoveries, does not exceed 14 percent of the BY gross patient revenues except that where a hospital's proposed percentage relationship of working capital and bad debts, net of recoveries, to proposed gross patient revenue represents an increase in the percentage relationship between current year authorized working capital and net bad debts to current year authorized gross patient revenues, the commission will consider that the hospital's budget request is not presumptively reasonable to the extent of the proposed BY percentage increase in the relationship.
- (b) The hospital's working capital requirement may also be adjusted to reflect other budget modifications which impact on working capital such as, but not limited to, reductions of proposed expenses. Bad debts may also be adjusted to reflect other budget modifications which impact on gross patient revenue.
(Effective August 23, 1984.)

Sec. 19a-160-113. Free care and settlement allowance

- (a) In general, the only free care provision which the commission shall consider as an application of funds will be the charity allowances of the hospital. Persons eligible for such allowances are the medically indigent. Hospitals will be required to file with the budget submission the charity allowance policy approved by the governing body. Such policy shall include the criteria for medical indigence. In addition, the hospital shall be required to furnish information with regard to the mechanism employed to ensure that the policy is communicated to all indigent patients eligible for such allowances as well as its conformance with Hill-Burton or other federal regulations. Changes in free care provisions as a percentage of gross revenue from current year authorized to budgeted levels will be deemed presumptively reasonable only to the extent that they are necessitated by any changes in federal, state, or municipal statutes, regulations or ordinances involving hospital reimbursement (e.g., Hill-Burton, medicare and medicaid regulations, etc.)
- (b) Courtesy allowances are not to be considered as an element of free care. Where a hospital has a self-insured hospitalization program for employees, retirees and their dependents, the charges incurred should be transferred to employee benefits expenses on the basis of the most current and appropriate cost/charge relationship.
- (c) The commission shall also consider as a financial requirement of a hospital settlement allowances which may result from circumstances such as an insurance settlement of liability cases or satisfaction of a lien or encumbrance. The commission will evaluate proposed settlement allowance on an individual basis.
(Effective August 23, 1984.)

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Sec. 19a-160-114. Non-operating revenues

- (a) In order for the commission to evaluate the hospital's forecast of BY non-operating revenues, the hospital shall be required to document that portion of its non-operating revenues which are derived from philanthropy and that portion derived from all other sources. Philanthropic non-operating revenues include unrestricted gifts, contributions and bequests and any unrestricted non-operating income derived from restricted philanthropic principal. Philanthropic contributions and any resultant restricted income are to be reported separately the hospital's non-philanthropic non-operating revenues.
- (b) In its analysis of non-operating revenues, derived from non-philanthropic sources the commission will evaluate the hospital's projections based on available historical and predictive information. Further, the commission will evaluate the hospital's projections for recurring revenue sources. Where the hospital does not realize the amount of non-operating revenue derived from non-philanthropic sources which served as a basis for the budget authorization during the budget period, the hospital may finance the deficiency through borrowing, or request an interim budget adjustment. Where no interim budget adjustment is authorized, the commission may consider an increase in the ensuing year's budget request equivalent to the shortfall. Should a hospital receive non-operating revenue derived from non-philanthropic sources in excess of the authorized, the excess may be applied as a source of revenue in the ensuing year's budget.
- (c) Unrestricted non-operating, non-philanthropic revenue levels shall be considered by the commission as a source of funds to cover non-capital operating expenses in the budget year unless the hospital agrees to restrict these funds for the replacement of capital assets or other uses agreed to by the commission.
(Effective August 23, 1984.)

Sec. 19a-160-115. Capital expenditure budgets

- (a) General: The commission will determine the relationship of applications of funds such as authorized capital expenditures, transfers to board designated funds, and retirement of debt principal to sources of funds such as depreciation, transfers from board designated funds, and commitment to long-term debt. In situations where funding requirements exceed the sources identified, the commission may modify the hospital's request. If the request is modified, any hospital objecting to the modification will be required to justify the proposed use of current patient revenue for plant expansion and replacement purposes.
- (b) Presumptively reasonable capital expenditures budget: The commission shall approve as presumptively reasonable the capital budgets of hospitals proposing the acquisition of capital assets when such budgets satisfy the following:
 - (1) The budget does not exceed the hospital's budget year aggregate major moveable equipment depreciation plus 10 percent and
 - (2) Patient revenues are not required to finance the acquisition of the proposed capital assets [FN1], and
 - (3) No new service, reviewable under section 19a-154, G.S., will be offered as a result of the acquisition of the proposed capital assets, and
 - (4) The commission is satisfied that the hospital's budget request is consistent with provisions of sec. 19a-153, G.S.
- (c) The commission may review all capital expenditure items for new or replacement equipment under the limits set forth in sec. 19a-155 of the General Statutes, as part of the budget submission process and may review capital expenditures for new equipment or replacement capital acquisitions in excess of such limits as part of the capital budget review. Where expenditures for such items are deferred, the commission will entertain appropriate filings under section 19a-155 of the General Statutes.

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(Effective August 23, 1984.)

Sec. 19a-160-116. Compliance

- (a) The following shall apply to hospitals which did not receive an exemption from the budget review process in the current year:
- (1) Where hospital's current year net revenues are in excess of the authorized budget, the net revenue amount in excess of such authorized budget after recognition of volume and inflation variations, is to be considered as a source of funds in the ensuing fiscal year, thus reducing net patient revenues in the ensuing fiscal year unless an alternate use of the funds is approved by the commission as a part of the budget process. Requests for such alternate use must be made to the commission in writing as part of the budget submission. In the event that a hospital proceeds with a commitment or actual application of an alternative use of excess revenues without commission authorization the hospital shall be at risk in the event that the commission finds such alternative use inappropriate as part of the budget process. Beginning with the budget submission for fiscal 1979, hospitals will be required to report as a source of funds in the budget year anticipated revenues in excess of the authorized budget for the current year after recognition of volume and inflation variation consistent with methodology presented in section 19a-160-105 and section 19a-160-108 and after recognition of inflation variations calculated in accordance with the methodology set forth in section 19a-160-107.
 - (2) Upon receipt of current year actual audited data pursuant to section 19a-161, G.S., further adjustment of the revenues and expenses of the authorized BY budget will be made if the CY actual revenues and expenses were above or below the projected actual revenues and expenses adjusted for presumptively reasonable variations attendant to volume changes, as defined in section 19a-160-108(2), under or over projections of inflation described in section 19a-160-107, and changes in the amount of actual non-operating income realized during the current year from non-philanthropic sources. Such adjustment will be made either to the hospital's current year authorized budget or the ensuing year's budget. The hospital's authorized capital expenditures budget shall be reduced by any amount projected to be expended by the hospital in excess of the current year authorized capital expenditures budget (including any modification to the hospital's financial requirements approved pursuant to section 19a-154, 19a-155, or 19a-156(c) of the General Statutes). At the time that the actual expenditures are known, any necessary adjustments will be made to the authorized capital expenditures budget.
 - (3) Where hospital net revenues are less than the authorized budget, the net revenue amount below such authorized budget, after recognition of volume variations and after recognition of inflation variations calculated in accordance with the methodology set forth in section 19a-160-107, is to be considered as an application of funds in the current year's authorized budget or in the ensuing fiscal year, thus increasing gross patient revenues in the current or ensuing fiscal year. Beginning with the budget submission for fiscal 1979, hospitals will be required to report as an application of funds in the budget year anticipated revenues below the authorized budget for the current year after recognition of volume variations and inflation updates consistent with methodology presented in section 19a-160-105 subsection 19a-160-107(f), and section 19a-160-108.
 - (4) In determining mid-year and final adjustments for fiscal periods beginning on or after October 1, 1980, due to volume variations, the results of paragraph (a), (b) and (c) above will be further adjusted for the effects of volume incentive

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- adjustments (19a-160-104), and the effects of volume and inflation on bad debts (19a-160-112), free care and settlement allowances (19a-160-113) and working capital (19a-160-112). The adjustment for working capital will be determined by multiplying the hospital's approved working capital percentage relationship (19a-160-112) by the: (1) ratio of reasonable net expense changes associated with volume changes, as determined in subsection 19a-160-105(c) of these regulations, and (2) the percentage change in the hospital's inflation factor, as described in subsection 19a-160-107(f) of these regulations. The adjustment for bad debts, free care, and settlement allowances will be determined by multiplying the hospital's approved percentage relationship of bad debts, free care, and settlement allowances by gross revenue changes associated with volume changes as determined in subsection 19a-160-105(c) of these regulations, and multiplying the resulting product by the percentage change in the hospital's inflation factor, as described in subsection 19a-160-107(f) of these regulations.
- (5) Beginning with the budget year which starts October 1, 1980, the hospitals shall submit monthly reports to the commission. Such monthly reports shall be submitted no later than the final business day of the month immediately following the reporting period. Such reports shall include the following information: gross routine and special service revenues by service, net expenses, patient days and discharges by service, average staffed beds by service, salaries and fees, and emergency room visits (patient admitted and patient discharged). Service areas for which reports shall be filed pursuant to this subsection are: non-maternity, maternity, newborn, clinic, private referred, and emergency room. Such reports shall include prior year actual and budget year actual data, and shall be submitted on forms supplied by the commission for such purpose.
- (b) In addition, for hospitals which did receive an exemption from the budget review process for the most recently completed fiscal year and either did or did not receive an exemption from the current year's budget review process, the amount by which the hospital realized excess net patient revenues as a result of exceeding its expense per equivalent admission shall be treated as a source of funds in the budget year. The amount of such excess net patient revenues shall be derived as follows:
- (1) The authorized net patient revenues as reported in the hospital's summary budget for the most recently completed fiscal year shall be divided by the net operating budgeted expenses as reported in said summary budget to determine the ratio of patient revenues to expenses;
 - (2) The amount by which the hospital's actual expense per equivalent admission for the most recently completed fiscal year exceeded the base period expense per equivalent admission as adjusted by the hospital's inflation and volume index as defined in sec. 19a-160-131(e) of the commission's regulations for the most recently completed fiscal year shall be multiplied by the actual number of equivalent admission, as defined in sec. 19a-160-132, for the most recently completed fiscal year;
 - (3) The amount of excess expenses derived pursuant to subsection (2) above shall be multiplied by the ratio derived pursuant to subsection (1) above to determine the amount of excess net patient revenues.
- (c) The following shall apply to hospitals which did not receive an exemption from the detailed budget review process in the most recently completed fiscal year (beginning with the fiscal year which starts October 1, 1982) but were exempt from the process in the current year (beginning with the fiscal year which starts October 1, 1983):
- (1) Where a hospital's net revenues for the most recently completed fiscal year are in excess of the authorized budget for that year, the net revenue amount in excess of such authorized budget, after recognition of volume and inflation

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variations, is to be considered as a source of funds in the budget year, in which the hospital fails to qualify for an exemption pursuant to sec. 19a-157, G.S.; and is subject to the provisions of sec. 19a-156, G.S. thus reducing authorized net patient revenues in the budget year unless an alternate use of funds is approved by the commission as a part of the budget process. Requests for such alternate uses must be made to the commission in writing as part of the budget submission. In the event that a hospital proceeds with a commitment or actual application of an alternative use of excess revenues without commission authorization the hospital shall be at risk in the event that the commission finds such alternative use inappropriate as part of the budget process. Hospitals will be required to report as a source of funds in the budget year in which the hospital fails to qualify for an exemption pursuant to sec. 19a-157, G.S.; and is subject to the provisions of sec. 19a-156 G.S. actual revenues in excess of the authorized budget for the most recently completed fiscal year after recognition of volume and inflation variations consistent with the methodology presented in sec. 19a-160-105, sec. 19a-160-107, and sec. 19a-160-108 of the commission's regulations.

In addition, with regard to the hospital's capital expenditures [\[EN1\]](#) budget, where a hospital's actual capital expenditures for the most recently completed fiscal year are in excess of the authorized budget for that year, the capital expenditures budget for the budget year in which the hospital fails to qualify for an exemption pursuant to sec. 19a-157, G.S.; and is subject to the provisions of sec. 19a-156, G.S. will be reduced by the amount expended by the hospital in excess of its authorized budget for the most recently completed fiscal year.

- (2) Where a hospital's net revenues for the most recently completed fiscal year are less than the authorized budget for that year, the net revenue amount below such authorized budget, after recognition of volume and inflation variations, is to be considered as an application of funds in the ensuing budget year. Hospitals will be required to report as an application of funds in the ensuing budget year actual revenues below the authorized budget for the most recently completed fiscal year after recognition of volume variations and inflation updates consistent with the methodology presented in sec. 19a-160-105, sec. 19a-160-107, and sec. 19a-160-108 of the commission's regulations.
- (3) The results of paragraphs (1) and (2) above will be further adjusted for the effects of volume incentive adjustments (19a-160-104), and the effects of volume and inflation on bad debts (19a-160-112), free care and settlement allowances (19a-160-113), and working capital (19a-160-112). The adjustment for working capital will be determined by multiplying the hospital's approved working capital percentage relationship (19a-160-112), by the: (1) ratio of reasonable net expense changes associated with volume changes, as determined in subsection 19a-160-105(c) of the commission's regulations, and (2) the percentage change in the hospital's inflation factor, as described in subsection 19a-160-107(f) of the commission's regulations. The adjustment for bad debts, free care, and settlement allowances will be determined by multiplying the hospital's approved percentage relationship of bad debts, free care, and settlement allowances by gross revenue changes associated with volume changes as determined in subsection 19a-160-105(c) of the commission's regulations, and multiplying the resulting product by the percentage change in the hospital's inflation factor, as

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- described in subsection 19a-160-107(f) of the commission's regulations.
- (d) In order that the commission may carry out the adjustments to authorized budgets, as allowed in subsections (a), (b), and (c), above, each hospital subject to the provisions of section 19a-161 of the Connecticut General Statutes must submit to the commission, on or before February 28, 1982 and annually thereafter, on forms supplied by the commission, the hospital's actual experience for the most recently completed fiscal year. Should a hospital propose an alternate use of funds, as explained in subsection (a) of this section, it must submit to the commission with the filing of these forms a written request for such an alternative use of funds.
(Effective August 23, 1984.)

Sec. 19a-160-117. Public hearing: budget modification

- (a) Pursuant to the provisions of sec. 19a-156(a), G.S. the commission shall hold a public hearing if after it denies or modifies a hospital's budget the hospital contests the commission's decision. In addition to the provisions governing hearings defined in sec. 19a-160-36 through sec. 19a-160-46 of the commission's regulations, the following shall apply:
- (1) Designation of hearing panel: The chairman shall appoint a hearing panel consisting of a commission member or members to evaluate relevant data and information related to the hospital's budget request.
 - (2) Prefiled testimony: Notwithstanding the provisions of sec. 19a-160-40(e) a hospital shall prefile an original and seven copies of testimony to be offered prior to the public hearing on such date as the commission shall direct, which date shall not be more than three (3) business days before such hearing. No prefiling of testimony shall be required unless the hospital receives at least five (5) business days notice in advance of the prefiling date.
 - (3) Pagination: The hospital shall paginate all budget submissions, prefiled testimony, and any late filed materials required by the commission.
 - (4) The commission's evaluation of a hospital's budget shall be based on, but not limited to, the results of the presumptively reasonable evaluations specified in sections 19a-160-100 through 19a-160-118 of these regulations as well as additional evidence presented at the public hearing.
(Effective December 17, 1984.)

Sec. 19a-160-118. Interim adjustments

- (a) Each hospital subject to the provisions of sec. 19a-156 of the Connecticut General Statutes shall be required to comply with the operating and capital budgets authorized by the commission. If in the course of the budget year, unforeseen [FN1] and material changes occur, the hospital should request adjustment of its previously authorized budget pursuant to section 19a-156(c), G.S.
- (b) As used in this section, unforeseen and material is defined to include:
- (1) Adjustments, other than for inflation, to the hospital's capital expenditures or operating budgets as a result of the commission's approval or modification of an application submitted pursuant to Connecticut General Statutes sec. 19a-154 or 19a-155.
 - (2) Increases or decreases, of more than 1% other than for inflation, in the financial requirements which served as the basis for the hospital's authorized operating budget or any increase of more than 1% in its capital expenditures budget attributable to:
 - (A) Acts of God;
 - (B) Compliance with any federal, state or local laws, statutes, ordinances, regulations passed or enforced after submission of the hospital's budget;

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- (C) Disaster losses in excess of insurance or extraordinary costs related to disaster losses not covered by outside sources and not known at the time of the budget authorization;
- (D) The correcting of deficiency citations issued for failure to comply with mandated government requirements related to hospital licensure and participation in programs pursuant to 42 U.S.C. sec. 395, et seq. and unknown to the hospital at the time of its budget authorization.
- (3) Any increase or decrease in the financial requirements which served as the basis for the hospital's authorized operating budget or any increase in the hospital's authorized capital expenditures budget as a result of an increase in the volume, as defined in section 19a-160-108 of these regulations, and which served as the basis for the hospital's authorized operating budget, in excess of 2%.
- (4) Any increase or decrease in the financial requirements which served as the basis for the hospital's authorized operating budget as the result of a change in volume, as defined in section 19a-160-108 of these regulations, which would result in the hospital exceeding the commission's presumptively reasonable fixed/variable formula set forth in section 19a-160-105 of these regulations.
- (5) Any other increase or decrease in the financial requirements which served as the basis for the hospital's authorized operating budget or any increase in the hospital's authorized capital expenditures budget determined by the commission to be unforeseen and material.
- (c) Any request for such budget adjustment shall include:
 - (1) The intended date of implementation;
 - (2) An explanation of the alterations in operating and/or capital budget items that the applicant proposes to place in effect during the current fiscal year, including supporting detail set forth in relation to the cost or revenue center affected;
 - (3) An explanation of the increases or decreases in rates and charges that the applicant proposes to make effective upon adoption of the proposed revised budget for the current fiscal year. Such explanation shall set forth the changes in net revenue, by revenue center, due to the proposed revised budget;
 - (4) All pertinent statistical or other data that the applicant deems necessary to support the request.

All of the above shall be prepared and presented by the applicant in a format acceptable to the commission.
- (d) Such requests to adjust approved budgets must be filed with the commission no later than seventy-five days prior to the intended date of implementation of the proposed revised budget for good cause shown the commission may waive the 75 day advance filing requirement.
- (e) All requests pursuant to this section shall be evaluated for reasonableness by applying these regulations and the criteria set forth in section 19a-153, G.S.
- (f) No later than forty-five days prior to the hospital's intended date of implementation of a revised budget, the commission shall notify the hospital in writing of its approval, denial or modification of the proposed revised budget. Should the commission modify or deny the budget revision request, it shall hold a hearing if within ten days of such notification the hospital requests such a hearing. Within thirty-five days after the close of the hearing the commission shall make a final decision and notify the hospital in writing. No later than thirty days after receipt of the final decision, the hospital must submit to the commission a revised schedule of charges and supporting budget forms which reflect the decision. (Effective August 23, 1984.)

Sec. 19a-160-119. Annual reporting to the commission

- (a) Applicability: Each hospital and any other health care facility or institution which
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submitted a budget under the provisions of Sec. 19a-156, General Statutes, or was issued a rate order pursuant to the provisions of Sections 19a-165 to 19a-166, inclusive, General Statutes, shall report with respect to its operations in the prior fiscal year by February 28th of each year.

(b) Content of Annual Report: The annual report shall consist of:

- (1) Financial statements and all related schedules and footnotes and in addition a separate report verifying the implementation of the authorized rate order, where applicable, for the most recently completed fiscal year which have been audited and certified to by an independent auditor or auditing firm;

For purposes of the annual report to be filed on February 28, 1988, the rate order verification shall be limited to the authorized rates for nonexempt inpatient services.

- (2) The Medicare Cost Report for the most recently completed fiscal year;
- (3) The most recent internal chart of organization for the facility, duly dated;
- (4) The most recent legal chart of corporate structure for the facility, duly dated;
- (5) The audited Blue Cross Report for the most recently completed fiscal year or a comparable report acceptable to the Commission;
- (6) A listing of capital expenditures as defined as §19a-160-101 of the Commission's regulations for the most recently completed fiscal year distinguishing between capital expenditures requiring authorization pursuant to Sec. 19a-154 and Sec. 19a-155, General Statutes, and all other capital expenditures;

This listing shall be in a format consistent with that required by the Commission for the applicable year's annual budget or rate order filed pursuant to Sec. 19a-156 or Sec 19a-165 to Sec. 19a-166, General Statutes.

- (7) Number of discharges and related number of patient days by town of origin, based on zip codes, and diagnostic category for the most recently completed fiscal year accounting for 100 percent of total discharges and related patient days;

Discharges from a town of origin based on zip codes which represent less than five percent of total discharges in a given diagnostic category may be aggregated provided that distinction is made between in state and out-of-state towns of origin for such discharges and related patient days.

- (8) Average length of stay and length of stay range by diagnostic category, age grouping and expected pay source;
- (9) Total number of discharges to home, to home health agency, another hospital, a skilled nursing facility, an intermediate care facility and all others;
- (10) Inpatient surgical procedures by diagnosis, principal surgical procedure and age grouping with related number of cases and patient days;
- (11) Number of total licensed beds and distribution of such beds by service, e.g., adult medical and surgical, maternity, pediatrics, newborn, psychiatric inpatient, rehabilitation, etc.;
- (12) Average number of staffed beds by service;
- (13) Average percent occupancy by service based on licensed bed distribution, (11) above, and staffed beds, (12) above.

An explanation of the derivation of patient days by service should be included, e.g., aggregation of midnight census counts for the fiscal year.

- (14) Effective February 28, 1986, and annually thereafter, the following shall also be included in the Annual Report for the most recently completed year:

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- (A) Outpatient surgical procedures including ambulatory surgery as defined in Sec. 19a-160-131(b) by principal surgical procedure and age grouping with related number of cases.
 - (B) Number of outpatients receiving: cardiac catheterizations, CT scans, and diagnostic testing in radiology department special procedures rooms:

Outpatient diagnostic testing with digital subtraction angiography capability should be included in the number of special procedures.
 - (C) Number of patients receiving pre-admission testing.
- (c) Determination of diagnostic categories and age groups

By January 1, 1985 and by December 1, 1985, the Commission shall advise those health care facilities and institutions subject to the provisions of this section of the diagnostic categories and age groupings to be used for fiscal years ending 1984 and 1985, respectively. By August 1, 1985, and annually thereafter the Commission shall advise such health care facilities and institutions of any changes to the diagnostic categories and age groupings to be used. Any such changes shall be applicable to the ensuing fiscal year.

(Effective February 24, 1988.)

Sec. 19a-160-120. [TRANSFERRED]

(Transferred to 19a-643-25, effective February 26, 1999.)

Sec. 19a-160-121 to 19a-160-129. [RESERVED]