

**Certificate of Need****Certificate of Need****Sec. 19a-613-1. Description**

The Office of Health Care Access (OHCA) division of the Department of Public Health derives its authority primarily from Chapter 368z of the Connecticut General Statutes. The powers of the Office are vested in and exercised by a deputy commissioner of Public Health, appointed as provided in section 19a-612d of the Connecticut General Statutes.

(added effective April 9, 2013)

**Sec.19a-613-2. Function**

The Office of Health Care Access is generally empowered to exercise specified grants of authority over the establishment and operation of health care facilities as defined in section 19a-630 of the Connecticut General Statutes. The Office is responsible for preparing the Statewide Health Care Facilities and Services Plan, administering the certificate of need process and collecting inpatient discharge data and financial data from hospitals.

(added effective April 9, 2013)

**Sec.19a-613-3. Official Address and Hours**

The principal office of the Office of Health Care Access is located at and all communications should be addressed to the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P. O. Box 340308, Hartford, CT 06134-0308. The office is open from 8:30 a.m. to 4:30 p.m. Monday through Friday except legal holidays.

(added effective April 9, 2013)

**Sec.19a-613-4. Public Information**

The public may inspect the regulations, decisions and all public records of the Office of Health Care Access at its office. Written requests for public information shall be filed on the Freedom of Information request forms available on the Office's website.

(added effective April 9, 2013)

**Sec.19a-630-1. Certificate Of Need**

Definitions. As used in sections 19a-630-1 to 19a-653-4, inclusive, of the Regulations of Connecticut State Agencies:

- (1) "Acquisition" means the acquisition through purchase, lease, donation or other comparable arrangement of a computed tomography scanner, magnetic resonance imaging scanner, positron emission tomography scanner, positron emission tomography-computed tomography scanner, linear accelerator or equipment that utilizes technology that has not previously been utilized in the state;
- (2) "Central Service Facility" means a health care facility or institution, person or entity engaged primarily in providing services for the prevention, diagnosis or treatment of human health conditions, serving one or more health care facilities, practitioners or institutions and satisfying the criteria for a central service facility as discussed in section 19a-630-2 of the Regulations of Connecticut State Agencies;
- (3) "Day", unless specified otherwise in statute or regulation, means a calendar day;
- (4) "Freestanding Emergency Department" means an emergency department that is not located on the main campus of a hospital and is held out to the public (by name, posted signs, advertising or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment;

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- (5) "Interventional cardiology" means non-surgical procedures used in the treatment of coronary artery and peripheral vascular disease and performed in the cardiac catheterization laboratory. Procedures include, but are not limited to, angioplasty, valvuloplasty, cardiac ablation, coronary thrombectomy, and congenital heart defect correction;
- (6) "Office" or "OHCA" means the Office of Health Care Access division of the Department of Public Health, as established by section 19a-612 of the Connecticut General Statutes;
- (7) "Provider" means any person or entity that provides health care services;
- (8) "Psychiatric residential treatment facility" means a psychiatric residential treatment facility as defined in 42 CFR 483.352.

(added effective April 9, 2013)

**Sec. 19a-630-2. Criteria For Determining If An Entity Is A Central Service Facility**

- (a) An entity shall be a central service facility if it meets one or more of the following criteria:
  - (1) The entity is institutional in nature and practice;
  - (2) Patient care is or may be the responsibility of the entity rather than of the individual physicians or practitioners;
  - (3) Nonmedical personnel, owners or managers can or may be able to influence the operation of the entity to a significant degree;
  - (4) With the exception of practicing physician groups, the entity that is or may be providing services for the prevention, diagnosis or treatment of human health conditions to two or more providers;
  - (5) The owner, partner or manager of an entity as described in subdivision (4) of this subsection is a physician who is not practicing medicine at the entity; or
  - (6) A partnership with general and managing partners exists.
- (b) In determining whether a particular entity meets any of the criteria in subsection (a) of this section, the commissioner, commissioner's designee or deputy commissioner may consider the following:
  - (1) Whether the entity is or may be licensed or designated as any type of health care facility or institution by the department;
  - (2) Whether the patients have any prior familiarity with the physician or practitioner or any ongoing relationship with the physician or practitioner;
  - (3) Whether services such as laboratory, pharmacy, x-ray, linear accelerator and imaging, are or may be available with no free choice of the provider of such services by the patient;
  - (4) Whether the entity can continue to function even if the license of its physician or physicians has, have been or may be suspended or revoked, since the entity can simply retain another physician or practitioner;
  - (5) Whether bills and charges are or may be determined by the entity rather than the individual physicians or practitioners who provide the care or the service;
  - (6) Whether income distribution is or may be determined by the entity rather than entirely by the individual physicians or practitioners who provide the care of service;
  - (7) Whether there are present interlocking relationships, corporate relationships or entities with other health related corporate relationships, entities or properties;
  - (8) Whether the location and services provided are a small part of a larger entity; and
  - (9) Any other information the commissioner, commissioner's designee or deputy commissioner deems relevant or pertinent.

(added effective April 9, 2013)

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**Certificate of Need****Sec. 19a-638-1. Increase In Operating Rooms**

Any outpatient surgical facility that increases the number of its operating rooms on and after October 1, 2010, shall file a notification with the Office indicating the date on which the operating rooms were added, the number of its operating rooms added and the total number of operating rooms including the new operating room or operating rooms.

(added effective April 9, 2013)

**Sec. 19a-638-2. Establishment Of Cardiac Services**

Interventional cardiology procedures that are authorized pursuant to a certificate of need may be performed by a health care facility or provider and several procedures may be authorized under one certificate of need. A facility that is authorized to provide open heart surgery is authorized to provide all of the interventional cardiology procedures listed in section 19a-630-1(5) of the Regulations of Connecticut State Agencies.

(added effective April 9, 2013)

**Sec. 19a-638-3. Replacement Of Imaging Equipment**

Any health care facility, person or provider that replaces equipment shall notify the Office of the date on which the equipment was replaced and the disposition of the replaced equipment pursuant to section 19a-638 of the Connecticut General Statutes. The notification shall also include the docket number of the certificate of need or certificate of need determination. The Office shall place the notification in the original file for the corresponding docket number.

(added effective April 9, 2013)

**Sec. 19a-638-4. Determinations**

All requests for determinations as to whether a certificate of need is required shall be submitted to the Office on a Determination Form, which is available on the Office's website. The Office shall not review a request for determination until a complete form has been submitted and all required information has been provided to the Office. Requests for determination may be submitted electronically in PDF format or via facsimile.

(added effective April 9, 2013)

**Sec. 19a-639a-1. Public Notification Of Certificate of Need Application**

Pursuant to section 19a-639a of the Connecticut General Statutes, not later than twenty days prior to the submission of a certificate of need application, the applicant shall publish notice that an application is to be submitted in a newspaper having substantial circulation in the area where the project is to be located. An applicant shall file the application not later than ninety days after publishing notice. The notice shall contain the following information:

- (1) A statement that the applicant is applying for a certificate of need pursuant to section 19a-638 of the Connecticut General Statutes;
- (2) A description of the scope and nature of the project;
- (3) The street address where the project is to be located; and
- (4) The total capital expenditure for the project.

(added effective April 9, 2013)

**Sec. 19a-639a-2. Newspapers with Substantial Circulation In Town Where Project Is To Be Located**

A list of towns in Connecticut and the corresponding newspapers of substantial circulation in each town are available on the Office's website. The Office will update the list as necessary.

(added effective April 9, 2013)

**Sec. 19a-639a-3. Certificate of Need Application**

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- (a) The application shall consist of the following:
- (1) The appropriate application form which should be filled out in its entirety and all supporting documents should be attached to the application and referenced as either an attachment or exhibit in the order in which they appear in the application for the specific type of proposal, as follows, which are available and may be downloaded from the Office's website:
    - (A) Establishment of a new health care facility as defined in section 19a-630 of the Connecticut General Statutes;
    - (B) Establishment of an outpatient surgical facility;
    - (C) Establishment of a freestanding emergency department;
    - (D) Transfer of ownership of a health care facility;
    - (E) Termination of inpatient or outpatient services by a short-term acute care general hospital or children's hospital;
    - (F) Termination of surgical services by an outpatient surgical facility or a facility that provides outpatient surgical services as part of the outpatient surgery department of a hospital pursuant to section 19a-638 of the Connecticut General Statutes;
    - (G) Termination of an emergency department by a short-term acute care general hospital;
    - (H) Establishment of cardiac services;
    - (I) Acquisition of any of the equipment enumerated in section 19a-638 of the Connecticut General Statutes;
    - (J) Increase in licensed bed capacity; and
    - (K) Increase in operating rooms by an outpatient surgical facility pursuant to section 19a-638 of the Connecticut General Statutes.
  - (2) A copy of the notice of the certificate of need application demonstrating that such notice was published for at least three consecutive days in a newspaper having substantial circulation in the town in which the project is going to be located pursuant to section 19a-639a of the Connecticut General Statutes;
  - (3) A description of the project setting forth the proposal in as much detail as possible. The description shall reference the applicable requirement for a certificate of need under section 19a-638 of the Connecticut General Statutes;
  - (4) The specific location of the facility, service or equipment;
  - (5) A detailed description of how the proposal relates to each of the guidelines and principles enumerated in section 19a-639 of the Connecticut General Statutes and any supporting documentation; and
  - (6) All other information as required by the specific application form, which is available on the Office's website.
- (b) One original and four copies of the application shall be submitted to the Office at 410 Capitol Avenue, MS#13HCA, Hartford, CT 06134. The application shall be accompanied by the five hundred dollar filing fee pursuant to section 19a-639a of the Connecticut General Statutes. If the application including attachments or exhibits does not exceed fifty pages, it may be filed electronically in accordance with subsection (c) of this section.
- (c) Applications not exceeding fifty pages may be filed electronically in PDF format. All applications exceeding fifty pages must be filed in accordance with subsection (b) of this section.
- (d) Applications shall be deemed received on the date and time at which the Office receives the document or the complete electronic version of the document. Any documents received after normal business hours shall be deemed received on the following business day.

(added effective April 9, 2013)

**Sec. 19a-639a-4. Certificate Of Need - Completeness Review**

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- (a) Pursuant to section 19a-639a of the Connecticut General Statutes, the Office shall have thirty days to review the application and request additional information as necessary to complete the application. The applicant shall have sixty days from the date of the request to provide responses to the request for additional information and said responses may be filed electronically in PDF format or via facsimile. If the applicant fails to respond within the sixty day time frame, the application shall be deemed withdrawn in accordance with section 19a-639a of the Connecticut General Statutes.
  - (b) Upon receipt of the responses, the Office shall have thirty days to review the responses and make a determination with respect to whether the application is complete or if further information is needed. If additional information is sought, the applicant shall have another sixty days to respond. If the applicant fails to respond within the sixty day time frame, the application shall be deemed withdrawn in accordance with section 19a-639a of the Connecticut General Statutes.
  - (c) The review cycle described above shall continue until the Office deems an application complete.
- (added effective April 9, 2013)

**Sec. 19a-639a-5. Certificate Of Need Review Period**

- (a) Pursuant to section 19a-639a of the Connecticut General Statutes, the ninety day review period for a completed application shall begin on the date the Office posts notice of the completed application on its website. No later than seven days after the thirty day review period for completeness has expired, the Office shall post notice of the completed application on its website. The Office shall also provide notice to the applicant that its application is complete via first class mail, facsimile or electronic mail and this notice shall include the date on which the ninety day review period expires. The posting on the Office website shall serve as notice to any interested members of the public.
  - (b) Extensions of the Review Period
    - (1) The Office may extend the review period for good cause for a total of sixty days in accordance with section 19a-639a of the Connecticut General Statutes. If the Office extends the review period, the Office shall provide notice to the applicant that review has been extended via first class mail, facsimile or electronic mail and this notice shall include the date on which the review period expires.
    - (2) Where a public hearing is held pursuant to section 19a-639a of the Connecticut General Statutes, the review period shall be extended for another sixty days after the date on which the public hearing record is closed. The Office shall notify the applicant of the date on which the public hearing record is closed via first class mail, facsimile or electronic mail and this notice shall include the date on which the review period expires.
- (added effective April 9, 2013)

**Sec. 19a-639a-6. Notice Of Public Hearing**

The Office shall provide notice of the date, time and place of the public hearing in a newspaper having substantial circulation in the town in which the project is to be located not less than two weeks prior to the date of the hearing pursuant to section 19a-639a of the Connecticut General Statutes. The Office shall also provide a copy of the notice via first class mail, facsimile or electronic mail to the applicant and any individuals or entities that have requested a hearing pursuant to section 19a-639a of the Connecticut General Statutes. Additionally, the Office shall post the notice of public hearing on its website.

(added effective April 9, 2013)

**Sec. 19a-639b-1. Expiration and Extension Of Certificate Of Need**

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- (a) A certificate of need shall expire two years from the date of issuance by the Office unless the applicant has requested an extension of the certificate of need at least thirty days in advance of the expiration of the certificate of need pursuant to section 19a-639b of the Connecticut General Statutes.
- (b) At a minimum, a request for an extension of a certificate of need shall contain the following:
  - (1) A detailed description of any change in the cost, configuration, services or scope of the project;
  - (2) A detailed description and documentation of any progress on the project including preparation of construction drawings, securing of necessary funds and building permits and commencement of any construction;
  - (3) An estimated timetable for commencement and completion of all remaining components of the project; and
  - (4) Documentation of an extenuating circumstance, including, but not limited to, delays occasioned by negotiations with vendors or contractors, beyond the control of the applicant that prevented the applicant from completing the project by the expiration date.
- (c) The following criteria shall be used to determine whether an extension will be granted to the applicant:
  - (1) Site procurement: The applicant shall have made progress toward permanent acquisition of the intended site for the project.
  - (2) Financial status: The applicant shall be able to provide documentation regarding finalizing any necessary loans or lease purchase arrangements.
  - (3) The applicant shall provide reasonable assurance that the project will be under construction or implemented within the requested extension time frame.

(added effective April 9, 2013)

**Sec. 19a-639b-2. Non-transferability Of The Certificate Of Need**

A certificate of need is non-transferable. A certificate of need or rights thereunder may not be sold, assigned, leased, transferred, mortgaged, or pledged. Any attempt to transfer a certificate of need shall result in the immediate voiding of the certificate of need.

(added effective April 9, 2013)

**Sec. 19a-639c-1. Relocation Of A Health Care Facility**

- (a) Pursuant to section 19a-639c of the Connecticut General Statutes, any health care facility that proposes to relocate its facility, shall submit a letter requesting that the Office make a determination as to whether a certificate of need is required. A form for the relocation of a health care facility, which shall be submitted with such letter, is available on the Office's website.
- (b) Based upon the information submitted by the applicant, the Office shall determine whether there has been substantial change in the payer mix or the population served by the health care facility that proposes to relocate. The applicant shall provide the percentages of total patient volume by payer source prior to the relocation and following the relocation.

(added effective April 9, 2013)

**Sec. 19a-639c-2. Certificate Of Need For Relocation**

Any health care facility that proposes to relocate its facility and is unable to demonstrate to the satisfaction of the Office that the relocation will not result in a substantial change in the payer mix or population served shall file a certificate of need for the establishment of a new health care facility pursuant to section 19a-638 of the Connecticut General Statutes.

(added effective April 9, 2013)

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**Certificate of Need****Sec. 19a-639e-1. Termination Of A Health Care Facility**

- (a) Any health care facility that was authorized through a certificate of need shall provide notice that it is terminating services not later than sixty days prior to the termination. The notification shall contain the following:
- (1) The name and location of the health care facility;
  - (2) Reason for closing the facility;
  - (3) Other facilities where patients may be able to obtain the services that are currently provided by the facility that intends to close; and
  - (4) Date on which the facility will be closed.
- (b) Any health care facility that was not authorized through a certificate of need and intends to close the facility shall notify the Office not later than sixty days prior to the termination of the facility. The notification shall contain the following:
- (1) The name and location of the health care facility;
  - (2) Reason for closing the facility that intends to close;
  - (3) Other facilities where patients may obtain the services that are currently provided by the facility that intends to close; and
  - (4) Date on which the services will no longer be provided or on which the facility will be closed.

(added effective April 9, 2013)

**Sec. 19a-639e-2. Termination Of Services Provided By A Health Care Facility**

- (a) Unless otherwise required to file a certificate of need application pursuant to the provisions of section 19a-638 of the Connecticut General Statutes, any health care facility that intends to terminate a service or services which were authorized pursuant to a certificate of need shall file a modification of the original certificate of need on the forms available on the Office's website. The applicant shall provide the following information to the Office:
- (1) The service or services that the facility will no longer provide;
  - (2) The reasons that the facility will no longer provide the service or services;
  - (3) Other facilities where the patients may obtain the service or services which the facility will no longer provide; and
  - (4) The date on which the service or services will be terminated.
- (b) Any health care facility that intends to terminate a service or services which were not authorized pursuant to a certificate of need shall notify the Office not later than sixty days prior to the termination of the service or services. The notification shall contain the following:
- (1) The service or services that the facility will no longer provide;
  - (2) The reason that the facility will no longer provide the service or services;
  - (3) Other facilities where the patients may obtain the service or services which the facility will no longer provide; and
  - (4) The date on which the service or services will be terminated.

(added effective April 9, 2013)

**Sec. 19a-643-207 Rules Of Practice**

The Office of Health Care Access division of the Department of Public Health shall follow the Rules of Practice under section 19a-9-1, et seq., of the Regulations of Connecticut State Agencies.

(added effective April 9, 2013)

**Certificate of Need****Sec. 19a-643-208 Consolidation Of Proceedings**

Proceedings involving related questions of law or fact may be consolidated at the direction of the commissioner, the commissioner's designee or a presiding officer.

(added effective April 9, 2013)

**Sec. 19a-653-1. Notification Of A Civil Penalty**

The commissioner or the commissioner's designee, prior to the imposition of any civil penalty under section 19a-653 of the Connecticut General Statutes, shall notify any facility, institution or person subject to such civil penalty in accordance with section 19a-653 of the Connecticut General Statutes.

(added effective April 9, 2013)

**Sec. 19a-653-2. Civil Penalty – Request For Hearing**

Pursuant to section 19a-653 of the Connecticut General Statutes, any health care facility or person to whom the notice of civil penalty was addressed may request a hearing to contest the imposition of the civil penalty. The Office shall notify the health care facility or person of the date, time and place of the hearing, not later than ten days after the Office's receipt of the request.

(added effective April 9, 2013)

**Sec. 19a-653-3. Civil Penalty – Request For Extension Of Time**

- (a) A request for an extension of time within which to file required data or information shall contain the following:
- (1) The reason why the health care facility or person was unable to comply with the original due date; and
  - (2) The date on which the information or data will be filed.
- (b) In reviewing the request for an extension of time, the Office shall consider the following:
- (1) Any extenuating circumstances that prevented compliance with the original due date;
  - (2) Demonstration of a good faith effort to comply with the appropriate statute, act, order, or regulations;
  - (3) Past history of compliance with the submission of data or information requirements;
  - (4) The length of the delay in filing;
  - (5) The degree of incompleteness or inaccuracy; and
  - (6) Any other relevant criteria.
- (c) If the request for an extension of time is granted, it shall be granted to a date certain. Failure to submit the required data or information by that extended date may result in the imposition of a civil penalty beginning on the day after the extended due date. The civil penalty shall become effective upon the expiration of the time extension and OHCA shall provide notice of the same to the person or health care facility.

(added effective April 9, 2013)

**Sec. 19a-653-4. Rescission Of Civil Penalty**

Upon receipt of the data or information or the filing of a certificate of need, the Office may rescind the civil penalty in whole or in part.

(added effective April 9, 2013)

**Certificate of Need****Sec. 19a-643-1 to 19a-643-110 [Repealed]**

(Repealed effective April 9, 2013)

**Sec. 19a-643-111 to 19a-643-199. [RESERVED]****Sec. 19a-643-200. General purpose**

Each hospital subject to Chapter 368z [FN1], including, but not limited, to sections 19a-613, 19a-637a, 19a-643, 19a-644, 19a-649, 19a-673c, 19a-676 and 19a-681 of the Connecticut General Statutes, shall be required to submit certain financial information and statistical data annually to the Office of Health Care Access for its review.

Nothing in sections 19a-643-200 through 19a-643-206, inclusive, shall be interpreted as preventing the office from reviewing any financial or statistical reporting requirement in carrying out its mandate under Connecticut laws.

(Added effective July 1, 1991; Amended effective November 1, 2007, formerly 19a-167g-51.)

**Sec. 19a-643-201. Definitions**

- (a) The definitions provided by section 19a-630, of the Connecticut General Statutes and sections 19a-643-10 and 19a-643-11 of the Regulations of Connecticut State Agencies, except as otherwise noted, shall govern the interpretation and application of sections 19a-643-200 to 19a-643-206, inclusive.
- (b) The following definitions shall apply to the review by the office of all matters concerning hospital financial information or statistical data reporting requirements, as applicable:
  - (1) "Affiliate" means a person, entity or organization controlling, controlled by, or under common control with another person, entity or organization, including but not limited to parent corporations, holding companies, related entities, joint ventures and partnerships. Factors to be considered include: common ownership of fifty or more percent; shared boards of directors; purpose; and whether an entity operates for the benefit of others. Control exists where an individual or organization has the power, directly or indirectly, to direct the actions or policy of an organization or entity. A person, entity or organization may be an affiliate for purposes of a particular project;
  - (2) "Ambulatory payment classification" or "APC" means the system of classifying outpatient department (OPD) services reimbursed under the Medicare program prospective payment system for hospital outpatient services as set forth in 42 USC 1833 (t) as from time to time amended;
  - (3) "Bad debts" means the year-end adjustment to a hospital's allowance for doubtful accounts due to the non-reimbursement of services rendered to patients from whom reimbursement was expected, resulting in the recording of bad debt expense. Bad debts exclude any financial activity not associated with patient accounts receivable;
  - (4) "Base year" means "base year" as defined in section 19a-659 of the Connecticut General Statutes;
  - (5) "Board-designated funds" means the unrestricted funds available for specific purposes or projects;
  - (6) "Budget year" means the twelve month fiscal period subsequent to the current year or base year beginning October 1<sup>st</sup> and ending the following September 30<sup>th</sup>. If John Dempsey Hospital of the University of Connecticut Health Center elects to operate and report on a state fiscal year basis, the budget year for that hospital shall be the twelve month period subsequent to the current year or base year beginning July 1<sup>st</sup> and ending the following June 30<sup>th</sup>;
  - (7) "By" means budget year;

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- (8) "Capital expenditures" means the expenditures for items which, at the time of acquisition have an estimated useful life of at least two years and a purchase price of at least \$5,000. In addition, capital expenditures shall include expenditures of at least \$10,000 for groups of related items with an expected life of more than two years, which are capitalized under generally accepted accounting principles. 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 the acquisition, improvement, expansion or replacement of plant or equipment or any combination thereof;
  - (C) Leased assets. The purchase price for leased assets shall be the fair market value of the leased assets at the time of lease as determined by the office;
  - (D) Maintenance expenditures capitalized in accordance with generally accepted accounting principles or provided for as part of any lease, lease purchase agreement, purchase contract, or similar or related agreement; and
  - (E) Donated Assets. Donations of property and equipment, which under generally accepted accounting principles are or would normally be capitalized at fair market value at the date of contribution if purchased rather than donated;
- (9) "Case mix" means the average of inpatient cases, as differentiated by DRG, treated by a specific hospital during a given fiscal year;
- (10) "Case mix index" means "case mix index" as defined in section 19a-659 of the Connecticut General Statutes;
- (11) "Champus or Tricare" means "Champus or Tricare" as defined in section 19a-659 of the Connecticut General Statutes;
- (12) "Charity care" means free or discounted health care services rendered by a hospital to persons who cannot afford to pay, including but not limited to, care to the uninsured patient or patients who are not expected to pay all or part of a hospital bill based on income guidelines and other financial criteria set forth in statute or in a hospital's charity care policies on file at the office. Bad debts, courtesy discounts, contractual allowances, self pay discounts, and charges for health care services provided to employees are not included under the definition of charity care;
- (13) "Contractual allowances" means the difference between hospital published charges and payments generated by negotiated agreements for a different or discounted rate or method of payment. Charity care and bad debts are not included under the definition of contractual allowances;
- (14) "Cost center" means an expense classification, which identifies the salary, non-salary 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" means the fiscal year consisting of a twelve month period, which is presently underway and which precedes the budget year. Also referred to as the base year;
- (16) "CY" means current year;
- (17) "Discharge" means any patient who was discharged on a date subsequent to the date admitted to the hospital for treatment as an inpatient; except that it shall also

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mean such patient was admitted and discharged on the same day where such patient:

- (A) Died; or
- (B) Left against medical advice; or
- (C) Was formally released from the hospital.

For purposes of this definition, patients transferred between an exempt unit and any non-exempt inpatient unit shall be considered discharged and readmitted;

- (18) "DRG" means Diagnosis Related Group;
- (19) "Endowment funds" means funds in which a donor has stipulated, as a condition of his or her 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;
- (20) "Equivalent discharges" means the result of multiplying inpatient discharges times the ratio of total gross revenue to inpatient gross revenue;
- (21) "Exempt inpatient" means a psychiatric inpatient or a rehabilitation inpatient treated in a unit meeting the criteria set forth in 42 CFR 412.22(e), as from time to time amended;
- (22) "Exempt Psychiatric Unit or Exempt Rehabilitation Unit" means respectively, an inpatient psychiatric unit or an inpatient rehabilitation unit of a general hospital that has been determined by Medicare as meeting the criteria set forth in 42 CFR 412.22(e), as from time to time amended;
- (23) "Fiscal year" means:
  - (A) For each acute care general and children's hospital, the fiscal year consisting of a twelve month period commencing on October 1st and ending the following September 30th; or
  - (B) For John Dempsey Hospital of the University of Connecticut Health Center, the hospital may elect to report on the basis of the hospital fiscal year defined in subparagraph (a), or may elect to operate and report to the office based on the state fiscal year consisting of a twelve month period commencing July 1st and ending the following June 30th. If John Dempsey Hospital chooses to operate and report to the office on a state fiscal year basis, the hospital shall comply with the provisions of section 19a-643-206 of the Regulations of Connecticut State Agencies as a continuing condition for qualifying to select or maintain the option of operating and reporting on a state fiscal year basis;
- (24) "Funded depreciation" means funds specifically set aside for the replacement of capital assets;
- (25) "FY" means fiscal year;
- (26) "Government discharges" means discharges for which the principal payer is Medicare including Medicare sponsored managed care organizations, medical assistance including Medicaid and medical assistance sponsored managed care organizations, and Champus or Tricare. A discharge will be classified as a government discharge, if Medicare, medical assistance including Medicaid, Champus or Tricare is responsible for a majority of the cost of service rendered to the patient;
- (27) "Gross inpatient revenue" means the total gross patient charges for hospital inpatient services consistent with Medicare principles of reimbursement;
- (28) "Gross outpatient revenue" means the total gross patient charges for hospital outpatient services consistent with Medicare principles of reimbursement;
- (29) "Gross revenue" means "Gross revenue" as defined in section 19a-659 of the Connecticut General Statutes;
- (30) "Health Insurance Portability and Accountability Act of 1996" or "HIPAA" means

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- Pub. L. 104-191 that, among other things, provides each person protections for maintaining health insurance when changing employment, coverage for preexisting conditions, and confidentiality of patient medical records;
- (31) "Hospital" means a health care facility or institution licensed by the Department of Public Health to provide both inpatient and outpatient services as one of the following:
- (A) A general hospital licensed by the Department of Public Health, including John Dempsey Hospital of the University of Connecticut Health Center, as a short-term, acute care general or children's hospital; or
  - (B) a specialty hospital licensed by the Department of Public Health as a chronic disease hospital that provides inpatient psychiatric, rehabilitation or hospice services;
- (32) "Inpatient non-exempt" means inpatients who are not patients in an exempt psychiatric unit or exempt rehabilitation unit;
- (33) "Managed care organization" means a "managed care organization" as defined in section 38a-1040 of the Connecticut General Statutes, or an eligible organization as defined by Medicare in 42 USC 1395mm (b) as from time to time amended, and which can also include health maintenance organizations (HMOs) and preferred provider organizations (PPOs);
- (34) "Medicaid" means the federal and state health insurance program established under Title XIX of the Social Security Act [FN1] to provide medical assistance on behalf of families with dependent children and for aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and which is administered by the Department of Social Services pursuant to Chapter 319v [FN2] of the Connecticut General Statutes;
- (35) "Medical assistance" means "medical assistance" as defined in section 19a-659 of the Connecticut General Statutes;
- (36) "Medical assistance underpayment" means "Medical assistance underpayment" as defined in section 19a-659 of the Connecticut General Statutes;
- (37) "Medicare" means the federal health insurance program provided for the aged and disabled in 42 USC 1395 through 42 USC 1995 ccc, inclusive, as from time to time amended;
- (38) "Medicare Cost Report" means Form 2552, the provider reimbursement report, any successor form and all supplemental schedules and attachments required to be filed annually pursuant to 42 CFR 413.20 (b) as from time to time amended;
- (39) "Medicare principles of reimbursement" means the reimbursement principles provided in 42 CFR 413, and unless cited as of a specific date, shall incorporate any subsequent amendments;
- (40) "Net revenue" means "net revenue" as defined in section 19a-659 of the Connecticut General Statutes;
- (41) "Nongovernmental" means any commercial or private payer and includes, but is not limited, to managed care organizations, health maintenance organizations (HMOs) and preferred provider organizations (PPOs);
- (42) "Non-operating revenue" means 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;
- (43) "Non-recurring items" means items from a base year or budget year that are not expected to occur again in the next fiscal year;
- (44) "Office" means the Office of Health Care Access;
- (45) "Operating expense" means the expenses necessary to maintain the functions of the hospital including, but not limited to, any collection agency or debt collection

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- expense;
- (46) "Other operating revenue" means revenue from non-patient goods and services. Such revenue should be normal to the operation of a hospital but should be accounted for separately from patient revenues and includes, but is not limited to, the following: revenue from gifts, grants, parking fees, recovery of silver from x-ray film, fees from educational programs, rental of health care facility space, sales from hospital gift shops, cafeteria meals, subsidies specified by the donor for research, educational or other programs, revenues restricted by the donor or grantor for operating purposes, and net assets released from restrictions. Bad debt recoveries shall not be considered to be other operating revenue;
- (47) "Outlier" means a medicare case for which a federal intermediary has issued an additional payment beyond the applicable federal prospective payment rate as prescribed by the medicare program;
- (48) "Outlier revenue" means the total revenue received by a hospital during a reporting period for all types of Medicare outliers;
- (49) "Parent corporation" means a corporate holding company or a hospital health system that controls through its governing body a hospital and the hospital's affiliates;
- (50) "Payer classifications" means payers in the following categories:
- (A) Nongovernmental: includes commercial and private payers;
  - (B) Champus or Tricare;
  - (C) Medicaid: includes medicaid contracted through medicaid managed care organizations;
  - (D) Medicare: includes medicare administered through designated fiscal intermediaries and carriers and medicare contracted through managed care organizations;
  - (E) Total medical assistance: includes medicaid and the state administered general assistance program contracted through general assistance managed care organizations;
  - (F) Other government payments: includes payments identified in 42 USC through 42 USC 710, inclusive, as from time to time amended;
  - (G) Uninsured: includes individuals with no insurance; and
  - (H) Other;
- (51) "Payer mix" means the proportionate share of itemized charges attributable to patients assignable to a specific payer classification to total itemized charges for all patients;
- (52) "Plant replacement and expansion funds" means funds donated for renewal, expansion or replacement of existing plant or a portion of existing plant;
- (53) "Preferred provider organization (PPO)" means a managed care organization, which provides health care coverage through leasing of contracts made with health care providers to insurers and employers for a fee, and which performs utilization review services;
- (54) "Related corporation" means a corporation that is related to a hospital where the corporation is an affiliate or where the hospital has an ownership interest of ten per cent or more in the corporation or where the corporation has an ownership interest in the hospital of ten per cent or more;
- (55) "Restricted funds" means funds temporarily or permanently restricted by donors for specific purposes. The term refers to specific purpose funds and endowment funds;
- (56) "Retained earnings" means the portion of stockholders' equity that accounts for the increase or decrease in contributed or paid-in capital due to net income, net losses and dividends paid;
- (57) "Self-pay discount" means the amount discounted by a hospital from its

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- published charges for, including but not limited to, an uninsured or underinsured patient from whom reimbursement is expected, as determined by the patient not having met the income guidelines and other financial criteria from the hospital's charity care policies on file at the office;
- (58) "Specific purpose funds" means funds restricted externally by a donor, or otherwise, for a specific purpose or project. Board-designated funds do not constitute specific purpose funds;
- (59) "Stockholders' equity" means the claims of ownership equity in an entity also known as contributed or paid-in capital, and retained earnings;
- (60) "Temporarily restricted funds" means 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;
- (61) "Third party payer" means a governmental agency, or, private nongovernmental entity that is liable by virtue of state or federal law or regulation or a contract to pay for all or a part of the cost of a patient's hospitalization or ambulatory services;
- (62) "Uncompensated care" means "Uncompensated care" as defined in section 19a-659 of the Connecticut General Statutes;
- (63) "Uninsured patient" means a patient who is without health insurance for whom the payer responsible for payment of the bill for hospital services rendered is the patient, the patient's parent or guardian or another responsible person, who is not a third party payer and who is not subsequently reimbursed by another payer for the cost of any of the services rendered to the patient. A patient shall not be classified as an uninsured patient, if such subsequent reimbursement takes place;
- (64) "Unrestricted funds" means funds which bear no external restrictions as to use or purpose and which can be used for any purpose, as distinguished from funds restricted externally for specific operating purposes, for plant replacement and expansion, or designated as endowment funds;
- (65) "Volume" means the quantity of specified inpatient or outpatient utilization statistics; and
- (66) "Working capital" means 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, affiliates or related organizations may be 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.

(Added effective December 27, 1991; Amended effective November 1, 2007, formerly 19a-167g-55; Subsection 23 amended effective April 9, 2013)

**Sec. 19a-643-202. Consistency**

Unless otherwise specified, all financial information and statistical data submitted to the office in compliance with sections 19a-643-200 through 19a-643-206, inclusive, of the Regulations of Connecticut State Agencies shall be prepared in accordance with the following principles:

- (a) "Consistency" means continued uniformity of reporting during a reporting period and from one reporting period to another in methods of accounting, valuation bases, methods of accrual and deferral, and statistical units of measure such as diagnosis related group relative weights. Any change in accounting procedures other than to comply with the filing requirements as prescribed by the office, which results in a lack of consistency and which is material in nature, must be brought to the attention of the office in a cover letter which will accompany the hospital's submission. The cover letter shall include both a description and analysis of the impact that such accounting change has on the data submitted.

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- (b) "Depreciation policies" means the determination of the estimated useful life of a depreciable asset in its normal operating or service life. The useful lives of hospital assets shall be based on the most recent American Hospital Association's useful life guidelines for depreciable assets.  
(Added effective April 20, 1990; Amended effective November 1, 2007, formerly 19a-167g-52.)

**Sec. 19a-643-203. Pricemaster**

- (a) A pricemaster, also known as a chargemaster, is the detailed schedule of all hospital charges that is required to be on file with the office in accordance with section 19a-681 of the Connecticut General Statutes.
- (b) Each acute care general or children's hospital shall file its most current pricemaster with the Office and shall be responsible for maintaining its accuracy and filing it in a timely manner. A hospital may start to charge for new drugs, supplies, tests and procedures that were not listed on its last hospital pricemaster filed with the office.  
(Added effective April 20, 1990; Amended effective November 1, 2007, formerly 19a-167g-54.)

**Sec. 19a-643-204. Filing of pricemaster data**

- (a) Each acute care general or children's hospital shall file with the office a copy of the pricemaster that was in effect on the last day of the month by no later than the fifteenth calendar day of the following month, which shall include all new or revised charges not previously reported to the office. Pricemaster data shall be filed in an electronic format and medium specified by the office.
- (b) Each pricemaster shall contain the following:
- (1) A column for an item code number which shall uniquely identify each item in the pricemaster and shall be consistent with the item code utilized on the hospital's detailed patient bills. This column shall be labeled "Item Code";
  - (2) A column for an item description which shall uniquely describe each item in the pricemaster and shall be consistent with the item description utilized on the hospital's detailed patient bills. This column shall be labeled "Item Description"; and
  - (3) A column for the item price in effect as of the last day of the month for which the pricemaster is applicable. This column shall be labeled "Item Price".
- (c) All pricemasters shall be filed with the office electronically in a format prescribed by the office. Each filing shall be accompanied by a cover letter that includes the month and year when the pricemaster took effect, the name of the file or files, and the name of the program used.
- (d) A hospital may be subject to a civil penalty of \$500 per occurrence assessed by the office in accordance with section 19a-681 of the Connecticut General Statutes, if the hospital is found not to be in compliance with this section.  
(Added effective April 20, 1990; Amended effective November 1, 2007, formerly 19a-167g-90.)

**Sec. 19a-643-205. [Repealed]**

(Repealed effective April 9, 2013)

**Sec. 19a-643-206. Annual reporting and twelve months actual filing**

- (a) Applicability to hospitals:
- (1) Each acute care general or children's hospital subject to the provisions of section 19a-644(a) of the Connecticut General Statutes shall report to the office by

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- February 28<sup>th</sup> of each year with respect to its operations for the most recently completed fiscal year in such form as the office may require; and
- (2) Each specialty hospital subject to the provisions of section 19a-644(d) of the Connecticut General Statutes shall report to the office by the end of the fifth month after the hospital's fiscal year ending date. The specialty hospital shall submit audited financial statements that are general purpose financial statements, which express the unqualified opinion of an independent certified public accounting firm for the most recently completed fiscal year for the hospital, or audited consolidated financial statements for the hospital's parent corporation and consolidating financial statements that at a minimum contain a balance sheet and statement of operations and that provide a breakout of the hospital's and each affiliate's numbers with a report of independent accountants on other financial information.
- (b) Content of Annual Reporting: The hospital's annual report for the most recently completed fiscal year shall consist of the following required information components to be submitted annually to the office by February 28<sup>th</sup> in accordance with sections 19a-509b (f), 19a-644, 19a-649 and 19a-673c of the Connecticut General Statutes:
- (1) Audited financial statements that are general purpose financial statements, which express the unqualified opinion of an independent certified public accounting firm for the most recently completed fiscal year for the hospital, each of its affiliates except for those affiliates that were inactive or that had an immaterial amount of total assets, and the hospital's parent corporation that include the following:
- (A) A separately bound original submitted by an independent certified public accounting firm and also a PDF version in Adobe Acrobat of all audited financial statements submitted;
- (B) A note in the hospital's audited financial statements that identifies individual amounts for the hospital's gross patient revenue, allowances, charity care and net patient revenue;
- (C) Audited consolidated financial statements for hospitals with subsidiaries and consolidating financial statements that at a minimum contain a balance sheet and statement of operations and that provide a breakout of the hospital's and each subsidiary's numbers with a report of independent accountants on other financial information; and
- (D) Audited consolidated financial statements for the hospital's parent corporation and consolidating financial statements that at a minimum contain a balance sheet and statement of operations and that provide a breakout of the hospital's and each affiliate's numbers with a report of independent accountants on other financial information;
- (2) The Medicare cost report for the most recently completed fiscal year, as filed in electronic media format, and any final audited Medicare cost reports for prior fiscal years submitted on paper, which have not been previously submitted to the office;
- (3) The most recent legal chart of corporate structure including the hospital, each of its affiliates and subsidiaries and its parent corporation, duly dated;
- (4) Separate current lists of officers and directors for the hospital, each of its affiliates and its parent corporation as of the February 28<sup>th</sup> annual reporting submission date;
- (5) A report that identifies by purpose, the ending fund balances of the net assets of the hospital and each affiliate as of the close of the most recently completed fiscal year, distinguishing between donor permanently restricted, donor temporarily restricted, board restricted and unrestricted fund balances. The hospital's interest in its foundation shall be deducted from the foundation's total fund balance;

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- (6) A report that identifies all transactions between the hospital and each of its affiliates during the most recently completed fiscal year including, but not limited to, the amount of any transfers of funds, transfers of assets, and sales/purchases of services or commodities, and all transactions between affiliates;
- (7) A report that identifies all expenditures incurred by each affiliate for the benefit of the hospital, e.g., subsidized housing for staff, during the most recently completed fiscal year, and the amount of any such expenditures;
- (8) A report that identifies all commitments or endorsements entered into by the hospital for the benefit of each affiliate;
- (9) The total number of discharges and the related number of patient days by town of origin, based on zip code and diagnostic category for the most recently completed fiscal year accounting for 100 percent of total discharges and related patient days;
- (10) The average length of stay and length of stay range by diagnostic category, age grouping and expected payer source;
- (11) The total number of discharges to a residence, a home health agency, another hospital, a skilled nursing facility, an intermediate care facility and to all other locations;
- (12) The total number of inpatient surgical procedures by diagnosis, principal surgical procedure and age grouping with the related number of cases and patient days;
- (13) Outpatient surgical procedures including ambulatory surgery by principal surgical procedure and age grouping with the related number of cases. For purposes of this section, ambulatory surgery is defined as surgical patient admissions discharged prior to the midnight census on the day of admission after the patient has undergone a surgical procedure requiring the use of a fully equipped operating room, i.e. one equipped to administer general anesthesia, whether or not the patient is admitted to a discrete ambulatory or same day surgery unit;
- (14) Case mix and revenue support schedules in a format acceptable to the office. Case mix shall be reported by identifying the number of discharges in each DRG. Revenue support schedules shall include identification of gross charges by payer classification for each DRG;
- (15) Information concerning uncompensated care that includes a copy of the hospital's policies and procedures related to charity care and bad debts that were in effect for the hospital's most recently completed fiscal year;
- (16) A report identifying all donations and funds, which are or have been restricted for the care of indigent patients at the end of the most recently completed fiscal year. The report shall include, but is not limited to, information which identifies the principal balance and all earned income for the previous year, as well as, projected interest income expected to be earned during the current fiscal year;
- (17) A report from each hospital that holds or administers one or more hospital bed funds that is maintained and annually compiled by the hospital for the most recently completed fiscal year, and that is permanently retained by the hospital and, upon the office's request, provides the following fiscal year information:
  - (A) the number of applications for hospital bed funds;
  - (B) the number of patients receiving hospital bed fund grants and the actual amounts provided to each patient from such funds;
  - (C) the fair market value of the principal of each individual hospital bed fund, or the principal attributable to each bed fund if held in a pooled investment;
  - (D) the total earnings for each hospital bed fund or the earnings attributable to each hospital bed fund;
  - (E) the dollar amount of earnings reinvested as principal, if any; and
  - (F) the dollar amount of earnings available for patient care;

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- (18) A report that provides the following hospital debt collection information:
- (a) whether the hospital uses a collection agent to assist with debt collection;
  - (b) the name of any collection agent used by the hospital;
  - (c) the hospital's processes and policies for assigning a debt to a collection agent and for compensating such collection agent for services rendered, and
  - (d) the recovery rate on accounts assigned to collection agents, exclusive of Medicare accounts, for the hospital's most recently completed fiscal year;
- (19) A report listing the salaries and fringe benefits for the ten highest paid positions in the hospital. Each position shall be identified by its complete, unabbreviated title. Fringe benefits shall include all forms of compensation whether actual or deferred, made to or on behalf of the employee whether full or part-time. Fringe benefits shall include but not be limited to the following:
- (A) The cost to the hospital of all health, life, disability or other insurance or benefit plans;
  - (B) The cost of any employer payments or liability to employee retirement plans or programs;
  - (C) The cost or value of any bonus, incentive or longevity plans not included under normal salary reporting guidelines;
  - (D) The cost or value of any housing, whether in the form of a house, apartment, condominium, dormitory or room of any type, whether full-time or only available for part-time use, if subsidized in full or in part by the hospital and not located directly within a hospital building offering direct patient care;
  - (E) The fair market value of any office space, furnishings, telephone service, support service staff, support service equipment, billing or collection services or similar benefits provided to any person for use when seeing non-hospital or private patients or clients. This value shall be prorated based on the total number of hospital and non-hospital patient billing units or provider man-hours involved. For purposes of this subparagraph, if both hospital and non-hospital clients are served from the same location, hospital patients are defined as patients who are billed directly by the hospital for the service provided and for whom the hospital retains the full payment received as part of its gross operating revenue;
  - (F) the fair market value of the cost or subsidy of the use of any automobile, transportation tickets or passes, free or reduced parking, travel expenses, hotel accommodations, etc.; and
  - (G) Any items of value available to employees and not specifically listed above;
- (20) A report containing the following:
- (A) The full name of the hospital and each joint venture, partnership and related corporation affiliated with the hospital;
  - (B) The name and address of the chief executive officer of the hospital and each affiliate listed under this subdivision;
  - (C) The name and address of the Connecticut agent for service for the hospital and each affiliate listed under this subdivision; and
  - (D) A brief description of what each affiliate is, does or proposes to do and the type of services provided or functions performed;
- (21) A report containing the salaries and the fair market value of any fringe benefits paid to hospital employees by each joint venture, partnership and related corporation, either directly or indirectly, and by the hospital to the employees of any of its affiliates. Indirect payments include, but are not limited to, payments made to each affiliate. For purposes of this section, a hospital employee is

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- anyone who provides a service, which incurs an expense for the hospital; and
- (22) A report of all transfers of assets, transfers of operations or changes of control involving the hospital's clinical or nonclinical services or functions from the hospital to a person or entity organized or operated on a for profit basis.
- (c) Content of Twelve Months Actual Filing. The hospital's twelve months actual filing for the most recently completed fiscal year shall consist of the following required information components to be submitted annually to the Office by March 31<sup>st</sup> in accordance with sections 19a-649 and 19a-676 of the Connecticut General Statutes:
- (1) Medicare managed care inpatient and outpatient charges, payments, discharges and patient days by payer;
  - (2) Medicaid managed care and medical assistance non-managed care inpatient and outpatient charges, payments, discharges and patient days by payer;
  - (3) Charity care, bad debts and total uncompensated care;
  - (4) Non-government payers' discount percentages, gross revenue, contractual allowances and payments either in total or by payer;
  - (5) Operating revenue and expenses including, but not limited to, gross revenue, deductions from gross revenue, other operating revenue, operating expenses and non-operating revenue;
  - (6) Discharges by DRG and the calculation of case mix adjusted discharges and case mix index;
  - (7) Inpatient and outpatient utilization statistics by service including licensed and staffed beds and percentage of occupancy, inpatient gross revenue and utilization statistics by payer, outpatient gross revenue by payer, total full time equivalent employees, and other services utilization statistics;
  - (8) Data inputs from hospital external source reports and external and internal source data reconciliations that include the reconciliation of data items from inputs of specific balance sheet, statement of operations and utilization statistics information and any other data contained in the hospital's most recent Medicare cost report and audited financial statements;
  - (9) A summary of gross revenue, net revenue, other operating revenue, revenue from operations, operating expenses, utilization statistics, case mix index, full time equivalent employees and related statistical analyses;
  - (10) Data inputs for inpatient and outpatient accrued charges and payments, payer mix, accrued discharges and patient days, average length of stay, case mix index and other required data elements used to calculate the disproportionate share hospital program underpayment calculations;
  - (11) A summary of inpatient and outpatient accrued charges and payments, accrued discharges, case mix index, other required data elements and a net revenue reconciliation to net revenue as defined by the office;
  - (12) A report providing the number of applicants for charity and reduced cost services, the number of approved applicants, and the total and average charges and costs of the amount of charity and reduced cost care provided; and
  - (13) A report of independent certified public accountants on applying agreed-upon procedures that provides the results of an independent audit of the level of charges, payments and discharges by primary payer related to Medicare, Medicaid, medical assistance, Champus, Tricare and non-governmental payers and the amount of Charity care and bad debts.
- (d) A hospital requesting a partial waiver of the information required to be submitted to the office by an affiliate must request the waiver at least thirty (30) calendar days prior to the due date of the required submission. The waiver request must include the following:
- (1) A legal chart of corporate structure showing the hospital and each of its affiliates and the lines of reporting authority and control;
  - (2) The name, address, title and telephone number of the President and Chief

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- Executive Officer of each affiliate;
- (3) A list identifying each affiliate for which a waiver of informational filings is requested, specifically identifying the filings to which the request pertains, when they are due, and the reasons for the request; and
  - (4) A statement signed under penalty of false statement by the President and Chief Executive Officer of the Connecticut hospital for each affiliate listed in (3) above, which states that the affiliate for which the partial waiver is requested:
    - (A) Does not direct or control the Connecticut hospital seeking the partial waiver; and
    - (B) Does not do business with or share facilities, finances, personnel or services with the Connecticut hospital; and
    - (C) Is not located in Connecticut and does not do business in Connecticut; or
    - (D) Has provided an explanation of why the hospital should be given a waiver of some or all of the affiliate's filing requirements even though (A), (B), or (C) above do not apply. The explanation shall include details of the extent to which (A), (B) and/or (C) do apply.

(Added effective December 27, 1991; Amended effective November 1, 2007, formerly 19a-167g-91.)