

Supplemental CON Application Form
Transfer of Ownership/Sale of Hospital
Conn. Gen. Stat. § 19a-638(a)(2) & § 19a-486

Applicant:

Project Name:

1. Project Description and Need: Change of Ownership or Control

- a. Describe the transition plan and how the applicants will ensure continuity of services. Provide a copy of a transition plan, if available.
- b. How/when will patients be notified of the change of ownership?
- c. For each applicant (and any new entities to be created as a result of the proposal), provide the following information as it would appear **prior** and **subsequent** to approval of this proposal:
 - i. Legal chart of corporate or entity structure including all affiliates
 - ii. Governance or controlling body
 - iii. List of owners and the % ownership and shares of each

2. Historical and Projected Volume

- a. In table format, provide inpatient historical volumes (three **full** years and the current year-to-date) for the number of discharges and patient days by service. Complete the tables below as follows:
 - i. For current fiscal year (CFY) periods 6 months or greater, report annualized volume, identify the months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify months.
 - ii. If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs.
 - iii. Fill in fiscal years. In a footnote, identify the period covered by the applicant’s FY (e.g., July 1-June 30, calendar year, etc.).

Note: the fiscal years reported on the Financial Worksheet(s) must match the financial projections, utilization and payer mix tables.

TABLE A
HISTORICAL AND CURRENT DISCHARGES

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

*CFY Months include _____

TABLE B
HISTORICAL AND CURRENT PATIENT DAYS

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

*CFY Months include _____

- b. Complete the following tables for the first three **full** fiscal years ("FY"). If the first year is a partial year, include that as well.

TABLE C
PROJECTED DISCHARGES BY SERVICE

Service	Projected Volume			
	Partial FY ____*	FY ____	FY ____	FY ____
Medical/Surgical				
Maternity				
Psychiatric				
Rehabilitation				
Pediatric				
Total				

*Partial FY Months include _____

TABLE D
PROJECTED PATIENT DAYS BY SERVICE

Service	Projected Volume			
	Partial FY ____*	FY ____	FY ____	FY ____
Medical/Surgical				
Maternity				
Psychiatric				
Rehabilitation				
Pediatric				
Total				

*Partial FY Months include _____

- c. Explain any increases and/or decreases in historical volumes reported in the tables above.
- d. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHS Tables C and D.

3. Clear Public Need

- a. Is the proposal being submitted due to provisions of the Federal Sherman Antitrust Act and Conn. Gen Stat. §35-24 et seq. statutes? Explain in detail.
- b. Is the proposal being submitted due to provisions of the Patient Protection and Affordable Care Act (PPACA)? Explain in detail.

4. Supplemental Questions

- a. Were alternative proposals or offers considered? If so, describe how these alternative proposal compared with respect to:
 - i. Provider diversity;
 - ii. Consumer choice;
 - iii. Access to affordable quality health care; and
 - iv. Expected financial performance of the hospital and/or health care system.
- b. In regard to health care services for hospital ownership changes:
 - i. Submit a plan demonstrating how health care services will be provided by the hospital for the first three fiscal years following the transfer of ownership;
 - ii. Complete the table below (note: it should reflect the information provided in the hospital services plan, above). List the inpatient and outpatient services currently offered by the hospital. For each service, indicate (by placing an "X" in the appropriate column) if applicants plan to consolidate, reduce, eliminate or expand or add any new service(s) in the three fiscal years following the transfer of ownership

HOSPITAL SERVICE PLAN FOR FIRST THREE FISCAL YEARS

Service Category	# of Available Inpatient Beds	Address of Service	Hours of Operation for o/p services	Consolidate	Reduce	Eliminate	Expand	New Service
Inpatient (list existing & planned)								

Outpatient (list existing & planned)								

- c. Provide a detailed explanation of any planned staffing changes following the hospital’s transfer of ownership and discuss how these changes will impact the accessibility, quality and affordability of care.
- d. Explain in detail how this proposal will help improve the hospital’s ability to align community benefit allocations with the most recent Community Health Needs Assessment (CHNA) and Implementation plan(s).
- e. Describe any changes to the hospital’s current charity care, uncompensated care, financial assistance policies and procedures or bed funds that will result from the proposal.
- f. Describe any plans to work with other community providers, such as federally qualified health centers or community health centers, to provide specialty care to patients or offer low cost programs tailored to the uninsured or underinsured.
- g. Provide a detailed explanation of the applicants’ top priorities following the ownership change in regard to:
 - i. Capital projects; and
 - ii. Service improvements.
- h. Describe any anticipated changes to existing payer contracts (e.g., commercial payers) as a result of this proposal and describe any payer contract negotiations anticipated in the upcoming year.
- i. Provide a list of all existing hospital commercial payer contracts and their dates of expiration.
- j. Explain in detail how the proposal will address any existing debt and/or pension obligations.
- k. Describe how the quality of care will be improved as a result of this proposal.
- l. For all applicants, provide copies of all Centers for Medicare & Medicaid Services (CMS) statement of deficiencies and corrective action plans for the two most recently completed federal fiscal years, including any financial penalties assessed that were related to hospital performance (e.g., readmissions).
- m. Describe what actions the applicant(s) have taken to address any CMS identified deficiencies reported in question m, above.

- n. Provide a copy of and describe any changes to the following policies and procedures as a result of this proposal:
- i. Hospital collection policies;
 - ii. Annual or periodic review and/or revision to the hospital's pricing structure (chargemaster or pricemaster).
- o. As required by Connecticut General Statute 19a-639a, as amended by Public Act 18-91), submit any financial gains realized by each officer, director, board member or senior manager of the hospital and of the purchaser, as a result of the transaction, in the table below. Add rows as necessary. For each such person, list:
- i. The specific person's name;
 - ii. Such person's position type and whether associated with the hospital, the purchaser or both;
 - iii. Whether the person affected is an Officer, Director, Board Member, Senior manager or more than one, if applicable;
 - iv. The amount of any expected increase or decrease in such person's salary, inclusive of bonuses;
 - v. The amount of any expected severance payments received by such person; and
 - vi. The value, based on the date of issuance, of any stock or stock options expected to be issued to such person.

FINANCIAL IMPACT ON CERTAIN HOSPITAL & PURCHASER ASSOCIATES

Name	Affiliated Organization	Position Type	Amount of increase/ (decrease) in salary	Severance Payment	Stock Value	Value of other financial gain	Total

- p. Provide monthly financial reports that include statistics for the current month, year-to-date and comparable month from the previous year for the following:

MONTHLY FINANCIAL MEASUREMENT/INDICATORS

i. Operating Performance:
Operating Margin
Non-Operating Margin
Total Margin
ii. Liquidity:
Current Ratio
Days Cash on Hand
Days in Net Accounts Receivables
Average Payment Period
iii. Leverage and Capital Structure:
Long-term Debt to Equity
Long-term Debt to Capitalization
Unrestricted Cash to Debt
Times Interest Earned Ratio
Debt Service Coverage Ratio
Equity Financing Ratio
iv. Additional Statistics:
Income from Operations
Revenue Over/(Under) Expense
EBITDA
Patient Cash Collected
Cash and Cash Equivalents
Bad Debt as % of Gross Revenue
Net Working Capital
Unrestricted Assets
Credit Ratings (S&P, Fitch, Moody's)

- q. For the most recent tax year, provide a copy of the hospital's IRS Form 990 (you may reference the filing if previously submitted to OHS pursuant to Section 19a-649, C.G.S.). If the proposal involves the merger or acquisition of a multiple hospital system, provide a copy for all privately owned, non-profit Connecticut hospitals involved in the proposal. With respect to the amounts listed on each line item within Part 1, Section 7 of Schedule H (Financial Assistance and Certain Other Community Benefits at Cost) and Part II of Schedule H (Community Building Activities), provide a projected amount for each line item for the first three years following the change in ownership and describe each hospital's future commitment to programmatic and financial support for the community benefit programs and building activities listed on Schedule H.
- r. Discuss in detail how the proposal will impact the hospital's negotiating position with vendors and/or payers.

- s. If an improved negotiating position is anticipated, quantify the tangible savings or additional costs for individual health care consumers and employers.
- t. What are the current Medicare core based statistical area (“CBSA”) assignments for each applicant?
- u. At any time in the last five years, have any of the applicants applied to the Medicare Geographic Classification Review Board (“MGCRB”) for a reassignment of its core based statistical area? If yes, please provide copies of such applications and decisions by the MGCRB.
- v. Within the next three years, does either applicant plan on seeking a reclassification of the CBSA assignment for any hospital within either system? If yes, provide copies of any pending applications with the MGCRB. If no applications are pending, provide a detailed explanation of the intent to apply, including proposed geographical reclassifications.
- w. Describe any plans for upgrades, consolidations or other meaningful changes to the Electronic Health Record (EHR) applications that are contemplated and that will affect the applicants or their affiliated provider groups. For any such upgrade, consolidation or change, include descriptions of the objectives of the effort, the specific applications in scope, the facilities that are affected, the proposed changes and timing of the resulting implementation.
- x. If the proposal involves an **out-of-state hospital/health care system applicant**, provide the number of Connecticut residents who received care in the applicant’s affiliated out-of-state facilities for the past three years, aggregated by year and broken out by inpatient/outpatient settings. Describe how the number of Connecticut residents receiving care in these out-of-state facilities may change as a result of the proposal.

- y. Provide the following information regarding physician groups that the applicants employ or are engaged with as affiliates. Specifically, provide the following, separately for each applicant's physician network:
- i. **Physician Network:** current number of employed physicians, separately for primary care and subspecialty care;
 - ii. **Total Unduplicated Patients:** number of unduplicated patients for the three most recent fiscal years;
 - iii. **Alternative Payment Models (APM) Participation:** number and percentage of patients (using *Total Unduplicated Patients*, above, as the denominator) that are included as attributed patients in shared savings contracts or other contracts in which the physicians/network are accountable for quality and total cost of care for 2015, 2016 and 2017. Please include shared savings arrangements, including those that are gain share only and those in which the applicants or their networks have more than nominal downside risk.
 - iv. **Advanced Alternative Payment Models (AAPM) Participation:** number and percentage of patients (using *Total Unduplicated Patients*, above, as the denominator) that are included as attributed patients in shared savings contracts or other contracts in which the physicians/network are accountable for quality and total cost of care, for the most recently completed fiscal years. Please limit this response to shared savings arrangements in which the applicants or their networks have more than nominal downside risk.
- z. Provide information regarding the hospital's parent company and their employed or affiliated physician groups with respect to the collection of socio-demographic data as follows:
- i. What race/ethnic categories is the Electronic Health Record (EHR) configured to collect?
 - ii. What sexual orientation and gender identity (SOGI) categories is the EHR configured to collect?
 - iii. What social determinant risk data is the EHR configured to collect?

- aa. For each applicant’s employed or affiliated physician group, complete the table below for the most recently completed fiscal year:
- i. Label the fiscal year and identify the months included;
 - ii. Place a check mark in the “No data” column if the socio-demographic category is not currently collected;
 - iii. For each socio-demographic category collected, provide a count of patients that “Elected to report” or “Elected not to report” the information;
 - iv. “Elected to report” and “Elected not to report” columns should sum to the “Unduplicated Patient Total.”

Category	Fiscal Year ____ *			
	No Data (✓)	Elected to report	Elected not to report	Unduplicated Patient Total
Race/ethnicity				
Language preference				
Sexual Orientation and Gender Identity				
Social Determinant of Risk				

*Fiscal Year months include: _____

5. For-profit Purchasers Only (Conn. Gen. Stat. § 19a-486d, as amended by Public Act 18-91)

- a. Describe in detail the purchaser’s commitment to provide health care to the uninsured and the underinsured following the hospital acquisition.
- b. In a situation where health care providers or insurers will be offered the opportunity to invest or own an interest in the purchaser or a related entity, what safeguards will be created to avoid a conflict of interest in regard to patient referral?