



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

Applicant:

Project Name:

Affidavit

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

Date

Subscribed and sworn to before me on _____

Notary Public/Commissioner of Superior Court

My commission expires: _____

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

TABLE A
HISTORICAL AND CURRENT DISCHARGES

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

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

**Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

***For periods greater than 6 months, report annualized volume, **identify the months covered** and the method of annualizing. For periods less than 6 months, report actual volume and **identify the months covered**.

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				

*Provide the number of patient days for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric).

**Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

***For periods greater than 6 months, report annualized volume, **identify the months covered** and the method of annualizing. For periods less than 6 months, report actual volume and **identify the months covered**.

- 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			
	FY**	FY**	FY**	FY**
Medical/Surgical				
Maternity				
Psychiatric				
Rehabilitation				
Pediatric				
Total				

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

**If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. In a footnote, identify the period covered by the Applicant's fiscal year FY (e.g. July 1-June 30, calendar year, etc.).

Note: please make sure that the fiscal years reported on the Financial Worksheet are the same fiscal years reported for the financial projections, utilization and payer mix tables (Main Form: OHCA Tables 4, 6, 7; Transfer of Ownership/Sale of Hospital Supplemental Form: Tables C and D).

TABLE D
PROJECTED PATIENT DAYS BY SERVICE

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

*Provide the number of patient days for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric).

**If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. In a footnote, identify the period covered by the Applicant's fiscal year FY (e.g. July 1- June 30, calendar year, etc.).

Note: please make sure that the fiscal years reported on the Financial Worksheet are the same fiscal years reported for the financial projections, utilization and payer mix tables (Main Form: OHCA Tables 4, 6, 7; Transfer of Ownership/Sale of Hospital Supplemental Form: Tables C and D).

- 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 volume.

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 and, if so, how did they compare to this proposal with respect to provider diversity, consumer choice and access to affordable quality health care?
- b. In regard to health care services for hospital ownership changes, complete the following:
 - 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 services in the three fiscal years following the transfer of ownership; and

- iii. indicate what, if any, new services the hospital will be adding 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	Consolidating	Reducing	Eliminating	Expanding	Adding New Service
Inpatient (list existing & planned)								
Outpatient (list existing & planned)								

- c. Please 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. How will this proposal affect the implementation plan developed to address priority health needs identified in the most recent Community Health Needs Assessment (CHNA)?
- 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. Explain in detail the capital projects that are deemed top priorities by the Applicants.
- h. Explain in detail the service improvements that are deemed top priorities by the Applicants.
- i. Describe any anticipated changes as a result of this proposal to existing payer contracts (e.g., Medicare, Medicaid or commercial payers).
- 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 maintained with 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.
- m. Provide a copy of and describe any changes to any of 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); and
- n. As required by Public Act 15-146 section 30 (to be codified, as amended, as Connecticut General Statute 19a-639a), 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. the amount of any expected increase or decrease in such person's salary, inclusive of bonuses;
 - iv. the amount of any expected severance payments received by such person; and
 - v. 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	Organization	Position Type*	Amount of increase/ (decrease) in salary	Severance Payment	Stock Value	Value of other financial gain	Total
1								
2								
3								
4								
5								
6								
7								

* Indicate whether an Officer, Director, Board Member or Senior manager (may select more than one, if applicable).

- o. 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)

- p. 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 OHCA). 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 the hospital's future commitment to programmatic and financial support for the community benefit programs and building activities listed on Schedule H.
- q. Discuss in detail how the proposal will impact the hospital's negotiating position with vendors and/or payers?
- r. If an improved negotiating position is anticipated, quantify the tangible savings for the health care consumer.
- s. Provide details of plans to ensure that future health care services provided, in relation to the proposal, adhere to the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve

quality and help eliminate health care disparities in the projected service area.
(For more details on CLAS standards can be found at
<http://minorityhealth.hhs.gov/>).

5. For-profit Purchasers Only (Conn. Gen. Stat. § 19a-486d)

- a. Describe in detail the purchasers 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?