*Disclaimer: This compilation of the Regulations of the Office of Health Care Access is unofficial and for the convenience of the public only. While every effort was made to attain complete accuracy herein, the reader is advised to consult the official publication of the Regulations of Connecticut State Agencies.

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS
"HOSPITAL FINANCIAL REVIEW REGULATIONS"
Sections 19a-643-200 through 19a-643-206

Sec. 19a-643-200. General Purpose

Each hospital subject to Chapter 368z, 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.

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 1st and ending the following September 30th. 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 1st and ending the following June 30th;

(7) "BY" means budget year;

(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 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 sections 19a-643-205 and 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 Pub. L. 104-191 that, among other things, provides each person protections for maintaining health insurance when changing employment, coverage for pre-existing 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 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 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 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 701 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 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.

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.

(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.

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.

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.

Sec. 19a-643-205. Hospital Budget Filing

(a) Applicability: Each acute care general or children's hospital shall submit to the office by March 31st of each year the hospital operating budget approved by the hospital's governing body for the fiscal year that commenced on October 1st, or July 1st for John Dempsey Hospital of the University of Connecticut Health Center, of the previous calendar year in such form as the office may require.

(b) Content of hospital budget filing: the hospital's approved operating budget filing shall consist of the following required information components to be submitted annually to the office by March 31st in accordance with section 19a-637a of the Connecticut General Statutes:

(1) Hospital budgeted revenue and expenses including, but not limited to, gross revenue, deductions from gross revenue, other operating revenue, operating expenses and non-operating revenue; and

(2) Hospital budgeted utilization statistics including, but not limited to, inpatient and outpatient statistics as determined by the office.

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 February 28th 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 28th 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 28th 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;

(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;

(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 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 31st 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 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.