Office of Health Care Access
FY 2017 Twelve Months Actual Filing
General Instructions

Each hospital licensed as an acute care general or children's hospital shall submit to the Office of Health Care Access (OHCA) the reporting requirements for the FY 2017 Twelve Months Actual Filing in accordance with Connecticut General Statutes (C.G.S.), Sections 19a-649 and 19a-676 and Section 19a-643-206 (c) of OHCA's Regulations. The FY 2017 Twelve Months Actual Filing General Instructions have been updated from prior years' Twelve Months Actual Filing general instructions and replace all previous versions.

All components of the hospital's FY 2017 Twelve Months Actual Filing must be received by OHCA by no later than Monday, April 2, 2018.

The FY 2017 Twelve Month Filing requirements will be met by completing the input forms and related reports within the Hospital Reporting System (HRS) and filing all Non HRS related documents as PDF files also in the HRS database. When naming the Non HRS files, use a filename that specifically identifies the hospital and the item being submitted. A Twelve Month Filing submission checklist with the Non-HRS related filing components in more detail is provided separately. Variance explanations will not be required for FY 2017 due to implementation of the new web portal. OHCA may ask specific questions on differences between FY 2016 amounts and FY 2017 amounts. OHCA will resume the collection of variance explanations in next year's filing.

Below is a table of the HRS and non-HRS related items that hospitals must provide to complete the FY 2017 Twelve Month Filing. Full descriptions for the HRS related reports along with detailed instructions on each of the filing requirements can be found in these instructions.

HRS Related Reports	Non - HRS Related Reports (PDF submission)
Report 100	Cover Letter
Report 125	Submission Checklist
Report 150	Filing Affidavit
Report 175	DPH License
Report 185	AUP-(Report 625)
Report 300	Support Schedules for Other Adjustments
Report 325	IRS 990 (Report 750)
Report 350	Report 450 Other O/P Visits breakout Line M10
Report 385	
Report 400	
Report 450	
Report 485	
Report 550	
Report 565	
Report 600	
Report 700	

Table of Contents

FY 2017 Twelve Months Actual Filing Docket Numbers

HOSPITAL	Docket Number
William W. Backus Hospital	17-001TM
Bridgeport Hospital	17-023TM
Bristol Hospital	17-002TM
Connecticut Children's Medical Center	17-025TM
Danbury Hospital	17-024TM
Day Kimball Hospital	17-003TM
John Dempsey Hospital	17-026TM
Greenwich Hospital	17-027TM
Griffin Hospital	17-028TM
Hartford Hospital	17-005TM
Hospital of Central Connecticut	17-015TM
Charlotte Hungerford Hospital	17-007TM
Johnson Memorial Hospital	17-029TM
Lawrence & Memorial Hospital	17-008TM
Manchester Memorial Hospital	17-010TM
Middlesex Hospital	17-012TM
MidState Medical Center	17-030TM
Milford Hospital	17-013TM
Norwalk Hospital	17-031TM
Rockville General Hospital	17-032TM
Sharon Hospital	17-033TM
Saint Francis Hospital and Medical Center	17-018TM
St. Mary's Hospital	17-019TM
St. Vincent's Medical Center	17-035TM
Stamford Hospital	17-034TM
Waterbury Hospital	17-021TM
Windham Community Memorial Hospital	17-022TM
Yale-New Haven Hospital	17-016TM

Non HRS Related Data Items Summary

1. **Hospital's cover letter** and **submission checklist;**

2. **Affidavit** – notarized Twelve Month Filing Affidavit that is signed and dated by the hospital CEO or CFO;

3. **DPH License** – a copy of the Hospital's Department of Public Health license as of September 30, 2017;

4. **AUP** – Independent Accountant's Report on Applying Agreed-Upon Procedures to Report 600;

5. **Supporting schedules** – for the Plus/Minus Other Adjustments lines reported on HRS Report 600 concerning the Net Revenue, Gross Revenue and Uncompensated Care Reconciliations;

6. **IRS 990** – The hospital and the hospital parent corporation's IRS Form 990, Return of Organization Exempt from Income Tax for FY 2017 (a signed time extension request should be submitted for each filing if the hospital has requested a time extension with the IRS. Hospitals may redact the donor names on Schedule B as OHCA will be posting the IRS 990's to our website; and

7. **Provide a breakout of the hospital's Other Outpatient Visits on line M10 from Report 450** – Hospitals should submit a summary of the individual components that comprise the amount and the document should be submitted as a PDF file.

The HRS Hospital Financial Statement input screen contains Audited Financial Statement data items for the completion of Reports 100, 125, 150, 175 and 185. Users should reference the HRS User Manual and Filing Guide for more details.

Report 100 – Hospital Balance Sheet Information

A report that provides detailed Balance Sheet information from the Hospital's Audited Financial Statements for the most recently completed fiscal year.

There are inputs for various sections of a Hospital's Balance Sheet including Assets (Current Assets, Non Current Assets, Net Fixed Assets) & Liabilities and Net Assets / Stockholder's Equity (Current Liabilities, Non Current Liabilities and Net Assets/Stockholder's Equity inputs.)

The Balance Sheet amounts must be for the hospital only and must exclude financial activity for all hospital affiliates, subsidiaries and out of state entities.

Error Messages – There are two error messages, on the Hospital Financial Statement input screen that are related to Report 100/125 that will appear if certain amounts do not agree. The error messages are noted below.

Report 100

1) Report 100 Total Assets must equal Total Liabilities + Net Assets / Stockholder's Equity.

Report 100 & 125

2) Report 100 Cash and Cash Equivalents must = Report 125 Cash and Cash Equivalents at end of year.

Report 125 – Hospital Statement of Cash Flow Information

A report that provides detailed statement of cash flow information from the Hospital's Audited Financial Statements for the most recently completed fiscal year.

There are inputs for various sections of a Hospital's Statement of Cash Flows including Operating Activities, Investing Activities and Financing / NonCapital Financing Activities.

The Statement of Cash Flow amounts must be for the hospital only and must exclude financial activity for all hospital affiliates, subsidiaries and out of state entities.

Error Messages – As noted previously, there is an error message on the Hospital Financial Statement input screen that is related to Report 100/125 that will appear if certain amounts do not agree. The error message is noted below:

Report 100 Cash and Cash Equivalents must = the Cash and Cash Equivalents at the end of the year.

Report 150 – Hospital Statement of Operations Information

A report that provides detailed Statement of Operations information from the Hospital's Audited Financial Statements for the most recently completed fiscal year.

There are inputs for various sections of a Hospital's Statement of Operations including Operating Revenues, Operating Expenses and Non Operating Gains / Losses.

The Statement of Operations amounts must be for the hospital only and must exclude financial activity for all hospital affiliates, subsidiaries and out of state entities.

Report 175 – Hospital Operating Expenses by Expense Category and Department

A report that provides detailed Hospital Operating Expenses by expense category for the most recently completed fiscal year.

Inputs include amounts by expense category for salaries and wages, fringe benefits, supplies and drugs, depreciation and amortization, interest expense and other operating expenses. The sum of these categories will populate the Operating Expense categories of Report 150.

The operating expense amounts to be entered must be for the hospital only and must exclude all financial activity for hospital affiliates, subsidiaries and out of state entities.

Report 185 – Hospital Financial and Statistical Data Analysis

A report that provides various forms of hospital financial information including a statement of operations summary, profitability summary, net assets summary, liquidity measures summary and solvency measures.

Statement of operations summary – provides hospital revenue and expense data by major category from the hospital's audited financial statements;

Profitability summary – provides hospital operating and total margins;

Net assets summary – provides hospital unrestricted net assets, total net assets and the change in total net assets;

Liquidity measures summary – provides the hospital's current ratio, days cash on hand, days revenue in patient accounts receivable, and average payment period; and

Solvency measures summary – provides the hospital's equity financing ratio, cash flow to total debt ratio, long term debt to capitalization ratio and debt service coverage ratio.

The HRS Health System Financial Statement input screen contains Audited Financial Statement data items for the completion of Reports 300, 325, 350, and 385. Users should reference the HRS User Manual and Filing Guide for more details.

Report 300 – Parent Corporation Consolidated Balance Sheet Information

A report that provides detailed balance sheet information from the hospital parent corporation's consolidated audited financial statements for the most recently completed fiscal year.

If a hospital is part of a system, that has a Connecticut entity as its immediate parent, the hospital with the largest amount of gross revenue for the fiscal year that is being reported on, should be the hospital completing the Health System Financial Statement inputs. All other hospitals in the system should click the Nothing to Report box on the input form.

There are inputs for various sections of a Hospital Parent Corporation's Balance Sheet including Assets (Current Assets, Non Current Assets, Net Fixed Assets) & Liabilities and Net Assets / Stockholder's Equity (Current Liabilities, Non Current Liabilities and Net Assets/Stockholder's Equity inputs.)

The Balance Sheet amounts to be entered must be for the consolidated hospital parent corporation and must include financial activity for the hospital and all hospital affiliates and subsidiaries and exclude any out of state hospital activity.

Error Messages – There are two error messages, on the Health System Financial Statement input screen that are related to Report 300/325 that will appear if certain amounts do not agree. The error messages are noted below.

Report 300

1) Report 300 Total Assets must equal Total Liabilities + Net Assets / Stockholder's Equity.

Report 300 & 325

2) Report 300 Cash and Cash Equivalents must = Report 325 Cash and Cash Equivalents at end of year.

Report 325 – Hospital Statement of Cash Flow Information

HRS Report 325. A report that provides detailed statement of cash flow information from the hospital parent corporations audited financial statements for the most recently completed fiscal year.

If a hospital is part of a system that has a Connecticut entity as its immediate parent, the hospital with the largest amount of gross revenue for the fiscal year that is being reported on, should be the hospital completing the Health System Financial Statement inputs. All other hospitals in the system should click the Nothing to Report box on the input form.

There are inputs for various sections of a Hospital Parent Corporation's Statement of Cash Flows including Operating Activities, Investing Activities and Financing / NonCapital Financing Activities.

The Statement of Cash Flow amounts must be for the consolidated hospital parent corporation and must include financial activity for the hospital and all hospital affiliates and subsidiaries and exclude any out of state hospital activity.

Error Messages – As noted previously, there is an error message on the Health System Financial Statement input screen that is related to Report 300/325 that will appear if certain amounts do not agree. The error message is noted below:

Report 300 Cash and Cash Equivalents must = the Cash and Cash Equivalents at the end of the year.

Report 350 – Parent Corporation Consolidated Statement of Operations Information

HRS Report 350. A report that provides detailed statement of operations information from the hospital parent corporation's consolidated audited financial statements for the most recently completed fiscal year.

If a hospital is part of a system that has a Connecticut entity as its immediate parent, the hospital with the largest amount of gross revenue for the fiscal year that is being reported on, should be the hospital completing the Health System Financial Statement inputs. All other hospitals in the system should click the Nothing to Report box on the input form.

There are inputs for various sections of a Hospital's Statement of Operations including Operating Revenues, Operating Expenses and Non Operating Gains / Losses.

The Statement of Operations amounts to be entered must be for the consolidated hospital parent corporation and must include financial activity for the hospital and all hospital affiliates and subsidiaries and exclude any out of state hospital activity.

Report 385 – Parent Corporation Consolidated Financial Data Analysis

A report that provides various forms of hospital parent corporation consolidated financial information including a statement of operations summary, profitability summary, net assets summary, liquidity measures summary, and solvency measures summary.

Statement of operations summary – provides hospital parent corporation revenue and expense data by major category from the hospital's audited financial statements;

Profitability summary – provides hospital parent corporation operating and total margins;

Net assets summary – provides hospital parent corporation unrestricted net assets, total net assets and the change in total net assets;

Liquidity measures summary – provides the hospital parent corporation's current ratio, days cash on hand, days revenue in patient accounts receivable, and average payment period; and

Solvency measures summary – provides the hospital parent corporation's equity financing ratio, cash flow to total debt ratio, long term debt to capitalization ratio and debt service coverage ratio.

The HRS Hospital Utilization Data input screen contains Utilization Data items for the completion of Reports 400 & 450. Users should reference the HRS User Manual and Filing Guide for more details.

Report 400 – Hospital Inpatient Bed Utilization by Department

A report that provides hospital inpatient utilization statistics by service or department including patient days, staffed beds, available beds and licensed beds.

Data will be entered for hospital inpatient services or departments including Adult Medical/Surgical, ICU/CCU excluding Neonatal ICU, Psychiatric: ages 0 to 17, Psychiatric: ages 18+, Rehabilitation, Maternity, Newborn, Neonatal ICU, Pediatric and Other services or departments.

Inputs include patient days, discharges or ICU/CCU patients, admissions, staffed beds and available beds. Total Hospital Licensed Beds and Bassinets is an input and should equal the total of the licensed beds and licensed bassinets numbers on the hospital's Department of Public Health (DPH) License as of September 30, 2017.

Please submit a copy of the hospital's DPH License as of September 30, 2017.

Staffed beds reported are the average number of staffed beds with sufficient staff to be occupied by patients during the fiscal year. This number may not exceed the number of available beds for each service or department or in total. Conversely, total available beds must not be lower than the number of staffed beds for each service department or in total. Both the occupancy of staffed beds and occupancy of available beds must be lower than 100% for each department listed above.

In reporting the utilization statistics for the inpatient services listed above, the hospital should report activity based on the patient type, not location. For example, if a Psychiatric Patient is admitted to the Adult Medical/Surgical unit due to a lack of available beds in the Psychiatric unit, Report 400 should reflect this patient as a psychiatric patient.

Note, only CT Children's Medical Center should report amounts in the ICU/CCU and NICU categories for admissions.

Error Messages – There are multiple error messages, on the Hospital Utilization input screen that are related to Report 400, that will appear if amounts do not agree. The error messages are noted below.

Report 400

1. Report 400 Occupancy of Staffed Beds must be less than or equal to 100%. –There is one check for each department (10 proofs in total).

2. Report 400 Occupancy of Licensed Beds must be less than or equal to 100%. –There is one check for each department (10 proofs in total).

Report 450 – Hospital Inpatient and Outpatient Other Services Utilization and Full Time Equivalent Employees

A report that provides various types of hospital inpatient and outpatient services utilization statistics by service or department and hospital full time equivalents.

Hospitals must report inpatient, outpatient, Emergency Department and other non-hospital Providers' utilization in the same way and consistent with how the hospital would bill the service(s) provided for reimbursement purposes. This would include using the appropriate Revenue and CPT/HCPCS codes.

Inputs include the number of CT scans, MRI scans, PET scans, PET/CT scans, radiation therapy procedures, cardiac catheterization procedures, cardiac angioplasty procedures, electrophysiology studies, surgical procedures, endoscopy procedures, hospital emergency room visits, hospital clinic visits, other hospital outpatient visits by service or department, and hospital full time equivalents data.

If the hospital is not the primary provider of CT scans, MRI scans, PET scans or PET/CT scans, the hospital must obtain the fiscal year volume for each of these types of scans from the primary provider of the scans.

Hospitals must provide a total staff count of its staff expressed in Full-Time Equivalents (FTEs) broken out in the following categories:

a) Total Nursing FTEs – the hospital must provide a total staff count of Hospital nursing personnel who provide direct services to patients (includes APRNs, RNs, LPNs and CNAs) and nursing administrative personnel.

b) Total Physician FTEs – the hospital must provide a total staff count of Hospital personnel who provide direct services to patients as physicians.

c) Other Medical Personnel – the hospital must provide a total staff count of Hospital personnel that provides direct patient care to patients. Examples would include clinical support, home health aides, patient care assistants, imaging techs and phlebotomists.

d) Non Medical Personnel FTEs – the hospital must provide a total staff count of hospital personnel that doesn't provide direct patient care to patients. Examples include administration, billers and coders, IT, materials management, security staff, transport and warehouse staff.

For data definitions a-d above, one FTE is defined as equal to 2,080 total hours paid for employee compensation or 40 hours per week for a period of 52 weeks. Another metric may be used if hospital employee policy for specific groups differs from the 2080 hour standard.

Section M, Other Hospital Outpatient Visits – OHCA is requesting hospitals provide a breakout of the individual components of the Other Outpatient Visits amount shown on **Line M10.**

Error Messages – There are multiple error messages on the Hospital Utilization input screen that are related to Report 450 and 485 that will appear if certain amounts do not agree. The error messages are noted below.

Report 450 & 485*

1. Report 450 Outpatient Surgical Procedures must = Report 485 Total Outpatient Surgical Procedures.
2. Report 450 Outpatient Endoscopy Procedures must = Report 485 Total Outpatient Endoscopy Procedures.
3. Report 450 Outpatient Emergency Dept Visits must = Report 485 Total Outpatient Hospital ER visits.

Remember to click the **Complete button for the Utilization inputs after the Report 485 inputs have been completed to check for error messages.*

The HRS Hospital Outpatient Utilization – Report 485 input screen contains Utilization Data items for the completion of Report 485. Users should reference the HRS User Manual and Filing Guide for more details.

Report 485 – Hospital Outpatient Surgical, Outpatient Endoscopy and Outpatient Emergency Room Services by Location

A report that provides hospital outpatient surgical procedures, outpatient endoscopy procedures and outpatient emergency room visits by location.

Hospitals must report Outpatient Surgical Procedures, Outpatient Endoscopy Procedures and Outpatient Emergency Room Visits in the same way and consistent with how the hospital would bill the service(s) provided for reimbursement purposes. This would include using the appropriate Revenue and CPT/HCPCS codes.

Inputs include the specific geographical location names and the corresponding number of hospital outpatient surgical procedures, outpatient endoscopy procedures and outpatient emergency room visits at each hospital geographical location.

Error Messages – There are multiple error messages, on the Hospital Utilization input screen that are related to Report 450 and 485 that will appear if certain amounts do not agree. The error messages are noted below.

Report 450 & 485*

1. Report 450 Outpatient Surgical Procedures must = Report 485 Total Outpatient Surgical Procedures.
2. Report 450 Outpatient Endoscopy Procedures must = Report 485 Total Outpatient Endoscopy Procedures.
3. Report 450 Outpatient Emergency Dept Visits must = Report 485 Total Outpatient Hospital ER visits.

Remember to click the **Complete button on the Hospital Utilization Data input screen after the Report 485 inputs have been entered to check for any error messages.*

The HRS Hospital Charges and Payments input screen contains data items for the completion of Report 550, 565 and 600. Users should reference the HRS User Manual and Filing Guide for more details.

Report 550 – Summary of Charges, Payments, Statistics and Uncompensated Care

A report that provides a summary of Charges, Payments, Statistics and Uncompensated Care for each major payer category.

Major payer categories include non-government including self-pay / uninsured, Medicare, State of Connecticut Medicaid, other medical assistance, total medical assistance including Medicaid, CHAMPUS/TRICARE and Uninsured.

Inputs include hospital inpatient accrued charges, inpatient accrued payments, outpatient accrued charges, outpatient accrued payments, discharges, patient days, and case mix index for each major payer category.

Additional inputs include accrued charges and accrued payments associated with non-government contractual allowances, charity care at charges, bad debts at charges, employee self-insurance gross revenue, and employee self-insurance allowance.

There are also inputs for plus/minus other adjustments to reconcile OHCA defined gross revenue, net revenue and uncompensated care to the hospital's audited financial statements.

Non-government contractual allowances must not include any deductions for Charity Care or Bad Debts on HRS Reports 550 or 600. If the hospital reports any Other Adjustments, provide the detail of the components in a PDF file. Please refrain from using any unexplained abbreviations and/or acronyms in providing the detail of these components.

Additional items on the report include:

Cost data summary – provides the hospital's ratio of cost to charges, private payment to cost ratio, Medicare payment to cost ratio, Medicaid payment to cost ratio, and uncompensated care cost including charity care and bad debt amounts.

Utilization measures – provides hospital patient days, discharges, average length of stay and Case Mix Index.

Calculations – Case Mix Adjusted Discharges, Outpatient Equivalent Discharges, Inpatient Payment per Case Mix Adjusted Discharges and Outpatient Payment per Outpatient Equivalent Discharges.

Ratios – Inpatient and Outpatient payer mix based on accrued charges, Inpatient and Outpatient payer mix based on accrued payments, Inpatient Payments to Inpatient Charges and Outpatient Payments to Outpatient Charges,

Error Messages – There are two error messages, on the Hospital Charges and Payments input screen related to Report 400 and 550 that may appear if certain amounts do not agree. The error messages are noted below.

Report 400/550

1. Report 400 Total Patient Days must = Report 550 Total Patient Days.

2. Report 400 Total Discharges must = Report 550 Total Discharges.

Major Payer Category Definitions

a. Major payer - the payer responsible for the highest percentage of the charges for the case. Major payers include Non-government (including the uninsured), Uninsured, Medicare, Medicaid, Total Medical Assistance, Other Medical Assistance and CHAMPUS/TRICARE.

b. Medicare - the federal health insurance program provided for the aged and disabled in 42 USC 1395 through 42 USC 1395 kkk-1, inclusive, as from time to time amended. Medicare includes Medicare administered programs through designated fiscal intermediaries and carriers and Medicare contracted programs through managed care organizations.

c. Nongovernmental - any commercial or private payer including the uninsured. Commercial payers include, but are not limited to, managed care organizations, health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

d. Uninsured / Self Pay Patient - individuals with no insurance for the patient services being provided. 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.

e. Medicaid - 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. Medicaid includes State of Connecticut Medicaid, fee-for-service Medicaid and Medicaid contracted through Medicaid managed care organizations.

f. Other Medical Assistance - the difference between Total Medical Assistance and Medicaid.

g. Total Medical Assistance - Medicaid, out-of-state-Medicaid and other State of Connecticut medical assistance programs.

h. CHAMPUS/TRICARE - as defined in section 19a-659 (7) of the Connecticut General Statutes, the federal Civilian Health and Medical Program of the Uniformed Services, as defined in 10 USC Section 1072 (4), as from time to time amended.

Charge and Payment Definitions

i. Inpatient accrued charges - the total inpatient accrued gross patient revenue for hospital inpatient services.

j. Outpatient accrued charges - the total accrued gross patient revenue for hospital outpatient services.

k. Total accrued charges - the total gross patient revenue for all patient services provided by a hospital.

l. Inpatient accrued payments - the total inpatient accrued charges less accrued inpatient contractual allowances.

m. Outpatient accrued payments - the total outpatient accrued charges less accrued outpatient contractual allowances.

n. Total accrued payments - the total accrued charges less total accrued contractual allowances.

o. Total Government deductions - the difference between total accrued charges and total accrued payments for Medicare, Total Medical Assistance and CHAMPUS/TRICARE.

p. Net revenue - as defined in Section 19a-659(14) of the Connecticut General Statutes, total gross revenue less contractual allowance, less the difference between government charges and government payments, less uncompensated care and other allowances.

q. Other Operating Revenue – Amount comes from the AFS inputs.

r. Total Operating Expenses – Amount comes from the AFS inputs.

Uncompensated Care Definitions

s. Charity Care – 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 OHCA. 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.

t. Bad Debts - the year-end adjustments to a hospital's allowance for doubtful accounts due to the non-reimbursement of services rendered to patients from whom reimbursement was expected. Bad debts exclude any financial activity not associated with patient accounts receivable.

u. Uncompensated Care - the total amount of charity care and bad debts determined by using the hospital's published charges and consistent with the hospital's policies regarding charity care and bad debts which have been and are on file at OHCA.

v. Cost of uncompensated care - uncompensated care charges times the ratio of total operating expense divided by the total of gross patient charges plus other operating revenue.

w. Cost to Charge Ratio (CCR) – the ratio that indicates the percentage of total operating expense to the total of gross patient charges plus other operating revenue for FY 2016 that was provided to the hospitals by OHCA.

Miscellaneous

x. Case mix index – the arithmetic mean of the Medicare diagnosis related group case weights assigned to each inpatient discharge for a specific hospital during a given fiscal year. The case mix index shall be calculated by dividing the hospital's total case mix adjusted discharges by the hospital's actual number of discharges for the fiscal year. The total case mix adjusted discharges shall be calculated by (A) multiplying the number of discharges in each diagnosis-related group by the Medicare weights in effect for that same diagnosis-related group and fiscal year, and (B) then totaling the resulting products for all diagnosis-related groups.

y. Discharge - 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 died, or left against medical advice, or was formally released from the hospital.

z. Employee self- insurance allowance - the amount of any difference between charges for employee self-insurance and related expenses determined by using the hospital's overall relationship of costs to charges.

aa. Non-government contractual allowances - the amount of discounts provided to nongovernmental payers pursuant to a written agreement.

Report 565 – Summary of Emergency Department Outpatient Charges and Payments

A report that provides a summary of Emergency Department Outpatient Charges and Payments by major payer category.

Inputs include Emergency Department outpatient accrued charges and payments by major payer category.

Major payer categories include non-government including self-pay / uninsured, Medicare, State of Connecticut Medicaid, other medical assistance, total medical assistance including Medicaid, CHAMPUS/TRICARE and Uninsured.

Report 600 – Summary of Charges, Payments and Uncompensated Care

A report that provides a summary of the hospital's Charges, Payments, and Uncompensated Care data that is used as the basis for the hospital's Report of Agreed Upon Procedures.

The report provides various items of information including inpatient, outpatient and total accrued charges by major payer category and inpatient, outpatient and total accrued payments by major payer category.

Other required data includes self insurance amounts, charity care and bad debts totals and net revenue, gross revenue and uncompensated care reconciliations to the hospital's audited financial statements.

Report 625 – Report of Independent Accountants on Applying Agreed-Upon Procedures to Report 600

A report of independent accountants on applying agreed-upon procedures that verifies the hospital's inpatient, outpatient, and total net revenues.

A Report of Independent Accountants on Applying Agreed-Upon Procedures to Report 600 is required as part of the hospital's verification of net revenue process set forth in Section 19a-649 (a), of the C.G.S.

See the reporting format and requirements for the Agreed-Upon Procedures Report included in *Attachment A o*f these general instructions for further details.

Report 700 – Statistical Analysis of Hospital Revenue and Expense

A report that provides a statistical analysis of the hospital's revenues and expenses using various utilization statistics.

The report provides a summary that includes the hospital's gross revenue and net revenue, total operating expenses, utilization statistics, net revenue and operating expense by statistics, total salary and fringe benefit expenses, FTE's and total salary and fringe benefit expense per FTE and by various statistics.

Statistics used in the analyses include patient days, discharges, equivalent patient days, equivalent discharges, and full time equivalent employees.

Report 750 – Hospital's and Hospital Parent Corporation's IRS Form 990, Return of Organization Exempt From Income Tax

A copy of the hospital's and the hospital parent corporation's IRS Form 990, Return of Organization Exempt from Income Tax.

Submit PDF files of the hospital's and the hospital parent corporation's FY 2017 IRS Form 990, Return of Organization Exempt From Income filed with the U.S. Department of the Treasury, Internal Revenue Service.

Schedule A and all Statements referenced in IRS Form 990 must be filed with OHCA. The hospital may redact the specific donor names on Schedule B.

Attachment A

OHCA Recommended Report of Independent Accountants on Applying Agreed-Upon Procedures

Fiscal Year Ended September 30, 2017
Twelve Months Actual Filing
Report of Independent Accountants on Applying Agreed-Upon Procedures

To the Board of Directors and Management
_____Hospital/Medical Center

We have performed the procedures enumerated below, which were agreed to by the State of Connecticut Office of Health Care Access (OHCA) and _____ Hospital/Medical Center (the "Hospital"), solely to assist the specified parties in evaluating the Hospital's compliance with OHCA's requirements for verification of Total Inpatient Payments, Total Outpatient Payments and Total Accrued Payments for the fiscal year ended September 30, 2017. The Hospital's management is responsible for compliance with those requirements. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in this report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose. We were informed by the Hospital's management and other personnel of the Hospital, who have responsibility for accounting and financial matters, that the filing is presented on the basis prescribed by OHCA's instructions and related OHCA correspondence.

Our procedures and findings were as follows:

1. We agreed the total inpatient payments per the hospital's records used to prepare Report 600 to total inpatient payments shown on Section I. D. of Report 600.

   Findings:

   No Exceptions were noted.

2. We agreed the total outpatient payments per the hospital's records used to prepare Report 600 to total outpatient payments shown on Section I. E. of Report 600.

   Findings:

   No Exceptions were noted.

3. We agreed the total payments per the hospital's records used to prepare Report 600 to total payments shown on Section I. F. of Report 600.

   Findings:

   No Exceptions were noted.

4. From the Hospital's records that were used to generate the Plus/Minus Other Adjustments total shown on Section II. A., Line 2 in the Net Revenue Reconciliation section of Report 600 (Plus/Minus Other Adjustments to OHCA Defined Net Revenue), we performed the following:

   a. Read the description of the amounts included in Other Adjustments and compared the description to OHCA's definition of items that are not components of net revenue. These components are adjustments necessary to reconcile OHCA defined net revenue to the hospital's audited financial statements / health system consolidated audited financial statements.

   b. Agreed amounts included in Other Adjustments to the Hospital's accounting records.

   Findings:

   No exceptions were noted.

   A description of items and their respective amounts that comprise other adjustments is as follows:

5. We have attached a copy of the Hospital's Report 600 from our review to this letter.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on Report 600. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the specified parties listed above and is not intended to be and should not be used by anyone other than these specified parties.

March , 2018