SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

► Complete if the organization answered 'Yes' to Form 990, Part IV, question 20.
► Attach to Form 990. ► See separate instructions.

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization
The New Milford Hospital, Inc.

Employer identification number
06-0669121

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If 'No,' skip to question 6a	1a	X	
b	If 'Yes,' was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to the various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing *free* care? If 'Yes,' indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☒ Other 400.0 %	3a	X	
b	Did the organization use FPG to determine eligibility for providing *discounted* care? If 'Yes,' indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% X Other 600.0 %	3b	X	
c	If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the 'medically indigent'?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If 'Yes,' did the organization's financial assistance expenses exceed the budgeted amount?	5b		X
c	If 'Yes' to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If 'Yes,' did the organization make it available to the public?	6b	X	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			938,932.	663,222.	275,710.	0.38
b Medicaid (from Worksheet 3, column a)			8,209,134.	5,633,663.	2,575,471.	3.53
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs	0	0	9,148,066.	6,296,885.	2,851,181.	3.91
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			333,509.		333,509.	0.46
f Health professions education (from Worksheet 5)			22,263.		22,263.	0.03
g Subsidized health services (from Worksheet 6)			898,531.	551,496.	347,035.	0.48
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			6,795.		6,795.	0.01
j **Total.** Other Benefits	0	0	1,261,098.	551,496.	709,602.	0.98
k **Total.** Add line 7d and 7j	0	0	10,409,164.	6,848,381.	3,560,783.	4.89

Part II Community Building Activities

Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development						
9	Other			17,906.	100.	17,806.	0.02
10	Total	0	0	17,906.	100.	17,806.	0.02

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount ... Part VI	2	2,560,334.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and rationale, if any, for including this portion of bad debt as community benefit ... Part VI	3	153,620.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		Part VI		

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	22,240,407.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	33,883,087.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-11,642,680.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:		Part VI

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a		X	
b	If 'Yes,' did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	Part VI	X	

Part IV Management Companies and Joint Ventures (see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1	New Milford MRI JV ,LLC	INACTIVE	100.0000		
2					
3					
4					
5					
6					
7					
8					
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10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities
(list in order of size, from largest to smallest — see instructions)

How many hospital facilities did the organization operate during the tax year? 1

Name, address and primary website address	Licensed hospital	General medical and surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 New Milford Hospital, Inc. 21 Elm Street New Milford, CT 06776	X	X					X	X		

Part V **Facility Information** *(continued)* Copy 1 of 1

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of hospital facility or facility reporting group New Milford Hospital, Inc.

For single facility filers only: line number of hospital facility (from Schedule H, Part V, Section A) 1

		Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)			
1 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If 'No,' skip to line 9	**1**	X	
If 'Yes,' indicate what the CHNA report describes (check all that apply):			
a [X] A definition of the community served by the hospital facility			
b [X] Demographics of the community			
c [X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d [X] How data was obtained			
e [X] The health needs of the community			
f [X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g [X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h [X] The process for consulting with persons representing the community's interests			
i [X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j [ ] Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a CHNA: 2012			
3 In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If 'Yes,' describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted Part VI	**3**	X	
4 Was the hospital facility's CHNA conducted with one or more other hospital facilities? If 'Yes,' list the other hospital facilities in Part VI. Part VI	**4**	X	
5 Did the hospital facility make its CHNA widely available to the public?	**5**	X	
If 'Yes,' indicate how the CHNA was made widely available (check all that apply):			
a [X] Hospital facility's website			
b [X] Available upon request from the hospital facility			
c [ ] Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):			
a [X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b [ ] Execution of the implementation strategy			
c [X] Participation in the development of a community-wide plan			
d [X] Participation in the execution of a community-wide plan			
e [ ] Inclusion of a community benefit section in operational plans			
f [ ] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g [ ] Prioritization of health needs in its community			
h [ ] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i [ ] Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If 'No', explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	**7**	X	
8a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	**8a**		X
b If 'Yes' to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	**8b**		
c If 'Yes' to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V **Facility Information** *(continued)* New Milford Hospital, Inc. Copy 1 of 1

			Yes	No
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	**9**	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	**10**	X	
	If 'Yes,' indicate the FPG family income limit for eligibility for free care: 400 %			
	If 'No,' explain in Part VI the criteria the hospital facility used.			
11	Used FPG to determine eligibility for providing *discounted* care?	**11**	X	
	If 'Yes,' indicate the FPG family income limit for eligibility for discounted care: 600 %			
	If 'No,' explain in Part VI the criteria the hospital facility used.			
12	Explained the basis for calculating amounts charged to patients?	**12**	X	
	If 'Yes,' indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[X] Asset level			
c	[X] Medical indigency			
d	[X] Insurance status			
e	[X] Uninsured discount			
f	[X] Medicaid/Medicare			
g	[X] State regulation			
h	[ ] Other (describe in Part VI)			
13	Explained the method for applying for financial assistance?	**13**	X	
14	Included measures to publicize the policy within the community served by the hospital facility?	**14**	X	
	If 'Yes,' indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The policy was posted on the hospital facility's website			
b	[ ] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[X] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[X] Other (describe in Part VI) Part VI			
Billing and Collections				
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	**15**	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			
17	Did the hospital facility or an authorized a third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?	**17**		X
	If 'Yes,' check all actions in which the hospital facility or a third party engaged:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			

Part V **Facility Information** *(continued)* New Milford Hospital, Inc. Copy 1 of 1

18 Indicate which efforts the hospital facility made before initiating any of the actions checked in line 17 (check all that apply)

- **a** [X] Notified patients of the financial assistance policy on admission
- **b** [X] Notified patients of the financial assistance policy prior to discharge
- **c** [X] Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills
- **d** [X] Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** [ ] Other (describe in Part VI)

Policy Relating to Emergency Medical Care

		Yes	No
19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**19**	X	

If 'No,' indicate why:

- **a** [ ] The hospital facility did not provide care for any emergency medical conditions
- **b** [ ] The hospital facility's policy was not in writing
- **c** [ ] The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)
- **d** [ ] Other (describe in Part VI)

Charges to Individuals Eligible for Financial Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- **a** [ ] The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- **b** [ ] The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- **c** [X] The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- **d** [ ] Other (describe in Part VI)

21 During the tax year, did the hospital facility charge any of its FAP-eligible individuals, to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?	**21**		X
If 'Yes,' explain in Part VI.			
22 During the tax year, did the hospital facility charge any FAP-eligible individuals an amount equal to the gross charge for any service provided to that individual?	**22**		X
If 'Yes,' explain in Part VI.			

Part V **Facility Information** *(continued)*

Section C. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 1

Name and address	Type of Facility (describe)
1 Laboratory Patient Services Center of New Milford 120 Park Lane New Milford, CT 06776	Diagnostic

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

Part III, Line 2 - Methodology Used To Estimate Bad Debt Expense

Part VI:Part III, Line 2:

Methodology Used To Estimate Bad Debt Expense

Bad debt expense is per the audited financial statements.

Part III, Line 3 - Methodology of Estimated Amount & Rationale for Including in Community Benefit

It is the policy of the Hospital to provide necessary care to all persons seeking treatment without discrimination on the grounds of age, race, creed, national origin or any other grounds unrelated to an individual's need for the service or the availability of the needed service at the Hospital. A patient is classified as a charity care patient by reference to established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is anticipated. In assessing a patient's inability to pay, the Hospital utilizes the generally recognized federal poverty income guidelines, but also includes certain cases where incurred charges are significant when compared to a responsible party's income and their countable assets. Those charges are not included in net patient service.

When private pay patients are sent to the collection agency their account is considered to be a bad debt. Subsequently, Medicaid may be granted for some of those patients. At that time those accounts would become charity care or a

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

Part III, Line 3 - Methodology of Estimated Amount & Rationale for Including in Community Benefit (continued)

community benefit.

Part III, Line 4 - Bad Debt Expense

The Hospital's estimation of the allowance for uncollectible accounts is based primarily upon the type and age of the patient accounts receivable and the effectiveness of the Hospital's collection efforts. The Hospital's policy is to reserve a portion of all self-pay receivables, including amounts due from the uninsured and amounts related to co-payments and deductibles, as these charges are recorded. On a monthly basis, the Hospital reviews its accounts receivable balances and various analytics to support the basis for its estimates. These efforts primarily consist of reviewing the following:

Historical write-off and collection experience using a hindsight or look-back approach;

Revenue and volume trends by payor, particularly the self-pay components;

Changes in the aging and payor mix of accounts receivable, including increased focus on accounts due from the uninsured and accounts that represent co-payments and deductibles due from patients;

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

Part III, Line 4 - Bad Debt Expense (continued)

Cash collections as a percentage of net patient revenue less the provision for bad debt; and

Trending of days revenue in accounts receivable.

The Hospital regularly performs hindsight procedures to evaluate historical write-off and collection experience throughout the year to assist in determining the reasonableness of its process for estimating the allowance for uncollectible accounts.

The amount of the allowance for uncollectible accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage and other collection indicators.

The Hospital's primary concentration of credit risk is patient accounts receivable, which consists of amounts owed by various governmental agencies, insurance companies and private patients. The Hospital manages the receivables by regularly reviewing

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

Part III, Line 4 - Bad Debt Expense (continued)

its patient accounts and contracts, and by providing appropriate allowances for uncollectible amounts. Significant concentrations of gross patient accounts receivable include 37% and 5%, and 37% and 6%, for Medicare and Medicaid, respectively, at September 30, 2013 and 2012, respectively.

Part III, Line 8 - Explanation Of Shortfall As Community Benefit

ART III, LINE 8:The Hospital's Medicare Shortfall should be treated as a community benefit as the organization strives to provide around the clock coverage, improved patient access, highest clinical quality as well as addressing the needs of the community by offering critical services to our geographic area. As a result, the organization must balance the cost of these programs against the continued decreasing government reimbursement levels, uninsured population and community needs.

Part III, Line 9b - Provisions On Collection Practices For Qualified Patients

PART III, LINE 9B:It is the policy of the hospital to provide "financial assistance" (either free care of reduced patient obligations) to persons or families where: (I) There is limited or no health insurance available; (II) The patient fails to qualify for governmental assistance (for example Medicare or Medicaid); (III) The patient cooperates with the hospital in providing the requested information; (IV) The patient demonstrates financial need and (V) The hospital makes an administrative

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

Part III, Line 9b - Provisions On Collection Practices For Qualified Patients (continued)

determination that financial assistance is appropriate.

After the hospital determines that a patient is eligible for financial assistance, the hospital will determine the amount of financial assistance available to the patient by utilizing the charitable assistance guidelines which are based upon the most recent federal poverty guidelines. The hospital shall regularly review this financial assistance policy to ensure that at all times it: (I) Reflects the philosophy and mission of the hospital; (II) Explains the decision process of who may be eligible for financial assistance and in what amounts and (III) Complies with all applicable state and federal laws, rules and regulations concerning the provision of financial assistance to indigent patients. Consistent with its mission, the hospital recognizes its obligation to the community it serves to provide financial assistance to indigent persons within the community. In furtherance of its charitable mission, the hospital will provide both (I) emergency treatment to any person requiring such care; and (II) essential, non-emergent care to patients who are permanent residents of its primary service area who meet the conditions and criteria set forth in this policy, without regard to the patients' ability to pay for such care. Elective procedures generally will not be considered essential, non-emergent care and usually will not be eligible for financial assistance. The

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Part III, Line 9b - Provisions On Collection Practices For Qualified Patients (continued)

hospital will collect from individuals on financial assistance if they received a partial charitable discount. All patients can apply for charitable care on balances they feel that they cannot afford.

Part V, Line 3 - Account Input from Person Who Represent the Community

New Milford Hospital

Danbury Hospital

Community Needs:

Effective strategies to improve community health involve active collaboration and commitment among health providers, public and community health agencies, educators, worksites, community and faith-based organizations and groups, and the public they serve.

The organization collaborates with community partners for assessment of community health needs and action planning. Danbury Hospital, and its affiliate partner, New Milford Hospital, participated in the development of a Community Report Card for the Housatonic Valley Region, a 10-district municipality that includes Danbury and New Milford, CT. The other eight towns are Bridgewater, Brookfield, New Fairfield,

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Part V, Line 3 - Account Input from Person Who Represent the Community (continued)

Newtown, Redding, Ridgefield and Sherman, CT, all towns within the primary service area of both hospitals. Developing a plan for health improvement in our region involves collective action by and sharing of expertise and resources across agencies and organizations in both the public and private sectors.

Activities:

1.Community Report Card (CRC) for Western Connecticut produced with indicators, including: community population and demographic data, economic stability, education, health status, health and lifestyle behaviors and risk factors, chronic and communicable diseases, and older adult health survey and focus group findings. Additional data from the CT Association of Directors of Health's Health Equity Index related to social determinants of health and health outcomes and United Way of CT's Infoline 2-1-1 database of health-related programs and services was included.

2.CRC Steering Committee developed - including leads from the City of Danbury Department of Health and Human Services, Western CT Health Network/Danbury Hospital-New Milford Hospital, United Way of Western Connecticut, New Milford Health

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Part V, Line 3 - Account Input from Person Who Represent the Community (continued)

Department, and the Regional YMCA of Western CT.

3.EDUCATION CONNECTION's Center for Healthy Schools & Communities met with the CRC Steering Committee to review the objectives and desired outcomes for these facilitated discussions.

4.Two Community Health Conversations with key community stakeholders in October 2012 - held in two locations (Danbury and New Milford, CT) to ensure accessibility by key stakeholders throughout the region. Attendees included a total of 52 representatives from hospitals; community health centers; school-based health centers; Visiting Nurse Associations/Services; municipal health, education, social service, senior centers and fire departments; non-profit organizations; and a legislator's office. Geographically, all 10 HVR municipalities were represented either directly or through regional agencies and organizations. During the Conversations, the need for collective commitment and responsibility in the prioritization of health issues and development of an action plan for health improvement were emphasized.

5.Priority Health areas identified - Participants in Conversations

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Part V, Line 3 - Account Input from Person Who Represent the Community (continued)

universally agreed that the Priority Health Issues (PHI) most representative of needs in the region were 1) prevention/reduction of most prevalent chronic diseases/health conditions (specifically obesity, hypertension, and type II diabetes), by addressing underlying risk factors; 2) substance use/abuse and co-related mental health issues; 3) older adult health, housing and social support needs; and 4) improved awareness and utilization of existing health and social programs and services. Each of these areas also recognizes that disparities in health care access and outcomes need to be addressed. Upon reaching consensus on the priority health issues, participants self-selected a workgroup to join based on their interests and expertise. Overall, data obtained from the Conversations provided high quality information needed to begin the community health improvement action planning process in the region. A broad diversity of community stakeholders attended both sessions, conversations were dynamic, and stakeholders were actively engaged in the process and expressed commitment to working together in the future to address the identified priority health issues.

6.Health Improvement Action Planning - Throughout 2013, the CRC Steering Committee and PHI workgroups continued to meet to further develop and refine their action plans. Consistent with each team's vision and mission, and informed by the

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Part V, Line 3 - Account Input from Person Who Represent the Community (continued)

CRC and Community Conversation findings, a Community Health Improvement Action Plan for Western CT by PHI has been developed. The plan addresses four priority community needs: substance abuse and related mental health issues; seniors' health and housing; chronic disease prevention; and health care access. It is important to note that Action Plans are dynamic documents and are influenced by emerging needs. With this in mind, the workgroups will continue to meet at least quarterly to expand upon, modify, and refine their PHI objectives, strategies, and action steps and to collectively evaluate progress towards achieving health improvement in the region.

7.Board Endorsement - The Community Report Card and Health Improvement Action Plan have been endorsed by the BOD and documents are available on the organization's website and available upon request.

8.New Milford Hospital, located in Litchfield County, also participated in the 2012 Litchfield County Community Health Needs assessment and has representation on the Litchfield County Community Transformation Grant Coalition Steering Committee. In collaboration with the Pomperaug Health District and New Milford Health Department with a Blood Pressure self-monitoring pilot to address an identified need related to chronic disease.

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Part V, Line 3 - Account Input from Person Who Represent the Community (continued)

To create a "new picture of health," our community members must be more engaged in order to best navigate an evolving health care system. We've used the strength of our network, through education, interaction and outreach, to keep our residents informed about the changing health care environment, and how available local resources can help them manage their own health while directing them to the right care in the right place and at the right time.

We survey our consumers on a regular and ongoing basis for their opinions and concerns.

New Milford Hospital expanded its nationally recognized Plow to Plate® initiative. Created in 2006 with local farms and community-based programs, Plow to Plate is now recognized as a model for healthy eating and community partnership. Plow to Plate has expanded to include a Signature Dish program, whereby New Milford Hospital engages local restaurants in community health. As of 2013, more than 20 area restaurants participate by offering at least one unique, healthy dish on their menu that meets the Plow to Plate nutrition guidelines. Every week the hospital invites older residents to its "Senior Suppers" to enjoy an inexpensive, healthy dinner in the

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Part V, Line 3 - Account Input from Person Who Represent the Community (continued)

cafeteria-one of the most popular hospital events while enjoying a social and healthful discussion.

Part V, Line 4 - List Other Hospital Facilities that Jointly Conducted Needs Assessment

The organization collaborates with community partners for assessment of community health needs and action planning. Danbury Hospital, and its affiliate partner, New Milford Hospital, participated in the development of a Community Report Card for the Housatonic Valley Region, a 10-district municipality that includes Danbury and New Milford, CT. The other eight towns are Bridgewater, Brookfield, New Fairfield, Newtown, Redding, Ridgefield and Sherman, CT, all towns within the primary service area of both hospitals. Developing a plan for health improvement in our region involves collective action by and sharing of expertise and resources across agencies and organizations in both the public and private sectors.

Part V, Line 14g - Other Means Hospital Facility Publicized the Policy

New Milford Hospital has messages on all statements providing how the patient can get assistance with their Hospital bill. Counselors are also available to provide further assistance.

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Part VI - Needs Assessment

PART VI,LINE 2:The Organization monitors and reports CMS information. Data includes basic demographics, along with health issue-specific information. Additionally, we survey our consumers on a regular and ongoing basis for their opinions and concerns.

Part VI - Patient Education of Eligibility for Assistance

PART VI,LINE 3:The Hospital has messages on all statements providing information regarding how the patient can get assistance with their hospital bill. Also signs are posted throughout the hospital and counselors are available to provide further assistance. All uninsured inpatients are interviewed by financial counselors and assessed for eligibility for assistance programs. The hospital provides informational handouts to all uninsured patients at the time of registration which refers them to financial counseling if they would like assistance with their bills. Further, the hospital mails notices to all self-pay accounts referring them to financial counseling if they need assistance. The collection department will also refer patients to financial counseling when a patient indicates that they cannot afford their balances; and finally, schedulers refer uninsured patients to financial counseling prior to their test or procedure.

One barrier to health care outlined in the Community Needs Assessment was that so many people were uninsured or underinsured. To help eliminate this barrier to

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Part VI - Patient Education of Eligibility for Assistance (continued)

needed care, in 2013 WCHN actively advocated for Access Health CT, the state's new health insurance marketplace, using grass roots communication to encourage enrollment in Access Health CT. WCHN held in-service trainings for our staff, participated in community educational forums and enrollment fairs, and distributed promotional materials throughout the Network and region. Our hospitals are now considered by the state a model hospital for promoting the significant benefits of insurance enrollment.

Part VI - Community Information

PART VI,LINE 4:The Hospital's primary service area is the city of New Milford and surrounding suburban towns that make up central Litchfield County. The region is generally employed and with average incomes. Constituents are predominantly Caucasian, skew somewhat older than other areas of CT and the U.S. Poverty levels are below other areas.

Part VI - Community Building Activities

PART VI, New Milford Hospital is actively engaged with the community that it serves. We provided $17,806 of net community benefit expenses related to community health improvement advocacy , workforce development and coalition building activities to learn about the community's health and other needs.

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Part VI - Explanation Of How Organization Furthers Its Exempt Purpose

PART VI,LINE 5:During fiscal year 2013, New Milford Hospital served 1,824 inpatients and cared for 56,020 outpatients. In addition, 17,850 patients came through our emergency department and 2,075 one-day surgery procedures were performed. Led by a team of skilled and dedicated healthcare professionals, New Milford Hospital's committment to clinical excellence and patient satisfaction were recognized by numerous prestigious organizations in 2013. The formation of Western Connecticut Health Network, a healthcare delivery system that combines the resources and expertise of Danbury Hospital, New Milford Hospital and their affiliates, represents a historical achievement. This affiliation gives us an opportunity to provide a higher level of care throughout the region in the most cost-effective manner while meeting the challenges posed by healthcare reform head on. Providing our physicians and medical team with the technological advances they need to succeed remains a priority. The Linear Accelerator cancer treatment system, 64 slice CT scanner, and the open bore MRI imaging system, for example, offer patients a sophisticated level of care rarely available in a community hospital. Knowledge is power when it comes to improving the health and wellness of people of all ages in Connecticut and New York. That's the message behind a number of hospital initiatives designed to build healthy communities.

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Part VI - Affiliated Health Care System Roles and Promotion

PART VI,LINE 6:Western Connecticut Health Network, Inc. (parent)

Western Connecticut Health Network's mission is to improve the health and well being of those we serve, which helps to further the hospital's exempt purpose.

Danbury Hospital:

Danbury Hospital provides medical services to the community regardless of the individual's ability to pay. Services include routine inpatient ancillary and outpatient care in support of the hospital's mission statement,to improve the health and well being of those we serve.For 2013, Danbury Hospital provided $4,954,000 in charity care.

New Milford Hospital:

New Milford Hospital's mission is to provide outstanding health care to the communities they serve through an uncompromising focus on clinical quality, compassionate service, and the creation of a medical"safe haven" for their patients and their families. For 2013, New Milford Hospital provided $1,048,932 in charity care.

Western Connecticut Medical Group:

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3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

Part VI - Affiliated Health Care System Roles and Promotion (continued)

The mission at Western Connecticut Medical Group is to provide safe, innovative, convenient and coordinated primary and specialty health care in the communities they serve and strive to be aware of and respond to their patients needs. They support a commitment to advance the health and well-being of individuals in their community by delivering quality care, participating in medical research and medical residency programs and the provision of medical services to patients. For 2013, Western Connecticut Medical Group provided $1,794,739 in charity care.

Western Connecticut Health Network Foundation, Inc.:
Western Connecticut Health Network Foundation Inc.'s mission is to raise funds, reinvest and administer these funds and make distributions to Danbury Hospital and other not-for-profit health care affiliates.

Western Connecticut Health Network Affiliates:
Western Connecticut Health Network Affiliates principal purpose is to provide outpatient health care services in various locations and also provide ambulance services to Danbury and surrounding towns, while serving those that cannot afford the care. Approximately $11,000 in charity care was provided during 2013.

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

Part VI - Affiliated Health Care System Roles and Promotion (continued)

Business Systems, Inc.

Business Systems, Inc, is a taxable corporation whose main business is the operation of Danbury Pharmacy, a retail pharmacy. The Pharmacy's revenue is comprised of prescription sales, over the counter sales, and wholesale sales (medical and surgical supplies) sold to office practices and clinicians that are not covered by insurance programs. At the end of 2013 the Danbury Pharmacy was sold to Walgreen's Pharmacy.

Western Connecticut Home Care, Inc.:

Western Connecticut Home Care, Inc. (WCHC) provides state of the art clinical services ranging from pediatric patients to the elderly utilizing best practice in home care to meet the needs of their patients. For 2013, WCHC provided $587,777 for charity care.

Eastern New York Medical Services

Eastern New York Medical Services (ENYMS) was formed in April, 2013.

The mission at ENYMS is to provide safe, innovative, convenient and coordinated

Part VI Supplemental Information

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1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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Part VI - Affiliated Health Care System Roles and Promotion (continued)

primary and gastro health care in the communities we serve and strive to be aware of and respond to our patients needs. For 2013, ENYMS provided approximately $1,000 for charity care.

Part VI - States Where Community Benefit Report Filed

CT

Additional Information

Schedule H, Part I, Line 6a.

The Community Benefit report is reported on a Network basis.

Schedule H, Part I, Line #7. Costing Methodology Used To Calculate The Amounts Reported In The Table:

Charity Care At Cost Percentage:

Line 7a.,(col.c) Total Gross Patient charges written off to charity (Income Statement) * Ratio of Patient Care Cost to Charge % (see below) plus Medicaid provider taxes= Total community benefit expense.

Line 7a.,(col.d) Revenue from Uncompensated Care Pools and programs (DSH * % of cost

Part VI Supplemental Information

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1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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Additional Information (continued)

of uncompensated care shown on the OCHA Schedule 500)= Direct offsetting revenue

Line 7a.,(col.e) Total Community Benefit Expenses - Revenue from Uncompensated Care Pools and programs (DSH * % of cost of uncompensated care shown on the OCHA Schedule 500) = Net community benefit expense.

Line 7a.,(col.f) Net community benefits expenses / total expenses = Percent of total expense. Total expenses from Part IX, line 25 column (a) was used for purposes of calculating Line 7a., column (f).

Line 7 b. Ratio of Cost To Charge for the Medicaid patients based on the Hospital's KREG cost accounting system.

Line 7 e. Actual expenses less any direct offsetting revenue.

Line 7 f. Actual expenses less any direct offsetting revenue.

Line 7 g. Ratio of Cost To Charge based on the Hospital's KREG cost accounting system. There are no physician clinics included in this amount.

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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Additional Information (continued)

Line 7 i. Actual expenses of the contributions.

Ratio Cost To Charge Calculation:

Total Operating Expenses divided by Adjusted Patient Care Cost

(Bad Debt, Other Operating Income and Intercompany Income are removed from the total operating expenses)

Adjusted Patient Care Cost divided by Gross Patient Charges= Ratio of patient care costs to charges