CONNECTICUT
Health Strategy

Draft
Hospitals' Community Benefit
Summary and Analysis Report
2022

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Acknowledgements

The Connecticut Office of Health Strategy (OHS), an executive state agency, is charged with overseeing Connecticut hospitals' community benefit program reporting and submits this report for public comment. This report is a summary and analysis of Connecticut hospitals' community benefit and fulfills OHS' obligation to develop a report and make it available for public comment, pursuant to Connecticut General Statutes (C.G.S.) §19a-127k, found in Appendix A.

OHS' mission is to implement comprehensive, data driven strategies that promote equal access to high quality health care, control costs, and ensure better health for the people of Connecticut. OHS is responsible for the oversight of hospitals' community benefit reporting in Connecticut.

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Executive Summary

Introduction

Pursuant to C.G.S. 19a-127k, the Office of Health Strategy (OHS) is responsible for producing an annual report with analyses, findings, and recommendations regarding Connecticut hospitals' community benefit programs. Community benefit refers to the services and activities nonprofit hospitals provide in order to obtain or maintain their tax-exempt status. The following document is OHS's first such annual report under this statute.

This report provides an overview of community benefit, reviews hospitals' latest Community Health Needs Assessments (CHNA) and Implementation Strategies, analyzes community benefit expense data from 2016 through 2022, assesses hospitals' Annual Status Reports, reviews hospitals' criteria for providing financial assistance and explores how hospitals approach those individuals holding "bad debt" - which consists of services for which a tax-exempt hospital anticipated but did not receive payment - discusses the punitive actions hospitals may take against individuals who hold bad debt, as well as reviews how hospitals are compensating certain employees, and examines who is overseeing these nonprofit facilities. The findings of this report cover 27 acute care hospitals from 2016 to 2022. In 2022, there were 23 acute care, nonprofit hospitals operating in Connecticut.

This report is intended to serve as a tool and a resource to better understand the landscape of hospital community benefit programs and their impact in the state.

Background

Community benefit categories outlined by the Internal Revenue Service (IRS) Form 990, Schedule H, Part I include: financial assistance at cost (also known as charity care), the reported unreimbursed costs from means-tested government programs, community health and operation expenses, subsidized health services, unfunded research, health professions education, and cash and in-kind contributions. In addition to Part I, the IRS allows hospitals to justify additional expenses as potential community benefit in Part II and Part III of the Schedule H. OHS does not have confirmation on whether these additional expenses are ultimately counted by the IRS as community benefit. In the IRS' annual report to Congress, Part I of the Schedule H is classified as community benefit, Part II is not reviewed or analyzed, and Part III categories are used for comparisons and not referred to as community benefit.[1] Therefore, the analyses in this report review community benefit expenses as documented by the hospitals in Part I of Schedule H. Expense data reported by hospitals in Part II and Part III that require justification to count as potential community benefit are included in this report separately.

In C.G.S. 19a-127k(a)(2) the Connecticut General Assembly has further defined a community benefit program, as consisting of the activities and services that promote preventive health care, improve health equity by reducing health disparities, and overall improve the health status of people in the region served by the hospital. This statute requires hospitals to submit an Annual Status Report to OHS, which includes data on their CHNA and Implementation Strategy. This document reviews data submitted through these reports.

[1] Tax Exempt & Government Entities Division, Internal Revenue Service. (2023). Report to congress on private tax-exempt, taxable and government-owned hospitals.

Key findings

1. In filing year 2022, the total community benefit expense in Connecticut was $1.7 billion which represents 11.78% of total expenses. Total nonprofit hospital revenues in the same period were $14.8 billion, and total expenses were $15 billion.

2. The majority of documented community benefit (61%) is the reported unreimbursed costs from Medicaid at $1 billion. The following top categories of community benefit expense comprise the following: $265 million for health professions education (15%); and $256 million for financial assistance at cost, also known as charity care (14%).

3. From 2016 to 2022, hospitals' total community benefit expense increased by $73 million, but decreased by 4 percentage points as a percentage of total hospital expenses.

4. Charity care, which is free or discounted care for patients that meet eligibility requirements, has declined by $88.6 million from 2016-2022, a 25.7% drop.

5. The decline in charity care has been accompanied by an increase in bad debt. Bad debt consists of services for which a tax-exempt hospital anticipated but did not receive payment. From 2016-2022, hospitals estimated $100 million of bad debt was attributable to individuals who would have qualified for charity care. Hospitals may report this particular debt as a community benefit by submitting rationale and methodology justifying it as a community benefit. OHS does not have information on whether that is accepted by the IRS or if any punitive actions were taken by the hospital against those individuals.

6. Connecticut hospitals have varying financial assistance policies, and several nonprofit hospitals have income limits for receiving charity care that are less generous or the same as for-profit hospitals not receiving tax-exemptions.

7. The U.S. Government Accountability Office (GAO) found the current tax-exemption structure may allow some hospitals to maintain a tax-exemption status by merely operating an emergency room open to all and accepting beneficiaries of Medicaid and Medicare, which are common among hospitals, while spending little to no money on other community benefit categories. In Connecticut, 11 of 23 hospitals claimed over 70% of community benefit expenses as the reported unreimbursed costs from Medicaid, four hospitals claimed over 80%, and one hospital claimed over 90%.

8. Community benefit expense reporting lacks transparency. Clarity on how expenses are calculated is needed since current calculations are reported as a net aggregate total to the IRS and the State. In addition, calculations are not standardized and may vary from hospital to hospital.

9. In filing year 2022, hospitals documented in total $815,574,263 for activities supporting hospitals' Implementation Strategy in their Annual Status Reports. This total includes $787.5 million that hospitals indicated also counted as community benefit, $10.1 million that counted

as community building, and an additional $18 million that hospitals funded and did not demonstrate either. The analysis shows that some hospitals reported higher expenses in their Annual Status Report than what was reported in the IRS Form 990 Schedule H.

10. Additional reportable expenses that may count as community benefit based on the hospitals' justification are reported in Part II and Part III of the Schedule H. These include community building activities ($14.1 million), bad debt ($23 million), and Medicare shortfall ($645.3 million) in filing year 2022. OHS is not able to confirm if the justifications were accepted by the IRS.

11. In filing year 2022, hospital and health system CEO/President's total compensation in Schedule J of the IRS Form 990 was $40.5 million; ranging from $320,000 to $5.5 million.

Data reviewed in this report comes from hospital and health system submissions to the IRS and to OHS through various reporting requirements. OHS has not substantiated this data.

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Acronyms

ACA……Patient Protection and Affordable Care Act
APCD……All-Payer Claims Database
CGS……Connecticut General Statutes
CHA……Catholic Health Association
CHNA……Community Health Needs Assessment
ECA……Extraordinary Collection Action
EMCP……Emergency Medical Care Policy
FAP……Financial Assistance Policy
FPG……Federal Poverty Guidelines
FPL……Federal Poverty Level
GAO……Government Accountability Office
HHC……Hartford HealthCare
HHCMG……Hartford HealthCare Medical Group
HRS……Hospital Reporting System
IRC……Internal Revenue Code
IRS……Internal Revenue Service
NEMG……New England Medical Group
OHS……Office of Health Strategy
PHE……Public Health Emergency
REL……Race, Ethnicity, and Language
SCHIP……State Children's Health Insurance Program
SDOH……Social Determinants of Health
YNHH……Yale New Haven Hospital
YNHHS……Yale New Haven Health Services

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Glossary

1. **Bad debt:** consists of services for which a tax-exempt hospital anticipated but did not receive payment.[2]
2. **Cash and in-kind contributions for community benefit:** are funds and in-kind services donated to community organizations or to the community at large for a community benefit purpose.[3] An example is event sponsorship, or contributions for providing technical assistance, or evaluation of community coalition efforts.
3. **Community benefit operations:** are costs associated with assigned staff and community health needs and/or assets assessment, as well as other costs associated with community benefit strategy and operations.[4] An example is the costs related to the Community Health Needs Assessment and developing the Implementation Strategy.[5]
4. **Community Building:** are the activities that help build the capacity of the community to address health needs and often address the "upstream" factors and social determinants that impact health, such as education, air quality, and access to nutritious food.[6]
5. **Community health improvement services** are activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services don't generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services.[7] Examples of a community health improvement service if it addresses a community health need and meets a community benefit objective are exercise classes, screenings (blood pressure, behavioral health, hearing, etc.), clinics for the underinsured or uninsured, assistance to enroll in public programs like Medicaid, or programs and activities that address social determinants of health (as long as they are not also documented as community building).[8]
6. **Costs from other means-tested programs:** is the shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries. This payment shortfall is not the same as a contractual allowance, which is the full difference between charges and government payments.[9] An example of another means-tested government program is a State Children's Health Insurance Program (SCHIP).
7. **Extraordinary collection actions:** actions taken by a hospital after the facility has made a reasonable effort to determine whether an individual is eligible for assistance under the hospital

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[2] Robert Wood Johnson Foundation & RTI International. (n.d.). Terms and glossary. Community benefit insight. https://www.communitybenefitinsight.org/?page=info.glossary

[3] Catholic Health Association. (2015). Community benefit categories and definitions: a guide for planning & reporting community benefit. 293–320. https://www.chausa.org/docs/default-source/community-benefit-guide-2015/2015-cb-guide-categories-definitions.pdf?sfvrsn=4

[4] *Id.*

[5] *Id.*

[6] Robert Wood Johnson Foundation and RTI International. (n.d). Community benefit spending 101. Community benefit insight. https://www.communitybenefitinsight.org/?page=info.cb101

[7] Internal Revenue Service. (2022). Instructions for Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/i990sh.pdf

[8] Catholic Health Association. (2015). Community benefit categories and definitions: a guide for planning & reporting community benefit. 293–320. https://www.chausa.org/docs/default-source/community-benefit-guide-2015/2015-cb-guide-categories-definitions.pdf?sfvrsn=4

[9] *Id.*

organization's financial assistance policy (FAP).[10] Examples of ECAs include but are not limited to selling an individual's debt to another party, such as a collection agency, reporting adverse information about an individual to consumer credit reporting agencies/bureaus, deferring or denying medically necessary care because of non-payment, suing a patient to: put a lien on property, foreclose on real property, or garnishing wages.

8. **Financial assistance policy:** is a widely publicized document that applies to all emergency and medically necessary care, addresses the financial assistance available to patients, criteria and eligibility for financial assistance, the basis for calculating amounts charged, the method for applying for financial assistance, the collections process, and a list of providers that are included and excluded from financial assistance.[11]
9. **Filing year:** may include different months depending on the hospital and refers to a hospital's fiscal year. Most hospitals use a fiscal year from October 1 – September 30; some hospitals in the data set used a calendar year, and in one case a condensed year due to a change in tax status.
10. **Health professions education:** are educational programs for physicians, interns and residents, medical students, nurses and nursing students, pastoral care trainees and other health professionals when that education is necessary for a degree, certificate, or training that is required by state law, accrediting body or health profession society.[12] An example of health professions education includes the direct costs of stipends, fringe benefits of interns, residents, and fellows in accredited graduate medical education programs.[13]
11. **Financial assistance at cost (charity care):** is free or discounted health services provided to persons who cannot afford to pay and who meet the eligibility criteria of the organization's financial assistance policy. [14] The IRS states charity care excludes bad debt. An example of charity care is providing an eligible patient a 50% discount on their medical bill.
12. **Medicaid (the reported unreimbursed costs from Medicaid)**: is the shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries. This payment shortfall is not the same as a contractual allowance, which is the full difference between charges and government payments.[15] An example is when a hospital treated a patient with Medicaid, and there is a negative difference between the hospital's costs incurred for treating the patient and the payment received. While the IRS suggests a standard method for calculating shortfall, it also allows hospitals to use their own methodologies. Hospital-specific methodologies are not available for review.

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[10] Internal Revenue Service. (n.d.-a). Billing and Collections – Section 501(r)(6). https://www.irs.gov/charities-non-profits/billing-and-collections-section-501r6

[11] Internal Revenue Service. (n.d.-b). Financial Assistance Policies (FAPs). https://www.irs.gov/charities-non-profits/financial-assistance-policies-faps

[12] Catholic Health Association. (2015). Community benefit categories and definitions: a guide for planning & reporting community benefit. 293–320. https://www.chausa.org/docs/default-source/community-benefit-guide-2015/2015-cb-guide-categories-definitions.pdf?sfvrsn=4

[13] Internal Revenue Service. (2022). Instructions for Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/i990sh.pdf

[14] Catholic Health Association. (2015). Community benefit categories and definitions: a guide for planning & reporting community benefit. 293–320. https://www.chausa.org/docs/default-source/community-benefit-guide-2015/2015-cb-guide-categories-definitions.pdf?sfvrsn=4

[15] *Id.*

13. **Research:** is any study or investigation the goal of which is to generate increased generalizable knowledge made available to the public, and the cost is funded by a tax-exempt or government entity, or internally with exceptions.[16] An example provided by the IRS is an evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols.
14. **Subsidized health services:** are clinical services provided despite a financial loss to the organization. The financial loss is measured after removing losses associated with bad debt, financial assistance, Medicaid, and other means-tested government programs.[17] An example of subsidized health services could be psychiatric inpatient beds.

A. Introduction: What is Community Benefit, Report Overview, and Background

What is Community Benefit?

Community benefits are the services and activities that nonprofit hospitals demonstrate for tax-exemption.[18, 19] This exemption provides relief from federal and state income tax, sales tax, and property tax, as well as indirect benefits such as issuing tax-free bonds and receiving charitable donations that provide the donor a tax deduction.[20, 21] It is important to note that there is no maximum or minimum community benefit expense amount required by the federal government, and hospitals are not required to measure if community benefits are improving community health.

There are a number of ways hospitals can demonstrate community benefit as required by the IRS. In Connecticut, the three most common expenses are: accepting patients on Medicaid; using funds to support health profession education; and providing financial assistance, which is free or discounted care to eligible patients, also known as charity care.

In 2022, the Connecticut General Assembly passed Public Act 22-58 as a step to strengthen the State's community benefit oversight and defined a community benefit program as "any voluntary program or activity to promote preventive health care, protect health and safety, improve health equity and reduce

[16] Internal Revenue Service. (2022). Instructions for Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/i990sh.pdf
[17] Internal Revenue Service. (2022). Instructions for Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/i990sh.pdf
[18] The Hilltop Institute. (n.d.). What are hospital community benefits?. https://hilltopinstitute.org/wp-content/uploads/publications/WhatAreHCBsTwoPager-Sept2019.pdf
[19] Catholic Health Association. (n.d.). Community benefit overview. https://www.chausa.org/communitybenefit/community-benefit
[20] Rosenbaum, S. A., Kindig, D. K., Bao, J., Byrnes, M. K., & O'Laughlin, C. (2015). The value of the nonprofit hospital tax exemption was $24.6 billion in 2011. *Medicaid's Evolving Delivery Systems*, *34*(7). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2014.1424?journalCode=hlthaff
[21] Herring, B., Gaskin, D., Zare, H., & Anderson, G. (2018). Comparing the value of nonprofit hospitals' tax exemption to their community benefits. *Inquiry*, *57, January-December 2020*. https://www.jstor.org/stable/27033482

health disparities, reduce the cost and economic burden of poor health and improve the health status for all populations within the geographic service areas of a hospital."[22]

Community Benefits can be impactful and meaningful in addressing social-related factors impacting health and reducing health inequities. Below are examples of programs that Connecticut hospitals have implemented to improve community health:

1. Middlesex Health partnered with the Middletown Health Department and the Ministerial Health Fellowship to create the Vaccine Equity Partnership Program, addressing COVID-19 vaccination disparities among communities of color and underserved populations.[23]
2. Backus Hospital has been working with Madonna Place, a Norwich-based nonprofit focused on strengthening families, to distribute 11,000 diapers monthly as part of the hospital's Diaper Connections program. [24]
3. Staff members of Bridgeport Hospital gave their time and expertise to high school students in physiology classes and participated in a career panel focused on physical therapy, nursing, radiology, and pharmacy careers.[25]

Nationally, hospital community benefit has garnered more attention after the COVID-19 pandemic, creating an opportunity for states and hospitals to strengthen community benefit activities that directly improve health outcomes. Some states are exploring ways to increase community benefit spend toward social needs. California proposed nonprofit hospitals demonstrate how they are supporting local health efforts to address social determinants of health, and each nonprofit hospital direct 25% of their community benefit dollars to these efforts.[26] Moreover, Maryland is changing their guidance and asking hospitals to link the needs identified in their Community Health Needs Assessments with their financial accounting.[27]

In addition to the changes from the pandemic, states are making note of hospitals' community benefit and taking action when required. Washington's Office of the Attorney General sued a health system for violations concerning the hospitals' charity care practices, resulting in hundreds of millions of dollars in medical/bad debt being returned or erased for patients and their families.[28] In North Carolina, the State Treasurer found that hospitals were reporting Medicare profits over $100 million in federally required

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[22] C.G.S. Sec. §19a-127k. (2022). Community benefit programs. Program reporting. Office of health strategy summary and analysis. https://www.cga.ct.gov/current/pub/chap_368a.htm#sec_19a-127k

[23] Connecticut Hospital Association. (2022). Community Benefit Report. https://www.cthosp.org/documents/web/CHA%20website/2022%20toolkit/2022%20Community%20Benefit%20Report.pdf

[24] Connecticut Hospital Association. (2024). Community Benefit Report. https://www.cthosp.org/documents/advocacy/2024/2024%20Toolkit%20Community%20Benefit%20Report.pdf

[25] *Id.*

[26] Barnett, K. (2022). Community benefit in California: A new chapter. https://www.phi.org/thought-leadership/community-benefit-in-california-a-new-chapter/

[27] The Hilltop Institute. (2021). HCB Reporting– FY 2021 key changes. https://hscrc.maryland.gov/Documents/July%20HCB%20Webinar%20Slides.pdf

[28] Johnson, G. (2024). After Washington State lawsuit, Providence Health System erases or refunds $158m in medical bills. https://apnews.com/article/ferguson-providence-medical-debt-swedish-hospital-168405fcf8525b2516a0ff571beca705

financial documents and claiming losses in the same year to the IRS of over $600 million, which may have counted as community benefit.[29]

At the federal level, there is Congressional bipartisan focus on hospitals' community benefit. A group of Senators sent a letter to the US Department of the Treasury nothing that they are "alarmed" by the overly broad definition of community benefit, and nonprofit hospitals engaging in punitive actions (extraordinary collection actions) that are not in the best interest of patients. The US House of Representatives held a hearing on the community benefit standard and heard expert testimony outlining short comings of the standard and current oversight. Additionally, the Health, Education, Labor, and Pensions Senate Committee released a staff report highlighting concerns regarding hospitals' debt collection practices and CEO compensation in light of their tax-exemption status.[30, 31, 32]

Furthermore, the Biden Administration proposed a new rule to protect people who have medical debt on their credit report, which includes bad debt write-offs by nonprofit hospitals that may count aspects of uncompensated care as community benefit.[33, 34] The Administration stated that "[hospitals] have a responsibility to offer non-predatory payment plans or financial assistance to all eligible patients."[35]

Community benefits hold an important role in improving health outcomes, reducing health inequities, making health care affordable, and addressing factors that lead to poor health. Community benefit reporting is a tool for states to advance efforts to improve health by providing more insight into how hospitals receiving federal, state, and local tax exemptions are investing in their communities, and if those efforts are leading to improved health outcomes.

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[29] North Carolina State Health Plan for Teachers and State Employees. (2022). Overcharged North Carolina hospitals profit on Medicare. https://www.shpnc.org/documents/shp-documents/what-health-north-carolina-hospitals-profit-medicare/download?attachment.

[30] U.S. Committee on Ways and Means. (2023). Hearing on tax-exempt hospitals and the community benefit standard: Hearings before Committee on Ways and Means, House, 118th Congress. https://gop-waysandmeans.house.gov/wp-content/uploads/2023/08/WEBSITE-April-26-2023-OS-Sub-Hearing-Transcript.pdf

[31] Warren, E., Cassidy, B., Warnock, R., Grassley, C.E. (2023). Letter to Commissioner Werfel and Commissioner Killen. https://www.grassley.senate.gov/imo/media/doc/grassley_colleagues_to_tigta_and_irs_-_nonprofit_hospital_tax_exemption.pdf

[32] Sanders, B. (2023). Executive Charity. https://www.sanders.senate.gov/wp-content/uploads/Executive-Charity-HELP-Committee-Majority-Staff-Report-Final.pdf

[33] Consumer Protection Financial Bureau. (n.d.). Small business advisory review panel for consumer reporting rulemaking. https://files.consumerfinance.gov/f/documents/cfpb_consumer-reporting-rule-sbrefa_outline-of-proposals.pdf

[34] The White House. (2022). FACT SHEET: The Biden Administration announces new actions to lessen the burden of medical debt and increase consumer protection. https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/11/fact-sheet-the-biden-administration-announces-new-actions-to-lessen-the-burden-of-medical-debt-and-increase-consumer-protection/.

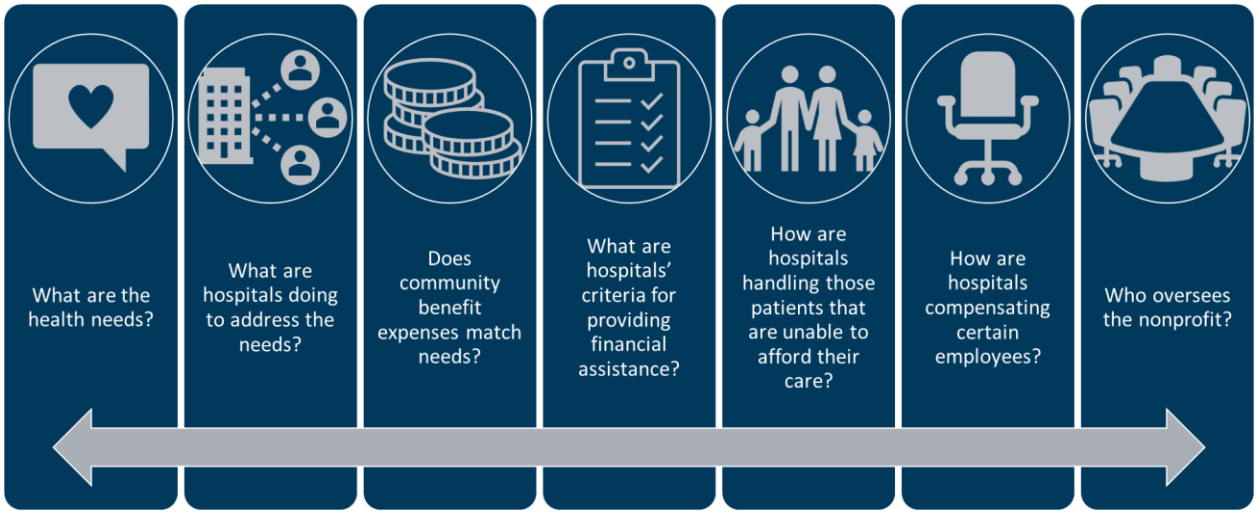
[35] *Id.*

Report Overview

This summary and analysis report is composed of:

A. An introduction and overview of hospitals' community benefit expenses, Community Health Needs Assessments and Implementation Strategies, and Financial Assistance Policies.
B. Methodologies used for the community benefit analyses.
C. Findings and discussion.
D. Recommendations.

The findings and discussion section of the report provides descriptive analyses and observations. This report also provides context and information regarding the following key questions:



Community Benefit Overview: Federal

There are currently three federal requirements for nonprofit hospitals to obtain or maintain their tax-exempt status:

1. Be organized and operated to achieve a charitable purpose.
2. Demonstrate one to six factors outlined by the IRS, colloquially known as community benefit.
3. Comply with requirements in the Patient Protection and Affordable Care Act (ACA).

Community Benefit started in 1956, when the Internal Revenue Service (IRS) released Revenue Ruling 56-185 which outlined four community benefit requirements that nonprofit hospitals must fulfill to be considered *charitable* organizations and obtain tax-exemption status. One of the main requirements for hospitals was to provide free or discounted "charity" care for eligible patients.

After the passage of Medicare and Medicaid in 1965, concern grew that there would be less need for charity care, and this potential decline threatened hospitals' tax-exempt status.[36] In 1969, the IRS released Revenue Ruling 69-545 which broadened the interpretation of *charitable* to include the promotion of health. This broadened interpretation means nonprofit hospitals today must be organized

[36] Rozier, M.D. (2020). Nonprofit hospital community benefit in the U.S.: A scoping review from 2010 to 2019. *Frontiers in Public Health*, *8*, 72. https://doi.org/10.3389/fpubh.2020.00072

and operated for a *charitable* purpose to be considered for tax-exemption. In addition to the expansion of *charitable*, Revenue Ruling 69-545 outlined six factors that hospitals may demonstrate as community benefit:

1. Operate an emergency room open to all, regardless of ability to pay.
2. Maintain a board of directors drawn from the community.
3. Maintain an open medical staff policy.
4. Provide hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare.
5. Use surplus funds to improve facilities, equipment, and patient care.
6. Use surplus funds to advance medical training, education, and research.

In determining if a hospital demonstrates any of these six factors, the IRS uses a community benefit standard. The agency notes that "no one factor is determinative in considering whether a nonprofit hospital meets the community benefit standard [and] the IRS weighs all the relevant facts and circumstances in evaluating these factors. Additional factors, such as whether a hospital provides financial assistance to those not able to pay, are relevant in determining whether the hospital is providing a benefit to the community."[37] Hospitals currently document their demonstration of community benefit in Schedule H of the IRS Form 990.

Community benefit categories outlined by the Internal Revenue Service (IRS) Form 990, Schedule H, Part I include: financial assistance at cost (also known as charity care), the unreimbursed costs from means-tested government programs, community health and operation expenses, subsidized health services, unfunded research, health professions education, and cash and in-kind contributions. In addition to Part I, the IRS allows hospitals to justify additional expenses as potential community benefit in Part II and Part III of the Schedule H. However, OHS does not have confirmation as to whether these additional justifications were accepted by the IRS and reclassified as community benefit.

[Intentionally left blank]

[37] Internal Revenue Service. (n.d.-c). Charitable hospitals - general requirements for tax-exemption under Section 501(c)(3). https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA) adding requirements for hospitals to keep their tax-exempt status. These requirements were codified in Internal Revenue Code Section §501(r), which require hospitals to:[38]

Complete a Community Health Needs Assessment and adopt an Implementation Strategy every three years.

Have a written Financial Assistance Policy (FAP) and Emergency Medical Care Policy.

Limit the amount charged for any emergency or other medically necessary care to a FAP-eligible individual to not more than the amount generally billed to individuals who have insurance covering such care.

Make a reasonable effort to determine whether an individual is eligible for assistance under the FAP before engaging in collection action against that individual.

A Community Health Needs Assessment (CHNA) outlines the identified needs within the community the hospital serves. Every three-year cycle hospitals are required to conduct a CHNA and adopt an Implementation Strategy that addresses such needs. The CHNA must define the community the hospital serves which includes geographic area, target populations and focus areas, and assess the health needs of that community. The hospital must solicit and consider input from stakeholders in the community as well as those served by the hospital, such as community members or those with expertise in public health. The hospital must also document the CHNA in a written report that is adopted by an authorized body of the hospital and make the report available to the public.[39]

The federal government also requires hospitals to adopt an implementation strategy, sometimes called a Community Health Improvement Plan (CHIP), which is a document that describes how the hospital plans to address identified health needs, or indicates health needs the hospital does not plan to address and why.[40]

The activities associated with completing the CHNA and implementation strategies can be counted as a community benefit expense.

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[38] Internal Revenue Service. (n.d.-d). Requirements for 501(c)(3) Hospitals under the Affordable Care Act – Section 501(r). https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

[39] Internal Revenue Service. (n.d.-e) Community health needs assessment for charitable hospital organizations - Section 501(r)(3). https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

[40] *Id.*

For a full review of hospitals' three federal requirements to obtain, or maintain, their nonprofit tax-exemption status, please see Appendix B.

Community Benefit Overview: Connecticut General Statutes (C.G.S.) §19a-127k

The State of Connecticut requires nonprofit and for-profit hospitals to report on their community benefit programs annually. Connecticut law designates the OHS to oversee community benefit reporting requirements, which include hospitals submitting certain documents to the State:

1. The hospitals' Community Health Needs Assessment (CHNA).
2. The hospitals' Implementation Strategy.
3. An Annual Status Report due annually on October 1.

In addition to the aforementioned, beginning in 2025, hospitals will be required to include information on how hospitals elicited meaningful participation from community benefit partners and diverse community members in the creation of the CHNA and Implementation Strategy; the names of the individuals responsible for developing the community benefit documents; a description of the planned methods for the ongoing evaluation of proposed actions; and corresponding process or outcomes measures for use in assessing CHNA and Implementation Strategy impact or progress.

The Annual Status Report is due annually, and includes:

1. A description of major updates regarding community health needs, priorities, and target populations, if any;
2. A description of progress made regarding the hospital's actions in support of its Implementation Strategy;
3. A description of any major changes to the proposed Implementation Strategy and associated hospital actions; and
4. A description of financial resources and other resources allocated or expended that supported the actions taken in support of the hospital's Implementation Strategy.

OHS received Annual Status Report submissions from all the nonprofit and for-profit acute care hospitals in 2023, and the report submissions are reviewed in this document.

In addition to the hospitals' reporting requirements, the state legislature requires OHS to publish this summary and analysis report open for public comment, identify and determine stakeholders that could assist in addressing identified community health needs, and to make recommendations to the Department of Public Health in the development of the State Health Plan. Connecticut General Statute §19a-127k is found in Appendix A.

B. Methodology

Sources

This report uses a variety of sources to achieve an objective review of hospitals' community benefit. These sources include, but are not limited to:

1. The IRS' Form 990 including both the hospitals' submissions to OHS and the IRS' 2022 Instructions for the Schedule H

2. Hospitals' CHNAs and Implementation Strategies from 2021/2022
3. Hospitals' Financial Assistance Policies and Emergency Medical Care Policies
4. Hospitals' Annual Status Reports
5. OHS' Financial Stability Report (2022)

Hospitals Reviewed

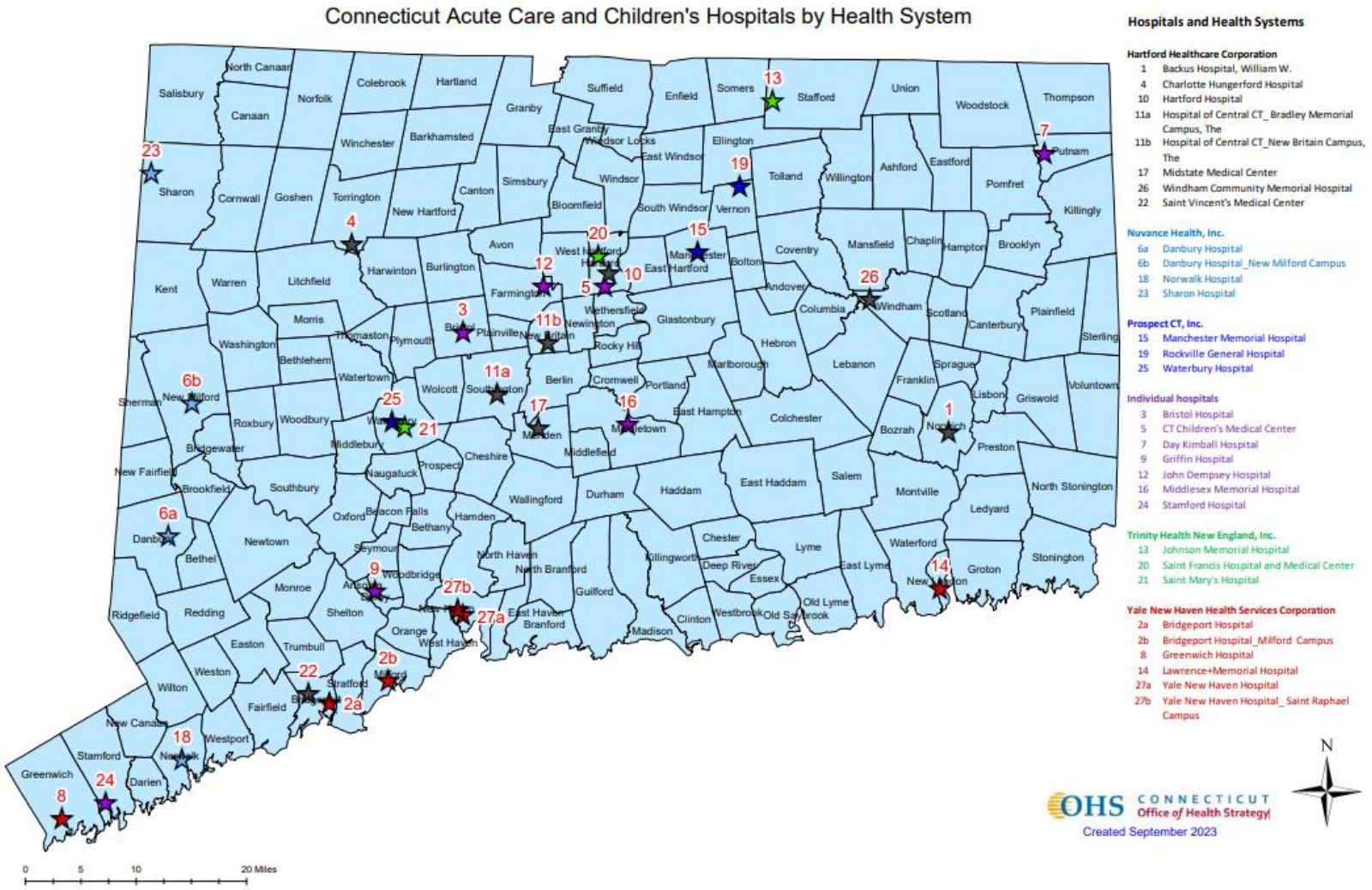
This report consists of nonprofit hospitals licensed as an acute care facility located within the geographic borders of Connecticut. In total, 27 Connecticut hospitals are included in some manner throughout this report because of the timeframe reviewed (2016-2022). As of March 2024, there are 23 nonprofit acute care hospitals in the state, as a result of consolidation or change from nonprofit to for-profit status. Most of the analyses are focused on the 23 nonprofit acute care hospitals required by Connecticut law.

Hospitals excluded from this report are those that are out-of-state, campus, or government hospitals, those not licensed as acute care, or hospitals that do not meet the Connecticut definition of hospital in Connecticut General Statutes §19a-127k, which defines hospital as it relates to community benefit programs in Connecticut. Examples of exclusions:

1. Westerly Hospital located in Rhode Island is not included, even though it is a part of a nonprofit health system headquartered in Connecticut.
2. Campuses of hospitals are not included separately, such as St. Raphael Hospital in New Haven, which is part of Yale New Haven Hospital.
3. Hospitals within hospitals that do not have separate licenses, such as Yale New Haven Children's Hospital, are not included separately.
4. Non-acute care hospitals such as the Hospital for Special Care and Gaylord Hospital. Some of these hospitals may demonstrate community benefit to the IRS.
5. Government-operated hospitals such as John Dempsey Medical Center and the West Haven VA Medical Services.

Hospitals analyzed in this report included and outlined in the below map are:

- Backus (Norwich)
- Bridgeport
- Bristol
- Charlotte Hungerford (Torrington)
- Central Connecticut (New Britain)
- Connecticut Children's (Hartford)
- Danbury
- Day Kimball (Putnam)
- Greenwich
- Griffin (Derby)
- Hartford
- Johnson Memorial (Stafford)
- Lawrence + Memorial (New London)
- Manchester
- Middlesex (Middletown)
- MidState (Meriden)
- Milford
- Norwalk
- Rockville
- St. Francis (Hartford)
- St. Mary's (Waterbury)
- St. Vincent's (Bridgeport)
- Sharon
- Stamford
- Waterbury
- Windham
- Yale New Haven


Connecticut Acute Care and Children's Hospitals by Health System
Hospitals and Health Systems
Hartford Healthcare Corporation
1 Backus Hospital, William W.
4 Charlotte Hungerford Hospital
10 Hartford Hospital
11a Hospital of Central CT_ Bradley Memorial Campus, The
11b Hospital of Central CT_New Britain Campus, The
17 Midstate Medical Center
26 Windham Community Memorial Hospital
22 Saint Vincent's Medical Center
Nuvance Health, Inc.
6a Danbury Hospital
6b Danbury Hospital_New Milford Campus
18 Norwalk Hospital
23 Sharon Hospital
Prospect CT, Inc.
15 Manchester Memorial Hospital
19 Rockville General Hospital
25 Waterbury Hospital
Individual hospitals
3 Bristol Hospital
5 CT Children's Medical Center
7 Day Kimball Hospital
9 Griffin Hospital
12 John Dempsey Hospital
16 Middlesex Memorial Hospital
24 Stamford Hospital
Trinity Health New England, Inc.
13 Johnson Memorial Hospital
20 Saint Francis Hospital and Medical Center
21 Saint Mary's Hospital
Yale New Haven Health Services Corporation
2a Bridgeport Hospital
2b Bridgeport Hospital_Milford Campus
8 Greenwich Hospital
14 Lawrence+Memorial Hospital
27a Yale New Haven Hospital
27b Yale New Haven Hospital_ Saint Raphael Campus
N
OHS CONNECTICUT Office of Health Strategy
Created September 2023
0 5 10 20 Miles

The above map includes all of the acute care hospitals in Connecticut.

Limitations

IRS' Form 990:

The report has multiple limitations. First, while OHS has access to net community benefit expense data provided by hospitals on the Schedule H of the IRS 990, OHS does not have information on how hospitals calculate the reported expenses. The IRS provides hospitals with worksheets to calculate their net community benefit expense, but hospitals are not required to use the worksheets, nor provide the calculations used to determine net community benefit expense.

Second, reported unreimbursed costs from Medicaid are the largest community benefit expense in Connecticut at over a billion dollars; however, the calculations hospitals use are not standardized. For example, the IRS worksheet for determining unreimbursed costs from Medicaid asks hospitals to use a cost-to-charge ratio to estimate their costs. Hospitals self-determine whether to use the IRS' suggested formula for a cost-to-charge ratio, to use their own ratio, or to use their cost accounting system if available. This means the calculations are not standardized and may vary from hospital to hospital with no insight as to how any ratio or cost is computed, whether the data is comparable, or what figures are included in the calculation.

Without clarity into how these expenses are calculated, stakeholders review net expenses in aggregate, and cannot parse how many dollars are being designated to improve community health, and how many of those dollars are going towards the hospitals' community benefit operations.

Third, reporting on the IRS Form 990 Schedule H requires analyzing six (6) factors that may demonstrate community benefit, which are documented in multiple sections with varying instructions. The questions to illicit information on the six factors are in different parts of the Schedule H, and hospitals are instructed to address the various factors in different ways. For example, the factor "use surplus funds to improve facilities, equipment, and patient care" is reported as a description in Part VI of the Schedule H whereas the factor "use surplus funds to advance medical training, education, and research" is reported as expense data (dollar amount) found in Part I. The differing measurement standard makes it difficult to compare the six factors.

Fourth, the IRS allows hospitals to justify additional expenses as potential community benefit in Part II and Part III of the Schedule H. OHS does not have confirmation on whether these additional justifications are accepted by the IRS as community benefit.

Hospitals' CHNAs and Implementation Strategies

The IRS does not require hospitals to link the activities noted in the Implementation Strategies to address health needs with the expenses documented in the IRS Form 990. While the State of Connecticut has taken strides to connect the activities supporting implementation strategies with the community benefit expenses through the annual status reports, the data submitted continues to be unclear. At times the reported data exceeds expenses in Form 990 and does not provide adequate detail demonstrating how the expenses are addressing health needs.

The IRS does not require hospitals to measure the impact of activities and services that hospitals adopt in their Implementation Strategies. In the State's required CHNA and Implementation Strategy reports, evaluation and measurement are required, but neither of these reports are required until 2025. Without measurement data, it is unclear if hospitals community benefit services and activities are improving health. While improving health is not a requirement of community benefit, it is a priority for the State of Connecticut.

Hospitals' Annual Status Reports

Connecticut hospitals submitted their Annual Status Reports to OHS in October, 2023. Some hospitals were able to document measures for how the activities supporting their Implementation Strategy were faring, as well as details on who was overseeing the activities. Hospitals that were unable to provide this information reported that they did not have a measurement system set up, or that the data was not finalized at the time of the report. Some submissions included data anomalies suggesting that there may be confusion on what is required to be submitted to OHS.

Data Analyzed

CHNA and Implementation Strategy Data

OHS reviewed the 2021/2022 cycle CHNA and Implementation Strategy reports conducted by nonprofit acute care hospitals. Community needs documented in this analysis include identified needs from the 2021/2022 cycle, and the needs hospitals indicated they were addressing in current strategies. Activities to address health needs in the Implementation Strategy were included if they were marked as in progress, or if the hospital indicated that they planned to work on it.

Nonprofit Hospitals' Community Benefit Expenses

Connecticut nonprofit, acute care hospitals' expense data was obtained from their IRS Form 990, Schedule H submissions to OHS. Hospitals' IRS Form 990 submissions may be found on OHS' public web portal: Financial Documents Page (ct.gov). OHS reviewed filing years 2016 – 2022 (seven years), staying consistent with a starting year of 2016 from previous community benefit work, and to capture years pre-pandemic. OHS conducted a descriptive analyses of the data, and calculated dollars as a percent of community benefit and total expense, as well as the percent change over the observed time period. When hospitals did not document dollar amounts with a community benefit category, OHS coded as nonapplicable and did not assume that the data is missing or 0. Calculations were conducted amongst the hospitals that reported dollar figures and determined by the valued percent. Some numbers may not add up due to rounding.

Connecticut Nonprofit Hospitals Compared to National Community Benefit Data

OHS obtained the IRS report that provides national community benefit data through a Freedom of Information Act request. To give context to the national and Connecticut data, OHS compared the two IRS data sets as: 1) a percentage of total community benefit expense, and 2) total community benefit expense as a percentage of hospitals' total expense. The IRS notes that their numbers may not add up due to rounding.

Hospitals' Annual Status Reports

OHS reviewed the Annual Status Reports submitted by hospitals for the first time in 2023. This report provides expense data from hospitals attributed to activities that support their Implementation

Strategies. These expenses are categorized as community benefit, community building, or as expenses that did not count as either. The data is compared to what hospitals submitted in their IRS Form 990.

Financial Assistance Policy, Emergency Medical Care Policy, and Billing and Collections Data

Financial Assistance Policies, Emergency Medical Care Policies, and billing and collections practices (sometimes all in the same document) were pulled from hospitals' submissions to OHS. These submissions may be found on OHS' public web portal: Financial Documents Page (ct.gov).

OHS documented nonprofit and for-profit hospitals' policies against federal requirements codified in Internal Revenue Code 501(r)(4). Since all hospitals included the Federal Poverty Guidelines (FPG) as criteria for eligible patients to receive financial assistance, OHS documented the Federal Poverty Level ceilings hospitals documented for either free or discounted care.

Extraordinary Collection Action (ECA) data from collection agents and their recovery rates were obtained from Hospital Reporting System Report 18. These reports may be found on OHS' public web portal: Hospital Reporting System - Reports (ct.gov)

Connecticut Nonprofit Hospitals' Executive Compensation Data

OHS obtained nonprofit hospitals' executive compensation data in the IRS Form 990 Schedule J for filing years 2016-2022. OHS calculated and reported on column (E), which is the summation of base, incentive, other reportable, other deferred compensation, bonus and nontaxable benefits. OHS used both compensation from the organization (row i) and from all related organizations (row ii). The IRS defines a related organization as "a parent, subsidiary, brother or sister organization under common control, a sponsoring organization of or contributing employer to a voluntary employee beneficiary association (VEBA), or a section 509(a)(3) supporting or supported organization of the filing organization."[41]

In addition, OHS used Reports 19A and 19B from its Hospital Reporting System for further context and data to understand how nonprofit hospitals are compensating executives. The definitions to compute compensation for both the IRS and for the HRS reports may be found in Appendix E.

Connecticut Nonprofit Hospitals' Community Boards

OHS obtained nonprofit hospitals' community board data in the IRS Form 990, Parts I and VII for filing year 2022. OHS noted all board members documented in the Form 990, regardless of when their term on the board expired, if they were members of the hospital medical or administrative staff, and the number that were independent. The IRS requires at least 50% of the governing board drawn from the community not be associated with administrative or medical staff. OHS reviewed this data as governing boards have the final say on community benefit, such as adopting a Community Health Needs Assessment and Implementation Strategy.

C. Findings & Discussion

The Findings & Discussion section of this report focuses on the descriptive analyses and findings to give context to the community benefit landscape in Connecticut.

[41] Internal Revenue Service. (n.d.-f). Exempt organization annual reporting requirements: Reporting compensation paid by related organization on Form 990. https://www.irs.gov/charities-non-profits/exempt-organization-annual-reporting-requirements-reporting-compensation-paid-by-related-organization-on-form-990

Community Health Needs Assessment and Implementation Strategy

Community Health Needs Assessments (CHNAs) and Implementation Strategies for the 23 nonprofit acute care hospitals in the state for the 2021/2022 cycle were reviewed to understand the needs within communities and the needs hospitals indicated they were going to address.

Every reviewed nonprofit hospital in Connecticut identified that social determinants of health (SDOH) are needs in their communities and are impacting health. SDOH are the non-medical factors that influence health outcomes, and the World Health Organization highlights that SDOH can be more important than health care or lifestyle choices influencing health, providing research that shows SDOHs account for between 30-55% of health outcomes.[42] SDOHs include social needs such as food, income, housing, education, and transportation. Some hospitals described SDOH in their Implementation Strategies broadly, and so OHS was unable to capture the specific SDOH to include in this analysis. The CHNAs reviewed revealed that the top six needs identified by **every** hospital were:

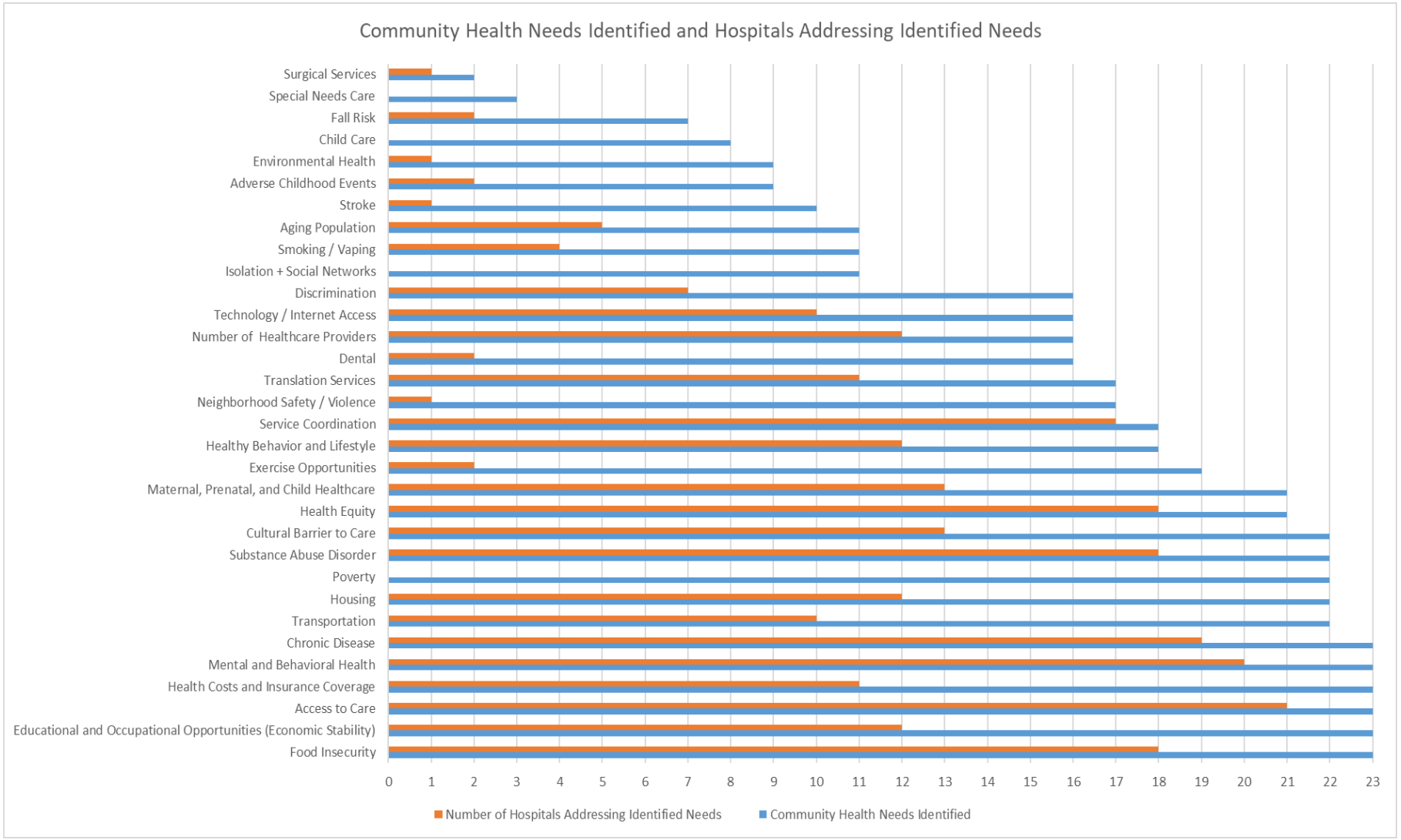
1. Mental and behavioral health.
2. Access to care.
3. Food insecurity.
4. Health costs and insurance coverage.
5. Chronic diseases.
6. Education and occupational opportunities (economic stability).

It is important to note that during the 2018/2019 CHNA cycle, not one need was identified by all hospitals.

Figure 1 outlines all of the needs identified by the hospitals (N=23) in 2021 or 2022, and includes the number of hospitals that indicated they are addressing those needs. The Y-axis includes the categorization for the needs identified in blue, the needs hospitals are addressing in orange, and the X-axis indicates the number of hospitals that identified those needs. Among the top three needs that hospital indicated as part of their Implementation Strategies, access to care is being addressed by 91% of hospitals (n=21), mental health and behavioral health by 87% of hospitals (n=20), followed by 83% of hospitals (n=19) addressing chronic disease.

[42] World Health Organization. (n.d.). Social determinants of health. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Figure 1: Community Health Needs Identified by Number of Hospitals Addressing Each Need (2021-2022)



Nonprofit Hospitals' Community Benefit Expense (2016-2022)

Nonprofit Hospitals' Community Benefit Expenses Overview

To document the six community benefit factors, the IRS provides Form 990, Schedule H. Notably, the six factors are documented inconsistently within the Schedule H, and the IRS requires different information for different factors as outlined in the limitations section of this report and further discussed below.

Part I consists of the community benefit categories that require expense data and are documented in the Schedule H as either:

A. Total financial assistance and means-tested government programs, or
B. Total other benefits

These two sections are then further segmented into the following categories that make up Part I of the Form 990, Schedule H:

A. Total financial assistance and means-tested government programs.
    1. Financial assistance at cost, also known as charity care.
    2. Unreimbursed costs from Medicaid.
    3. Costs of other means-tested government programs, such as State Children's Health Insurance Programs.
B. Total other benefits.
    4. Community health improvement services and community benefit operations.
    5. Health professions education.
    6. Subsidized health services.
    7. Research.
    8. Cash and in-kind contributions for community benefit.

Definitions and examples of the eight community benefit categories are found in the Glossary section of this report.

In addition to Part I, the IRS allows hospitals to report additional expenses as potential community benefit in Part II and Part III of the Schedule H with a justification. However, OHS does not have confirmation on whether these additional expenses were accepted by the IRS to count as community benefit. Therefore, the community benefit analyses below strictly review community benefit expenses as documented by the hospitals in Part I of Schedule H, and not expenses requiring additional information or justification in Parts II and III of the Schedule H that may or may not have been accepted by the IRS as community benefit.

In the IRS' annual "Report to Congress on Private Tax-Exempt, Taxable and Government-Owned Hospitals" the agency reports community benefit expenses documented on Part I of the Schedule H. Part II, Community Building Activities, are not included, and Part III is included as a comparison for uncompensated care, and not noted as community benefit.[43]

[43] Tax Exempt & Government Entities Division, Internal Revenue Service. (2023). Report to Congress on private tax-exempt, taxable and government-owned hospitals.

A few examples of these additional expense justifications that appear in Part II and Part III:

- The IRS explicitly prohibits hospitals from counting bad debt in Part I with other uncompensated care community benefit categories. Instead, the IRS allows hospitals to document total bad debt expense, as well as the amount of bad debt the hospital estimates is attributable to individuals eligible under the organization's financial assistance policy (FAP) in Part III of the Schedule H. Only the bad debt that hospitals believe is attributable to patients eligible under the hospital's FAP may count as community benefit if the hospital also includes the methodology and rationale in Part VI, if any, for this portion of bad debt to be considered community benefit.
- The IRS splits the Medicaid and Medicare factor into two different sections of the Schedule H. For Medicaid, the IRS requests expense data in Part I to count as community benefit. For Medicare, the IRS asks hospitals to report expense data in Part III of the Schedule H, and to describe why Medicare shortfalls should be treated as community benefit as well as the costing methodology or sources used to determine the amount in Part VI.
- Community Building activities (Part II of the Schedule H) are "the activities that help build the capacity of the community to address health needs and often address the 'upstream' factors and social determinants that impact health, such as education, air quality, and access to nutritious food." For community building activities to count as community benefit, the IRS requires a description in Part VI of the Schedule H of how the community building activities promoted the health of the communities the hospital serves. The IRS also states that hospitals must choose whether these activities count as community health improvement services (Part I), or as community building (Part II); they cannot count as both. There is support for changes in the reporting structure to automatically count community building as community benefit without additional justification.[44, 45, 46] These activities are reported in the Annual Status Reports section of this report.

[44] Rosenbaum, S., Byrnes, M., & Young, G. (2016). Modifying hospital community benefit tax policy: Easing regulation, advancing population health. https://www.healthaffairs.org/content/forefront/modifying-hospital-community-benefit-tax-policy-easing-regulation-advancing-population

[45] Rosenbaum, S., Rieke, A., & Byrnes, M. (2014). Encouraging nonprofit hospitals to invest in community building: The role of IRS 'Safe harbors.' https://www.healthaffairs.org/content/forefront/encouraging-nonprofit-hospitals-invest-community-building-role-irs-safe-harbors

[46] Riley, T., Clary, A., & Higgins, E. (2019). Identifying gaps in federal oversight of hospitals' community benefit investments - opportunities for state policy. https://nashp.org/identifying-gaps-in-federal-oversight-of-hospitals-community-benefit-investments-opportunities-for-state-policy/

Nonprofit Hospitals' Schedule H Part I Community Benefit Expenses in Aggregate

Figure 2 – Hospitals' Annual Total Community Benefit Expense (2016-2022)

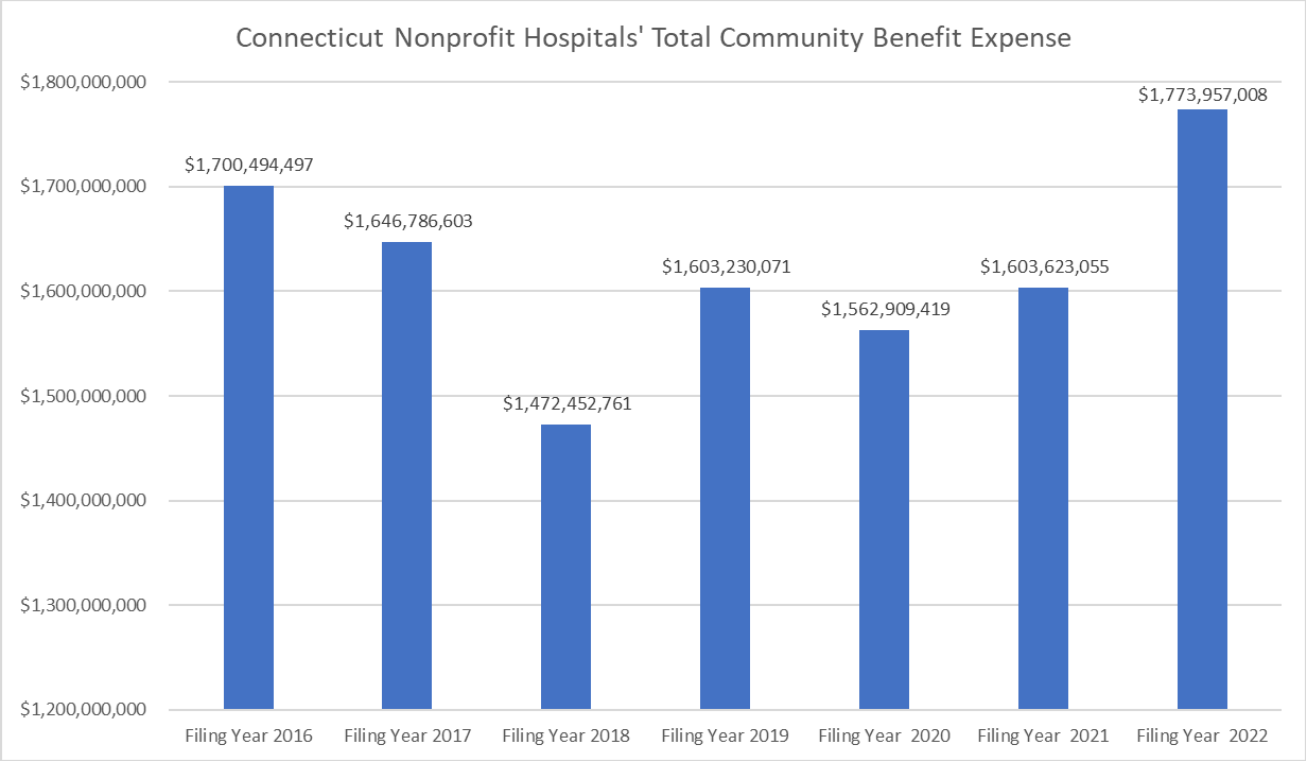


Figure 2 reports the net total community benefit expense in Connecticut over the seven (2016-2022) observed filing years (FY). Figure 2 reflects that community benefit has fluctuated with a steady decrease between 2016-2018, followed by an increase from 2018-2019 then a reduction from 2019 to 2020 and steadily increased from 2020-2022. This increase (2020-2022) and decrease between 2020-2021may be reflective of the global pandemic and changes in hospital utilization. Notably, the 2022 total community benefit expense is the highest it has been since 2016 at $1.7 billion, and roughly $170 million or 10.6% more than the previous year (2021).

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Figure 3: Hospitals' Annual Community Benefit Expense by Benefit Category (2016-2022)

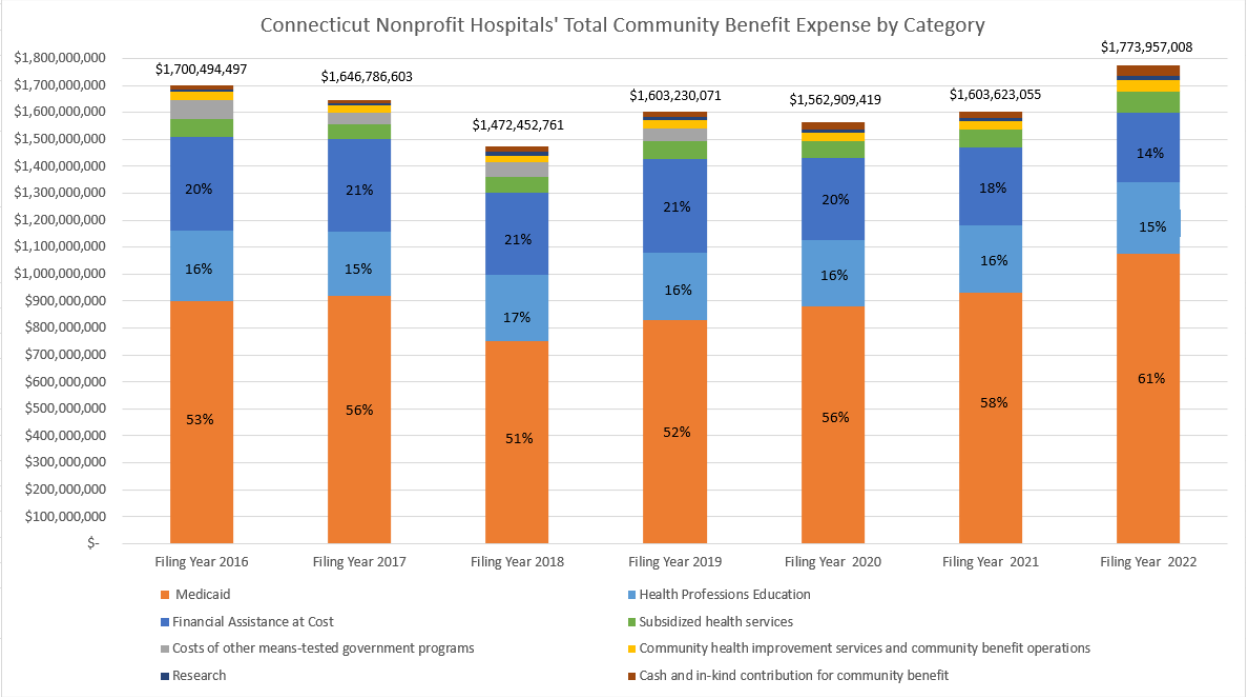

Figure 3 shows total expense by community benefit category over the seven observed filing years, and the expenses as a percentage of total community benefit for Medicaid, Financial Assistance at cost, and Health Professions Education. In 2022, the reported unreimbursed costs from Medicaid (referred to in the Schedule H as "Medicaid") was the largest community benefit expense followed by Health Professionals Education and Financial Assistance at cost. Between 2021-2022, reported unreimbursed Medicaid costs increased by over $146.3 million, nearly three times the amount it increased between 2020-2021 ($51.6 million). It is important to note that due to the COVID-19 Public Health Emergency (PHE), Medicaid eligibility redeterminations were paused and enrollment increased approximately by 15% from 2020 to 2022.[47]

[47] Connecticut Department of Social Services. (n.d). Workbook: people served. https://dssdashboards.ct.gov/views/PeopleServed/PeopleServed?%3Aembed=yes&%3Atoolbar=yes&%3Arevert=yes&%3AshowShareOptions=false

Table 1: Connecticut Nonprofit Hospitals' Total Community Benefit Expense by Filing Year (2016-2022)

Connecticut Nonprofit Hospitals' Total Community Benefit Expense

Schedule H	Filing Year 2016	Filing Year 2017	Filing Year 2018	Filing Year 2019	Filing Year 2020	Filing Year 2021	Filing Year 2022
Financial Assistance at Cost	$ 344,844,514	$ 342,741,512	$ 304,728,594	$ 344,298,104	$ 306,485,259	$ 287,077,698	$ 256,221,292
Medicaid	$ 898,481,395	$ 918,436,011	$ 752,298,844	$ 829,856,416	$ 878,499,462	$ 930,183,118	$ 1,076,538,948
Costs of other means-tested government programs	$ 68,369,260	$ 41,339,920	$ 52,577,205	$ 46,194,252	$ 256,459	$ 17,858	$ 36,025
Total Financial Assistance and Means-Tested Government Programs	$ 1,311,695,169	$ 1,302,517,443	$ 1,109,604,643	$ 1,220,348,772	$ 1,185,241,180	$ 1,217,278,674	$ 1,332,796,265
Community health improvement services and community benefit operations	$ 30,157,773	$ 27,283,014	$ 25,851,331	$ 30,672,119	$ 32,465,889	$ 32,178,059	$ 45,749,387
Health Professions Education	$ 263,704,838	$ 239,297,743	$ 244,594,057	$ 251,128,821	$ 246,558,450	$ 251,782,512	$ 265,924,277
Subsidized health services	$ 69,824,157	$ 55,565,017	$ 59,986,430	$ 67,709,063	$ 59,865,586	$ 65,779,762	$ 75,980,410
Research	$ 9,925,901	$ 9,299,774	$ 13,901,341	$ 14,537,834	$ 11,616,198	$ 10,441,344	$ 15,724,789
Cash and in-kind contribution for community benefit	$ 15,186,659	$ 12,823,612	$ 18,514,959	$ 18,833,462	$ 27,162,116	$ 26,162,704	$ 37,781,880
Total Other Benefits	$ 388,799,328	$ 344,269,160	$ 362,848,118	$ 382,881,299	$ 377,668,239	$ 386,344,381	$ 441,160,743
Total Community Benefit	$ 1,700,494,497	$ 1,646,786,603	$ 1,472,452,761	$ 1,603,230,071	$ 1,562,909,419	$ 1,603,623,055	$ 1,773,957,008

Table 1 includes exact figures for each of the eight Schedule H categories by filing year. In 2022, a little over $1 billion of community benefit expenses came from the reported unreimbursed costs from Medicaid, followed by $265 million in Health Professions Education and $256 million in Financial Assistance.

Between 2016-2022, two categories decreased. Costs of other means-tested government programs dropped by over 99%, or $68.3 million. This is mostly attributed to a decrease in 2019 when a hospital was acquired by one health system from a different health system; the new system owning the hospital did not document this category. The other drop between 2016-2022 is $88.6 million in financial assistance at cost (charity care), or about 26%.

Only one community benefit category decreased between 2021 and 2022: financial assistance at cost (charity care) decreased by 12% ($30,856,406). Seven of the eight categories increased between 2021-2022, including:

1. The reported unreimbursed costs from Medicaid increased by 14% ($146,355,830).
2. Costs of other means-tested government programs increased by 50% ($18,167).
3. Community health improvement services and community benefit operations increased 30% ($13,571,328).
4. Health professions education increased by 5% ($14,141,765).
5. Subsidized health services by 13% ($10,200,648).
6. Research increased by 34% ($5,283,445), and
7. Cash and in-kind contribution for community benefit increased by 31% ($11,619,176).

In aggregate, community benefit allocation increased by approximately $170 million between 2021 and 2022, driven by the year-over-year increase in reported unreimbursed costs from Medicaid of about

$146 million. A recent study using 2019 data, found that nonprofit hospitals and for-profit hospitals had similar unreimbursed costs from Medicaid as a share of their total expenses.[48]

Expenses for health professions education was the second largest benefit at $265,924,277. Health professions education are the unreimbursed costs incurred on training programs for being licensed to practice as a health professional. While health professions education increased approximately $14 million between 2021 and 2022, data trends suggest that the category fluctuates year to year.

Financial assistance at cost (charity care) is free or discounted care hospitals provide to patients that meet the hospitals' eligibility criteria. The absolute amount of charity care has been steadily declining since 2019 resulting in an $88 million decrease by 2022. 2022 is the first observed year that charity care is not the second largest benefit to communities in Connecticut. The change between charity care and health professions education does not appear to be due to significant changes in funding for the latter, but instead the continual decline in charity care.

The decline in charity care is notable as it is the most historic community benefit, and a direct benefit people obtain from nonprofit hospitals that are organized and operated for a charitable purpose. In a letter to the IRS, a group of four (4) bipartisan US Senators cited a study from the Lown Institute which found that out of 1,773 nonprofit hospitals evaluated, 77% spent less on charity care and community investment than the estimated value of their tax breaks.[49]

It should be noted that this decrease in charity care occurred during years where Medicaid coverage has expanded, and during the COVID-19 pandemic when the federal government approved continuous Medicaid coverage, and there were increases in enrollment. It is challenging to understand if the drop in charity care is related to the increases in Medicaid, as it is optional for hospitals to provide data on the number of patients served through charity care and Medicaid in their Form 990s. Moreover, understanding the link between these two categories is made difficult by the lack of transparency in how charity care expenses and the unreimbursed costs from Medicaid are calculated.

[48] Bai, G., Zare, H., & Hyman, D. A. (2022). Evaluation of unreimbursed Medicaid costs among nonprofit and for-profit US hospitals. *JAMA Network Open.*, *5*(2). doi:10.1001/jamanetworkopen.2021.48232 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789009

[49] Lown Institute. (2023). Fair share spending: How much are hospitals giving back to their communities? https://lownhospitalsindex.org/2023-fair-share-spending/

Table 2: Connecticut Nonprofit Hospitals' Community Benefit as Percent of Total Community Benefit Expense by Filing Year (2016-2022)

Connecticut Nonprofit Hospitals' Community Benefit as % of Total Community Benefit Expense

Schedule H	Filing Year 2016	Filing Year 2017	Filing Year 2018	Filing Year 2019	Filing Year 2020	Filing Year 2021	Filing Year 2022
Financial Assistance at Cost	20.28%	20.81%	20.70%	21.48%	19.61%	17.90%	14.44%
Medicaid	52.84%	55.77%	51.09%	51.76%	56.21%	58.01%	60.69%
Costs of other means-tested government programs	4.02%	2.51%	3.57%	2.88%	0.02%	0.001%	0.002%
Total Financial Assistance and Means-Tested Government Programs	77.14%	79.09%	75.36%	76.12%	75.84%	75.91%	75.13%
Community health improvement services and community benefit operations	1.77%	1.66%	1.76%	1.91%	2.08%	2.01%	2.58%
Health Professions Education	15.51%	14.53%	16.61%	15.66%	15.78%	15.70%	14.99%
Subsidized health services	4.11%	3.37%	4.07%	4.22%	3.83%	4.10%	4.28%
Research	0.58%	0.56%	0.94%	0.91%	0.74%	0.65%	0.89%
Cash and in-kind contribution for community benefit	0.89%	0.78%	1.26%	1.17%	1.74%	1.63%	2.13%
Total Other Benefits	22.86%	20.91%	24.64%	23.88%	24.16%	24.09%	24.87%
Total Community Benefit	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table 2 above looks at each community benefit expense as a percentage of the total community benefit expense. In 2022, the reported unreimbursed costs from Medicaid constituted 60.69% of the total, followed by 14.99% in Health Professions Education and 14.44% for Financial Assistance (charity care).

The remaining five categories make up just under ten percent (10%) of community benefit. Expenses to improve community health or support other entities through staff time or cash donations make up less than five percent (5%) of total community benefit expenses.

Table 3: Connecticut Nonprofit Hospitals' Community Benefit as Percent of Total Expense by Filing Year (2016-2022)

Connecticut Nonprofit Hospitals' Total Community Benefit as a % of Total Expense

Schedule H	Filing Year 2016	Filing Year 2017	Filing Year 2018	Filing Year 2019	Filing Year 2020	Filing Year 2021	Filing Year 2022
Financial Assistance at Cost	3.21%	3.29%	2.76%	2.86%	2.35%	2.07%	1.70%
Medicaid	8.36%	8.81%	6.81%	6.91%	6.74%	6.70%	7.15%
Costs of other means-tested government programs	0.64%	0.40%	0.48%	0.38%	0.00%	0.00%	0.00%
Total Financial Assistance and Means-Tested Government Programs	12.21%	12.50%	10.05%	10.15%	9.10%	8.77%	8.85%
Community health improvement services and community benefit operations	0.28%	0.26%	0.23%	0.26%	0.25%	0.23%	0.30%
Health Professions Education	2.45%	2.30%	2.21%	2.09%	1.89%	1.81%	1.77%
Subsidized health services	0.65%	0.53%	0.54%	0.56%	0.46%	0.47%	0.50%
Research	0.09%	0.09%	0.13%	0.12%	0.09%	0.08%	0.10%
Cash and in-kind contribution for community benefit	0.14%	0.12%	0.17%	0.16%	0.21%	0.19%	0.25%
Total Other Benefits	3.62%	3.30%	3.29%	3.19%	2.90%	2.78%	2.93%
Total Community Benefit	15.83%	15.80%	13.33%	13.34%	12.00%	11.56%	11.78%

In Table 3, community benefit expenses are shown as a percentage of hospitals' total expense. In 2022, total community benefit expenses (last row) represented 11.78% of hospitals total expenses, which is around a four percent (4%) decrease from 2016 (15.83%). From 2016 to 2022, hospitals' total expenses have increased by 40%. While community benefit expenses have increased by $73 million over this time, they have decreased by four percentage points (4%) as a percentage of hospitals' total expense.

Connecticut Nonprofit Hospitals Community Benefit Expense Compared to National Data

To better understand how Connecticut hospitals' community benefit expenses compare to national data, OHS reviewed the IRS' "Report to Congress on Private Tax-Exempt, Taxable and Government-Owned Hospitals" published in August 2023.[50] The report is retrospective, and the last year of data available is filing year 2019. Table 4 includes both national and Connecticut community benefit data for filing year 2019. National data includes all nonprofit hospitals, while Connecticut data includes only nonprofit acute care hospitals. The leftmost column includes the community benefit categories the IRS used for community benefit expense, and the next three columns (in green) are the national and Connecticut data as a percentage of total community expense, as well as the difference (delta Δ) between the two. The three remaining columns (in yellow) are formatted the same but focus on community benefit as a percent of total hospital expense.

Table 4: National IRS Community Benefit Data and Connecticut Data as Percent of Total Community Benefit Expense and as Percent of Total Expense for Filing Year 2019

Community Benefit National & Connecticut IRS Data - Filing Year 2019						
Type of Community Benefit	Percent of Total Community Benefit Expense			Percent of Total Expense		
	National	Connecticut	Δ	National	Connecticut	Δ
Total Community Benefits	100%	100%	0%	9.47%	11.78%	2.31%
Total financial assistance and means-tested government programs	61.78%	75.13%	13.35%	5.85%	8.85%	3.00%
Financial assistance at cost	18.32%	14.44%	-3.88%	1.74%	1.70%	-0.04%
Medicaid	42.11%	60.69%	18.58%	3.99%	7.15%	3.16%
Costs of other means-tested government programs	1.36%	0.002%	-1.35%	0.13%	0.0002%	-0.13%
Total other benefits	38.22%	24.87%	-13.35%	3.62%	2.93%	-0.69%
Community health improvement services and community benefit operations	4.05%	2.58%	-1.47%	0.38%	0.30%	-0.08%
Health professions education	15.71%	14.99%	-0.72%	1.49%	1.77%	0.28%
Subsidized health services	10.48%	4.28%	-6.20%	0.99%	0.50%	-0.49%
Research	4.74%	0.89%	-3.85%	0.45%	0.10%	-0.35%
Cash and in-kind contributions for community benefit	3.25%	2.13%	-1.12%	0.31%	0.25%	-0.06%

Table 4 shows that the reported unreimbursed costs from Medicaid is the only category of community benefit expense higher (18.58%) than the national community benefit expense totals (42.11% compared to 60.69%). All other community benefit categories in Connecticut were less than national figures. Table 4 also shows that Connecticut has a greater total percent of community benefit expense (11.78%) compared to the national data (9.47%). This is due to a greater expense by Connecticut hospitals in two categories: the reported unreimbursed costs from Medicaid (Δ 3.16%) and health professions education (Δ 0.28%) data. Connecticut hospitals expense less in the other six categories when compared to national total expenses.

The 2019 national data demonstrates that Connecticut hospitals concentrated their community benefit expenses on the reported unreimbursed costs from Medicaid as compared to the national total. While Connecticut has data demonstrating an increase in Medicaid community benefit expenses from 2018-2022, national data has not yet been released for comparative analysis.

[50] Tax Exempt & Government Entities Division, Internal Revenue Service. (2023). Report to Congress on private tax-exempt, taxable and government-owned hospitals.

Nonprofit Hospitals' Total Schedule H Part I Community Benefit Expenses by Hospital

To better understand the role of individual hospitals' contribution to total community benefit expense in Connecticut, OHS broke down the cumulative totals by hospital, and by health system. Hospitals not associated with a health system were categorized as "Independent." Each analysis uses filing year (FY) 2022 data from Connecticut's 23 nonprofit acute care hospitals.

Figure 4 is the legend that categorizes each of the 5 groupings by color: independent hospitals are yellow, Hartford HealthCare (HHC) hospitals are in orange, Trinity Health of New England hospitals are blue-gray, Nuvance Health hospitals are green, and Yale New Haven Health Services (YNHHS) hospitals are in light blue. Table 5 compares hospitals' "total community benefit" in dollar amounts sorted from largest to smallest against hospitals' "community benefit as a percentage of the hospital's total expense." As seen below, while Yale New Haven Hospital had the greatest expense in dollar amount ($573.5 million), the precent of total expense ranked seventh with 14.5%.

Figure 4: Hospital System Categorization by Color

Legend	
Independent	Bristol, Connecticut Children's, Day Kimball, Griffin, Middlesex, Stamford
HHC	Backus, Central Connecticut, Charlotte Hungerford, Hartford, MidState, St. Vincent's, Windham
Trinity	Johnson Memorial, St. Francis, St. Mary's
Nuvance	Danbury, Norwalk, Sharon
YNHHS	Bridgeport, Greenwich, Lawrence + Memorial, Yale New Haven

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Table 5: Hospitals' Total Community Benefit Expenses in Dollars Compared to Total Community Benefit as Percent of Total Expense (2022)

	Total Community Benefit		
1	Yale New Haven	$	573,554,615
2	Hartford	$	137,235,416
3	Bridgeport	$	134,073,187
4	Connecticut Children's	$	112,695,864
5	Danbury	$	89,007,110
6	St. Francis	$	85,170,097
7	Stamford	$	78,518,877
8	Middlesex	$	72,606,343
9	Lawrence + Memorial	$	70,245,138
10	Greenwich	$	57,577,523
11	Central Connecticut	$	55,907,820
12	Norwalk	$	48,552,246
13	Backus	$	43,112,270
14	St. Vincent's	$	38,862,177
15	St. Mary's	$	32,625,865
16	Bristol	$	32,432,732
17	MidState	$	32,419,488
18	Griffin	$	28,669,111
19	Charlotte Hungerford	$	12,898,152
20	Sharon	$	12,271,675
21	Windham	$	10,934,108
22	Day Kimball	$	9,445,299
23	Johnson Memorial	$	5,141,895

	Total Community Benefit as % of Total Expense	
1	Connecticut Children's	25.4%
2	Bristol	20.9%
3	Sharon	16.8%
4	Bridgeport	16.1%
5	Middlesex	15.9%
6	Lawrence + Memorial	15.9%
7	Yale New Haven	14.5%
8	Stamford	11.7%
9	Norwalk	11.5%
10	Griffin	11.4%
11	Danbury	11.3%
12	Greenwich	10.9%
13	St. Mary's	10.1%
14	St. Francis	9.2%
15	Backus	9.2%
16	Central Connecticut	9.1%
17	Windham	8.9%
18	Day Kimball	7.9%
19	MidState	7.6%
20	Charlotte Hungerford	6.8%
21	St. Vincent's	6.8%
22	Johnson Memorial	6.8%
23	Hartford	6.2%

While Yale New Haven Hospital, Hartford Hospital, and Bridgeport Hospital had the three largest community benefit expenses in dollar amounts at $573.5 million, $137.2 million, and $134 million, with Yale New Haven expensing nearly four times as much as Hartford; Connecticut Children's Hospital, Bristol Hospital, and Sharon Hospital had the greatest percentages of total expense at 25.4%, 20.9%, and 16.8%, respectively. Hartford Hospital had the second highest amount of community benefit expense ($137.2 million) yet had smallest percentage of total expense in the state (6.2%). When examining health systems, Hartford HealthCare associated hospitals each spent less than 10% of total expenses on community benefit and made up seven of the ten hospitals with the lowest amount of community benefit as a percent of total expense (Table 5. Independent hospitals make up 3 of the top 5 hospitals (and half of the top 10) with the highest amount of community benefit a as a percent of total expense.

Nonprofit Hospitals' Total Schedule H Part I Community Benefit by Expenses Category

The following tables examine community benefit categories by hospital to better understand the allocation of hospitals' community benefit expense in filing year 2022. Only two of the eight community benefit categories are documented by every hospital.

Reported Unreimbursed Costs from Medicaid

Medicaid (the reported unreimbursed costs from Medicaid) is the shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries. This payment shortfall is not the same as a contractual allowance, which is the full difference between charges and

government payments.[51] Table 6 compares hospital expense on reported unreimbursed costs from Medicaid to the expense as a percentage of total community benefit.

Table 6: Hospital Expenses on Reported Unreimbursed Costs from Medicaid Compared to Expenses as Percent of Total Community Benefit (2022)

	Medicaid		
1	Yale New Haven	$	339,315,142
2	Bridgeport	$	84,543,467
3	Connecticut Children's	$	80,542,996
4	Stamford	$	68,685,746
5	St. Francis	$	63,477,994
6	Hartford	$	59,720,594
7	Danbury	$	50,318,684
8	Central Connecticut	$	40,426,615
9	Backus	$	36,121,453
10	Middlesex	$	31,032,377
11	Norwalk	$	28,802,223
12	MidState	$	28,277,178
13	Greenwich	$	25,662,104
14	Lawrence + Memorial	$	25,654,463
15	St. Vincent's	$	24,319,041
16	St. Mary's	$	23,948,768
17	Bristol	$	15,974,327
18	Griffin	$	12,944,403
19	Charlotte Hungerford	$	9,573,663
20	Windham	$	8,060,998
21	Day Kimball	$	7,366,197
22	Sharon	$	7,008,403
23	Johnson Memorial	$	4,762,112

	Medicaid as % of Total Community Benefit	
1	Johnson Memorial	93%
2	Stamford	87%
3	MidState	87%
4	Backus	84%
5	Day Kimball	78%
6	St. Francis	75%
7	Charlotte Hungerford	74%
8	Windham	74%
9	St. Mary's	73%
10	Central Connecticut	72%
11	Connecticut Children's	71%
12	Bridgeport	63%
13	St. Vincent's	63%
14	Norwalk	59%
15	Yale New Haven	59%
16	Sharon	57%
17	Danbury	57%
18	Bristol	49%
19	Griffin	45%
20	Greenwich	45%
21	Hartford	44%
22	Middlesex	43%
23	Lawrence + Memorial	37%

As noted in Table 6, Yale New Haven, similar to total community benefit, documents four times as much as the next hospital, Bridgeport. Yale New Haven documented the highest amount of unreimbursed funds from Medicaid ($339,315,142), while Johnson Memorial documented the least ($4,762,112). Despite Yale New Haven allocating the most in dollars to Medicaid, the dollars as a percentage of total benefit ranks 15th (59%) compared to Johnson Memorial which documents the smallest expense towards Medicaid, the same category also makes up nearly their entire amount of their community benefit (93%), and is the highest percentage in the state. Lawrence + Memorial has the lowest percentage of Medicaid as total of community benefit expense at 37%.

Of all hospitals (N=23), four hospitals (17%) documented 80% or greater contribution of their community benefit towards Medicaid– Johnson Memorial part of the Trinity Health of New England System (93%), Stamford categorized as independent (87%), and MidState (87%) and Backus (84%) hospital both included in the Hartford Health Care System. Nearly half (48%, n=11) of nonprofit hospitals documented 70% or

[51] Catholic Health Association. (2015). Community benefit categories and definitions: A guide for planning & reporting community benefit. 293–320. https://www.chausa.org/docs/default-source/community-benefit-guide-2015/2015-cb-guide-categories-definitions.pdf?sfvrsn=4

greater and nearly three-quarters (74%, n=17) of nonprofit hospitals documented 50% or greater of their community benefit to serving Medicaid patients.

The designation of reimbursement for uncompensated care from Medicaid services has allowed for the current tax-exemption structure of certain hospitals to "maintain a tax exemption by operating an emergency room open to all and accepting patients on Medicare or Medicaid, which are common among hospitals, while spending little to no money on charity care or other community benefit activities" as noted in the Government Accountability Office 2020 Community Benefit report.[52]

Health Professional Education

Health professions education expenses are the unreimbursed costs incurred on training programs for being licensed to practice as a health professional and are the second highest community benefit expense amongst Connecticut hospitals. These are educational programs for physicians, interns and residents, medical students, nurses and nursing students, pastoral care trainees and other health professionals when that education is necessary for a degree, certificate, or training that is required by state law, accrediting body or health profession society.[53]

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[52] US Government Accountability Office. (2020). Opportunities exist to improve oversight of hospitals' tax-exempt status. https://www.gao.gov/assets/d20679.pdf

[53] Catholic Health Association. (2015). Community benefit categories and definitions: A guide for planning & reporting community benefit. 293–320. https://www.chausa.org/docs/default-source/community-benefit-guide-2015/2015-cb-guide-categories-definitions.pdf?sfvrsn=4

Table 7: Hospital Expenses on Health Professional Education Compared to Expenses as Percent of Total Community Benefit (2022)

		Health Professions Education
1	Yale New Haven	$ 102,287,430
2	Hartford	$ 46,982,303
3	Connecticut Children's	$ 22,675,507
4	Danbury	$ 17,056,541
5	St. Francis	$ 16,438,296
6	Bridgeport	$ 13,433,406
7	Middlesex	$ 10,646,541
8	Central Connecticut	$ 9,477,297
9	Norwalk	$ 8,634,899
10	St. Mary's	$ 6,198,856
11	Greenwich	$ 3,534,246
12	Backus	$ 2,447,880
13	St. Vincent's	$ 2,417,324
14	Lawrence + Memorial	$ 1,798,975
15	Griffin	$ 1,302,808
16	Windham	$ 360,841
17	Sharon	$ 127,416
18	Day Kimball	$ 93,144
19	Charlotte Hungerford	$ 10,567
	Bristol	-
	Johnson Memorial	-
	MidState	-
	Stamford	-

		Health Professions Education as a % of Total Community Benefit
1	Hartford	34%
2	Connecticut Children's	20%
3	St. Francis	19%
4	Danbury	19%
5	St. Mary's	19%
6	Yale New Haven	18%
7	Norwalk	18%
8	Central Connecticut	17%
9	Middlesex	15%
10	Bridgeport	10%
11	St. Vincent's	6%
12	Greenwich	6%
13	Backus	6%
14	Griffin	5%
15	Windham	3%
16	Lawrence + Memorial	3%
17	Sharon	1%
18	Day Kimball	1%
19	Charlotte Hungerford	0.1%
	Bristol	-
	Johnson Memorial	-
	MidState	-
	Stamford	-

Table 7 reveals that 83% (n=19) of hospitals reported community benefit expenses towards health professions education. Of those that reported, only one hospital spent greater than one-third of its total percentage on community benefit towards this category. Nearly half (9 of 19) spent between 10%-20% while the remaining hospitals spent 6% or less. Furthermore, Yale New Haven expensed the most ($102,287,430) towards health professions education, which made up 18% of its community benefit. Hartford Hospital documented the second highest amount ($46,982,303), which made up 34% of their community benefit expense and was the highest in the state. While Hartford Hospital's dollar amount was half of Yale New Haven's, Hartford's dollar amount as a percentage of total community benefit was nearly double Yale New Haven's. Charlotte Hungerford documented the smallest dollar amount at $10,567, which made up 0.1% of the hospital's community benefit.

Financial Assistance

Financial assistance at cost, better known as charity care, is free or discounted care for eligible patients. Table 8 below compares hospital dollars for financial assistance at cost compared to expense as a percent of total community benefit.

Table 8: Hospital Expenses on Financial Assistance at Cost Compared to Expenses as Percent of Total Community Benefit (2022)

	Financial Assistance at Cost		
1	Yale New Haven	$	106,027,679
2	Bridgeport	$	26,300,138
3	Greenwich	$	23,707,921
4	Lawrence + Memorial	$	18,694,202
5	Hartford	$	15,428,503
6	Danbury	$	13,273,056
7	St. Vincent's	$	7,440,464
8	Norwalk	$	7,291,293
9	Stamford	$	6,889,730
10	Central Connecticut	$	4,896,982
11	St. Francis	$	4,091,623
12	Backus	$	3,775,116
13	MidState	$	3,579,562
14	Griffin	$	3,547,406
15	St. Mary's	$	2,294,564
16	Bristol	$	2,151,903
17	Charlotte Hungerford	$	1,818,949
18	Windham	$	1,677,890
19	Middlesex	$	1,601,363
20	Connecticut Children's	$	747,843
21	Sharon	$	552,391
22	Johnson Memorial	$	338,852
23	Day Kimball	$	93,862

	Financial Assistance at Cost as a % of Total Community Benefit	
1	Greenwich	41%
2	Lawrence + Memorial	27%
3	Bridgeport	20%
4	St. Vincent's	19%
5	Yale New Haven	18%
6	Windham	15%
7	Norwalk	15%
8	Danbury	15%
9	Charlotte Hungerford	14%
10	Griffin	12%
11	Hartford	11%
12	MidState	11%
13	Stamford	9%
14	Central Connecticut	9%
15	Backus	9%
16	St. Mary's	7%
17	Bristol	7%
18	Johnson Memorial	7%
19	St. Francis	5%
20	Sharon	5%
21	Middlesex	2%
22	Day Kimball	1%
23	Connecticut Children's	1%

Table 8 shows Yale New Haven ($106,027,679), Bridgeport ($26,300,138), Greenwich ($23,707,921), and Lawrence + Memorial ($18,694,202) - all part of Yale New Haven Health Services - expensed the most money towards financial assistance at cost (charity care). Similar to the Medicaid figures, Yale New Haven documented four times as much charity care as the next closest hospital, which also is in the same system.

Greenwich Hospital documented the highest proportion of their community benefit for financial assistance at cost (41%) followed by Lawrence + Memorial (27%). YNHHS hospitals make up 80% of the top five spots, and over one-third (n=8) expensed 15% or more of their community benefit on charity care. This data demonstrates that YNHHS provides the most charity care across the state, both in dollars and as a percentage of what makes up their hospitals' community benefit.

Nearly half (47.8%, n=11) of hospitals documented less than 10% of their total community benefit expense towards charity care. Day Kimball provided the least amount of charity care ($93,862) to patients. Middlesex (2%), Day Kimball (1%), and Connecticut Children's (1%) documented the smallest proportion for their community benefit expense toward providing patients free or discounted care. Though Connecticut's Children's expensed more on charity care than others ($747,843), this amount

represented the lowest percentage total towards charity care statewide. As further discussed in the Financial Assistance Policy section of this report, Day Kimball crafted their eligibility requirements for financial assistance differently than other nonprofit hospitals.

Middlesex (2%), Day Kimball (1%), and Connecticut Children's (1%) documented the smallest proportion for their community benefit expense toward providing patients free or discounted care. Connecticut Children's provides nearly eight times the amount of charity care as Day Kimball, but for both hospitals these constitute only one percent of their community benefit expense.

Financial assistance at cost decreased amongst 57% (n=13) of hospitals for a total of ($53,797,038) between 2021-2022. In contrast, 43% (n=10) of hospitals increased charity care by $22,940,632. Overall, the difference in charity care from 2021-2022 was a decrease of $30,856,406.

Table 9: Differences in Financial Assistance at Cost by Hospital from 2021-2022

		Financial Assistance at Cost			
		2021	2022	Change in Amount	% Change
1	Hartford	$ 8,784,464	$ 15,428,503	$ 6,644,039	75.63%
2	St. Vincent's	$ 1,950,336	$ 7,440,464	$ 5,490,128	281.50%
3	MidState	$ 1,192,901	$ 3,579,562	$ 2,386,661	200.07%
4	Central Connecticut	$ 2,573,946	$ 4,896,982	$ 2,323,036	90.25%
5	Backus	$ 1,495,808	$ 3,775,116	$ 2,279,308	152.38%
6	Griffin	$ 2,072,580	$ 3,547,406	$ 1,474,826	71.16%
7	Charlotte Hungerford	$ 697,815	$ 1,818,949	$ 1,121,134	160.66%
8	Windham	$ 627,543	$ 1,677,890	$ 1,050,347	167.37%
9	Danbury	$ 13,104,369	$ 13,273,056	$ 168,687	1.29%
10	Day Kimball	$ 91,396	$ 93,862	$ 2,466	2.70%
11	Johnson Memorial	$ 359,129	$ 338,852	$ (20,277)	-5.65%
12	Connecticut Children's	$ 848,987	$ 747,843	$ (101,144)	-11.91%
13	Bristol	$ 2,365,007	$ 2,151,903	$ (213,104)	-9.01%
14	Sharon	$ 774,044	$ 552,391	$ (221,653)	-28.64%
15	Stamford	$ 7,163,244	$ 6,889,730	$ (273,514)	-3.82%
16	St. Mary's	$ 2,737,876	$ 2,294,564	$ (443,312)	-16.19%
17	Lawrence + Memorial	$ 19,334,715	$ 18,694,202	$ (640,513)	-3.31%
18	Middlesex	$ 2,301,326	$ 1,601,363	$ (699,963)	-30.42%
19	Norwalk	$ 8,576,460	$ 7,291,293	$ (1,285,167)	-14.98%
20	St. Francis	$ 5,477,108	$ 4,091,623	$ (1,385,485)	-25.30%
21	Bridgeport	$ 29,696,364	$ 26,300,138	$ (3,396,226)	-11.44%
22	Greenwich	$ 27,495,762	$ 23,707,921	$ (3,787,841)	-13.78%
23	Yale New Haven	$ 147,356,518	$ 106,027,679	$ (41,328,839)	-28.05%

As seen in Table 9, four hospitals decreased their financial assistance by 25% or more: St. Francis (25.3%), Yale New Haven Hospital (28.05%), Sharon (28.64%) and Middlesex (30.42%). However, when considered as a portion of all decreases ($53,797,038), Yale New Haven's $41.3M reduction accounts for 76.8% of the total. YNHH's influence on the category is so impactful that if one were to remove it from the analysis, overall charity care would have increased between 2021-2022.

YNHHS associated hospitals also have three of the largest dollar decreases in charity care, which is of note when considering Table 8 which shows that YNHHS hospitals in 2022 provided the most charity care overall. When examining increases in financial assistance, all of the HHC associated hospitals saw increases in their charity care expenses, with some increasing assistance by upwards of 200% or more.

Community Health Improvement and Community Benefit Operations

Community health improvement services and community benefit operations are activities that improve a community. The IRS defines community health improvement services as "activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services don't generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services."[54] The Catholic Health Association provides examples: community health education, community-based clinical services, support services like enrollment assistant in public programs and transportation, community-based chaplaincy programs and spiritual care, and community health initiatives addressing specific health targets and goals.[55] This is the first category reviewed that is focused on improving a community's health, and not focused on the programs provided to individuals when they arrive at the hospital, or to increase staff training.

Table 10: Hospital Expenses on Community Health Improvement Services and Community Benefit Operations Compared to Expenses as Percent of Total Community Benefit (2022)

		Community Health Improvement Services and Community Benefit Operations
1	Yale New Haven	$ 13,506,840
2	Middlesex	$ 8,674,632
3	Bristol	$ 6,730,265
4	Connecticut Children's	$ 3,112,754
5	St. Vincent's	$ 2,859,691
6	Bridgeport	$ 2,325,375
7	Hartford	$ 1,417,799
8	Central Connecticut	$ 880,815
9	Griffin	$ 860,748
10	Greenwich	$ 793,890
11	Lawrence + Memorial	$ 777,305
12	Charlotte Hungerford	$ 720,012
13	St. Francis	$ 659,046
14	Stamford	$ 632,329
15	Backus	$ 615,742
16	MidState	$ 377,988
17	Windham	$ 343,724
18	Norwalk	$ 171,590
19	St. Mary's	$ 142,756
20	Danbury	$ 106,086
21	Johnson Memorial	$ 29,331
22	Sharon	$ 10,669
	Day Kimball	-

		Community Health Improvement Services and Community Benefit Operations as a % of Total
1	Bristol	21%
2	Middlesex	12%
3	St. Vincent's	7%
4	Charlotte Hungerford	6%
5	Windham	3%
6	Griffin	3%
7	Connecticut Children's	3%
8	Yale New Haven	2%
9	Bridgeport	2%
10	Central Connecticut	2%
11	Backus	1%
12	Greenwich	1%
13	MidState	1%
14	Lawrence + Memorial	1%
15	Hartford	1%
16	Stamford	1%
17	St. Francis	1%
18	Johnson Memorial	1%
19	St. Mary's	0.4%
20	Norwalk	0.4%
21	Danbury	0.1%
22	Sharon	0.1%
	Day Kimball	-

[54] Internal Revenue Service. (2022). Instructions for Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/i990sh.pdf

[55] Catholic Health Association. (2015). Community benefit categories and definitions: a guide for planning & reporting community benefit. 293–320. https://www.chausa.org/docs/default-source/community-benefit-guide-2015/2015-cb-guide-categories-definitions.pdf?sfvrsn=4

In 2022, Table 10 shows Yale New Haven expensed the highest dollar amount ($13,506,840) towards this category, followed by three independent hospitals: Middlesex ($8,674,632), Bristol ($6,730,265), and Connecticut Children's ($3,112,754). Day Kimball is the sole hospital that did not document any community benefit in this category. Out of the 22 reporting hospitals, Bristol and Middlesex documented the highest proportion of community benefits in this category (21% and 12%, respectively). The other 19 hospitals expensed less than 10%, with 11 hospitals documenting community health improvement services as one percent or less of their total community benefit.

Table 11 adds up each hospitals community health improvement services and community benefit operations, and aggregates them by their associated health system, or as a grouping of independent hospitals. Three independent hospitals combined (Middlesex, Bristol, and Connecticut Children's) spent more than Hartford HealthCare, Trinity Health of New England, and Nuvance Health system hospitals combined ($18,517,651 versus $8,335,249). The Yale New Haven Health system documented the second highest amount ($17,403,410) with Yale New Haven Hospital accounting for 77.6% of said dollar amount.

Table 11: Community Health Improvement Services and Community Benefit Operations by hospital grouped into health system (2022)

Community Health Improvement Services and Community Benefit Operations

Middlesex	$	8,674,632
Bristol	$	6,730,265
Connecticut Children's	$	3,112,754
Griffin	$	860,748
Stamford	$	632,329
Day Kimball	$	-
Independent Total	**$**	**20,010,728**

St. Vincent's	$	2,859,691
Hartford	$	1,417,799
Central Connecticut	$	880,815
Charlotte Hungerford	$	720,012
Backus	$	615,742
MidState	$	377,988
Windham	$	343,724
HHC Total	**$**	**7,215,771**

St. Francis	$	659,046
St. Mary's	$	142,756
Johnson Memorial	$	29,331
Trinity Health Total	**$**	**831,133**

Norwalk	$	171,590
Danbury	$	106,086
Sharon	$	10,669
Nuvance Total	**$**	**288,345**

Yale New Haven	$	13,506,840
Bridgeport	$	2,325,375
Greenwich	$	793,890
Lawrence + Memorial	$	777,305
YNHHS Total	**$**	**17,403,410**

Subsidized Health Services

Subsidized health services consist of services that address an identified need provided at a loss, such as psychiatric inpatient beds. Table 12 highlights 18 of 23 hospitals documented community benefit for subsidized health services, with Middlesex providing the highest dollar amount ($20,042,544), more than double from the next hospital (Griffin, $9,497,906). Backus expensed the least amount out of the contributing hospitals ($80,079), preceded by four other Hartford HealthCare associated facilities. All three Connecticut based Trinity hospitals did not document any subsidized health services.

Table 12: Hospital Expenses on Subsidized Health Services Compared to Expenses as Percent of Total Community Benefit (2022)

	Subsidized Health Services	
1	Middlesex	$ 20,042,544
2	Griffin	$ 9,497,906
3	Bristol	$ 7,576,237
4	Yale New Haven	$ 7,302,904
5	Bridgeport	$ 7,248,267
6	Sharon	$ 4,546,667
7	Hartford	$ 4,083,811
8	Greenwich	$ 3,768,168
9	Norwalk	$ 2,822,426
10	Lawrence + Memorial	$ 2,396,384
11	Day Kimball	$ 1,861,959
12	St. Vincent's	$ 1,741,521
13	Danbury	$ 1,647,225
14	Charlotte Hungerford	$ 619,101
15	Windham	$ 484,119
16	MidState	$ 142,460
17	Central Connecticut	$ 118,632
18	Backus	$ 80,079
	Connecticut Children's	-
	Johnson Memorial	-
	St. Francis	-
	St. Mary's	-
	Stamford	-

	Subsidized Health Services as a % of Total Community Benefit	
1	Sharon	37%
2	Griffin	33%
3	Middlesex	28%
4	Bristol	23%
5	Day Kimball	20%
6	Greenwich	7%
7	Norwalk	6%
8	Bridgeport	5%
9	Charlotte Hungerford	5%
10	St. Vincent's	4%
11	Windham	4%
12	Lawrence + Memorial	3%
13	Hartford	3%
14	Danbury	2%
15	Yale New Haven	1%
16	MidState	0.4%
17	Central Connecticut	0.2%
18	Backus	0.2%
	Connecticut Children's	-
	Johnson Memorial	-
	St. Francis	-
	St. Mary's	-
	Stamford	-

Table 12 shows that Sharon documented the highest proportion (37%) of their community benefits towards subsidized health services, followed by four independent hospitals (Griffin, Middlesex, Bristol, and Day Kimball), all of which this category made up 20% or more of their community benefit expense. The rest (13 hospitals) documented less than 10% of their community benefits expenditures on subsidized health services.

Cash and In-Kind Contributions

Cash and in-kind contributions for community benefit are funds and in-kind services donated to community organizations or to the community at large for a community benefit purpose.53 An example is event sponsorship, or contributions for providing technical assistance, or evaluation of community coalition efforts. Table 13 compares hospital expenses for cash and in-kind contributions for community benefit as compared to those dollars as a percentage of total community benefit.

Table 13: Hospital Expenses on Cash and In-Kind Contributions for Community Benefit Compared to Expenses as Percent of Total Community Benefit (2022)

		Cash and In-Kind Contributions for Community Benefit		Cash and In-Kind Contributions for Community Benefit as a % of Total Community Benefit
1	Lawrence + Memorial	$ 20,923,809	1	29.8%
2	Hartford	$ 7,652,627	2	5.6%
3	Yale New Haven	$ 5,114,620	3	2.9%
4	Stamford	$ 2,311,072	4	1.3%
5	Griffin	$ 380,967	5	1.2%
6	Middlesex	$ 325,964	6	0.9%
7	Bridgeport	$ 222,534	7	0.4%
8	St. Francis	$ 189,138	8	0.2%
9	Charlotte Hungerford	$ 155,860	9	0.2%
10	Greenwich	$ 111,194	10	0.2%
11	Central Connecticut	$ 107,479	11	0.2%
12	St. Vincent's	$ 84,136	12	0.2%
13	Backus	$ 72,000	13	0.2%
14	MidState	$ 42,300	14	0.2%
15	St. Mary's	$ 40,921	15	0.1%
16	Norwalk	$ 14,915	16	0.1%
17	Connecticut Children's	$ 11,750	17	0.1%
18	Johnson Memorial	$ 11,600	18	0.03%
19	Windham	$ 6,536	19	0.02%
20	Sharon	$ 2,458	20	0.01%
	Bristol	-		-
	Danbury	-		-
	Day Kimball	-		-

Table 13 shows that Lawrence + Memorial documented the highest dollar amount ($20,923,809) towards cash and in-kind contributions which accounted for 29.8% of their for community benefit. This was more than double that of Hartford hospital who reported $7,652,627 which accounted for 5.6% of total community benefit. Bristol, Danbury, and Day Kimball did not report any cash and in-kind contributions for community benefit.

The remaining hospitals that reported in this section documented less than 3% of their community benefits in this category, of which 15 hospitals documented less than 1% of their community benefits on cash and in-kind contributions, including Yale New Haven which expensed the third highest dollar amount.

Research

Research is the unfunded research by the organization or funded by a tax-exempt organization or government. Research is any study or investigation the goal of which is to generate increased generalizable knowledge made available to the public, and the cost is funded by a tax-exempt or government entity, or internally with exceptions.54 An example provided by the IRS is an evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols. As seen in Table 14, only eight hospitals reported research as a community benefit.

Table 14: Hospital Expenses on Research Compared to Expenses as Percent of Total Community Benefit (2022)

		Research	Research as a % of Total Community Benefit
1	Danbury	$ 6,605,518	7.4%
2	Connecticut Children's	$ 5,605,014	5.0%
3	Hartford	$ 1,949,779	1.7%
4	Norwalk	$ 814,900	1.4%
5	St. Francis	$ 314,000	0.4%
6	Middlesex	$ 282,922	0.4%
7	Griffin	$ 128,985	0.4%
8	Sharon	$ 23,671	0.2%
	Backus	-	-
	Bridgeport	-	-
	Bristol	-	-
	Central Connecticut	-	-
	Charlotte Hungerford	-	-
	Day Kimball	-	-
	Greenwich	-	-
	Johnson Memorial	-	-
	Lawrence + Memorial	-	-
	MidState	-	-
	St. Mary's	-	-
	St. Vincent's	-	-
	Stamford	-	-
	Windham	-	-
	Yale New Haven	-	-

Of those hospitals that documented research, Danbury and Connecticut Children's had the highest amounts totaling almost $15.7 million ($6,605,518 and $5,605,014, respectively), and Sharon had the smallest amount ($23,671). Danbury and Connecticut Children's have the two highest percentages of total community benefit, with the remaining six reporting less than 2%, and four of those six documenting less than 1%.

Cost of Other Means-Tested Government Programs

Costs from other means-tested programs is the shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries. This payment shortfall is not the same as a contractual allowance, which is the full difference between charges and government payments. An example of another means-tested government program is a State Children's Health Insurance Program (SCHIP). As seen in Table 15, only $36,025 is documented in this category in total, with the bulk coming from Day Kimball ($30,137), followed by Griffin ($5,888). Neither the dollar amounts in Figure 17, or the percentages in Figure 18, constitute a significant portion of community benefit, with Day Kimball's and Griffin's constituting 0.32% and 0.02% of the hospital's community benefit, respectively.

Table 15: Hospital Expenses on Cost of Other Means-Tested Government Programs Compared to Expenses as Percent of Total Community Benefit (2022)

		Costs of Other Means-Tested Government Programs	Costs of Other Means-Tested Government Programs as a % of Total Community Benefit
1	Day Kimball	$ 30,137	0.32%
2	Griffin	$ 5,888	0.02%
	Backus	-	-
	Bridgeport	-	-
	Bristol	-	-
	Central Connecticut	-	-
	Charlotte Hungerford	-	-
	Connecticut Children's	-	-
	Danbury	-	-
	Greenwich	-	-
	Hartford	-	-
	Johnson Memorial	-	-
	Lawrence + Memorial	-	-
	Middlesex	-	-
	MidState	-	-
	Norwalk	-	-
	Sharon	-	-
	St. Francis	-	-
	St. Vincent's	-	-
	Stamford	-	-
	Windham	-	-
	Yale New Haven	-	-
	St. Mary's	-	-

Connecticut Nonprofit Annual Status Reports

What is it, and why is it important?

Annual Status Reports were submitted by Connecticut acute care hospitals for filing year 2022 for the first time in 2023. They must include:

1. A description of major updates regarding community health needs, priorities and target populations, if any;
2. A description of progress made regarding the hospital's actions in support of its Implementation Strategy;
3. A description of any major changes to the proposed Implementation Strategy and associated hospital actions; and
4. A description of financial resources and other resources allocated or expended that supported the actions taken in support of the hospital's Implementation Strategy.

For this report, OHS is not including the responses for #1-3. Responses to #1-3 are mostly qualitative in nature, and instead OHS has made hospitals' submissions available on its community benefit website: Hospital Community Benefit (ct.gov).[56] OHS recommends readers review these submissions, as the responses provide valuable insights, and give perspective into how much hospitals are focusing on measuring the impact of their Implementation Strategy activities.

Response #4 can be reviewed quantitatively and is included in this report. Responses had to be 1) based on the filing year of the hospitals' most recently completed IRS Form 990 (FY 2022), pursuant to Connecticut General Statutes §19a-649 2) align with a community health need, and 3) indicate if the activities taken align or not with the IRS Form 990 community benefit or community building categories. To better understand the funding for activities that support hospitals' Implementation Strategies, OHS included hospitals' community benefit expenses outlined earlier in this report to provide context.

Note, since hospitals had been working on their Implementation Strategies in 2021/2022, the funds supporting their Implementation Strategy actions and documented in their Annual Status Reports may be based on the hospitals' previous Implementation Strategy. Given this one-year limitation, OHS is not reviewing how the health needs in the CHNA and Implementation Strategies reviewed in this report, compare with what hospitals provided in their Annual Status Reports.

The Annual Status Report gives the State additional information about how hospitals' community benefit or community building expenses are funding activities that support their Implementation Strategy. Hospitals had the opportunity to correct or clarify their submissions if their report failed to indicate whether the implementation strategy was considered 1) a community benefit activity or service; 2) a community building activity; 3) neither a community benefit nor a community building activity; and/or 4) if the amount documented in the Annual Status Report exceeded the total community benefit or building reported to the IRS.

Waterbury Hospital, Manchester Memorial Hospital, and Rockville General Hospital are all for-profit not tax-exempt facilities that do not fill out an IRS Form 990. Therefore, they are not included in the analysis below. Based on their Annual Status Reports to OHS, Waterbury documented $267,548 in community

[56] Hospital submissions to the Annual Status Report can be found at https://portal.ct.gov/OHS/Pages/Hospital-Community-Benefit

health improvement services towards supporting their Implementation Strategy activities, and $3,200 on health profession education. Manchester and Rockville's submissions did not include any dollar amounts (documented as "not available").

Annual Status Report Data

Annual Status Reports for filing year 2022 were submitted to OHS by hospitals for the first time in 2023. These reports provide OHS additional information regarding expenses hospitals are attributing to the activities supporting their implementation strategy which are intended to address identified needs. These expenses are categorized as community benefit, community building expenses, or neither. OHS used the data to better understand how much of community benefit expenses, community building expenses, or expenses that didn't qualify as either are going to activities that support implementation strategies.

Throughout these tables, implementation strategy activities may not be applicable to each category, meaning that the hospital does not have an activity associated with the implementation plan, resulting in no data. Also, some hospitals report a greater percentage of spending towards activities related to implementation strategies than indicated in their total community benefit and community building dollars reported on the IRS Form 990. OHS cannot conclusively determine what accounts for these inconsistencies.

In total, all 23 hospitals reported $815,574,263 in activities that supported their implementation strategies. The following sections break down this amount into Community Benefit expenses (44.4%), Community Building expenses (72%), or expenses that did not count as either.

Community Benefit (Part I)

While there is no federal requirement for hospitals to associate community benefit expenses to implementation strategies, the following tables reflect how much funding hospitals associated towards activities supporting the implementation strategy and the percentage as a total community benefit category in the Annual Status Report (see Table 16).

Hospitals reported a total of $787.4 million (44.4% of expenses) towards Implementation Strategy activities categorized as a community benefit expenses. When compared to the total Community Benefit expenses reported to the IRS for filing year 2022, some of the amounts reported in the Annual Status Reports categorized as community benefit exceed the total reported in Form 990, Schedule H.

Table 16: Hospital Total Community Benefit, Total Funding for Activities Supporting Hospitals' Implementation Strategies, and Activities Total Funding as Percent of Total Community Benefit by Hospital (2022)

Hospital	**Total Community Benefit (Form 990)**	**Total Activities Supporting Implementation Strategy (Annual Status Report)**	**Total Activities as % of Total Community Benefit**
Backus	$ 43,112,270	$ 311,657	0.7%
Bridgeport	$ 134,073,187	$ 113,235,091	84.5%
Bristol	$ 32,432,732	$ 387,631	1.2%
Central Connecticut	$ 55,907,820	$ 392,962	0.7%
Charlotte Hungerford	$ 12,898,152	$ 506,678	3.9%
Connecticut Children's	$ 112,695,864	$ 525,000	0.5%
Danbury	$ 89,007,110	$ 156,681	0.2%
Day Kimball	$ 9,445,299	$ 134,387	1.4%
Greenwich	$ 57,577,523	$ 51,328,057	89.1%
Griffin	$ 28,669,111	$ 429,269	1.5%
Hartford	$ 137,235,416	$ 1,018,487	0.7%
Johnson Memorial	$ 5,141,895	$ 12,279	0.2%
Lawrence + Memorial	$ 70,245,138	$ 69,847,575	99.4%
Middlesex	$ 72,606,343	$ 16,785,096	23.1%
MidState	$ 32,419,488	$ 198,249	0.6%
Norwalk	$ 48,552,246	$ 199,484	0.4%
Sharon	$ 12,271,675	$ 37,192	0.3%
St. Francis	$ 85,170,097	$ 380,739	0.4%
St. Mary's	$ 32,625,865	$ 82,369	0.3%
St. Vincent's	$ 38,862,177	$ 3,009,612	7.7%
Stamford	$ 78,518,877	$ 80,000,000	101.9%
Windham	$ 10,934,108	$ 785,774	7.2%
Yale New Haven	$ 573,554,615	$ 447,691,399	78.1%
Total	**$ 1,773,957,008**	**$ 787,455,668**	**44.4%**

Table 16 shows out of the 23 nonprofit hospitals, five hospitals documented greater than 50% of total activities supporting implementation strategies was associated with community benefit expense.

Tables 17-22 represent implementation strategy expenses by community benefit category as reported by hospitals. The tables also include the total community benefit reported for that category to determine the implementation strategy expense as a percentage of that specific community benefit category.

Financial Assistance at Cost (Charity Care)

Table 17: Hospital Total Financial Assistance at Cost, Funding for Activities Supporting Hospitals' Implementation Strategies and Categorized as Financial Assistance at Cost, and Activities as Percent of Total Financial Assistance at Cost by Hospital (2022)

Hospital	Financial Assistance at Cost (Form 990)	Activities supporting Implementation Strategy (Annual Status Report)	Activities as % of Financial Assistance at Cost
Backus	$ 3,775,116	-	-
Bridgeport	$ 26,300,138	$ 26,300,138	100%
Bristol	$ 2,151,903	-	-
Central Connecticut	$ 4,896,982	-	-
Charlotte Hungerford	$ 1,818,949	-	-
Connecticut Children's	$ 747,843	-	-
Danbury	$ 13,273,056	-	-
Day Kimball	$ 93,862	-	-
Greenwich	$ 23,707,921	$ 23,707,921	100%
Griffin	$ 3,547,406	-	-
Hartford	$ 15,428,503	-	-
Johnson Memorial	$ 338,852	-	-
Lawrence + Memorial	$ 18,694,202	$ 18,694,202	100%
Middlesex	$ 1,601,363	-	-
MidState	$ 3,579,562	-	-
Norwalk	$ 7,291,293	-	-
Sharon	$ 552,391	-	-
St. Francis	$ 4,091,623	-	-
St. Mary's	$ 2,294,564	-	-
St. Vincent's	$ 7,440,464	-	-
Stamford	$ 6,889,730	$ 80,000,000	1161%
Windham	$ 1,677,890	-	-
Yale New Haven	$ 106,027,679	$ 106,027,679	100%
Total	**$ 256,221,292**	**$ 254,729,940**	**99%**

Charity care is free or discounted care for patients that meet eligibility requirements. Some hospitals may include bad debt when reporting these numbers, though the IRS does account for bad debt as charity care in Part I of the 990 Schedule H. Table 17 shows that all (n=23) hospitals allocated funds to financial assistance at cost. In total, 99% of this community benefit category is attributed to Implementation Strategy activities. Nearly one-fourth (22%, n=5) associated some percentage of financial assistance at cost as an activity supporting their Implementation Strategy with four out of the five hospitals reporting 100% of financial assistance expenses associated to addressing an identified need. Stamford hospital reported $73.1 million more in Financial Assistance at Cost as activities supporting the Implementation Strategy than what was reported as Financial Assistance at Cost to the IRS.

Reported Unreimbursed Costs from Medicaid

Table 18: Hospital Total Reported Unreimbursed Costs from Medicaid, Funding for Activities Supporting Hospitals' Implementation Strategies and Categorized as Reported Unreimbursed Costs from Medicaid, and Activities as Percent of Total Reported Unreimbursed Costs from Medicaid by Hospital (2022)

Hospital	Medicaid (Form 990)	Activities supporting Implementation Strategy (Annual Status Report)	Activities as % of Medicaid
Backus	$ 36,121,453	-	-
Bridgeport	$ 84,543,467	$ 84,543,467	100%
Bristol	$ 15,974,327	-	-
Central Connecticut	$ 40,426,615	-	-
Charlotte Hungerford	$ 9,573,663	-	-
Connecticut Children's	$ 80,542,996	-	-
Danbury	$ 50,318,684	-	-
Day Kimball	$ 7,366,197	-	-
Greenwich	$ 25,662,104	$ 25,662,104	100%
Griffin	$ 12,944,403	-	-
Hartford	$ 59,720,594	-	-
Johnson Memorial	$ 4,762,112	-	-
Lawrence + Memorial	$ 25,654,463	$ 25,654,463	100%
Middlesex	$ 31,032,377	$ 8,277,364	27%
MidState	$ 28,277,178	-	-
Norwalk	$ 28,802,223	-	-
Sharon	$ 7,008,403	-	-
St. Francis	$ 63,477,994	-	-
St. Mary's	$ 23,948,768	-	-
St. Vincent's	$ 24,319,041	-	-
Stamford	$ 68,685,746	-	-
Windham	$ 8,060,998	-	-
Yale New Haven	$ 339,315,142	$ 339,315,142	100%
Total	**$ 1,076,538,948**	**$ 483,452,540**	**45%**

Medicaid (the reported unreimbursed costs from Medicaid) is the shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries. Table 18 above shows that all hospitals (n=23) reported funds towards the unreimbursed costs from Medicaid. In total, 45% of this community benefit category is attributed to Implementation Strategy activities. However, only five (5) hospitals attributed the reported unreimbursed costs from Medicaid as an activity supporting their Implementation Strategy with four out of the five hospitals reporting 100% of unreimbursed Medicaid costs expenses to address an identified need. Middlesex hospital reported $8.2 million (27%) of their total unreimbursed costs from Medicaid as activities supporting their Implementation Strategy.

Community Health Improvement Services and Community Benefit Operations

Table 19: Hospital Total Community Health Improvement Services and Community Benefit Operations, Funding for Activities Supporting Hospitals' Implementation Strategies and Categorized as Community Health Improvement Services and Community Benefit Operations, and Activities as Percent of Total Community Health Improvement Services and Community Benefit Operations by Hospital (2022)

Hospital	Community health improvement services and community benefit operations (Form 990)	Activities supporting Implementation Strategy (Annual Status Report)	Activities as % of Community health improvement services and community benefit operations
Backus	$ 615,742	$ 242,232	39%
Bridgeport	$ 2,325,375	$ 632,131	27%
Bristol	$ 6,730,265	$ 387,631	6%
Central Connecticut	$ 880,815	$ 182,316	21%
Charlotte Hungerford	$ 720,012	$ 392,138	54%
Connecticut Children's	$ 3,112,754	$ 525,000	17%
Danbury	$ 106,086	$ 125,685	118%
Day Kimball	$ -	$ 65,195	-
Greenwich	$ 793,890	$ 423,532	53%
Griffin	$ 860,748	$ 131,609	15%
Hartford	$ 1,417,799	$ 1,018,487	72%
Johnson Memorial	$ 29,331	$ 8,799	30%
Lawrence + Memorial	$ 777,305	$ 401,208	52%
Middlesex	$ 8,674,632	$ 336,524	4%
MidState	$ 377,988	$ 198,249	52%
Norwalk	$ 171,590	$ 157,544	92%
Sharon	$ 10,669	$ 31,839	298%
St. Francis	$ 659,046	$ 295,657	45%
St. Mary's	$ 142,756	$ 63,955	45%
St. Vincent's	$ 2,859,691	$ 1,361,129	48%
Stamford	$ 632,329	-	-
Windham	$ 343,724	$ 296,761	86%
Yale New Haven	$ 13,506,840	$ 2,026,201	15%
Total	**$ 45,749,387**	**$ 9,303,822**	**20%**

Community health improvement services and community benefit operations are activities that improve a community. Table 19 shows that 22 hospitals allocated funds to health improvement services and community operations. In total, 20% of this community benefit category is attributed to Implementation Strategy activities. While Stamford allocated funds to this benefit, none were attributed to implementation activities, whereas Day Kimball attributed funds to implementation activities but did not allocate funds to this category. Two hospitals, Danbury (118%), and Sharon (298%), reported a greater expenditure more expenses in this community benefit category in their Annual Report than what was reported to the IRS. suggesting that they spent more than was originally expected. Over half (55%, n=11) of hospitals allocated less than 50% of their health improvement services funds to implementation strategy activities.

Health Professions Education

Table 20: Hospital Total Health Professions Education, Funding for Activities Supporting Hospitals' Implementation Strategies and Categorized as Health Professions Education, and Activities as Percent of Total Health Professions Education by Hospital (2022)

Hospital	Health Professions Education (Form 990)	Activities supporting Implementation Strategy (Annual Status Report)	Activities as % of Health Professions Education
Backus	$ 2,447,880	$ 69,425	3%
Bridgeport	$ 13,433,406	-	-
Bristol	$ -	-	-
Central Connecticut	$ 9,477,297	$ 196,146	2%
Charlotte Hungerford	$ 10,567	-	-
Connecticut Children's	$ 22,675,507	-	-
Danbury	$ 17,056,541	$ 2,021	0.01%
Day Kimball	$ 93,144	-	-
Greenwich	$ 3,534,246	-	-
Griffin	$ 1,302,808	-	-
Hartford	$ 46,982,303	-	-
Johnson Memorial	$ -	-	-
Lawrence + Memorial	$ 1,798,975	$ 1,798,975	100%
Middlesex	$ 10,646,541	$ 14,274	0.13%
MidState	$ -	-	-
Norwalk	$ 8,634,899	$ 12,840	0.15%
Sharon	$ 127,416	-	-
St. Francis	$ 16,438,296	-	-
St. Mary's	$ 6,198,856	-	-
St. Vincent's	$ 2,417,324	-	-
Stamford	$ -	-	-
Windham	$ 360,841	$ 4,894	1%
Yale New Haven	$ 102,287,430	-	-
Total	**$ 265,924,277**	**$ 2,098,575**	**1%**

Health professions education expenses are the unreimbursed costs incurred on training programs for being licensed to practice as a health professional. Table 20 shows that 19 hospitals reported funds towards health professions education. In total, 1% of this community benefit category is attributed to Implementation Strategy activities. Over one-third (37%, n=7) associated some percentage of health professions education as an activity supporting their Implementation Strategy. Lawrence + Memorial attributed 100% of that expense to activities supporting their Implementation Strategy, while the remaining spending was less than 3% by each of the other hospitals.

Subsidized Health Services

Table 21: Hospital Total Subsidized Health Services, Funding for Activities Supporting Hospitals' Implementation Strategies and Categorized as Subsidized Health Services, and Activities as Percent of Total Subsidized Health Services by Hospital (2022)

Hospital	Subsidized health services (Form 990)	Activities supporting Implementation Strategy (Annual Status Report)	Activities as % of Subsidized health services
Backus	$ 80,079	-	-
Bridgeport	$ 7,248,267	$ 1,591,785	22%
Bristol	$ 7,576,237	-	-
Central Connecticut	$ 118,632	-	-
Charlotte Hungerford	$ 619,101	-	-
Connecticut Children's	$ -	-	-
Danbury	$ 1,647,225	-	-
Day Kimball	$ 1,861,959	$ 69,192	4%
Greenwich	$ 3,768,168	$ 1,528,910	41%
Griffin	$ 9,497,906	-	-
Hartford	$ 4,083,811	-	-
Johnson Memorial	$ -	-	-
Lawrence + Memorial	$ 2,396,384	$ 2,396,384	100%
Middlesex	$ 20,042,544	$ 8,111,984	40%
MidState	$ 142,460	-	-
Norwalk	$ 2,822,426	-	-
Sharon	$ 4,546,667	-	-
St. Francis	$ -	-	-
St. Mary's	$ -	-	-
St. Vincent's	$ 1,741,521	$ 1,648,483	95%
Stamford	$ -	-	-
Windham	$ 484,119	$ 484,119	100%
Yale New Haven	$ 7,302,904	-	-
Total	**$ 75,980,410**	**$ 15,830,857**	**21%**

Subsidized health services consist of services that address an identified need provided at a loss, such as psychiatric inpatient beds. Table 21 shows that 18 hospitals reported funds towards subsidized health services. In total, 21% of this community benefit category is attributed to Implementation Strategy activities. Nearly two-fifths (39%, n=7) of hospitals attributed some percentage of subsidized health services as an activity supporting their Implementation Strategy. Two hospitals, Lawrence + Memorial and Windham, attributed 100% of those expenses as activities supporting their Implementation Strategy, while over half (n=4) spent less than half towards this strategy.

Cash and In-kind Contribution

Table 22: Hospital Total Cash and In-Kind Contribution for Community Benefit, Funding for Activities Supporting Hospitals' Implementation Strategies and Categorized as Cash and In-Kind Contribution for Community Benefit, and Activities as Percent of Total Cash and In-Kind Contribution for Community Benefit by Hospital (2022)

Hospital	Cash and in-kind contribution for community benefit (Form 990)	Activities supporting Implementation Strategy (Annual Status Report)	Activities as % of Cash and in-kind contribution for community benefit
Backus	$ 72,000	-	-
Bridgeport	$ 222,534	$ 167,570	75%
Bristol	$ -	-	-
Central Connecticut	$ 107,479	$ 14,500	13%
Charlotte Hungerford	$ 155,860	$ 114,540	73%
Connecticut Children's	$ 11,750	-	-
Danbury	$ -	$ 28,975	-
Day Kimball	$ -	-	-
Greenwich	$ 111,194	$ 5,590	5%
Griffin	$ 380,967	$ 297,660	78%
Hartford	$ 7,652,627	-	-
Johnson Memorial	$ 11,600	$ 3,480	30%
Lawrence + Memorial	$ 20,923,809	$ 20,902,343	100%
Middlesex	$ 325,964	$ 44,950	14%
MidState	$ 42,300	-	-
Norwalk	$ 14,915	$ 29,100	195%
Sharon	$ 2,458	$ 5,353	218%
St. Francis	$ 189,138	$ 85,082	45%
St. Mary's	$ 40,921	$ 18,414	45%
St. Vincent's	$ 84,136	-	-
Stamford	$ 2,311,072	-	-
Windham	$ 6,536	-	-
Yale New Haven	$ 5,114,620	$ 322,377	6%
Total	**$ 37,781,880**	**$ 22,039,934**	**58%**

Cash and in-kind contributions for community benefit are funds and in-kind services donated to community organizations or to the community at large for a community benefit purpose. Table 22 shows that 20 hospitals allocated funds to cash and in-kind contributions for community benefit. In total, 58% of this community benefit category is attributed to Implementation Strategy activities. Nearly three-quarters (n=14) of hospitals attributed cash and in-kind contributions for community benefit as an activity supporting their Implementation Strategy. While Danbury did not allocate funds to this benefit category, it did attribute funds to an implementation activity. Nearly half (46%, n=6) spent over 70% of their funding towards implementation activities in this category. Two hospitals, Norwalk (195%) and Sharon (218%), reported more cash and in-kind contribution expenses supporting their implementation strategy in their Annual Status Reports than what was reported as community benefit to the IRS suggesting that they spent more than was originally expected.

Community Building Activities (Part II)

Community building activities help build the capacity of the community to address health needs and often address the "upstream" factors and social determinants that impact health, such as education, air quality, and access to nutritious food. Community building activities do not automatically count as community benefit. Per the IRS, these activities reported in Part II of Schedule H, may count as community benefit if hospitals provide a description in Part VI of the Schedule H of how these activities promote the health of the communities it serves. OHS does not have information on whether these activities are accepted by the IRS as community benefit expenses. The IRS also states that community building activities cannot count as both community health improvement services (Part I), and as community building (Part II) and must be reported in either Part I or II to avoid duplication. There is advocacy and support for federal changes in the reporting structure to count community building activities reported in Part II as community benefit without additional justification.[57, 58, 59]

Hospitals can report Implementation Strategy activities categorized as community building in the Annual Status Report. Table 23 represents the total expenses reported by hospitals as community building activities in the IRS Form 990, Schedule H, Part II and the total expenses reported as activities supporting the hospitals' Implementation Strategy categorized as community building in the Annual Status Report.

Hospitals reported a total of $10,108,208 million (72% of expenses) towards Implementation Strategy activities categorized as a community building expense. When compared to the total Community Building expenses reported to the IRS for filing year 2022, some of the amounts reported in the Annual Status Reports categorized as community building exceed the total reported in Form 990, Schedule H.

Table 23 shows that for filing year 2022, 20 hospitals reported expenses to Community Building activities to the IRS. However, only two-thirds (65%, n=13) of hospitals attributed all or some of these expenses to activities supporting the Implementation Strategy in the Annual Status Reports. Two hospitals, Bristol and Day Kimball, attributed 100% of their community building expenses as supporting their Implementation Strategy while Stamford Hospital reported $3.3 million (3902%) towards these activities.

[57] Rosenbaum, S., Byrnes, M., & Young, G. (2016). Modifying hospital community benefit tax policy: Easing regulation, advancing population health. https://www.healthaffairs.org/content/forefront/modifying-hospital-community-benefit-tax-policy-easing-regulation-advancing-population

[58] Rosenbaum, S., Rieke, A., & Byrnes, M. (2014). Encouraging nonprofit hospitals to invest in community building: the role of IRS 'Safe harbors.' https://www.healthaffairs.org/content/forefront/encouraging-nonprofit-hospitals-invest-community-building-role-irs-safe-harbors

[59] Riley, T., Clary, A., & Higgins, E. (2019). Identifying gaps in federal oversight of hospitals' community benefit investments - opportunities for state policy. https://nashp.org/identifying-gaps-in-federal-oversight-of-hospitals-community-benefit-investments-opportunities-for-state-policy/

Table 23: Hospital Total Community Buidling, Funding for Activities Supporting Hospitals' Implementation Strategies, and Total Activities as a percent of Total Community Building by Hospital (2022)

Hospital	**Total Community Building (Form 990)**	**Total Activities Supporting Implementation Strategy (Annual Status Report)**	**Total Activities as % of Total Community Building**
Backus	$ 31,634	-	-
Bridgeport	$ 71,967	$ 18,708	26%
Bristol	$ 5,600,000	$ 5,600,000	100%
Central Connecticut	$ 292,536	$ 146,268	50%
Charlotte Hungerford	$ 22,156	-	-
Connecticut Children's	$ 1,118,679	$ 530,000	47%
Danbury	$ 123,208	$ 16,639	14%
Day Kimball	$ 5,127	$ 5,127	100%
Greenwich	$ 986,438	$ 500	0.05%
Griffin		-	-
Hartford	$ 543,340	$ 260,938	48%
Johnson Memorial		-	-
Lawrence + Memorial	$ 18,290	-	-
Middlesex	$ 180,821	-	-
MidState	$ 117,206	$ 58,603	50%
Norwalk	$ 849,922	320	0.04%
Sharon	$ 5,469	$3,206	59%
St. Francis	-	-	-
St. Mary's	$ 60,900	$ 30,450	50%
St. Vincent's	$ 14,530	$ -	
Stamford	$ 88,085	$ 3,437,449	3902%
Windham	$ 1,567	-	-
Yale New Haven	$ 3,974,013	-	-
Total	**$ 14,105,888**	**$ 10,108,208**	**72%**

Other Expenses for Activities Supporting the Implementation Strategies

In the Annual Status Report, hospitals can document additional expenses that are supporting their Implementation Strategies but are not counted as either community benefit or community building. Table 24 documents expenses hospitals indicated were supporting hospitals' Implementation Strategy, but did not count as community benefit or community building.

Table 24: Hospital Total Funding for Activities that Supported the Implementation Strategy, but Did Not Count as Community Benefit or Community Building (2022)

Hospital	Activities that did not count as community benefit / building
Backus	-
Bridgeport	$ 477,436
Bristol	-
Central Connecticut	-
Charlotte Hungerford	-
Connecticut Children's	-
Danbury	-
Day Kimball	-
Greenwich	$ 375,356
Griffin	-
Hartford	-
Johnson Memorial	-
Lawrence + Memorial	$ 31,804
Middlesex	-
MidState	-
Norwalk	-
Sharon	-
St. Francis	-
St. Mary's	-
St. Vincent's	-
Stamford	$ 12,450,889
Windham	-
Yale New Haven	$ 4,674,902
Total	**$ 18,010,387**

Nearly one-quarter (n=5) of hospitals reported additional expenses totaling $18,010,387 for activities that supported their Implementation Strategies. Out of the total, 69% ($12,450,889) of these expenses was reported from Stamford Hospital.

In summary, most of the community building expenses (72%) are supporting hospitals' implementation strategy activities. Moreover, hospitals are dedicating an additional $18 million to these activities. Less than 50% of community benefit expenses ($787 million) are connected to an activity in their implementation strategy. Of that $787 million, a majority of the dollars (93.7%) come from the reported

unreimbursed costs from Medicaid ($483 million), and charity care ($254 million), while there is significantly less spending (4%) in community health improvement services ($9.3 million) or cash and in-kind contributions ($22 million) that more likely address social factors that impact health.

The above data reveal a substantial variation in the way that hospitals link their community benefit and community building funding to their implementation strategies outlined in the Annual Reports. While not required by the IRS to make such a connection, most hospitals did report funds from community benefit and community building being used towards strategies adopted to address issues in the Community Health Needs Assessment. In future community benefit program reporting from hospitals, OHS will receive additional information from hospitals regarding outcomes and measures of how their Implementation Strategy investments are addressing identified health needs in their CHNAs. Activities like community health improvement services and cash and in-kind contributions are more focused on improving a community's health, and less focused on offsetting the costs of healthcare. That is why Implementation Strategy investments are critical to addressing the needs in a community.

Financial Assistance Policy, Emergency Medical Care Policy, Bad Debt and Billing and Collections Practices

Financial Assistance Policies (FAPs)

What is a Financial Assistance Policy?

IRC section §501(r)(4) requires tax-exempt hospitals to have a Financial Assistance Policy (FAP). While the federal government does not require minimum requirements for financial assistance eligibility, hospitals must establish criteria for free or discounted care and make that criteria publicly available. At minimum, a hospitals' FAP must:[60]

1. Apply to all emergency and other medically necessary care provided by the hospital facility, including all such care provided in the hospital facility by a substantially-related entity;
2. Be widely publicized; and include:
    a. The eligibility criteria for financial assistance and whether such assistance includes free or discounted care;
    b. The basis for calculating amounts charged to patients;
    c. The method for applying for financial assistance;
    d. In the case of a hospital facility that does not have a separate billing and collections policy, the actions that may be taken in the event of nonpayment, including, but not limited to, any extraordinary collections actions (ECAs); the process and timeframes used in taking these actions; and the office, department, committee, or other body with the final authority or responsibility for determining that the hospital facility has made reasonable efforts to determine whether an individual is FAP-eligible and may therefore engage in ECAs against the individual;
    e. If applicable, any information obtained from sources other than an individual seeking financial assistance that the hospital facility uses, and whether and under what

[60] Internal Revenue Service. (n.d.-b). Financial Assistance Policies (FAPs). https://www.irs.gov/charities-non-profits/financial-assistance-policies-faps

circumstances it uses prior FAP-eligibility determinations, to presumptively determine that the individual is FAP-eligible; and

f. A list of any providers, other than the hospital facility itself, delivering emergency or other medically necessary care in the hospital facility that specifies which providers are covered by the hospital facility's FAP and which are not.

FAPs may be found on hospitals' websites, as well as on OHS' Financial Documents Portal. Note on the OHS portal, some hospitals do not title the document as a Financial Assistance Policy, but instead as an "Uncompensated Care Policy," or a close variation of such.

Why are Financial Assistance Policies Important?

Financial Assistance Policies (FAP), which include the criteria for a patient to receive charity care, aim to reduce the financial burden for eligible patients, which in effect improves health care access. The FAP a requirement of the ACA, which heavily emphasized the importance of health care access. Financial Assistance Policies directly impact access to health care for individuals who are uninsured or underinsured and can greatly affect a patient's financial stability.

Financial Assistance, also known charity care, is also provided by for-profit hospitals that do not receive tax-exemption status. A Harvard study found there were no differences in charity care as a percent of total expense between for-profit and nonprofit hospitals.[61] In Connecticut, four Connecticut nonprofit hospitals have less generous or the same Financial Assistance Policies in terms of income requirements when compared to some for-profit hospitals.

Financial Assistance programs provide a benefit to many low-to-moderate income patients who would otherwise delay care or fall in medical debt and experience significant consequences. A literature review on medical cost and access shows that Americans are struggling with the cost of healthcare. Data from Gallup revealed that 38% of Americans delayed care in 2022 due to cost and that this delay was for more serious care than not.

Financial Assistance Policies Reporting

Nonprofit hospitals must make "reasonable efforts" to determine if an individual is eligible for financial assistance. Per federal rules, nonprofit hospitals must allow patients up to 240 days after discharge to submit a financial assistance application. Nonprofit hospitals are required to submit eligibility limits for free and discounted care, total dollar amount spent on financial assistance and total dollar amount written off as bad debt. Hospitals are not required to report how many financial assistance applications were filled, approved, denied or appealed or demographic information for those patients applying for financial assistance.

Financial Assistance Policies Analysis

All of the hospitals included in this report, nonprofit and for-profit, had in place a Financial Assistance Policy (FAP) with eligibility requirements for free and discounted care based on the Federal Poverty

[61] Bruch , J. D., & Bellamy, D. (2020). Charity Care: Do Nonprofit Hospitals Give More than For-Profit Hospitals? *Journal of General Internal Medicine* , *36*, 3279–3280. Retrieved from https://link.springer.com/article/10.1007/s11606-020-06147-9

Guidelines (FPG).[62] The IRS does not require FAP eligibility criteria be based on the Federal Poverty Guidelines, but since all the Connecticut hospitals did use this as a standard eligibility criterion, it is used in this analysis. FAPs generally stated income requirements were based on gross earnings, with a few exceptions. Several of the hospitals indicated in their FAPs additional considerations are taken into account when providing financial assistance, such as when an individual faces catastrophic medical expenses, or if they are medically indigent. For a list of hospitals' FPG tables, see Appendix C. Free care by all hospitals was documented as covering 100% of the hospitals' charges, while discounted care, in all but one case, was based on a sliding scale and differed from hospital to hospital. The 2022 Federal Poverty Guidelines for the contiguous states, including Connecticut, are provided in Table 25. The first column indicates the number of members to a household, and the second column specifies the 2022 Federal Poverty Level (FPL) annual incomes. Columns 3 through 9, the first row are the percentage above the Federal Poverty Level, with the subsequent rows showing the corresponding dollar amount associated with the FPL and household size.

For example, an individual living alone is considered a household size of one (1), whereas two parents and two children are considered four (4). The family of two parents and two children (household size of 4) need a household income below $83,250 (or 300% of the Federal Poverty Level) to potentially receive a 50% or more discount from fictitious "Hospital Alpha."

Table 25: 2022 Federal Poverty Guidelines with Household Size, Federal Poverty Level, and the dollar amounts associated with Percentages above the Federal Poverty Level

Household Size	2022 FPL	125%	200%	250%	300%	400%	500%	550%
1	$ 13,590	$ 16,988	$ 27,180	$ 33,975	$ 40,770	$ 54,360	$ 67,950	$ 74,745
2	$ 18,310	$ 22,888	$ 36,620	$ 45,775	$ 54,930	$ 73,240	$ 91,550	$ 100,705
3	$ 23,030	$ 28,788	$ 46,060	$ 57,575	$ 69,090	$ 92,120	$ 115,150	$ 126,665
4	$ 27,750	$ 34,688	$ 55,500	$ 69,375	$ 83,250	$ 111,000	$ 138,750	$ 152,625
5	$ 32,470	$ 40,588	$ 64,940	$ 81,175	$ 97,410	$ 129,880	$ 162,350	$ 178,585
6	$ 37,190	$ 46,488	$ 74,380	$ 92,975	$ 111,570	$ 148,760	$ 185,950	$ 204,545
7	$ 41,910	$ 52,388	$ 83,820	$ 104,775	$ 125,730	$ 167,640	$ 209,550	$ 230,505
8	$ 46,630	$ 58,288	$ 93,260	$ 116,575	$ 139,890	$ 186,520	$ 233,150	$ 256,465

Free Care (100% Discount)

The IRS does not have requirements for how generous the eligibility criteria must be to provide financial assistance and leaves it to hospital/health systems' Board of Directors to ultimately decide/approve. This part of the analysis is solely focused on hospitals/health systems' income requirements for charity care (financial assistance).

OHS compiled hospitals' maximum household income requirements for free care (100% discount), found in Table 26. The first column of Table 26 indicates the hospital or health system. The four major health systems across all their respective hospitals had the same FAP and are therefore denoted by the health system. For example, the hospitals within Yale New Haven Health Services used the same Financial

[62] Annual Update of the HHS Poverty Guidelines, 87 F.R. 3315 (January 21, 2022). https://aspe.hhs.gov/sites/default/files/documents/175e430d7dd4b1622d7245bc8664b3c2/HHS-Poverty-Guidelines-Fed-Register-2022.pdf

Assistance Policy. The second column indicates the corresponding maximum percentage above the Federal Poverty Level (FPL) to receive free care.

Table 26: Health System/Hospital's Household Income Ceilings for Free Care for an Individual and a Family of Four (2022)

Health System/Hospital	FPL Free Care	Individual Income	Family of 4 Income
Nuvance Health Network	300%	$40,770	$83,250
Bristol	250%	$33,975	$69,375
Connecticut Children's	250%	$33,975	$69,375
Day Kimball	250%	$33,975	$69,375
Griffin	250%	$33,975	$69,375
Hartford Health Care	250%	$33,975	$69,375
Stamford	250%	$33,975	$69,375
Yale New Haven Health Services	250%	$33,975	$69,375
Middlesex	200%	$27,180	$55,500
Waterbury	200%	$27,180	$55,500
Trinity Health of New England	200%	$27,180	$55,500
Manchester	125%	$16,988	$34,688
Rockville	125%	$16,988	$34,688

As noted in Table 26, free charity care varies based on hospital and health system. In 2022, Nuvance Health Network hospitals (Danbury, Norwalk, and Sharon) had the most generous household income maximum, up to 300% of the FPL – twice as generous as some of their peers; though 60% (n=8) made free care assistance available to those families up to 250%-300% FPL. Under Nuvance's policy, a family of four earning at or below $83,250 (300% FPL) may be eligible for free care; whereas that same family would not qualify for free care at hospitals who required a lower FPL threshold for such assistance—at or below $69,375 for 250% FPL, $55,500 for 200% FPL, or $34,688 for 125% FPL. As noted in the table, the same family of four, depending upon where they receive their healthcare will have a very different experience with charity care and potential for medical debt.

Day Kimball Hospital delineated insured and uninsured patients in their FAP for free or discounted care. A 100% discount may be provided to uninsured patients, and a 75% discount may be provided to insured patients, both with a household income up to 250% of the FPL.

Middlesex Hospital and the Trinity Health of New England health system (St. Mary's, St. Francis, and Johnson Memorial hospitals) had the least generous FAPs for *nonprofits* when considering the maximum household income for free care (Table 26). Waterbury Hospital, a *for-profit* hospital that does not

receive a tax-exemption and is not organized and operated for a charitable purpose, shares with the four nonprofits the same maximum household income up to 200% of the FPL.

At 200% of the FPL, an individual must earn at or below $27,180 to qualify for free care (Tables 25 and 26). Connecticut Medicaid income eligibility for an individual with no children starts at 138% FPL at or below $18,754[63] or. For-profit Manchester Memorial and Rockville Hospitals are not required to provide financial assistance, and it is of note that their income requirements (125% of FPL) are more stringent than Medicaid income eligibility for an individual.

Further, in 2022 the Connecticut minimum wage was $14.00.[64] A Connecticut resident that worked 40 hours a week grossed annually $29,120, falling above the 200% FPL at $27,180 (Table 25). Based on minimum wage and the FAP household income requirements, those making minimum wage would not qualify for free care from: Middlesex Hospital, St. Mary's Hospital, St. Francis Hospital, and Johnson Memorial Hospital.

Discounted Care

In addition to free care, hospitals provide discounted care for eligible patients. In all but one case (Day Kimball Hospital), the health systems or hospitals used a sliding scale for discounted care.

As noted in Table 27, discounted charity care varies based on hospital and health system. In 2022, Yale New Haven Health Services provided the most generous household income maximum, up to 550% of the FPL; though 85% (n=11) provided discounted care to those families up to 400%-500% FPL. Under Yale New Haven Health Services' policy, a family of four earning at or below $152,625 (550% FPL) would be eligible for discounted care; whereas that same family would not qualify for discounted care at hospitals who required a lower FPL threshold for such assistance—at or below $138,750 for 500% FPL, $111,000 for 400% FPL, or $69,375 for 250% FPL. As noted in the table, the same family of four, depending upon where they receive their healthcare may have a very different experience with charity care and potential for medical debt.

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[63] 2022 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii). https://aspe.hhs.gov/sites/default/files/documents/4b515876c4674466423975826ac57583/Guidelines-2022.pdf

[64] Connecticut Department of Labor's Office of Research. (n.d.). State of Connecticut - Minimum Wage Information. https://www1.ctdol.state.ct.us/lmi/ctminimumwage.asp

Table 27: Health System/Hospital's Household Income Ceilings for Discounted Care for an Individual and a Family of Four (2022)

Health System/Hospital	FPL Discounted Care	Individual Income	Family of 4 Income
Yale New Haven Health Services	550%	$74,745	$152,625
Connecticut Children's	500%	$67,950	$138,750
Middlesex	500%	$67,950	$138,750
Bristol	400%	$54,360	$111,000
Griffin	400%	$54,360	$111,000
Hartford HealthCare	400%	$54,360	$111,000
Manchester	400%	$54,360	$111,000
Nuvance Health Network	400%	$54,360	$111,000
Rockville	400%	$54,360	$111,000
Stamford	400%	$54,360	$111,000
Trintiy Health of New England	400%	$54,360	$111,000
Waterbury	400%	$54,360	$111,000
Day Kimball	250%	$33,975	$69,375

Within Yale New Haven Health Services, the maximum FPL requirement of 550% applies to patients differently: uninsured patients may receive a 70% discount, and insured patients may receive a 15% discount (see Appendix C). In context, an individual making $74,745 or a family of four making $152,625 or less at 550% of FPL may be eligible for a discount (see Tables 25 and 27).

Day Kimball Hospital's FAP is the least generous in consideration of household income above the FPL for discounted care, and is less than the three for-profit hospitals that do not receive a tax-exemption. Day Kimball does not use a sliding scale for a discount and indicates a 75% discount is considered for insured patients at or below 250% of the federal poverty level.

As shown in Appendix C, the levels of discount vary by hospitals and health systems.

Other Considerations

In addition to household income and the Federal Poverty Guidelines, hospitals considered other factors when determining eligibility for financial assistance, including where the patient lives (for example the primary services area, or if they live in the United States), insurance status, if the patient/family are medically indigent – which is the inability to gain access to, or to pay for, health care because of financial disadvantages[65] - and in some cases when the hospitals' charges are an unspecified percentage of the

[65] Nutter, D. O. (1987). Medical indigency and the public health care crisis. *New England Journal of Medicine*, *316*(18), 1156–1158. https://doi.org/10.1056/nejm198704303161813

patient's income, or the charges would be catastrophic for the patient. Hospitals noted in some cases the facility will take into account other facts and circumstances at their discretion in determining eligibility.

FAP Requirements

The federal government has minimum requirements hospitals' must include in their Financial Assistance Policies per the Internal Revenue Code (IRC). OHS reviewed these minimum requirements against the nonprofit hospitals' FAPs. The minimum requirements included below are only those in which a hospitals' FAP required further discussion.

The first requirement from Internal Revenue Code section §501(r)(4) states:

> "…A HOSPITAL FACILITY'S FAP MUST – (I) APPLY TO ALL EMERGENCY AND OTHER MEDICALLY NECESSARY CARE PROVIDED BY THE HOSPITAL FACILITY, INCLUDING ALL SUCH CARE PROVIDED IN THE HOSPITAL FACILITY BY A SUBSTANTIALLY-RELATED ENTITY…"[66]

In Hartford HealthCare (HHC) hospitals' FAP, it has an "Exclusions" section that does not mention that emergency care is not covered. In Appendix C of the FAP, the policy notes "With respect to the provision of emergency and medically necessary care in HHC's facility, care provided by the following independent providers is not covered by this Policy:

1. "Services provided by emergency department physicians at MidState Medical Center, Windham Memorial Hospital and The Hospital of Central Connecticut Bradley Campus."

The relationship between the independent Emergency Department physicians at the three noted hospitals, and if they are considered substantially-related organization(s)[67] is unclear, given the need for more information on the two's relationship. In effect, Hartford HealthCare has two Financial Assistance Policies, one for those seeking emergency care at four of the system's hospitals, and another for those seeking emergency care at the system's other three hospitals. It is not clear with current documentation if the emergency medicine physicians at the three noted hospitals are aware that their charges are not covered under the hospitals' FAP, and as noted at the beginning of this section could impact health care access. The IRS prohibits hospitals as part of their Emergency Medical Care Policy in engaging in actions that discourage individuals from seeking emergency medical care.

Discussed further in this report, hospitals are permitted to exclude providers, e.g., physicians, nurse practitioners, physician assistants, etc. from their FAP.

The second requirement noted for this report:

> "THE METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE"[68] [in the FAP].

Day Kimball Hospital's 2022 Financial Assistance Policy does not include information for individuals on the method for applying for financial assistance. It does include processing guidelines, but does not tell one how to apply.

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[66] 26 CFR 1.501(r)-4.
[67] 26 CFR 1.501(r)-1(b)(28).
[68] Internal Revenue Service. (n.d.-b). Financial Assistance Policies (FAPS). https://www.irs.gov/charities-non-profits/financial-assistance-policies-faps

The last FAP requirement reviewed in this report are for hospitals to provide:

> "A LIST OF ANY PROVIDERS, OTHER THAN THE HOSPITAL FACILITY ITSELF, DELIVERING EMERGENCY OR OTHER MEDICALLY NECESSARY CARE IN THE HOSPITAL FACILITY THAT SPECIFIES WHICH PROVIDERS ARE COVERED BY THE HOSPITAL FACILITY'S FAP AND WHICH ARE NOT."[69]

Hartford HealthCare's FAP includes a list of provider specialties that are excluded: radiologists, pathologists, and anesthesiologist. The relationship between providing medically necessary care, and providing a list of providers excluded from the FAP - both requirements in a FAP - is a tightrope. Theoretically, a pathologist who is paid by the hospital, and who never meets the patient or is chosen by the patient, may provide medically necessary care by reviewing the patient's cells sample and determining if that patient has cancer. However, because the pathologist is excluded from the FAP, individuals who do not have insurance that covers charges related to the pathologist, may be on the hook for the full cost of that pathologist reviewing their cells to determine if they have cancer, since the FAP doesn't apply to excluded providers, such as the pathologist.

In addition to the three specialty providers excluded by Hartford HealthCare, it is also noted that certain care provided by Hartford HealthCare Medical Group (HHCMG) – the primary care branch of HHC - is excluded. Specifically, the FAP only applies to services provided in a facility – read hospital - location, which is found in a separate appendix of HHC hospitals' FAP. HHCMG services are *not covered* for office and telehealth visits. OHS' data review of the Financial Assistance Policies shows that excluding primary care services at an office is not the standard across the state. Yale New Haven Health Services' (YNHHS) FAP states that their primary care providers, New England Medical Group (NEMG), includes all services for financial assistance.

Converse to the HHC's approach of providing specialty, YNHHS' FAP provides a full list of the specific provider (name and specialty) that are excluded from the FAP. Examples (excluding provider names) of specific provider specialties that are excluded from financial assistance include at YNHHS include: Emergency Medicine, Pediatrics, Psychiatry, Obstetrics and Gynecology (OB/GYN), Internal Medicine, Anesthesiology, Radiology, Pathology, Surgery, Ophthalmology, Orthopedics, Neurology, Therapeutic Radiology, Child Psychiatry, Dermatology, Laboratory Medicine, and certain physician's from Yale School of Medicine at Smilow Cancer Center. Patients must be aware of the provider list and who their provider is in order to understand if the care they receive from a provider may not be eligible for charity care.

For Nuvance Health Network, the FAPs indicate the providers not covered by the FAP are located in Appendix 1. However, there is no Appendix 1 located in the document. Notice 15-46 from the IRS clarifies that hospitals may maintain the provider list in a document separate from the FAP,[70] and OHS located the lists on Nuvance's website.

Trinity Health of New England FAPs indicate that the list of providers included/excluded from the FAP is posted at their facilities. IRS Notice 15-46 permits maintaining the list in a document separate from the

[69] Internal Revenue Service. (n.d.-b). Financial Assistance Policies (FAPS*)*. https://www.irs.gov/charities-non-profits/financial-assistance-policies-faps

[70] Robbins, S. N. (n.d.). Notice 2015-46 clarifications to the requirement in the treasury regulations under § 501(r)(4) that a hospital facility's financial assistance policy include a list of providers. https://www.irs.gov/pub/irs-drop/n-15-46.pdf

FAP, but OHS is unable to confirm if the document is available for patients and their families at Trinity Health Ministry facilities.

Day Kimball Hospital did not provide a list of excluded providers in its FAP, nor does it include a list on its website.

Griffin Hospital and Middlesex Hospital did not provide a list of excluded providers in their FAPs, but do provide the list on their website.

Emergency Medical Care Policy

In addition to having an FAP, hospitals must have an Emergency Medical Care Policy (EMCP). An EMCP at minimum must:

1. Establish a written policy for a hospital facility that requires the hospital facility to provide, without discrimination, care for emergency medical condition to individuals regardless of whether they are FAP-eligible.
2. The Policy prohibits the hospital facility from engaging in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.
3. The Policy requires the hospital facility to provide the care for emergency medical conditions that the hospital facility is required to provide under Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations.

All of the Connecticut nonprofit acute care hospitals satisfied having an Emergency Medical Care Policy within their FAPs or as a separate document.

Bad Debt and Billing and Collections Practices

Introduction to Bad Debt

Bad debt refers to when a nonprofit hospital provided services for which the facility anticipated payment, but did not receive payment. In such cases when the facility believes it will not receive payment, the hospital is permitted to write-off this debt against their accounts receivable. This differs from charity care, in which the hospital did not expect to receive payment, because the patient met the hospitals' Financial Assistance Policy eligibility criteria.

Hospitals may justify their bad debt as community benefit in cases when the facility believes the debt is reasonably attributable to patients eligible under the organization's FAP.[71] To count as community benefit, the IRS asks hospitals to provide the methodology and rationale for including the bad debt as community benefit. The IRS prohibits hospitals from reporting bad debt as uncompensated care in Part I of the Schedule H, which includes charity care and the reported unreimbursed costs from Medicaid. Instead, bad debt hospitals want to justify as community benefit must document the expense in Part III,

[71] Internal Revenue Service. (2022). Instructions for Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/i990sh.pdf

with the appropriate justification in Part VI of Schedule H. From 2016 to 2022, Connecticut nonprofit hospitals documented around $100 million in bad debt as potential community benefit.

The standard governing bad debt – Revenue from Contracts with Customers (Topic 606) - changed over the observed time period of this report (2016-2022). The prior standard was the difference between the amount the hospital billed patients and the amount their patients ended up actually paying, even in instances when the hospital never expected to receive the full amount billed. A Modern Healthcare article provides the following example: if a patient owed $100 and paid $10, the hospital could report $90 as bad debt.[72] In the new standard, hospitals are allowed only to report bad debt in instances when an adverse event, such as bankruptcy or loss of employment, prevents a patient from paying what the hospital expected to receive based on historical experience.[73, 74] Returning to the $100 owed by a patient example, bad debt depends on what the hospital expects to receive; if historically they know they will only receive $10, and the patient pays $10 but not the remaining $90, the hospital cannot write-off $90 worth of bad debt. Alternatively, if the patient paid $8 and the hospital expected $10, the facility could write off $2 of bad debt. While the standard governing bad debt is stricter, the increase in the amount of bad debt write-offs further reviewed may be attributable to another change from the Financial Accounting Standards Board (FASB), which allowed bad debt to be considered an Implicit Price Concession.

Bad Debt and Extraordinary Collection Actions (ECAs)

Regardless of how bad debt is written-off by hospitals, it does not mean that debt goes away for the patient / their family. For initial nonpayment, charitable hospitals may take punitive action against patients, known as extraordinary collection actions (ECA). Federal rules require hospitals to wait at least 120 days before initiating ECA, notify the patient at least 30 days before initiating ECA, and suspending ECA while financial assistance applications are pending and until decision is made. The ECAs hospitals are allowed to take against patients include:[75]

1. Selling an individuals' debt to another party, such as a collections agency
2. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus
3. Deferring or denying, or requiring payment before providing medically necessary care because of an individual's previous nonpayment
4. Actions that require a legal or judicial process, including but not limited to:
    a. Placing a lien on and individual's property
    b. Foreclosing on an individual's real property
    c. Attaching or seizing an individual's bank account or any other personal property
    d. Commencing a civil action against an individual
    e. Causing an individual's arrest
    f. Causing an individual to be subject to a writ of body attachment
    g. Garnishing an individual's wages

[72] Bannow, T. (2018). New bad debt accounting standards likely to remake community benefit reporting. https://www.modernhealthcare.com/article/20180317/NEWS/180319904/new-bad-debt-accounting-standards-likely-to-remake-community-benefit-reporting

[73] *Id.*

[74] Advisory Board. (2018). The definition of "bad debt" just changed. Here's what you need to know. https://www.advisory.com/daily-briefing/2018/03/23/bad-debt

[75] 26 CFR 1.501(r)-6(b).

ECAs in practice mean hospitals may sell a patient's debt even if the patient is on a payment schedule and making on-time payments.[76, 77] Hospitals may report debt to credit bureaus, which in turn may hurt the patient's chance of getting a loan or make them only eligible for subprime loans. Hospitals can also take patients to court to garnish their wages or have a lien placed on their home.

Medical debt that is written-off by hospitals as bad debt can have significant consequences for Americans. The Commonwealth Fund notes that "A significant amount of medical debt is either sold or assigned to third-party debt-collecting agencies, who often engage in aggressive efforts to collect on the debt, creating stress for patients. Both hospitals and debt collectors have won judgments against patients, allowing them to take money directly from a patient's paycheck or place liens on a patient's home. In some cases, patients have also lost their homes. Medical debt can also have a negative impact on a patient's credit score."[78] According to Urban Institute data, as of February 2022, 1 in 10 people in Connecticut had medical debt in collections [a debt-collecting agency].[79]

Both the Biden Administration and the credit reporting agencies are working to remove medical debt from being reportable on an individuals' credit report, since it is noted that one's ability to pay their medical debt is not indicative of their ability to pay debt, or their creditworthiness.[80, 81]

A bipartisan group of US Senators (Elizabeth Warren, Bill Cassidy, MD, Raphael Warnock, and Charles E Grassley) wrote the IRS "alarmed" with nonprofit hospitals tax-exemption in light of an overly broad definition of community benefit and aggressive debt collection practices.[82] The Senators cited findings including hospitals putting liens on thousands of patients homes, charging uninsured patients full price when they should have received free or discounted care, withholding care for patients who had unpaid medical bills in areas with limited options for care, filing tens-of-thousands of lawsuits against patients

[76] Lodge, M. (2024). What happens when medical bills go to collection? https://time.com/personal-finance/article/what-happens-when-medical-bills-go-to-collection/

[77] Sanders, B. (2023). Executive charity. https://www.sanders.senate.gov/wp-content/uploads/Executive-Charity-HELP-Committee-Majority-Staff-Report-Final.pdf

[78] Kona, M. & Raimugia, V. (2023). State protections against medical debt: A look at policies across the U.S. https://www.commonwealthfund.org/publications/fund-reports/2023/sep/state-protections-medical-debt-policies-across-us

[79] Urban Institute. (n.d.). Debt in America: An interactive map. https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=medcoll&state=9

[80] The White House. (2022). FACT SHEET: The Biden Administration announces new actions to lessen the burden of medical debt and increase consumer protection. https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/11/fact-sheet-the-biden-administration-announces-new-actions-to-lessen-the-burden-of-medical-debt-and-increase-consumer-protection/.

[81] Consumer Financial Protection Bureau. (2023). Have medical debt? Anything already paid or under $500 should no longer be on your credit report. https://www.consumerfinance.gov/about-us/blog/medical-debt-anything-already-paid-or-under-500-should-no-longer-be-on-your-credit-report/

[82] Warren, E., Cassidy, B., Warnock, R., Grassley, C.E. (2023). Letter to Commissioner Werfel and Commissioner Killen. https://www.grassley.senate.gov/imo/media/doc/grassley_colleagues_to_tigta_and_irs_-_nonprofit_hospital_tax_exemption.pdf

for wage-garnishment or debt-collection efforts, and efforts to "wring money" out of patients and "pressure them to pay" when they were eligible for free care.[83, 84, 85, 86]

This report does not include data on how many individuals have ECAs taken against them, or which ECAs are taken against them as that information is not available to the State. However, the Hospital Reporting System (HRS) Report 18 – Hospital Collection Placement Policies and Collection Agent Information, publicly available on OHS' web portal – includes some information regarding extraordinary collection actions.

Listed in Tables 28-32 are the collection agents (including collection agencies and law firms) that each hospital contracts with as well as each agents' recovery rates (excluding Medicare accounts), separated by hospital and system affiliation. The definition of collection agent and recovery rate are as follows:

- Collection agent – a company that lenders [in this case, hospitals] use to recover funds that are past due or are from accounts that are in default.[87]
- Recovery Rate – the extent to which principal and accrued interest on defaulted debt can be recovered, expressed as a percentage of face value.[88]

Tables 28-32 include the recovery rates for the accounts to which each collection agent was assigned. All nonprofit hospitals in Connecticut contracted with a collection agent to pursue unpaid bills. These agents engaged in ECAs as part of their actions.

[Intentionally left blank]

[83] Benjamin, E. R., & Dunker, A. (2021). Discharged into debt nonprofit hospitals file liens on patients' homes. https://smhttp-ssl-58547.nexcesscdn.net/nycss/images/uploads/pubs/Liens.pdf
[84] Grassley, C. (2015). Grassley seeks answers from non-profit hospital over billing, lawsuits. https://www.grassley.senate.gov/news/news-releases/grassley-seeks-answers-non-profit-hospital-over-billing-lawsuits
[85] Grassley Presses UVA Medical Center On Tax-Exempt Obligations. (2019, October 17). https://www.grassley.senate.gov/news/news-releases/grassley-presses-uva-medical-center-tax-exempt-obligations
[86] Kliff, S. & Silver-Greenberg, J. (2023). This nonprofit health system cuts off patients with medical debt. https://www.nytimes.com/2023/06/01/business/allina-health-hospital-debt.html
[87] Investopedia. (n.d.-a). Collection agency: Definition, how it works, and regulations. https://www.investopedia.com/terms/c/collectionagency.asp
[88] Investopedia. (n.d.-b). Recovery rate: definition and how to calculate the percentage. https://www.investopedia.com/terms/r/recovery-rate.asp

Table 28: 2022 Yale New Haven Health Services Hospitals' Contracted Collection Agents and Recovery Rates

Yale New Haven Health Services

Hospital	Contracted Collection Agent	Recovery Rate
Bridgeport	American Adjustment Bureau	7.00%
	Arcadia	4.70%
	Links	5.90%
	DCM Bankruptcy	17.80%
	DCM Probate	99.70%
	BDM International Collections	31.40%
	Sunbelt International Collections	10.00%
Greenwich	American Adjustment Bureau	14.10%
	Arcadia	11.70%
	Links	6.10%
	DCM Bankruptcy	21.90%
	DCM Probate	155.00%
	BDM International Collections	52.60%
	Sunbelt International Collections	42.40%
Lawrence + Memorial	American Adjustment Bureau	10.20%
	Arcadia	8.60%
	Links	8.10%
	DCM Bankruptcy	17.20%
	DCM Probate	93.50%
	BDM International Collections	13.30%
	Sunbelt International Collections	1.10%
Yale New Haven	American Adjustment Bureau	9.40%
	Arcadia	7.00%
	Links	6.90%
	DCM Bankruptcy	12.80%
	DCM Probate	105.00%
	BDM International Collections	19.90%
	Sunbelt International Collections	26.40%

Table 29: 2022 Hartford HealthCare Hospitals' Contracted Collection Agents and Recovery Rates

Hartford HealthCare

Hospital	Contracted Collection Agent	Recovery Rate
Backus	Arcadia	7.55%
	Nair and Levin	5.73%
Central Connecticut	Arcadia	6.72%
	Nair and Levin	3.36%
Charlotte Hungerford	Arcadia	8.27%
	Nair and Levin	5.24%
Hartford	Arcadia	4.71%
	Nair and Levin	9.10%
MidState	Arcadia	8.66%
	Nair and Levin	4.77%
St. Vincent's	Arcadia	5.95%
	Nair and Levin	3.18%
Windham	Arcadia	6.76%
	Nair and Levin	6.72%

Table 30: 2022 Nuvance Health Hospitals' Contracted Collection Agents and Recovery Rates

Nuvance Health

Hospital	Contracted Collection Agent	Recovery Rate
Danbury	Credit Center Incorporated	20.50%
	Simko Law Firm	31.00%
	American Adjustment Bureau	13.00%
Norwalk	Credit Center Incorporated	20.90%
	LoveJoy and Rimer	27.00%
	American Adjustment Bureau	7.00%
	Credit Management Company	18.00%
	Eastern Collections	1.67%
Sharon	Collection Bureau of the Hudson Valley	13.00%
	SOS	40.00%

Table 31: 2022 Trinity Health of New England Hospitals' Contracted Collection Agents and Recovery Rates

Trinity Health of New England

Hospital	Contracted Collection Agent	Recovery Rate
Johnson Memorial	American Adjustment Bureau	18.00%
Saint Francis	Nair and Levin	11.51%
	American Adjustment Bureau	17.54%
Saint Mary's	American Adjustment Bureau	13.30%
	Parallon	14.20%

Table 32: 2022 Independent Hospitals' Contracted Collection Agents and Recovery Rates

Independent Hospitals

Hospital	Contracted Collection Agent	Recovery Rate
Bristol	American Adjustment Bureau	19.20%
	Parallon	11.30%
Connecticut Children's	American Adjustment Bureau	15.00%
Day Kimball	Sherloq	11.00%
	Michalik, Bauer, Silvia, & Cicarillo LLP	32.00%
Griffin	Parallon	21.10%
	American Adjustment Bureau	27.98%
Middlesex	TCORS	1.35%
	Arcadia	11.51%
Stamford	ROI	4.90%
	Mark Sank & Associates	14.78%
	Law Offices Howard Lee Schiff	0.37%
	MAF	5.94%

Bad Debt Analysis

OHS reviewed hospitals' IRS Form 990s and found that Connecticut nonprofit hospitals have written-off more bad debt in the last three years, than they have provided charity care to patients (Figure 5). Because hospitals do not report on how many financial assistance applications were filled/approved or how many Extraordinary Collection Actions (ECAs) the hospital initiated, OHS is not able to determine if the number of patients receiving charity care is higher or lower than those patients experiencing ECAs. If the IRS accepts a hospital's rationale, bad debt for certain Financial Assistance Policy-eligible individuals may count as community benefit.

Figure 5: Total Nonprofit Hospitals' Bad Debt and Charity Care Expenses (2016-2022)

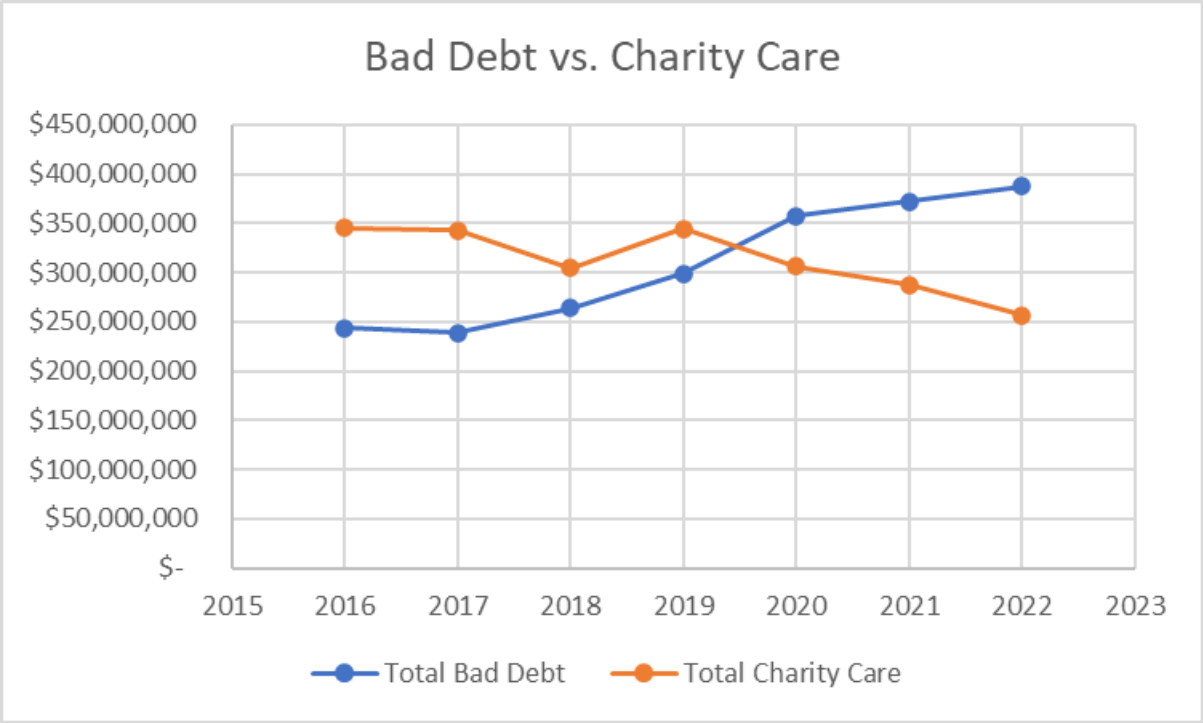

Figure 5 shows the data for bad debt and charity care from 2015-2023. In 2016, Connecticut's nonprofit hospitals provided approximately $350 million in charity care, and wrote-off approximately $243 million in bad debt. In 2020 - the first year of the COVID-19 pandemic - nonprofit hospitals for the first time wrote-off more bad debt than they provided free or discounted care. This trend has continued into 2022, with nonprofit hospitals writing off more than $387 million in bad debt, and reporting charity care expenses just south of $250 million, or $130 million less than the amount of bad debt that hospitals wrote-off.

Figure 6: Total Nonprofit Hospitals' Bad Debt Expense (2016-2022)

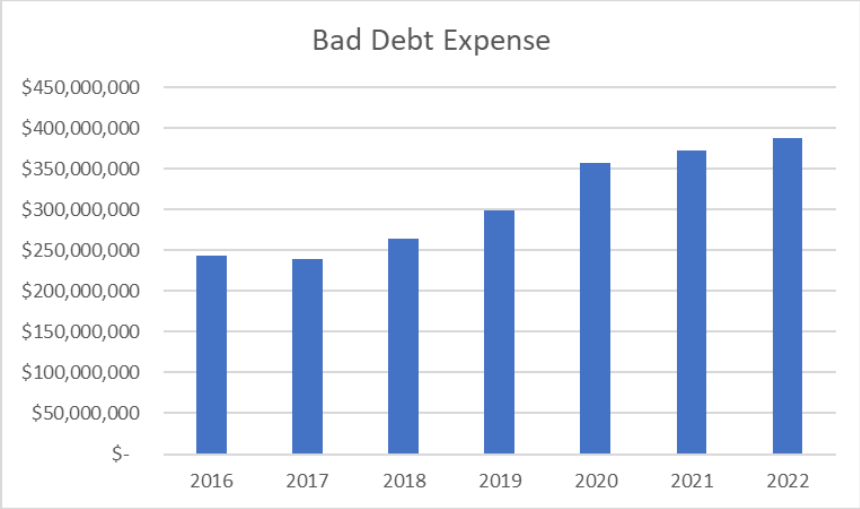

Figure 6 expresses the blue line (total bad debt) from Figure 5 as a bar graph. The x-axis is the filing year, and the y-axis illustrates the amount of bad debt written-off for that year. From 2018 to 2022, bad debt write-offs have increased by approximately $141.7 million. From 2016 to 2022, Connecticut hospitals wrote-off $2.1 billion in bad debt. Without further transparency, it is not clear if the $2 billion worth of debt had punitive actions (ECAs) taken against patients that sought care in Connecticut.

Table 33: Nonprofit Hospitals' Total Bad Debt Expense with Year-Over-Year Increases/Decreases (2016-2022)

Filing Year	Total Bad Debt	% Change Over Year
2016	$ 243,435,616	
2017	$ 239,000,105	-1.82%
2018	$ 264,208,955	10.55%
2019	$ 299,056,304	13.19%
2020	$ 357,295,411	19.47%
2021	$ 371,816,203	4.06%
2022	$ 387,214,683	4.14%

Table 33 is a breakdown of the bar graph in Figure 6. The first column is the filing year, the second column indicates the total bad debt written-off by the reviewed hospitals, and the third column is the percent change year-over-year. Table 33 shows that there were double digit increases year-over-year between 2018 and 2020, and 2021 and 2022 were the highest years on record for Connecticut (column 2), with 2022 being approximately $137 million more than in 2016. Since 2018, bad debt has continued to rise in Connecticut as financial assistance for patient drops.

Figure 7: Total Nonprofit Hospitals' Bad Debt Expense as Percent Change from 2016-2022

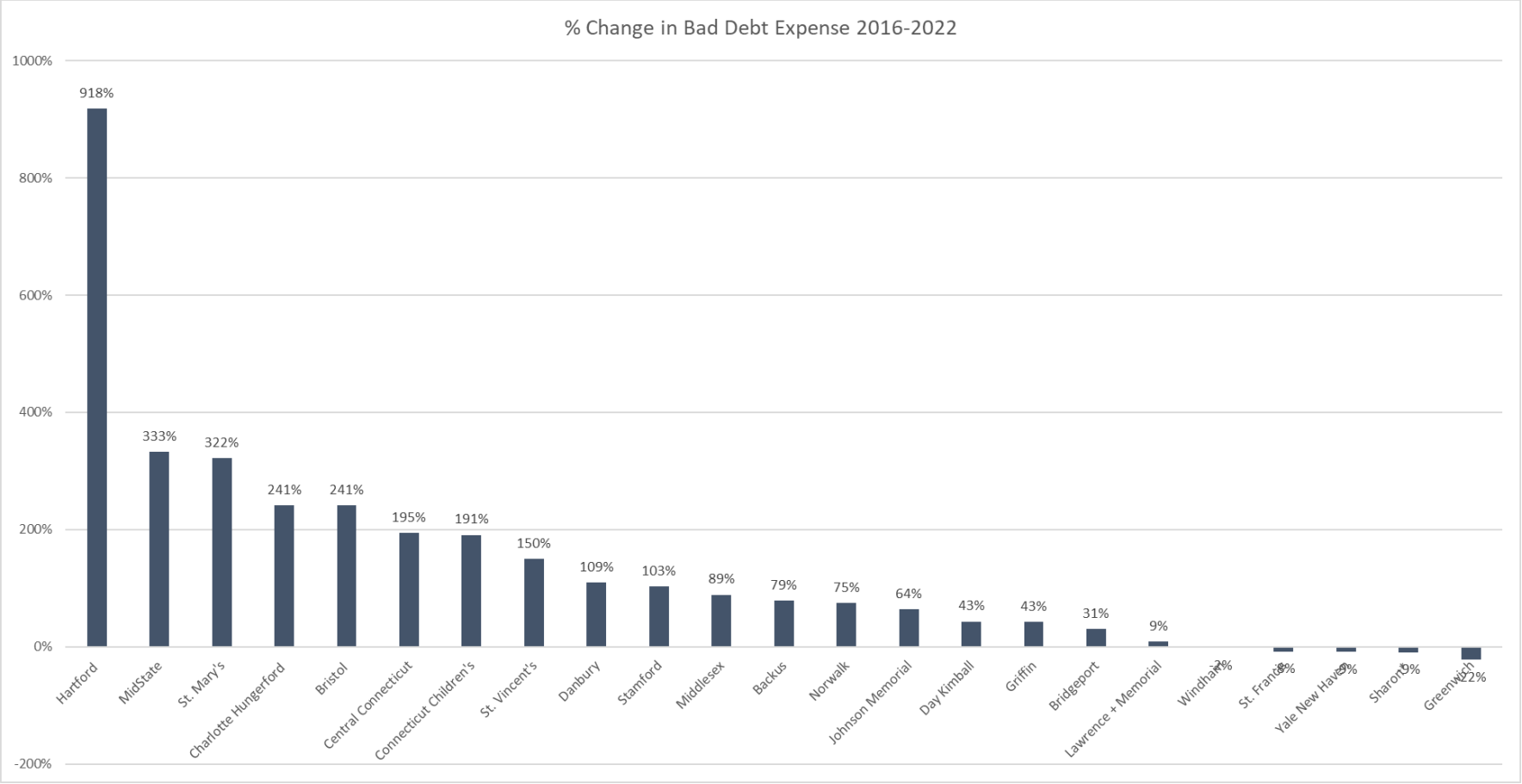

Figure 7 is a bar graph, the x-axis (horizontal) are the nonprofit hospitals, and the y-axis indicates increase or decrease in bad debt as a percentage from 2016 to 2022. It shows that Hartford Hospital increased the amount of bad debt they wrote-off by 918%, with the next closest hospitals being MidState and St. Mary's at increases of 333% and 322%, respectively.

Charlotte Hungerford and Bristol both increased bad debt write-offs by 241%, and five hospitals (Central Connecticut, Connecticut Children's, St. Vincent's, Danbury, and Stamford) have increased write-offs by over 100%. Seven hospitals increased write-offs between 30%-90%, and six hospitals showed decreases in their total bad debt write-offs. Of note, while Yale New Haven Hospital shows a 9% decrease, that is indicative of the measure itself; in 2021, Yale New Haven Hospital wrote-off approximately $92.9 million in patient bad debt, more than any other hospital over the observed seven-year period. Lacking transparency beyond knowing collection agent names and recovery rates, it is not clear what is happening with the billion dollars' worth of debt, or which extraordinary collections actions are being taken against patients which is further reviewed in this report.

Table 34: Nonprofit Hospitals' Total Bad Debt Expense by Hospital By Year

Hospital	2016	2017	2018	2019	2020	2021	2022
Backus	$ 8,148,488	$ 6,788,033	$ 6,897,000	$ 7,571,797	$ 11,414,722	$ 12,945,709	$ 14,590,813
Bridgeport	$ 15,691,920	$ 15,545,225	$ 13,097,196	$ 17,937,092	$ 19,092,076	$ 16,239,951	$ 20,479,613
Bristol	$ 2,209,664	$ 2,853,719	$ 2,939,623	$ 6,044,318	$ 6,386,438	$ 7,281,546	$ 7,530,602
Central Connecticut	$ 6,729,000	$ 5,489,000	$ 7,640,000	$ 6,243,411	$ 13,948,280	$ 16,156,013	$ 19,830,054
Charlotte Hungerford	$ 2,054,040	$ 2,559,232	$ 2,033,000	$ 3,527,245	$ 4,656,221	$ 5,673,073	$ 7,010,247
Connecticut Children's	$ 1,605,446	$ 4,354,151	$ 2,082,672	$ 3,817,147	$ 3,177,467	$ 2,774,460	$ 4,669,829
Danbury	$ 6,524,062	$ 8,369,265	$ 8,534,892	$ 11,357,543	$ 8,305,667	$ 6,846,883	$ 13,654,712
Day Kimball	$ 3,460,363	$ 2,396,181	$ 3,196,626	$ 2,730,880	$ 4,283,289	$ 4,195,867	$ 4,960,324
Greenwich	$ 15,919,399	$ 10,751,757	$ 14,602,003	$ 16,442,469	$ 13,562,439	$ 11,889,490	$ 12,390,419
Griffin	$ 524,574	$ 434,067	$ 774,954	$ 816,998	$ 706,945	$ 862,799	$ 748,776
Hartford	$ 4,677,909	$ 12,487,000	$ 17,510,000	$ 8,029,866	$ 34,758,726	$ 40,074,286	$ 47,640,257
Johnson Memorial	$ 1,261,634	$ 2,354,604	$ 2,329,620	$ 2,536,488	$ 2,133,056	$ 1,878,436	$ 2,069,359
Lawrence + Memorial	$ 9,904,254	$ 12,186,865	$ 2,386,277	$ 6,140,000	$ 9,787,201	$ 7,539,315	$ 10,818,183
Manchester	$ 10,662,336	$ -	$ -	$ -	$ -	$ -	$ -
Middlesex	$ 10,993,577	$ 13,557,441	$ 16,058,848	$ 17,273,230	$ 14,753,657	$ 17,148,415	$ 20,768,625
MidState	$ 2,744,000	$ 4,785,000	$ 3,889,000	$ 3,763,659	$ 10,239,225	$ 10,543,764	$ 11,874,689
Milford	$ 3,982,595	$ 3,356,833	$ 3,329,226	$ 1,532,928	$ -	$ -	$ -
Norwalk	$ 4,228,622	$ 4,443,170	$ 6,819,833	$ 8,749,584	$ 6,483,848	$ 5,635,877	$ 7,406,852
Rockville	$ 1,985,773	$ -	$ -	$ -	$ -	$ -	$ -
Sharon	$ -	$ 1,116,838	$ 2,284,495	$ 1,368,255	$ 1,900,161	$ 412,764	$ 1,015,098
St. Francis	$ 14,575,173	$ 12,097,274	$ 19,148,353	$ 24,044,016	$ 19,913,903	$ 13,997,251	$ 13,427,708
St. Mary's	$ 1,900,245	$ 6,668,222	$ 7,767,190	$ 10,875,277	$ 10,131,955	$ 6,479,349	$ 8,019,526
St. Vincent's	$ 8,350,781	$ 6,264,015	$ 7,130,409	$ 7,694,558	$ 22,342,164	$ 22,884,508	$ 20,877,588
Stamford	$ 37,347,560	$ 39,312,823	$ 33,696,973	$ 39,859,945	$ 46,366,898	$ 62,987,451	$ 75,698,000
Waterbury	$ 761,283	$ -	$ -	$ -	$ -	$ -	$ -
Windham	$ 4,324,000	$ 2,562,000	$ 1,693,000	$ 2,612,601	$ 4,398,412	$ 4,468,900	$ 4,244,526
Yale New Haven	$ 62,868,918	$ 58,267,390	$ 78,367,765	$ 88,086,997	$ 88,552,661	$ 92,900,096	$ 57,488,883
Total	**$ 243,435,616**	**$ 239,000,105**	**$ 264,208,955**	**$ 299,056,304**	**$ 357,295,411**	**$ 371,816,203**	**$ 387,214,683**

Table 34 is a breakout of each observed nonprofit hospitals' bad debt write-offs with the corresponding year; with the bottom row an aggregate for all of the Connecticut hospitals.

Broken out, Tables 35 through 39 provide the current nonprofit hospitals with the corresponding filing year and amount of bad debt the hospital wrote-off. Tables 35 through 38 are hospitals associated by system, and Table 39 includes the independent hospitals.

Table 35: Hartford HealthCare Hospitals' Total Bad Debt Expense by Hospital By Year, and as Percent Change from 2016-2022

Hartford HealthCare

Hospital	2016	2017	2018	2019	2020	2021	2022	% Change 16'-22'
Backus	$ 8,148,488	$ 6,788,033	$ 6,897,000	$ 7,571,797	$ 11,414,722	$ 12,945,709	$ 14,590,813	79%
Central Connecticut	$ 6,729,000	$ 5,489,000	$ 7,640,000	$ 6,243,411	$ 13,948,280	$ 16,156,103	$ 19,830,054	195%
Charlotte Hungerford	$ 2,054,040	$ 2,559,232	$ 2,033,000	$ 3,527,245	$ 4,656,221	$ 5,673,073	$ 7,010,247	241%
Hartford	$ 4,677,909	$ 12,487,000	$ 17,510,000	$ 8,029,866	$ 34,758,726	$ 40,074,286	$ 47,640,257	918%
MidState	$ 2,744,000	$ 4,785,000	$ 3,889,000	$ 3,763,659	$ 10,239,225	$ 10,543,764	$ 11,874,689	333%
St. Vincent's	$ 8,350,781	$ 6,264,015	$ 7,130,409	$ 7,694,558	$ 22,342,164	$ 22,884,508	$ 20,877,588	150%
Windham	$ 4,324,000	$ 2,562,000	$ 1,693,000	$ 2,612,601	$ 4,398,412	$ 4,468,900	$ 4,244,526	-2%
Total	**$ 37,028,218**	**$ 40,934,280**	**$ 46,792,409**	**$ 39,443,137**	**$ 101,757,750**	**$ 112,746,343**	**$ 126,068,174**	**240%**

Table 4: Yale New Haven Health Services Hospitals' Total Bad Debt Expense by Hospital By Year, and as Percent Change from 2016-2022

Yale New Haven Health Services

Hospital	2016	2017	2018	2019	2020	2021	2022	% Change 16'-22'
Bridgeport	$ 15,691,920	$ 15,545,225	$ 13,097,196	$ 17,937,092	$ 19,092,076	$ 16,239,951	$ 20,479,613	31%
Greenwich	$ 15,919,399	$ 10,751,757	$ 14,602,003	$ 16,442,469	$ 13,562,439	$ 11,889,490	$ 12,390,419	-22%
Lawrence + Memorial	$ 9,904,254	$ 12,186,865	$ 2,386,277	$ 6,140,000	$ 9,787,201	$ 7,539,315	$ 10,818,183	9%
Yale New Haven	$ 62,868,918	$ 58,267,390	$ 78,367,765	$ 88,086,997	$ 88,552,661	$ 92,900,096	$ 57,488,883	-9%
Total	**$ 104,384,491**	**$ 96,751,237**	**$ 108,453,241**	**$ 128,606,558**	**$ 130,994,377**	**$ 128,568,852**	**$ 101,177,098**	**-3%**

Table 37: Nuvance Health Hospitals' Total Bad Debt Expense by Hospital By Year, and as Percent Change from 2016-2022

Nuvance Health

Hospital	2016	2017	2018	2019	2020	2021	2022	% Change 16'-22'
Danbury	$ 6,524,062	$ 8,369,265	$ 8,534,892	$ 11,357,543	$ 8,305,667	$ 6,846,883	$ 13,654,712	109%
Norwalk	$ 4,228,622	$ 4,443,170	$ 6,819,833	$ 8,749,584	$ 6,483,848	$ 5,635,877	$ 7,406,852	75%
Sharon	$ -	$ 1,116,838	$ 2,284,495	$ 1,368,255	$ 1,900,161	$ 412,764	$ 1,015,098	-9%
Total	**$ 10,752,684**	**$ 13,929,273**	**$ 17,639,220**	**$ 21,475,382**	**$ 16,689,676**	**$ 12,895,524**	**$ 22,076,662**	**105%**

Note Sharon Hospital is comparing 2017-2022.

Table 38: Trinity Health of New England Hospitals' Total Bad Debt Expense by Hospital By Year, and as Percent Change from 2016-2022

Trinity Health of New England

Hospital	2016	2017	2018	2019	2020	2021	2022	% Change 16'-22'
Johnson Memorial	$ 1,261,634	$ 2,354,604	$ 2,329,620	$ 2,536,488	$ 2,133,056	$ 1,878,436	$ 2,069,359	64%
St. Francis	$ 14,575,173	$ 12,097,274	$ 19,148,353	$ 24,044,016	$ 19,913,903	$ 13,997,251	$ 13,427,708	-8%
St. Mary's	$ 1,900,245	$ 6,668,222	$ 7,767,190	$ 10,875,277	$ 10,131,955	$ 6,479,349	$ 8,019,526	322%
Total	**$ 17,737,052**	**$ 21,120,100**	**$ 29,245,163**	**$ 37,455,781**	**$ 32,178,914**	**$ 22,355,036**	**$ 23,516,593**	**33%**

Table 39: Independent Hospitals' Total Bad Debt Expense by Hospital By Year, and as Percent Change from 2016-2022

Independent Hospitals

Hospital	2016	2017	2018	2019	2020	2021	2022	% Change 16'-22'
Bristol	$ 2,209,664	$ 2,853,719	$ 2,939,623	$ 6,044,318	$ 6,386,438	$ 7,281,546	$ 7,530,602	241%
Connecticut Children's	$ 1,605,446	$ 4,354,151	$ 2,082,672	$ 3,817,147	$ 3,177,467	$ 2,774,460	$ 4,669,829	191%
Day Kimball	$ 3,460,363	$ 2,396,181	$ 3,196,626	$ 2,730,880	$ 4,283,289	$ 4,195,867	$ 4,960,324	43%
Griffin	$ 524,574	$ 434,067	$ 774,954	$ 816,998	$ 706,945	$ 862,799	$ 748,776	43%
Middlesex	$ 10,993,577	$ 13,557,441	$ 16,058,848	$ 17,273,230	$ 14,753,657	$ 17,148,415	$ 20,768,625	89%
Milford	$ 3,982,595	$ 3,356,833	$ 3,329,226	$ 1,532,928	$ -	$ -	$ -	-62%
Stamford	$ 37,347,560	$ 39,312,823	$ 33,696,973	$ 39,859,945	$ 46,366,898	$ 62,987,451	$ 75,698,000	103%
Total	**$ 60,123,779**	**$ 66,265,215**	**$ 62,078,922**	**$ 72,075,446**	**$ 75,674,694**	**$ 95,250,538**	**$ 114,376,156**	**90%**

Note Milford Hospital is comparing 2016-2019.

For bad debt write-offs, the IRS allows hospitals to justify their bad debt as community benefit in cases when the facility believes the debt is reasonably attributable to patients eligible under the organization's FAP.[89] Over the seven observed years of data, the following 12 Connecticut hospitals documented bad debt as potential community benefit, outlined in Table 40.

Table 40: Bad Debt Expense Documented as Potential Community Benefit by Hospital, By Year, and the Number of Years Hospitals Have Claimed Bad Debt as Potential Community Benefit Over the Observed Time Period

Hospital	2016	2017	2018	2019	2020	2021	2022	Total	How many years
Backus	$ 2,184,007	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,184,007	1
Bristol	$ 552,416	$ 713,430	$ 734,906	$ 1,511,080	$ 2,232,019.00	$ 2,204,992	$ 2,111,660	$ 10,060,503	7
Connecticut Children's	$ -	$ 1,222,649	$ 583,148	$ 1,491,835	$ 1,241,832.00	$ 776,849	$ 1,315,952	$ 6,632,265	6
Danbury	$ 1,287,818	$ 1,156,186	$ 510,371	$ 670,095	$ -	$ -	$ -	$ 3,624,470	4
Day Kimball	$ 370,259	$ 256,391	$ 283,124	$ 283,456	$ 159,731.00	$ 156,471	$ 159,094	$ 1,668,526	7
Manchester	$ 2,300,726	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,300,726	1
Middlesex	$ 1,099,358	$ 1,355,744	$ 1,605,884	$ 1,727,323	$ 1,475,366.00	$ 1,714,841	$ 2,076,863	$ 11,055,379	7
Milford	$ 300,473	$ 162,099	$ -	$ -	$ -	$ -	$ -	$ 462,572	2
Norwalk	$ 1,888,503	$ 1,984,320	$ 402,370	$ 437,479	$ -	$ -	$ -	$ 4,712,672	4
Rockville	$ 1,504,520	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,504,520	1
St. Mary's	$ 1,330,172	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,330,172	1
Stamford	$ -	$ -	$ -	$ 9,235,549	$ 11,494,354.00	$ 14,443,023	$ 17,357,551	$ 52,530,477	4
Total	**$ 12,818,252**	**$ 6,850,819**	**$ 4,119,803**	**$ 15,356,817**	**$ 16,603,302**	**$ 19,296,176**	**$ 23,021,120**	**$ 98,066,289**	-
% of Bad Debt	**5.3%**	**2.9%**	**1.6%**	**5.1%**	**4.6%**	**5.2%**	**5.9%**	**4.5%**	-

Table 40 includes which hospitals and how much of bad debt was written-off as potential community benefit between 2016-2022. Five hospitals – Bristol, Connecticut Children's, Day Kimball, Middlesex, and Stamford – documented bad debt they believe was reasonably attributable to patients under the organization's FAP. The data shows that these five are all independent hospitals not associated with a bigger health system, and over half-off of the bad debt write-offs as potential community benefit came from Stamford Hospital.

[89]Internal Revenue Service. (2022). Instructions for Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/i990sh.pdf

Figure 8: Total Bad Debt Attributed to FAP-Eligible Individuals

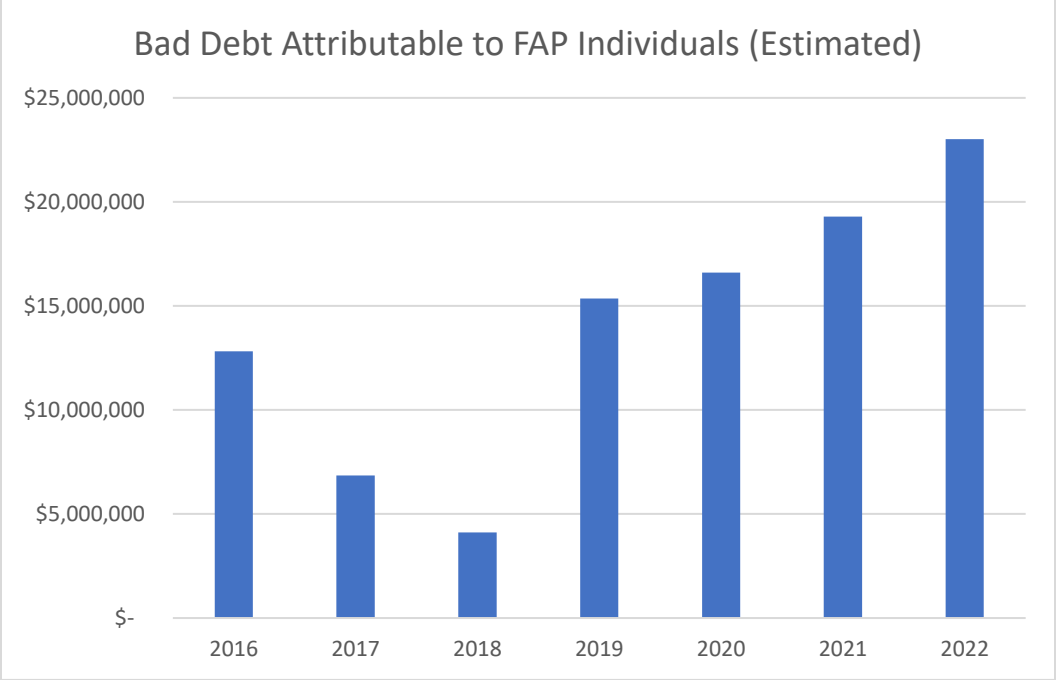

Figure 8 outlines the amount of bad debt estimated to FAP eligible individuals. Unlike the overall bad debt write-offs, the bad debt associated with FAP individuals declined between 2016-2018; increased by over $10 million between 2018 and 2019; and continued to increase between 2019-2022. Notably, hospitals are documenting continuous increases in bad debt that they believe is attributable to those who should receive financial assistance, while financial assistance (charity care) is declining. Approximately $98 million in bad debt has been estimated as attributable to FAP eligible patients since 2016. In 2022, $23 million of bad debt was attributed to FAP eligible patients and may have counted as community benefit. Current ECA data provided by hospitals on bad debt they believe was attributable to people eligible for financial assistance is not available, and it is unclear if hospitals take punitive action against patients they believe would have qualified for charity care.

Figure 9: Bad Debt Attributed to FAP-Eligible Individuals as a Percent of Total Bad Debt Expense

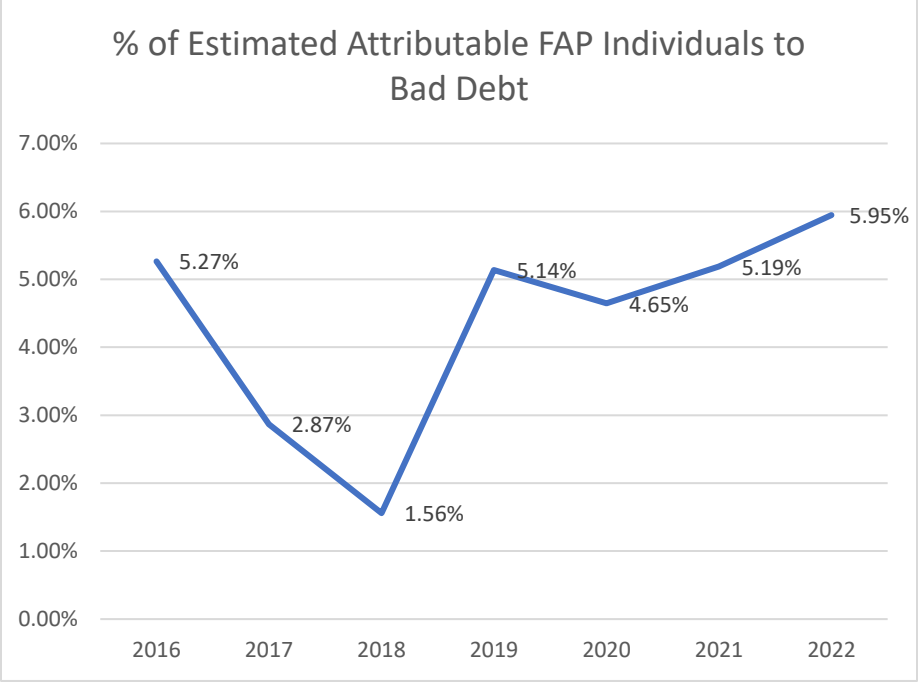

Figure 9 provides a look at the FAP eligible bad debt as a percentage of total bad debt write-offs. There is a notable increase of 3.58% between 2018 and 2019. In 2022, 5.95% or $23 million of $378 million was claimed by hospitals as potential community benefit.

Connecticut Nonprofit Hospitals' Executive Compensation Analysis

In light of the Congressional bipartisan focus on community benefit and executive compensation, OHS reviewed both hospital and health system executive compensation data to better understand the Connecticut community benefit landscape.[90, 91] The connection with hospitals' tax-exemption and executive compensation stems from IRS Revenue Ruling 56-185 which states a charitable organization [tax-exempt] may "not inure net earnings, directly or indirectly, to the benefit of any private shareholder or individual, including distribution of profits, payment of excessive rents or salaries, or the use of the facilities to serve their private interest." Overtime this revenue ruling was modified, and today the IRS uses the Organizational and Operational Tests, which the agency notes is in addition to the Internal Revenue Code 501(r) requirements reviewed earlier in this report (CHNA, FAP, limit on charges, billing and collections).

The IRS prohibits private inurement to be tax-exempt, and in the Organizational and Operational Tests states "No part of their [tax-exempt organization] net earnings is allowed to inure to the benefit of any private shareholder or individual."

Hospital and health system executive compensation as it relates to community benefit has gained attention in the US Congress. In the US Senate, the Health, Education, Labor, and Pensions Committee Chair Bernie Sanders released a Majority Staff Report that raised concerns with hospitals/health systems not providing enough charity care in consideration of "significant compensation."[92]

Executive Compensation Review

Two sources of data were used: the IRS Form 990, Schedule J; and OHS Hospital Reporting System (HRS) Reports 19A and 19B. OHS notes that there is wide variation in executive compensation across hospitals and systems. The relationship between executive compensation and community benefit requires further research and review.

IRS Form 990, Schedule J includes compensation information for certain officers, directors, trustees, key employees, and the highest compensated employees. The HRS captures the ten highest paid employees for the hospital (Report 19A) and health system (Report 19B). The Schedule J and HRS reports have different instructions on what to include in executive compensation. OHS noted that due to these differences, there are instances where a CEO's compensation in the Schedule J would be a top ten paid employee for the hospital, but that individual is not included in the corresponding hospital's HRS Report 19A. Calculations for these reports vary, and the instructions for calculating compensation for both sources may be found in Appendix E.

Table 41 provides compensation data from both data sources, and outlines from left to right the hospital, corresponding health system, title, IRS compensation data from the Form 990 Schedule J, HRS Report 19A for hospitals, and HSR Report 19B for the health systems.

[92] Sanders, B. (2023). Executive Charity. https://www.sanders.senate.gov/wp-content/uploads/Executive-Charity-HELP-Committee-Majority-Staff-Report-Final.pdf

Table 41 - Hospital and Health System Total Compensation for the President / Chief Executive Officer, by IRS Data and by HRS Data

Filing Year 2022 Hospital and Health System Total Compensation for President / Chief Executive Officer (CEO)					
Hospital	**Health System**	**President / CEO**	**IRS Form 990 Schedule J - Total**	**HRS Report 19A (Hospital) - Total**	**HRS Report 19B (Health System) - Total**
Backus	HHC	Director & President	$992,371	-	-
Bridgeport	YNHHS	President/Trustee	$1,294,766	-	-
Bristol	Independent	President, CEO, & CFO	$1,122,122	$993,262	$970,559
Central Connecticut	HHC	President/Director	$803,696	-	-
Charlotte Hungerford	HHC	CEO/President	$1,021,767	-	-
Connecticut Children's	Independent	Director - President/CEO	$1,666,820	$2,010,243	$2,010,243
Danbury	Nuvance	President	$910,141	$962,216	-
		System - President/CEO	$3,066,460	$728,358	$1,748,708
Day Kimball*	Independent	See note below	-	-	-
Greenwich	YNHHS	President / Trustee	$1,215,917	-	-
Griffin	Independent	President & CEO, BOD Secretary	$764,853	$797,104	$797,104
Hartford	HHC	President & CEO	$1,396,590	-	$1,546,705
		System - Director, President & CEO	$4,859,533	-	$3,786,090
Johnson Memorial**	Trinity	President	$489,494	$470,403	-
Lawrence + Memorial	YNHHS	President / Trustee	$1,363,259	-	$1,405,504
Middlesex	Independent	President/CEO	$1,642,505	$1,700,630	$1,700,630
Midstate	HHC	Director/President	$803,696	-	-
Norwalk	Nuvance	President	$767,588	$804,458	-
Sharon	Nuvance	President	$320,327	$280,495	-
St. Francis**	Trinity	President	$937,734	$740,186	-
		System - Director, President/CEO	$1,964,832	-	$1,625,079
St. Mary's**	Trinity	President	$352,187	$342,658	-
St. Vincent's	HHC	President	$492,613	-	-
Stamford	Independent	President & CEO	$1,469,980	$1,844,145	$1,844,145
Windham	HHC	See Backus; Director/President	$992,371	-	-
Yale New Haven	YNHHS	President/Trustee	$1,852,859	$2,025,618	$2,025,618
		EVP & CEO/Trustee	$2,454,213	-	$2,868,975
		System - CEO/Trustee	$5,518,962	$21,000,100	$21,000,100
	TOTALS		**$40,537,656**	**$34,699,876**	**$43,329,460**

Sources:

1) IRS Form 990, Schedule J (may be found on OHS' public portal: https://dphhrswebportal.ct.gov/FinancialDocuments)
2) HRS Reports 19A and 19B (may be found on OHS' public portal: https://dphhrswebportal.ct.gov/Reports)

Notes:

1) Both the IRS Form 990, Schedule J and OHS Reports 19A and 19B are for filing year 2022. Filing year may include different months depending on the hospital. Most hospitals use a fiscal year from October 1 – September 30
2) Positions indicated are for any President or CEO of the hospital or health system. If a health system President or CEO was identified, the position was indicated with the hospital with the largest revenues
3) Data presented is for active positions in the IRS 990. Positions listed as former Directors, President, or CEO were not provided unless there was no replacement for the person that left
4)*Neither Day Kimball Hospital's IRS 990 or HRS Reports 19A or 19B provide a name for the President or CEO position
5)**Trinity hospitals' IRS Form 990's lists all three of the names as CEO. OHS internal records were used to determine President and CEO

Connecticut Nonprofit Hospitals' Community Boards Analysis

The IRS requires nonprofit hospitals' governing boards to include members from the community, and those members should represent over 50% of the governing board. If less than 50%, the IRS notes hospitals may be serving private interests rather than the public's interest. Moreover, those members from the medical or administrative staff should not participate in questions of inurement, or private benefit to those members of staff. For example, a nonprofit hospital CEO should not be deciding their own compensation.

The IRS standard for board of directors does not have requirements on socioeconomic status for those members who are drawn from the community. A diverse board of directors from varying socioeconomic statutes may lead to diverse viewpoints.

In review of the 23 nonprofit hospitals' community boards, OHS found no instances in which members from the community constituted less than 50% of membership. Moreover, OHS found that no hospital indicated that items like compensation include those individuals in question, and there were little to no instances of members being paid, and those who were paid often were members of the medical or administrative staff.

For a complete list of community board members, see Appendix D.

D. Recommendations

State Recommendations

This is the first OHS report under the updated Connecticut statutes regarding hospitals' community benefit programs.[93] It was the first time both for hospitals to submit information to OHS, and for OHS to conduct an analysis of hospital community benefit expenses, CHNAs, implementation strategies and other relevant information. OHS identified significant limitations when trying to understand the full picture of community benefit expenses. In 2022, the reported unreimbursed costs from Medicaid were the largest community benefit expense (61%) in Connecticut at over a billion dollars; however, the calculations hospitals use are not standardized and not available for public review. For example, the IRS worksheet for determining unreimbursed costs from Medicaid asks hospitals to use a cost-to-charge ratio to estimate their costs. Hospitals self-determine whether to use the IRS' suggested formula for a cost-to-charge ratio, use their own ratio, or to use their cost accounting system if available. This means the calculations are not standardized and may vary from hospital to hospital. Calculations may vary with respect to how any ratio or cost is computed, whether the data is comparable, or what figures are included in the calculation.

In order to improve the analysis of this report, OHS recommends the following:

1. **Expand community benefit reporting to include the calculations and figures (worksheets) used to determine the community benefit expenses found in the Form 990, Schedule H.** This information is already available as hospitals are instructed by the IRS to keep their worksheets that contain this information. Over 60% ($1 billion) of community benefit are the estimated

[93] Conn. Gen. Stat. § 19a-127k. (2022).

unreimbursed costs from Medicaid which continues to increase year-over-year. Conversely, charity care has consistently dropped year-over-year. With no clarity on what ratios are being used, the number of individuals being attributed, or any details beyond the net summation that is provided in the Schedule H, it is unclear if hospitals use similar calculations, if drops are due to the number of beneficiaries or other changes, or exact formulas used to justify community benefit. This information will help the State better understand changes to community benefit, and how the expenses are being calculated to determine if there is a standard across hospitals or there is significant variation. If so, OHS can recommend a standard to improve the data analysis and findings of this report.

2. **Expand reporting requirements to include investments made in local health efforts and community-based organizations to address social determinants of health as identified in CHNAs and outlined in the Implementation Strategy**. Every Connecticut nonprofit acute care hospital already documents how they are addressing health needs like social determinants of health. Additional reporting can include measuring outcomes of how these investments are improving local community health.

Other considerations:

Connecticut currently provides state and local tax relief to nonprofit hospitals using the federal standard for community benefit. The state could explore setting its own standards to address some of the issues like the lack of a consistent reporting standard and challenges with the current structure at the federal level. Such standards could include standardizing reporting, setting a minimum amount for community benefit spending, increasing connection between community benefit expense and interventions that improve health outcomes, restricting punitive actions hospitals can take against patients with medical debt or requiring surplus funds for medical training, education, and research be aligned with long-term community needs. Below are examples from other states that have set some standards in efforts to increase effectiveness and impact of community benefit expenses to overall population and community health.

- Illinois state law requires nonprofit hospitals to spend the amount of their property tax relief on services that address health care needs for underserved and low-income individuals and sets a value on how much they need to spend on these activities.
- In 2019, Oregon passed a law expanding and standardizing income limits for charity care by reducing free care for those earning less than 200% of the FPL and creating a sliding scale for those between 200-400% of the FPL.
- Oregon and California have set a floor for community benefit spending based on hospitals' previous levels of expenses. In Oregon, the state sets the minimum requirement in collaboration with hospitals every two years based on a 3-year average of unreimbursed care, operating margin multiplier and net patient revenue.
- In New Jersey, hospitals contributing less than 12 percent of their operating budget to community benefit expenses are required to pay a daily $3 per-bed fee to their local governments to support services that would otherwise be supported with these taxes.

Federal Recommendations

The Government Accountability Office in a 2020 report "Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status" provides the following federal recommendations that have not been addressed:

1. Congress should consider specifying in the Internal Revenue Code what services and activities it considers sufficient community benefit.
2. The Commissioner of Internal Revenue should update Form 990, including Schedule H and instructions where appropriate to ensure that the information demonstrating the community benefits a hospital is providing is clear and can be easily identified by Congress and the public, including the community benefit factors.

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All facts, figures, and sources are noted, hyperlinked, or denoted as a footnote at the bottom of the respective page in the report. If you have a question regarding the sources used in this report, please email: ohs@ct.gov with the subject "OHS Community Benefit Report – Sources Question."

Appendix A

Sec. 19a-127k. Community benefit programs. Program reporting. Office of Health Strategy summary and analysis. (a) As used in this section:

(1) “Community benefit partners” means federal, state and municipal government entities and private sector entities, including, but not limited to, faith-based organizations, businesses, educational and academic organizations, health care organizations, health departments, philanthropic organizations, organizations specializing in housing justice, planning and land use organizations, public safety organizations, transportation organizations and tribal organizations, that, in partnership with hospitals, play an essential role with respect to the policy, system, program and financing solutions necessary to achieve community benefit program goals;

(2) “Community benefit program” means any voluntary program or activity to promote preventive health care, protect health and safety, improve health equity and reduce health disparities, reduce the cost and economic burden of poor health and improve the health status for all populations within the geographic service areas of a hospital, regardless of whether a member of any such population is a patient of such hospital;

(3) “Community benefit program reporting” means the community health needs assessment, implementation strategy and annual report submitted by a hospital to the Office of Health Strategy pursuant to the provisions of this section;

(4) “Community health needs assessment” means a written assessment, as described in 26 CFR 1.501(r)-(3);

(5) “Health disparities” means health differences that are closely linked with social or economic disadvantages that adversely affect one or more groups of people who have experienced greater systemic social or economic obstacles to health or a safe environment based on race or ethnicity, religion, socioeconomic status, gender, age, mental health, cognitive, sensory or physical disability, sexual orientation, gender identity, geographic location or other characteristics historically linked to discrimination or exclusion;

(6) “Health equity” means that every person has a fair and just opportunity to be as healthy as possible, which encompasses removing obstacles to health, such as poverty, racism and the adverse consequences of poverty and racism, including, but not limited to, a lack of equitable opportunities, access to good jobs with fair pay, quality education and housing, safe environments and health care;

(7) “Hospital” means a nonprofit entity licensed as a hospital pursuant to chapter 368v that is required to annually file Internal Revenue Service form 990. “Hospital” includes a for-profit entity licensed as an acute care general hospital;

(8) “Implementation strategy” means a written plan, as described in 26 CFR 1.501(r)-(3), that is adopted by an authorized body of a hospital and documents how such hospital intends to address the needs identified in the community health needs assessment; and

(9) “Meaningful participation” means that (A) residents of a hospital's community, including, but not limited to, residents of such community that experience the greatest health disparities, have an appropriate opportunity to participate in such hospital's planning and decisions, (B) community

participation influences a hospital's planning, and (C) participants receive information from a hospital summarizing how their input was or was not used by such hospital.

(b) On and after January 1, 2023, each hospital shall submit community benefit program reporting to the Office of Health Strategy, or to a designee selected by the executive director of the Office of Health Strategy, in the form and manner described in subsections (c) to (e), inclusive, of this section.

(c) Each hospital shall submit its community health needs assessment to the Office of Health Strategy not later than thirty days after the date on which such assessment is made available to the public pursuant to 26 CFR 1.501(r)-(3)(b), provided the executive director of the Office of Health Strategy, or the executive director's designee, may grant an extension of time to a hospital for the filing of such assessment. Such submission shall contain the following:

(1) Consistent with the requirements set forth in 26 CFR 1.501(r)-(3)(b)(6)(i), and as included in a hospital's federal filing submitted to the Internal Revenue Service:

(A) A definition of the community served by the hospital and a description of how the community was determined;

(B) A description of the process and methods used to conduct the community health needs assessment;

(C) A description of how the hospital solicited and took into account input received from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the community health needs assessment, and a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the community health needs assessment;

(F) An evaluation of the impact of any actions that were taken, since the hospital finished conducting its immediately preceding community health needs assessment, to address the significant health needs identified in the hospital's prior community health needs assessment; and

(2) Additional documentation of the following:

(A) The names of the individuals responsible for developing the community health needs assessment;

(B) The demographics of the population within the geographic service area of the hospital and, to the extent feasible, a detailed description of the health disparities, health risks, insurance status, service utilization patterns and health care costs within such geographic service area;

(C) A description of the health status and health disparities affecting the population within the geographic service area of the hospital, including, but not limited to, the health status and health disparities affecting a representative spectrum of age, racial and ethnic groups, incomes and medically underserved populations;

(D) A description of the meaningful participation afforded to community benefit partners and diverse community members in assessing community health needs, priorities and target populations;

(E) A description of the barriers to achieving or maintaining health and to accessing health care, including, but not limited to, social, economic and environmental barriers, lack of access to or availability of sources of health care coverage and services and a lack of access to and availability of prevention and health promotion services and support;

(F) Recommendations regarding the role that the state and other community benefit partners could play in removing the barriers described in subparagraph (E) of this subdivision and enabling effective solutions; and

(G) Any additional information, data or disclosures that the hospital voluntarily chooses to include as may be relevant to its community benefit program.

(d) Each hospital shall submit its implementation strategy to the Office of Health Strategy not later than thirty days after the date on which such implementation strategy is adopted pursuant to 26 CFR 1.501(r)-(3)(c), provided the executive director of the Office of Health Strategy, or the executive director's designee, may grant an extension to a hospital for the filing of such implementation strategy. Such submission shall contain the following:

(1) Consistent with the requirements set forth in 26 CFR 1.501(r)-(3)(b)(6)(i), and as included in a hospital's federal filing submitted to the Internal Revenue Service:

(A) With respect to each significant health need identified through the community health needs assessment, either (i) a description of how the hospital plans to address the health need, or (ii) identification of the health need as one which the hospital does not intend to address;

(B) For significant health needs described in subparagraph (A)(i) of this subdivision, (i) a description of the actions that the hospital intends to take to address the health need and the anticipated impact of such actions, (ii) identification of the resources that the hospital plans to commit to address the health need, and (iii) a description of any planned collaboration between the hospital and other facilities or organizations to address the health need;

(C) For significant health needs identified in subparagraph (A)(ii) of this subdivision, an explanation of why the hospital does not intend to address such health need; and

(2) Additional documentation of the following:

(A) The names of the individuals responsible for developing the implementation strategy;

(B) A description of the meaningful participation afforded to community benefit partners and diverse community members;

(C) A description of the community health needs and health disparities that were prioritized in developing the implementation strategy with consideration given to the most recent version of the state health plan prepared by the Department of Public Health pursuant to section 19a-7;

(D) Reference-citing evidence, if available, that shows how the implementation strategy is intended to address the corresponding health need or reduction in health disparity;

(E) A description of the planned methods for the ongoing evaluation of proposed actions and corresponding process or outcome measures intended for use in assessing progress or impact;

(F) A description of how the hospital solicited commentary on the implementation strategy from the communities within such hospital's geographic service area and revisions to such strategy based on such commentary; and

(G) Any other information that the hospital voluntarily chooses to include as may be relevant to its implementation strategy, including, but not limited to, data, disclosures, expected or planned resource outlay, investments or commitments, including, but not limited to, staff, financial or in-kind commitments.

(e) On or before October 1, 2023, and annually thereafter, each hospital shall submit to the Office of Health Strategy a status report on such hospital's community benefit program, provided the executive director of the Office of Health Strategy, or the executive director's designee, may grant an extension to a hospital for the filing of such report. Such report shall include the following:

(1) A description of major updates regarding community health needs, priorities and target populations, if any;

(2) A description of progress made regarding the hospital's actions in support of its implementation strategy;

(3) A description of any major changes to the proposed implementation strategy and associated hospital actions; and

(4) A description of financial resources and other resources allocated or expended that supported the actions taken in support of the hospital's implementation strategy.

(f) Notwithstanding the provisions of section 19a-755a, and to the full extent permitted by 45 CFR 164.514(e), the Office of Health Strategy shall make data in the all-payer claims database available to hospitals for use in their community benefit programs and activities solely for the purposes of (1) preparing the hospital's community health needs assessment, (2) preparing and executing the hospital's implementation strategy, and (3) fulfilling community benefit program reporting, as described in subsections (c) to (e), inclusive, of this section. Any disclosure made by said office pursuant to this subsection of information other than health information shall be made in a manner to protect the confidentiality of such information as may be required by state or federal law.

(g) A hospital shall not be responsible for limitations in its ability to fulfill community benefit program reporting requirements, as described in subsections (c) to (e), inclusive, of this section, if the all-payer claims database data is not provided to such hospital, as required by subsection (f) of this section.

(h) On or before April 1, 2024, and annually thereafter, the executive director of the Office of Health Strategy shall develop a summary and analysis of the community benefit program reporting submitted by hospitals under this section during the previous calendar year and post such summary and analysis on its Internet web site and solicit stakeholder input through a public comment period. The Office of Health Strategy shall use such reporting and stakeholder input to:

(1) Identify additional stakeholders that may be engaged to address identified community health needs including, but not limited to, federal, state and municipal entities, nonhospital private sector health care providers and private sector entities that are not health care providers, including community-based organizations, insurers and charitable organizations;

(2) Determine how each identified stakeholder could assist in addressing identified community health needs or augmenting solutions or approaches reported in the implementation strategies;

(3) Determine whether to make recommendations to the Department of Public Health in the development of its state health plan; and

(4) Inform the state-wide health care facilities and services plan established pursuant to section 19a-634.

(i) Each for-profit entity licensed as an acute care general hospital shall submit community benefit program reporting consistent with the reporting schedules of subsections (c) to (e), inclusive, of this section, and reasonably similar to what would be included on such hospital's federal filings to the Internal Revenue Service, where applicable.

Appendix B

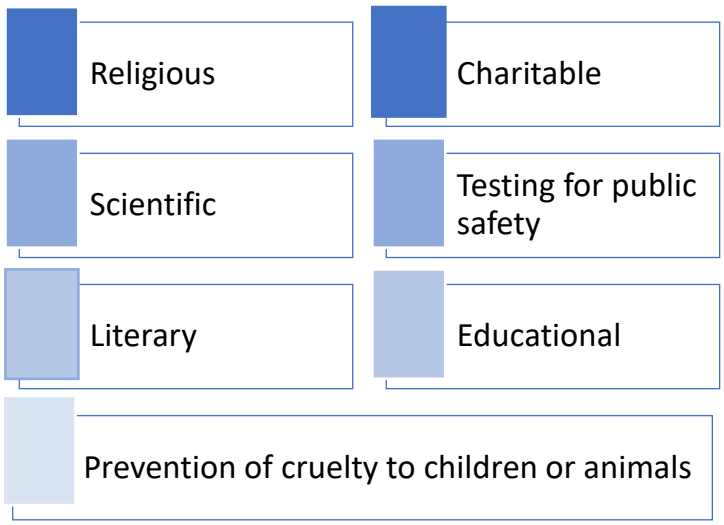
Connecticut hospitals have three federal requirements to obtain, or maintain, their nonprofit, tax-exemption:

1. Be organized and operated to achieve a charitable purpose
2. Demonstrate one to six factors outlined by the IRS, colloquially known as community benefit
3. Comply with requirement in the Patient Protection and Affordable Care Act (ACA

The State of Connecticut has no additional requirements for Connecticut hospitals to obtain, or maintain their nonprofit, tax-exemption status. This differs from other states such as Oregon, which requires nonprofit hospitals to meet a minimum threshold on community benefit spending;[94] or Illinois, which requires a minimum level of charity care or health services to low-income or underserved individuals in order to qualify for exemption from Illinois property and sales taxes.[95]

The Organization and Operation Requirements to Achieve a Charitable Purpose

Internal Revenue Code (IRC) §501(c)(3) holds "In order to be exempt as an organization described in section 501(c)(3), an organization must be both organized and operated exclusively for one or more [of] the following purposes:



Two years later in Revenue Ruling 56-185 – a revenue ruling is the IRS' official interpretation of the Internal Revenue Code, statutes, tax treaties, and regulations[96] - the Treasury division concluded that

[94] Oregon Health Authority. (n.d.). Community Benefit Minimum Spending Floor Methodology Announcement for Hospital Fiscal Years 2022 and 2023. https://www.oregon.gov/oha/hpa/analytics/pages/hospital-reporting.aspx
[95] The Hilltop Institute. (n.d.-i). Community Benefit State Law Profiles. https://hilltopinstitute.org/our-work/hospital-community-benefit/hospital-community-benefit-state-law-profiles/
[96] Internal Revenue Service. (n.d.-e). Understanding IRS Guidance - A Brief Primer. https://www.irs.gov/newsroom/understanding-irs-guidance-a-brief-primer#:~:text=A%20revenue%20ruling%20is%20an,a%20specific%20set%20of%20facts.

hospitals can be nonprofit, tax-exempt organizations if they are organized and operated primarily for educational, scientific or a public charitable purpose; and that usually the ground for exemption is for a public charitable purpose. The IRS notes this could be demonstrated by a hospital providing charity care for those unable to pay for services rendered. Revenue Ruling 56-185 outlined four requirements for a hospital to establish itself as a public, charitable organization:

1. Be organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick
2. Be operated to the financial extent feasible for those unable to pay for services rendered, known today as charity care
3. Not restrict use of the hospital and its facilities to a particular group of physicians
4. Not inure net earnings, directly or indirectly, to the benefit of any private shareholder or individual, including distribution of profits, payment of excessive rents or salaries, or the use of the facilities to serve their private interest

The first requirement to be a charitable organization has been established by all Connecticut nonprofit hospitals by virtue of the facilities obtaining/maintaining their tax-exemption 501(c)(3) status. Today, the IRS provides the Organizational and Operational Tests.

The second condition requiring charity care was removed in 1969, and the third requirement is still in effect. The fourth requirement has been modified.[97]

Requirements for Demonstrating the Six Factors

In 1969, the IRS released Revenue Ruling 69-545, modifying Revenue Ruling 56-185. Notably, it removed charity care as a requirement for hospitals to be considered nonprofits, and outlined six factors hospitals may demonstrate in order to qualify for nonprofit, tax-exemption status:

1. *Operate an emergency room open to all, regardless of ability to pay*
2. *Maintain a board of directors drawn from the community*
3. *Maintaining an open medical staff policy*
4. *Provide hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare*
5. *Use surplus funds to improve facilities, equipment, and patient care*
6. *Use surplus funds to advance medical training, education, and research*

[97] 26 CFR 1.501(c)(3)-1(b)(4). https://www.ecfr.gov/current/title-26/part-1/section-1.501(c)(3)-1#p-1.501(c)(3)-1(b)(4)

In determining if a hospital demonstrates community benefit, the IRS uses a community benefit standard when examining the six factors. The agency notes that "no one factor is determinative in considering whether a nonprofit hospital meets the community benefit standard [and] the IRS weighs all the relevant facts and circumstances in evaluating these factors. Additional factors, such as whether a hospital provides financial assistance to those not able to pay, are relevant in determining whether the hospital is providing a benefit to the community."[98] To document demonstration of community benefit, the IRS uses the Schedule H, found in the Form 990 - a tax document submitted to the IRS by nonprofit organizations in the United States.

The six factors from 1969 are still used today by the IRS in weighing hospitals' community benefit. Given the importance of the six factors, OHS has provided the IRS' breakdown of these factors, as well as further details on the IRS' Form 990, Schedule H:[99]

1. Open Emergency Room

The IRS weighs if a hospital operates a full-time emergency room open to everyone, regardless of an individual's ability to pay. All nonprofit acute care hospitals in Connecticut are operating a full-time emergency room open to everyone per hospitals' self-reporting in the IRS Form 990 Schedule H, Part V.

2. Community Board

A hospital's governing board that the IRS refers to as a community board, colloquially known as a Board of Directors or Board of Trustees, should be composed of community members in addition to members of the hospital medical or administrative staff / their representatives. The IRS makes clear that control (>50%) of the governing body by the hospital's medical or administrative staff / their representatives may be serving a private interest rather than the public interests. Hospitals may provide a narrative response regarding their community boards in the Schedule H, Part VI. However, the IRS does not explicitly direct hospitals to report on it, like they do for other community benefit factors. The compositions of Connecticut nonprofit, acute care hospitals' community boards are examined in this report.

3. Open Medical Staff Policy

Hospitals are not allowed to restrict medical staff privileges to a limited group of physicians. The IRS expresses that limiting is likely to be operating for the private benefit of staff physicians rather than for the public interest. It is not possible to determine if Connecticut nonprofit hospitals restrict medical staff privileges as the IRS Form 990 Schedule H Part VI does not explicitly require hospitals to provide that information.

4. Care for All/Ability to Pay

Hospitals are required to admit patients with the ability to pay for non-emergency services to the extent facilities are available, in a nondiscriminatory manner. The only way to verify hospitals are compliant with this community benefit factor is in the Form 990 Schedule H, Part I. For example, Part I provides

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[98] Internal Revenue Service. (n.d.). Charitable Hospitals - General Requirements for Tax-Exemption Under Section 501(c)(3). https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3

[99] *Id.*

data on the amount of financial assistance that was provided, but does not offer an opportunity for hospitals to articulate any further information on carrying for all.

5. & 6. Surplus Funds

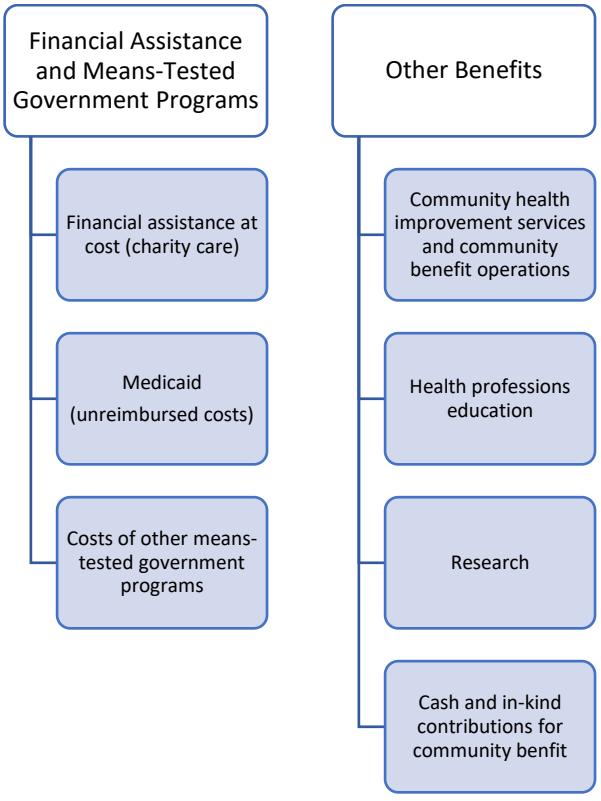
If a hospital operates with an annual surplus of funds, it should be using them to improve the quality of patient care, facilities and equipment, as well as advance its medical training, education, and research programs. Hospitals may respond with how they are using surplus funds to promote health in the Form 990 Schedule H, Part VI. However, the IRS does not explicitly direct tax-exempt hospitals to report on it.

The IRS Form 990 Schedule H

In 2008, the IRS introduced the Schedule H for nonprofit, tax-exempt hospitals to complete annually in their Form 990 submission. Hospitals use the Schedule H to document evidence that they are demonstrating community benefit, and are in compliance with federal requirements to obtain/maintain their tax-exemption status.

The IRS recognizes services and activities listed in Part I of the Schedule H as community benefit. The IRS also allows hospitals to input expense information for Part II (community building), and Part III (bad debt and the unreimbursed costs from Medicare). However, Parts II and III must be justified to the IRS in order to demonstrate community benefit. Since OHS does not have final data on what the IRS is counting as community benefit in their review of the community benefit standard, the agency does not include those items that must be justified.

Part I of the Schedule H is composed of the following sections and categories:



Patient Protection and Affordable Care Act Requirements

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA), adding requirements for hospitals to obtain or maintain their 501(c)(3) nonprofit, tax-exemption status. These requirements were codified in IRC section §501(r), which require hospitals to:[100]

Complete a Community Health Needs Assessment and adopt an Implementation Strategy every three years.

Have a written Financial Assistance Policy (FAP) and Emergency Medical Care Policy.

Limit the amount charged for any emergency or other medically necessary care to a FAP-eligible individual to not more than the amount generally billed to individuals who have insurance covering such care.

Make a reasonable effort to determine whether an individual is eligible for assistance under the FAP before engaging in collection action against that individual.

The IRS provides the following details regarding the 501(r) requirements of the Internal Revenue Code:[101]

Community Health Needs Assessment and Implementation Strategy

Essentially, a Community Health Needs Assessment (CHNA) identifies the needs of the community (e.g., mental and behavioral health, substance abuse, access to care, food and housing insecurity). An Implementation Strategy – sometimes referred to as an Implementation Plan or Community Health Improvement Plan - is what community needs the hospital will and will not focus on addressing. Nonprofit hospitals are required to conduct a CHNA every three years, and adopt an implementation strategy. There is no federal requirement for hospitals to document the link between the activities or services performed in the Implementation Strategy, with the dollar amounts reported in the Schedule H. The CHNA and Implementation Strategies hospitals completed in 2021/2022 are reviewed in this report.

Financial Assistance Policies and Emergency Medical Care Policies

The Internal Revenue Code requires nonprofit hospitals have a written Financial Assistance Policy (FAP). The FAP must apply to all medically necessary and emergency care provided by the hospital, or by a substantially related entity. Hospitals' FAPs may be found on OHS' Hospital Reporting System Portal,

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[100] Internal Revenue Service. (n.d.). Hospitals Under the Affordable Care Act – Section 501(r). https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3

[101] *Id.*

typically titled by the hospitals as a Financial Assistance Policy, an Uncompensated Care Policy, or similar variation of such. The FAP requirements and findings are discussed further in this report.

In addition to the FAP, hospitals are required to establish a written Emergency Medical Care Policy. This policy requires hospitals provide emergency medical care to all regardless of their ability to pay in accordance with the Emergency Medical Treatment and Labor Act (EMTALA). The Emergency Medical Care Policy requirements and finds are discussed further in this report.

Limitation on Charges

Hospitals and their substantially-related entities must limit the amount charged for any emergency or other medically necessary care it provides to a FAP. The amount charged cannot be more than the amount generally billed (AGB) to individuals who have insurance. All of the Connecticut, nonprofit acute care hospitals reviewed in this report noted in their respective FAPs that they limit charges to the AGB.

Billing and Collections

The Internal Revenue Code requires hospitals to make reasonable efforts to determine whether an individual is eligible for assistance under the hospital's FAP before engaging in extraordinary collection actions (ECAs) against that individual. ECAs include but are not limited to selling a patient's debt to a collection agency, refusing care to the patient for past due bills, taking the patient to court, or reporting adverse information about a patient to consumer credit reporting agencies. The last ECA may be outlawed if a proposed rule by the Biden Administration goes into effect.

Federal Requirements Summary

In summary, Connecticut hospitals volunteer to meet several requirements in order to keep their nonprofit, tax-exemption status, including:

1. The public, charitable requirements for hospitals in IRC 501(c)(3)
2. Revenue Ruling 69-545, which modified Revenue Ruling 56-185
3. ACA requirements codified in IRC 501(r)

Several states have additional requirements for hospitals to be recognized at the state level as nonprofit, tax-exempt organizations.[102] While Connecticut does not have additional requirements for hospitals to be considered nonprofit, tax-exempt organizations, it does have in statute requirements concerning what hospitals are reporting.

[102] The Hilltop Institute. (n.d.). Community Benefit State Law Profiles. https://hilltopinstitute.org/our-work/hospital-community-benefit/hospital-community-benefit-state-law-profiles/

Appendix C

Federal Poverty Guidelines (FPG) Tables from hospitals.

Hartford HealthCare hospitals have the same standard FPG table.

Hartford HealthCare

Financial Assistance Policy
Updated January 1, 2022

APPENDIX A

Federal Poverty Guidelines Effective January 2022

2022		250%** FPG	275%** FPG	300%** FPG	325%** FPG	400%** FPG
Size of Family	Poverty Guideline	100% Awarded	75% Awarded	50% Awarded	25% Awarded	25% Awarded
1	$13,590	$33,975	$37,373	$40,770	$44,168	$54,360
2	$18,310	$45,775	$50,353	$54,930	$59,508	$73,240
3	$23,030	$57,575	$63,333	$69,090	$74,848	$92,120
4	$27,750	$69,375	$76,313	$83,250	$90,188	$111,000
5	$32,470	$81,175	$89,293	$97,410	$105,528	$129,880
6	$37,190	$92,975	$102,273	$111,570	$120,868	$148,760
7	$41,910	$104,775	$115,253	$125,730	$136,208	$167,640
8	$46,630	$116,575	$128,233	$139,890	$151,548	$186,520

** For families with more than 8 members, add $4,720 (** multiplying factor) for each additional member.

Yale New Haven Health hospitals have the same standard FPG table.

Federal Poverty Guidelines (FPG) & Sliding Scale for Financial Assistance

FPG amounts are updated periodically in the Federal Register by the United States Department of Health and Human Services. Current FPG amounts are available at http://aspe.hhs.gov/poverty-guidelines.

As of January 31, 2022, FPG amounts were as follows. ***These amounts are subject to change.*** Patients eligible for financial assistance under this Policy will receive assistance at all Yale New Haven Health Hospitals as follows:

	FAP Name	Free Care	Sliding Scale A	Sliding Scale B	Sliding Scale C	Discounted Care
	Coverage Eligibility	Insured or Uninsured Patients	Insured Patients	Insured Patients	Insured Patients	Uninsured Patients
	FAP Discount	100%	85%	25%	15%	70%
	Gross Income Eligibility	0% - 250% FPL	251% - 350% FPL	351% - 450% FPL	451% - 550% FPL	251% - 550% FPL
Family Size	1	$0 - $33,975	$33,976 - $47,565	$47,566 - $61,155	$61,156 - $74,745	$33,976 - $74,745
	2	$0 - $45,775	$45,776 - $64,085	$64,086 - $82,395	$82,396 - $100,705	$45,776 - $100,705
	3	$0 - $57,575	$57,576 - $80,605	$80,606 - $103,635	$103,636 - $126,665	$57,576 - $126,665
	4	$0 - $69,375	$69,376 - $97,125	$97,126 - $124,875	$124,876 - $152,625	$69,376 - $152,625
	5	$0 - $81,175	$81,176 - $113,645	$113,646 - $146,115	$146,116 - $178,585	$81,176 - $178,585
	6	$0 - $92,975	$92,976 - $130,165	$130,166 - $167,355	$167,356 - $204,545	$92,976 - $204,545

AGB percentages are calculated annually. Calendar year 2022 AGB (% of charges) per Hospital are: BH 32.01%, GH 34.52%, LMH 38.1%, YNHH 34.29% and WH 30.45%. Accordingly, the percentage discount most favorable to YNHHS patients eligible for discounted care under this Policy for 2022 would be to pay no more than 30% of gross charges.

Nuvance Health hospitals have the same standard FPG table.

EXHIBIT 1

FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES Based on 2022 Federal Poverty Guidelines*

Family Size**	Federal Poverty Guidelines (2022)	At or Below 300% Federal Poverty Guidelines *(100% write-off)*	>300% - 350% Poverty Guidelines *(75% write-off)*	>350% to 400% Poverty Guidelines *(AGB Discount)****
1	$13,590	$0 to $40,770	$40,771 to $47,565	$47,566 to $54,360
2	$18,310	$0 to $54,930	$54,931 to $64,085	$64,086 to $73,240
3	$23,030	$0 to $69,090	$69,091 to $80,605	$80,606 to $92,120
4	$27,750	$0 to $83,250	$83,251 to $97,125	$97,126 to $111,000
5	$32,470	$0 to $97,410	$97,411 to $113,645	$113,646 to $129,880
6	$37,190	$0 to $111,570	$111,571 to $130,165	$130,166 to $148,760
7	$41,910	$0 to $125,730	$125,731 to $146,685	$146,686 to $167,640
8	$46,630	$0 to $139,890	$139,891 to $163,205	$163,206 to $186,520

*** This Exhibit shall be updated from time to time to reflect the most current FPGs issued by the U.S. Department of Health and Human Services.**

**** For *family* units with more than 8 members, to determine the federal poverty guideline base figure, add $4,720.00 for each additional member.**

Trinity Health of New England hospitals have the same standard FPG table.

Saint Francis Hospital and Medical Center
Community Assistance Program
Eligibility Criteria On or After 02/01/2022
2022 Poverty Guidelines

FAMILY SIZE	ANNUAL GROSS INCOME POVERTY	200%	400%
1	13,590	27,180	54,360
2	18,310	36,620	73,240
3	23,030	46,060	92,120
4	27,750	55,500	111,000
5	32,470	64,940	129,880
6	37,190	74,380	148,760
7	41,910	83,820	167,640
8	46,630	93,260	186,520
9	51,350	102,700	205,400
10	56,070	112,140	224,280

Rate

SLIDING SCALE
A = SELF PAY DISCOUNT only
B = PATIENT OWES MEDICARE
C = FULL ASSIST 100%

WEEKLY GROSS INCOME	MONTHLY GROSS INCOME	ANNUAL INCOME	SLIDING SCALE FAMILY SIZE 1	2	3	4	5	6	7	8	9	10
0 - 521	0 - 2,265	27,180	C	C	C	C	C	C	C	C	C	C
522 - 702	2,266 - 3,052	36,620	B	C	C	C	C	C	C	C	C	C
703 - 883	3,053 - 3,838	46,060	B	B	C	C	C	C	C	C	C	C
884 - 1,043	3,839 - 4,530	54,360	B	B	B	C	C	C	C	C	C	C
1,044 - 1,064	4,531 - 4,625	55,500	A	B	B	C	C	C	C	C	C	C
1,065 - 1,245	4,626 - 5,412	64,940	A	B	B	B	C	C	C	C	C	C
1,246 - 1,405	5,413 - 6,103	73,240	A	B	B	B	B	C	C	C	C	C
1,406 - 1,427	6,104 - 6,198	74,380	A	A	B	B	B	C	C	C	C	C
1,428 - 1,608	6,199 - 6,985	83,820	A	A	B	B	B	B	C	C	C	C
1,609 - 1,767	6,986 - 7,677	92,120	A	A	B	B	B	B	B	C	C	C
1,768 - 1,789	7,678 - 7,772	93,260	A	A	A	B	B	B	B	C	C	C
1,790 - 1,970	7,773 - 8,558	102,700	A	A	A	B	B	B	B	B	C	C
1,971 - 2,129	8,559 - 9,250	111,000	A	A	A	B	B	B	B	B	B	C
2,130 - 2,151	9,251 - 9,345	112,140	A	A	A	A	B	B	B	B	B	C
2,152 - 2,491	9,346 - 10,823	129,880	A	A	A	A	B	B	B	B	B	B
2,492 - 2,853	10,824 - 12,397	148,760	A	A	A	A	A	B	B	B	B	B
2,854 - 3,215	12,398 - 13,970	167,640	A	A	A	A	A	A	B	B	B	B
3,216 - 3,577	13,971 - 15,543	186,520	A	A	A	A	A	A	A	B	B	B
3,578 - 3,939	15,544 - 17,117	205,400	A	A	A	A	A	A	A	A	B	B
3,940 - 4,301	17,118 - 18,690	224,280	A	A	A	A	A	A	A	A	A	B

Finance Procedure No. RE.PFS.3 Page 19

Bristol Health

Financial Assistance Policy
Appendix B

Sliding Scale Discounts for Eligible Uninsured Individuals and the AGB Percentage

At or below 250% of FPL	100% discount
251% - 350% of FPL	85% discount
351% - 400% of FPL	75% discount

The Amount Generally Billed or "AGB" is calculated annually using a "look back method" based on Medicare fee-for-service rates, including Medicare beneficiary cost-sharing amounts and all private health insurers that paid hospital and professional claims for the prior fiscal year. The sum of these total payments is then divided by the sum of total charges to identify the "AGB percentage." The AGB percentage for fiscal year 2020 is 60.15%. The discounts listed above are applied after applicable charges have been reduced by 60.15%. This analysis is completed, and the AGB percentage may be revised, on an annual basis.

Connecticut Children's

FAMILY SIZE	Federal Poverty Level Guideline (FPLG)	250% 100% PFA	500% 45% PFA
1	$13,590.00	$0 - $33,975.00	$33,975.01 - $67,950.00
2	$18,310.00	$0 - $45,775.00	$45,775.01 - $91,550.00
3	$23,030.00	$0 - $57,575.00	$57,575.01 - $115,150.00
4	$27,750.00	$0 - $69,375.00	$69375,01 - $138,750.00
5	$32,470.00	$0 - $81,175.00	$81,175.01 - $162,350.00
6	$37,190.00	$0 - $92,975.00	$92,975.01 - $185,950.00
7	$41,910.00	$0 - $104,775.00	$104,775.01 - $209,550
8	$46,630.00	$0 - $116,575.00	$116,575.00 - $233,150.00
**Each Additional Person	4,720	x2.5	x5.0

All Day Kimball Hospital patients who are determined to have no active insurance for a given date of service will have their associated charges adjusted to the hospital's most recently calculated AGB as described in Section III.

1. Uninsured patients who show proof of denial from the State of Connecticut Department of Social Services (DSS) office may qualify for 100% financial assistance if they meet all of the following criteria:

   a. Single account balance of $250 or greater OR accounts spanning six months totaling $500 or greater (individual) OR accounts spanning six months totaling $1000 or greater for 2 or more family members (under same guarantor).

   b. Household (Family) Income up to 250% of the Federal Poverty Level

   DKH will consider the total medical expenses faced by an uninsured family and the family's ability to pay for those expenses, and offer greater assistance when possible to those individuals or families facing catastrophic medical expenses.

Insured patients may qualify for a 75% financial assistance discount on the remaining balance after insurance payments are made. After this discount is approved and applied, the remaining amount of the balance that the patient will be responsible for shall be no more than the amounts generally billed (AGB) to individuals who have Medicare for emergency or medically necessary care.

1. In order to qualify for a 75% financial assistance discount of the patient balance, an insured patient must meet all of the following criteria:

   a. Single account balance of $250 or greater OR accounts spanning six months totaling $500 or greater (individual) OR accounts spanning six months totaling $1000 or greater for 2 or more family members (under same guarantor).

   b. Household (Family) Income up to 250% of the Federal Poverty Level.

2. Insured patients who have exhausted their insurance benefits during the time period during which services were rendered, and who can produce documentation to confirm benefits exhaustion, will be deemed "uninsured" under Section A of this policy. If approved for financial assistance, it will be an episodic granting.

Size of Family	of 250% HHS Poverty Income Guidelines: 100% FreeCare Greater / Up to Than	of 280% HHS Poverty Income Guidelines: 85% FreeCare 15% Patient Share Greater / Up to Than	of 310% HH s Poverty Income Guidelines: 75% FreeCare 25% Patient Share Greater / Up to Than	of 340% HHS Poverty Income Guidelines: 50% FreeCare 50% Patient Share Greater / Up to Than	of 370% HHS Poverty Income Guidelines: 35% FreeCare 65% Patient Share Greater / Up to Than	of 400% HHS Poverty Income Guidelines: 30% FreeCare 70% Patient Share Greater / Up t Than
1	0-30,350	30,351 - 33,992	33,993 -37,634	37,635 - 41,276	41,277 - 44,918	49,919 - 48,560
2	0-41,150	41,151 - 46,088	46,089 - 51,026	51,027 - 55,964	55,965 - 60,902	60,903 - 65,840
3	0- 51,950	51,951 - 58,184	58,185 - 64,418	64,419 - 70,652	70,653 - 76,886	76,887 - 83,120
4	0-62,750	62,751 - 70,280	70,281 - 77,810	77,811 - 85,340	85,341 - 92,870	92,871 - 101,400
5	0- 73,550	73,551 - 82,376	82,377 - 91,202	91,203 - 100,028	100,029 - 108,854	108,855 - 117,680
6	0- 84,350	84,351 - 94,472	94,473 - 104,594	104,595 - 114,716	114,717 - 124,838	124,839 - 134-960
7	0-92,850	92,851 - 103,992	103,993 - 115,134	115,135 - 126,276	126,277 - 137,418	137,419 - 148,560
8	0-103,300	103,301 - 115,696	115,697 - 128,092	128,093 - 140,488	140,489 - 152,884	152,885 - 165,280

Consideration will be given in providing financial assistance on a case-by-case basis to those patients who have exhausted their insurance benefits and/or who have exceeded their financial eligibility criteria but face extraordinary medical costs including deductibles, coinsurance and co- payments.

MIDDLESEX HOSPITAL
ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE
EFFECTIVE DATE: February 1, 2022

PERCENT DISCOUNT ELIGIBLE FOR:	100%	100%	95%	85%	75%	70%
PERCENT POVERTY INCOME GUIDELINE:	100%	200%	225%	250%	275%	500%
	POVERTY LEVEL AT OR BELOW:	GROSS ANNUAL INCOME LESS THAN OR EQUAL TO:	GROSS ANNUAL INCOME LESS THAN OR EQUAL TO:	GROSS ANNUAL INCOME LESS THAN OR EQUAL TO:	GROSS ANNUAL INCOME LESS THAN OR EQUAL TO:	GROSS ANNUAL INCOME LESS THAN OR EQUAL TO:
SIZE OF HOUSEHOLD - 1						
ADJUSTED GROSS INCOME	$13,590	$27,180	$30,578	$33,975	$37,373	$67,950
SIZE OF HOUSEHOLD - 2						
ADJUSTED GROSS INCOME	$18,310	$36,620	$41,198	$45,775	$50,353	$91,550
SIZE OF HOUSEHOLD - 3						
ADJUSTED GROSS INCOME	$23,030	$46,060	$51,818	$57,575	$63,333	$115,150
SIZE OF HOUSEHOLD - 4						
ADJUSTED GROSS INCOME	$27,750	$55,500	$62,438	$69,375	$76,313	$138,750
SIZE OF HOUSEHOLD - 5						
ADJUSTED GROSS INCOME	$32,470	$64,940	$73,058	$81,175	$89,293	$162,350
SIZE OF HOUSEHOLD - 6						
ADJUSTED GROSS INCOME	$37,190	$74,380	$83,678	$92,975	$102,273	$185,950
SIZE OF HOUSEHOLD - 7						
ADJUSTED GROSS INCOME	$41,910	$83,820	$94,298	$104,775	$115,253	$209,550
SIZE OF HOUSEHOLD - 8						
ADJUSTED GROSS INCOME	$46,630	$93,260	$104,918	$116,575	$128,233	$233,150
FOR FAMILY UNITS OF MORE THAN 8 MEMBERS, ADD TO ADJUSTED GROSS INCOME FOR EACH ADDITIONAL MEMBER:	$4,720	$9,440	$10,620	$11,800	$12,980	$23,600

ADJUSTED GROSS INCOME IS DEFINED AS WAGES, SALARIES, TIPS, ALIMONY RECEIVED, ETC. PLUS INTEREST AND OTHER INVESTMENT INCOME LESS ALIMONY PAID AS DEFINED BY IRS REGULATIONS. PERSONS WITH SCHEDULE A ITEMIZED DEDUCTIONS MAY BE GIVEN SPECIAL CONSIDERATION IF THEY PROVIDE A COPY OF THEIR MOST RECENT FEDERAL INCOME TAX RETURN. DISCOUNTS AND ADJUSTED GROSS INCOME LEVELS ARE SUBJECT TO CHANGE WITH CHANGES IN THE PROVERTY INCOME GUIDELINES, FEDERAL TAX LAWS AND AT THE DISCRETION OF THE MIDDLESEX HOSPITAL.

B. **Determination of Discount Off Eligible Individual Obligation.** The discount to be provided to the Eligible Individual Obligation shall be determined according to the following sliding scale; the discounts indicated will applied to the Eligible Individual Obligation, dependent upon income level:

250% of FPG and below	100% discount
251% of FPG to 300% of FPG	90% discount
301% of FPG to 350% of FPG	80% discount
351% of FPG to 399% of FPG	70% discount
400% of FPG	60% discount

Appendix D

Appendix D includes the individuals who make up the Board of Directors/Trustees for each of the acute care nonprofit hospitals in Connecticut. Some hospitals included former members in their Form 990 filings, and therefore are also included in this report.

Hospital	Name of Board Member	Board Member's Occupation(s)
Backus	Donna Handley	Director/President
	Joanne Chaurette, MD	Director
	Mark Tramontozzi, MD	Director
	Mary Barry, MD	Chair
	Anita Lee	Director
	Anthony Joyce, III	Director
	Carina Vora, DDS	Director
	Henry Beck	Vice Chair
	Lee-Ann Gomes	Director
	Mark DePonte, MD	Director
	Stephen Larcen, PhD	Director
Charlotte Hungerford	Bimal Patel	Director & President
	Rocco Orlando III, MD	Director
	Daniel McIntyre	CEO/Pres/Director (Thru 12/21)
	Joseph Abreu, MD	Director
	Frank Buonocore, Jr.	Director (Thru 12/21)
	Richard Dutton, MD	Director
	Stephanie Fowler, MD	Director
	John Janco	Director
	John Lavieri	Director
	Dianne Libby	Vice Chair/Director
	Douglas O'Connell	Director
	James O'Leary	Director (Thru 12/21)
	Maria Coutant Skinner, LCSW	Chair/Director
	Jeffrey Borghesi	Director
	Edwin Booth, Jr.	Director
	Cathy-Lynne Coyle	Director
	Maria Gonzalez	Director
Central Connecticut	Aziz Benbrahim, MD	Director (Thru 9/22)
	Gary Havican	President/Director
	Letterio Asciuto, MD	Director (Thru 10/21)

	Howard Boey, MD	Director
	Phillip Boiselle, MD	Director
	Bruce Eldridge	Director
	Vincent Fortunato	Director
	Nadine Francis-West	Vice Chair
	Jason Howey	Director
	David Hyman, DDS	Director
	Cynthia Ann Hall McCraven, MD	Director
	John Rathgeber	Director
	George Springer, Jr., Esq	Chair
	Alex Toribio	Director
	Stephen Subasic	Director
Hartford	Bimal Patel	President & CEO
	Arnold Chase	Director
	Samuel Gray Jr.	Director
	Allison Lawrence	Director
	Brian MacLean	Director
	Michael O'Loughlin, MD	Director
	Dariush Owlia, MD	Director
	E. Carol Polifroni	Director
	Matthew Saidel, MD	Director
	Elease Wright	Director
	Eric Zachs	Chair
	Alexia Cruz	Vice Chair
MidState	Gary Havican	President/ Director
	Howard Boey, MD	Director
	Vincent Fortunato, MD	Director
	Jason Howey	Director
	Nadine Francis-West	Vice Chair
	Cynthia Ann Hall McCraven, MD	Director
	Bruce Eldridge	Director
	Phillip Boiselle, MD	Director
	John Rathgeber	Director
	David Hyman, DDS	Director
	Alex Toribio	Director
	George Springer Jr. Esq	Chair
	Aziz Benbrahim, MD	Director
St. Vincent's	William Jennings	President
	Carol Birks	Director
	Robin Cautin	Director
	Peter Cimino, MD	Director

	Helene Glotzer	Director through June 2022
	Douglass Grabe	Director
	Rahul Gupta, MD	Director
	Debra Liewbowitz	Director
	Jane Manning	Director
	Barbara Miller	Director through March 2022
	Alfred Pavlis	Director through May 2022
	Dara Richards, MD	Director
	Lucy Teixeira	Director
	Strick Woods, MD	Director
	John Petillo	Chair through June 2022
	George Estrada	Chair
	Deacon Patrick Toole	Vice Chair
Windham	Donna Handley	Director/President
	Joanne Chaurette, MD	Director (through 10/21)
	Mark Tramontozzi, MD	Director
	Mary Barry, MD	Chair
	Henry Beck	Vice Chair
	Mark DePonte, MD	Director
	Lee-Ann Gomes	Director
	Anthony Joyce, III	Director
	Stephen Larcen, MD	Director
	Anita Lee	Director

Hospital	Name of Board Member	Board Member's Occupation(s)
Bridgeport	Vincent Petrini	Trustee
	Anne Diamond	President/Trustee
	Tito Vasquez, MD	Trustee
	Murali Chiravuri, MD	Trustee
	Mihaela Costin, MD	Trustee
	John Falconi	Chairman/Trustee
	Adrienne Houel	Trustee
	Meredith Kazer	Trustee
	Thomas Lenci	Trustee
	Richard Meisenheimer	Trustee
	Emil Meshberg	Trustee
	Ronald Noren	Vice Chairman/Trustee
	Meredith Reuben	Trustee

	Ed Rodriguez	Trustee
	Jeffrey Tengel	Trustee
	Gary Zimmerman, MD	Vice Chairman/Trustee
Greenwich	Christopher O'Connor	Trustee
	Dianne Kelly	Trustee/President
	Thomas Pellechi, MD	Trustee/Co-chair
	Felice Zwas, MD	Trustee
	Mark Chrostowksi, MD	Trustee/Chair
	Preston Baldwin	Trustee
	Sheryl Battles	Trustee
	William Berkley	Trustee/Chair
	Marc Gabelli	Trustee
	Frank Gilbride	Trustee/Secretary
	Christopher Howes, MD	Trustee/Chair
	Anne Juge	Trustee/Treasurer
	Robin Kanarek	Trustee
	Sally Lochner	Trustee
	Barbara Miller	Trustee/Vice Chair
	Jack Mitchell	Trustee
	Christine Randolph	Trustee
	Karen Rubin	Trustee
	Susan Salice	Trustee
	Hannah Strasser	Trustee
	Ranjan Tandon	Trustee
	Bobby Walker Jr.	Trustee
Lawrence + Memorial	William Aseltyne	Trustee
	Patrick L Green	President / Trustee
	David F Reisfeld	Trustee
	James Mitchell	Chairman/Trustee
	Kathleen Holt	Vice Chair/Trustee
	Robert Nardone	Secretary/Treasurer/Trustee
	Todd Blue	Trustee
	Stephen Greene	Trustee
	Ross J Sanfilippo	Trustee
	Rev Catherine Zall	Trustee
	John Holstein	Trustee
	Marie Peakman	Trustee
	Niall Duhig	Trustee
Yale New Haven	Marna Borgstom	CEO/Trustee
	Christopher O'Connor	EVP and CEO/Trustee
	Thomas Balcezak, MD	EVP COO/Trustee

	Keith Churchwell, MD	President/Trustee
	Joni Hansson. MD	Trustee
	Eugenia Vining, MD	Trustee
	Nita Ahuja, MD	Trustee
	Victor Bolden	Trustee
	Nancy Brown, MD	Trustee
	Vincent Calarco	Trustee
	Kerwin Charles	Trustee
	Erik Clemons	Trustee
	Jocelyn Cunningham	Trustee
	James Elrod	Trustee
	Mary Farrell	Chairman/Trustee
	William Ginsberg	Trustee
	Aaron Hollander	Secretary/Trustee
	Thomas B Ketchum	Trustee
	Ann Kurth, PhD	Trustee
	Marietta Lee	Trustee
	Lina Koch Lorimer	Vice Chair/Trustee
	Sister Rosemary Moynihan	Trustee
	Stephen Murphy	Trustee
	Peter Salovey	Trustee
	Michael Sproule	Trustee
	James Torgerson	Trustee

Hospital	Name of Board Member	Board Member's Occupation(s)
Danbury	Sharon Adams	President
	Dahlia Plummer, MD	Director/Staff Physician
	Cornelius Ferreira, MD	Director/ Sys. Chairman
	Bruce D. Haims, Esq	Vice Chairman
	Mary Garrett	Director/Chairman (From 1/1)
	Spencer Houldin	Chairman (Thru 12/31)/Director
	Anthea Disney	Director
	Carrie L. Amos	Director
	Dominick Colabella	Director (Until 2/1)
	Donald Jones	Director (From 1/1 to 9/30)
	Greg Oneglia	Director (Thru 12/31)
	James Moskowitz	Director
	Lisa A. Esneault	Director

	Mary Alice Donius	Director (Thru 9/2)
	Robert Hackney	Director (From 1/1)
Norwalk	Peter Cordeau	President Norwalk Hospital
	Amy Ahasic, MD	Director
	Thomas Ayoub, MD	Director
	Pablo Colon	Director; Vice Chairman (from 1/1)
	Patricia S. Bam	Chairman (to 12/31); Director
	Thomas Dubin	Vice Chairman (to 12/31); Chairman (from 1/1)
	Amy Schafrann	Director (to 12/31)
	Curtis Stewart	Director
	Danielle Robinson, PhD	Director
	Ervin R. Shames	Director (to 12/31)
	George Bauer	Director
	James Dimonekas	Director (from 1/1)
	Karen Gottlieb	Director
	Leonard Dinardo	Director (from 1/1)
	Mary Grace Gudis	Director
	Michael L. Witherspoon, JD	Director
	Peter Campbell	Director
	Peter Herbert	Director
	Sarah Tripodi	Director
	Susan Beyman	Director
	Susan Weinberger	Director
Sharon	Mark K Hirko, MD	President Sharon Hospital (to 7/5)
	Christina McCulloch	President Sharon Hospital (from 7/5)
	Pari Forood	Vice Chairman
	Richard Cantele	Chairman
	Hugh Hill	Director
	James Quella	Director
	Joel Jones	Director
	John Charde, MD	Director
	Kathryn Palmer-House	Director
	Kenneth Schechter	Director
	Margaret Coughlan, MD	Director
	Mehrdad Noorani	Director
	Miriam Tannen, RN, NP-C	Director
	Randall R Dwenger, MD	Director

Hospital	Name of Board Member	Board Member's Occupation(s)
Johnson Memorial	Reginald Eadie, MD	Director; TH of NE President & CEO
	Emily Brower	Director; Trinity Health SVP
	Haris Athar, MD	Director, SFMC Medical Staff Pres
	James Smith	Director; Chair
	Joann Price	Director; Vice Chair
	Most Rev Juan Miguel Betancourt	Director
	Gregory Davis	Director
	Robert Gumbardo, MD	Director
	Walter Harrison, PhD	Director
	Karl Krapex	Director
	Nancy Kroebber	Director
	Joycee Mandell	Director
	Barbara Mullen, CSJ	Director
	Michelle Theroux	Director
St. Francis	Reginald Eadie, MD	Director; TH of NE President CEO
	Emily Browner	Director; Trinity Health SVP
	Haris Athar, MD	Director; Medical Staff President
	James Smith	Director; Chair
	Joann Price	Director; Vice Chair
	Most Rev. Juan Miguel Betancourt	Director
	Gregory Davis	Director
	Robert Gumbardo, MD	Director as of 1/22
	Nakia Hall	Director through 12/21
	Walter Harrison	Director
	Karl Krapek	Director
	Nancy Kroeber	Director as of 1/22
	Paul Mancinone	Director through 12/21
	Joyce Mandell	Director
	Angela Mattie	Director through 12/21
	Joseph Mengacci	Director through 12/21
	Barbara Mullen, CSJ	Director
	Michelle Theroux	Director as of 1/22
St. Mary's	Reginald Eadie, MD	Director; TH of NE President CEO
	Emily Browner	Director; Trinity Health SVP
	Haris Athar, MD	Director; Medical Staff President
	James Smith	Director; Chair
	Joann Price	Director; Vice Chair
	Most Rev. Juan Miguel Betancourt	Director
	Gregory Davis	Director

	Robert Gumbardo, MD	Director as of 1/22
	Nakia Hall	Director through 12/21
	Walter Harrison	Director
	Karl Krapek	Director
	Nancy Kroeber	Director as of 1/22
	Paul Mancinone	Director through 12/21
	Joyce Mandell	Director
	Angela Mattie	Director through 12/21
	Joseph Mengacci	Director through 12/21
	Barbara Mullen, CSJ	Director
	Michelle Theroux	Director as of 1/22

Hospital	Name of Board Member	Board Member's Occupation(s)
Bristol	Kurt Barwis	President, CEO, CFO
	Jennifer McCallister, MD	Medical Staff Representative
	Sharon Adler, MD	Medical Staff Rep (Thru 1/22)
	Lisa Casey	Director
	Jarre Betts	Director
	Bradford Meacham	Director
	Joseph Lockwood	Director
	Glenn Heiser	Chairman
	John Lodovico, Jr.	Vice Chairman
	Jeffrey Kaye, MD	Medical Staff Representative
	William Hamzy	Director (Thru 10/21)
	Louis Auletta, Jr.	Secretary/Treasurer
	Yong-Sung Chyun, MD	Director
	Michael Heimbach	Director
	Irene Bassock	Director
	Katarzyna Lessard	Director
	Lexie Mangum	Director
Connecticut Children's	James E. Shmerling, DHA	CEO & President/Director
	Michael Isakoff, MD	President of Med Staff/Director
	David M. Roth, Esq.	Chairman/Director
	James W. Fanelli, CFP	Vice Chairman/Director
	Tina Brown-Stevenson	Secretary/Director
	Andrea Balogh	Director
	Scott Braunstein	Director
	Shari Cantor	Director

	James Hall II	Director
	Christopher Holley	Director
	Jeff Klenk	Director
	Preston Kodak III	Director
	Dorothy Levine, MD	Director
	Megan Mackey, EDD	Director
	Burke Magnus	Director
	Otis Maynard	Director
	Carlos Mouta	Director
	Michelle Murphy	Director
	Nicole Murray, MD	Director
	Jonathan Rubin	Director
	Tina St. Pierre	Director
	Andrew Zeitlin	Director
Day Kimball	Richard Wilcon, MD	President, Med Staff (Start 7/22)
	Michael Baum, MD	Director
	Anthony Chieffalo, MD	Director (Thru 2/22)
	Paul Matty, MD	Director
	Krista Matsen, MD	Director
	Janice Thurlow	Chairwoman
	Peter Deary	Vice Chair
	Kathy Rocha	Secretary
	Edwin Higgins	Assistant Secretary/Treasurer
	Kyle Kramer	CEO/Director
	Karen Cole	Director (Start 2/22)
	Jay Cyr	Director (Start 2/22)
	Matthew Desaulnier	Director (Start 2/22)
	Anne Lamody	Director (Start 2/22)
	Daniel Sullivan	Director (Start 2/22)
	Nancy Weiss	Director
	Steven Wexler, MD	Director
	James Zahansky	Director (Start 2/22)
	Kevin P. Johnston	Director
	Shawn McNerney	Director (Thru 12/21)
	Jeffrey Paul	Director (Thru 12/21)
Griffin	Patrick A. Charmel	CEO/President, BOD Secretary
	Frederick Browne, MD	Trustee
	Maria Dawe, MD	Trustee/Physician
	John W. Betkowski III	Trustee/Chairman
	Robert G. Reiss	Trustee
	Phillip White	Trustee

	Nancy Dinardo	Trustee
	Mark Peterson	Trustee
	Laura Marasco	Trustee
	Kenneth Baldyga	Trustee
	Joseph Sokol, MD	Trustee
	Joseph Andreana	Trustee
	Themis Klarides	Trustee
	John J. Zaprzalka	Trustee
	James Tickey	Trustee (From 1/22)
	Donna Digianvittorio	Trustee
	Edward J. McCreery III, Esq.	Trustee
	Jean Crum Jones, MPH, RD	Trustee
	Floyd Moir	Trustee (Resigned 1/22)
	George S. Logan	Trustee
	Gerald T. Weiner, Esq.	Trustee
	Harold Schwartz, MD	Trustee
	Frederick Stanek, Esq.	Trustee
Middlesex	Vincent Capece, JR.	President/ CEO
	David C. Benoit	Director
	Jean M. D'Aquila	Director
	John J. Gauthier	Director
	Robert C. Hinton	Director
	Chandler J. Howard	Director
	Jonathan D. Levine, MD	Secretary
	Mark D. Lorenze, MD	Asst Secretary
	Bruce S. MacMillian	Director
	Darrel G. Pataska	Chairman
	Christine H. Repasy	Director
	Gary M. Wallace	Director
	Mark Bertolami	Director
Stamford	Kathleen A Silard	President and CEO
	Michael Ebright, MD	Physician Director (SHMG)
	Shara Israel, MD	Physician Director (SHMG)
	James Thomas	Vice Chair
	Patrick Hackett	Chairman
	Cheryl De Vonish	Director
	Elizabeth Zea	Director
	F. Carl Mueller, MD	Director
	Hoyt Harper II	Director
	Lucy Galbraith	Director
	Mallory Martino	Director

	Matthew Dumas	Director
	Michael Diliberto	Director
	Paul Giusti	Director

Appendix E

IRS Schedule J Compensation, Instructions

Part II. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

Enter information for certain individuals listed on Form 990, Part VII, Section A, as described below. Report compensation for the calendar year ending with or within the organization's tax year paid to or earned by the following individuals.

- Each of the organization's former officers, former directors, former trustees, former key employees, and former five highest compensated employees listed on Form 990, Part VII, Section A.
- Each of the organization's current officers, directors, trustees, key employees, and five highest compensated employees for whom the sum of Form 990, Part VII, Section A, columns (D), (E), and (F) (disregarding any decreases in the actuarial value of defined benefit plans) is greater than $150,000.
- Each of the organization's current and former officers, directors, trustees, key employees, and five highest compensated employees who received or accrued compensation from any unrelated organization or individual for services rendered to the filing organization, as reported on line 5 of Form 990, Part VII, Section A. List in Part III the name of each unrelated organization that provided compensation to such persons, the type and amount of compensation it paid or accrued, and the person receiving or accruing such compensation, as explained in the instructions for Form 990, Part VII, Section A, line 5.

All current key employees listed on Form 990, Part VII, Section A, must also be reported on Schedule J, Part II, because their reportable compensation, by definition, exceeds $150,000.

Do not list any individuals in Schedule J, Part II, that aren't listed on Form 990, Part VII, Section A. Do not list in Part II management companies or other organizations providing services to the organization. Do not list highest compensated independent contractors reported on Form 990, Part VII, Section B.

For each individual listed, enter compensation from the organization on row (i), and compensation from all related organizations on row (ii). Related organizations are explained in the Glossary in the Instructions for Form 990. Any type and amount of reportable compensation from related organizations that was excluded from Form 990, Part VII, Section A, column (E), under the $10,000-per-related-organization exception, must be included on Schedule J, Part II, columns (B)(i), (B)(ii), and (B)(iii). If there is no compensation to report in a particular column, enter “-0-.”

If the organization answered “Yes” to Form 990, Part VII, Section A, line 5, report such compensation from the unrelated organization as if it were received from the organization, and enter the name of the unrelated organization in Part III.

For a table showing how and where to report certain types of compensation on Schedule J, see the instructions for line 1 of Form 990, Part VII, Section A.

Any type and amount of other compensation that was excluded from Form 990, Part VII, Section A, under the $10,000-per-item exception for certain other compensation items, must be included in Schedule J, Part II, column (C) or (D).

For purposes of Part II, a listed person is a person required to be listed in Part II.

Column (A). Enter the name and title of each person who must be listed in Part II.

Column (B). Amounts reported on Form 990, Part VII, Section A, columns (D) and (E), must be broken out between columns (B)(i), (B)(ii), and (B)(iii).

For certain kinds of employees, such as certain members of the clergy and religious workers who aren't subject to social security and Medicare taxes as employees, the amount in box 5 of Form W-2 may be blank or less than the amount in box 1 of Form W-2. In this case, the amount required to be reported in box 1 of Form W-2 for the listed persons must be reported, as appropriate, in columns (B)(i), (B)(ii), and (B)(iii).

Column (B)(i). Enter the listed person's base compensation included in box 1 or box 5 (whichever is greater) of Form W-2, box 6 of Form 1099-MISC, or box 1 of Form 1099-NEC issued to the person. Base compensation means nondiscretionary payments to a person agreed upon in advance, contingent only on the payee's performance of agreed-upon services (such as salary or fees).

Column (B)(ii). Enter the listed person's bonus and incentive compensation included in box 1 or box 5 (whichever is greater) of Form W-2, box 6 of Form 1099-MISC, or box 1 of Form 1099-NEC issued to the person. Examples include payments based on satisfaction of a performance target (other than mere longevity of service), and payments at the beginning of a contract before services are rendered (for example, signing bonus).

Column (B)(iii). Enter all other payments issued to the listed person and included in box 1 or box 5 (whichever is greater) of Form W-2, box 6 of Form 1099-MISC, or box 1 of Form 1099-NEC but not reflected in column (B)(i) or (B)(ii). Examples include, but aren't limited to, current-year payments of amounts earned in a prior year, payments under a severance plan, payments under an arrangement providing for payments upon the change in ownership or control of the organization or similar transaction, deferred amounts and earnings or losses in a nonqualified defined contribution plan subject to section 457(f) when they become substantially vested, and awards based on longevity of service.

Column (C). Enter all current-year deferrals of compensation for the listed person under any retirement or other deferred compensation plan, whether qualified or nonqualified, that is established, sponsored, or maintained by or for the organization or a related organization. Report as deferred compensation the annual increase or decrease in actuarial value, if any, of a defined benefit plan, but don't report earnings or losses accrued on deferred amounts in a defined contribution plan. Do not enter in column (C) any payments of compensation included in box 1 or box 5 (whichever is greater) of Form W-2, box 6 of Form 1099-MISC, or box 1 of Form 1099-NEC issued to the listed person for the calendar year ending with or within the organization's tax year. Enter a reasonable estimate if actual numbers aren't readily available.

For this purpose, deferred compensation is compensation that is earned or accrued in, or is attributable to, 1 year and deferred for any reason to a future year, whether or not funded, vested, or subject to a substantial risk of forfeiture. This includes earned but unpaid incentive compensation deferred under a deferred compensation plan. But don't report in column (C) a deferral of compensation that causes an amount to be deferred from the calendar year ending with or within the tax year to a date that isn't more than 2½ months after the end of the calendar year ending with or within the tax year. Note that

different rules can apply for determining whether an arrangement provides for deferred compensation for purposes of Internal Revenue Code provisions such as section 83, 409A, 457(f), or 3121(v).

Do not report deferred compensation in column (C) before it is earned or accrued under the principles described. For this purpose, deferred compensation is generally treated as earned or accrued in the year that services are rendered, except when entitlement to payment is contingent on satisfaction of specified organizational goals or performance criteria (other than mere longevity of service) under the deferred compensation plan. If the payment of an amount of deferred compensation requires the employee to perform services for a period of time, the amount is treated as accrued or earned ratably over the course of the service period, even though the amount isn't funded and may be subject to a substantial risk of forfeiture until the service period is completed.

Report deferred compensation for each listed person regardless of whether such compensation is deferred as part of a deferred compensation plan that is administered by a separate trust, as long as the plan is established, sponsored, or maintained by or for the organization or a related organization for the benefit of the listed person.

The following examples illustrate when deferred compensation is considered earned or accrued, as well as when and how it is to be reported. In these examples, assume that the amounts deferred aren't reported in box 1 or box 5 of Form W-2, prior to the year during which the amounts are paid.

Example 1. An executive participates in Organization A's nonqualified deferred compensation plan. Under the terms of the plan beginning January 1 of calendar year 1, the executive earns for each year of service an amount equal to 2% (0.02) of their base salary of $100,000 for that year. These additional amounts are deferred and aren't vested until the executive has completed 3 years of service with Organization A. In year 4, the deferred amounts for years 1 through 3 are paid to the executive. For each of the years 1 through 3, Organization A enters $2,000 of deferred compensation for the executive in column (C). For year 4, Organization A enters $6,000 in column (B)(iii) and $6,000 in column (F).

Example 2. Under the terms of the executive’s employment contract with Organization B beginning July 1 of calendar year 1, an executive is entitled to receive $50,000 of additional compensation after completing 5 years of service with the organization. The compensation is contingent only on the longevity of service. The $50,000 is treated as accrued or earned ratably over the course of the 5 years of service, even though it isn't funded or vested until the executive has completed the 5 years. Organization B makes a payment of $50,000 to the executive in calendar year 6. Organization B enters $5,000 of deferred compensation in column (C) for calendar year 1 and $10,000 for each of calendar years 2 through 5. For calendar year 6, Organization B enters $50,000 in column (B)(iii) and $45,000 in column (F).

Example 3. An executive participates in Organization C's incentive compensation plan. The plan covers calendar years 1 through 5. Under the terms of the plan, the executive is entitled to earn 1% (0.01) of Organization C's total productivity savings for each year during which Organization C's total productivity savings exceed $100,000. Earnings under the incentive compensation plan will be payable in year 6, to the extent funds are available in a certain “incentive compensation pool.” For years 1 and 2, Organization C's total productivity savings are $95,000. For each of years 3, 4, and 5, Organization C's total productivity savings are $120,000. Accordingly, the executive earns $1,200 of incentive compensation in each of years 3, 4, and 5. The executive does not earn anything under the incentive

compensation plan in years 1 and 2 because the relevant performance criteria weren't met in those years. Although the amounts earned under the plan for years 3, 4, and 5 are dependent upon there being a sufficient incentive compensation pool from which to make the payment, Organization C enters $1,200 of deferred compensation in column (C) in years 3, 4, and 5. In year 6, Organization C pays $3,600 attributable to years 3, 4, and 5, and enters $3,600 in column (B)(ii) and $3,600 in column (F).

Example 4. A new executive participates in Organization D's nonqualified defined benefit plan, under which the executive will receive a fixed dollar amount per year for a fixed number of years beginning with the first anniversary of retirement. The benefits don't vest until the executive serves for 15 years with Organization D. Because the benefits should be treated as accruing ratably over the 15 years, for year 1 the actuarial value of 1/15th of the benefits is reported as deferred compensation in column (C). For year 2, the actuarial value of 2/15ths of the benefits minus last year's value of 1/15th is reported as deferred compensation in column (C). For year 3, the actuarial value of 3/15ths of the benefits minus last year's value of 2/15ths is reported, and so on.

Column (D). Nontaxable benefits are benefits specifically excluded from taxation under the Internal Revenue Code. Report the value of all nontaxable benefits provided to or for the benefit of the listed person, other than benefits disregarded for purposes of section 4958 under Regulations section 53.4958-4(a)(4). Common nontaxable and section 4958 disregarded benefits, referred to as fringe benefits below, are discussed in detail beginning on this page.

Depending on the type of benefit, fringe benefits can be provided only to employees or also to persons other than employees, such as directors, trustees, and independent contractors. Fringe benefits can be entirely personal in nature or can combine personal and business elements.

The taxability of a benefit can depend upon the form in which it is provided. For example, a cash housing allowance is ordinarily reportable in box 5 of Form W-2. Under section 119, housing provided for the convenience of the employer can be excludable, and the fair rental value of in-kind housing provided to certain school employees can be part taxable and part excludable, depending on facts and circumstances. Taxable benefits must be reported on Form W-2.

The following benefits provided for a listed person must be reported in column (D) to the extent not reported as taxable compensation in box 1 or box 5 of Form W-2, box 6 of Form 1099-MISC, or box 1 of Form 1099-NEC.

- Value of housing provided by the employer, except to the extent such value is a working condition fringe.
- Educational assistance.
- Health insurance.
- Medical reimbursement programs.
- Life insurance.
- Disability benefits.
- Long-term care insurance.
- Dependent care assistance.
- Adoption assistance.
- Payment or reimbursement by the organization of (or payment of liability insurance premiums for) any penalty, tax, or expense of correction owed under chapter 42 of the Internal Revenue

Code, any expense not reasonably incurred by the person in connection with a civil judicial or civil administrative proceeding arising out of the person's performance of services on behalf of the organization, or any expense resulting from an act or failure to act with respect to which the person has acted willfully and without reasonable cause.

The list above is not all-inclusive.

Disregarded benefits. Disregarded benefits under Regulations section 53.4958-4(a)(4) need not be reported in column (D). Disregarded benefits generally include fringe benefits excluded from gross income under section 132. These benefits include the following.

- No-additional cost service.
- Qualified employee discount.
- De minimis fringe.
- Reimbursements under an accountable plan.
- Working condition fringe.
- Qualified transportation fringe.
- Qualified moving expense reimbursement.
- Qualified retirement planning services.
- Qualified military base realignment and closure fringe.

De minimis fringe. A de minimis fringe is a property or service the value of which, after taking into account the frequency with which similar fringes are provided by the employer to the employees, is so small as to make accounting for it unreasonable or administratively impractical.

Working condition fringe. A working condition fringe is any property or service provided to an employee to the extent that, if the employee paid for the property or service, the payment would be deductible by the employee under section 162 (ordinary and necessary business expense) or section 167 (depreciation).

In some cases, property provided to employees may be used partly for business and partly for personal purposes, such as automobiles. In that case, the value of the personal use of such property is taxable compensation, and the value of the use for business purposes properly accounted for is a working condition fringe benefit. Cell phones provided to employees primarily for business purposes (other than compensation) are a working condition fringe benefit; in such case, the employee's personal use is a de minimis fringe. See Notice 2011-72, 2011-38 I.R.B. 407. See Pub. 587, Business Use of Your Home, for special rules regarding deductibility of home expenses for business use.

Accountable plan amounts. An accountable plan is a reimbursement or other expense allowance arrangement that meets each of the following rules.

1. The expenses covered under the plan must be reasonable employee business expenses that are deductible under section 162 or other provisions of the Code.
2. The employee must adequately account to the employer for the expenses within a reasonable period of time.
3. The employee must return any excess allowance or reimbursement within a reasonable period of time. See Regulations section 1.62-2 and Pub. 535, Business Expenses, for explanations of accountable plans.

The method by which benefits under an accountable plan are provided (whether reimbursement, cash advances with follow-up accounting, or charge by the employee on company credit card) isn't material. Payments that don't qualify under the accountable plan rules, such as payments for which the employee didn't adequately account to the organization, or allowances that were more than the payee spent on serving the organization, are compensation.

Directors and trustees are treated as employees for purposes of the working condition fringe provisions of section 132. Therefore, treat cash payments to directors or trustees made under circumstances substantially identical to the accountable plan provisions as a section 132 working condition fringe.

See Pub. 15-B, Employer's Tax Guide to Fringe Benefits; Pub. 521, Moving Expenses; and Unreimbursed Employee Expenses in Pub. 529, Miscellaneous Deductions, for further explanation of section 132 fringe benefits and for determining whether a given section 132 fringe benefit is available to nonemployees, such as directors and trustees, or to persons who no longer work for the organization.

Column (F). Enter in column (F) any payment reported in this year's column (B) to the extent such payment was already reported as deferred compensation to the listed person on a prior Form 990, 990-EZ, or 990-PF. For this purpose, the amount must have been reported as compensation specifically for the listed person on the prior form.

Part III. Supplemental Information

Use Part III to provide narrative information, explanations, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. List in Part III the name of each unrelated organization that provided compensation to persons listed in Form 990, Part VII, Section A; the type and amount of compensation the unrelated organization paid or accrued; and the person receiving or accruing such compensation. Also use Part III to provide other narrative explanations and descriptions, as applicable. Identify the specific part and line(s) that the response supports.

HRS Reports 19A and 19B, Instructions

Report 19A – Salaries and Fringe Benefits of the Ten Highest Paid Hospital Employees

Report 19B – Salaries and Fringe Benefits of the Ten Highest Paid Health System Employees

Reports listing the salaries and fringe benefits for the ten highest paid employees in the hospital and health system. Each position shall be identified by a name and complete job title and may be entered in any order as they are sorted by total combined salary and fringe benefits by the system. Inputs are as follows:

a. Employee Name (first and last);

b. Position Title of the employee[103] - Enter the specific job title which denotes each individual position's department or area of responsibility in the hospital / health system. Please note that generic position titles (e.g., "MD") are not acceptable

[103] Hospital Financial Review Regulations Sec. 19a-643-206(b)(19)

c. Salary (accrued) for the fiscal year ending September 30th from payroll records

d. Fringe benefits for the fiscal year ending September 30th from payroll records and other hospital / health system records

A text box is provided at the bottom of both the Report 19A and 19B input forms to allow hospitals to explain any of the data entered in the input section of the reports. Filling out the text boxes is completely voluntary and not required by hospitals.

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 Salary and Fringe Benefit data inputs on Report 19B. All other hospitals in the system should click the Nothing to Report box on the input form.

Fringe benefits[104] shall include all forms of compensation whether actual or deferred, made to or on behalf of the employee whether full time or part-time and shall include, but not be limited to, the following:

a. The cost to the hospital / health system of all health, life, disability or other insurance or benefit plans;

b. For the hospital / health system, the cost of any employer payments or liability to employee retirement plans or programs;

c. For the hospital / health system the cost or value of any bonus, incentive or longevity plans not included under normal salary reporting guidelines;

d. The cost or value of any housing, whether in the form of a house, apartment, condominium, dormitory or room of any type, whether full-time or only available for part-time use, if subsidized in full or in part by the hospital / health system and not located directly within a hospital building offering direct patient care;

e. The fair market value of any office space, furnishings, telephone service, support service staff, support service equipment, billing or collection services or similar benefits provided to any person for use when seeing non-hospital / health system or private patients or clients. This value shall be prorated based on the total number of hospital / health system and non-hospital / health system patient billing units or provider man-hours involved. For purposes of this subparagraph, if both hospital / health system and non-hospital / health system clients are served from the same location, hospital / health system patients are defined as patients who are billed directly by the hospital / health system for the service provided and for whom the hospital / health system retains the full payment received as part of its gross operating revenue;

f. For the hospital / health system, the fair market value of the cost or subsidy of the use of any automobile, transportation tickets or passes, free or reduced parking, travel expenses, hotel accommodations, etc.; and

g. Any items of value available to employees and not specifically listed above.

[104] Hospital Financial Review Regulations Sec. 19a-643-206(b)(19)(A through G)