CONNECTICUT
Health Strategy

Connecticut Health Systems Financial Status (FY2023)

In Context

State of Connecticut

Office of Health Strategy

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Introduction

Hospitals play a unique and essential role in providing care for a wide range of acute and chronic conditions. This role typically includes 24/7 availability for emergency care and operating as a safety net for those with limited means to pay for healthcare services. Connecticut's cost growth benchmark reporting found that hospital spending accounted for 40% of Connecticut healthcare spending in 2022, and nearly 50% of spending in the commercial insurance market.[1] Hospitals also frequently employ a significant proportion of a state's workforce and can be economic drivers in their communities.

Connecticut Office of Health Strategy (OHS) data analysis reveals that hospitals have been one of the major contributors to healthcare spending growth in Connecticut during the past several years, contributing to circumstances that have made healthcare unaffordable for many.[2] Surveys conducted in Connecticut and nationwide reflect the struggle residents face: consumers forego insurance, delay or skip needed care and take on medical debt due to the high cost of healthcare.[3,4] Research has also demonstrated that the increasing cost of healthcare depresses wage growth, with a recent study even connecting rising hospital prices to negative impacts on local economies.[5,6] The State must understand these variables, and the financial strengths and vulnerabilities of healthcare systems, to advance public policy that will effectively support access to affordable, high-quality care and local economies.

Purpose of this report

This report provides a summary assessment of the financial health of Connecticut's five multi-hospital systems, including ownership and composition. The report provides important context for understanding the relative stability of our community health systems in a market that has experienced significant change over recent years.

[1] Connecticut Office of Health Strategy. *Cost Growth Benchmark Initiative, 2021-2022 Performance*. May 13, 2024.
[2] Michael Bailit, "What is Driving Health Care Spending Upward in States with Cost Growth Targets?" *Health Affairs Forefront* (2022).
[3] Healthcare Value Hub. *Connecticut Residents Struggle to Afford High Healthcare Costs; Worry about Affording Healthcare in the Future; Support Government Action across Party Lines*. 2022.
[4] Kunna Lopes, Alex Montero, Marley Presiado and Liz Hamel. Kaiser Family Foundation. *Americans' Challenges with Health Care Costs*. 2024.
[5] Kurt Hager, Ezekiel Emanuel, and Dariush Mozaffarian, "Employer-Sponsored Health Insurance Premium Cost Growth and Its Association With Earnings Inequality Among US Families," *JAMA Network Open* (2024).
[6] Zarek Brot-Goldberg, Zack Cooper, Stuart Craig, Lev Klarnet, Ithai Lurie and Corbin Miller, "Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers," *National Bureau of Economic Research* (2024).

Data Sources
This report draws on data from many sources – including hospital reporting to OHS, as well as Connecticut's state, federal, and publicly available hospital financial documents.

Key Findings

1. **Five systems own and operate 20 of Connecticut's 27 hospitals (74%), with two systems (Yale New Haven Health and Hartford HealthCare) accounting for over half of the statewide market.** Hospital acquisitions and affiliations occurring over the last decade have increased consolidation in Connecticut. This consolidation has, in turn, resulted in several concentrated hospital markets within the state.

2. **Most Connecticut health systems had challenging years in fiscal year 2022 (FY22) and some in FY23. Despite this, Hartford HealthCare and Yale New Haven Health are in very strong financial positions. Trinity Health of New England is in a moderate financial position when considering the performance of its corporate parent, while Nuvance Health and Prospect Connecticut (Prospect CT) are struggling.** Prospect CT has reached a particularly concerning financial position and remains engaged in legal action related to a planned merger with Yale New Haven Health.

Connecticut's health systems with the largest net patient service revenue (Yale New Haven Health, Hartford Healthcare, and Trinity Health of New England) have substantial financial reserves and have maintained profitability even during the past few years, when the industry nationwide has struggled.

Overview of Connecticut's Hospital Landscape

Composition and Ownership

Connecticut has 27 non-federal, short-term, acute hospitals, 26 of which are privately owned.[7] Connecticut Children's Medical Center is a pediatric hospital. UConn's John Dempsey Hospital is the state's only public hospital.

Two health systems command over half of the statewide market in terms of both discharge volume and net patient revenue.

- The largest health system, **Yale New Haven Health**, is a nonprofit health system which consists of four hospitals across six campuses and accounts for roughly one third of the hospital market in Connecticut (approximately 31% of 2023 discharges and 35% of 2023 net patient revenue).[8] Yale New Haven Health is also the state's second largest employer.[9] Yale New Haven Health operates one hospital in Rhode Island in addition to its Connecticut facilities.

- **Hartford HealthCare** is also a nonprofit health system. It consists of seven hospitals across eight campuses and accounts for over a quarter of the market (approximately 29% of 2023 discharges and 27% of 2023 net patient revenue).[10]

Three other multi-hospital systems operate in the state: Trinity Health of New England (Trinity), Prospect Medical, and Nuvance Health.

- **Trinity Health of New England** operates three acute care hospitals in Connecticut and one in Massachusetts[11]; the Connecticut hospitals accounted for approximately 9% of discharges and 8% of net patient revenue in Connecticut in 2023.[12] Trinity Health of New England is a subsidiary of Michigan-based nonprofit Trinity Health, which owns 101 hospitals across the country and operates in 27 states. [13]

[7] Four hospitals have multiple campuses, as seen in Table 1.
[8] State of Connecticut Office of Health Strategy. Hospital Reporting System. Reports 550. 2023. FY2023 Report 550 was not available for Charlotte Hungerford Hospital, Midstate Medical Center, or The Hospital of Central Connecticut; 2022 data was used for these hospitals.
[9] Yale New Haven Health. *About Us*.
[10] State of Connecticut Office of Health Strategy. Hospital Reporting System. Reports 550. 2023. FY2023 Report 550 was not available for Charlotte Hungerford Hospital, Midstate Medical Center, or The Hospital of Central Connecticut; 2022 data was used for these hospitals.
[11] Trinity Health of New England, *About Us* and Trinity Health FY22 Audited Financial Statements
[12] State of Connecticut Office of Health Strategy. Hospital Reporting System. Reports 550. 2023. FY2023 Report 550 was not available for Charlotte Hungerford Hospital, Midstate Medical Center, or The Hospital of Central Connecticut; 2022 data was used for these hospitals.
[13] Trinity Health of New England. *About Us*.

- **Nuvance Health**, a nonprofit health system which operates three hospitals in Connecticut and three in the Hudson Valley of New York, made up 9% of 2023 discharges and 8% of 2023 net patient revenue.[14]
- **Prospect Medical Holdings**, a private equity-owned system based in California, operates three Connecticut hospitals as well as 11 across three other states.[15] **Prospect CT**, as Prospect's Connecticut operations are known, accounted for 6% of Connecticut discharges and 3% of net patient revenue in 2023.[16]

The remaining 17% of discharges and 18% of net patient revenue were distributed among seven independent hospitals in 2023.

Table 1 below lists key facts and statistics for Connecticut's non-federal, short-term, acute care hospitals, including location, system ownership, staffed beds, total discharges, patient days, and patient revenue.

Hospital Competition and Consolidation in Connecticut

Healthcare provider markets in the United States have become increasingly concentrated, and therefore less competitive. The Herfindahl-Hirschman Index (HHI) is a measure of concentration which examines the number and distribution of competitors within a market. The Health Care Cost Institute's (HCCI) Healthy Marketplace Index uses HHI to assess hospital concentration in hospital markets using healthcare claims for Medicare FFS members and commercially insured individuals. HCCI evaluated hospital concentration in three Connecticut metropolitan areas: Bridgeport-Stamford-Norwalk, Hartford-West Hartford-East Hartford, and New Haven-Milford. The Healthy Marketplace Index found the hospital markets in each metropolitan area to be concentrated in 2021 (the most recent year for which data are available), with the Bridgeport area being "moderately concentrated" and the other two metros being "highly concentrated."[17] These observations are consistent with the findings of OHS' 2024 report on hospital and health system consolidation in the state.[18]

[14] State of Connecticut Office of Health Strategy. Hospital Reporting System. Reports 550. 2023. FY2023 Report 550 was not available for Charlotte Hungerford Hospital, Midstate Medical Center, or The Hospital of Central Connecticut; 2022 data was used for these hospitals.
[15] Prospect Medical Holdings, Inc. *Hospital Locations*. Note that Prospect also owns two behavioral health facilities outside of Connecticut.
[16] State of Connecticut Office of Health Strategy. Hospital Reporting System. Reports 550. 2023. FY2023 Report 550 was not available for Charlotte Hungerford Hospital, Midstate Medical Center, or The Hospital of Central Connecticut; 2022 data was used for these hospitals.
[17] Health Care Cost Institute. *Hospital Concentration Index*. 2023.
[18] State of Connecticut Office of Health Strategy. Impacts of Connecticut Hospital and Health Care System Consolidation. 2024

Table 1 Statistics for non-federal, short-term general acute care hospitals in Connecticut[19]

Hospital	City	Health System	Staffed Beds	Percent of Total Beds	Total Discharges	Patient Days	Gross Patient Revenue ($000)
Backus Hospital	Norwich	Hartford HealthCare	187	2.2%	11,485	54,137	$1,465,140
Bridgeport Hospital	Bridgeport	Yale New Haven Health	429	5.0%	18,558	104,119	$2,879,282
Bridgeport Hospital Milford Campus	Milford	Yale New Haven Health	106	1.2%	2,032	9,873	$157,278
Bristol Hospital	Bristol	N/A	138	1.6%	4,478	20,547	$616,198
Charlotte Hungerford Hospital	Torrington	Hartford HealthCare	108	1.3%	5,283	23,824	$613,725
Connecticut Children's Medical Center	Hartford	N/A	187	2.2%	7,196	50,119	$1,186,662
Danbury Hospital	Danbury	Nuvance Health	374	4.3%	17,390	82,816	$2,501,320
Danbury Hospital New Milford Campus	New Milford	Nuvance Health	85	1.0%	1,636	6,716	$172,137
Day Kimball Hospital	Putnam	N/A	104	1.2%	3,104	12,687	$306,333
Greenwich Hospital	Greenwich	Yale New Haven Health	185	2.1%	10,082	49,433	$1,613,841
Griffin Hospital	Derby	N/A	117	1.4%	6,882	30,330	$1,069,720
Hartford Hospital	Hartford	Hartford HealthCare	946	11.0%	39,212	232,644	$5,563,497
Hospital of Central Connecticut Bradley Memorial Campus	Southington	Hartford HealthCare	42	0.5%	2,371	10,176	$95,778
Hospital of Central Connecticut New Britain Campus	New Britain	Hartford HealthCare	280	3.2%	12,790	72,345	$1,911,909
Johnson Memorial Hospital	Stafford Springs	Trinity Health	64	0.7%	1,112	3,839	$152,151
Lawrence and Memorial Hospital	New London	Yale New Haven Health	252	2.9%	11,276	61,650	$1,401,695
Manchester Memorial Hospital	Manchester	Prospect Medical Holdings	227	2.7%	6,547	27,490	$744,640
Middlesex Hospital	Middletown	N/A	207	2.6%	9,538	44,047	$1,619,957

[19] This list includes 31 hospitals, as four of Connecticut's 27 hospitals have multiple campuses. Note that though it is not a general acute care hospital, Connecticut Children's Medical Center is included on this list.

Financial Status – Hartford Health

Hospital	City	Health System	Staffed Beds	Percent of Total Beds	Total Discharges	Patient Days	Gross Patient Revenue ($000)
Midstate Medical Center	Meriden	Hartford HealthCare	143	1.7%	9,224	43,289	$1,072,129
Norwalk Hospital	Norwalk	Nuvance Health	206	2.4%	8,468	40,872	$1,210,884
Rockville General Hospital	Vernon	Prospect Medical Holdings	102	1.2%	228	732	$125,255
Saint Francis Hospital	Hartford	Trinity Health	485	5.6%	18,600	95,775	$2,881,890
Saint Mary's Hospital	Waterbury	Trinity Health	158	1.8%	7,356	29,481	$1,071,615
Saint Vincent's Medical Center	Bridgeport	Hartford HealthCare	315	3.7%	12,236	64,938	$1,922,481
Sharon Hospital	Sharon	Nuvance Health	67	0.8%	1,123	4,417	$138,943
Stamford Hospital	Stamford	N/A	305	3.5%	12,974	72,801	$3,589,181
John Dempsey Hospital	Farmington	University of Connecticut Health Center	159	1.8%	10,170	43,840	$1,768,000
Waterbury Hospital	Waterbury	Prospect Medical Holdings	244	2.8%	10,778	50,254	$1,069,736
Windham Hospital	Willimantic	Hartford HealthCare	46	0.5%	2,104	7,413	$366,278
Yale New Haven Hospital	New Haven	Yale New Haven Health	1,601	18.6%	58,314	408,610	$11,966,398
Yale New Haven Saint Raphael Campus	New Haven	Yale New Haven Health	573	6.7%	19,829	95,382	$1,343,588
		TOTAL	**8,629**	**100%**	**335,180**	**1,804,477**	**$51,410,981**

SOURCE: American Hospital Directory.

Consolidation Trends and Attempts

Similar to changes in hospital markets across the country, Connecticut has seen actual and proposed changes in the ownership, management, and affiliations of acute care hospitals in recent years:

In 2013, Backus Hospital affiliated with Hartford HealthCare.[20]

In 2014 and 2015, Trinity Health (MI) entered the Connecticut market by acquiring Saint Francis, Saint Mary's, and Johnson Memorial Hospitals.[21,22,23]

In 2016, Yale New Haven Health acquired Lawrence and Memorial Hospital.[24]

In 2016, Prospect Medical Holdings acquired Eastern Connecticut Health Network (comprised of Manchester Memorial Hospital and Rockville General Hospital) and Waterbury Hospital.[25]

In 2017, Charlotte Hungerford Hospital affiliated with Hartford HealthCare.[26]

The Connecticut hospital landscape experiences multiple changes in 2019:

- Nuvance Health was formed by the merger of Western Connecticut Health System's four hospitals with Health Quest Systems, which owned Sharon Hospital as well as three hospitals in New York.[27]
- Hartford HealthCare acquired Saint Vincent's Medical Center.[28]
- Yale New Haven Health's Bridgeport Hospital acquired Milford Hospital.[29]

The impacts of these acquisitions and affiliations on the Connecticut healthcare marketplace were recently outlined in a report developed for the state by Altarum.[30] The report found that hospital consolidation from 2013 to 2019 led to increased market power between 2016 and

[20] Adam Benson. "Backus, Hartford HealthCare affiliation wins state approval," *Norwich Bulletin.* July 24, 2013.
[21] "Saint Francis and Trinity Health announce merger," *HealthCare Dive.* December 18, 2014.
[22] Arielle Levin Becker. "St. Mary's Hospital to join national chain, St. Francis," *CT Mirror.* September 19, 2015.
[23] Tim Jenson. "Johnson Hospital Acquired by Trinity Health - New England," *Patch*. December 1, 2015.
[24] Mary O'Leary. "Lawrence + Memorial agrees to join Yale New Haven Health System," *New Haven Register.* July 15, 2015.
[25] Prospect Medical Holdings, Inc. *Prospect Medical Holdings Background*.
[26] Ben Lambert. "Charlotte Hungerford Hospital to enter into affiliation with Hartford HealthCare," *CT Insider*. November 21, 2017.
[27] Lanning Taliaferro. "Network Formerly Known As HealthQuest Reveals New Name, Look," *Patch*. August 19, 2019.
[28] "St. Vincent's Medical Center joins Hartford HealthCare," *Hartford HealthCare*. October 1, 2019.
[29] Michael C Bingham. "YNHH gets green light to acquire Milford Hospital," *Hartford Business Journal*. June 11, 2019.
[30] Altarum on behalf of State of Connecticut Office of Health Strategy. *Impacts of Connecticut Hospital and Health Care System Consolidation (2016-2021)*. March 26, 2024.

2021 for hospitals in seven (of nine) Connecticut regions, resulting in faster growing inpatient and outpatient prices for the hospitals that gained market power.

There are additional consolidating transactions in the state that are in progress as of the completion date of this report:

- In 2022, Yale New Haven Health reached agreement to buy Prospect Medical's three Connecticut hospitals. In May 2024, Yale New Haven announced that it was suing Prospect for "defaulting on rent and tax liabilities, allowing its facilities to deteriorate, mismanaging assets, driving away physicians and vendors and engaging in a pattern of irresponsible financial practices."[31] Prospect has filed a countersuit.[32] On January 11, 2025, the parent company of Prospect CT Inc. filed for Chapter 11 Bankruptcy in the US Bankruptcy Court in Northern Texas.
- In February 2024, Nuvance Health announced its intention to join Northwell Health, a transaction that would see Nuvance's system of eight hospitals in Connecticut and New York become part of a 28-hospital system across the two states.[33]

[31] Jenna Carlesso. "Yale New Haven Health wants out of deal to buy Prospect hospitals," *CT Mirror*. May 3, 2024.
[32] Jenna Carlesso. "Prospect Medical files countersuit against YNHH in hospital sale," *CT Mirror*. June 6, 2024.
[33] Jenna Carlesso. "Nuvance hospital system to merge with Northwell Health," *CT Mirror.* February 28, 2024.

Financial Status

Rising hospital spending and prices put growing pressure on Connecticut households, employers, state and local government. Hospitals' financial status – their ability to operate sustainably, adequately funding their operations so that they can provide services to patients and communities – is an equally important concern. Between January and May 2024 alone, 13 hospital and emergency departments closed nationally.

This report presents analysis of financial performance for Connecticut's five multi-hospital health systems: Hartford HealthCare Corporation, Nuvance Health, Inc., Prospect CT, Inc., Trinity Health of New England, Inc., and Yale New Haven Health Services Corporation. This report assesses financial performance based on six years of consolidated audited financial statements and data submissions to OHS and compares those results to national median ranges ("reference ranges"), guided by Fitch Ratings national medians for more than 200 non-profit hospitals and healthcare systems from 2013-2022 (the most recent data available[34]). These ranges provide an indicator of **relative financial health** but do not necessarily represent desirable financial performance from a policy perspective.

In addition to providing contextual information about each system (net patient service revenue (NPSR) and payer mix), we assess their financial performance across eight measures of profitability, liquidity, solvency, and adequacy of capital spending, outlined in the Guide to Understanding Hospital Spending through Financial Analysis, published through the Peterson-Milbank Program for Sustainable Health Care Costs.[35] **Appendix B provides more information on the calculation and interpretation of each indicator.**

When assessing health system financial status, we considered performance in totality. We reviewed performance and trends across six years, as some measures can demonstrate significant volatility from year-to-year and short-term performance can be misleading. Readers should note that of the eight measures, Days Cash on Hand (DCOH) is a particularly critical indicator; it reflects multiple years of financial performance up to the latest fiscal year. Additionally, without sufficient cash, an organization will be unable to meet its financial obligations.

[34] The year 2022 was generally a challenging one for the hospital industry, as it coped with the multiple effects of higher input costs and a tight labor market due to COVID-19. Updated data for 2023 will be published by Fitch Ratings in the summer of 2024.
[35] Pauly, et al. "Guide to Understanding Hospital Spending through Financial Analysis," Peterson-Milbank Program for Sustainable Health Care Costs. April 2024. The eight measures were selected as high-priority indicators following consultation with Nancy Kane, Professor of Health Policy and Management, Emerita at the Harvard School of Public Health. Dr. Kane has extensively studied and published on the financial and managerial performance of healthcare organizations for over 40 years.

Hartford HealthCare Corporation

Hartford HealthCare Corporation (HHCC) is one of Connecticut's two dominant hospital systems; it operates seven Connecticut hospitals across eight campuses as well as a physician group, inpatient and outpatient behavioral health provider organizations, a home health agency, nursing homes, rehabilitation facilities, and other holdings.

The financial ratios and findings below rely on data and information from HHCC's consolidated audited financial statements, augmented by data HHCC submitted to OHS.[36]

Table 2 Hartford HealthCare - Net Patient Service Revenue and Payer Mix

	2023
Net Patient Service Revenue	$5.19 billion
Payer Mix (as a Percentage of NPSR)	
Medicare	40%
Medicaid	12%
Commercial	45%
Self-Pay	3%

SOURCE: Hartford HealthCare FY2023 Audited Financial Statements. Payer Mix: "Medicare" includes Medicare Advantage plans; "Medicaid" includes Connecticut Medicaid revenue and Medicaid/Medicaid managed care plan revenue from other states.

[36] The authors relied on audited financial statements as the primary data source for every health system with the exception of Prospect CT. The authors elected to use audited financial statement data rather than data submitted by health systems to OHS for multiple reasons:

- Level of detail available in audited financial statements and footnotes - In some cases, audited financial statement data were more detailed than data collected by OHS, and footnotes to audited financial statements provide valuable additional detail and explanation. Note that footnotes are provided for the consolidated entity only, and generally cannot be used for analysis of Connecticut operations only.
- Ability to produce system-level analyses - OHS reports are limited to each system's Connecticut operations, and hence less appropriate for systems with a significant proportion of out-of-state business. This is particularly important for the two systems – Nuvance and Trinity – that have a larger proportion of business in other states; in these instances, consolidating statements to the audited financial statements and health system-submitted reports to OHS were used to analyze of Connecticut-only business.

For Prospect CT, OHS reports were the primary data source; they provided more detail than the audited financial statements submitted to OHS.

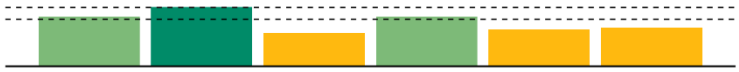
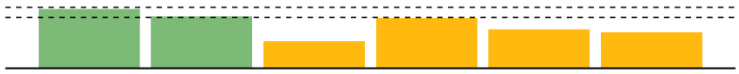
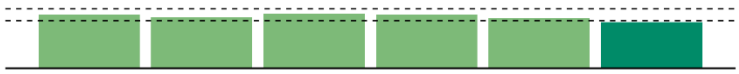
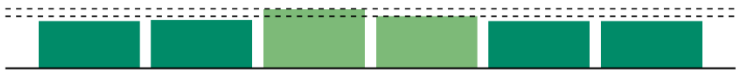
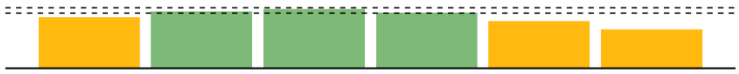
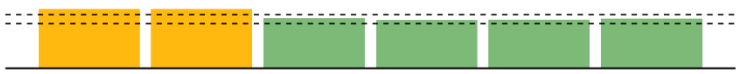
Note that figures in audited financial statements and OHS reports do not always align; reasons include exclusion of out-of-state operations from OHS reports, and use of different categories and reporting practices in audited financial statements than in OHS reports. OHS reports are available through the OHS Hospital Reporting System "Reports" page. Audited financial statements are available through the OHS Hospital Reporting System "Financial Documents" page, as well as through public sources such as DACBond, Electronic Municipal Market Access (EMMA) (nonprofit hospitals), Electronic Data Gathering, Analysis and Retrieval (EDGAR) system (publicly traded companies), and the Federal Audit Clearinghouse (organizations receiving federal funds over a certain threshold).

Though the system has experienced lower-than-historical profitability in recent years, **HHCC has a very strong financial position (see** Figure 1**.** It benefits from significant market share, the second largest net revenue in the state, and unrestricted net assets, owned outright, without debt financing, of $3.1 billion. HHCC saw high growth during the FY18-FY23 review period; Hartford's NPSR[37] grew 7% from FY22 to FY23 and an average of 13% over the six-year period. During the same period, HHCC's profitability remained strong, particularly when excluding interest, tax, depreciation, and amortization expenses (EBITDA); liquidity was strong; covered its debts; and appeared to be adequately funding capital expenditures. In addition, it had high levels of unrestricted cash, investments, and board-designated funds (over $2 billion) available if it faces challenges in the years ahead. Based on two of the major bond rating agencies, Fitch and Standard & Poor standards Hartford's payer mix is adequate.[38] Revenue from government payers revenue represented just over half of HHCC's NPSR in FY23.

[37] Where sourced from OHS reports, NPSR is NPSR less Provision for Bad Debt.

[38] Standard & Poor considers extremely or very strong payer mix to be NPSR less than 25% Medicare, less than 5% Medicaid, and more than 55% commercial; strong or adequate payer mix to be NPSR 25-50% Medicare, 5-20% Medicaid, and 30-55% commercial; and vulnerable or highly vulnerable payer mix to be NPSR over 50% Medicare, over 20% Medicaid, or less than 30% commercial. Fitch Ratings considers combined Medicaid and self-pay gross revenue below 25% to be adequate, while combined Medicaid and self-pay gross revenue above 30% is considered very weak. Note: Moody's rating criteria related to payer mix were not publicly available. "Criteria | Governments | U.S. Public Finance: U.S. And Canadian Not-For-Profit Acute Care Health Care Organizations," *S&P Global*. April 1, 2022. "U.S. Not-For-Profit Hospitals and Health Systems Rating Criteria," *Fitch Ratings*. November 18, 2020.

Figure 1 Hartford HealthCare – Summary of Financial Status

Financial Measures	Performance Relative to Reference Range 2018 2019 2020 2021 2022 2023	Reference Range
Operating EBITDA Margin		8-10%
Total EBITDA Margin		10-12%
Days Cash on Hand (all unrestricted sources)		100-200
Days in Patient Accounts Receivable*		40-50
Long-Term Debt to Capitalization*		35-40%
EBITDA Debt Service Coverage		3-4
Capital Expenditures to Depreciation		105-115%
Average Age of Plant*		10-12

* Lower value indicates more favorable financial performance for indicated measures. NOTES: Dashed lines = reference range. Solid line = 0. Dark green bars indicate performance favorable compared with reference range; light green bars indicate performance within reference range; yellow bars indicate performance unfavorable compared with reference range.

The following analysis reviews HHCC performance on key measures of profitability, liquidity, solvency, and capital expenditures over the years FY18-FY23.

Profitability: HHCC demonstrated strong profitability during the FY18-23 period, particularly for EBITDA measures years averaging a 7.6% operating EBITDA margin and an 8.7% total EBITDA margin, annually. While profitability was generally below the reference range for FY20-23, operating and total EBITDA margins exceeded 5% every year. In the most recent year analyzed, HHCC had an operating and total EBITDA margin of 6.5% and 7.1%, respectively.

Table 3 Hartford HealthCare - Profitability Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Operating EBITDA Margin	8.4%	10.1%	5.7%	8.4%	6.3%	6.5%	8-10%
Total EBITDA Margin	11.7%	10.2%	5.4%	9.9%	7.7%	7.1%	10-12%

SOURCE: Hartford HealthCare Audited Financial Statements, FY2018-FY2023.

Liquidity: HHCC's DCOH was comfortably within the reference range when investments and other assets limited as to use were included as funds available within one year if needed. This is in line with a 2023 rating action commentary by Fitch Ratings affirming HHCC's A+ bond rating, which referenced HHCC's 152 DCOH.[39] HHCC successfully received timely payment for patient services, reflected by days in patients accounts receivable within the reference range or favorably low over the six years reviewed.

Table 4 Hartford HealthCare – Liquidity Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Days Cash on Hand (all unrestricted sources)	177.8	168.6	171.9	176.8	156.4	146.5	100-200
Days in Patient Accounts Receivable*	45.4	43.0	46.2	45.3	42.2	38.7	40-50

SOURCE: Hartford HealthCare Audited Financial Statements, FY2018-FY2023.

* Lower value indicates more favorable financial performance for indicated measures.

Solvency: HHCC's OHS-reported financials reveal healthy solvency. This includes favorably low long-term debt to capitalization, a measure which compares debt to available assets; performance was within or below the reference range for all years analyzed. HHCC saw some fluctuation in EBITDA Debt Service Coverage during the period of analysis, but performance was generally favorable compared to the reference range. The exceptions were FY20 and FY23, which saw very low EBITDA Debt Service Coverage (0.7 and 2.0 respectively). In FY20, this was caused by low excess of revenue over expenses along with notably high payments of long-term debt in that year; in FY23, it was caused by high prior year current long-term debt due to use of a $100 million line of credit in FY22. HHCC's EBITDA Debt Service Coverage ratio improved in FY21 due to large excess of revenue over expenses along with low payments of long-term debt in that year. Note that for purposes of this analysis, unrealized changes in investment portfolio value and restricted net assets were excluded from the calculation.

[39] The discrepancy between Fitch's Days Cash on Hand calculation for FY22 and the data presented here is likely due to additional knowledge held by the rating agency regarding limited use assets that may be available for use within one year, e.g., for debt-repayment purposes. Note that OHS calculates Hartford's Days Cash on Hand as well below the reference range, varying between from 41-45 between FY18 and FY23, representing only cash and cash equivalents and short-term investments.

Table 5 Hartford HealthCare – Solvency Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Long-Term Debt to Capitalization*	31.6%	32.4%	39.5%	35.2%	31.7%	31.6%	35-40%
EBITDA Debt Service Coverage	3.6	6.6	0.7	12.1	7.0	2.0	3-4

SOURCE: Hartford HealthCare Audited Financial Statements, FY2018-FY2023.

* Lower value indicates more favorable financial performance for indicated measures.

Capital Expenditures: From FY18-23, HHCC's five-year average capital spending was 98% of depreciation, indicating that the system was largely maintaining its assets, rather than investing in major improvements; however, this followed major investments (140% of depreciation) in FY17, and may represent the cyclical nature of capital spending.

Table 6 Hartford HealthCare – Capital Expenditure Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Capital Expenditures to Depreciation	97%	108%	113%	106%	90%	74%	105-115%
Average Age of Plant*	13.3	13.3	11.2	10.8	10.9	11.1	10-12

SOURCE: Hartford HealthCare Audited Financial Statements, FY2018-FY2023.

* Lower value indicates more favorable financial performance for indicated measures.

Nuvance Health

Nuvance Health is a six-hospital system, operating three hospitals across four campuses in Connecticut[40] and three in New York, in addition to outpatient facilities and physician organizations, a surgery center, a nursing home, home care providers, and urgent care. It was formed in 2019 through the merger of Western Connecticut Health Network (CT) and Health Quest Systems (NY).

The financial ratios and related findings below focus on Nuvance's entire operations, based on publicly available consolidated audited financial statements, and on Connecticut operations from OHS reports and consolidating statements to the audited financial statements.[41] Local hospital performance must be viewed in the context of its corporate parent, the finances of which are likely to drive resource allocation, internal transfers from the affiliate back to the parent organization, and in extreme circumstances, decisions related to service line reductions or facility closures. Data sources are noted throughout this section. The 2019 merger that created Nuvance makes longer-term tracking of trends challenging. Where necessary, this analysis uses data on Nuvance's Connecticut operations from the audited financial statements consolidating statements for multi-year comparisons between the former Western Connecticut Health Network and Nuvance's Connecticut hospitals only, and calculates multi-year averages during the post-merger period only (FY20-FY23).

Table 7 Nuvance Health – Net Patient Service Revenue and Payer Mix

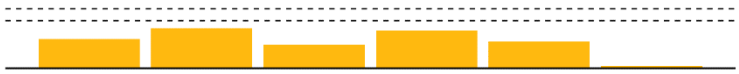
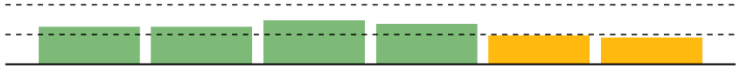
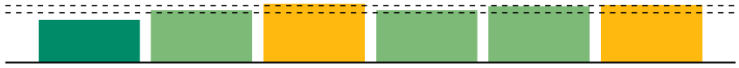
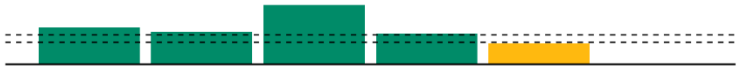
	2023
Net Patient Service Revenue	$2.56 billion
Net Patient Service Revenue – CT Only	$1.39 billion *54% of total NPSR*
Payer Mix (as a Percentage of NPSR)	
Medicare	43%
Medicaid	9%
Commercial	48%
Self-Pay	0%

SOURCE: Nuvance Health FY2023 Audited Financial Statements; includes non-CT subsidiaries. Connecticut-only NPSR drawn from Consolidating Statements to the FY2023 Audited Financial Statements. Payer Mix: "Medicare" includes Medicare Advantage plans; "Medicaid" includes Connecticut Medicaid revenue and Medicaid/Medicaid managed care plan revenue from other states.

[40] Note: OHS submissions consider the Danbury and New Milford campuses of Danbury Hospital as one entity; other sources refer to Nuvance as a seven-hospital system, with four hospitals in Connecticut.
[41] Recent rating actions by Moody's and S&P were also considered.

Nuvance Health is in a weak financial position (see Figure 2). Various measures of profitability, liquidity, and solvency show that performance in FY22 and FY23 was concerning. Both Moody's and S&P issued rating downgrades and negative outlooks to Nuvance in 2023; this was the second downgrade from S&P since 2022. One factor cited by both rating agencies was a FY23 drop in unrestricted net assets of nearly $84 million from the FY22 total of $1.48 billion. Both rating agencies also point to multiple years of low operating profit – and in FY23, an operating loss of $164 million, reductions in liquid assets, and high expenses that will continue to impact profitability. These factors are discussed in more depth below. The rating agencies' commentaries suggested that Nuvance was likely to be required by bondholders to bring on consultants to help address low performance, a sign of significant financial concern. For Nuvance, this was driven by low Debt Service Coverage, which has been below levels required in bond covenants for two consecutive years. Nuvance has an adequate payer mix, with just over half of its patient revenue from government payers but only 9% from Medicaid or self-pay in FY23.

Figure 2 Nuvance Health – Summary of Financial Status

Financial Measures	Performance Relative to Reference Range 2018 2019 2020 2021 2022 2023	Reference Range
Operating EBITDA Margin		8-10%
Total EBITDA Margin		10-12%
Days Cash on Hand (all unrestricted sources)		100-200
Days in Patient Accounts Receivable*		40-50
Long-Term Debt to Capitalization*		35-40%
EBITDA Debt Service Coverage		3-4
Capital Expenditures to Depreciation		105-115%
Average Age of Plant*		10-12

* Lower value indicates more favorable financial performance for indicated measures. NOTES: Dashed lines = reference range. Solid line = 0. Dark green bars indicate performance favorable compared with reference range; light green bars indicate performance within reference range; yellow bars indicate performance unfavorable compared with reference range.

In February 2024, Northwell Health and Nuvance announced an agreement to merge. Northwell is New York's largest health system; in FY23 it had just under $14 billion in NPSR and over $6

billion in net assets.[42] In Moody's analysis of the merger announcement, the rating agency finds that this merger would be "credit positive" for Nuvance, but was unlikely to harm Northwell's credit.[43]

The following analysis reviews Nuvance's performance (and Western Connecticut Health Network's in FY18-19) on key measures of profitability, liquidity, solvency, and capital expenditures over FY18-FY23.

Profitability: During the FY18-FY23 period, Western Connecticut Health Network and Nuvance showed moderate Operating EBITDA and Total EBITDA Margins, with margins dropping at the end of the review period. Though margins were below the reference for every year reviewed, they were nonetheless positive, indicating that the system was profitable after removal of financing and non-cash expenses (interest, depreciation, and amortization). Like many systems, Nuvance saw lower profitability in FY20, with some improvement in FY21 and challenges again in FY22. These numbers were supported by federal COVID-19 relief funding; when these funds are excluded, Total EBITDA Margin was considerably lower: 0.8% in FY20, 6.6% in FY21, and 4.0% in FY22. Nuvance's profitability was lowest in FY23, when Operating and Total EBITDA margins were just above breakeven.

Nuvance's Connecticut operations show similar profitability to the system as a whole. Since its first year of operation as Nuvance (FY20), the system had a system-wide average Operating EBITDA Margin of 3.9%, similar to the 4.1% four-year average for Nuvance's Connecticut operations; average system-wide Total EBITDA Margin was 5.5%, slightly lower than the 6.4% achieved by Connecticut operations. As with the full Nuvance system, performance was lowest in FY22 and FY23.

Table 8 Nuvance Health – Profitability Measures

Financial Measures	2018 *Western CT HN*	2019 *Western CT HN*	2020 *Nuvance Health*	2021 *Nuvance Health*	2022 *Nuvance Health*	2023 *Nuvance Health*	Reference Range
Operating EBITDA Margin	4.9%	6.7%	4.0%	6.4%	4.5%	0.4%	8-10%
Operating EBITDA Margin – CT Only			4.7%	6.6%	2.9%	2.3%	
Total EBITDA Margin	8.2%	7.5%	7.6%	8.1%	6.0%	0.3%	10-12%
Total EBITDA Margin – CT Only			9.3%	9.3%	5.0%	2.0%	

SOURCE: Nuvance Health Audited Financial Statements, FY20-23 (includes non-CT subsidiaries) and Western Connecticut Health Network Audited Financial Statements, FY18-19. Connecticut-only values drawn from CT OHS reports, with additional detail from consolidating statements of the Western Connecticut Health Network and Nuvance Health Audited Financial Statements.

[42] Northwell Health FY23 Audited Financial Statement; NPSR total is inclusive of physician practice revenue.
[43] Moody's rates Northwell as A3 stable and Nuvance as Baa3 negative.

Liquidity: As of FY23, Nuvance had moderate liquidity. Days Cash on Hand was within the reference range for FY18-21, though cash in FY20-21 was bolstered by one-time federal COVID-19 relief funds; without this additional cash infusion, Days Cash on Hand would have been 120.8 and 130.9 days, respectively. Days Cash on Hand dropped below the reference range in FY22 and declined again in FY23. Days in Accounts Receivable was within or favorably below the reference range, indicating timely collection of payments related to care delivery.

Nuvance's Connecticut Hospitals show higher Days Cash on Hand than the system as a whole for FY20, after which performance fell below the system as a whole; performance fell below the reference range for every year after FY21. However, this is less relevant than system-level Days Cash on Hand and may reflect corporate practices for carrying cash at the parent organization rather than throughout the system. Nuvance's Connecticut hospitals are efficient at collecting payments for patient care, with Days in Patient Accounts Receivable within or just below the reference range.

Table 9 Nuvance Health – Liquidity Measures

Financial Measures	**2018** *Western CT HN*	**2019** *Western CT HN*	**2020** *Nuvance Health*	**2021** *Nuvance Health*	**2022** *Nuvance Health*	**2023** *Nuvance Health*	**Reference Range**
Days Cash on Hand (all unrestricted sources)	125.8	126.4	147.7	136.7	96.1	90.0	100-200
Days Cash on Hand (all unrestricted sources) – CT Only			156.2	117.4	68.3	79.0	
Days in Patient Accounts Receivable*	46.1	41.7	39.4	38.7	41.7	38.2	40-50
*Days in Patient Accounts Receivable – CT Only**			40.2	42.6	41.9	38.6	

SOURCE: Nuvance Health Audited Financial Statements, FY20-23 (includes non-CT subsidiaries) and Western Connecticut Health Network Audited Financial Statements, FY18-19. Connecticut-only values drawn from CT OHS reports, with additional detail from consolidating statements of the Western Connecticut Health Network and Nuvance Health Audited Financial Statements.

* Lower value indicates more favorable financial performance for indicated measures

Solvency: During the FY18-23 period, Nuvance's performance on two measures of solvency deteriorated. Long-Term Debt to Capitalization was unfavorably high or at the top of the reference range for FY20 and FY22-23, indicating relatively low cash available to pay debts. EBITDA Debt Service Coverage was above or within the reference range until FY22, when it dropped below the reference range. However, EBITDA Debt Service Coverage was again below the reference range in FY23 (0.11). As mentioned above, low performance on Debt Service

Coverage resulted in a breach of debt covenants. As a result, Nuvance's bond agreements require that they bring on a consultant to address low performance.

Nuvance's Connecticut operations performed better on Long-Term Debt to Capitalization than the system as a whole; performance was favorably low on this measure. Performance on EBITDA Debt Service Coverage was mixed compared to the system, but also dropped sharply in FY23. As with liquidity, Connecticut-only performance these measures are likely skewed by corporate practices related to how debt is managed at the system-level and are less meaningful than Nuvance's system-level performance on liquidity measures.

Table 10 Nuvance Health – Solvency Measures

Financial Measures	**2018** *Western CT HN*	**2019** *Western CT HN*	**2020** *Nuvance Health*	**2021** *Nuvance Health*	**2022** *Nuvance Health*	**2023** *Nuvance Health*	**Reference Range**
Long-Term Debt to Capitalization*	29.8%	36.6%	41.3%	36.8%	39.5%	40.5%	35-40%
*Long-Term Debt to Capitalization – CT Only**			35.4%	29.7%	29.5%	30.1%	
EBITDA Debt Service Coverage	5.0	4.4	8.1	4.2	2.9	0.1	3-4
EBITDA Debt Service Coverage – CT Only			6.6	6.4	3.1	1.3	

SOURCE: Nuvance Health Audited Financial Statements, FY20-23 (includes non-CT subsidiaries) and Western Connecticut Health Network Audited Financial Statements, FY18-19. Connecticut-only values drawn from CT OHS reports, with additional detail from consolidating statements of the Western Connecticut Health Network and Nuvance Health Audited Financial Statements.

* Lower value indicates more favorable financial performance for indicated measures.

Capital Expenditures: Capital Expenditures to Depreciation is unfavorable compared to the reference range for most years reviewed; however, major investments in FY20 resulted in a six-year average of 97%; this may reflect the cyclical nature of capital spending, though it is still below the reference range. Nuvance's Average Age of Plant was unfavorably high in FY23, indicating that the system may need to make additional capital investments to maintain its facilities and invest in current technology.

Nuvance's Connecticut hospitals appear not to have received considerable capital investments since the merger; the five-year average of Capital Expenditures to Depreciation is 72%, and only 62% since the merger. This lack of investment has led to rising Average Age of Plant, now well above the reference range for Nuvance's Connecticut hospitals.

Table 11 Nuvance Health – Capital Expenditure Measures

Financial Measures	2018 *Western CT HN*	2019 *Western CT HN*	2020 *Nuvance Health*	2021 *Nuvance Health*	2022 *Nuvance Health*	2023 *Nuvance Health*	Reference Range
Capital Expenditures to Depreciation	95%	85%	194%	93%	63%	64%	105-115%
Capital Expenditures to Depreciation – CT Only			57%	70%	69%	53%	
Average Age of Plant*,	12.4	12.9	14.4	14.5	13.4	14.5	10-12
*Average Age of Plant – CT Only**			13.6	15.2	15.2	15.9	

SOURCE: Nuvance Health Audited Financial Statements, FY20-23 (includes non-CT subsidiaries) and Western Connecticut Health Network Audited Financial Statements, FY18-19. Connecticut-only values drawn from CT OHS reports, with additional detail from consolidating statements of the Western Connecticut Health Network and Nuvance Health Audited Financial Statements.

* Lower value indicates more favorable financial performance for indicated measures.

Prospect CT

Prospect CT (Prospect) is the Connecticut subsidiary of Prospect Medical Holdings (CA), a private equity-owned system which operates hospitals in four states, in addition to behavioral health facilities and outpatient physician practices.

The financial ratios and findings below focus on Prospect CT, largely using data reported by Prospect CT to OHS, which is the most detailed data source for this entity, with additional detail from the Prospect CT audited financial statements submitted to OHS; other data sources are noted as needed. Prospect CT would most accurately be considered in the context of its corporate parent. Financial performance of the corporate parent is likely to drive resource allocation, internal transfers from the affiliate back to the parent organization, and in extreme circumstances, decisions related to service line reductions or facility closures. However, as a private equity-owned entity, parent company Prospect Medical Holdings' audited financial statements are not publicly available, and hence discussion of the parent organization's financial status is limited to other sources where information is available.

Table 12 Prospect CT – Net Patient Service Revenue and Payer Mix

	2023
Net Patient Service Revenue	$556.3 million
Payer Mix (as Percentage of NPSR)	
Medicare	42%
Medicaid	17%
Managed Care/Commercial	38%
Self-Pay/Other	3%

SOURCES: CT OHS; Prospect CT FY2023 Audited Financial Statements.

The data available and discussed below suggest that Prospect CT is in a concerning financial position (see Figure 3). This finding is echoed by recent court filings regarding Prospect's planned merger with Yale New Haven Health, which have been widely reported in Connecticut and national news sources. These filings claim that Prospect has failed to operate its Connecticut hospitals in good faith, including paying rent and other expenses.[44,45,46,47,48,49] In addition, separate court filings by the Connecticut Hospital Association allege Prospect has

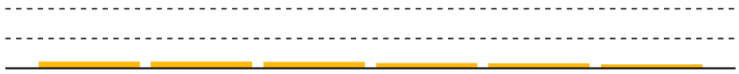
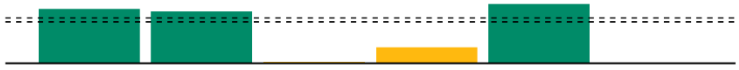
[44] Jenna Carlesso. "Yale New Haven Health wants out of deal to buy Prospect hospitals," *CT Mirror.* May 3, 2024.
[45] Emily Olsen. "Yale New Haven sues to get out of Prospect hospital acquisition," *Healthcare Dive.* May 8, 2024.
[46] YNHHS v. PMH Court Filings.
[47] Jenna Carlesso. "Prospect Medical files countersuit against YNHH in hospital sale," *CT Mirror*. June 6, 2024.
[48] Ed Stannard. "Prospect Medical sues Yale New Haven to try to force it to buy three CT hospitals," *Hartford Courant*. June 6, 2024.
[49] YNHHS v. PMH Countersuit Court Filings.

failed to pay membership dues.[50] **Though limited information is available related to Prospect Medical Holdings (CA), a few notable findings suggest concerning financial position among the parent organization as well**. In 2019, Moody's withdrew Prospect Medical Holdings' credit rating from a prior rating of B3 (non-investment grade) with a negative outlook. A May 2024 S&P rating action for Medical Properties Trust, [51] Prospect Medical Holdings' major landlord, states: "…[O]ne of the company's largest tenants, Prospect Medical Holdings, had significant operational issues in 2023 and completed a recapitalization plan including a rent restructuring in May 2023. Following this recapitalization, Prospect made expected rent payments through early 2024 but has either paid rent late or short-paid rent each of the past few months. Medical Properties Trust provided financial support to Prospect in the past, and the recent payment issues reintroduce the risk of further support, along with uncertain rent collections." Prospect's operations in other states face allegations similar to those made by Yale New Haven Health and the Connecticut Hospital Association; a judge recently required Prospect Medical Holdings to pay vendors $17 million within 10 days to cover outstanding invoices on behalf of its two Rhode Island hospitals.[52] On January 11, 2025, the parent company of Prospect CT Inc. filed for Chapter 11 Bankruptcy in the US Bankruptcy Court in Northern Texas.

In FY23, Prospect had unrestricted net assets/stockholder's equity of -$95.6 million,[53] reflecting negative assets owned outright and without debt financing. Average NPSR growth from FY18-23 was flat (0.0%). As of FY23, Prospect's payer mix is adequate, with 40% of revenue from commercial payers; at 17%, it has a higher proportion of revenue from Medicaid than most other Connecticut health systems reviewed in this report.

[50] Dave Altimari. "Prospect Medical sued by CT Hospital Association over unpaid fees," *CT Mirror.* May 15, 2024.
[51] "Medical Properties Trust Inc. Downgraded To 'B-' From 'B+' On Tenant Struggles, Refinancing Concerns; Outlook Negative," *S&P Global. May 16, 2024.*
[52] Ian Donnis. "Judge orders owner of two Rhode Island hospitals to pay $17 million," *The Public's Radio*. June 12, 2024.
[53] FY23 Draft Audited Financial Statements for Prospect CT. This number varies from that provided to CT OHS (-$91.9 million).

Figure 3 Prospect CT – Summary of Financial Status

Financial Measures	Performance Relative to Reference Range 2018 2019 2020 2021 2022 2023	Reference Range
Operating EBITDA Margin		8-10%
Total EBITDA Margin		10-12%
Days Cash on Hand (all unrestricted sources)		100-200
Days in Patient Accounts Receivable*		40-50
Long-Term Debt to Capitalization*		35-40%
EBITDA Debt Service Coverage		3-4
Capital Expenditures to Depreciation**		105-115%
Average Age of Plant*,**		10-12

** Prospect CT did not report FY23 depreciation and amortization amounts, so it is not possible to calculate Capital Expenditures to Depreciation or Average Age of Plant for that year.

* Lower value indicates more favorable financial performance for indicated measures. NOTES: Dashed lines = reference range. Solid line = 0. Dark green bars indicate performance favorable compared with reference range; light green bars indicate performance within reference range; yellow bars indicate performance unfavorable compared with reference range.

The following analysis reviews Prospect's performance on key measures of profitability, liquidity, solvency, and capital expenditures over the years FY18-FY23.

Profitability: Prospect had low profitability compared with the reference range for most years and saw losses for Operating and Total EBITDA Margins in FY22 and FY23. Losses were significant in FY23, with Total EBITDA Margin in the negative double digits. From FY18-FY23, average Operating and Total EBITDA Margins were 1.5% and 0.1%, respectively.

Table 13 Prospect CT – Profitability Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Operating EBITDA Margin	6.2%	3.7%	6.8%	3.3%	(1.6%)	(9.3%)	8-10%
Total EBITDA Margin	6.0%	2.0%	5.2%	0.4%	(0.7%)	(12.5%)	10-12%

SOURCE: CT OHS; Prospect CT Audited Financial Statements for FY18-23 (income tax amounts).

Liquidity: From FY18-23, Prospect kept very little cash on hand, reflected in Days Cash on Hand below 25 for every year reviewed. Low cash on hand is typical of for-profit hospitals, and may reflect a corporate practice of carrying cash at the parent organization rather than throughout the system; however, given concerns about Prospect's ability to pay bills and keep up with expenses, it may in fact reflect low cash systemwide. Prospect was successful in timely collection of patient accounts receivable between FY18-22, apparent in Days in Patient Accounts Receivable within or just above the reference range; however, this was not the case for the most recent year, when Audited Financial Statement data showed Days in Patient Accounts Receivable to be very unfavorable (71.5 days) compared to the reference range.

Table 14 Prospect CT – Liquidity Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Days Cash on Hand (all unrestricted sources)	22.5	23.6	20.4	17.0	15.7	13.4	100-200
Days in Patient Accounts Receivable*	52.9	48.7	40.7	41.1	28.3	71.5	40-50

SOURCE: CT OHS; Prospect CT Audited Financial Statements for FY18-23 (income tax amounts).

* Lower value indicates more favorable financial performance for indicated measures.

Solvency: In FY21-23, Prospect performed unfavorably compared to reference ranges on solvency measures, indicating its high debt compared with its revenue and assets. Long-Term Debt to Capitalization was within the reference range for FY18-19, and just slightly unfavorably above the reference range in FY20. However, this measure increased sharply in FY21 indicating very little capital compared to debt; the extremely high value for FY22 reflects Prospect's negative net assets/stockholder's equity (-$8.6M, in comparison to $14.1M in long-term debt net of current portion), and FY23's negative value reflects that negative net assets/stockholder's equity was larger than total non-current long-term debt (-$91.4M compared with $13.6M). Prospect's EBITDA Debt Service Coverage in FY21-23 showed performance far outside of the reference range, with low and negative values reflecting low and negative Total EBITDA Margin in those years.

Table 15 Prospect CT – Solvency Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Long-Term Debt to Capitalization*	26.4%	38.0%	40.5%	67.5%	257.5%	(17.5%)	35-40%
EBITDA Debt Service Coverage	2.5	1.0	4.7	0.5	(0.6)	(4.1)	3-4

SOURCE: CT OHS; Prospect CT Audited Financial Statements for FY18-23 (income tax amounts). Note that OHS values for current payments on long-term debt differ from those provided in the Prospect CT Audited Financial Statements; these calculations rely on OHS reports.

* Lower value indicates more favorable financial performance for indicated measures.

Capital Expenditures: Prospect showed high variability in measures of capital expenditures from FY18-22; Prospect did not report FY23 depreciation and amortization in draft Prospect CT FY23 Audited Financial Statements or in its reports to OHS, so it is not possible to assess capital spending for that year. Variability in capital expenditures measures may be at least partially caused by the sale of most of Prospect Medical Holdings (CA)'s property, plant, and equipment to Medical Properties Trust in 2019 (Prospect now leases its facilities from Medical Properties Trust). Capital Expenditures to Depreciation ranged from 3% (indicating spending of less than $1 million in FY20, compared with depreciation expense of $24.3 million) to 151% in FY22. FY22 values should be viewed with particular caution, as Prospect reported depreciation expenses of $8.3 million, far below the $20-25 million reported annually from FY18-FY22. Prospect also reported highly variable accumulated depreciation, resulting in inconsistent Average Age of Plant. In FY22, Average Age of Plant was 15.6, unfavorably above the reference range. Given the variability in Prospect's performance, questions about the underlying data, and the added complexity of the sale-leaseback arrangement between Prospect and Medical Trust Properties, the authors have little confidence in these results, and have not relied upon them in making conclusions about Prospect's overall financial status.

Table 16 Prospect CT – Capital Expenditure Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Capital Expenditures to Depreciation	138%	132%	3%	40%	151%	**	105-115%
Average Age of Plant*,	15.6	3.4	4.2	4.9	15.6	**	10-12

** Prospect CT did not report FY23 depreciation and amortization amounts, so it is not possible to calculate Capital Expenditures to Depreciation or Average Age of Plant for that year.
SOURCE: CT OHS.

* Lower value indicates more favorable financial performance for indicated measures.

Trinity Health of New England

Trinity Health is a national not-for-profit health system based in Michigan. It owns 101 hospitals across the country and operates in 27 states.[54] Trinity Health, via subsidiary Trinity Health New England, operates three hospitals in Connecticut and one hospital in Massachusetts (Mercy Hospital in Springfield), along with other subsidiaries and affiliated organizations in both states.[55] This report will subsequently refer to Trinity Health of New England as "Trinity" and Trinity Health as "Trinity Health (MI)" for ease.[56]

The financial ratios and related findings below focus on Trinity's entire operations – the organization's holdings in both Connecticut and Massachusetts – based on publicly available consolidated audited financial statements, and on Connecticut operations based on data from OHS reports and consolidating statements to the audited financial statements. Trinity should be viewed in the context of the corporate parent, Trinity Health (MI), one of the largest health systems in the country. Financial performance of the corporate parent is likely to drive resource allocation, internal transfers from the affiliate back to the parent organization, and in extreme circumstances, decisions related to service line reductions or facility closures. The ratios presented below rely largely on data from Trinity's consolidated audited financial statements, providing additional commentary specific to Trinity's Connecticut operations where feasible based on data from Trinity's reports to CT OHS.

Table 17 Trinity Health of New England – Net Patient Service Revenue and Payer Mix

	2023
Net Patient Service Revenue*	$1.82 billion
Net Patient Service Revenue – CT Only	$1.45 billion *80% of total NPSR*
Payer Mix (as Percentage of NPSR)	
Medicare	41%
Medicaid	20%
Blue Cross	16%
Commercial and other	21%
Uninsured	1%

[54] Trinity Health. *About Us*.
[55] The financial analysis of Trinity Health of New England relies primarily on audited financial statements for fiscal years 2018-2023 unless otherwise indicated. Mercy Hospital (MA) and other subsidiaries based outside of Connecticut are excluded from reports provided to the State of Connecticut; this results in some discrepancies between the figures reported to OHS and Trinity Health of New England's consolidated audited financial statements.
[56] Where this analysis references the finances of Trinity Health (MI), data is drawn from audited financial statements for FY2018-2022, accessed via Digital Assurance Certification (DACBond.com). Recent rating actions by Fitch Ratings were also considered.

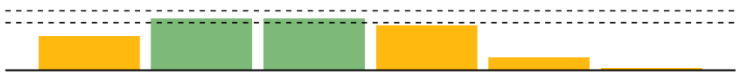
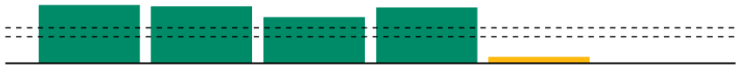
SOURCE: Trinity Health of New England FY2023 Audited Financial Statements. NPSR includes capitation revenue.

The data provided in this section demonstrate that, considered on its own, Trinity is in a poor financial position. However, **when considered in the context of its parent organization, Trinity Health (MI), Trinity has robust financial support and a strong financial position (see Figure 4).** Trinity has moderate unrestricted net assets; however, parent organization Trinity Health (MI) has unrestricted net assets of over $17 billion. By Connecticut-only NPSR ($1.45 billion), Trinity is the third largest health system in Connecticut. Average NPSR growth for Trinity was 1.4% from 2018-2023, though Connecticut operations experienced lower average annual growth during that period (0.8%). Trinity has an adequate payer mix, though it has the highest proportion of revenue from Medicaid (20%) of all Connecticut systems.

However, while FY22 and 2023 were challenging years for Trinity, and to a lesser extent Trinity Health (MI), particularly in terms of profitability, analysts predict strong performance in the future. In November 2023, Fitch Rating's affirmed Trinity Health (MI)'s bond rating at AA-("very high credit quality") with a stable outlook; Fitch's rating analysis included an expectation that despite lower than historical profitability in FY22 and even more so in FY23, Trinity Health (MI) would improve operating performance in subsequent years. Notably, Trinity's audited financial statements[57] document transfers from Trinity to Trinity Health (MI), of $15.6 million to $23.1 million annually between FY18-FY23, for a six-year total of $108.8 million dollars. This amount was approximately triple Trinity's total income from operations during the same period ($33.6 million, noting losses greater than $70 million in both FY22 and FY23) and represents significant extraction of resources to an out-of-state parent company.

[57] See Consolidated Statement of Changes in Net Assets.

Figure 4 Trinity Health of New England – Summary of Financial Status

Financial Measures	Performance Relative to Reference Range 2018 2019 2020 2021 2022 2023	Reference Range
Operating EBITDA Margin		8-10%
Total EBITDA Margin		10-12%
Days Cash on Hand (all unrestricted sources)		100-200
Days in Patient Accounts Receivable*		40-50
Long-Term Debt to Capitalization*		35-40%
EBITDA Debt Service Coverage		3-4
Capital Expenditures to Depreciation		105-115%
Average Age of Plant*		10-12

* Lower value indicates more favorable financial performance for indicated measures. NOTES: Dashed lines = reference range. Solid line = 0. Dark green bars indicate performance favorable compared with reference range; light green bars indicate performance within reference range; yellow bars indicate performance unfavorable compared with reference range.

The following analysis reviews Trinity's performance on key measures of profitability, liquidity, solvency, and capital expenditures over the years FY18-FY23; the analysis focuses on audited financial statements submitted by Trinity Health of New England but reflects on the potential impact of Trinity Health (MI)'s finances and operations on this subsidiary.

Profitability: Trinity's EBITDA profit margins were below the reference range for most of the FY2018-2023 period, except for Operating EBITDA margins in FY19-20; however, both Operating and Total EBITDA Margins were positive every year during this period except in FY23, and above 5% every year except for FY22-23. Profitability decreased significantly in FY22, a challenging year for many hospitals, and again in FY23, resulting in breakeven Operating EBITDA (0.4%) and Total EBITDA (-0.1%) margins. Despite recent performance, Trinity maintained average margins of 5.6% (Operating EBITDA) and 5.0% (Total EBITDA) over the six years studied.

When considering Trinity's Connecticut operations alone, profitability was slightly higher for most years. In FY18-FY20, Connecticut hospitals were slightly higher than Trinity Health of New

England as a whole and were within the Operating and Total EBITDA Margins reference ranges except for FY18 Total EBITDA Margin. As described above, profitability dipped in FY21 and dropped sharply in FY22-23; FY22 performance was worse than for Trinity Health of New England, including losses on Total EBITDA Margin in FY22, and FY23 margins were similar to the full system. Some of these differences may reflect the inability to remove the impact of Unrealized Gains/(Losses) for Connecticut-only Total EBITDA Margin (see footnote).

Table 18 Trinity Health of New England – Profitability Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Operating EBITDA Margin	5.8%	8.7%	8.7%	7.6%	2.2%	0.4%	8-10%
Operating EBITDA Margin – CT Only	8.4%	10.9%	8.9%	6.4%	1.1%	0.1%	
Total EBITDA Margin[58]	5.7%	8.3%	7.1%	8.0%	0.9%	(0.1%)	10-12%
Total EBITDA Margin – CT Only[59]	9.0%	11.1%	10.7%	9.8%	(0.7%)	0.4%	

SOURCE: Trinity Health of New England Audited Financial Statements, FY2018-FY2023; includes non-CT subsidiaries. Connecticut-only values drawn from CT OHS reports.

Liquidity: Trinity made timely collection of patient accounts receivable within days favorably below the reference range for every year except FY23. Trinity has not amassed significant liquid assets, as demonstrated by low Days Cash on Hand except in FY20 and FY21. A portion of the increase in Days Cash on Hand in those two years was attributable to federal COVID-19 Provider Relief Fund grants of $132.8 million and $59.2 million, resulting in 73.6 and 88.1 Days Cash on Hand, respectively. However, Trinity's liquid assets are not a reflection of the health of its corporate parent, which had over 200 Days Cash on Hand in F21 -FY23, according to the parent's audited financial statements. In their November 2023 Rating Commentary, Fitch Ratings references a healthy 174 Days Cash on Hand in FY23.

For Trinity's Connecticut hospitals, Days Cash on Hand was similarly below the reference range, except in FY20-21; this reflects the bump in cash due to the federal COVID-19 relief described above which kept the hospitals at Trinity's level. Trinity's Connecticut hospitals were efficient at collecting payment for patient care delivered, with Days in Accounts Receivable below the reference range for every year except FY23.

[58] Trinity combines Realized Gains/(Losses) and Unrealized Gains/(Losses) on their audited financial statements; Unrealized Gains/(Losses) were extracted manually based on information provided in AFS footnotes.

[59] Trinity lists $0 in Unrealized Gains/(Losses) on its reports to OHS. This means that it is not possible to calculate Total EBITDA Margin exclusive of Unrealized Gains/(Losses). While the consolidating statements of the audited financial statements allow for manual removal of unrealized gains and losses and the system-level, this is not possible when considering Connecticut operations alone.

Table 19 Trinity Health of New England – Liquidity Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Days Cash on Hand (all unrestricted sources)	37.1	47.3	100.3	99.6	39.1	24.7	100-200
Days Cash on Hand (all unrestricted sources) – CT Only	19.8	34.0	79.9	70.2	33.5	21.3	
Days in Patient Accounts Receivable*	33.5	33.5	31.1	33.1	38.1	42.7	40-50
*Days in Patient Accounts Receivable – CT Only**	30.7	30.6	28.7	31.0	36.6	43.2	

SOURCES: Trinity Health of New England Audited Financial Statements, FY2018-FY2023; includes non-CT subsidiaries. Connecticut-only values drawn from CT OHS reports.

* Lower value indicates more favorable financial performance for indicated measures.

Solvency: Trinity had mixed performance on measures of solvency from FY18 to FY23. Long-Term Debt to Capitalization was unfavorably high every year. However, this was driven by low unrestricted net assets, also a cause of low Days on Cash on Hand. As discussed above, this is likely less a reflection of Trinity's financial health than of corporate practice of keeping liquid assets at the parent corporation rather than with local subsidiaries. Trinity's EBITDA Debt Service Coverage was favorable compared to the reference range except in FY22 and FY23, a reflection of limited Total EBITDA Margin in those years.

Performance of Trinity's Connecticut operations on Long-Term Debt to Capitalization was similar to the system as a whole, that is, unfavorably above the reference range for every year except FY21. The hospitals' performance on EBITDA Debt Service Coverage was significantly better than Trinity's for FY19-21 though both performed favorably compared with the reference range; and well below the reference range in FY22 and FY23. These measures could be skewed by corporate practices related to how debt is managed at the system-level and are less meaningful than Trinity's system-level performance on liquidity measures; in addition, for Connecticut operations, EBITDA Debt Service Coverage includes Unrealized Gains/(Losses), and hence is not a reliable indicator.

Table 20 Trinity Health of New England – Solvency Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Long-Term Debt to Capitalization*	61.4%	63.7%	59.5%	48.1%	53.2%	62.2%	35-40%
*Long-Term Debt to Capitalization – CT Only**	52.9%	52.6%	46.3%	36.4%	40.7%	50.9%	
EBITDA Debt Service Coverage[60]	6.6	6.4	5.2	6.3	0.7	(0.1)	3-4
EBITDA Debt Service Coverage – CT Only[61]	7.2	9.2	8.7	8.4	(0.6)	0.4	

SOURCE: Trinity Health of New England Audited Financial Statements, FY2018-FY2023; includes non-CT subsidiaries. Connecticut-only values drawn from CT OHS reports.

* Lower value indicates more favorable financial performance for indicated measures.

Capital Expenditures: Trinity's investments in capital projects, including property, plant, and equipment, were low from FY18-FY22, with a significant investment in FY23. Capital Expenditures to Depreciation was well below 100% every year during this period except in FY23 (125%).The six-year average for this measure was 71.8%, indicating that Trinity's assets are depreciating much faster than they are making new capital investments. However, Trinity also had Average Age of Plant favorably below the reference range, reflecting low accumulated depreciation. This suggests that Trinity may have made major investments prior to this analysis period. Trinity will need to continue making investments at least equal to the level of annual depreciation within the next few fiscal years to stay within the reference range for this measure and continue to have well-maintained, current facilities.

Investment in capital expenditures was similar for Trinity's Connecticut operations as for Trinity as a whole, resulting in similar values for Capital Expenditures to Depreciation, which was unfavorable compared to the reference range. The exception was in FY23, when Capital Expenditures to Depreciation for Trinity's Connecticut operations was significantly higher than for Trinity, 152% versus 125%. Trinity's Connecticut operations showed extremely low average age of plant; however, the authors consider these findings to be unreliable. Though Connecticut operations represent 80% of Trinity's NPSR, accumulated depreciation shown on OHS's reports is only 30-56% of accumulated depreciation on the full audited financial statements in FY18-23.

[60] Trinity combines Realized Gains/(Losses) and Unrealized Gains/(Losses) on the consolidating statements to their audited financial statements; Unrealized Gains/(Losses) were extracted manually based on information provided in AFS footnotes.
[61] Trinity lists $0 in Unrealized Gains/(Losses) on its reports to OHS. This means that it is not possible to calculate EBITDA Debt Service Coverage exclusive of Unrealized Gains/(Losses).

Table 21 Trinity Health of New England – Capital Expenditure Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Capital Expenditures to Depreciation	76%	56%	41%	61%	71%	125%	105-115%
Capital Expenditures to Depreciation – CT Only	80%	58%	37%	62%	79%	152%	
Average Age of Plant*	5.4	6.2	6.7	7.5	8.5	10.2	10-12
*Average Age of Plant – CT Only**	2.9	3.7	4.5	5.8	6.8	8.5	

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SOURCE: Trinity Health of New England Audited Financial Statements, FY2018-FY2023; includes non-CT subsidiaries. Connecticut-only values drawn from CT OHS reports.

* Lower value indicates more favorable financial performance for indicated measures

Yale New Haven Health

Yale New Haven Health (YNHH) owns five hospitals, including four in Connecticut and one in Rhode Island, in addition to medical groups, home health and hospice, and other provider types.

The financial ratios and findings below rely on data and information from YNHH's consolidated audited financial statements. In addition to YNHH's Connecticut business, these statements include subsidiaries operating in Rhode Island (Westerly Hospital and the Westerly Hospital Foundation). This analysis does not include Connecticut-only analyses, however, Connecticut operations account for 98% of YNHH's NPSR.

Table 22 Yale New Haven Health – Net Patient Service Revenue and Payer Mix

	2023
Net Patient Service Revenue	$5.77 billion
Net Patient Service Revenue – CT Only	$5.65 billion *98% of total NPSR*
Payer Mix (as Percentage of NPSR)	
Medicare	34%
Medicaid	15%
Non-Governmental[62]	51%

SOURCE: YNHH Audited Financial Statements, FY2018-FY2023; includes non-CT subsidiaries.

The data provided below indicate that despite a strong market position and significant reserves, the health system has faced some financial headwinds since FY20, particularly related to profitability. In May and June 2023, respectively, Moody's Investors Service and Fitch Ratings both downgraded YNHH's bond ratings, citing weak financial performance since FY20, and particularly limited profit from operations, reduced liquidity, and large anticipated capital investment needs. However, both rating agencies gave YNHH a stable outlook, anticipating that the system would return to greater operating profitability and otherwise improve its liquidity in the medium-term. A June 2024 Fitch Ratings rating action commentary affirmed YNHH's A+ rating and stable outlook, citing increases in inpatient and surgical volumes in FY23 and through mid-FY24, as well as implementation of a performance improvement plan launched in 2022.

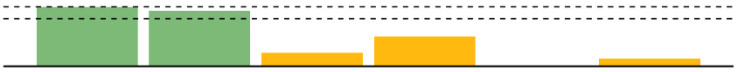
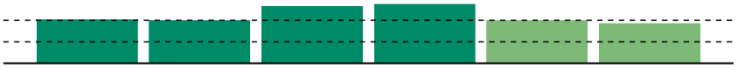
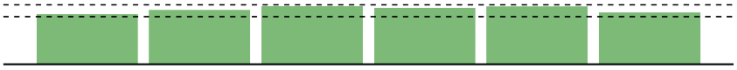
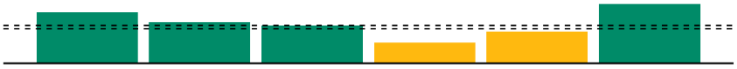
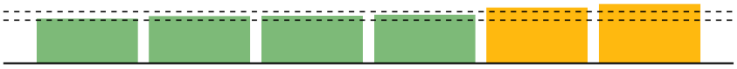
Despite these challenges, YNHH has a robust financial position (see Figure 5). Its bond ratings are high, it has extremely high current assets (cash and investments), unrestricted net assets of over $3.7 billion in FY23 and the highest annual NPSR in the state. Anticipated major investments – a new neuroscience tower which will result in high capital expenditures over the next few fiscal years, along with the possible purchase of the three Prospect CT hospitals

[62] YNHH's FY23 Audited Financial Statements do not provide additional breakdown for the "non-governmental" payer category.

(subject to ongoing legal action) – are likely to expand its market share, though they may require the system to take on additional debt. YNHH has an adequate payer mix.[63]

The following analysis reviews YNHH's performance on key measures of profitability, liquidity, solvency, and capital expenditures over the years FY18-FY23.

Figure 5 Yale New Haven Health – Summary of Financial Status

Financial Measures	Performance Relative to Reference Range 2018	2019	2020	2021	2022	2023	Reference Range
Operating EBITDA Margin							8-10%
Total EBITDA Margin							10-12%
Days Cash on Hand (all unrestricted sources)							100-200
Days in Patient Accounts Receivable*							40-50
Long-Term Debt to Capitalization*							35-40%
EBITDA Debt Service Coverage							3-4
Capital Expenditures to Depreciation							105-115%
Average Age of Plant*							10-12

* Lower value indicates more favorable financial performance for indicated measures. NOTES: Dashed lines = reference range. Solid line = 0. Dark green bars indicate performance favorable compared with reference range; light green bars indicate performance within reference range; yellow bars indicate performance unfavorable compared with reference range.

Profitability: During the FY18-FY23 period, YNHH had variable profitability. In FY18 profit margins – particularly EBITDA Operating and Total Margins – were very strong, exceeding the reference ranges; FY19 margins were also robust. Like many health systems, YNHH saw lower profitability in FY20. While YNHH saw margins bounce back somewhat in FY21, it again struggled in FY22 and FY23. Note that while margins were consistently below the reference

[63] The June 2024 Fitch Ratings analysis refers to YNHH's payer mix as "modest" and provides detail not included in audited financial statements, noting that Medicaid and self-pay have risen above 25% of gross revenue; this is not comparable to the payer mix data provided in Table X, above, which provides payer mix as a percentage of NPSR.

range from FY20 onward, EBITDA margins have stayed at or above breakeven. From FY18-FY23, average Operating and Total EBITDA Margins were 4.7% and 6.8%, respectively.

Table 23 Yale New Haven Health– Profitability Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Operating EBITDA Margin	10.0%	9.3%	2.3%	5.0%	0.0%	1.3%	8-10%
Total EBITDA Margin	13.8%	9.7%	3.6%	7.4%	3.2%	3.1%	10-12%

SOURCE: YNHH Audited Financial Statements, FY2018-FY2023; includes non-CT subsidiaries.

Liquidity: YNHH has very strong liquidity. Its Days Cash on Hand has consistently been near the top of or above the reference range. The particularly high FY20 and 21 values include some one-time funds due to federal COVID relief programs, advanced Medicare payments and deferred tax payments which were settled as of FY22). In addition, Days in Patient Accounts Receivable was within the reference range, reflecting timely collection of payments for care delivery.

Table 24 Yale New Haven Health – Liquidity Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Days Cash on Hand (all unrestricted sources)	205.8	201.3	266.1	276.8	199.7	186.3	100-200
Days in Patient Accounts Receivable*	42.1	45.5	49.0	47.4	48.6	43.6	40-50

SOURCE: YNHH Audited Financial Statements, FY2018-FY2023; includes non-CT subsidiaries.

* Lower value indicates more favorable financial performance for indicated measures.

Solvency: During the FY18-23 period, YNHH's Long-Term Debt to Capitalization was favorably below the reference range, indicating a low level of debt compared to available assets. EBITDA Debt Service Coverage was within or favorably above the reference range for every year reviewed except in FY21, which was caused by the use of a line of credit in FY20.

Table 25 Yale New Haven Health – Solvency Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Long-Term Debt to Capitalization*	24.0%	20.5%	29.6%	28.0%	29.8%	28.2%	35-40%
EBITDA Debt Service Coverage Excluding Unrealized Gains/(Losses)	10.5	7.2	3.1	1.6	3.5	3.4	3-4

SOURCE: YNHH Audited Financial Statements, FY2018-FY2023; includes non-CT subsidiaries.

* Lower value indicates more favorable financial performance for indicated measures.

Capital Expenditures: Capital Expenditures to Depreciation was favorable compared to the reference range for most years reviewed. Looking across this six-year period, average Capital Expenditures to Depreciation was 123%, driven by particularly high capital spending in FY18, FY19, and FY23. However, lower capital spending in more recent years, and particularly in FY21 ($138M, compared with a range of $204M-$307M during the rest of the FY18-FY22 period) has driven Average Age of Plant up; in FY22-23 it was unfavorably above the reference range. This suggests that an increase in capital spending will be needed to keep up with depreciation as assets age. The June 2024 Fitch Ratings analysis projects that YNHH's capital expenditures will top 250% of depreciation in the short-term as YNHH seeks to construct its new tower and neuroscience center, and may be higher than depreciation in future years, which will likely lead to improvements in Average Age of Plant.

Table 26 Yale New Haven Health – Capital Expenditure Measures

Financial Measures	2018	2019	2020	2021	2022	2023	Reference Range
Capital Expenditures to Depreciation	156%	125%	116%	62%	97%	181%	105-115%
Average Age of Plant*,	10.4	11.0	11.1	11.3	13.0	13.8	10-12

SOURCE: YNHH Audited Financial Statements, FY2018-FY2023; includes non-CT subsidiaries.

* Lower value indicates more favorable financial performance for indicated measures.

Summary and Implications

Hospitals are a critical component of Connecticut's healthcare system. This report considers Connecticut health systems holistically, including composition, ownership, and finances.

- Connecticut's health care system is dominated by system-owned hospitals – especially YNHH and HHHC – and mergers, acquisitions, and affiliations have increased market consolidation over the past decade. A recent report by Altarum found that consolidation spurred commercial price increases in Connecticut.[64]

- The state's two largest health systems (HHCC and YNHH) are in strong financial positions, as is Trinity Health of New England due to the backing of its national parent company. Nuvance Health and Prospect CT, in contrast, are vulnerable; both are in the process of merging with or being acquired by larger health systems, pending legal action in the case of Prospect CT.

The data and analysis included in this report describe hospital system financial performance with the goal of providing background and context for the state as it considers potential policy options to ensure access to high-quality hospital services and to improve affordability for consumers, employer purchasers and the Connecticut's health systems with the largest net patient service revenue (Yale New Haven Health, Hartford Healthcare, and Trinity Health of New England) have substantial financial reserves and have maintained profitability even during the past few years, when the industry nationwide has struggled.

Connecticut is already pursuing many important strategies to increase affordability and transparency, including through its cost growth benchmark program, primary care spending target, and state scrutiny of mergers and acquisitions. Recent and future efforts may also impact affordability for hospital services in Connecticut. Efforts include elimination of facility fees for on-campus hospital outpatient services, implemented in July 2024; and the state's recently announced acceptance into the federal States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model to implement hospital global budgets, launching in 2027.

This report has been produced to inform and support OHS as it considers legislative priorities for the 2025 session, in addition to non-legislative strategies under its purview.

[64] Altarum on behalf of State of Connecticut Office of Health Strategy. *Impacts of Connecticut Hospital and Health Care System Consolidation (2016-2021)*. March 26, 2024.

Appendix: Definitions of Eight Key Financial Measures

This section describes and provides formulas for each of the eight key measures used to assess health system financial health. The measures are adapted from Pauly, et al. "Guide to Understanding Hospital Spending through Financial Analysis," published by the Peterson-Milbank Program for Sustainable Health Care Costs (April 2024).

Profitability Metrics
Operating EBITDA Margin (%)
Key Question for states: Are the hospital or health system's *core activities* profitable, excluding financing and tax expenses?
Description: Operating EBITDA Margin represents the earnings a hospital or health system generates from its core operating activities before accounting for interest expenses, income taxes, and non-cash expenses such as depreciation and amortization. Earnings should exclude investment income and other sources of non-operating income. This metric can be useful for assessing the profitability of a hospital or health system's core operations without the influence of financing factors (interest, taxes, depreciation, amortization).
Formula: Operating EBITDA Margin = (Net Operating Income + Interest Expense + Tax Expense + Depreciation + Amortization Expense / Operating Revenue) x 100
Benchmark Range: 8-10%.
Notes: Calculation excludes "Investment returns on net assets without donor restrictions (portion included in operating revenue ONLY)" (row 115) and non-recurring expenses (row C84).
Total EBITDA Margin (%)
Key Question for states: Are the hospital or health system's total activities profitable (including non-operating activities), excluding financing and tax expenses?
Description: Total EBITDA Margin is a financial metric used to evaluate the overall operating performance and profitability of the entity for both the core business as well as non-core, usually "passive" activities such as investment income and philanthropy. Total EBITDA Margin represents the overall earnings a hospital or health system generates from both core and peripheral activities before accounting for interest expenses, income taxes, and non-cash expenses such as depreciation and amortization.
Formula: Total EBITDA Margin = (Net Income (removing unrealized gains or losses in the value of financial assets such as stocks and bonds) + Interest Expense + Tax Expense + Depreciation + Amortization Expenses / Operating Revenue + Non-Operating Revenue) x 100
Benchmark Range: 10-12%.
Notes: Calculation excludes "Investment returns on net assets without donor restrictions (portion included in operating revenue ONLY)" (row 115), non-recurring expenses (rows 84 and 96), and unrealized gains (losses) (row 95).

Liquidity Metrics
Days Cash on Hand (all unrestricted sources) (# days)
Key Question: For how long could the hospital or health system operate and pay its bills without additional income?
Description: Days Cash on Hand is a financial metric that measures the number of days a hospital or health system can continue to operate using its financial assets (unrestricted cash and investments) without any additional cash inflows. It is calculated by dividing the total unrestricted cash and investments by the average daily operating expenses of the hospital or health system.
Formula: Days Cash on Hand = (Cash and Cash Equivalents + unrestricted investments) / (Average Daily Operating Expenses)
Benchmark Range: 100-200.
Notes:
- Cash and Cash Equivalents refer to the total amount of cash and other financial assets that can be converted into cash, such as short-term investments, treasury bills, and commercial paper, as well as stocks and bonds reported as “noncurrent.” It should exclude donor-restricted or trustee-held funds (such as reserves legally /contractually required for debt service, self-insurance, and risk-based reserves) but include Board-designated and other unrestricted investments.
- Average Daily Operating Expenses refer to the average amount of money a hospital or health system spends on its daily operations, such as salaries, rent, utilities, and other expenses (it should exclude non-cash items like depreciation and amortization). It is calculated by dividing Operating Expenses by 365.
Days in Accounts Receivable (# days)
Key Question: How long does it take the hospital or health system to collect payments from payers and patients?
Description: Days in Accounts Receivable (Days in AR) is a financial metric that measures the average number of days it takes for a hospital or health system to collect payment from its customers or clients (in this case, payers and patients) after providing a service or making a sale on credit. It is a key indicator of how efficiently a hospital or health system manages its accounts receivable, which are amounts owed to it by payers or patients for goods or services provided; a lower value for Days in AR represents better financial performance.
Formula: Days in AR = Total Accounts Receivable (net) / (Net Patient Revenue / 365)
Benchmark Range: 40-50. Lower value indicates more favorable financial performance for this measure.
Note: Sometimes audited financial statements list Patient Accounts Receivable separately from other types of expected payments (e.g., donor contributions). If so, this metric should be limited to Patient Account Receivables.

Debt Capacity and Solvency Metrics
EDITA Debt Service Coverage (ratio)
Key Question: Are the hospital or health system's earnings enough to pay its debt?
Description: EBITDA Debt Service Coverage is a financial metric that measures a hospital or health system's ability to pay its debt obligations. It is calculated by dividing the hospital or health system's total EBITDA by its debt service. Debt service refers to the amount of money required to pay the principal and interest on outstanding long-term debt. A higher ratio indicates that a hospital or health system is more capable of servicing its debts. Some analysts also calculate this ratio using Operating EBITDA.
Formula: EBITDA Debt Service Coverage = EBITDA / (prior year Current Long-Term Debt + current year Interest Expense)
Benchmark Range: 3-4.
Notes: Calculation excludes unrealized gains (losses) on investments (row 95).
Long-Term Debt to Total Capitalization (%)
Key Question: How much debt does the hospital or health system hold, compared to its available assets?
Description: Long-Term Debt to Total Capitalization is a ratio that measures the total amount of outstanding long-term debt as a percentage of the firm's total capitalization. Total capitalization means the hospital or health system's total available assets (unrestricted assets), minus the its total liabilities. The ratio is an indicator of the hospital or health system's leverage, or level of debt used to purchase assets. A higher ratio indicates a higher degree of leverage, which could mean greater financial risk if the hospital or health system struggles to meet its debt service obligations; a lower ratio indicates that the hospital or health system is less reliant on debt and represents stronger financial performance.
Formula: Long-Term Debt to Total Capitalization = (Total Long-Term Debt / (Total Long-Term Debt + Shareholders' Equity)) x 100
Benchmark Range: 35-40%. Lower value indicates more favorable financial performance for this measure.
Note: The term "Shareholders Equity" is used in for-profit organizations. Not-for-profit organizations use the term "Net Assets."

Capital Expenditure Metrics
Capital Expenditures to Depreciation (%)
Key Question: Is the hospital or health system replacing fixed assets as they age and investing in new assets?
Description: The ratio of Capital Expenditures to Depreciation is a financial metric used to assess how much a hospital or health system is investing in its long-term assets, such as property, plant, and equipment (PP&E), relative to the depreciation expense it recognizes on those assets. This ratio provides insight into whether the entity is investing in maintaining and expanding its productive capacity or simply replacing depreciated assets. It is best to measure this over a 3-5-year period if the information is available, as capital investments are made in multi-year cycles.
Formula: Capital Expenditures to Depreciation = (Capital Expenditures / Depreciation Expense) x 100
Benchmark Range: 105-115%.
Note: Capital Expenditures are found on the Cash Flow Statement within the organization's audited financial statements.
Average Age of Plant (# years)
Key Question: How old, on average, are the hospital or health system's fixed assets?
Description: Average Age of Plant is a financial and operational metric used to assess the age of a hospital or health system's assets, particularly those related to delivering patient care. It provides insight into how old the infrastructure of the facilities is on average. This metric includes all the fixed assets that an organization owns. Fixed assets typically include items such as buildings, machinery, equipment, vehicles, and furniture that are necessary for conducting operations. A higher average age of the plant may indicate that assets are aging and might require maintenance, repair, replacement, or technological upgrades to remain efficient, effective, and competitive.
Formula: Average Age of Plant = Accumulated Depreciation / Annual Depreciation Expense
Benchmark Range: 10-12. Lower value indicates more favorable financial performance for this measure.