

**Office of Health Care Access
FY 2014 Twelve Months Actual Filing
General Instructions**

General Filing Requirements:

Each hospital licensed as an acute care general or children's hospital shall submit to the Office of Health Care Access (OHCA) the reporting requirements for the FY 2014 Twelve Months Actual Filing in accordance with Section 19a-649 of the Connecticut General Statutes (C.G.S.), as amended by Public Act (PA) 13-234, Section 19a-676 of the C.G.S., and Section 19a-643-206 (c) of OHCA's Regulations. The FY 2014 Twelve Months Actual Filing General Instructions have been updated from prior years' twelve months actual filing general instructions and replace all previous versions.

The FY 2014 Twelve Months Actual Filing requirements will be met by completing the input forms and related reports within the Hospital Reporting System (HRS) and filing in hard copy and/or as PDF files in Adobe Acrobat all other related documents. **All components of the hospital's FY 2014 Twelve Months Actual Filing must be received by OHCA by no later than Tuesday, March 31, 2015.**

The hospital must submit an original document and one copy of all required hard copy (non database) documents to OHCA. For 12 Months Actual Filing HRS Report definitions please see *Attachment B*.

Noted below is a list of the non-HRS related items that the hospital must provide to complete the 2014 Twelve Month Filing along with the method of submitting (*hard copy or PDF files in Adobe Acrobat*) as required by OHCA. **Please submit all required electronic files through our secure internet site. Please reference the Twelve Month Filing submission checklist for a summary of these filing components and how they should be submitted. When naming your files, please use a filename that easily identifies the hospital and the item being submitted.**

- Hospital's **cover letter** and **submission checklist** (*hard copy & pdf file*)
- **Affidavit** – notarized Twelve Month Filing Affidavit that is signed and dated by the hospital CEO or CFO (*hard copy & PDF file*);
- **DPH License** – a copy of the Hospital's Department of Public Health license as of September 30, 2014 (*PDF file*);
- **AUP** – Independent Accountant's Report on Applying Agreed-Upon Procedures to Report 600 (*hard copy and PDF file*);
- **Supporting schedules** – for the Plus/Minus Other Adjustments lines reported on HRS Report 600 concerning the Net Revenue, Gross Revenue and Uncompensated Care Reconciliations (*PDF files*);
- **Variance Explanations** – An explanation of variances in HRS Reports 100, 150, 300, 350, 450, 500 and 650 for differences between the FY 2013 and FY 2014 input amounts, which result in a % greater than plus or minus 25% in the % Difference Column. **Also, an**

explanation of variances between FY 2013 and FY 2014 input amounts which result in a % greater than plus or minus 50% in the difference column of Report 175 .

Provide the variance explanations on a hard copy of the Excel report next to the line number. Note, the hospital only needs to provide variance explanations for input amounts and won't be required to provide variance explanations for amounts that are calculated. Please be thorough with your explanations to avoid the need for follow up completeness questions from OHCA staff even if this includes describing a group of variances in a paragraph. *(PDF files)*;

- **IRS 990** – The hospital and the hospital parent corporation’s IRS Form 990, Return of Organization Exempt from Income Tax for FY 2014 (a signed time extension request should be submitted for each filing if the hospital has requested a time extension with the IRS, *(PDF files)*);

FY 2014 Twelve Months Actual Filing Docket Numbers

HOSPITAL	Docket Number
William W. Backus Hospital	14-001TM
Bridgeport Hospital	14-023TM
Bristol Hospital	14-002TM
Connecticut Children’s Medical Center	14-025TM
Danbury Hospital	14-024TM
Day Kimball Hospital	14-003TM
Essent-Sharon Hospital	14-033TM
John Dempsey Hospital	14-026TM
Greenwich Hospital	14-027TM
Griffin Hospital	14-028TM
Hartford Hospital	14-005TM
Hospital of Central Connecticut	14-015TM
Charlotte Hungerford Hospital	14-007TM
Johnson Memorial Hospital	14-029TM
Lawrence & Memorial Hospital	14-008TM
Manchester Memorial Hospital	14-010TM
Middlesex Hospital	14-012TM
MidState Medical Center	14-030TM
Milford Hospital	14-013TM
New Milford Hospital	14-017TM
Norwalk Hospital	14-031TM
Rockville General Hospital	14-032TM
Saint Francis Hospital and Medical Center	14-018TM
St. Mary’s Hospital	14-019TM
St. Vincent’s Medical Center	14-035TM
Stamford Hospital	14-034TM
Waterbury Hospital	14-021TM
Windham Community Memorial Hospital	14-022TM
Yale-New Haven Hospital	14-016TM

The FY 2014 Twelve Months Actual Filing requirements include the following components:

1. Report 100 - Hospital Balance Sheet Information

HRS Report 100. A report that provides detailed balance sheet information from the hospital's audited financial statements for the most recently completed fiscal year.

Inputs include amounts for various types of hospital current assets, non-current assets whose use is limited, net fixed assets, current liabilities, long term debt, long term liabilities and net assets. The balance sheet amounts to be entered must be for the hospital only and must exclude financial activity for all hospital affiliates and subsidiaries.

The Hospital must provide an explanation for each difference between the FY 2013 and FY 2014 amounts, which results in a % greater than plus or minus 25% in the % Difference Column of HRS Report 100. Variance explanations should be submitted on a hard copy of the Excel report next to the line number and should be for input amounts only. OHCA is not requiring variance explanations for amounts that are calculated.

2. Report 150 - Hospital Statement of Operations Information

HRS Report 150. A report that provides detailed statement of operations information from the hospital's audited financial statements for the most recently completed fiscal year.

Inputs include amounts for hospital gross revenue, allowances, charity care, other deductions, other operating revenue, net assets released from restrictions, operating expenses and non-operating revenue. The statement of operations amounts to be entered must be for the hospital only and must exclude all financial activity for hospital affiliates and subsidiaries.

The Hospital must provide an explanation for each difference between the FY 2013 and FY 2014 amounts, which results in a % greater than plus or minus 25% in the % Difference Column of HRS Report 150. Variance explanations should be submitted on a hard copy of the Excel report next to the line number and should be for input amounts only. OHCA is not requiring variance explanations for amounts that are calculated.

3. Report 165 – Hospital Gross Revenue, Net Revenue and Statistics by Payer

HRS Report 165. A report that provides detailed hospital gross revenue, net revenue, utilization statistics and outpatient Emergency Department outpatient data by payer for the most recently completed fiscal year.

Inputs include amounts by payer for hospital inpatient and outpatient gross revenue, inpatient and outpatient net revenue, discharges, patient days, outpatient visits, and Emergency Department outpatient gross revenue, outpatient net revenue and outpatient (treated and

discharged) visits. The inputs are further broken down by payer that include amounts for Medicare traditional, Medicare managed care, Medicaid, Medicaid Managed Care, CHAMPUS / TRICARE, commercial insurance, non-government managed care, workers compensation, self-pay/uninsured and other payers.

The gross revenue, net revenue and statistical amounts to be entered must be for the hospital only and must exclude all financial and statistical activity for hospital affiliates and subsidiaries. Each section's total amount must agree with the corresponding total amount reported on HRS Reports 400, 450 or 550.

4. Report 175 – Hospital Operating Expenses by Expense Category and Department

HRS Report 175. A report that provides detailed hospital operating expenses by expense category and by department for the most recently completed fiscal year.

In Section I., inputs include amounts by expense category for hospital salaries and wages, fringe benefits, contractual labor fees, medical supplies and pharmaceutical costs, depreciation and amortization, interest expense, malpractice insurance cost, utilities, business expenses and other operating expenses. See the IRS Form 990 expense categories. In Section II., inputs include amounts by hospital department for various types of general services, professional services, special services, routine services and other departments. See the FY 2014 Medicare Cost Report for expenses by department.

(NEW) OHCA is now requesting an explanation of variances between FY 2013 and FY 2014 input amounts which result in a % greater than plus or minus 50% in the difference column.

The operating expense amounts to be entered must be for the hospital only and must exclude all financial activity for hospital affiliates and subsidiaries. The total operating expense amount by expense category and by department must agree with the total operating expense amount on HRS Report 150.

5. Report 185 – Hospital Financial and Statistical Data Analysis

HRS Report 185. A report that provides various forms of hospital financial and statistical information including a statement of operations summary, profitability summary, net assets summary, cost data summary, liquidity measures summary, solvency measures summary, utilization measures summary, gross revenue payer mix percentages, and net revenue payer mix percentages.

There is no direct input entered for this report. It is a reconfiguration of the data input that is entered for HRS Reports 100, 150, 400, 450 and 500. The statement of operations summary provides hospital revenue and expense data by major category from the hospital's audited financial statements. The profitability summary provides hospital operating, non-operating and total margins. The net assets summary provides hospital unrestricted net assets, total net assets and the change in total net assets. The cost data summary provides the

hospital's ratio of cost to charges, private payment to cost ratio, Medicare payment to cost ratio, Medicaid payment to cost ratio, and uncompensated care cost including charity care and bad debt amounts.

The liquidity measures summary provides the hospital's current ratio, days cash on hand, days revenue in patient accounts receivable, and average payment period. The solvency measures summary provides the hospital's equity financing ratio, cash flow to total debt ratio, long term debt to capitalization ratio and debt service coverage ratio. The utilization measures summary provides hospital patient days, discharges, average length of stay, staffed beds, licensed beds, available beds, occupancy of staffed beds, occupancy of available beds, and full time equivalent employees. The gross revenue and net revenue payer mix percentages provides the hospital payer mix percentages for non-government, Medicare, Medicaid, other medical assistance uninsured, and CHAMPUS / TRICARE payers.

Other sections include Discharges and Case Mix Index by Non Government, Medicare, Medical Assistance, Medicaid, Other Medical Assistance, CHAMPUS/TRICARE, Uninsured and Total. There is also a section for Emergency Department visits treated and admitted, treated and discharged and in total and a formula for average age of plant.

6. Report 200 – Hospital Medicare Managed Care Activity

HRS Report 200. A report that provides Medicare managed care activity by payer.

Inputs include hospital Medicare managed care inpatient and outpatient charges, inpatient and outpatient payments, discharges, patient days, outpatient visits (excluding Emergency Department visits), and Emergency Department outpatient visits (treated and discharged visits) and Emergency Department inpatient admissions for each individual Medicare managed care payer. The Medicare managed care amounts to be entered must be for the hospital only and must exclude all financial activity for hospital affiliates and subsidiaries.

7. Report 250 – Hospital Medicaid Managed Care Activity

HRS Report 250. A report that provides Medicaid managed care activity by payer.

Any data related to the Administrative Service Organization should be recorded as regular Medicaid and should not be reported on Report 250. Activity for Charter Oak Health Plan (Sunsetted on December 31, 2013) should still be considered commercial.

Inputs include hospital Medicaid managed care inpatient and outpatient charges, inpatient and outpatient payments, discharges, patient days, outpatient visits (excluding Emergency Department visits) and Emergency Department outpatient visits (treated and discharged visits) and Emergency Department inpatient admissions for each individual Medicaid managed care payer. The Medicaid managed care amounts to be entered must be for the hospital only and must exclude all financial activity for hospital affiliates and subsidiaries.

8. Report 300 – Parent Corporation Consolidated Balance Sheet Information

HRS Report 300. A report that provides detailed balance sheet information from the hospital parent corporation's consolidated audited financial statements for the most recently completed fiscal year.

Inputs include amounts for various types of hospital parent corporation consolidated current assets, non-current assets whose use is limited, net fixed assets, current liabilities, long term debt, long term liabilities and net assets. The balance sheet amounts to be entered must be for the consolidated hospital parent corporation and must include financial activity for the hospital and all hospital affiliates and subsidiaries.

The Hospital must provide an explanation for each difference between the FY 2013 and FY 2014 amounts, which results in a % greater than plus or minus 25% in the % Difference Column of HRS Report 300. Variance explanations should be submitted on a hard copy of the Excel report next to the line number and should be for input amounts only. OHCA is not requiring variance explanations for amounts that are calculated.

9. Report 350 – Parent Corporation Consolidated Statement of Operations Information

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

Inputs include amounts for hospital parent corporation consolidated gross revenue, allowances, charity care, other deductions, other operating revenue, net assets released from restrictions, operating expenses and non-operating revenue. The statement of operations amounts to be entered must be for the consolidated hospital parent corporation and must include financial activity for the hospital and all hospital affiliates and subsidiaries.

The Hospital must provide an explanation for each difference between the FY 2013 and FY 2014 amounts, which results in a % greater than plus or minus 25% in the % Difference Column of HRS Report 350. Variance explanations should be submitted on a hard copy of the Excel report next to the line number and should be for input amounts only. OHCA is not requiring variance explanations for amounts that are calculated.

10. Report 385 – Parent Corporation Consolidated Financial Data Analysis

HRS Report 385. A report that provides various forms of hospital parent corporation consolidated financial information including a statement of operations summary, profitability summary, net assets summary, liquidity measures summary, and solvency measures summary.

There is no direct input entered for this report. It is a reconfiguration of the data input that is entered for HRS Reports 300 and 350. The statement of operations summary provides hospital parent corporation consolidated revenue and expense data by major category from the hospital parent corporation's consolidated audited financial statements. The profitability summary provides the hospital parent corporation's operating, non-operating and total margins. The net assets summary provides the hospital parent corporation's unrestricted net assets, total net assets and the change in total net assets.

The liquidity measures summary provides the hospital parent corporation's current ratio, days cash on hand, days revenue in patient accounts receivable, and average payment period. The solvency measures summary provides the hospital parent corporation's equity financing ratio, cash flow to total debt ratio, and long term debt to capitalization ratio.

11. Report 400 – Hospital Inpatient Bed Utilization by Department

HRS Report 400. A report that provides hospital inpatient utilization statistics by service or department including patient days, staffed beds, available beds and licensed beds.

Inputs include patient day, staffed bed and available bed numbers for various hospital inpatient services or departments including Adult Medical/Surgical, ICU/CCU excluding Neonatal ICU, Psychiatric: ages 0 to 17, Psychiatric: ages 18+, Rehabilitation, Maternity, Newborn, Neonatal ICU, Pediatric and other services or departments. Total Licensed Beds and Bassinets are input as one number that is the total of the two licensed beds and licensed bassinets numbers on the hospital's Department of Public Health (DPH) License as of September 30, 2014. *Please submit a copy of the hospital's DPH License as of September 30, 2014.*

Staffed beds reported are the average number of staffed beds with sufficient staff to be occupied by patients during the fiscal year. This number may not exceed the number of available beds for each service or department or in total.

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

HRS Report 450. A report that provides various types of hospital inpatient and outpatient services utilization statistics by service or department and hospital full time equivalents.

Inputs include the number of CT scans, MRI scans, PET scans, PET/CT scans, linear accelerator procedures, cardiac catheterization procedures, cardiac angioplasty procedures, electrophysiology studies, surgical procedures, endoscopy procedures, hospital emergency room visits, hospital clinic visits, other hospital outpatient visits by service or department, and hospital full time equivalents for nursing personnel, physicians and employees other than nursing personnel and physicians. If the hospital is not the primary provider of CT scans, MRI scans, PET scans or PET/CT scans, the hospital must obtain the fiscal year volume for each of these types of scans from the primary provider of the scans. For total Nursing FTEs,

hospitals must provide a total staff count of Hospital nursing personnel who provide direct services to patients (which includes APRNs, RNs, LPNs and CNAs) and also nursing administrative personnel.

The Hospital must provide an explanation for each difference between the FY 2013 and FY 2014 amounts, which results in a % greater than plus or minus 25% in the % Difference Column of HRS Report 450. Variance explanations should be submitted on a hard copy of the Excel report next to the line number and should be for input amounts only. OHCA is not requiring variance explanations for amounts that are calculated.

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

HRS Report 485. A report that provides hospital outpatient surgical procedures, outpatient endoscopy procedures and outpatient emergency room visits by location.

Inputs include the specific geographical location names and the corresponding number of hospital outpatient surgical procedures, outpatient endoscopy procedures and outpatient emergency room visits at each hospital geographical location. The total number of hospital outpatient surgical procedures, outpatient endoscopy procedures and outpatient emergency room visits must all agree with the corresponding total reported on HRS Report 450.

Due to the amendment of Section 19a-670, C.G.S. by Public Act 11-44, please disregard DSH Upper Payment Limit and Baseline Underpayment calculations for Reports 500, 550 and 600 as being the official calculations for the DSH program.

14. Report 500 – Calculation of DSH Upper Payment Limit and Baseline Underpayment Data: Comparative Analysis

HRS Report 500. A report that provides a calculation of the hospital's Disproportionate Share Hospital (DSH) program upper payment limit and baseline underpayment data and a comparative analysis of hospital data between the most recently completed fiscal year and the prior fiscal year.

Inputs include hospital inpatient accrued charges, inpatient accrued payments, discharges, case mix index, patient days, outpatient accrued charges, and outpatient accrued payments for each major payer category. Major payer categories include Medicare, non-government including self-pay and uninsured, uninsured, State of Connecticut Medicaid, other medical assistance, total medical assistance including Medicaid and other medical assistance, and CHAMPUS/TRICARE.

Additional inputs in Column 4 include accrued charges and accrued payments associated with non-government contractual allowances, other operating revenue, total operating

expenses, charity care at charges, bad debts at charges, employee self-insurance allowance, employee self-insurance gross revenue, plus/(minus) other adjustments to OHCA defined net revenue, gross revenue and uncompensated care, and net revenue, gross revenue and uncompensated care from the hospital's audited financial statements.

Non-government contractual allowances must not include any deductions for Charity Care or Bad Debts on HRS Reports 500, 550, 600 and 685. If the hospital reports any Other Adjustments, provide the detail of the components in hard copy. Please refrain from using any unexplained abbreviations and/or acronyms in providing the detail of these components.

The Hospital must provide an explanation for each difference between the FY 2013 and FY 2014 amounts, which results in a % greater than plus or minus 25% in the % Difference Column of HRS Report 500. Variance explanations should be submitted on a hard copy of the Excel report next to the line number and should be for input amounts only. OHCA is not requiring variance explanations for amounts that are calculated.

15. Report 550 – Calculation of DSH Upper Payment Limit and Baseline Underpayment Data

HRS Report 550. A report that provides a calculation of the hospital's DSH program upper payment limit and baseline underpayment data.

There is no direct input entered for this report. It is a reconfiguration of the data input that is entered for HRS Report 500. The report provides various DSH program items of information including inpatient, outpatient and total accrued charges and inpatient, outpatient and total accrued payments by major payer; inpatient and outpatient payer mix percentages based on accrued charges and accrued payments by major payer; discharges, patient days, average length of stay and case mix index by major payer as well as other required data; DSH upper payment limit calculations; calculated underpayment (upper limit methodology); calculated underpayment before upper limit (baseline methodology); ratios by major payer of inpatient payments to inpatient charges and outpatient payments to outpatient charges; and net revenue, gross revenue and uncompensated care reconciliations.

16. Report 600 – Summary of DSH Upper Payment Limit and Baseline Underpayment Data: Agreed-Upon Procedures

HRS Report 600. A report that provides a summary of the hospital's DSH program upper payment limit and baseline underpayment data that is used as the basis for the hospital's Report of Agreed Upon Procedures.

There is no direct input entered for this report. It is a reconfiguration of the data input that is entered for HRS Report 500. The report provides various DSH program items of information including inpatient, outpatient and total accrued charges and accrued payments by major payer; accrued discharges and case mix index by major payer as well as other

required data including charity care and bad debts, total other operating revenue and total operating expenses; and net revenue, gross revenue and uncompensated care reconciliations to the hospital's audited financial statements.

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

Report 625. A report of independent accountants on applying agreed-upon procedures that verifies the hospital's inpatient, outpatient, and total net revenues.

A Report of Independent Accountants on Applying Agreed-Upon Procedures to Report 600 is required as part of the hospital's verification of net revenue process set forth in Section 19a-649 (a), of the C.G.S. See the reporting format and requirements for the Agreed-Upon Procedures Report included in *Attachment A* of these general instructions for further details.

18. Report 650 – Hospital Uncompensated Care

HRS Report 650. A report that provides a summary of the hospital's charity care, bad debts and uncompensated care activity for the most recently completed fiscal year.

The charity care, bad debts and uncompensated care total amounts on HRS Report 650 must agree with the charity care, bad debts and uncompensated care amounts reported on HRS Report 500, HRS Report 550 and HRS Report 600.

Inputs include the number of applicants for charity care and reduced cost services, the number of approved applicants, and the total charges for the amount of charity care and reduced cost services provided. Inputs for charity care also include the hospital's FY 2013 ratio of cost to charges provided by OHCA; total charity care charges broken down by inpatient charges, outpatient charges (excluding Emergency Department charges), and Emergency Department outpatient charges; and the number of patient days, discharges, outpatient visits (excluding Emergency Department visits) and Emergency Department outpatient visits. Inputs for bad debts include total bad debts broken down by inpatient bad debts, outpatient bad debts (excluding Emergency Department bad debts), and Emergency Department outpatient bad debts.

The Hospital must provide an explanation for each difference between the FY 2013 and FY 2014 amounts, which results in a % greater than plus or minus 25% in the % Difference Column of HRS Report 650. Variance explanations should be submitted on a hard copy of the Excel report next to the line number and should be for input amounts only. OHCA is not requiring variance explanations for amounts that are calculated.

19. Report 685 – Hospital Non-Government Gross Revenue, Contractual Allowances, Accrued Payments and Discount Percentage

HRS Report 685. A report that provides a summary of the hospital's non-government payer activity including the hospital's total non-government gross revenue, contractual allowances, accrued payments and discount percentage.

There is no direct input entered for this report. It is a reconfiguration of the data input that is entered for HRS Report 500. The report provides the hospital's total non-government gross revenue, contractual allowances, accrued payments and discount percentage for the most recently completed fiscal year. The accrued payments associated with non-government contractual allowances must exclude any reduction for uncompensated care.

20. Report 700 – Statistical Analysis of Hospital Revenue and Expense

HRS Report 700. A report that provides a statistical analysis of the hospital's revenue and expense using various utilization statistics.

There is no direct input entered for this report. It is a reconfiguration of the data input that is entered for HRS Reports 150, 175, 450 and 500. The report provides a summary that includes the hospital's gross revenue and net revenue, total operating expenses, utilization statistics, case mix index and adjusted statistics, salary and fringe benefits expense, full time equivalent employees (FTE) and related statistical analyses.

The related statistical analyses include gross revenue and net revenue per statistic, operating expense per statistic, salaries and fringe benefits expense per FTE, and salary and fringe benefits expense per statistic. Statistics used in the analyses include patient days, discharges, average length of stay, equivalent patient days, equivalent discharges, case mix index, case mix adjusted patient days, case mix adjusted discharges, case mix adjusted equivalent patient days, case mix adjusted equivalent discharges, and full time equivalent employees.

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

Report 750. A copy of the hospital's and the hospital parent corporation's IRS Form 990, Return of Organization Exempt from Income Tax.

Submit PDF files of the hospital's and the hospital parent corporation's FY 2014 IRS Form 990, Return of Organization Exempt From Income filed with the U.S. Department of the Treasury, Internal Revenue Service. **Please note that Schedule A and all Statements referenced in IRS Form 990 must be filed with OHCA pursuant to Public Act 13-234 and that the hospital may redact the specific donor names on Schedule B.**

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

Fiscal Year Ended September 30, 2014
Twelve Months Actual Filing
Report of Independent Accountants on Applying Agreed-Upon Procedures

To the Board of Directors and Management
_____Hospital/Medical Center

We have performed the procedures enumerated below, which were agreed to by the State of Connecticut Department of Public Health, Office of Health Care Access Division (OHCA) and _____ Hospital/Medical Center (the “Hospital”), solely to assist the specified parties in evaluating the Hospital’s compliance with OHCA’s requirements for verification of Total Inpatient Payments, Total Outpatient Payments and Total Accrued Payments for the fiscal year ended September 30, 2014. The Hospital’s management is responsible for compliance with those requirements. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in this report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose. We were informed by the Hospital’s management and other personnel of the Hospital, who have responsibility for accounting and financial matters, that the filing is presented on the basis prescribed by OHCA’s instructions and related OHCA correspondence.

Our procedures and findings were as follows:

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

Findings:

No Exceptions were noted.

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

Findings:

No Exceptions were noted.

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

Findings:

No Exceptions were noted.

4. From the Hospital's records that were used to generate the Plus/Minus Other Adjustments total shown on Section III. A., Line 3 in the Net Revenue Reconciliation section of Report 600 (Plus/Minus Other Adjustments to OHCA Defined Net Revenue), we performed the following:
 - a. Read the description of the amounts included in Other Adjustments and compared the description to OHCA's definition of items that are not components of net revenue. These components are adjustments necessary to reconcile OHCA defined net revenue to the hospital's Audited Financial Statements.
 - b. Agreed amounts included in Other Adjustments to the Hospital's accounting records.

Findings:

No exceptions were noted.

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

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

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

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

March , 2015

FY 2014 Twelve Months Actual Filing HRS Reports Definitions**1. Report 100 – Hospital Balance Sheet Information****Definitions - General**

Since the source of HRS Reports 100, 150, 300, 350 are audited financial statements. The amounts to be reported must comply with accounting principles generally accepted in the United States (“GAAP”). The following definitions are being provided as a general guide and are not intended to contradict GAAP or the hierarchy of GAAP.

ASSETS:

- a. **Current Assets** - cash and other assets or resources expected to be realized in cash or consumed within the normal business cycle in usually one year. These are assets that are available to meet the cost of operations or to pay current liabilities.
- b. **Cash and cash equivalents** – all cash and highly liquid financial instruments that are both readily convertible to cash and so near to maturity that they represent an insignificant risk of changes in value due to interest rate changes. Cash and cash equivalents include cash, commercial paper, money market funds, certificate of deposits and corporate and government bonds which are readily available to be converted to liquid assets within three months.
- c. **Short-term investments** – excluding cash and cash equivalents, any other investments, primarily money market accounts, mutual funds and U.S. treasury notes with a maturity period of less than one year.
- d. **Accounts receivable (Less: Allowance for doubtful accounts)** – the amounts owed on open patient accounts including final settlements and appeals for the current year net of the allowance for doubtful accounts.
- e. **Current assets whose use is limited for current liabilities** – the current assets that are segregated and limited to meet current obligations.
- f. **Due from affiliates** – any receivable from an affiliate expected to be received in one year or less.
- g. **Due from third party payors** – the amounts due from third parties for retroactive adjustments such as final settlements or appeals expected to be received in one year or less.
- h. **Inventory of supplies** - medical and surgical supplies, pharmaceuticals, linens, uniforms, food, housekeeping, and maintenance and office supplies.
- i. **Prepaid expenses** - expenses that have been paid prior to having been accrued or incurred.

- j. Other current assets - all other current assets such that the calculated total current assets amount equals the amount reported in the audited financial statements.
- k. Total current assets - the sum of all current assets.
- l. Non-current assets – cash and other assets or resources not expected to be realized in cash or consumed within the normal business cycle. The normal business cycle is usually one year.
- m. **Non-current assets whose use is limited** – cash and other assets or resources not expected to be realized in cash or consumed within the normal business cycle, and that are restricted as to use. Non-current assets whose use is limited primarily include assets held by a trustee under indenture agreements, held by a captive insurance company, and held as donor restricted investments.
- n. Assets held by trustee – non-current assets whose use is limited that are held by a third party. Specifically excludes assets limited as to use by the reporting entity.
- o. Board designated for capital acquisition – non-current assets set aside by the governing body of an entity for a specific purpose such as to purchase land, equipment, capital leases, research, education or other non-current assets, or to be used in construction projects.
- p. Funds held in escrow – funds held by an agent usually for the retirement of long term debt. Specifically excludes assets limited as to use by the reporting entity.
- q. Other non-current assets whose use is limited – all other non-current assets whose use is limited such that the calculated total non-current assets whose use is limited amount equals the amount reported in the audited financial statements.
- r. Interest in the net assets of the foundation – the equity interest in the net assets of one or more foundations.
- s. Long-term investments – the sum of all marketable securities and other investments with a maturity of greater than one year as well as property held for investment purposes.
- t. Other Non-current assets – all other non-current assets such that the calculated total non-current assets amount equals the amount reported in the audited financial statements.
- u. **Net Fixed assets** – the assets intended to be held over the long term including land, property, equipment, furniture and other equipment.
- v. Property, plant & equipment – property, buildings and fixtures and equipment that are recorded at cost.
- w. Less: Accumulated depreciation – the total depreciation expense accumulated for property, plant and equipment that is usually recorded using the straight-line method.

- x. Property, plant and equipment, net – property, plant and equipment less accumulated depreciation.
- y. Construction in progress – the cost of construction that has started but has not been completed.
- z. Total net fixed assets – the sum of property, plant and equipment, net plus construction in progress.
- aa. Total assets - the sum of all short term and long term assets.

LIABILITIES AND NET ASSETS:

- a. **Current Liabilities** – obligations expected to be realized within the normal business cycle that is usually one year.
- b. Accounts payable and accrued expenses – the total amount owed to creditors for goods and services accruing to the current year but not payable until the following year.
- c. Salaries, wages and payroll taxes – the total amount owed to employees and governmental units accruing to the current year but not payable until the following year.
- d. Due to third party payors - the sum of the amounts owed to commercial payers, Medicare, Medicaid and any other payer other than the patient.
- e. Due to affiliates – the sum of the amounts owed to all affiliates of the reporting entity.
- f. Affiliate - a person, entity or organization controlling, controlled by, or under common control with another person, entity or organization, including but not limited to parent corporations, holding companies, related entities, joint ventures and partnerships. Factors to be considered include: common ownership of fifty or more percent; shared boards of directors; purpose; and whether an entity operates for the benefit of others. Control exists where an individual or organization has the power, directly or indirectly, to direct the actions or policy of an organization or entity. A person, entity or organization may be an affiliate for purposes of a particular project.
- g. Bonds payable – the sum of the amounts owed to repay fixed or variable rate bonds.
- h. Notes payable – the sum of the amounts owed to repay a written debt obligation.
- i. Current portion of long term debt – the total amount of all long term debt obligations that will be due within one year.

- j. Current portion of notes payable – the total amount of all notes payable that will be due within one year.
- k. Other current liabilities – all other current liabilities such that the calculated total current liabilities amount equals the amount reported in the audited financial statements.
- l. Total current liabilities - the sum of all current debt.
- m. **Long term debt** – the total financial obligations with a maturity date of more than one year.
- n. Bonds payable (Net of current portion) – the total amount of all bonds payable less the current portion of all bonds payable.
- o. Notes payable (Net of current portion) – the total amount of all notes payable less the current portion of all notes payable.
- p. Total long term debt – the sum of bonds payable (net of current portion) and notes payable (net of current portion).
- q. Accrued pension liability – the amount such that the projected benefit obligation exceeds the fair market value of the plan assets, if applicable.
- r. Other long term liabilities – all other long term liabilities such that the calculated total long term liabilities amount equals the amount reported in the audited financial statements.
- s. Total long term liabilities – the sum of all long term liabilities.
- t. Total Liabilities – the sum of all current and long term liabilities
- u. **Net Assets** – the amount of total assets that exceed total liabilities.
- v. Unrestricted net assets or equity – In the case of not-for-profit entities, the portion of net assets that have no donor restrictions as to use. For-profit entities will report this amount as equity.
- w. Temporarily restricted net assets – net assets that have been restricted by the donor for use to a specific timeframe or purpose.
- x. Permanently restricted – net assets that have been restricted by the donor to be maintained by the entity in perpetuity. The income generated from these funds can either be temporarily restricted or unrestricted.
- y. Total net assets or equity - the sum of unrestricted, temporarily restricted and permanently restricted net assets.

- z. Total Liabilities and Net Assets – The sum of total current liabilities, long term debt, and net assets.

2. Report 150 – Hospital Statement of Operations Information

- a. **Operating revenue** – earnings derived directly or indirectly from providing patient services.
- b. Total gross patient revenue – the total gross patient charges for all patient services before deductions for allowances, charity care and other deductions.
- c. Allowances – the sum of government and non-government allowances plus / (minus) prior year settlements.
- d. Charity Care – the care provided to patients who meet certain criteria under the entities written charity care policy. Charity care can be without charge or at amounts less than established rates.
- e. Other deductions – all other reductions to total gross revenue such that the calculated total net patient revenue equals the amount reported in the audited financial statements.
- f. Total net patient revenue – total gross patient revenue minus the sum of allowances, charity care and other deductions.
- g. Provision for Bad Debts – the adjustment to a hospital’s allowance for doubtful accounts due to the non-reimbursement of services rendered to patients from whom reimbursement was expected. Bad debts exclude any financial activity not associated with patient accounts receivable.
- h. Other operating revenue – all non-patient service operating revenue. Specifically other operating revenue includes, but is not limited to, fees from educational programs, rental of health care facility space, sales of medical and pharmaceutical supplies, sales of cafeteria meals, sales of scrap, gift shop sales, vending machines and excludes net assets released from restrictions for use in operations.
- i. Net assets released from restrictions for operations – when restrictions expire on temporarily restricted net assets intended for operations, the net assets are reclassified as unrestricted net assets and are reported on the statement of operations as net assets released from restrictions for use in operations.
- j. Total operating revenue - the sum of net patient revenue, other operating revenue and net assets released from restrictions for use in operations.
- k. **Operating Expenses** – the cost incurred while carrying out ongoing and central activities.
- l. Salaries and wages – physician and non-physician salaries and wages.

- m. Fringe Benefits – include, but are not limited to, the cost of all health, life, disability or other insurance or benefit plans, employee retirement plans, the cost or value of any bonus or incentive or longevity plans that are not included under normal salary reporting guidelines, the cost or value of any housing, and any items of value that are not specifically listed above.
- n. Physician Fees – the total compensation earned by physicians and residents on a fee for service basis for services rendered. This would include fee arrangements with physicians for patient care services and fees paid to physicians for educational services. Excludes fees paid directly to physicians by patients or their insurers.
- o. Supplies and Drugs – all non-salary expenses associated with medical supplies as well as all pharmaceutical and general drug costs.
- p. Depreciation and amortization expense – the expiration of the service life of fixed assets, which is charged as an expense during the year usually using the straight-line method, plus bond issuance costs that are being amortized over time.
- q. Interest expense – all interest paid on borrowing for operations, buildings, or equipment. Interest on borrowings during the construction phase should be treated in accordance with generally accepted accounting principles. Lease interest costs for operating and capitalized leases should also be included.
- r. Malpractice insurance costs – the total cost of medical malpractice insurance including primary insurance and any other form of medical malpractice insurance.
- s. Other operating expenses - all other operating expenses such that the calculated total operating expenses amount equals the amount reported in the audited financial statements.
- t. Total operating expenses - the sum of all operating expenses.
- u. Income/(loss) from operations – total operating revenue less total operating expenses.
- v. Non-operating revenue - income, interest and dividends from investments including net realized gains/(losses) on trading securities, other than temporary impairment losses, losses on refinancing transactions, gifts, contributions and donations all net of related expenses for the hospital and the hospital's net interest in its foundation. All of the previously noted items must be free of any donor restrictions.
- w. Income from investments – the income, interest and dividends in securities, real estate or any other type of asset that is not used for ongoing and central operations.
- x. Gifts, contributions and donations - the total of cash, securities, real estate, fixed assets, materials, services and other assets that have been provided by donors with no restrictions and for which the donors receive no direct private benefit.

- y. Other Non-operating gains/(losses) - all other non-operating gains/(losses) such that the calculated total non-operating gains/(losses) amount equals the amount reported in the audited financial statements.
- z. Total Non-operating revenue – the sum of income from investments and gifts, contributions and donations and other non-operating gains/(losses).
- aa. Excess/(Deficiency) of Revenue over Expenses – total operating revenue less total operating expenses plus total non-operating revenue.
- bb. Unrealized Gains / (Losses) – The difference between the carrying value of an investment and the value which the investment could be sold.
- cc. All Other Adjustments – Any other items required to be disclosed under accounting principles and guidelines.
- dd. Principal Payments – The total amount of principal payments made on hospital debt.

3. Report 165 – Hospital Gross and Net Revenue and Statistics by Payer¹

- a. Gross inpatient revenue - the total gross patient charges for hospital inpatient services consistent with Medicare principles of reimbursement.
- b. Gross outpatient revenue - the total gross patient charges for hospital outpatient services consistent with Medicare principles of reimbursement.
- c. Gross revenue - as defined in Section 19a-659 (13) of the Connecticut General Statutes, the total gross patient charges for all patient services provided by a hospital.
- d. Net revenue - as defined in Section 19a-659 (14) of the Connecticut General Statutes, the total gross revenue less contractual allowances, less the difference between government charges and government payments, less uncompensated care and other allowances

Payer classifications – see the following payer categories:

1. Nongovernmental: includes commercial and private payers;
2. CHAMPUS or TRICARE;
3. Medicaid: includes State of Connecticut Medicaid and Medicaid contracted through Medicaid managed care organizations;
4. Medicare: includes Medicare administered through designated fiscal intermediaries and/or carriers and Medicare contracted through managed care organizations;
5. Total medical assistance: includes Medicaid and any other state of CT medical assistance programs;

¹ Hospital Financial Review Regulations Sec.19a-643-201(b)(27-29),(33),(34),(37),(41),(50),(53),(63)

6. Other government payments: includes payments identified in 42 USC 701 through 42 USC 710, inclusive, as from time to time amended;
 7. Uninsured: includes individuals with no insurance; and
 8. Other payers: includes Out of State activity.
- e. Nongovernmental - any commercial or private payer and includes, but is not limited, to managed care organizations, health maintenance organizations (HMOs) and preferred provider organizations (PPOs).
 - f. Preferred Provider Organization (PPO) - a managed care organization, which provides health care coverage through leasing of contracts made with health care providers to insurers and employers for a fee, and which performs utilization review services.
 - g. CHAMPUS or TRICARE - as defined in section 19a-659 (7) of the Connecticut General Statutes, the federal Civilian Health and Medical Program of the Uniformed Services, as defined in 10 USC 1072 (4), as from time to time amended.
 - h. Managed Care Organization - a “Managed Care Organization” as defined in Section 38a-1040 of the Connecticut General Statutes, or an eligible organization as defined by Medicare in 42 USC 1395mm (b) as from time to time amended, and which can also include health maintenance organizations (HMOs) and preferred provider organizations (PPOs).
 - i. Medicaid - the federal and state health insurance program established under Title XIX of the Social Security Act to provide medical assistance on behalf of families with dependent children and for aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and which is administered by the Department of Social Services pursuant to Chapter 319v of the Connecticut General Statutes.
 - j. Medicare - the federal health insurance program provided for the aged and disabled in 42 USC 1395 through 42 USC 1395 kkk-1, inclusive, as from time to time amended.
 - k. Uninsured patient - a patient who is without health insurance for whom the payor responsible for payment of the bill for hospital services rendered is the patient, the patient’s parent or guardian or another responsible person, who is not a third party payor and who is not subsequently reimbursed by another payor for the cost of any of the services rendered to the patient. A patient shall not be classified as an uninsured patient, if such subsequent reimbursement takes place.
 - l. Self-Pay - an uninsured or underinsured patient from whom reimbursement is expected.

4. Report 175 – Hospital Operating Expenses by Expense Category and by Department

Operating Expenses by Category – Section I. of Report 175

- a. Nursing Salaries – salaries and wages paid to all nursing positions including direct patient care nursing and nursing administration.
- b. Physician Salaries – physician compensation including salaries and wages for all physicians and residents engaged in patient care and educational activities. Residents include Externs and Fellows.
- c. Non-Nursing, Non-Physician Salaries – salaries and wages paid to employees who are not classified as either nursing personnel or physicians.
- d. Nursing Fringe Benefits – fringe benefits paid to all nursing positions including direct patient care and nursing administration.
- e. Physician Fringe Benefits – fringe benefits paid to all physicians and interns engaged in patient care and educational activities. Residents exclude Externs and Fellows.
- f. Non Nursing, Non Physician Fringe Benefits – fringe benefits paid to employees who are not classified as either nursing personnel or physicians.
- g. Nursing Fees - total compensation earned by nurses on a fee basis for services rendered to the hospital.
- h. Physician Fees - total compensation earned by physicians and residents on a fee for service basis for services rendered to the hospital.
- i. Non Nursing, Non Physician Fees - total compensation earned by employees that are not either physicians, residents, or nurses on a fee for service basis for services rendered to the hospital.
- j. Medical Supplies - all non-salary expenses associated with medical supplies.
- k. Pharmaceutical Costs - all non-salary expenses associated with pharmaceutical and general drug costs.
- l. Depreciation - Building - the expiration of the service life of the physical plant, which is charged as an expense during the year, usually using the straight-line method.
- m. Depreciation - Equipment - the expiration of the service life of equipment, which is charged as an expense during the year, usually using the straight-line method.

- n. Amortization – bond issuance costs that are being amortized over time.
- o. Bad Debts - the adjustment to a hospital's allowance for doubtful accounts due to the non-reimbursement of services rendered to patients from whom reimbursement was expected, resulting in the recording of bad debt expense. Bad debts exclude any financial activity not associated with patient accounts receivable.
- p. Interest Expense – all interest paid on borrowing for operations, buildings, or equipment.
- q. Malpractice Insurance Cost - the total cost of medical malpractice insurance including primary insurance and any other form of medical malpractice insurance.
- r. Water – expenses paid to the water company for water usage.
- s. Natural Gas – expenses paid to the natural gas company for natural gas usage.
- t. Oil - expenses paid to the oil company for oil usage.
- u. Electricity - expenses paid to the electric company for electricity usage.
- v. Telephone - expenses paid to the telephone company for telephone service.
- w. Other Utilities - expenses paid for miscellaneous utility usage not categorized by one of the above categories.
- x. Accounting Fees – expenses paid to certified public accounting firms for work related to the hospital's financial records.
- y. Legal Fees – expenses paid to attorneys and their law firms for legal advice on hospital matters.
- z. Consulting Fees – expenses paid for independent consultants and/or consulting firms hired by the hospital.
- aa. Dues and Memberships – expenses paid for dues and memberships to national or local organizations.
- bb. Equipment Leases – expenses paid for all medical and non-medical equipment leased by the hospital.
- cc. Building Leases – expenses paid for buildings or office space leased by the hospital.
- dd. Repairs and Maintenance – expenses paid for repairing equipment or maintaining the hospital's physical plant.

- ee. Insurance Expense – expenses paid for insurance on the hospital physical plant or on hospital employees.
- ff. Travel – expenses paid for work related travel.
- gg. Conferences – expenses paid for holding or attending conferences.
- hh. Property Tax – expenses paid for taxes on the hospital’s building and equipment.
- ii. General Supplies – expenses paid for supplies used in the hospital regardless of department.
- jj. Licenses and Subscriptions – expenses paid for specialty licenses needed by hospital members or for fees paid for trade publications.
- kk. Postage and Shipping – expenses paid for postage, certified mail and overnight delivery charges.
- ll. Advertising – expenses paid for advertising in newspapers, magazines, trade journals, etc.
- mm. Corporate Parent / System Fees – expenses for management fees, corporate allocation percentage, intercompany or affiliation fees paid to a parent organization.
- nn. Computer Software – expenses for contracts and maintenance for computer programs and licenses.
- oo. Computer Hardware & Small Equipment – expenses for purchases of computer equipment and small equipment.
- pp. Dietary / Food Services – expenses for purchases for groceries, food and beverages, spoilage, and food supplies.
- qq. Lab Fees / Red Cross Charges – expenses for lab tests and purchases of blood from the Red Cross.
- rr. Billing & Collection / Bank Fees – expenses for billing and collecting of patient balances and fees charged by banks.
- ss. Recruiting / Employee Education & Recognition – expenses for costs related to staff development and training, tuition, service awards, etc.
- tt. Laundry / Linen – expenses for hospital laundry and linen services.
- uu. Professional / Physician Fees – expenses for physician fees and professional services.
- vv. Waste Disposal – expenses for costs of any hazardous waste, medical waste, or trash removal.

- ww. Purchased Services – Medical – expenses for purchased services that are medically related to patient care.
- xx. Purchased Services – Non Medical – expenses for purchases services that are non-medically related to patient care.
- yy. Other Operating Expenses - any miscellaneous operating expenses the hospital may incur that cannot be classified in any of the above listed categories.

Operating Expenses by Department – Section II. of Report 175

- a. General Services – General Services operating expenses are to be entered for each applicable department.
- b. Professional Services - Professional Services operating expenses are to be entered for each applicable department.
- c. Special Services - Special Services operating expenses are to be entered for each applicable department.
- d. Routine Services – Routine Services operating expenses are to be entered for each applicable department.
- e. Other Departments – Other Departments operating expenses are to be entered if the hospital has a department that cannot be categorized into one of the four categories listed above.

5. Report 185 – Hospital Financial and Statistical Data Analysis

See the definitions listed under Reports 100, 150, 400, 450, 500 and 650.

6. Report 200 – Hospital Medicare Managed Care Activity

Medicare Managed Care Discharges, Patient Days, Outpatient Visits & Emergency Room Visits by individual payer – the charges, payments, patient days, outpatient visits, Emergency Department outpatient visits and Emergency Department inpatient admissions associated with each individual Medicare Managed Care payer. The potential payers in the Medicare Managed Care Program are Aetna, Anthem BC/BS - Medicare Blue Connecticut, Connecticut, Inc., CIGNA Healthcare, Evercare, HealthNet of Connecticut, Humana, Oxford Health Plans, Inc. – Medicare Advantage, Secure Horizons, Unicare Life and Health, United Healthcare Insurance Company, Universal American, Wellcare of Connecticut and the miscellaneous payer category referred to as ‘Other Medicare Managed Care’, which should be used for reporting the activity for out-of-state plans and residual activity from any in-state plans that are not listed above.

7. Report 250 – Hospital Medicaid Managed Care Activity

Since the Medicaid program changed on January 1, 2012, some of the following definitions for Report 250 are only applicable through the time periods prior to January 2012.

Medicaid Managed Care Discharges, Patient Days, Outpatient Visits & Emergency Room Visits by individual payer - the charges, payments, patient days, outpatient visits, Emergency Department outpatient visits and Emergency Department inpatient admissions associated with each individual Medicaid Managed Care payer. The potential payers in the Medicaid Managed Care Program are Aetna, Anthem BC/BS - Blue Care Family Plan, Community Health Network of CT, HealthNet (Healthy Options) United Healthcare, Wellcare/Preferred One, and the miscellaneous payer category referred to as 'Other Medicaid Managed Care', which should be used for reporting the activity for out-of-state plans and residual activity from any in-state plans that are not listed above.

The **Husky Part A** plan covers services under the Medicaid Managed Care Program. Charges and payments related to Husky Part A should be reported under Medicaid Managed Care. The **Husky Part B** plan covers services under Title XXI (State Children's Health Program- SCHIP). Charges and payments related to Husky Part B should be included with Non-Governmental Contractual payer information on HRS Reports 165, 500 and 685.

Beginning January 1, 2012, DSS contracted with a single medical administrative services organization (ASO) to coordinate medical care across several health care coverage programs. The new model replaced the former managed care delivery system. The ASO will authorize and manage the medical health services for all Husky A, Husky B, and Charter Oak Health Plan clients. The ASO will also authorize and manage the medical health services for the Medicaid Aged, Blind and Disabled (ABD) and Low Income Adult (LIA) populations. The portion of the program that serves Medicaid ABD participants will be referred to as Husky C; the portion that serves Medicaid LIA will be known as Husky D. Effective January 1, 2014, all children will be enrolled in Title XIX/Medicaid. Activity for Charter Oak Health Plan should still be considered commercial up until December 31, 2013.)

8. Report 300 – Parent Corporation Consolidated Balance Sheet Information

See the definitions listed under Report 100 above.

9. Report 350 – Parent Corporation Consolidated Statement of Operations Information

See the definitions listed under Report 150 above.

10. Report 385 – Parent Corporation Consolidated Financial Data Analysis

See the definitions listed under Report 100 and Report 150 above.

11. Report 400 – Actual Hospital Inpatient Bed Utilization by Department

HRS Report 400 provides a summary of actual FY 2013 Patient Days, Staffed Beds and Available Beds by inpatient service. The hospitals must provide these statistics for the following inpatient service departments:

Adult Medical/Surgical	Maternity
ICU/CCU (excluding Neonatal ICU)	Newborn
Psychiatric - by age group : Age = 0-17, Age = 18+	Neonatal ICU
Rehabilitation	Pediatric
	Other

In reporting the utilization statistics for the inpatient services listed above, the hospitals must adhere to the following rules:

- a. Discharges or ICU/CCU Patients
In Column 3a, the number of discharges or ICU/CCU patients by department.
- b. Admissions
In Column 3b, the number of hospital admissions by department.
- c. Staffed Beds
In Column 4, the average number of beds with sufficient staff occupied by patients during the fiscal year. This number may not exceed the number of available beds for each service department or in total.
- b. Available Beds
In Column 5, the average number of beds in service in nursing units that could be occupied by patients during the fiscal year. This number must not be lower than the number of staffed beds for each service department or in total.
- c. Occupancy of Staffed Beds
In Column 6, the Percentage of Occupancy of Staffed Beds must be less than 100.0% for each department listed above.
- d. Occupancy of Available Beds
In Column 7, the Percentage of Occupancy of Available Beds must be less than 100.0% for each department listed above.
- e. Total Licensed Beds and Bassinets
At the bottom of Column 3, the sum of the two licensed beds and licensed bassinets numbers on the hospital’s Department of Public Health (DPH) License as of September 30, 2014.

12. Report 450 – Actual Hospital Inpatient, Outpatient, and Outpatient Other Services Utilization and Full Time Equivalent Employees

Hospitals must report inpatient, outpatient, Emergency Department and other Non-Hospital Providers' other services utilization as defined by the following revenue and procedure codes:

Report 450 – Instructions for Selected Data Fields

Line #	Actual Services	Revenue Codes ¹	CPT/HCPCS Codes ²
A.1 - A.4	CT Scans (Tests) ³	0350-0359	70450-70498, 71250-71275, 72125-72133, 72191-72194, 72292, 73200-73206, 73700-73706, 74150-74178, 74261-74263, 75571-75574, 75635, 76380, 76497, 77011-77014, 77078, 78072, 78607, 0042T
B.1 - B.4	MRI Scans (Tests) ⁴	0610, 0611, 0612, 0614, 0619	70336, 70540, 70542, 70543, 70544-70549, 70551-70555, 70557-70559, 71550-71552, 71555, 72141, 72142, 72146-72158, 72159, 72195-72197, 72198, 73218-73223, 73225, 73718-73723, 73725, 74181-74183, 74185, 75557-75565, 76390, 76498, 77021-77022, 77058, 77059, 77084, C8900-8902, C8903-C8908, C8909-8920, C8931-8936, 0159T
C.1 - C.4	PET Scans (Tests) ⁵	0404	77424, 77425, 78459, 78491, 78492, 78608, 78609, 78811-78813, G0219, G0235, G0252
D.1 - D.4	PET/CT Scans ⁶		78814-78816
E.1 - E.2	Linear Accelerator Procedures ⁷		77371, 77372, 77373, 77401-77423, 77435, G0173, G0251, G0339, G0340
K.	Emergency Room Visits ⁸	0450-0459	99281-99288

Report 450 – Instructions for Selected Data Fields

Line #	Actual Services	Revenue Codes ¹	CPT/HCPCS Codes ²
L.		Hospital Clinic Visits:	
L.1	Substance Abuse Treatment Clinic Visits	0944, 0945	
L.2	Dental Clinic Visits	0512	
L.3	Psychiatric Clinic	0513	90791-90792, 90791 or 90792 + 90785,

	Visits ⁹		90832, 90834, 90837 + 90833, 90836, 90838, 99201-99255, 99004-99337, 99341-99350. 90832, 90834, 90837+ 90785 or 90833, 90836, 90838, 99201-99255, 99004-99337, 99341-99350, 90832-90838, 90839, 90840, 90832-90838 +90785+90832, 90834, 90837 or 90833, 90836, 90838, 90845-90849, 90853+90785, 90863+90832, 90834, 90837 or 99201-99255, 99281-99285, 99304-99337, 99341-99350 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90882, 90885, 90887, 90889, 90899 and any other codes and code changes which are consistent with the 2014 CPT Codes Manual Psychiatry Services Section, pages 358-362.
L.4	Medical Clinic Visits ¹⁰	0515, 0516, 0517	
L.5	Specialty Clinic Visits ¹¹	0510, 0511, 0514, 0519	
	Total Hospital Clinic Visits	0944, 0945, 0512, 0513, 0515, 0516, 0517, 0510, 0511, 0514, 0519	
M.		Other Hospital Outpatient Visits	
M.1	Rehabilitation ¹²	0421, 0431, 0441	
M.2	Cardiac Rehabilitation ¹³	0943	93797, 93798
M.3	Chemotherapy ¹⁴	0331, 0332, 0335	96401-96549
M.4	Gastroenterology ¹⁵		43200-43232, 43234-43272, 44360-44397, 45300-45392, 46600-46615, 74210-74363
M.5	Other ¹⁶		
	Total Other Hospital Outpatient Visits	0421, 0431, 0441, 0943, 0331, 0332, 0335	

Please provide total counts on what the hospital reports on patient billing forms UB-04/CMS-1450, CMS-1500 or the electronic equivalents per discharge or encounter. Refer to Columns 3 and 4 for instructions on specific line numbers. Codes listed in the two columns are effective as at January 1, 2012 and change concurrently with the Centers of Medicare and Medicaid Services (CMS) claims processing updates. For line numbers where both revenue and CPT codes can be provided, please report data using only one of the two coding systems.

¹Revenue codes and service units are as reported on CMS 1450 fields 42 and 26 or the electronic equivalent and as defined by the most current version of the National Uniform Billing Committee (NUBC) Official UB-04 Data Specification Manual Form Locators 42 and 46.

²American Medical Association (AMA) annually updates Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes and units of service reported under CMS-1500 fields 24D and 24G or UB-04/CMS-1450 fields 44 and 46 or the electronic equivalent.

³CPT January 2012

⁴CPT January 2012

⁵⁻⁶CPT January 2012

⁷CPT/HCPCS codes obtained from CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 1139, issued by the Department of Health and Human Services, CMS on December 22, 2006 and implemented January 2, 2007.

⁸Includes all registered patient encounters to the ED. ED services performed at satellite campuses operating under the hospital license number are to be reported in the ED volume.

⁹CPT January 2014 Psychiatry Services

¹⁰Includes pediatric, urgent care and family practice clinic visits.

¹¹Includes cardiac, chronic pain, OB-GYN and other clinic visits.

¹²Include any medical, health related-therapy, social and/or vocational services to help disabled persons attain or retain their maximum functional capacity (i.e. physical therapy, occupational, and/or speech therapy). **EXCLUDE** respiratory, cardiac rehabilitation and chronic obstructive pulmonary disease services and diagnostic tests performed on an outpatient basis. Both hospital-based and off-site hospital owned facility visits.

¹³Provide the outpatient cardiac rehabilitation visits assigned revenue codes or CPT codes.

¹⁴Provide the outpatient chemotherapy visits assigned revenue codes or CPT codes.

¹⁵Provide the outpatient gastroenterology visits assigned revenue codes or CPT codes.

¹⁶ Provide the outpatient other visits not listed under Sections M.1 through M.4.

Report 450 - Cardiac Procedure Definitions

Cardiac Catheterization

Definition: Diagnostic procedure involving insertion of catheter to assess coronary anatomy, conduction, and hemodynamics.

ICD-9-CM Codes: 37.21, 37.22, and 37.23

Outpatient: Same day admission and discharge in order to receive diagnostic cardiac procedures.

Inpatient: Duration between admission and discharge dates greater than one day.

Coding Instructions: Patients are considered to have received 1 cardiac catheterization procedure if their medical record includes any of the ICD-9-CM codes listed above.

- Multiple catheterization codes corresponding to the same visit to the cardiac catheterization laboratory are considered to constitute 1 cardiac catheterization (e.g., a patient receiving ICD-9-CM cardiac catheterization procedure codes 37.21 and 37.22 during 1 catheterization laboratory visit generates 1 cardiac catheterization procedure).
- If during the same admission, the patient receives a cardiac catheterization, leaves the cardiac catheterization laboratory but later returns to it and receives (an) additional catheterization procedure(s), then this (these) additional catheterization procedure(s) is (are) considered to constitute a second cardiac catheterization procedure (e.g., a patient receiving ICD-9-CM cardiac catheterization procedure codes 37.21 and 37.22 during one catheterization laboratory visit, leaves the catheterization laboratory, but returns and receives an ICD-9-CM cardiac catheterization code 37.22 generates 2 cardiac catheterization procedures).

Angioplasty

Definition: Percutaneous transluminal intervention to restore blood flow in (a) blocked coronary artery(ies).

ICD-9-CM Codes: .66, 36.03, 36.04, 36.06, and 36.07

Primary Angioplasty: Performed as an emergency procedure due to ongoing, refractory, unrelenting cardiac compromise, with or without hemodynamic instability. Most typically performed on patients with a primary diagnosis of Acute Myocardial Infarction (ICD-9-CM Codes 410.00 – 410.90) with ST-Segment Elevation or a primary diagnosis of Left Bundle Branch Blockage (ICD-9-CM Codes 426.2 – 426.3, 426.50 – 426.54).

- *ST-Segment Elevation Guidelines (Use either):*
 - *ACC/NDR definition:* New or presumed new ST segment elevation at the J point in two or more contiguous leads with cut-off points >0.2mV in leads V1, V2, or V3, or >0.1 in other leads; or development of any Q wave in leads V1 through V3, or the development of a Q-wave > to 30 ms (0.03s) in leads I, II, aVL, aVF, V4, V5, or V6 - Q wave changes must be present in any two contiguous leads, and be > to 1 mm in

depth.
<ul style="list-style-type: none"> ○ <i>CPORT Definition:</i> Myocardial ischemia of at least 30 minutes duration but less than 12 hours of ongoing ischemic cardiac pain at presentation, and either: At least 1mm of ST-segment elevation in 2 or more contiguous ECG leads, or at least 1mm ST-segment depression in leads V₁ and V₂ consistent with true posterior wall infarction/injury, or presumed new Left Bundle Branch Blockage.
<p>Elective Angioplasty: Angioplasty performed as a non-emergent procedure. See primary angioplasty definition for emergent guidelines.</p>
<p>Coding Instructions: Patients are considered to have received 1 angioplasty procedure if their medical record includes any of the ICD-9-CM codes listed above.</p>
<ul style="list-style-type: none"> • Multiple angioplasty codes corresponding to the same visit to the cardiac catheterization laboratory are considered to constitute one angioplasty (e.g., a patient receiving ICD-9-CM procedure codes .66 and 36.07 during 1 catheterization laboratory visit generates 1 angioplasty procedure). • If during the same admission, the patient receives an angioplasty, leaves the cardiac catheterization laboratory but later returns to it and receives (an) additional angioplasty procedure(s), then this (these) additional angioplasty procedure(s) is (are) considered to constitute a second angioplasty procedure (e.g., a patient receiving ICD-9-CM angioplasty procedure codes .66 and 36.07 during one catheterization laboratory visit, leaves the catheterization laboratory, but returns and receives ICD-9-CM angioplasty code 36.06 generates 2 angioplasty procedures).

<p>Report 450 - Cardiac Electrophysiological Services (EPS)</p>
<p>Definition: Invasive cardiac diagnostic procedures used to assess the heart’s electrical functioning and the location and source of irregular heartbeats.</p>
<p>ICD-9-CM Codes: 00.50, 00.51, 00.52, 00.53, 00.54, 37.26, 37.27, 37.33, 37.34, 37.71, 37.72, 37.73, 37.74, 37.75, 37.76, 37.77, 37.78, 37.79, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.97, 37.98, 99.61.</p>
<p>Coding Instructions: Patients are considered to have received 1electrophysiologic study if their medical record includes any one the ICD-9-CM codes listed above and has at least one of the following primary diagnosis codes or clinical signs/symptoms: 426.0, 426.10, 426.12, 426.13, 426.51, 426.52, 426.53, 426.54, 427.81, 780.2, 780.4, 426.7, 427.0, 427.1, 427.31, 427.32, 427.41, 427.42, 427.5, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9., 410.00 – 410.92, 412, 414.8, 425.4, 745.4, 745.5, 745.60, 745.61 and 745.69.</p>
<ul style="list-style-type: none"> • Multiple cardiac electrophysiological study codes corresponding to the same visit to the electrophysiology/cardiac catheterization laboratory are considered to constitute one cardiac electrophysiological study (e.g., a patient receiving an ICD-9-CM procedure codes 00.50 and 00.51 during 1 electrophysiology/catheterization laboratory visit generates 1 cardiac electrophysiological study).
<ul style="list-style-type: none"> • If during the same admission, the patient receives a cardiac electrophysiological study, leaves the electrophysiology/cardiac catheterization laboratory but later returns to it and receives (an) additional cardiac electrophysiological study, then this (these)

additional cardiac electrophysiological study(ies) (are) considered to constitute a second cardiac electrophysiological study (e.g., a patient receiving a cardiac electrophysiological study (code 00.50) during one electrophysiology/ cardiac catheterization laboratory visit, leaves the electrophysiology/cardiac catheterization laboratory, but returns and receives a cardiac electrophysiological study (code 00.50) generates 2 cardiac electrophysiological studies).

Report 450 - Hospital Staff Full Time Equivalent Employees

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

- a. Total Nursing FTEs – the hospital must provide a total staff count of Hospital nursing personnel who provide direct services to patients (includes APRNs, RNs, LPNs and CNAs) and nursing administrative personnel.
- b. Total Physician FTEs – the hospital must provide a total staff count of Hospital personnel who provide direct services to patients as physicians.
- c. Total Non-Nursing and Non-Physician FTEs – the hospital must provide a total staff count of hospital personnel other than nursing or physician personnel.

For data definitions a., b. and c. above, one FTE is defined as equal to 2,080 total hours paid for employee compensation or 40 hours per week for a period of 52 weeks.

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

See the definitions listed under Report 450 above.

14. Report 500 – Calculation of DSH Upper Payment Limit and Baseline Underpayment Data: Comparative Analysis

- a. Major payer - the payer responsible for the highest percentage of the charges for the case. Major payers include Non-government (including the uninsured), Uninsured, Medicare, Medicaid, Total Medical Assistance, Other Medical Assistance and CHAMPUS/TRICARE.
- b. Medicare - the federal health insurance program provided for the aged and disabled in 42 USC 1395 through 42 USC 1395 kkk-1, inclusive, as from time to time amended. Medicare includes Medicare administered programs through designated fiscal intermediaries and carriers and Medicare contracted programs through managed care organizations.
- c. Nongovernmental - any commercial or private payer including the uninsured. Commercial payers include, but are not limited to, managed care organizations, health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

- d. Uninsured - individuals with no insurance for the patient services being provided.
- e. Uninsured patient - a patient who is without health insurance for whom the payer responsible for payment of the bill for hospital services rendered is the patient, the patient's parent or guardian or another responsible person, who is not a third party payer and who is not subsequently reimbursed by another payer for the cost of any of the services rendered to the patient. A patient shall not be classified as an uninsured patient, if such subsequent reimbursement takes place.
- f. Medicaid - the federal and state health insurance program established under Title XIX of the Social Security Act to provide medical assistance on behalf of families with dependent children and for aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and which is administered by the Department of Social Services pursuant to Chapter 319v of the Connecticut General Statutes. Medicaid includes fee-for-service Medicaid and Medicaid contracted through Medicaid managed care organizations.
- g. Other Medical Assistance - the difference between Total Medical Assistance and Medicaid.
- h. Total Medical Assistance - Medicaid, out-of-state-Medicaid and other State of Connecticut medical assistance programs.
- i. CHAMPUS or TRICARE - the federal Civilian Health and Medical Program of the Uniformed Services, as defined in 10 USC Section 1072 (4), as from time to time amended.
- j. Inpatient accrued charges - the total inpatient accrued gross patient revenue for hospital inpatient services consistent with Medicare principles of reimbursement.
- k. Inpatient accrued payments - the total inpatient accrued charges less accrued inpatient contractual allowances.
- l. Case mix index – the arithmetic mean of the Medicare diagnosis related group case weights assigned to each inpatient discharge for a specific hospital during a given fiscal year. The case mix index shall be calculated by dividing the hospital's total case mix adjusted discharges by the hospital's actual number of discharges for the fiscal year. The total case mix adjusted discharges shall be calculated by (A) multiplying the number of discharges in each diagnosis-related group by the Medicare weights in effect for that same diagnosis-related group and fiscal year, and (B) then totaling the resulting products for all diagnosis-related groups.
- m. Discharge - any patient who was discharged on a date subsequent to the date admitted to the hospital for treatment as an inpatient, except that it shall also mean such patient was admitted and discharged on the same day, where such patient died, or left against medical advice, or was formally released from the hospital.

- n. Outpatient accrued charges - the total accrued gross patient revenue for hospital outpatient services consistent with Medicare principles of reimbursement.
- o. Outpatient accrued payments - the total outpatient accrued charges less accrued outpatient contractual allowances.
- p. Non-government contractual allowances - the amount of discounts provided to nongovernmental payers pursuant to a written agreement.
- q. Other Operating revenue - revenue from non-patient goods and services. Such revenue should be normal to the operation of a hospital but should be accounted for separately from patient revenues and includes, but is not limited to, the following: revenue from gifts, grants, parking fees, recovery of silver from x-ray film, fees from educational programs, rental of health care facility space, sales from hospital gift shops, cafeteria meals, subsidies specified by the donor for research, educational or other programs, revenues restricted by the donor or grantor for operating purposes, and net assets released from restrictions. Bad debt recoveries shall not be considered to be other operating revenue.
- r. Operating expense - the expenses necessary to maintain the functions of the hospital including, but not limited to, any collection agency or debt collection expense.
- s. Charity Care – free or discounted health care services rendered by a hospital to persons who cannot afford to pay, including but not limited to, care to the uninsured patient or patients who are not expected to pay all or part of a hospital bill based on income guidelines and other financial criteria set forth in statute or in a hospital’s charity care policies on file at OHCA. Bad debts, courtesy discounts, contractual allowances, self-pay discounts, and charges for health care services provided to employees are not included under the definition of charity care.
- t. Bad Debts - the year-end adjustments to a hospital’s allowance for doubtful accounts due to the non-reimbursement of services rendered to patients from whom reimbursement was expected. Bad debts exclude any financial activity not associated with patient accounts receivable.
- u. Uncompensated Care - the total amount of charity care and bad debts determined by using the hospital’s published charges and consistent with the hospital’s policies regarding charity care and bad debts which have been and are on file at OHCA.
- v. Total accrued charges - the total gross patient revenue for all patient services provided by a hospital.
- w. Total Government deductions - the difference between total accrued charges and total accrued payments for Medicare, Total Medical Assistance and CHAMPUS/TRICARE.

- x. Employee self- insurance allowance - the amount of any difference between charges for employee self-insurance and related expenses determined by using the hospital's overall relationship of costs to charges.
- y. Total accrued payments - the total accrued charges less total accrued contractual allowances.
- z. Net revenue - as defined in Section 19a-659(14) of the Connecticut General Statutes, total gross revenue less contractual allowance, less the difference between government charges and government payments, less uncompensated care and other allowances, plus uncompensated care program disproportionate share hospital payments from the Department of Social Services.
- aa. Medical assistance underpayment – the amount calculated by dividing the total net revenue by the total gross revenue, and then multiplying the quotient by the total medical assistance charges, and then subtracting medical assistance payments from the product.
- bb. Cost of uncompensated care - uncompensated care charges times the ratio of total operating expense divided by the total of gross patient charges plus other operating revenue.

15. Report 550 – Calculation of DSH Upper Payment Limit and Baseline Underpayment Data

See the definitions listed under Report 500 above.

16. Report 600 – Summary of DSH Upper Payment Limit and Baseline Underpayment Data: Agreed-Upon Procedures

See the definitions listed under Report 500 above.

17. Report 650 – Hospital Uncompensated Care

- a) Applicants - for purposes of this HRS Report, applicants are considered to be patients and do not represent individual encounters by a single patient.
- b) Charity Care Charges – the total amount of hospital charity care charges associated with free or discounted health care services rendered by a hospital to persons who cannot afford to pay, including but not limited to, care to the uninsured patient or patients who are not expected to pay all or part of a hospital bill based on income guidelines and other financial criteria set forth in statute or in a hospital’s charity care policies on file at OHCA. Bad debts, courtesy discounts, contractual allowances, self-pay discounts, and charges for health care services provided to employees are not included under the definition of charity care charges.
- c) Ratio to Cost Charges (RCC) – the ratio that indicates the percentage of total operating expense to the total of gross patient charges plus other operating revenue for FY 2013 that was provided to the hospitals by OHCA.

- d) Patient Days – the number of days that a patient received inpatient hospital services that included each day’s 12:00 a.m. midnight census.
- e) Discharges – the number of patients who were discharged on a date subsequent to the date admitted to the hospital for treatment as inpatients, except that it shall also mean such patients who were admitted and discharged on the same day, where such patients died or left against medical advice or were formally released from the hospital.
- f) Outpatient Emergency Department Visits – the number of visits by patients seen in a hospital emergency room that were treated and discharged.
- g) Outpatient Visits (Excludes ED Visits) – the number of visits by patients who have not been admitted to the hospital while receiving hospital services on an outpatient basis, excluding outpatient Emergency Department visits. Each appearance of a patient in the hospital constitutes one visit regardless of the number of diagnostic tests and/or therapeutic treatments that the patient receives during each outpatient visit.
- h) Charity Care— free or discounted health care services rendered by a hospital to persons who cannot afford to pay, including but not limited to, care to the uninsured patient or patients who are not expected to pay all or part of a hospital bill based on income guidelines and other financial criteria set forth in statute or in a hospital’s charity care policies on file at OHCA. Bad debts, courtesy discounts, contractual allowances, self-pay discounts, and charges for health care services provided to employees are not included under the definition of charity care.
- i) Bad Debts - the year-end adjustments to a hospital’s allowance for doubtful accounts due to the non-reimbursement of services rendered to patients from whom reimbursement was expected. Bad debts exclude any financial activity not associated with patient accounts receivable.
- j) Uncompensated Care - the total amount of charity care and bad debts determined by using the hospital’s published charges and consistent with the hospital’s policies regarding charity care and bad debts which have been approved by and are on file at OHCA.

18. Report 685 – Hospital Non-Government Gross Revenue, Contractual Allowances, Accrued Payments and Discount Percentage

See the definitions listed under Report 500 above.

19. Report 700 – Statistical Analysis of Hospital Revenue and Expense

See the definitions listed under Reports 150, 175, 450 and 500 above.