SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

► Complete if the organization answered 'Yes' to Form 990, Part IV, question 20.
► Attach to Form 990. ► See separate instructions.
► Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

The New Milford Hospital, Inc.

Employer identification number

06-0669121

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			737,981.	205,443.	532,538.	0.82
b Medicaid (from Worksheet 3, column a)		8,307	8,198,705.	5,779,094.	2,419,611.	3.73
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs	0	8,307	8,936,686.	5,984,537.	2,952,149.	4.55
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	152	6,871	273,220.	37,555.	235,665.	0.36
f Health professions education (from Worksheet 5)	1	1	396.		396.	0.
g Subsidized health services (from Worksheet 6)		633	906,705.	623,085.	283,620.	0.44
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits	153	7,505	1,180,321.	660,640.	519,681.	0.80
k **Total.** Add lines 7d and 7j	153	15,812	10,117,007.	6,645,177.	3,471,830.	5.35

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

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development	1	1	347.		347.	
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building	5	6,176	74,770.		74,770.	0.12
7	Community health improvement advocacy	2	263	2,051.		2,051.	
8	Workforce development						
9	Other						
10	Total	8	6,440	77,168.	0.	77,168.	0.12

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount Part VI	2	754,130.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and rationale, if any, for including this portion of bad debt as community benefit Part VI	3			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements. Part VI				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	20,760,082.		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	30,624,628.		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-9,864,546.		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: Part VI				

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees and physicians - see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

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

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

Name, address, primary website address, and state license number	Licensed hospital	General medical and surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 New Milford Hospital, Inc. 21 Elm Street New Milford, CT 06776 www.newmilfordhospital.org 0032	X	X					X	X		

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

Section B. Facility Policies and Practices

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

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

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 1

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

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

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

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

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

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☐ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☐ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Section C)

Policy Relating to Emergency Medical Care

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

If 'No,' indicate why:

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

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

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

- a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☒ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by 'Facility A,' 'Facility B,' etc.

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

Facility: New Milford Hospital, Inc.

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

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

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

Facility: New Milford Hospital, Inc.

New Milford Hospital, and its affilate partner, Danbury Hospital, participated in the development of a Community Report Card for the Housatonic Valley Region, a 10-district municipality that includes Danbury and New Milford, CT.

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

Facility: New Milford Hospital, Inc.

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

Part V Facility Information *(continued)*

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

How many non-hospital health care facilities did the organization operate during the tax year? 0

Name and address	Type of Facility (describe)

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8, and 9b.

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

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

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

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

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

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

Part I, Line 6a - Related Organization Community Benefit Report

Part I, Line 6a & 6b: The Community Benefit report is reported on a Network basis. It contains the organization's community benefit programs and services' descriptions and financial data. The form is made available to the public on the Office of Health Care Access' website:

http://www.ct.gov/dph/lib/dph/ohca/hospitalfillings/2012/irs990/nmilf990_hospital_2012.pdf

Part I, Line 7 - Explanation of Costing Methodology

Part I, Line 7 - Explanation of Costing Methodology

Charity Care At Cost Percentage:

Total Gross Patient charges written off to charity (Income Statement) * Patient Cost to Charge % (see below) = Total Community Benefit Expense

Total Community Benefit Expenses - Revenue from Uncompensated Care Pools and programs (DHS * % of cost of uncompensated care shown on the OCHA Schedule 500) = Net community benefits expenses

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8, and 9b.

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

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

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

Part I, Line 7 - Explanation of Costing Methodology (continued)

Net community benefits expenses * total expenses = % of total expenses Ratio Cost To Charge Calculation

Total Operating Expenses divided by Adjusted Patient Care Cost (Bad Debt, Other Operating Income and Intercompany Income are removed from the total operating expenses) Adjusted Patient Care Cost divided by Gross Patient Charges

Ratio Cost To Charge Calculation:

Total Operating Expenses divided by Adjusted Patient Care Cost (Bad Debt, Other Operating Income and Intercompany Income are removed from the total operating expenses)

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

Part I, Line 7g - Costs Associated With Physicans Clinics

Part I, Line 7g - Costs Associated With Physicans Clinics

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8, and 9b.

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

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

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

Part I, Line 7g - Costs Associated With Physicans Clinics (continued)

There are no physician clinics included in this amount.

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

The ratio of cost to charges is applied to the bad debt expense on the audited financial statements.

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

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

When private pay patients are sent to the collection agency their account is

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8, and 9b.

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

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

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

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

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

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

considered to be a bad debt. Subsequently, Medicaid may be granted for some of those patients. At that time those accounts would become charity care or a community benefit.

Part III, Line 4 - Bad Debt Expense

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

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

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

Changes in the aging and payor mix of accounts receivable, including increased

Part VI Supplemental Information

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

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

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

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

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

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

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

focus on accounts due from the uninsured and accounts that represent co-payments and deductibles due from patients;

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

Trending of days revenue in accounts receivable

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

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

The Hospital's primary concentration of credit risk is patient accounts receivable,

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8, and 9b.

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

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

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

which consists of amounts owed by various governmental agencies, insurance companies and private patients. The Hospital manages the receivables by regularly reviewing its patient accounts and contracts, and by providing appropriate allowances for uncollectible amounts. Significant concentrations of gross patient accounts receivable include 41% and 6%, and 37% and 5%, for Medicare and Medicaid, respectively, at September 30, 2014 and 2013, respectively.

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

New Milford Hospital's Medicare shortfall should be treated as a community benefit as the organization strives to provide 24/7 coverage, improved patient access, highest clinical quality as well as addressing the needs of the community by offering critical services to our geographic area. As a result, the organization must balance the cost of these programs against the continued decreasing government reimbursement levels, uninsured population and community needs.

A cost accounting system is used to calculate the shortfall, which is Medicare Net Patient Revenue less applicable costs.

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

It is the policy of the hospital to provide "financial assistance" (either free care of reduced patient obligations) to persons or families where: (I) There is limited

Part VI Supplemental Information

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

or no health insurance available; (II) The patient fails to qualify for governmental assistance (for example Medicare or Medicaid); (III) The patient cooperates with the hospital in providing the requested information; (IV) The patient demonstrates financial need and (V) The hospital makes an administrative determination that financial assistance is appropriate.

After the hospital determines that a patient is eligible for financial assistance, the hospital will determine the amount of financial assistance available to the patient by utilizing the charitable assistance guidelines which are based upon the most recent federal poverty guidelines. The hospital shall regularly review this financial assistance policy to ensure that at all times it: (I) Reflects the philosophy and mission of the hospital; (II) Explains the decision process of who may be eligible for financial assistance and in what amounts and (III) Complies with all applicable state and federal laws, rules and regulations concerning the provision of financial assistance to indigent patients. Consistent with its mission, the hospital recognizes its obligation to the community it serves to provide financial assistance to indigent persons within the community. In furtherance of its charitable mission, the hospital will provide both (I) emergency treatment to any person requiring such care; and (II) essential, non-emergent care to patients who

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

are permanent residents of its primary service area who meet the conditions and criteria set forth in this policy, without regard to the patients' ability to pay for such care. Elective procedures generally will not be considered essential, non-emergent care and usually will not be eligible for financial assistance. The hospital will collect from individuals on financial assistance if they received a partial charitable discount. All patients can apply for charitable care on balances they feel that they cannot afford.

Part VI - Needs Assessment

Part VI, Line 2: Needs Assessment: The Community Forum was attended by 37 community stakeholders from the Housatonic Valley Region (HVR). This included representatives from 5 Health Departments/Districts (Danbury, New Milford, Bethel, Newtown, and Pomperaug), Western CT Health Network, Danbury EMS, the Bethel Visiting Nurse Association, the United Way of Western CT, the Regional YMCA, the Housatonic Valley Coalition Against Substance Abuse, the Mid-Western CT Council on Alcoholism, the AmerCares Free Clinic, the CIFC Community Health Center, Doctor's Express Urgent Care Center, the Regional Educational Service Center, the Danbury Fire Department, the New Milford Senior Center, and the Peter and Camen Lucia Buck Foundation. Two community health conversations with key community stakeholders in October 2012 - held in two locations (Danbury and New Milford, CT) to ensure accessibility by key

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Part VI - Needs Assessment (continued)

stakeholders throughout the region. Attendees included a total of 52 representatives from hospitals; community health centers; school-based health centers; Visiting Nurse Associations/Services; municipal health, education, social service, senior centers and fire departments; non-profit organizations; and a legislator's office. Geographically, all 10 HVR municipalities were represented either directly or through regional agencies and organizations.

The Western CT Health Network (of which New Milford Hospital is a part) conducted a Physician Resource Assessment to evaluate the supply of healthcare providers within its combined service area towns. This is done to document community need for healthcare providers, and to develop a plan to the healthcare needs of the community served.

Part VI - Patient Education of Eligibility for Assistance

PART VI,LINE 3:The Hospital has messages on all statements providing information regarding how the patient can get assistance with their hospital bill. Also signs are posted throughout the hospital and counselors are available to provide further assistance. All uninsured inpatients are interviewed by financial counselors and assessed for eligibility for assistance programs. The hospital provides informational handouts to all uninsured patients at the time of registration which

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

refers them to financial counseling if they would like assistance with their bills. Further, the hospital mails notices to all self-pay accounts referring them to financial counseling if they need assistance. The collection department will also refer patients to financial counseling when a patient indicates that they cannot afford their balances; and finally, schedulers refer uninsured patients to financial counseling prior to their test or procedure. The policy and applications for assistance are also available online.

Part VI - Community Information

Part VI, Line 4: Community Information: New Milford Hospital serves an area with a population of about 48,000 people. The Primary Service Area includes New Milford, Washington, Kent and Bridgewater (in CT), and the Secondary Service Area includes Sherman, Roxbury and Cornwall (in CT) and Wingdale (in NY). This service area is comprised of the suburban Town of New Milford surrounded by moderately affluent residential and rural towns. No other general medical/surgical hospitals are located in this service area. New Milford has a median household income of $84,110, and a poverty rate of 4.6%. The uninsured population rate is estimated to be 9.3%. Although the population of the primary and secondary service areas is expected to remain virtually level from 2010 to 2015, the cohort aged 65 and over is expected to increase by 4.64%, while the age 20-44 age cohort is forecast to decline 1.57% over

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Part VI - Community Information (continued)

the same time period.

Part VI - Community Building Activities

Relates to Line #6, Coalition Building totalling $74,770:

Part II: Community Building Activities: Western Connecticut Health Network (WCHN) participates as a member of a regional collaborative representing the Housatonic Valley Region and ten municipalities. A Steering Committee comprised of health care providers, community-based providers, and local government agencies met quarterly to oversee a community health improvement plan (CHIP) that was developed utilizing data from a report card and previous community conversations that focused on four priority health indicators (PHI). Each indicator has objectives, strategies and work groups that carry out these objectives: The four PHI workgroups have designated a leader and met at least quarterly to further develop and refine their action plans. During April 2014 the Center for Health Schools & Communities @ Education Connection facilitated a Community Forum to provide a "feedback loop" to community stakeholders. Overall, data obtained from the Conversations provided high quality information to frame the beginning of a community health improvement change process in the region.

1. Prevention and Education of Most Prevalent Chronic Diseases/Health Conditions:

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Part VI - Community Building Activities (continued)

Obesity, Type 2 diabetes, and hypertension were identified as the most prevalent health conditions in the community. The PHI team goals are to increase healthy eating options, enhance access to physical activities, and promote a universal healthy lifestyle. In July 2014, the PHI team received the YMCA Diabetes Prevention Program Grant which was used to fund their diabetes prevention program. The team also participated in National Walk Day, which garnered over 150 people from the Housatonic Valley Region and formation of 3 community walking groups. A wellness campaign building on the "5, 2, 1, 0 Let's Go" messaging and collaboration with health providers, schools and businesses is being developed.

2. Improving Access/Utilization to Substance Abuse and Mental Health Services: Mental health issues and substance abuse continue to be prevalent issues in the community. This PHI team is collaborating with 12 Local Prevention Councils, the CT Prevention Framework, and other entities to increase outreach efforts. Their goals are to identify gaps in services and access, provide education, and increase awareness regarding services and programs. There is awareness to vulnerable target groups in need of enhanced services and supports, such as the homeless population and youth. The team worked to improve education and information dissemination, and supported integration of a "question-persuade-refer" model for suicide prevention.

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Part VI - Community Building Activities (continued)

3. Improve Assessment and Service Planning to Senior Health: Senior citizens, particularly homebound elderly and immigrants, are in need of assessment and service planning to address their health, housing, and social support needs. The main goal is to increase awareness, services, and education for senior health. This team is supporting and collaborating with the Aging in Place initiatives funded by the Peter and Carmen Lucia Buck Foundation, which includes the "Safe at Home" program that delivers home safety items to seniors.

4. Improve Awareness and Utilization of Existing Health and Social Programs/Services: This team focused on enhancing awareness and utilization of existing programs and services in the community, including support of Infoline 2-1-1 and 5 Health Access CT Assistor sites by target populations. It also established a partnership with FamilyWize to provide promotional materials for distribution to health providers and key community sites.

The individual CHIP Steering Committee members, including WCHN, support the importance of shared commitment and responsibility in development and execution of its recommended action plans for health improvement.

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Part VI - Community Building Activities (continued)

Relates to line #2, Economic Development and line #7, Community Health Improvement Advocacy totalling $2,398:

Part II: Community Health Improvement Advocacy: Largely state and local elected officials and agency heads were lobbied in support of maintaining patient access to essential services for the uninsured and underinsured. As part of this effort, miscellaneous expenses are noted in Part II-B 1i.

Part VI - Explanation Of How Organization Furthers Its Exempt Purpose

Part VI, Line 5: Promotion of community health. New Milford Hospital served 994,504 persons through over 253 health events. One of the highest impact outreach activities includes 11,650 individuals served through several health fairs. Attendees were offered cancer and blood pressure screenings, and received information on topics ranging from integrative medicine, nutrition, orthopedic advancements and Lyme Disease.

Over 50% of the Board Members are independent and do not get paid by New Milford Hospital. New Milford Hospital also has an open medical staff.

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Part VI - Explanation Of How Organization Furthers Its Exempt Purpose (continued)

Surplus funds are used to provide innovative technology to clinical care in addition to expanding our service area.

Part VI - Affiliated Health Care System Roles and Promotion

Part VI, Line 6: Western Connecticut Health Network (WCHN) is an integrated health care delivery system comprised of three community hospitals and their affiliated entities. In addition to New Milford, Danbury and Norwalk Hospitals, the continuum of care includes a large medical group, home health care services, a nationally renowned biomedical research institute, the WCHN and Norwalk Hospital Foundations, and other related affiliates. WCHN's mission is to improve the health of every person we serve through the efficient delivery of excellent, innovative and compassionate care. For 2014, WCHN provided $10,362,060 in total charity care.

New Milford, Danbury and Norwalk Hospitals provide medical services to the community regardless of the individual's ability to pay. Services include routine inpatient ancillary and outpatient care in support of the hospital's mission statement, to improve the health and well-being of those we serve. For 2014, WCHN provided charity care in the following amounts: Norwalk Hospital $4,331,000, Danbury Hospital $4,731,000, and New Milford Hospital $346,000.

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

Western Connecticut Medical Group/Norwalk Hospital Physicians & Surgeons: The mission of Western Connecticut Medical Group is to provide safe, innovative, convenient and coordinated primary and specialty health care in the communities they serve and strive to be aware of and respond to their patients'needs. They support a commitment to advance the health and well-being of individuals in their community by delivering quality care, participating in medical research and medical residency programs and the provision of medical services to patients. For 2014, WCMG/NHP&S provided $880,627 in charity care.

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

Western Connecticut Health Network Affiliates principal purpose is to provide outpatient health care services in various locations and also provide ambulance services to Danbury and surrounding towns, while serving those that cannot afford the care. For 2014, WCHN Affiliates provided $1,454 in charity care.

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

Western Connecticut Home Care, Inc. (WCHC) provides state of the art clinical services ranging from pediatric patients to the elderly utilizing best practice in home care to meet the needs of their patients. For 2014, WCHC provided $70,695 in charity care.

Eastern New York Medical Services (ENYMS) was formed in April, 2013. The mission at ENYMS is to provide safe, innovative, convenient and coordinated primary and gastro health care in the communities we serve and strive to be aware of and respond to our patients' needs. For 2014, ENYMS provided $1,284

Part VI - States Where Community Benefit Report Filed

CT