COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

January 18, 2022

Governor Jared Polis
136 State Capitol
Denver, CO 80203

Dear Governor Polis:

Enclosed, please find the Department of Health Care Policy and Financing's legislative report, Hospital Expenditure Report.

Section 25.5-4-402.8, C.R.S. requires the Department, on or before January 15, 2020, and on or before January 15 each year thereafter, the state department shall submit the annual hospital expenditure report to: the public health care and human services committee of the house of representatives, or any successor committee; the health and human services committee of the senate, or any successor committee; the joint budget committee of the general assembly; the governor; and the state board.

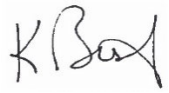
In addition, Section 25.5-1-703, C.R.S., enacted with the adoption of HB 19-1320, requires the Department to include a summary of the hospital community benefit implementation reports submitted by hospitals to the Department.

This report details the activities the Department has undertaken to implement HBs 19- 1001 and 19-1320 to date.

In addition to providing these reports as directed through legislation, the Department is analyzing the rise in Colorado hospital prices, costs, and profits in the state and its impact on the cost of health care coverage for consumers and businesses. The Department is undertaking this analysis as directed by the General Assembly. In the coming months, the Department will publish additional reports and analytical tools examining this topic. The additional reporting and tools will be posted on the Department's website at Colorado.gov/pacific/hcpf/hospital-reports-hub.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,



Kim Bimestefer
Executive Director

KB/nad

Enclosure(s): Health Care Policy & Financing 2022 Hospital Expenditure Report

cc: Elisabeth Arenales, Senior Health Policy Advisor, Governor's Office
Legislative Council Library
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Tracy Johnson, Medicaid Director, HCPF
Bonnie Silva, Community Living Interim Office Director, HCPF
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Anne Saumur, Cost Control Office Director, HCPF
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Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

January 18, 2022

The Honorable Susan Lontine, Chair
House Health and Insurance Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Lontine:

Enclosed, please find the Department of Health Care Policy and Financing's legislative report, Hospital Expenditure Report.

Section 25.5-4-402.8, C.R.S. requires the Department, on or before January 15, 2020, and on or before January 15 each year thereafter, the state department shall submit the annual hospital expenditure report to: the public health care and human services committee of the house of representatives, or any successor committee; the health and human services committee of the senate, or any successor committee; the joint budget committee of the general assembly; the governor; and the state board.

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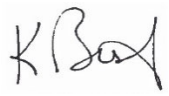

Kim Bimestefer
Executive Director

KB/nad

Enclosure(s): Health Care Policy & Financing 2022 Hospital Expenditure Report

Cc: Representative David Ortiz, Vice Chair, Health and Insurance Committee
Representative Mark Baisley, Health and Insurance Committee
Representative Ron Hanks, Health and Insurance Committee
Representative Chris Kennedy, Health and Insurance Committee
Representative Karen McCormick, Health and Insurance Committee
Representative Kyle Mullica, Health and Insurance Committee
Representative Emily Sirota, Health and Insurance Committee
Representative Matt Soper, Health and Insurance Committee
Representative Brianna Titone, Health and Insurance Committee
Representative Tonya Van Beber, Health and Insurance Committee
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Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

January 18, 2022

The Honorable Dafna Michaelson Jenet, Chair
House Public & Behavioral Health Care & Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Michaelson Jenet:

Enclosed, please find the Department of Health Care Policy and Financing's legislative report, Hospital Expenditure Report.

Section 25.5-4-402.8, C.R.S. requires the Department, on or before January 15, 2020, and on or before January 15 each year thereafter, the state department shall submit the annual hospital expenditure report to: the public health care and human services committee of the house of representatives, or any successor committee; the health and human services committee of the senate, or any successor committee; the joint budget committee of the general assembly; the governor; and the state board.

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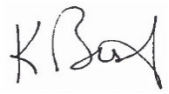

Kim Bimestefer
Executive Director

KB/ND

Enclosure(s): Health Care Policy & Financing 2022 Hospital Expenditure Report

Cc: Representative Emily Sirota, Vice Chair, Public & Behavioral Health & Human Services Committee
Representative Judy Amabile, Public & Behavioral Health & Human Services Committee
Representative Mary Bradfield, Public & Behavioral Health & Human Services Committee
Representative Lisa Cutter, Public & Behavioral Health & Human Services Committee
Representative Serena Gonzales-Gutierrez, Public & Behavioral Health & Human Services Committee
Representative Ron Hanks, Public & Behavioral Health & Human Services Committee
Representative Richard Holtorf, Public & Behavioral Health & Human Services Committee
Representative Iman Jodeh, Public & Behavioral Health & Human Services Committee
Representative Rod Pelton, Public & Behavioral Health & Human Services Committee
Representative Naquetta Ricks, Public & Behavioral Health & Human Services Committee
Representative Dave Williams, Public & Behavioral Health & Human Services Committee
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Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

January 18, 2022

The Honorable Julie McCluskie
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative McCluskie:

Enclosed, please find the Department of Health Care Policy and Financing's legislative report, Hospital Expenditure Report.

Section 25.5-4-402.8, C.R.S. requires the Department, on or before January 15, 2020, and on or before January 15 each year thereafter, the state department shall submit the annual hospital expenditure report to: the public health care and human services committee of the house of representatives, or any successor committee; the health and human services committee of the senate, or any successor committee; the joint budget committee of the general assembly; the governor; and the state board.

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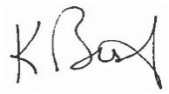

Kim Bimestefer
Executive Director

KB/nad

Enclosure(s): Health Care Policy & Financing 2022 Hospital Expenditure Report

Cc: Senator Dominick Moreno, Vice-Chair Joint Budget Committee
Senator Chris Hansen, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Edmond Toy, Budget Analyst, Office of State Planning and Budgeting
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Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

January 18, 2022

The Honorable Rhonda Fields, Chair
Senate Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Fields:

Enclosed, please find the Department of Health Care Policy and Financing's legislative report, Hospital Expenditure Report.

Section 25.5-4-402.8, C.R.S. requires the Department, on or before January 15, 2020, and on or before January 15 each year thereafter, the state department shall submit the annual hospital expenditure report to: the public health care and human services committee of the house of representatives, or any successor committee; the health and human services committee of the senate, or any successor committee; the joint budget committee of the general assembly; the governor; and the state board.

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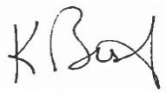

Kim Bimestefer
Executive Director

KB/nad

Enclosure(s): Health Care Policy & Financing 2022 Hospital Expenditure Report

Cc: Senator Joann Ginal, Vice Chair, Health and Human Services Committee
Senator Janet Buckner, Health and Human Services Committee
Senator Sonya Jaquez Lewis, Health and Human Services Committee
Senator Barbara Kirkmeyer, Health and Human Services Committee
Senator Cleave Simpson, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee
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Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

January 18, 2022

David Pump, President
1570 Grant Street
Denver, CO 80211

Dear Mr. Pump:

Enclosed, please find the Department of Health Care Policy and Financing's legislative report, Hospital Expenditure Report.

Section 25.5-4-402.8, C.R.S. requires the Department, on or before January 15, 2020, and on or before January 15 each year thereafter, the state department shall submit the annual hospital expenditure report to: the public health care and human services committee of the house of representatives, or any successor committee; the health and human services committee of the senate, or any successor committee; the joint budget committee of the general assembly; the governor; and the state board.

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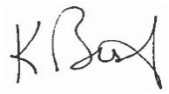

Kim Bimestefer
Executive Director

KB/nad

Enclosure(s): Health Care Policy & Financing 2022 Hospital Expenditure Report

Cc: Morgan Honea, Vice-President, Medical Services Board
Martha Cecile Fraley, MD, Medical Services Board
William Kinnard, MD, Medical Services Board
Simon Hambidge, MD, Medical Services Board
An Nguyen, DDS, Medical Services Board
Barry Martin, MD, Medical Services Board
Amanda Moorer, Medical Services Board
Christina Mulkey, Medical Services Board
Vincent Scott, Medical Services Board
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Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Hospital Expenditure Report Key Findings

This report reflects financial data submitted in the midst of the ongoing COVID-19 Pandemic. The Department will continue to monitor the pandemic's financial impact on hospitals in this and future reports as more data becomes available. The percent of patients covered by public programs continues to grow, largely driven through the impact of the Affordable Care Act, the COVID-19 induced recession that began in 2020, and the aging Colorado population. Specifically, in 2020, 60% of hospital patients were covered by Medicare and Medicaid compared to 55.2% in 2014.

COVID-19 Impacts on Net Patient Revenue, Commercial Payers Still Primary Payer

- For hospitals that reported for all years between 2014 and 2020 (57 hospitals), net patient revenue grew from $11.9 billion to roughly $16.4 billion, an increase of 35.5% from 2014, or an average of 5.2% each year over the period. The Department is looking into what type of hospitals and which payers are driving this increase.
- For the 82 hospitals that submitted in 2020, net patient revenue totaled $17.9 billion and was primarily composed of the commercial payer category at 51.3% ($9.2 billion), followed by Medicare at 25.2% ($4.5 billion), and Medicaid at 17.1% ($3.1 billion).
- For the hospitals that submitted in 2019 and 2020, net patient revenues increased by 2.3%, $406.1 million.
- These figures do not include $1.07 billion in federal COVID-19 stimulus payments distributed in 2020, which hospitals recorded either as other operating revenue or non-operating revenue (and some of the funds may be recorded in 2021).
- Given that the net patient revenue does not include federal COVID-19 stimulus, it is notable that hospitals' patient revenues increased between 2019 and 2020 despite the movement of covered lives from commercial to Medicaid due to the COVID-19 pandemic-induced economic downturn, the stay-at-home effort and the hold on elective procedures during the first months of the pandemic.

Rural Hospitals Are Unique

- When looking at the dataset with 57 hospitals between 2019 and 2020, small hospitals saw an increase in net patient revenue of $32.9 million or 5.5%.
- Using a straight average (not weighting by hospital volume, but averaging for each submitting hospital), Colorado hospitals provide more outpatient services (64.7%) than inpatient services (32.3%), with significant variation between types of hospitals. Specifically, the average small hospital, typically critical access and rural hospitals, provides three times more outpatient services (75.6%) than inpatient services, while large hospital systems provide an average of 48.5% inpatient and 51.2% outpatient services. This higher outpatient utilization in the small, often rural hospitals, aligns with the strategic opportunity to repurpose unused inpatient rural beds to meet emerging community needs through stimulus investment dollars.
- When looking at uncompensated care, the small peer group uncompensated care charges decreased by 7.7% from 2019 to 2020, while the medium peer group

uncompensated care charges increased by 2.4% and the large peer group increased uncompensated care charges by only 0.8%.

- Small hospitals had the largest percent growth in total operating expense between 2019 and 2020 at 7.9%. Small hospital peer group's proportion of expenses allocated for patients was the lowest at 60.5%. This low patient expense ratio is indicative of the opportunity to invest in rural hospitals to enable their transformation and modernization; investment would improve rural hospitals' ability to meet the care demand needs of their communities and increase net patient revenues so they can more efficiently cover overhead expenses.

Operating Expenses Increased – Patient Service Expenses and General & Administrative Primary Drivers

- When looking at the 57 hospitals who reported each year between 2014 and 2020, total operating expense increased from $11.7 billion to $16.0 billion, an increase of $4.3 billion or 37.1%.
- Hospital operating expenses totaled $17.6 billion in 2020, mostly driven by patient expenses (72.0%) representing $12.5 billion of all operating expense. Conversely, 28.0% of all hospital operating expenses do not go towards servicing patients directly. The Department will be evaluating this opportunity, by hospital and by category (i.e., General Administration, Building and Equipment, etc.) in future reports.
    - ✓ Patient service expenses generate 63.9% of all operating expenses, and 8.0% for "other" patient related expenses. Together, these equal total patient expenses.
    - ✓ General and administrative expenses, at 14.7%, represented the second largest driver of hospital expenses ($2.6 billion). Building and equipment expenses made up 9.1% of all operating expenses ($1.6 billion). "Other" expenses totaled $724.7 million or 4.2% of all operating expenses.
    - ✓ When included as an operating expense, uncompensated care costs represent 2.7% of operating expenses. These costs do not make up a significant portion of a hospital's expenses.

- Between 2019 and 2020, total operating expenses increased $758.6 million (4.6%), while net patient revenue increased by 2.3%.
    - ✓ Indicative that large hospitals have operational economies of scale, a greater proportion of the large hospital peer group's operating expenses were allocated for patients (73.3%, which still indicates an opportunity to explore the 26.7% non-patient related operating expenses), while the small hospital peer group's proportion of expenses allocated for patients was the lowest (60.5%). Of the peer groups, the small hospital peer group has the largest proportion of other expenses (11.1%) and general and administration (17.4%).

Unexpectantly, Uncompensated Care Relatively Flat Since 2018, Despite the COVID-19-Induced Economic Downturn

- Bad debt is the portion of revenue that a hospital does not expect to collect and is recorded as an offset to revenue. Charity care is the portion of revenue that a hospital has determined will not be paid by a patient through the hospital's charity care program and is recorded as an offset to revenue.
- Uncompensated care costs which include both charity care and bad debt totaled $493.9 million in 2020, up slightly (0.7% or $11.6 million) from 2019.
- In reviewing the two components of uncompensated care, the increase in charity care is offset by a comparable decrease in bad debt. From 2019 to 2020, bad debt decreased by 15.2% or $110.7 million, whereas charity care increased by 13.2%, or $122.4 million.
- Reflective of the financial challenges of an uninsured person's ability to pay and utilization of the hospital's charity care program, the self-pay payer category was the largest portion of uncompensated costs and its components (bad debt costs and charity care costs) in 2020 with $301.3 million, or 61.0%.
- Between 2014 and 2020, bad debt charges decreased by $66.1 million, or a decrease of 9.6% and charity care increased $17.5 million. This indicates that with the expansion of Medicaid, increased coverage and lower uninsured rate, hospitals' uncompensated care decreased dramatically while net patient revenue grew, not including the $1.07 billion federal COVID-19 stimulus.

The Hospital Expenditure Report is one in a series of reports related to hospitals the Department publishes. Additional reports including the Colorado Hospital Accountability and Sustainability Enterprise; Hospital Cost, Profits and Price; Hospital Community Benefit Accountability; and other reports are available on the Hospital Reports Hub at Colorado.gov/hcpf/hospital-reports-hub.

The Department will also be releasing a separate report that outlines hospital reserves (days cash on hand) and profit insights in February 2022.

Hospital Expenditure Report

Annual Report

January 15, 2022

COLORADO
Department of Health Care Policy & Financing

Contents

I. Overview

The purpose of the Hospital Expenditure Report is to fulfill the directive in House Bill (HB) 19-1001 to "annually prepare a written hospital expenditure report detailing uncompensated hospital costs and the different categories of expenditures".[1] To serve this directive, this report provides data summaries and analysis of Colorado hospitals that have submitted financial and utilization data to the Department of Health Care Policy & Financing (the Department).

Also included in this report is a map of Colorado hospitals as well as the Department of Regulatory Agencies' Division of Insurance (DOI) regions. A list of definitions is available as well.

A. Legislative Background

Under § 25.5-4-402.8, C.R.S., the Department shall annually prepare a written hospital expenditure report detailing the uncompensated hospital costs and the different categories of expenditures made by hospitals in the state. The Department shall consult with the Colorado Healthcare Affordability and Sustainability Enterprise Board (CHASE Board) in the development of the report. In compiling the Hospital Expenditure Report, the Department shall use publicly available data sources whenever possible. Each hospital in the state shall make information available to the Department for the compilation of the data set for and the completion of the Hospital Expenditure Report.

B. Background to this Report

Provided directly to the Department, hospitals submit audited financial statements, Medicare Cost Reports, and the Department's 'Hospital Expenditure Report template' which covers utilization and other financial data not provided in the audited financial statements or Medicare Cost Reports. The Department compiles all the submitted templates and creates the Hospital Expenditure dataset, which is the source of information used for this report.

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[1] Hospital Transparency Measures to Analyze Efficacy, HB19-1001. 2019 Regular Session. (2019). Available from www.leg.colorado.gov/bills/hb19-1001.

Data submitted represent most Colorado hospitals. For 2020, hospitals submissions account for 99.7% of all licensed hospital beds. The **Hospital Expenditure Report Detailed Dataset by Hospital** displays the status of hospital data submissions and data for all hospital data submissions for 2014 through 2020 with notes when applicable.

C. Methodology and Limitations

The data within this report represents the cumulation of both historic and current financial and utilization data reported to the Department. For the historical data submission process, hospitals had the option to submit reports from the Colorado Hospital Association's DATABANK Program[2] or to complete the Department's Acquisition, Financial and Utilization Reporting Tool. Most health systems or hospitals submitted a DATABANK report. For the current data submission process (FY 2019 forward), hospitals only utilized the Department's reporting tool. With this standardized submission process the Department can compare hospitals between each other and over the years with more certainty.

The Department presents the data by peer grouping based on the number of licensed beds. The three hospital peer groups are as follow: small with 25 or fewer beds, medium with 26 to 90 beds and large with 91 or more beds. The Department also presents the data by the Department of Regulatory Agencies' (DOI) geographic regional rating areas.

The **Hospital Expenditure Report Detailed Dataset by Hospital** is a representation of the dataset compilation, with both the historic data submissions and the current data submissions. As discussed in the previous section, not all hospitals submitted data. While all Colorado hospitals are listed in these tables, blank fields indicate hospitals that did not submit data for that year. In some cases, the hospital was not open at that time.

[2] CHA DATABANK is an online program available to Colorado Hospital Association members and serves as a centralized location for the collection of hospital utilization and financial data.

There are limitations in the dataset, including the following:

- Historic dataset does not have bad debt and charity care by payer type. Because of this limitation, uncompensated care and net patient revenue are not available by payer type for the 2014 to 2018 dataset.

- Historic dataset is not fully complete:

    - Some hospitals did not report for all years that the hospital was open. For example, if a hospital was acquired by a health system, the health system submission only included data for the years that hospital was part of a health system.

    - Reported data is not complete for all years and/or for all categories even if a hospital has reported some data. This report looks at 2014 through 2020 because this was the most complete section of data collected.

To address the limitations of the dataset, the Department is analyzing trends for the most comprehensive period of the dataset (2014 through 2020, and 2019 to 2020). The aggregate and hospital peer group analysis within the report includes hospitals that submitted data for all years. This analytical approach is referred to as a same-store analysis.

- For the trend analyses, of the 77 hospitals open for the period, 57 hospitals are part of the analysis within the body of the report, representing 93.8% of licensed beds.

- For the 2019 to 2020 analyses, of the 84 hospitals open, 78 hospitals are part of the analysis within the body of the report, representing 98.8% of licensed beds.

Other limitations include the analysis of hospital volume or the number of hospital patients. There is a challenge in using a volume metric when hospitals have different volume metrics for inpatient services, like discharges or patient days, and outpatient services like outpatient visits. Currently, the Department is not including an analysis that adjusts to a

"per patient" or "per bed" basis. The Department has provided two volume metrics within the **Hospital Expenditure Report Detailed Dataset by Hospital**: discharges and outpatient visits.

1. A Note on Submissions

For the completion of the report, the bill requires hospitals to submit three forms of financial and utilizations information: Medicare Cost Reports, audited financial statements and the completion of a data submission template. The Department believes hospitals have made a good-faith effort to satisfy the bill requirements. The hospitals that did not submit a template and are not included within the analysis of this report include:

- Middle Park Medical Center and
- Yuma District Hospital.

The Department will continue to work with hospitals to gather missing data points where possible and improve upon the report.

The Hospital Expenditure Report presents aggregated information on Colorado hospitals, with hospital-specific information in the **Hospital Expenditure Report Detailed Dataset by Hospital** of this report.

2. COVID-19 Pandemic

During the FY 2020, the COVID-19 Pandemic affected hospital expenses. Given the longevity of the COVID-19 Pandemic, the full extent to its impact will not be apparent for some time. The Department will continue to monitor hospital finances, specifically looking to the changes within expenses.

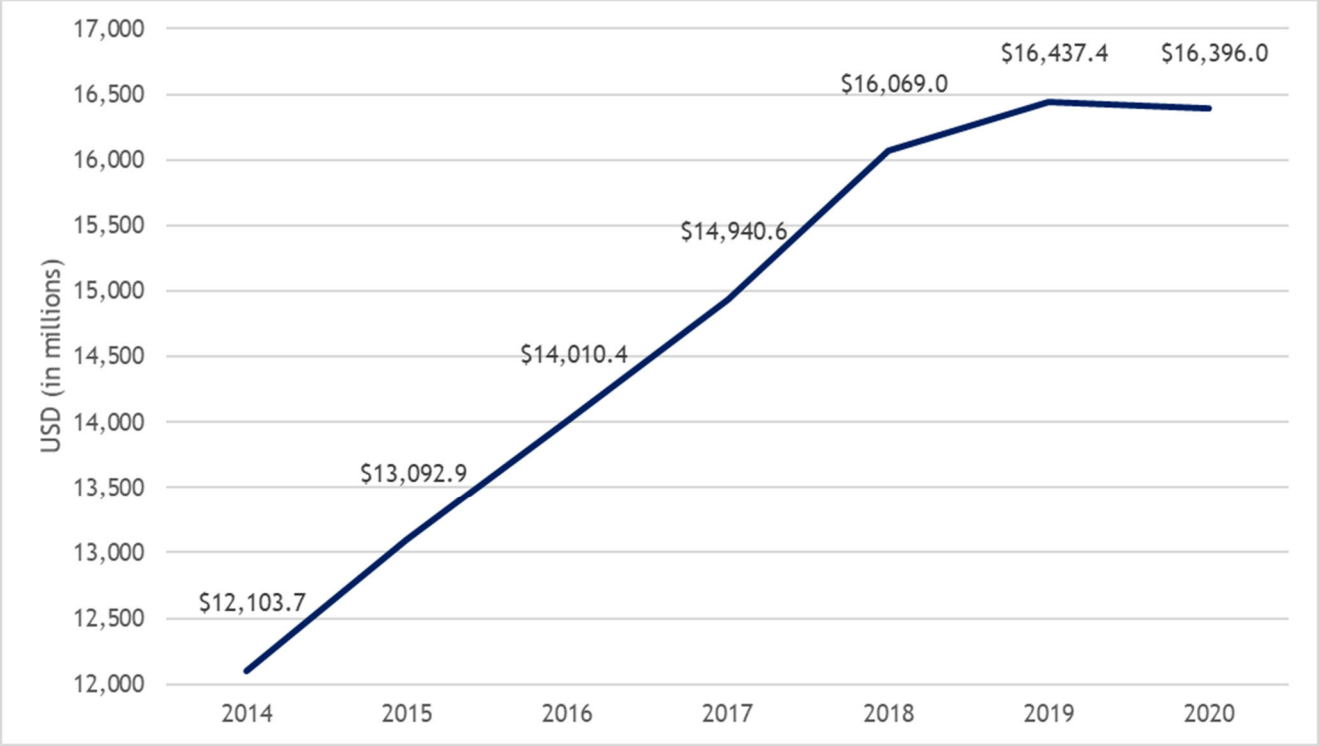
II. Financial Analysis

A. Net Patient Revenue in Total

Net patient revenue approximates the payments a hospital receives for patient services. Net patient revenue is calculated by totaling all charges the hospital billed to patients, subtracting the total of all contractual allowances for each major payer, such as Medicare, Medicaid, commercial, etc., then subtracting uncompensated care. In the 2014 to 2020 analysis

that follows, the Department is only comparing hospitals that reported from 2014 to 2020. Due to this, the total figures in this section will differ from later sections of the analysis. Additionally, the following graph does not reflect 2020 federal COVID-19 stimulus funding; hospitals recorded the stimulus funds as either other operating revenue or non-operating revenue.

Graph 1: Total Net Patient Revenue (in millions)



Graph 1 above presents net patient revenue in total for each year in the period. From 2014 to 2020, net patient revenue grew by 35.5%, or increased approximately $4.3 billion. For the 57 hospitals that reported data for all years, net patient revenue grew by an average of 5.2% a year.

In the analysis that follows, **Table 1**, the Department reports the breakdown of net patient revenue by hospital peer groups, which groups hospitals by the number of licensed beds. The three groups are small: 25 beds or fewer, medium: 26 to 90 beds, and large: 91 beds and more.

Table 1: Net Patient Revenue by Hospital Peer Groups (in millions)

Peer Group	2014	2015	2016	2017	2018	2019	2020
Large	$10,815.8	$11,657.3	$12,432.9	$13,259.4	$14,222.1	$14,512.7	$14,445.2
Medium	$884.9	$991.1	$1,111.3	$1,188.3	$1,299.0	$1,329.9	$1,323.0
Small	$403.0	$444.5	$466.2	$492.9	$547.9	$594.8	$627.8
Total	$12,103.70	$13,092.9	$14,010.4	$14,940.6	$16,069.0	$16,437.4	$16,396.0

Each hospital peer group had growth for net patient revenue from 2014 to 2020. Overall, net patient revenue increased by $4.3 billion, as stated above. Between 2014 and 2020, the large peer group primarily made up the bulk of the overall increase with $3.6 billion whereas the medium and small peer groups increased by $438.1 million and $224.7 million, respectively.

Table 2: Net Patient Revenue Percent Change by Hospital Peer Groups

Peer Group	Net Patient Revenue % Change (2019- 2020)
Large	-0.5%
Medium	-0.5%
Small	5.5%
Total	-0.3%

In **Table 2**, above, the percent change of net patient revenue between 2019 and 2020 for each hospital peer group is displayed, with the Large, Medium and Total year over year change remaining relatively flat. Individually, the large peer group decreased by $67.5 million, or a reduction of 0.5%. The medium peer group decreased $6.9 million, or a decrease of 0.5%. Unlike the other peer groups, the small peer group increased by $32.9 million, or an increase of 5.5%.

B. Net Patient Revenue by Payer Type

Net patient revenue by payer type approximates the payments a hospital receives for a particular payer type.

Table 3 below shows net patient review by major payer type for 2019 and 2020 and includes all hospitals reporting data: 78 hospitals in 2019 and 82 in 2020. The figures will not match figures in in Graph 1 and Table 2 which include only the 57 hospitals that reported data for years 2014 to 2020. For more information see the Methodology and Limitations section above. In

addition to the peer groups for FY 2020, statewide totals are presented by payer type for the DOI regions.

Table 3: 2019-2020 Net Patient Revenue by Payer Type (in millions)

Major Payer Type	2019	2020	Net Patient Revenue % Change (2019- 2020)
Medicare	$4,574.8	$ 4,537.1	-0.8%
Medicaid	$2,633.4	$ 3,076.5	16.8%
Commercial	$9,677.0	$ 9,222.9	-4.7%
Self-Pay	$145.8	$ 281.9	93.3%
Colorado Indigent Care Program (CICP)/Other	$536.6	$ 855.3	59.4%
Total	$17,567.6	$ 17,973.7	2.3%[3]

In **Table 3**, totals for net patient revenue by payer type is represented in millions. In 2020, total net patient revenue was $17,973.7 million. The commercial payer category made up approximately half (51.3%) of total net patient revenue with $9,222.9 million. The next largest payer category was Medicare, which roughly 25% of total net patient revenue with $4,537.1 million. Medicaid net patient revenue was $3,076.5 million, or 17.1% of total. The two remaining categories make up a little under 7% with CICP/Other net patient revenue totaling $855.3 million and self-pay totaling $281.9 million: or 4.8% and 1.6%, respectively. Together, public and CICP/Other payers represent 47.1% while commercial payers represent 51.3%.

[3] Table 3 reflects the year over year change for the 78 hospitals that reported in 2019 and the 82 that reported in 2020. The net patient revenue change when only the 78 hospitals reporting in both 2019 and 2020 are compared is 1.5%.

Table 4: 2020 Net Patient Revenue by Payer Type by Hospital Peer Group (in millions)

Payer Type	Large	Medium	Small
Medicare	$ 3,606.2	$ 527.8	$ 403.0
Medicaid	$ 2,613.7	$ 254.1	$ 208.7
Commercial	$ 7,668.7	$ 1,139.7	$ 414.4
Self-Pay	$ 131.5	$ 121.7	$ 28.8
CICP/Other	$ 738.6	$ 56.6	$ 60.1
Total	$ 14,758.8	$ 2,100.0	$ 1,115.0

In **Table 4**, 2020 net patient revenue by payer type is broken down by hospital peer groups. For the large peer group, net patient revenue totaled $14,758.8 million or approximately 82.1% of total net patient revenue. The commercial payer category makes up approximately half (52.0%) of the large peer group, with $7,668.7 million. For the medium peer group, net patient revenue totaled $2,100.0 million or 11.7% of 2020 total net patient revenue. The split of net patient revenue by payer category was similar for the large and the medium peer groups: the medium peer group was approximately half commercial payer category with $1,139.7 million (54.3%). Medicare represented $527.8 million, or 25.1%. For the small peer group, 2020 net patient revenue totaled $1,115.0 million, or 6.2% of total net patient revenue. Commercial net patient revenue is the largest portion of the small peer group's total net patient revenue, with $414.4 million, or 37.2%. The Medicare category with $403.0 million or 36.1% of the total, represented a larger portion of the small peer groups net patient revenue compared to the large and medium peer groups at 24.4% and 25.1%, respectively.

Table 5: 2020 Net Patient Revenue by Payer by DOI region (in millions)

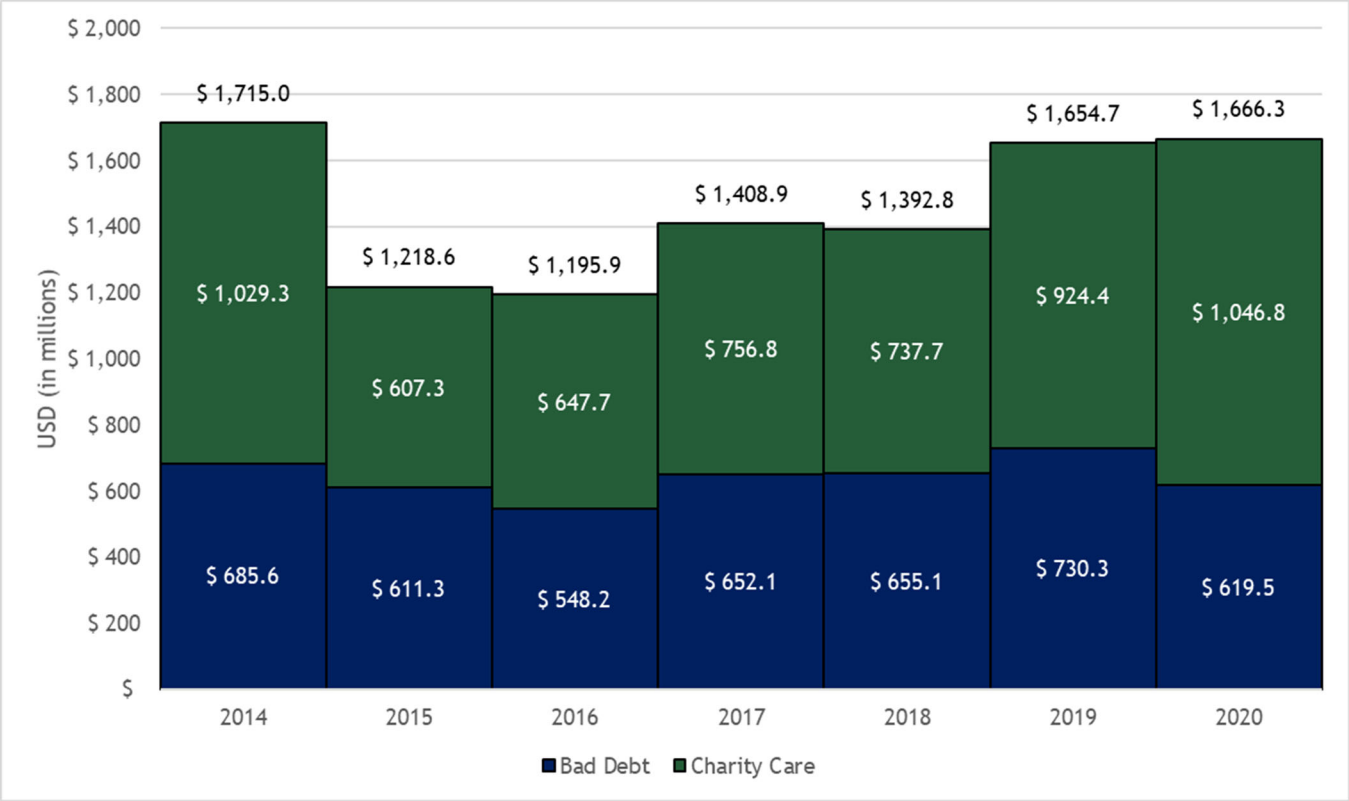
Payer Type	Medicare	Medicaid	Commercial	Self-pay	CICP/ Other	Total
Boulder	$ 252.3	$ 115.7	$490.8	$ 11.7	$ 56.3	$ 926.8
Colorado Springs	$ 484.4	$ 384.6	$ 870.5	$ 5.0	$ 163.9	$ 1,908.4
Denver	$ 2,229.6	$ 1,748.4	$ 5,357.7	$ 71.4	$ 444.6	$ 9,851.7
East	$ 239.2	$ 161.9	$ 210.7	$ 12.2	$ 26.2	$ 650.2
Ft. Collins	$ 373.4	$ 155.4	$ 755.3	$ 16.2	$ 55.4	$ 1,355.6
Grand Junction	$ 177.6	$ 106.1	$ 239.5	$ 104.4	$ 54.4	$ 682.0
Greeley	$ 134.1	$ 87.5	$ 266.4	$ 9.8	$ 34.4	$ 532.3
Pueblo	$ 216.2	$ 145.2	$ 212.6	$ 19.4	-$ 13.4	$ 580.1
West	$ 430.1	$ 171.8	$ 819.4	$ 31.8	$ 33.5	$ 1,486.6
Total	$ 4,537.1	$ 3,076.5	$ 9,222.9	$ 281.9	$ 855.3	$ 17,973.7

In **Table 5**, 2020 net patient revenue by payer type is broken down by the nine DOI regions. The Denver region represented most of the net patient revenue with $ 9,851.7 million, or 54.8% of total net patient revenue. Overall, the Denver region represented most for each of the region's total net patient revenue. The exception is the self-pay category, which was more evenly distributed across all regions, with Grand Junction as the outlier with $104.4 million, or 37.0%. In most regions, commercial net patient revenue represented the highest proportion of total net patient revenue; using a straight average, the percentage of commercial total net patient revenue for all regions is 46.9%. Medicare was the second largest in terms of net patient revenue for each DOI region; when using a straight average, Medicare net patient revenue approximated 28.2% for all regions. In 2020, the East and Pueblo regions were more evenly distributed between Medicare, Medicaid, and commercial payers in comparison to the rest of the DOI regions.

C. Uncompensated Care Charges in Total

Uncompensated care is the total amount of care a hospital provides that does not expect to, or will not, receive compensation for providing the service. There are two main components that make up uncompensated care, bad debt and charity care, both are expressed within this section of the report in terms of charges written-off. When a hospital records bad debt and charity care in their books, they do so in terms of the total charges for that procedure not collected, not in terms of the typical costs associated with that procedure.

Graph 2: Uncompensated Care Charges by Type (in millions)



The data in Graph 2, indicates overall uncompensated care has declined since 2014, but has seen an uptick since 2018. From 2019 to 2020, charity care increased by 13.2%, an increase of $122.4 million. Bad debt has decreased over the period by 15.2%, or $110.7 million. Combined, bad debt and charity care increased 0.7%, or $11.6 million. Between 2019 and 2020, uncompensated care only grew 0.7% compared to 18.8% growth between 2018 and 2019. The Department will continue to analyze this in the coming years to better understand the impact of the COVID-19 pandemic on these trends.

Table 6: Uncompensated Care Charges by Hospital Peer Groups (in millions)

Peer Group	2014	2015	2016	2017	2018	2019	2020
Large	$1,582.1	$1,120.0	$1,092.8	$1,273.3	$1,277.1	$1,528.4	$1,541.4
Medium	$84.6	$61.7	$64.4	$89.8	$71.3	$83.5	$85.5
Small	$48.2	$36.9	$38.8	$45.8	$44.4	$42.6	$39.4
Total	$1,715.0	$1,218.6	$1,195.9	$1,408.9	$1,392.8	$1,654.7	$1,666.3

Table 7: Uncompensated Care Charges Percent Change by Hospital Peer Groups

Peer Group	Uncompensated Care Charges % Change (2019 -2020)
Large	0.8%
Medium	2.4%
Small	-7.7%
Total	0.7%

In the table above, **Table 6**, uncompensated care is broken down by the hospital peer groups, while **Table 7** shows uncompensated growth care from 2019 to 2020 for each of the hospital peer groups. In 2020, 92.5% of uncompensated care occurs in the large peer group. Overall, uncompensated care for the large peer group increased by 0.8% and in the Medium peer group by 2.4%, while uncompensated care in the Small peer group decreased by 7.7%.

3. Charity Care Charges

One main component of uncompensated care is charity care. It is defined as health services for which hospitals do not expect to receive, in full or in part, payment because the hospital had determined, with the assistance of the patient, the patient's inability to pay.[4]

Table 8: Charity Care Charges by Hospital Peer Group

Peer Group	2014	2015	2016	2017	2018	2019	2020
Large	$980.7	$573.2	$615.9	$712.8	$703.3	$882.9	$997.0
Medium	$32.7	$24.2	$24.8	$33.0	$23.7	$29.3	$37.2
Small	$16.0	$9.9	$7.0	$11.0	$10.6	$12.2	$12.6
Total	$1,029.3	$607.3	$647.7	$756.8	$737.7	$924.4	$1,046.8

Table 9: Charity Care Charges Percent Change by Hospital Peer Group

Peer Group	Charity Care Charges % Change (2019 -2020)
Large	12.9%
Medium	27.0%
Small	3.2%

[4] Definition of Uncompensated Care. Retrieved from https://www.aha.org/system/files/2019-01/uncompensated-care-fact-sheet-jan-2019.pdf.

Peer Group	Charity Care Charges % Change (2019 -2020)
Total	13.2%

The data in **Table 8** shows how charity care was distributed amongst the hospital peer groups and in total. **Table 9** shows the percent change for each hospital peer group from 2019 to 2020. Overall, charity care increased by $122.4 million, or as mentioned above, 13.2% from 2019 to 2020. The large peer group represented most of the overall increase ($114.0 million) over the period, or an increase of 12.9%. The medium and small peer groups increased by roughly $7.9 million and $385.2 thousand, respectively. The medium peer group increased the most (27.0%) while the small peer group increased by 3.2%.

4. Bad Debt Charges

The other portion of uncompensated care is bad debt. Bad debt is a record of lost revenue for health services for which a hospital determined the patient had a financial responsibility to pay, but that patient did not pay.[10] This contrasts with charity care, in which hospitals have determined before the billing process begins that partial or full non-payments would occur for patients.

Table 10: Bad Debt Charges by Hospital Peer Group (in millions)

Peer Group	2014	2015	2016	2017	2018	2019	2020
Large	$601.5	$546.8	$476.9	$560.5	$573.7	$645.6	$544.4
Medium	$51.9	$37.5	$39.5	$56.8	$47.6	$54.2	$48.3
Small	$32.2	$27.0	$31.8	$34.8	$33.8	$30.4	$26.8
Total	$685.6	$611.3	$548.2	$652.1	$655.1	$730.3	$619.5

Table 11: Bad Debt Charges Percent Change by Hospital Peer Group

Peer Group	Bad Debt Charges % Change (2019 -2020)
Large	-15.7%
Medium	-10.9%
Small	-12.0%
Grand Total	-15.2%

In **Table 10**, bad debt is displayed in total, by year and by peer group. In **Table 11**, the percent change for each category in **Table 10** is presented. On the aggregate level, bad debt decreased by $110.7 million between 2019 and 2020, or a decrease of 15.7%. Like charity care the large peer group made up the bulk of the decrease in overall bad debt for the period. Bad debt for the large peer group decreased by $101.2 million, or 15.7%. The medium peer group saw a decrease in bad debt of $5.9 million, or 10.9%, while the small peer group, saw a decrease in bad debt over the period of $3.7 million, or a decrease of 12.0%.

D. Uncompensated Care Costs by Payer Type

Uncompensated care costs are calculated by adding charity care and bad debt charges together and multiplying by a cost-to-charge ratio. Each individual hospital has a cost-to-charge ratio and it is calculated by total expenses (exclusive of bad debt) and dividing that figure by the sum of total charges and other operating revenue. The table below represents uncompensated care costs by payer types.

Table 12: 2020 Uncompensated Care Costs by Payer Type (in millions)

Major Payer	Bad Debt Costs	Charity Care Costs	Uncompensated Care Costs
Medicare	$ 11.3	$ 5.0	$ 16.2
Medicaid	$ 8.9	$ 5.0	$ 13.8
Commercial	$ 59.7	$ 19.7	$ 79.2
Self-pay	$ 124.9	$ 176.4	$ 301.3
CICP/ Other	$ 12.8	$ 70.5	$ 83.3
Total	$ 217.4	$ 276.5	$ 493.9

In **Table 12**, uncompensated care costs are represented for bad debt and charity care, by payer type. In 2020, uncompensated care costs totaled $493.9 million. The Self-pay category represented 61% or $301.3 million, while CICP/Other represented 16.9% or $83.3 million in uncompensated care costs. The lowest proportion of uncompensated care costs came from the Medicaid with $13.8 million or 2.8% followed closely by Medicare with $16.2 million in uncompensated care costs, or 3.3%. Between 2019 and

2020, total uncompensated care costs increased by 9.2% or an increase of $41.4 million. In the future, the Department will analyze whether the COVID-19 stimulus funding was sufficient to cover the growth of uncompensated care costs between 2019 and 2020.

Charity care costs totaled $276.5 million, or 56% of total uncompensated care. The self-pay payer category represented 63.8% of charity care in 2020 or $176.4 million. The second largest category for charity care uncompensated care costs was the CICP/Other category, totaling $70.5 million, or 25.5%. Between 2019 and 2020, total charity care costs increased by 11.6%, or $28.7 million.

Bad debt costs were $217.4 million, representing approximately 44.0% of total uncompensated care costs. The self-pay category made up half of the costs for bad debt with 57.5%, or $124.9 million. The next highest category was the commercial payers representing 27.4%, or $59.5 million. Between 2019 and 2020, total bad debt costs increased by 6.2%, or $12.7 million.

1. Charity Care Costs

Table 13: 2020 Charity Care Costs by Payer by Peer Group (in million)

Payer Type	Large	Medium	Small	Total
Medicare	$ 3.6	$ 0.6	$ 0.8	$ 5.0
Medicaid	$ 3.4	$ 1.3	$ 0.3	$ 5.0
Commercial	$ 15.8	$ 2.7	$ 1.2	$ 19.7
Self-pay	$ 161.8	$ 9.0	$ 5.5	$ 176.4
CICP/ Other	$ 58.6	$ 9.8	$ 2.0	$ 70.5
Total	$ 243.3	$ 23.4	$ 9.8	$ 276.5

In **Table 13**, charity care costs are broken down by hospital peer groups and by major payer types. In 2020, the large peer group represented 88% of charity care costs ($243.3 million). The large peer group's Self-pay category represented 66.5% of the large peer group's charity care costs or $161.8 million. The medium

peer group made up approximately 8.5% of total charity care costs, or $23.4 million. Unlike the large or the small peer groups, the CICP/Other category made up most charity care costs for the medium peer group with $9.8 million, or 42.0% of total charity care costs. The small peer group represented approximately 3.5% of total charity care costs with $9.8 million. Like the large peer group, the self-pay payer category made up most of the small peer group's charity care costs with $5.5 million, or approximately 56.2% of total charity care costs. Overall, the large peer group made up most charity care costs for each payer type, ranging from 69.3% (Medicaid) and 91.8% (Self-pay).

Table 14: 2020 Charity Care Costs by Payer Type by DOI Region (in millions)

DOI Region	Medicare	Medicaid	Commercial	Self-pay	CICP/ Other	Total
Boulder	$ 0.9	$ 0.3	$ 1.5	$ 6.6	$ 0.7	$ 10.1
Colorado Springs	$ 0.4	$ 0.2	$ 2.2	$ 10.5	$ 7.3	$ 20.5
Denver	$ 1.6	$ 2.9	$ 9.2	$ 119.4	$ 41.4	$ 174.5
East	$ 0.6	$ 0.2	$ 0.6	$ 3.2	$ 2.8	$ 7.3
Ft. Collins	$ 0.2	($ 0.02)	$ 1.3	$ 9.0	$ 4.7	$ 15.1
Grand Junction	$ 0.3	$ 0.3	$ 1.7	$ 5.5	$ 1.7	$ 9.7
Greeley	$ 0.1	($ 0.2)	$ 0.6	$ 13.8	$ 1.4	$ 15.8
Pueblo	$ 0.1	$ 0.1	$ 0.4	$ 1.5	$ 3.5	$ 5.6
West	$ 0.7	$ 1.2	$ 2.2	$ 6.9	$ 7.0	$ 18.0
Total	$ 5.0	$ 5.0	$ 19.7	$ 176.4	$ 70.5	$ 276.5

In **Table 14**, charity care costs are represented in total for each payer type broken down by DOI regions. In 2020, total charity care costs were $276.5 million. Most charity care costs were in the Denver region with $174.5 million, or 63.1%. The second largest region in total for charity care costs was the Colorado Springs region with $20.5 million, or 7.4%.

2. Bad Debt Costs

Table 15: 2020 Bad Debt Costs by Payer by Peer Group (in millions)

Payer Type	Large	Medium	Small	Total
Medicare	$ 4.9	$ 2.2	$ 4.2	$ 11.3
Medicaid	$ 6.5	$ 0.5	$ 1.9	$ 8.9
Commercial	$ 42.2	$ 10.1	$ 7.2	$ 59.5
Self-pay	$ 83.2	$ 28.7	$ 13.0	$ 124.9
CICP/ Other	$ 9.3	$ 0.5	$ 3.1	$ 12.8
Total	$ 146.1	$ 41.9	$ 29.3	$ 217.4

In **Table 15**, bad debt costs are broken down by hospital peer groups and by major payer types. In 2020, the large peer group made up most of bad debt costs which totaled $146.1 million, or 67.2%. Self-pay made up 56.9% of bad debt costs for the large peer group, or $83.2 million. The second largest payer category was the commercial payer, with $42.2 million, or 28.8%. The medium peer group made up approximately 19.3% of total bad debt costs, or $41.9 million. Like the large peer group, the self-pay category made up most of bad debt costs for the medium peer group with $28.7 million, or 68.4%. The small peer group made up approximately 13.5% of total bad debt costs with $29.3 million. Like the large and medium peer group, the self-pay category made up most of the small peer group's bad debt costs with $13.0 million, or 44.4%. Overall, the large peer group made up most of the bad debt costs for each payer type, ranging from 43.8% (Medicare) and 73.1% (Medicaid). The self-pay category made up most of total bad debt costs with $124.9 million, or 57.4%, followed by the Commercial payer group with $59.5 million, or 27.3%.

Table 16: 2020 Bad Debt Costs by Payer Type by DOI Region (in millions)

DOI Region	Medicare	Medicaid	Commercial	Self-Pay	CICP/ Other	Total
Boulder	$ 1.1	($ 0.1)	$ 3.6	$ 2.7	($ 0.02)	$ 7.2
Colorado Springs	($ 0.3)	$ 0.9	$ 7.4	$ 16.1	$ 0.6	$ 24.7
Denver	$ 2.7	$ 5.0	$ 27.3	$ 57.5	$ 5.9	$ 98.5
East	$ 1.6	$ 0.7	$ 1.8	$ 7.9	$ 0.9	$ 12.9
Ft. Collins	$ 0.6	$ 0.5	$ 6.4	$ 9.5	$ 0.1	$ 17.1
Grand Junction	$ 1.0	$ 0.1	$ 2.7	$ 10.7	$ 0.6	$ 15.2
Greeley	$ 0.7	$ 0.6	$ 3.0	$ 4.0	$ 0.2	$ 8.6
Pueblo	($ 0.06)	($ 0.1)	($0.1)	$ 0.2	$ 2.1	$ 2.0
West	$ 3.9	$ 1.4	$ 7.3	$ 16.3	$ 2.4	$ 31.2
Total	$ 11.3	$ 8.9	$ 59.5	$ 124.9	$ 12.8	$ 217.4

In **Table 16**, bad debt costs are represented in total for each payer type and broken down by DOI regions. In 2020, total bad debt costs were $217.4 million. Most bad debt costs were in the Denver region with $98.5 million, or 45.3%. The second largest region in total for bad debt costs was the West region with $31.2 million, or 14.4%. The Denver region was the driver of bad debt costs in 2020 and made up the largest portion of each payer type.

E. Operating Expenses

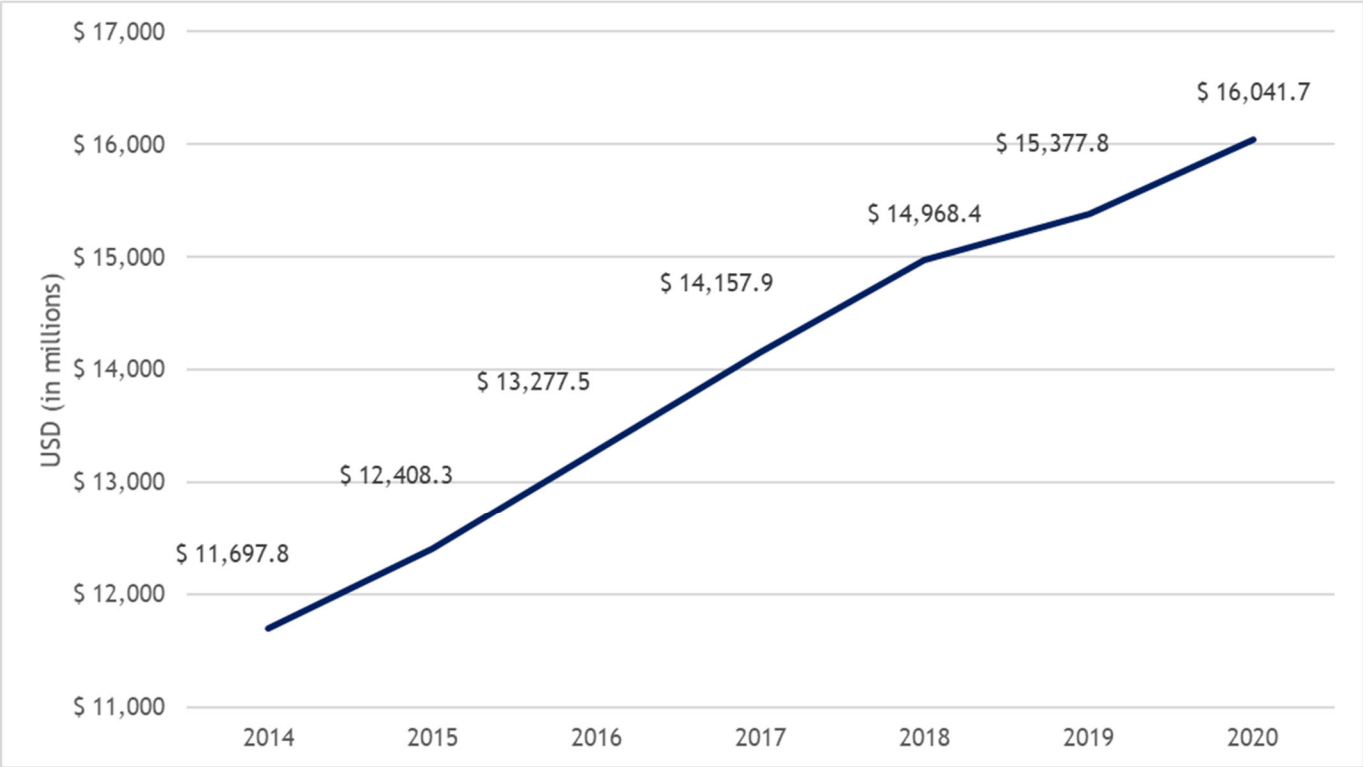
Operating expenses for hospitals are the expenses incurred from the normal business operations of running and operating a hospital. For a hospital, some of these expenses could include salaries, rent, management fees, purchase of supplies and utilities. In this section, the Department will break down total operating expenses by expense type and review total operating expense over the period.

1. Total Operating Expense Growth 2014 to 2020

This section of the analysis is only looking at hospitals open for the full period of the dataset (from 2014 to 2020) and reported data for all years. In **Graph 3**, total operating expense for all reporting hospitals is displayed for the period of 2014 to 2020. Between this period, the total operating expenses increased by

roughly $4.3 billion, or 37.1%. Between 2019 and 2020, total operating expenses grew by 4.3% or $663.9 million.

Graph 3: Total Operating Expense



Each year, total operating expenses grew between 7.0% and 2.7%, with an average growth of $723.9 million each year, or 5.4%. Between 2019 and 2020, total operating expenses grew by 4.3%, an increase of $663.9 million.

Between 2019 and 2020, when segregated by hospital peer group, total operating expenses growth is greatest for the small peer group in terms of percent change (7.9%), see **Tables 17** and **18**. The large peer group saw the largest growth in dollars with an increase of $538.9 million, or 4.0%.

Table 17: Total Operating Expense by Total and by Hospital Peer Group (in millions)

Peer Group	2014	2015	2016	2017	2018	2019	2020
Large	$10,296.1	$10,874.1	$11,628.3	$12,406.9	$13,091.9	$13,372.7	$13,911.6
Medium	$978.4	$1,083.1	$1,166.5	$1,235.4	$1,319.7	$1,408.6	$1,486.4
Small	$423.3	$451.1	$482.7	$515.6	$556.8	$596.5	$643.7
Total	$11,697.8	$12,408.3	$13,277.5	$14,157.9	$14,968.4	$15,377.8	$16,041.7

Table 18: Total Operating Expense Percent Change by Hospital Peer Group

Peer Group	Total Operating Expense % Change (2019 -2020)
Large	4.0%
Medium	5.5%
Small	7.9%
Total	4.3%

2. Operating Expense Mix

Hospitals submitted around 30 different types of expenses. Expense types ranged from the highest expense category (salaries, benefits, and wages) to small fill-in categories for expenses like bank fees and debt issuance.

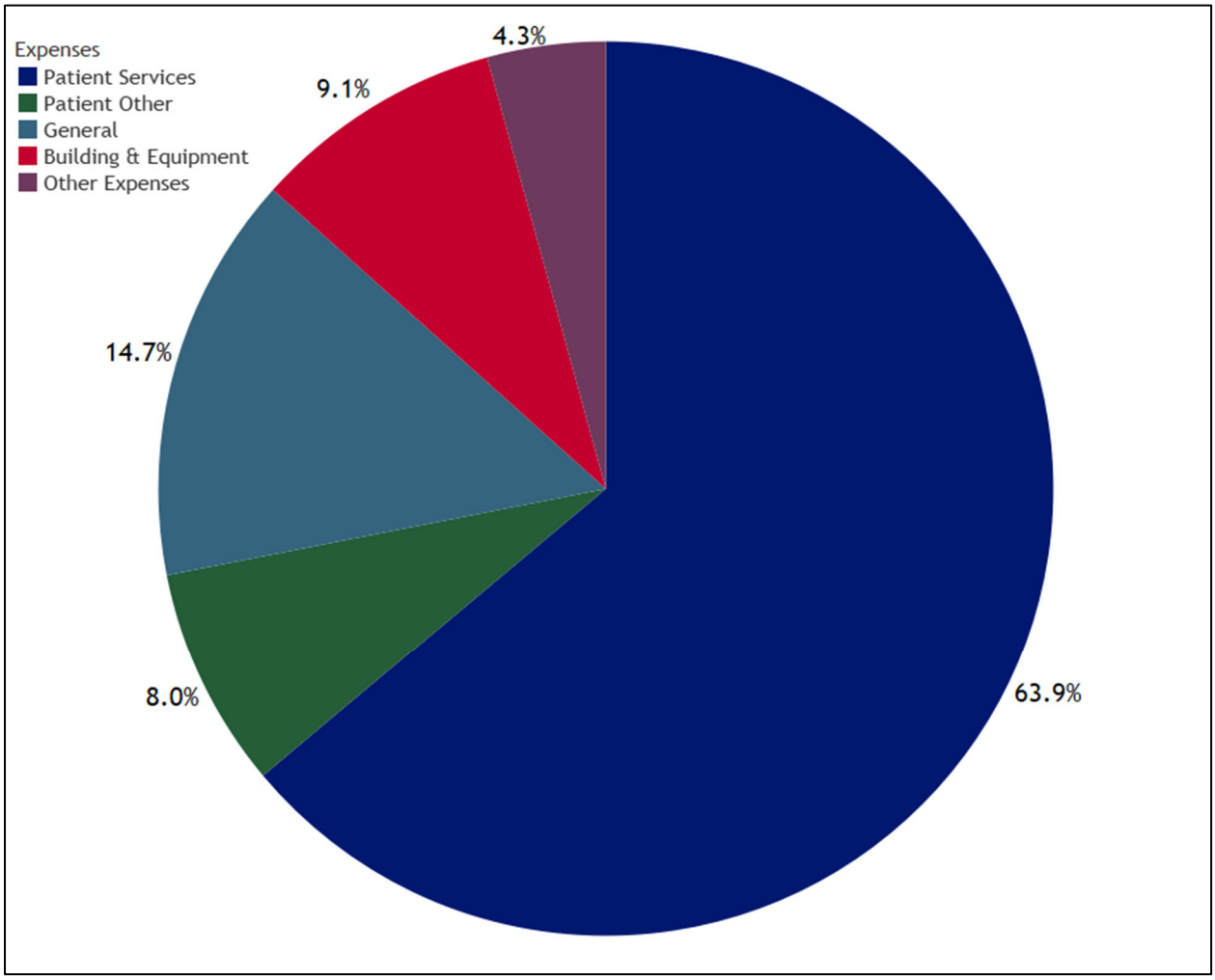
To better understand operating expenses, in addition to reporting the total for each expense type, the Department also asked hospitals to allocate expenses into four categories: direct patient, patient other, general and administrative, and other.

This portion of the analysis will include all hospitals that submitted in 2020, which is data for 82 of the 84 hospitals. The totals below will not match total operating expenses reported in Graph 3 and Table 17 because those numbers are for 57 of 77 hospitals that reported data for years 2014 to 2020. For more information see the **Methodology and Limitations** section above.

The pie chart in **Graph 4** displays a statewide mix of aggregate operating expenses by type for 2020, showing most Colorado hospital expenses are for patient services. **Table 19,** below, provides a more detailed breakdown of operating expenses and uses colors to indicate how the expenses are included in the

operating expense pie chart of **Graph 4.**Patient expenses (service and other) represent approximately 71.9% of Colorado hospital operating expenses. Patient service expenses make up 63.9% of operating expenses, while patient other expenses make up 8.0% of operating expenses.[5] General and administrative expenses represent 14.7% of operating expenses and building and major equipment expenses make up 9.1% of operating expenses. Other expenses represent approximately 4.3% of all operating expenses.

Graph 4: 2020 Mix of Operating Expenses by Type



[5] For expenses that hospitals allocated as being for patients, the Department chose expense lines that clearly relate to patient services to be classified as patient services, while the remainder are classified as patient other. Examples of expenses that hospitals reported as being for patients that fall in the patient other category include: contracted services, general other, insurance expense, management fees, provider fees, and purchased services.

Table 19: 2020 Mix of Operating Expenses by Type (in millions)

Expense Type	Expense	Direct Patient	Patient Other	General/ Admin	Other	Total
Services	Salaries, Wages, & Benefits	$5,867.1	$539.0	$1,113.6	$236.7	$7,756.3
Services	Physician Remuneration	$979.1	$8.6	$17.2	$29.1	$1,034.0
Services	Total Supplies	$3,142.9	$56.2	$64.2	$37.1	$3,300.4
Services	All Other	$460.6	$181.8	$0.0	$0.0	$642.4
Other	Interest	$122.4	$0.2	$73.5	$21.3	$217.5
Other	Provider Fee	$303.7	$330.0	$69.2	$316.6	$1,019.4
Other	All Other	$465.5	$188.4	$1,255.5	$110.0	$2,019.4
Building and Equipment	Depreciation	$780.4	$6.5	$204.2	$74.9	$1,066.0
Building and Equipment	Leases & Rental	$129.4	$9.2	$42.2	$4.8	$185.6
Building and Equipment	Maintenance & Utilities	$154.5	$41.7	$121.3	$24.6	$342.1
Total	**Total**	**$12,405.5**	**$1,361.5**	**$2,960.9**	**$855.2**	**$17,583.1**

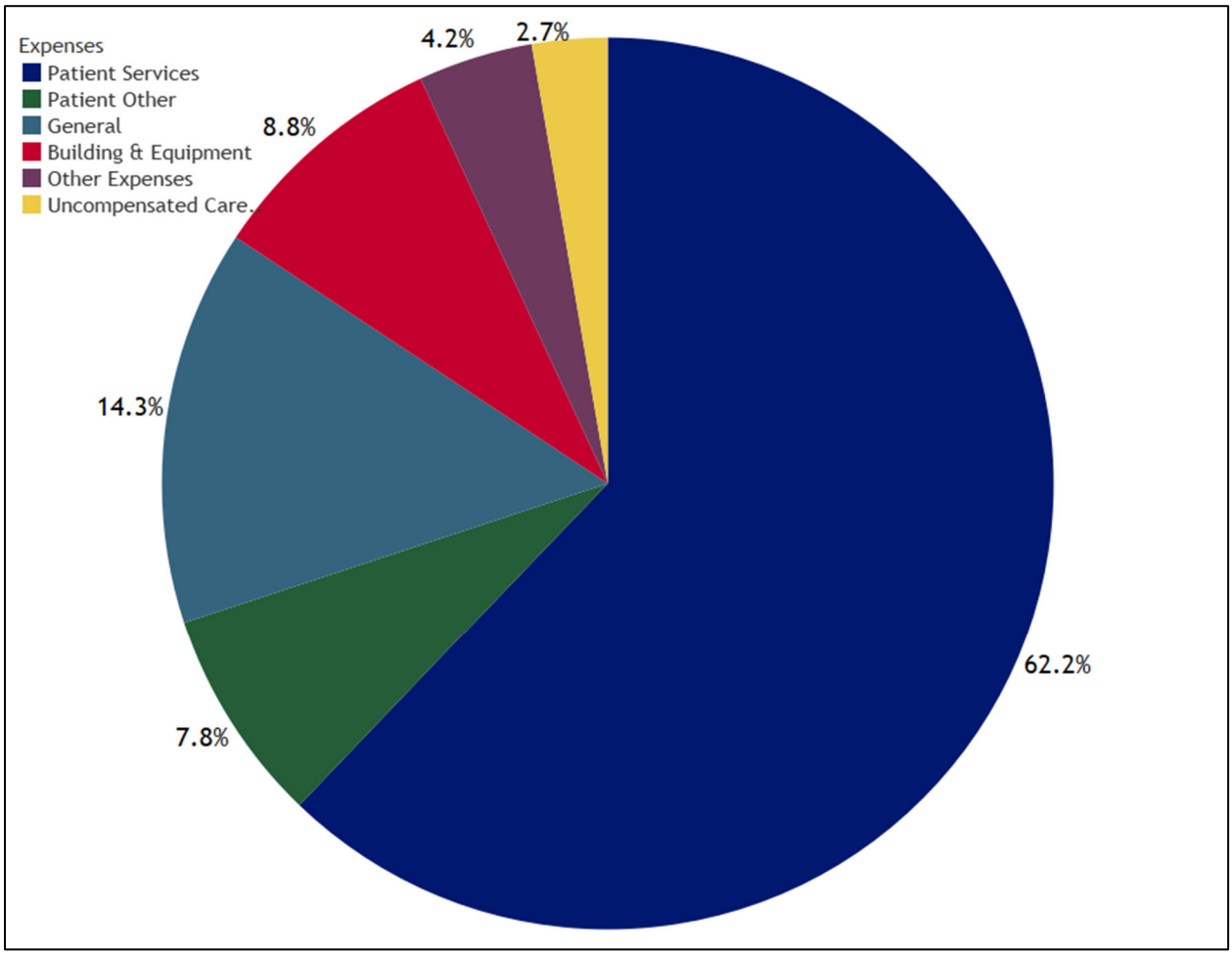
In **Table 20**, the expense type categories are for years 2019 and 2020. Here, the Department will only compare hospitals that submitted in both 2019 and 2020. Between 2019 and 2020, total patient service expenses increased by $1.6 billion, or an increase of 17.4%. For patient other expenses, there was a decrease of $237.6 million, or 14.6%. Between 2019 and 2020, general and administrative expenses increased by 9.2%, or $216.0 million, while building and major equipment expenses increased by 4.1%, or $62.4 million. Overall, total operating expenses increased $758.6 million, or 4.6%. Since the issue of the unallocated expenses was not a factor in 2020, a portion of these changes, especially patient related expenses, are most likely due to this better allocation from hospitals.

Table 20: 2019 to 2020 Operating Expense Type Totals (in millions)

Expense Type	2019	2020	Percent Change
Patient Services	$ 9,506.3	$ 11,161.3	17.4%
Patient Other	$ 1,632.5	$ 1,394.8	-14.6%
General	$ 2,351.1	$ 2,567.1	9.2
Building and Equipment	$ 1,512.4	$ 1,574.8	4.1%
Other	$ 1,037.1	$ 724.7	-30.1%
Unallocated	$ 624.8	$ 0.0	-100.0%
Total	$ 16,664.2	$17,422.8	4.6%

The legislation directs the Department to present uncompensated care costs as they relate to overall operating costs. Hospitals record uncompensated care as a write-off to gross charges (an offset to revenue) and is accounted for within the presentation of net patient revenue throughout the report. The following analysis includes all 2020 hospitals, not just those who reported in prior years. As depicted in **Graph 5**, uncompensated care costs represent 2.7% of costs when included as an operating expense. When uncompensated care costs are included as a patient expense, total patient expenses represent 72.7% of operating expenses.

Graph 5: 2020 Mix of Operating Expenses with Uncompensated Care Costs by Type



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Below (**Graph 6** and **Table 21**) represents the mix of operating expense types by hospital peer group for all hospitals that reported in 2020.

Graph 6: 2020 Operating Expense Mix by Hospital Peer Groups

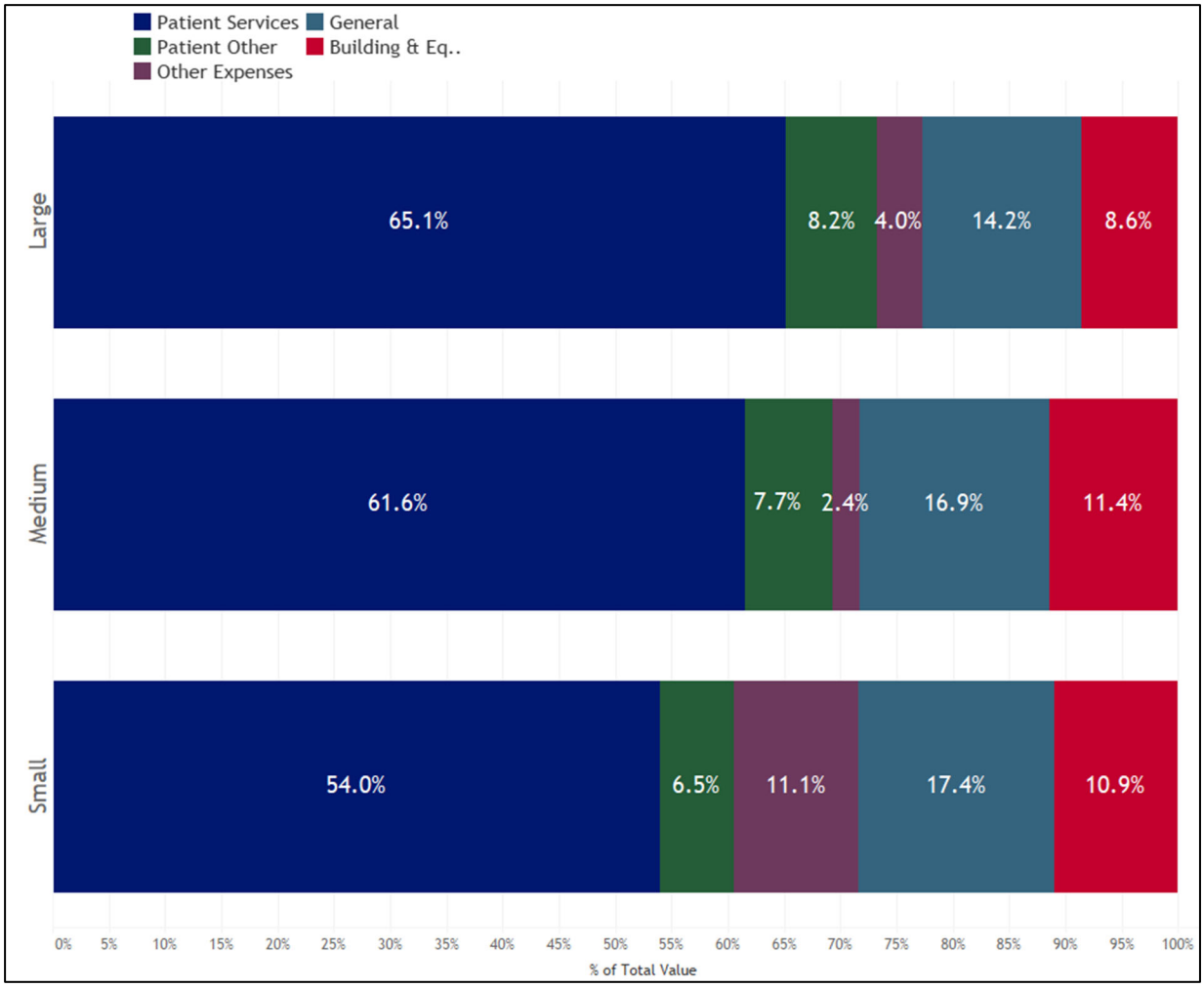

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Table 21: 2020 Operating Expense Mix by Hospital Peer Group

Expense Type or Expense	Large	Medium	Small
Patient	**73.3%**	**69.3%**	**60.5%**
Patient Service	65.1%	61.6%	55.2%
Patient Other	8.2%	7.7%	6.1%
General/Administration	**14.2%**	**16.9%**	**17.4%**
Building & Major Equipment	**8.6%**	**11.4%**	**10.9%**
Depreciation	5.8%	7.6%	6.4%
Leases & Rental	1.0%	1.6%	1.2%
Maintenance & Utilities	1.8%	2.2%	3.3%
Other	**4.0%**	**2.4%**	**11.1%**
Grand Total	100.0%	100.0%	100.0%

In 2019, some hospitals in the medium and small category did not allocate their expenses to these categories. Given this limitation, trended analysis for the medium and small peer groups will not be performed.

The breakdown of expenses by peer groups had the following findings:

- The proportion of 2020 and 2019 expenses for large hospitals were similar, with some minor changes. General and administrative costs were the same in 2019 and 2020. There was a slight shift in the proportion of costs for patient services, which increased from 61.7% to 65.1%, while the proportion of building and major equipment expenses decreased 0.1% between 2019 and 2020.

- When compared to the other peer groups, a greater proportion of the large hospital peer group's operating expenses were allocated for patients (patient services plus patient other) at 73.3%. The small hospital peer group's proportion of expenses allocated for patient services plus patient other was the lowest amongst peer groups at 60.5%. The small hospital peer group has the largest

proportion of other expenses (11.1%) and general and administration (17.4%). The Department will continue to watch the proportion of patient expenses in medium and small hospitals as more accurate data, like 2020, is submitted in the years to come.

When operating expenses are reviewed by DOI region (**Graph 7** and **Table 22**), there is regional variation in expense mix when allocated to patient as well as general and administration categories. The Fort Collins region has the highest proportion of expenses allocated to total patient with 77.8%, followed by Colorado Springs with 76.4%. When averaging the region's percentages, building and major equipment expenses were approximately 9.0%, with the Greeley region being the highest (13.9%) with Pueblo as the lowest region (7.1%). On average in 2020, general and administrative expenses were approximately 15.6% between all regions. The regions with the highest proportion of general and administrative expenses were the East (19.2%) and the West (19.2%) regions. This is likely since most hospitals within these regions are small or medium hospitals, which reflects the peer group analysis of expenses.

Graph 7: 2020 Operating Expense Mix by DOI Region

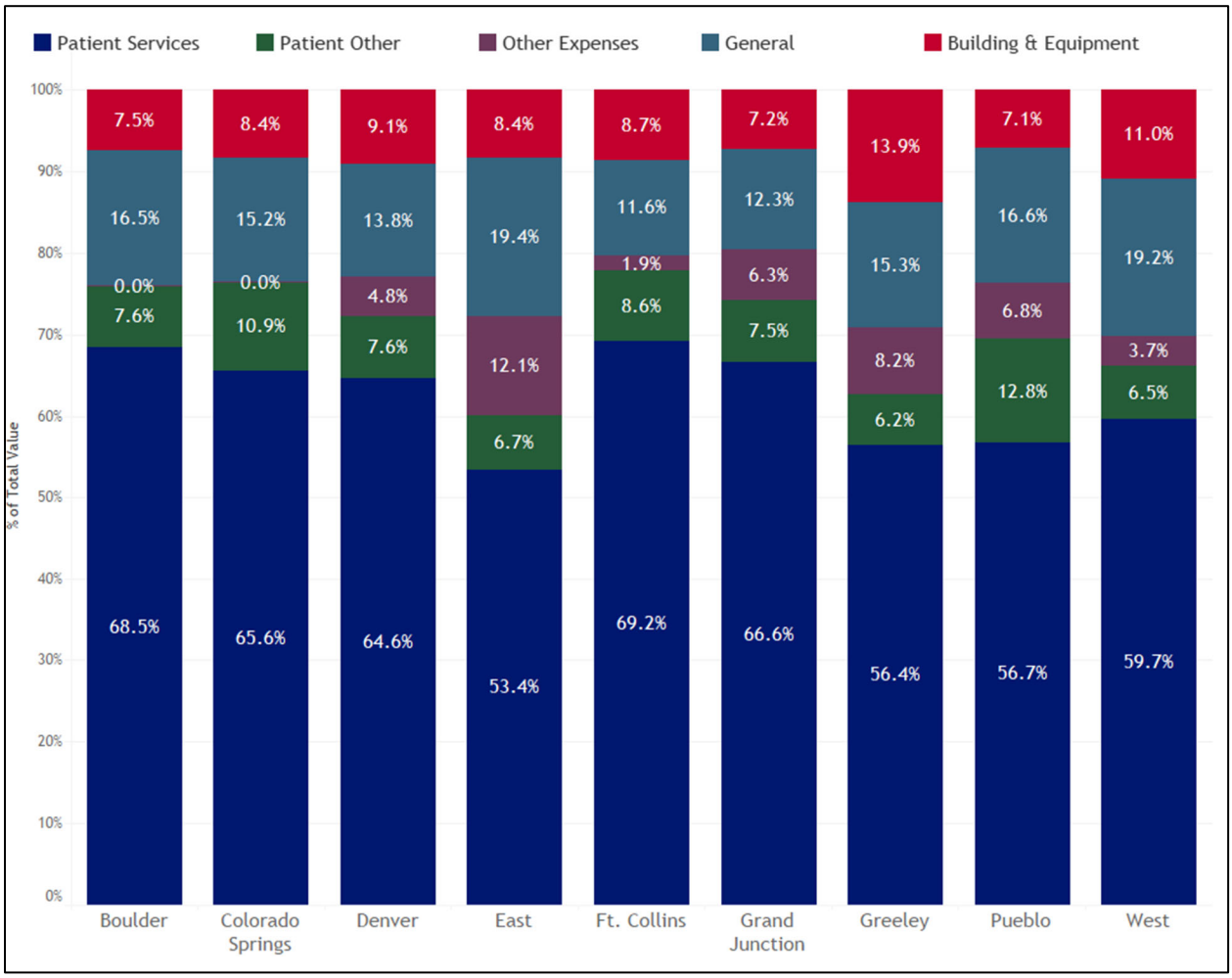

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Table 22: 2020 Operating Expense Mix by DOI Region

DOI Region	Boulder	CO Springs	Denver	East	Ft Collins	Grand Junction	Greeley	Pueblo	West
Patient	**76.0%**	**76.4%**	**72.3%**	**60.1%**	**77.8%**	**74.1%**	**62.7%**	**69.5%**	**66.2%**
Patient Service	68.5%	65.6%	64.6%	53.4%	69.2%	66.6%	56.4%	56.7%	59.7%
Patient Other	7.6%	10.9%	7.6%	6.7%	8.6%	7.5%	6.2%	12.8%	6.5%
General/ Administration	**16.5%**	**15.2%**	**13.8%**	**19.4%**	**11.6%**	**12.3%**	**15.3%**	**16.6%**	**19.2%**
Building & Major Equipment	**7.5%**	**8.4%**	**9.1%**	**8.4%**	**8.7%**	**7.2%**	**13.9%**	**7.1%**	**11.0%**
Depreciation	5.9%	5.3%	6.2%	4.3%	5.2%	5.4%	10.3%	4.3%	6.7%
Leases & Rental	1.0%	1.5%	1.0%	0.6%	0.9%	0.9%	0.1%	0.9%	1.6%
Maintenance & Utilities	0.6%	1.5%	1.8%	3.4%	2.6%	0.9%	3.5%	1.9%	2.7%
Other	**0.0%**	**0.0%**	**4.8%**	**12.1%**	**1.9%**	**6.3%**	**8.2%**	**6.8%**	**2.7%**
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

In **Table 23**, the percent change for comparable total expense categories are displayed. Between 2019 and 2020, total payroll expense increased by 5.1% (an increase of $287.3 million), whereas total salaries, wages, and benefits increased by 4.5% (an increase of $333.6 million). 2020 saw a decrease in contracted labor expenses by 10.1%, or a decrease of $27.1 million. Between 2019 and 2020, total supplies expenses increased by 3.1%, or $97.1 million. There was a decrease of approximately 20.0%, or $45.7 million, for lease and rental expenses. For maintenance and utilities there was a decrease of 3.5%, or a decrease of $12.1 million. The Department will continue to review and monitor these trends in future years to analyze the impact of the COVID-19 Pandemic on hospital expenses.

Table 23: 2019 -2020 Operating Expenses Percent Change

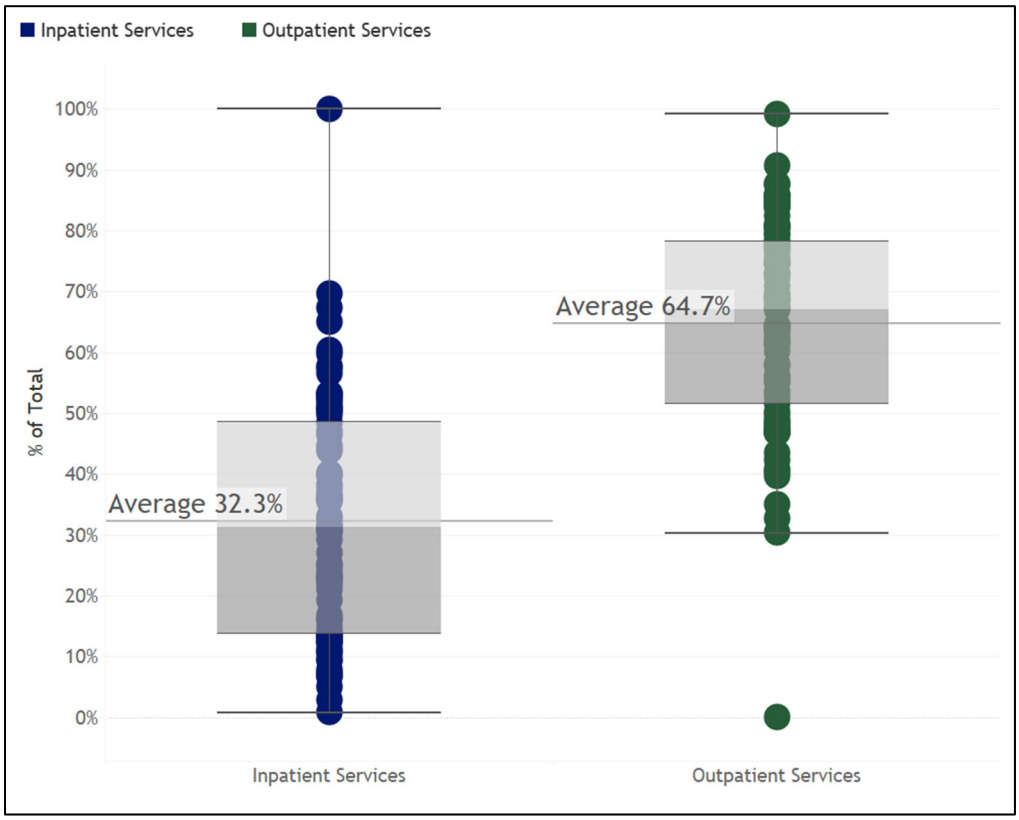
Expense	% Change (2019 - 2020)
Total payroll	5.1%
Employee benefits	5.2%
Contracted labor	-10.1%
Total salaries, wages, benefits	4.5%
Total supplies	3.1%
Depreciation	13.3%
Leases & Rental	-20.0%
Maintenance & Utilities	-3.5%
Interest	0.9%

3. Inpatient and Outpatient Service Split

The Department is using hospital submitted charge information to determine the expenses split between inpatient and outpatient services. This was determined after reviewing hospital submissions and consulting with hospital stakeholders.

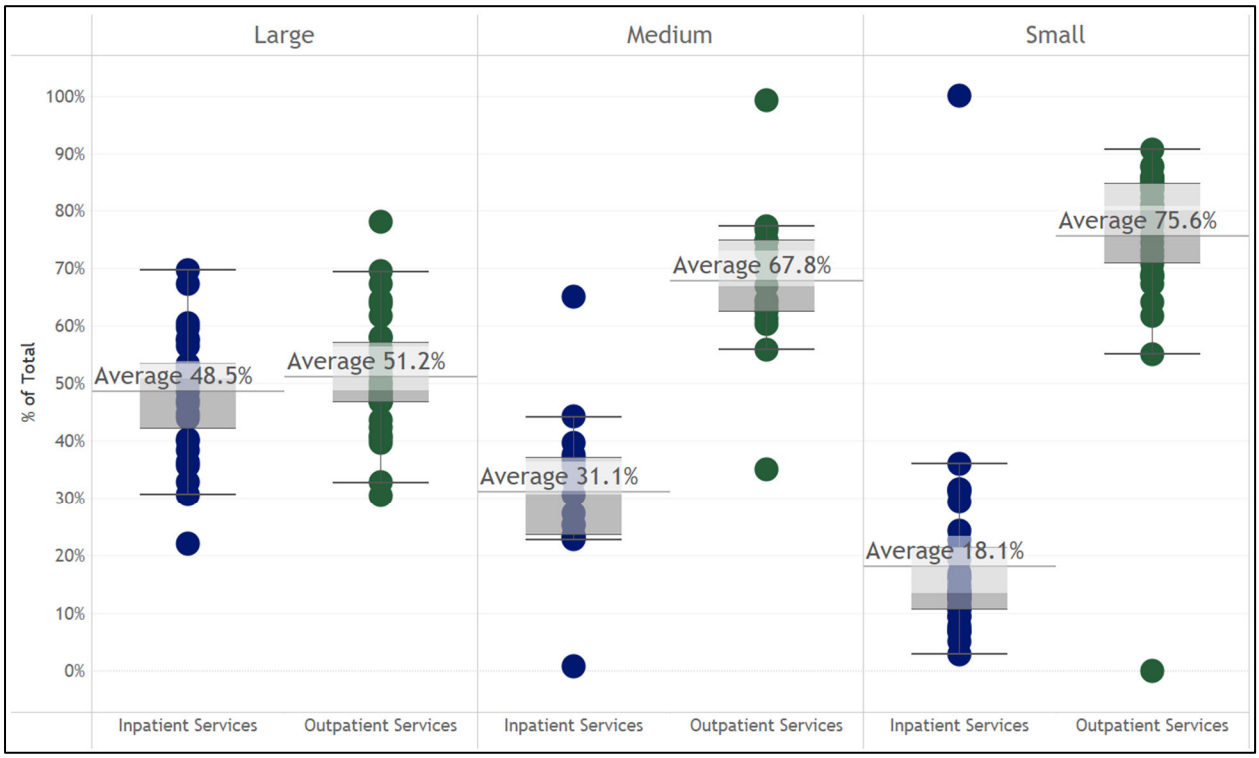
Graph 8 represents the averaged proportion of expenses that are for inpatient and outpatient services for all hospitals that submitted during 2020. On average, inpatient expenses represented 32.3% while outpatient services represented 64.7%.

Graph 8: 2020 Inpatient and Outpatient Expense Split



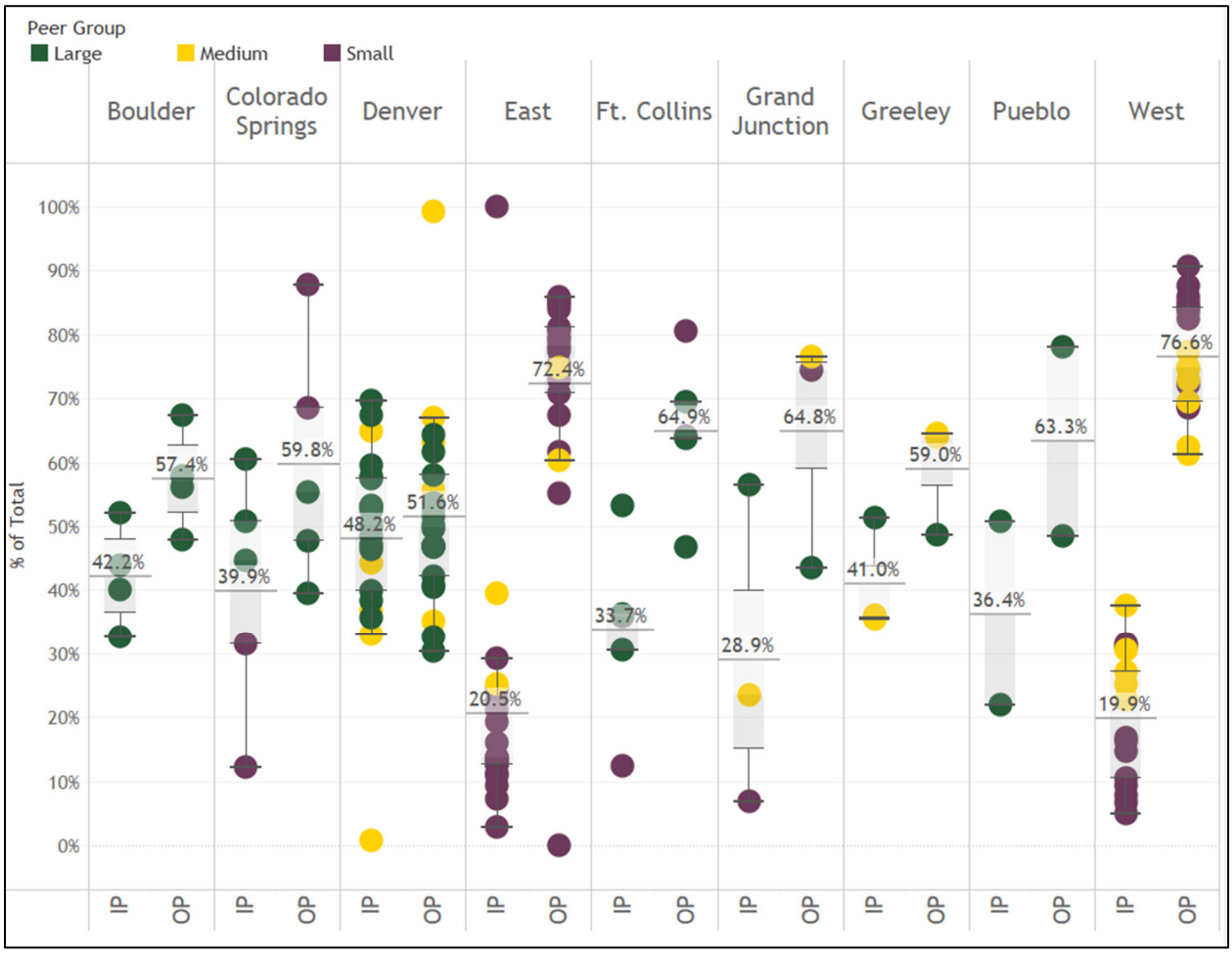
Looking at the inpatient and outpatient service split reveals the variation amongst the hospital peer groups (**Graph 9**). The large group does not reflect the split present in **Graph 8**. The inpatient and outpatient split for the large peer group is fairly even, 48.5% for inpatient and 51.2% outpatient. The medium peer group's inpatient and outpatient service split is more like the overall averaged values, with inpatient services representing 31.1% of expenses while outpatient services represent an average of 67.8%. The small peer group's expenses are the most heavily weighted towards outpatient services as hospitals in that peer group reported 75.6% of their service expenses for outpatient services and 18.1% for inpatient services. This higher outpatient utilization in the small, often rural hospitals, aligns with the strategic opportunity to repurpose unused inpatient rural beds to meet emerging community needs.

Graph 9: 2020 Inpatient and Outpatient Expense Split by Hospital Peer Group



As seen in **Graph 10**, regions with more small and medium hospitals have more outpatient service expenses than inpatient service expenses. Along with size, distance from the state's most populous metropolitan region, Denver, seems to correspond with the proportion of expenses allocated between inpatient and outpatient services. In the regions with the highest proportion of small and medium hospitals (the East and West regions), the split between inpatient and outpatient is most noticeable, with small hospitals having the highest proportion of outpatient services and lower inpatient services compared to their regional peers.

Graph 10: 2020 Inpatient (IP) and Outpatient (OP) Expense Split by DOI Region



F. Payer Mix

Payer mix is the percentage composition of all the payer types that make up hospital services. The Department assesses payer mix by looking at the proportion of payer types that make up total charges.[6] To assess payer mix, proportions of charges are calculated. The dataset has five payer types: Medicare, Medicaid, commercial, self-pay, and CICP/Other.

[6] A hospital's chargemaster is a layer of financial values tied to services rendered that applies to all patients. Two patients who receive the same services will be "charged" the same amount. What the patients and their insurance coverage will end up paying varies based on their insurance's negotiated rate with the hospital. As the top layer of the charge system is universal amongst patients, charges are a good indication of the proportion of services associated with a payer type.

Graph 11 and **Table 24** shows payer mix has not changed significantly between 2014 and 2020, but there has been some shift between payer types. In 2020, more people were insured through public programs (60.0% Medicaid/Medicare payer mix) than in 2014 (55.1% Medicaid/Medicare payer mix). Interestingly, and despite the COVID-19-induced recession which caused an increase in Coloradans covered by Medicaid in 2020, Medicaid payer mix increased from 2014 to 2017 (from 19.3% to 22.3%). It was then consistent between 2018 and 2020, even decreasing slightly, perhaps reflecting the healthier population moving from employer sponsored commercial coverage and onto Medicaid.

Graph 11: Payer Mix

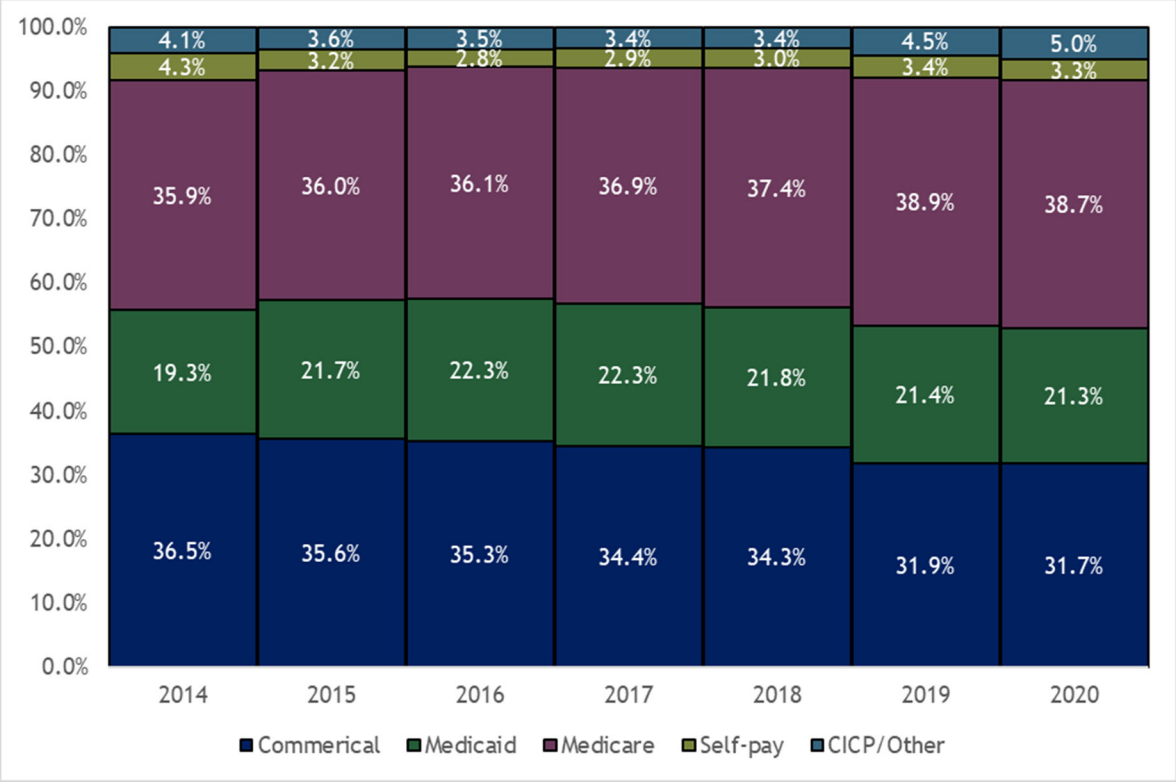


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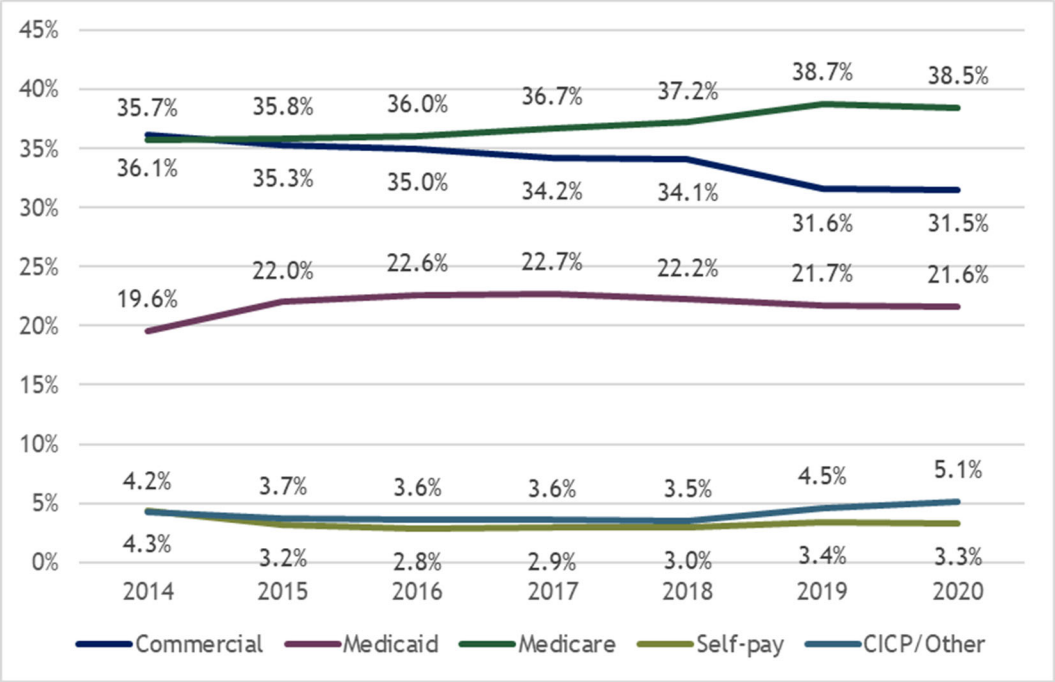
Table 24: Payer Mix

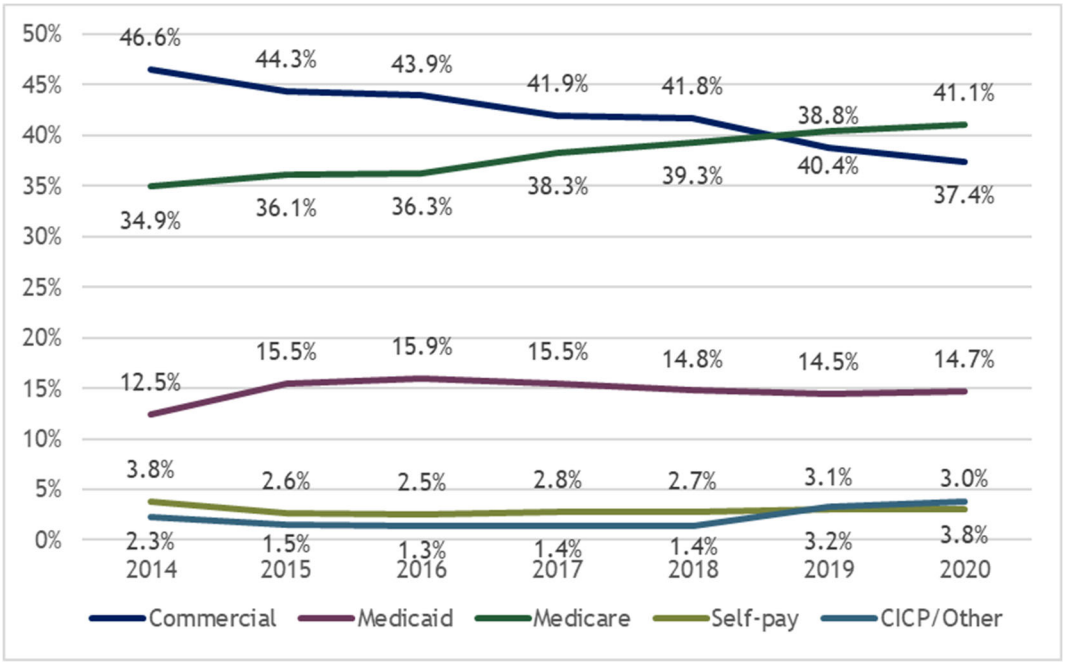
Year	Commercial	Medicaid	Medicare	Self-pay	CICP/Other
2014	36.5%	19.3%	35.9%	4.3%	4.1%
2015	35.6%	21.7%	36.0%	3.2%	3.6%
2016	35.3%	22.3%	36.1%	2.8%	3.5%
2017	34.4%	22.3%	36.9%	2.9%	3.4%
2018	34.3%	21.8%	37.4%	3.0%	3.4%
2019	31.9%	21.4%	38.9%	3.4%	4.5%
2020	31.7%	21.3%	38.7%	3.3%	5.0%

The Department also looked at payer mix by the hospital peer groups, displayed in **Graphs 12 to 14**. Some interesting findings from this view of the data are that the small peer group has the lowest commercial payer mix for all years (26.3% in 2020) and this hospital peer group also has the highest proportion of self-pay payer types (3.9% in 2020). Most patients seen at small peer group hospitals are covered through Medicare. Medicare is now the largest payer mix of the large and medium peer group's payer mix as well. Between 2019 and 2020, the medium peer group's Medicare portion grew to 41.1% from 40.4%. For all hospital peer groups, there was an increase in the proportion of Medicaid payer mix between 2014 and 2017, with slight decreases since 2018 – again, an interesting insight given the COVID-19-induced recession.

Graph 12: Large Hospital Peer Group Payer Mix



Graph 13: Medium Hospital Peer Group Payer Mix



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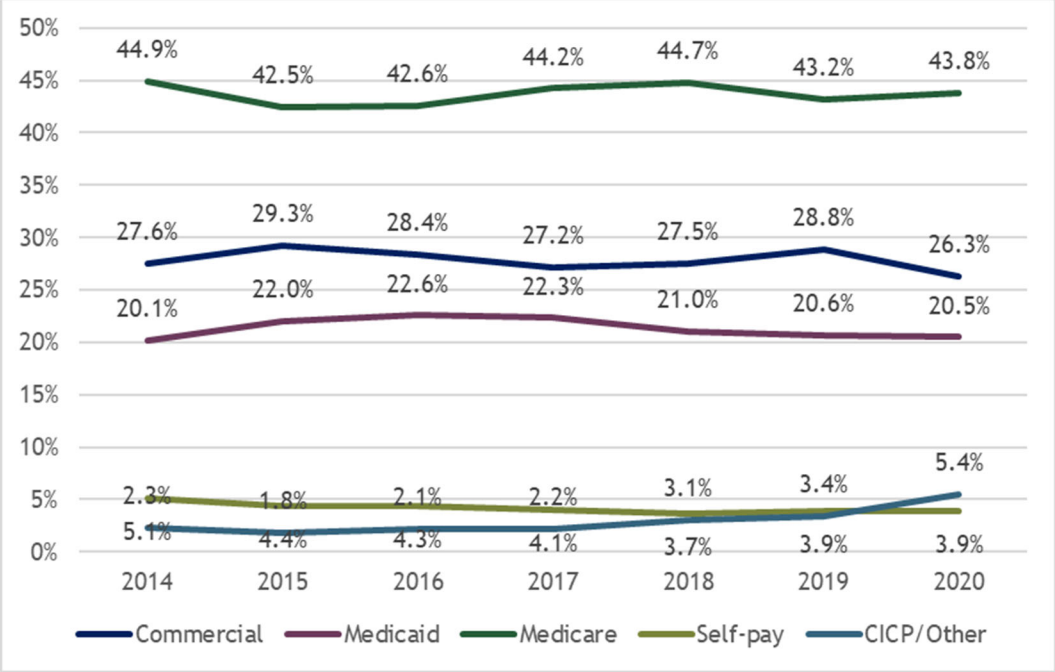
Graph 14: Small Hospital Peer Group Payer Mix



III. Conclusion

The Department thanks all of Colorado's hospitals for their help with the completion of this report. Without their feedback and thoughtfulness during the submission process, this report would not be as robust as it is.

Satisfying requirements from HB 19-1001, this report provides information on hospital uncompensated care and operating expenses and other financial fields.

When reviewing all hospitals submitting data in 2020, consider the following major findings:

- In 2020, net patient revenue totaled $17.9 billion, primarily composed of the commercial payer category at 51.3% ($9.2 billion), followed by Medicare at 25.2% ($4.5 billion) and Medicaid at 17.1% ($3.1 billion).

- In 2020, hospitals experienced $493.9 million in total uncompensated care costs. Reflective of the financial challenges of an uninsured person's ability to pay and utilization of the hospital's charity care program, the self-pay payer category was the largest portion of uncompensated costs and its

components (bad debt costs and charity care costs) in 2020 were $301.3 million, or 61.0%.

- Hospital operating expenses totaled $17.6 billion in 2020, mostly driven by patient expenses (72.0%) representing $12.5 billion of all operating expense. 28.0% of all operating expenses do not go towards servicing patients directly. Patient service expenses generate 63.9% of all operating expenses and 8.0% for other patient related expenses. Summed together these equal the total patient expenses. General and Administrative expenses were the second largest type of expenses at $2.6 billion or 14.7%. Building and equipment expenses represented 9.1% of all operating expenses ($1.6 billion). When included as an operating expense, uncompensated care costs represent 2.7% of operating expenses. These costs do not make up a significant portion of a hospital's expenses.

For hospitals that submitted in both 2019 and 2020, the year over year comparison found:

- Across all reporting hospitals, the average hospital provides more outpatient services than inpatient services, with 32.3% for inpatient services and 64.7% for outpatient services. The average small hospital, which are typically critical access and rural hospitals, provide three times more outpatient services (75.6%) than inpatient services, while large hospital systems provide an average of 48.5% inpatient and 51.2% outpatient services.

- For hospitals that reported for all years between 2014 and 2020, net patient revenue grew from $11.9 billion to roughly $16.4 billion, an increase of 35.5% from 2014, or an average of 5.2% over the period. The Department is looking into what type of hospitals and which payers are driving this increase.

- Using the dataset inclusive of all hospitals submitting in both years, between 2019 and 2020, net patient revenue increased by $264.6 million, or an 1.5% increase. Given that the net patient revenue does not include federal COVID-19 stimulus, it is notable that hospitals' patient revenues increased between 2019 and 2020 despite the stay-at-home effort and the hold on elective procedures during the first months of the pandemic.

- Uncompensated care costs increased 9.2% between 2019 and 2020, with charity care representing $276.5 million or 56.0%, and bad debt costs representing $217.4 million, or 44.0%. The self-pay payer type category was the largest portion of uncompensated costs in 2020 with $301.3 million, or 61.0% and also the largest in both charity care and bad debt, $176.4 million and $124.9 million, respectively.

- Uncompensated care charges increased minimally by 0.7% between 2019 and 2020, or $11.6 million, driven by the large and medium peer group hospitals. The medium peer group increased its total uncompensated care charges by 2.4% from 2019 and the large peer group, increased by 0.8%. The small peer group decreased its total uncompensated care charges by 7.7%.

- In reviewing the two components of uncompensated care (bad debt and charity care) the data shows that from 2019 to 2020 bad debt charges decreased by 15.2% overall, or approximately a decrease of $110.7 million, whereas charity care charges increased by 13.2%, or an increase of $122.4 million. The small peer group decreased its total uncompensated care charges by 7.7%, the medium peer group increased its total uncompensated care charges by 2.4% from 2019, and finally the large peer group, increased by 0.8%.

- Between 2019 and 2020, total operating expenses increased $758.6 million to $17.4 billion. Patient service expenses increased the most (a $1.6 billion increase), but some of this increase is likely because of Department efforts to ensure no unallocated expenses.

- Total operating expenses increased on average $723.9 million per year or 5.4%. Total operating expenses increased by approximately $663.8 million to a total of $16.0 billion between 2019 and 2020.

- The Department's analysis shows the mix of expenses that make up total operating expenses remains relatively consistent. Salaries, wages, and benefits were the largest operating expense for all peer groups through the years. However, proportions of salaries, wages and benefits among the hospital peer groups varied. The smaller the hospital size peer group, the greater the proportion of salaries, wages and benefits expense and general

& administrative expenses. Additionally, with the breakdown of allocation type, most expense types were allocated to the patient category.

Between 2019 and 2020, hospital peer groups had the following findings for operating expense analysis:

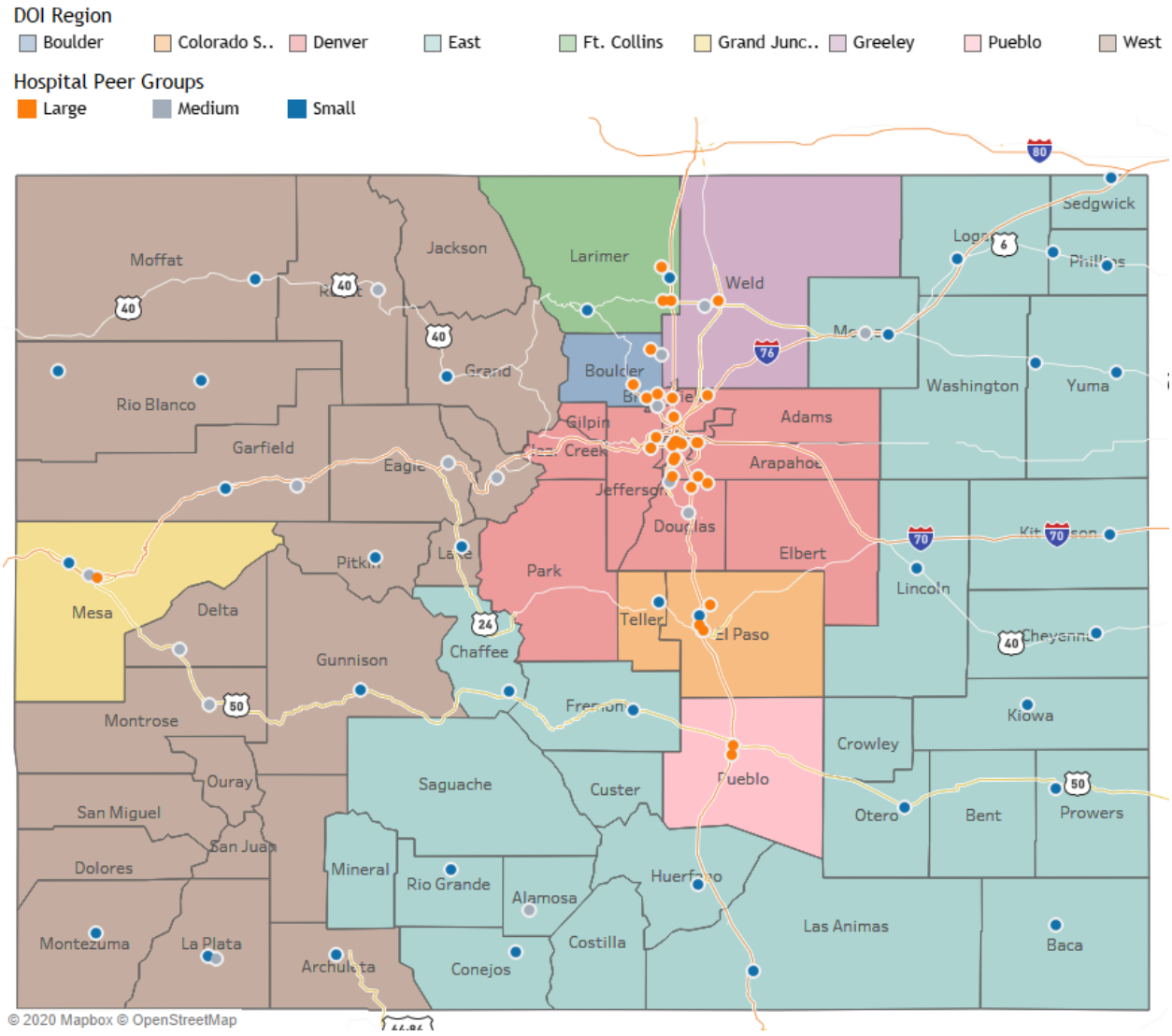
- The proportion of expense types for large hospitals remained largely the same between 2019 and 2020. General and administrative costs were the same proportion. Patient services increased from 61.7% to 65.1%. Building and major equipment expenses stayed relatively flat (down 0.1%) between 2019 and 2020.
- A greater proportion of the large hospital peer group's operating expenses were allocated for patients (73.3%), while the small hospital peer group's proportion of expenses allocated as for patients was the lowest at 60.5%. This indicates that large hospitals have operational economies of scale.
- The small hospital peer group has the largest proportion of "other" expenses (11.1%) and general and administration (17.4%).

With the Department's payer mix analysis, between 2014 and 2019 the conclusion is there were shifts in payer mix from commercial and self-pay categories to Medicare and Medicaid over the period. Between 2019 and 2020, small decreases in Medicare, Medicaid, and commercial payers were shifted to the CICP/Other category. Additionally, the payer mix for the small hospital peer group had the lowest percentage of commercial when compared to the large and medium hospital peer groups. Among other reasons, this explains the lower margins associated with the smaller rural hospitals and why they struggle to make the modernization investments that the larger systems can afford to make.

See the **Hospital Expenditure Report Detailed Dataset by Hospital** for a full report of each hospital's data.

IV. Map & Definitions

A. Map of Colorado Hospitals Identified by Hospital Peer Group and DOI Regions



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B. Definitions

Affordable Care Act (ACA): The comprehensive federal health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Bad debt: The sum of all charged amounts a provider billed but did not receive payment for the service.

Charity care: The sum of all charged amounts determined by the health care provider to be charity care and thus unreceived revenue.

Colorado Healthcare Affordability and Sustainability Enterprise Board (CHASE Board): The CHASE Board makes recommendations to the Medical Services Board regarding the implementation of the health care affordability and sustainability fee. The CHASE Board also directs the implementation of delivery system reform incentive payments program and monitors the impact of the fee on the health care market.

Contractual allowances: Also known as adjustments, contractual allowances are the difference between what a health care provider charges for the care provided to the patient and what the provider will be contractually paid by a third-party (commercial insurer and/or government program such as Medicare, Medicaid, etc.).

Critical access hospitals: A hospital qualified as a critical access hospital under 42 U.S.C. § 1395i4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and Environment

Department of Health Care Policy & Financing (Department): A department of the government of the State of Colorado.

DATABANK Program: An online program available to Colorado Hospital Association members and serves as a centralized location for the collection of hospital utilization and financial data.

Depreciation expense: The decrease in the fair value of a tangible asset, reported as an expense for the reporting period.

Discharge: A record of a formal release of a patient. This excludes newborns leaving with mothers, death on arrivals and includes death.

General hospital: A hospital licensed as a general hospital by the Colorado Department of Public Health and Environment. Sometimes referred to as a "short-stay, acute care hospital".

Health system: Also known as hospital system. A multi-hospital system is two or more hospital owned, leased, sponsored or contract managed by a central organization.

Hospital peer groups: For the purposes of this report hospital peer groups are determined by grouping together number of licensed beds (for a definition of licensed beds please see below). The three (3) peer groups are as follow: the small peer group with 25 or fewer beds, the medium peer group with 26 to 90 beds, and the large peer group with 91 or more beds.

House Bill 19-1001: The Hospital Transparency Measures to Analyze Efficacy Bill signed into law on March 28, 2019.

Interest expense: Expenses for mortgages, bonds, notes, lines-of-credit, convertible debt and any other short-term or long-term borrowings.

Licensed beds: The maximum number of beds a licensure agency, such as the state or other governing body, allows a hospital or health facility to operate at any given time. Provide the number of beds at the end of the fiscal year.

Long-term care hospital: A general hospital that is certified as a long-term care hospital by the Colorado Department of Public Health and Environment. Sometimes referred to as a sub-acute care hospital or long-term acute care hospital.

Major payer groups: A major payer in health care is the entity or individual paying the medical bill or claim. The major payers for the purposes of this report are Medicare, Medicaid, commercial and self-pay. Others can

include compensation programs, like workman's compensation, and other government programs, like TRICARE/CHAMPUS.

Medicare Cost Reports: Medicare hospital cost report, form Center for Medicare and Medicaid Services (CMS) 2552-96 or CMS 2552-10, or any successor form created by CMS, and the annual required submission of worksheets and schedules by Medicare certified providers used for Medicare reimbursement

Net patient revenue: Net patient revenue approximates the payments a hospital receives for patient services. Net patient revenue is calculated by totaling all charges the hospital billed to patients, subtracting contractual allowances, and then subtracting bad debt and charity care.

Table 14: Net Patient Revenue Calculation

Calculation	Variable
	Total charges
-	Total contractual allowance
-	Total charity care
-	Total bad debt
=	Net patient revenue

Other expense: The difference between total operating expense and specified categories of expenses (salaries, wages, and benefits, supply, interest, and depreciation). These expenses might be for taxes, utilization, contract services, fees, insurance, marketing expenses, etc.

Outpatient visit: Determined by counting only one visit day for each calendar day a patient visits an outpatient department or multiple outpatient departments.

Psychiatric Hospital: A hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

Rehabilitation hospital: An inpatient rehabilitation facility.

Salaries, Wages and Benefit Expense: Salaries and wages paid to hospital employees and employee benefits paid and provided by the hospital. These

include employee expenses for physicians, interns, residents, other trainees, facility employees and home office wages.

Supply expense: The sum of all expenses related to medical supplies, food, housekeeping, maintenance, general facility upkeep, minor equipment, administration, and medical drugs.

Total operating expense: The sum of all operating expenses to run the hospital. This includes expenses like materials, supplies, contract services, management fees and home office allocations, depreciation, interest, taxes, consultants' services, utilities, pharmaceuticals, and insurance.

Table 15: Total Operating Expense Calculation

Calculation	Variable
	Depreciation
+	Interest
+	Salaries, wages, and benefits
+	Supplies
+	All other expenses
=	Total operating expenses

Uncompensated care: Health care or services provided by hospitals or health care providers that are not reimbursed.

COLORADO
Department of Health Care Policy & Financing

Hospital Community Benefit Key Findings

House Bill (HB) 19-1320 created part 7 of article 1 of title 25.5, C.R.S. entitled "health care providers' accountability to communities." The legislation requires hospitals to meaningfully engage with their communities for feedback on their community benefit activities and to report their community benefit expenditures to the Department of Health Care Policy and Financing. The legislation was an important step to understand the community benefits Colorado's hospitals provide to their respective communities. Hospitals are investing 6% of their patient revenues received in the community. Such contributions are significant, appreciated, valued and noted immediately below. However, opportunities exist to strengthen hospitals' accountability to their communities, and those opportunities are also identified below. Notably, the currently reported information does not provide enough detail to identify where and how the funds were invested and whether the community benefit investments match communities' identified needs.

Community Investments Reported

- Overall, Colorado hospitals invested $836.3 million in community benefits in 2020, not including Medicaid shortfall[1]. These investments equal 6% of hospital patient revenue received.
- Investments by category are as follows:
  - ✓ Free or reduced-cost health care services: $199.5 million, 24% of total
  - ✓ Programs addressing health behaviors or risks: $485.5 million, 58% of total
  - ✓ Programs that addressed social determinants of health: $23.1 million, 3% of total
  - ✓ Other investments that addressed community identified needs: $128.2 million, 15% of total

Opportunities to Improve Hospitals' Accountability to their Communities

- Hospitals are not fully complying with the statute, including the important public meeting requirements. The General Assembly should establish corrective action obligations and financial penalties for non-compliance.
- In order to have a better understanding of the hospitals tax exemption benefit compared to their community benefit spending, the General Assembly should direct the Office of the State Auditor, working in conjunction with the Colorado Department of Revenue, to the best of its ability estimate the value of all federal, state and local taxes for reporting hospitals as defined in 25.5-1-701, C.R.S. Such a report should compare the estimated value of each reporting hospital's tax exemptions to its investment in addressing community health needs as set forth in 25.5-1-703(3)(d)(I)(C), C.R.S.
- The specific investments made by hospitals are not clear in the current reporting requirements. Because of this, the Department cannot report what was actually completed by a hospital, its value to the community, or alignment with community

[1] Medicaid shortfall is the difference between a hospital's cost of care for Medicaid eligible patients and the payments that the hospital receives for these services.

needs. The Department can only distinguish the investment category, i.e., health behaviors or risks or social determinants of health. Therefore, the General Assembly should enable the Department to establish in rule the details of the hospital community investment reporting requirements to ensure that the intent of HB 19-1320 is achieved and that the Department can provide better insights into how the hospital community investment dollars are being spent, by hospital and across the state.

- There is no consistent national standard on what qualifies as community benefit and the current law does not require a minimum expenditure in any category or set priorities. The General Assembly should specify what services and activities it considers sufficient community benefit, establish community benefit minimum expenditures and declare community benefit priorities, such as behavioral health services, housing, access to nutritious food, health care disparities and public health.
- To improve hospitals' accountability to the communities they serve, the General Assembly should establish a requirement for hospitals to directly tie community identified needs to community benefit expenditures, while prioritizing those voiced needs based on shared statewide priorities as recommended above.
- To ensure hospital community benefit investments impact community health, the General Assembly should require hospitals to regularly and meaningfully evaluate the impact of their community benefit investments on community health.

The Hospital Community Benefit Accountability Report is one in a series of reports related to hospitals the Department publishes. Additional reports including the Colorado Hospital Accountability and Sustainability Enterprise; Hospital Cost, Profits and Price; Hospital Expenditure Report; and other reports are available on the Hospital Reports Hub at Colorado.gov/hcpf/hospital-reports-hub.

Hospital Community Benefit Accountability

Annual Report

January 15, 2022

COLORADO
Department of Health Care Policy & Financing

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COLORADO
Department of Health Care Policy & Financing

I. Overview

House Bill (HB) 19-1320 requires nonprofit tax-exempt general hospitals, Denver Health Medical Center, and University of Colorado Hospital to complete a community health needs assessment every three years and an annual community benefit implementation plan every year. Critical access hospitals are not required to participate but are encouraged to do so. Each reporting hospital is required to convene a public meeting at least once per year to seek feedback on the hospital's community benefit activities and implementation plans. These hospitals are required to submit a report to the Department of Health Care Policy & Financing (the Department) that includes, but is not limited to the following:

- Information on the public meeting held.
- The most recent Community Health Needs Assessment.
- The most recent Community Benefit Implementation Plan.
- The most recent submitted Internal Revenue Service (IRS) form 990 including Schedule H.
- A description of investments included in IRS form 990 Schedule H.
- Expenses included on IRS form 990.

Report links and additional information can be found on the Hospital Community Benefit Accountability webpage.

II. Reporting

Under § 25.5-1-700, C.R.S., the Department is required to submit an aggregated report including the information below based on the submissions it has received.

1. The amount that each reporting hospital invested in:
    a. Free or reduced-cost health care services addressing community identified health needs.
    b. Programs addressing health behaviors or risks.
    c. Programs addressing social determinants of health.
    d. All services and programs addressing community identified health needs.
2. A summary of the reporting hospitals' investments that have been effective in improving community health outcomes.

3. Any legislative recommendations the Department has for the General Assembly.

The Department received 45 submissions[1], and of those, two (2) were critical access hospital and one (1) was a new facility[2] with limited information available to report. All hospitals required to report did so.[3]

III. Summary

House Bill (HB) 19-1320 created part 7 of article 1 of title 25.5, C.R.S. entitled "health care providers' accountability to communities." The legislation requires hospitals to meaningfully engage with their communities for feedback on their community benefit activities and to report their community benefit expenditures to the Department of Health Care Policy and Financing. The legislation was an important step to understand the community benefits Colorado's hospitals provide to their respective communities. Hospitals are investing 6% of their patient revenues received in the community. Such contributions are significant, appreciated, valued and noted immediately below. However, opportunities exist to strengthen hospitals' accountability to their communities, and those opportunities are also identified below. Notably, the currently reported information does not provide enough detail to identify where and how the funds were invested and whether the community benefit investments match communities' identified needs.

The Recommendations and Department Oversight sections below outline opportunities to improve oversight and require more detailed, specific reporting. These recommendations, if followed, will improve the state's understanding of where the community dollars were actually invested and increase hospitals' accountability to their communities.

[1] The Hospital Community Benefit Accountability Report was due from reporting hospitals on July 1, 2021; however, the Department delayed the due date of the first report to Sept. 1, 2021 due to the novel coronavirus (COVID-19) public health emergency.

[2] Children's Hospital Colorado, Colorado Springs

[3] Critical Access Hospitals (CAH) are not required to report but are encouraged to do so.

IV. Recommendations

The Department makes the following recommendations to the General Assembly:

1. Hospitals are not fully complying with the statute, including the important public meeting requirements. The General Assembly should establish corrective action and financial penalties for non-compliance.
2. In order to have a better understanding of the hospitals tax exemption benefit compared to their community benefit spending, the General Assembly should direct the Office of the State Auditor, working in conjunction with the Colorado Department of Revenue, to the best of its ability estimate the value of all federal, state and local taxes for reporting hospitals as defined in 25.5-1-701, C.R.S. Such a report should compare the estimated value of each reporting hospital's tax exemptions to its investment in addressing community health needs as set forth in 25.5-1-703(3)(d)(I)(C), C.R.S.
3. The specific investments made by hospitals are not clear in the current reporting requirements as evidenced by *Appendix E Investments Reported by Hospital* on page 24. Because of this, the Department cannot report what was actually completed by a hospital, its value to the community, or alignment with community needs. It can only distinguish the investment category, i.e., health behaviors or risks or social determinants of health. Therefore, the General Assembly should enable the Department to establish in rule the details of the hospital community investment reporting requirements to ensure that the intent of HB 19-1320 is achieved and that the Department can provide better insights into how the hospital community investment dollars are being spent, by hospital and across the state.
4. There is no consistent national standard on what qualifies as community benefit and the current law does not require a minimum expenditure in any category or set priorities. The General Assembly should specify what services and activities it considers sufficient community benefit, establish community benefit minimum expenditures and declare community benefit priorities, such as behavioral health services, housing, access to nutritious food, health care disparities and public health.
5. To improve hospitals' accountability to the communities they serve, the General Assembly should establish a requirement for hospitals to directly tie

community identified needs to community benefit expenditures, while prioritizing those voiced needs based on shared statewide priorities as recommended above.

6. To ensure hospital community benefit investments impact community health, the General Assembly should require hospitals to regularly and meaningfully evaluate the impact of their community benefit investments on community health.

V. Department Oversight

In addition to these recommendations to the General Assembly, the Department will:

1. Research other states' hospital community benefit requirements and reporting to inform our analysis, reporting and recommendations. For example, New York requires hospitals to demonstrate their commitment to meeting community health care needs, providing charity care and improving underserved individuals' access to health care services through robust reporting and Oregon establishes a hospital community benefit spending floor.
2. Analyze and report additional information from the hospitals' IRS 990 Schedule H form, such as Medicaid shortfall[4], research and staff education expenditures.
3. To the best of our ability with available data, analyze and report the amount of community benefit and estimated taxes that would have been collected.
4. Strengthen hospitals' reporting requirements to the extent possible under current law, including requirements for robust evidenced-based data.
5. Evaluate whether the cost shift to commercial payers not only covers the Medicaid shortfall, but also covers the entire costs of hospitals' community investment.

[4] Medicaid shortfall is the difference between a hospital's cost of care for Medicaid eligible patients and the payments that the hospital receives for these services.

VI. Findings

A. Compliance with Public Meeting Requirements

Some hospitals did a better job of conducting their public meetings than others. Examples of best practices include:

- Centura Health hospitals held combined meetings where communities overlap, held meetings on multiple days and times, posted meeting notices in newspapers, offered American Sign Language and other translation services, and sent surveys following the meetings to gather additional feedback on community needs.

- SCL Health hospitals combined meetings and used breakout rooms during meetings to have discussions and questions on specific topics, posted meeting notices in several newspapers and on social media, and sent a survey after meetings to solicit ideas and concerns.

On the other hand, some hospitals including National Jewish Health, Children's Hospital Colorado and Denver Health Medical Center did not invite the Department to their public meetings, which was not compliant with the legislation. Community Hospital in Grand Junction and all Banner Health hospitals failed to hold a public meeting at all, which was also non-compliant with the legislation.

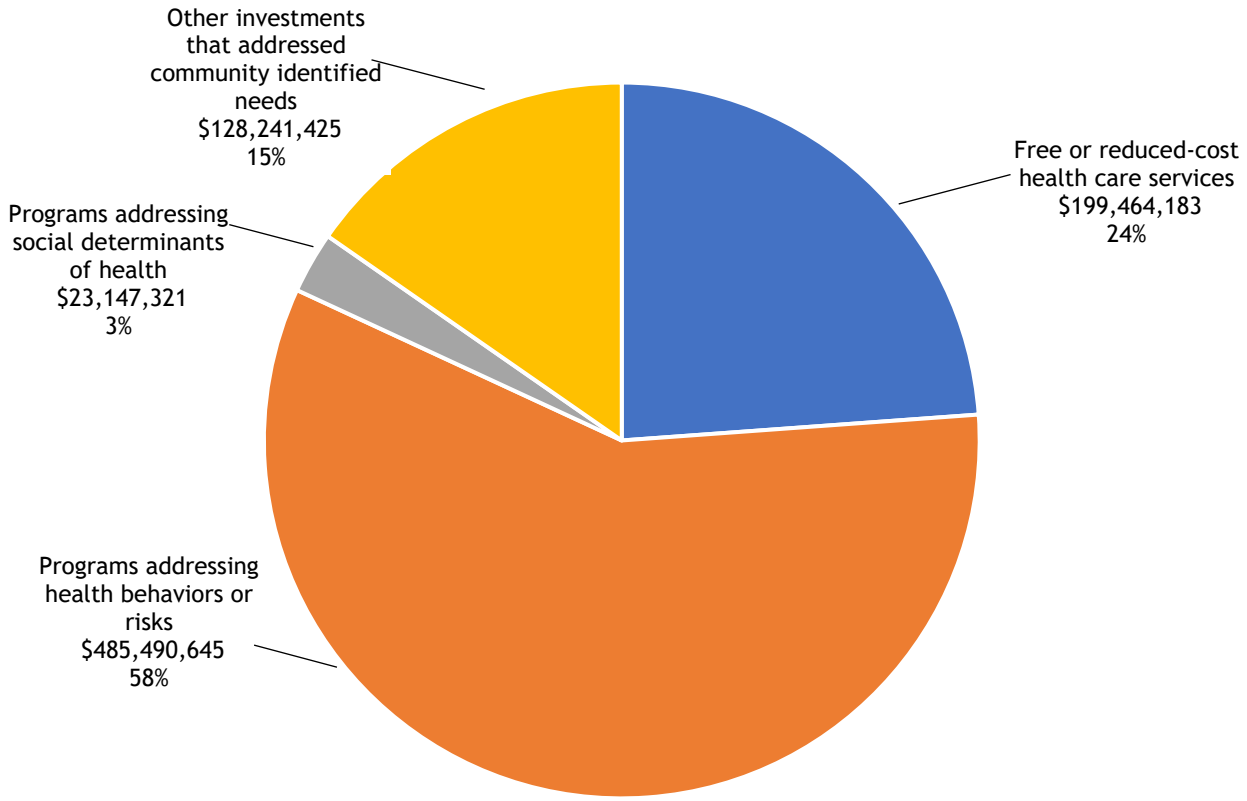
B. Overall Investments

The overall investments across all categories reported totaled $836,343,574, which is 6% of their patient revenue received. Free or reduced-cost health care services represents 24% of the total, programs addressing health behaviors or risks represents 58% of the total, programs addressing social determinants of health represents 3% of the total, and other investments that addressed community identified needs represents 15% of the total. This is summarized in the bullets and Figure *1* below.

- Free or reduced-cost health care services: $199,464,183 (24%)
- Programs addressing health behaviors or risks: $485,490,645 (58%)
- Programs that addressed social determinants of health: $23,147,321 (3%)

- Other investments that addressed community identified needs: $128,241,425 (15%)

Figure 1 Community Investments by Category

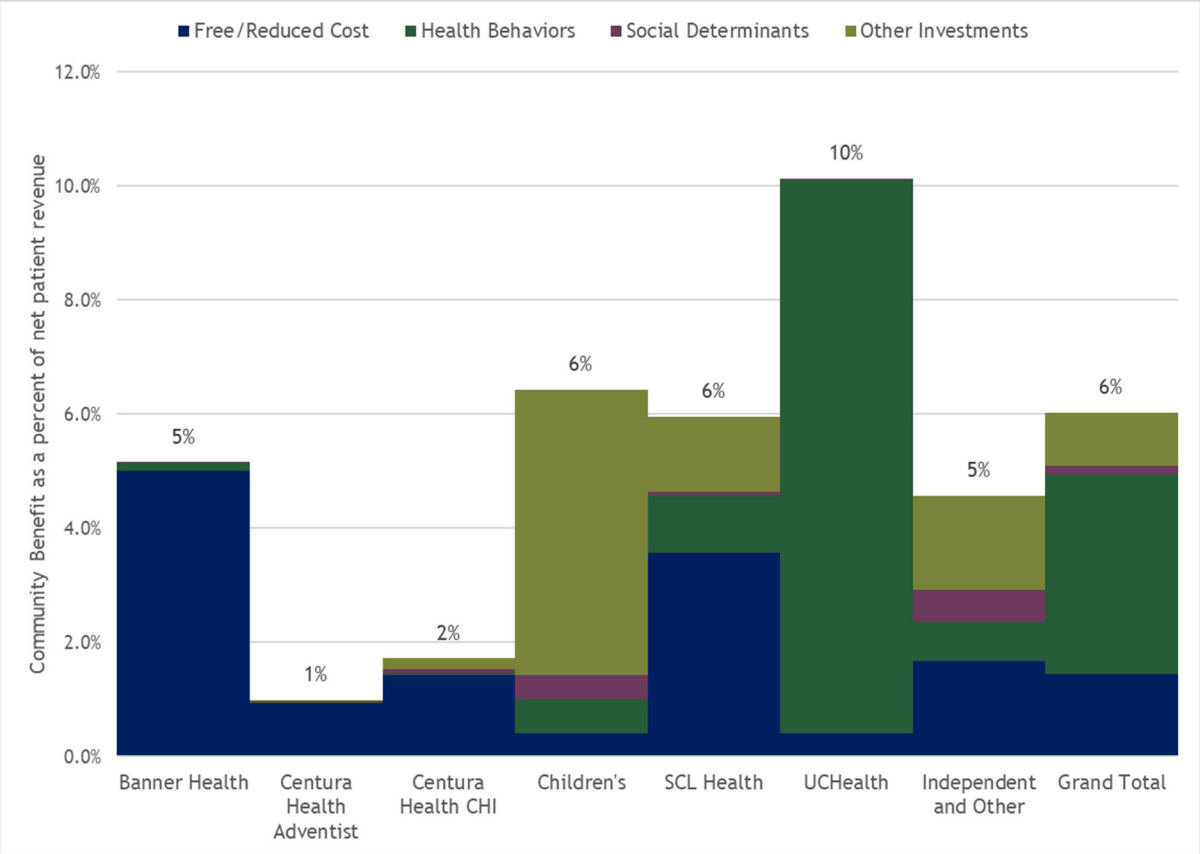


C. Community Investment Compared to Net Patient Revenue

The Department has examined the community benefit as a percentage of net patient revenue to quantify what percentage of these nonprofit hospitals' payments go back into the community. Net patient revenue approximates the payments a hospital receives for patient services. This is calculated by totaling all charges a hospital billed to patients, subtracting all contractual allowances and then subtracting any allowances for bad debt or charity care. Overall,

hospitals' community investments[5] represent 6% of total net patient revenue[6]. *Figure 2* below shows what proportion each category of community benefit makes up the total benefit as a percentage of net patient revenue by system.

Figure 2 Community Benefit Percentage of Net Patient Revenue



D. Community Health Needs Assessments

Nonprofit tax exemption depends in part on a hospital conducting a Community Health Needs Assessment (CHNA) every three years and implementing a strategy to meet the community health needs identified through the CHNA[7].

[5] As defined in the statute, i.e., free or reduced-cost health care services and investments that address community identified health needs. This excludes Medicaid shortfall.

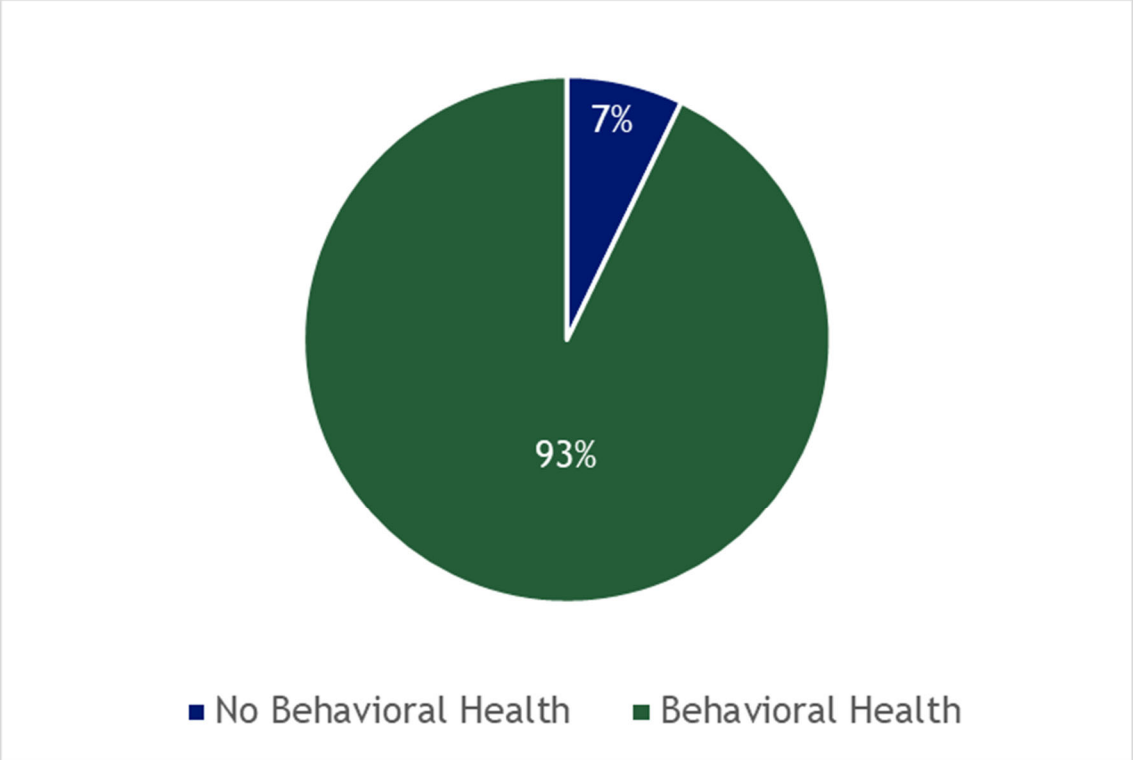
[6] Net patient revenue approximates the payments a hospital receives for patient services. Net patient revenue is calculated by totaling all charges the hospital billed to patients, subtracting contractual allowances and then subtracting bad debt and charity care.

[7] See irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

A CHNA is a local health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis. Health needs can include access to care, mental health/behavioral health, health education, chronic disease, and social determinants of health (housing instability, food insecurity, transportation needs, utility help needs and interpersonal safety).

An evaluation of submitted CHNAs shows that 93% of hospitals' CHNAs included behavioral health as a priority for the community. However, hospitals' community benefit expenditures reported to the Department lack sufficient detail to determine whether the community benefit investments match the communities' identified needs. This is an opportunity for more detailed, specific reporting from hospitals to tie their identified needs of the community to their community benefit investment spending.

Figure 3 Community Health Needs Assessments Behavioral Health Prioritization



E. Benefit of Tax Exemption Status

Generally, for-profit corporations pay taxes while nonprofits do not and are tax-exempt. These taxes include income tax, sales tax, property, and personal property taxes. Most hospitals are nonprofit organizations and federally tax exempt. Colorado also exempts nonprofits from taxes.

Most of the costs nonprofit hospitals consider community benefits, including Medicaid shortfall and free and reduce care costs, are the same types of costs also incurred by for-profit, tax paying hospitals.[8] Evaluation of the taxpaying HealthONE system hospitals shows it incurs Medicaid shortfall and charity care (e.g., free and reduced care costs) at a similar amount to the tax exempt UCHealth System hospitals.[9] See Table *1* and *Table 2* below.

Table 1 HealthONE Community Benefit

Hospital Name	Medicaid Shortfall	Charity Care Costs	Other Benefits	Total Community Benefit
North Suburban Medical Center	$41,402,071	$3,524,001		
Presbyterian/St. Luke's Medical Center	$ 90,564,466	$2,720,789		
Rose Medical Center	$30,608,612	$1,464,777		
Sky Ridge Medical Center	$13,249,563	$1,715,377		
Swedish Medical Center	$60,756,106	$5,466,421		
The Medical Center of Aurora	$55,557,232	$5,473,154		
HealthONE Total	**$292,138,050**	**$20,364,520**	**$16,600,000**	**$329,102,570**

[8] See pages 38-40, Hospital Cost, Price & Profit Review, August 2021.
[9] HealthONE's values for Medicaid shortfall and costs for charity care programs were evaluated from the Hospital Expenditure Report 2019 dataset and its other community benefits come from evaluation of community health improvements, community building activities, Health professional education, cash and in-kind contributions, and research investment from page 24 of HealthONE's 2019 Community Impact Report.

As shown in Table 2, community benefit expenditures for major hospital systems in Colorado exceed the estimated tax exemption when Medicaid shortfall, free and reduced cost care, and other community investments (which include research and health professions education expenses) are included. However, since for profit, tax paying hospitals, also have Medicaid shortfall and free and reduced cost care expenditures, evaluating community benefit investments by investment categories provides more insight. Taking Children's Hospital Colorado, for example, the largest categories of community benefit expenditures are for other community investments[10] and Medicaid shortfall. Analysis of Children's Hospital Colorado's other community investments shows most of those expenditures were for research and health professions education expenses. Moreover, the community benefit expenditure information reported by hospitals lacks sufficient detail to determine the value to the community.

For purposes of this analysis to evaluate how hospitals' tax exemption compares to their community benefit investments, the Department applied a tax rate to net income. However, since net income is used as a substitute for taxable income, there may be additions and subtractions that are not considered in this analysis. The Department's estimated value of tax exemption is the sum of a hospital's estimated federal corporate income tax, estimated state corporate income tax and estimated property taxes. It does not include exempted business fees or the value of access to tax-exempt bond markets.[11]

For a more in-depth evaluation of the value of non-profit hospitals' tax exemption, the General Assembly may wish to direct the Office of the State Auditor, working in conjunction with the Colorado Department of Revenue, to the best of its ability estimate the value of all federal, state and local tax expenditures for reporting hospitals as defined in 25.5-1-701, C.R.S.

[10] Further, Children's Hospital Colorado's other community investments are comprised mostly of research and health professions education expenses, $42 million out of $60 million.
[11] Analysis reflects federal corporate income tax of 21% and Colorado tax rate of 4.55%, with sales and property tax rates varying by location. See appendix D for a detailed description of the Department's estimated tax exemption methodology.

Table 2 Community Benefit, Medicaid Shortfall, Estimated Tax Exemption by System

Hospital System	Free or Discounted Services	Health Behaviors or Risks	Social Determinants of Health	Other community identified needs	Total Community Benefit	Medicaid Shortfall	Estimated Value of Tax Exemption
Banner Health	$32,021,544	$957,630	$23,703	$0	$33,002,877	$31,447,228	$21,662,157
Centura Health Adventist	$11,223,734	$264,265	$175,322	$214,630	$11,877,951	$93,013,473	$41,887,059
Centura Health CHI	$28,451,187	$771,276	$1,532,959	$3,746,940	$34,502,362	$147,039,811	$75,986,612
Children's	$4,947,187	$7,205,568	$5,041,992	$60,455,896	$77,650,643	$186,078,313	$36,429,204
SCL Health	$62,130,500	$17,360,640	$1,148,502	$22,818,052	$103,457,694	$101,338,689	$45,050,410
UCHealth	$18,140,546	$442,108,785	$1,145,878	$0	$461,395,209	$271,998,581	$258,197,072
Independent + San Luis Valley	$40,823,746	$16,811,882	$14,077,234	$41,004,907	$112,717,769	$134,834,624	$80,755,640

UCHealth hospitals report significantly more community investment than other systems, which is a positive note in this report. Of their investments, more than $442 million where in in health behaviors or risks. The information reported by UCHealth, however, shows that much of this investment is for provider recruitment and for education and training for health care professionals. There are insufficient details of UCHealth's health behaviors or risks community investments to determine the value to the community. This reinforces the need for more detailed community reporting by hospitals to assess the value to the community.

VII. Appendix A Reporting Hospitals

Table 3 Reporting Hospitals

Hospital	County	Hospital System
Avista Adventist Hospital	Boulder	Centura Health
Boulder Community Health	Boulder	
Castle Rock Adventist Hospital	Douglas	Centura Health
Children's Hospital Colorado	Arapahoe	
Children’s Hospital Colorado, Colorado Springs	El Paso	
Community Hospital	Mesa	
Delta County Memorial Hospital	Delta	
Denver Health and Hospital Authority	Denver	
East Morgan County Hospital	Morgan	Banner Health
Fort Collins Medical Center	Larimer	Banner Health
Good Samaritan Medical Center	Boulder	SCL Health
Littleton Adventist Hospital	Arapahoe	Centura Health
Longmont United Hospital	Boulder	Centura Health
Lutheran Medical Center	Jefferson	SCL Health
McKee Medical Center	Larimer	Banner Health
Mercy Regional Medical Center	La Plata	Centura Health
Montrose Memorial Hospital	Montrose	
National Jewish Health	Denver	
North Colorado Medical Center	Weld	Banner Health
Parker Adventist Hospital	Douglas	Centura Health
Parkview Medical Center	Pueblo	
Penrose-St Francis Health Services	El Paso	Centura Health
Platte Valley Medical Center	Adams	SCL Health
Porter Adventist Hospital	Denver	Centura Health
Saint Joseph Hospital	Denver	SCL Health
San Luis Valley Health	Alamosa	

Hospital	County	Hospital System
St Anthony Hospital	Jefferson	Centura Health
St Anthony Hospital North Health Campus	Adams	Centura Health
St Anthony Summit Medical Campus	Summit	Centura Health
St Mary Corwin Hospital	Pueblo	Centura Health
St Mary's Regional Medical Center	Mesa	SCL Health
St Thomas More Hospital	Fremont	Centura Health
Sterling Regional Medical Center	Logan	Banner Health
UCHealth Broomfield Hospital	Broomfield	UCHealth
UCHealth Grandview Hospital	El Paso	UCHealth
UCHealth Greeley Hospital	Weld	UCHealth
UCHealth Highlands Ranch Hospital	Douglas	UCHealth
UCHealth Longs Peak Hospital	Weld	UCHealth
UCHealth Medical Center of the Rockies	Larimer	UCHealth
UCHealth Memorial Hospital	El Paso	UCHealth
UCHealth Poudre Valley Hospital	Larimer	UCHealth
UCHealth University of Colorado Hospital	Arapahoe	UCHealth
UCHealth Yampa Valley Medical Center	Routt	UCHealth
Vail Health	Eagle	
Valley View Hospital	Garfield	

VIII. Appendix B Investment Amounts by Hospital

Table 4 Investment Amounts

Hospital	Free or Discounted Services	Health Behaviors	Social Determinants of Health	Other community identified needs	Total
Avista Adventist Hospital	$2,197,067	$200,715	$23,056	$0	$2,420,838
Boulder Community Health	$3,017,967	$196,240	$76,889	$109,440	$3,400,536
Castle Rock Adventist Hospital	$800,506	$0	$19,106	$18,962	$838,574
Children's Hospital Colorado	$4,548,083	$7,205,568	$5,041,992	$60,455,896	$77,251,539
Children's Hospital Colorado, Colorado Springs	$399,104	$0	$0	$0	$399,104
Community Hospital	$7,916,174	$98,176	$135,200	$16,978	$8,166,528
Delta County Memorial Hospital	$656,218	$0	$0	$0	$656,218
Denver Health and Hospital Authority	$8,634,393	$0	$0	$34,709,148	$43,343,541
East Morgan County Hospital	$443,791	$5,277	$1,731	$0	$450,799
Fort Collins Medical Center	$670,714	$82,980	$0	$0	$753,694
Good Samaritan Medical Center	$3,359,884	$188,523	$107,948	$1,725,230	$5,381,585
Littleton Adventist Hospital	$1,920,226	$25,756	$46,948	$92,073	$2,085,003
Longmont United Hospital	$3,582,797	$0	$9,748	$77,533	$3,670,078
Lutheran Medical Center	$9,705,117	$823,190	$520,428	$0	$11,048,735
McKee Medical Center	$3,326,673	$242,939	$0	$0	$3,569,612

Hospital	Free or Discounted Services	Health Behaviors	Social Determinants of Health	Other community identified needs	Total
Mercy Regional Medical Center	$2,470,801	$3,433	$124,657	$592,653	$3,191,544
Montrose Memorial Hospital	$9,875,113	$718,054	$0	$0	$10,593,167
National Jewish Health	$83,785	$13,383,428	$13,383,428	$0	$26,850,641
North Colorado Medical Center	$27,376,836	$605,001	$20,535	$0	$28,002,372
Parker Adventist Hospital	$2,946,983	$7,540	$62,245	$9,285	$3,026,053
Parkview Medical Center	$4,278,180	$41,055	$42,458	$0	$4,361,693
Penrose-St Francis Health Services	$8,275,975	$329,870	$513,163	$372,469	$9,491,477
Platte Valley Medical Center	$7,078,080	$401,281	$53,213	$744,923	$8,277,497
Porter Adventist Hospital	$3,358,952	$30,254	$23,967	$94,310	$3,507,483
Saint Joseph Hospital	$19,415,423	$1,997,822	$155,070	$20,315,196	$41,883,511
San Luis Valley Health	$838,630	$947,259	$28,061	$0	$1,813,950
St Anthony Hospital	$5,769,596	$247,253	$308,125	$0	$6,324,974
St Anthony Hospital North Health Campus	$5,040,375	$0	$429,059	$26,974	$5,496,408
St Anthony Summit Medical Campus	$1,703,059	$123,232	$144,092	$196,347	$2,166,730
St Mary Corwin Hospital	$1,608,584	$67,488	$4,115	$2,480,964	$4,161,151
St Mary's Regional Medical Center	$22,571,996	$13,949,824	$311,843	$32,703	$36,866,366
St Thomas More Hospital	$625,730	$5,322	$0	$0	$631,052
Sterling Regional Medical Center	$647,321	$26,710	$3,168	$0	$677,199

Hospital	Free or Discounted Services	Health Behaviors	Social Determinants of Health	Other community identified needs	Total
UCHealth Broomfield Hospital	$184,000	$2,878,701	$58	$0	$3,062,759
UCHealth Grandview Hospital	$110,014	$4,477,474	$53	$0	$4,587,541
UCHealth Greeley Hospital	$848,031	$25,265,289	$4,941	$0	$26,118,261
UCHealth Highlands Ranch Hospital	$294,523	$11,561,579	$57	$0	$11,856,159
UCHealth Longs Peak Hospital	$584,998	$25,098,588	$5,287	$0	$25,688,873
UCHealth Medical Center of the Rockies	$2,364,020	$63,803,176	$27,997	$0	$66,195,193
UCHealth Memorial Hospital	$3,787,628	$93,112,803	$804,455	$0	$97,704,886
UCHealth Poudre Valley Hospital	$2,875,792	$56,998,196	$118,629	$0	$59,992,617
UCHealth University of Colorado Hospital	$6,139,531	$156,430,262	$14,951	$0	$162,584,744
UCHealth Yampa Valley Medical Center	$952,009	$2,482,717	$169,450	$0	$3,604,176
Vail Health	$110,192.35	$320,149.85	$363,843.85	$6,170,341	$6,964,527.05
Valley View Hospital	$6,069,312	$1,107,520	$47,354	$0	$7,224,186
Totals	**$199,464,183**	**$485,490,645**	**$23,147,321**	**$128,241,425**	**$836,343,574**

IX. Appendix C Investments by Division of Insurance Region

Figure 4 Total of All Investments Reported

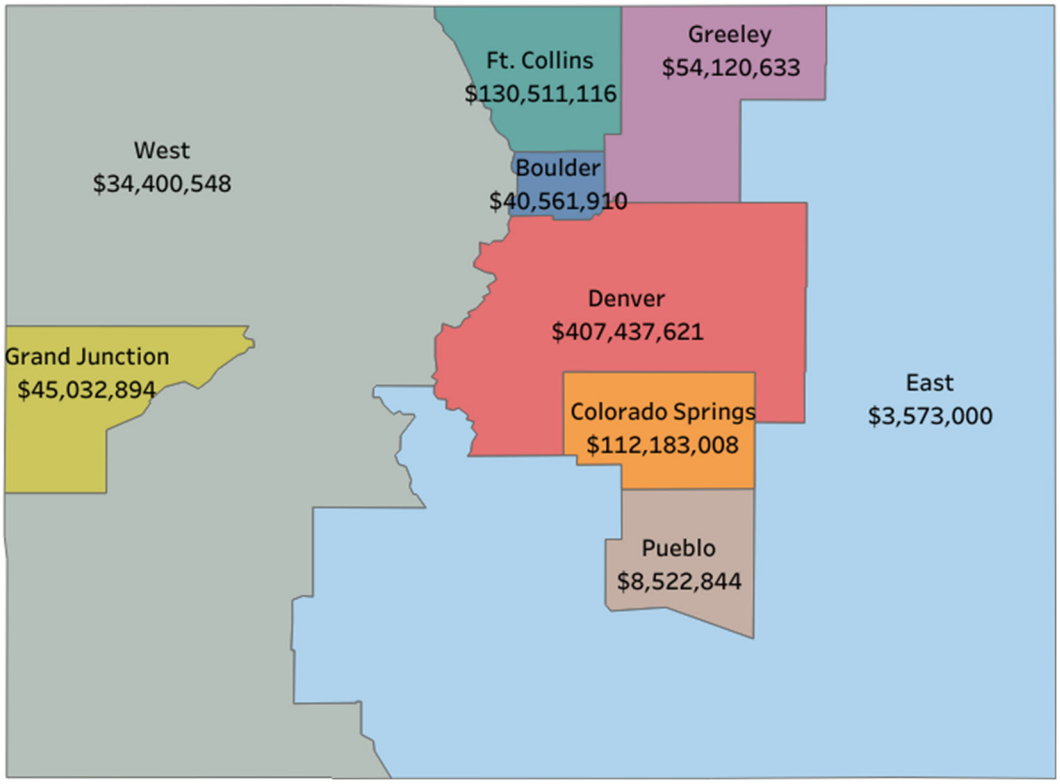


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Figure 5 Free or Reduced-Cost Health Care Services

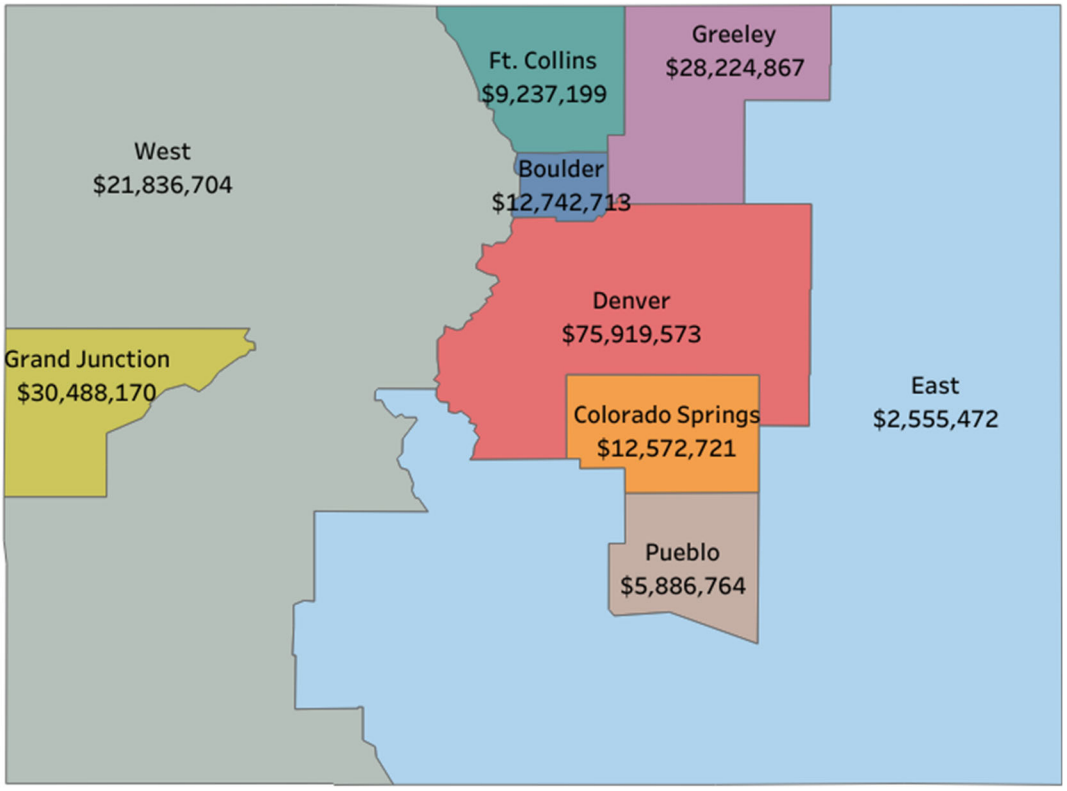

Figure 6 Programs Addressing Health Behaviors or Risks

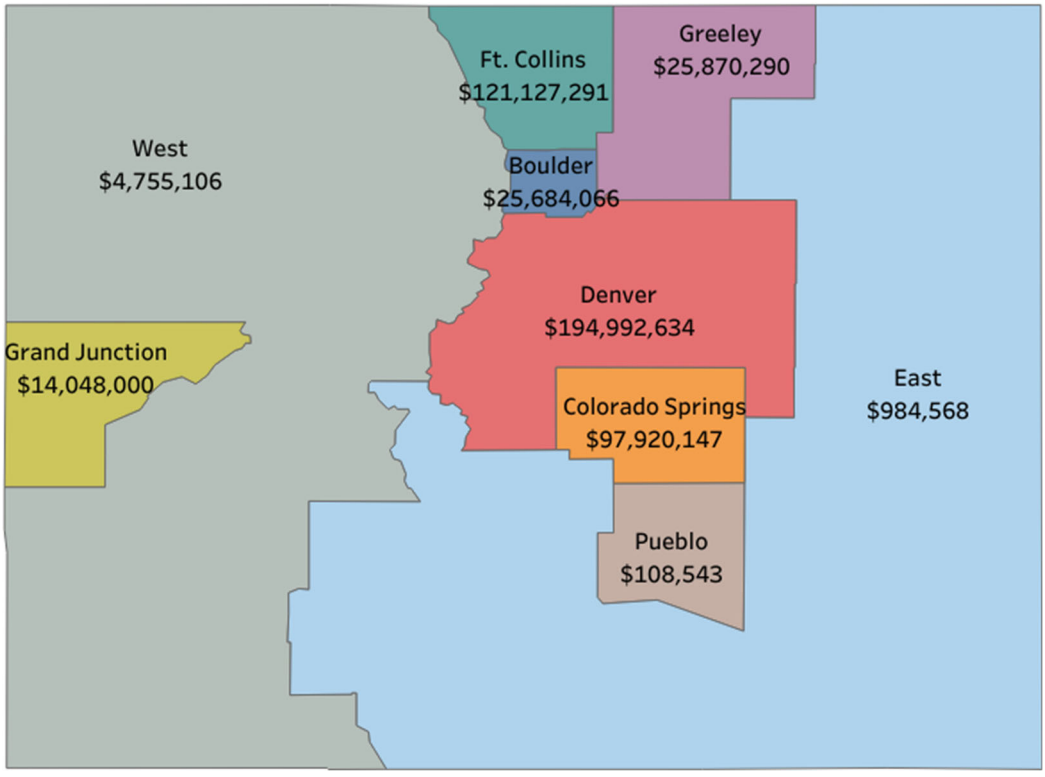

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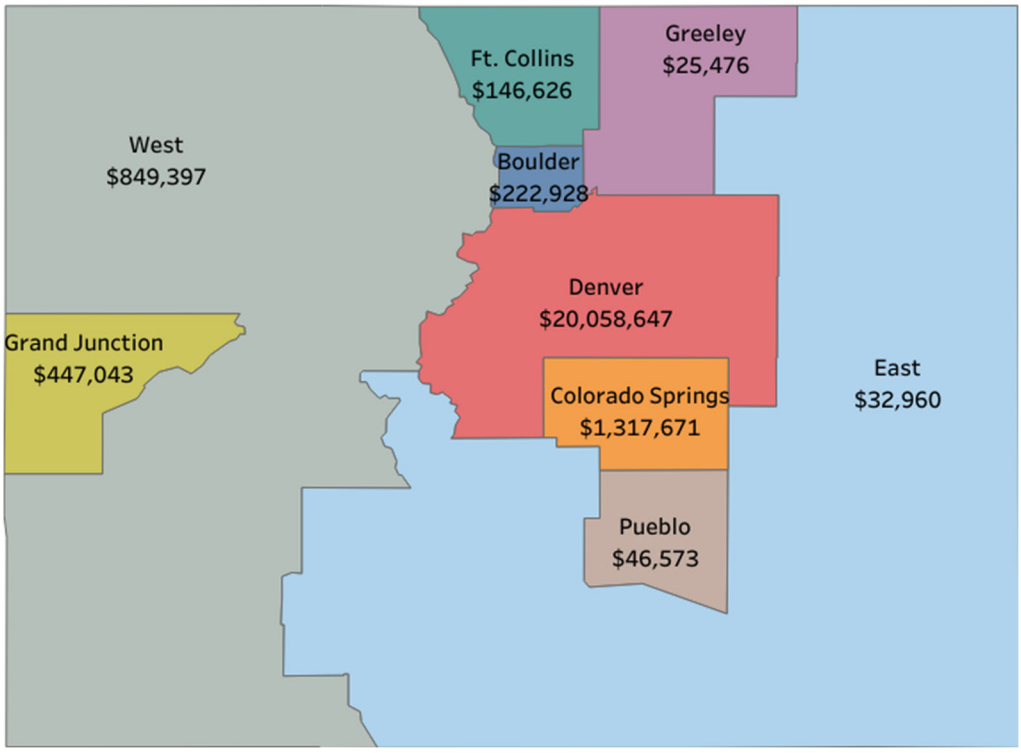
Figure 7 Programs Addressing Social Determinants of Health



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X. Appendix D Estimated Tax Exemption Methodology

Methodology

The value of tax-exempt status is the total value of taxes, business fees exempted, and access to tax-exempt bonds. Because of the constraints of publicly available information, this analysis only includes a valuation of taxes. The Department's estimated value of tax exemption is the sum of a hospital's estimated federal corporate income tax, estimated state corporate income tax, and estimated property taxes.

- Federal corporate income tax is estimated by multiplying a hospital's net income as reported through the Hospital Transparency program by the federal corporate tax rate of 21.0%
- State corporate income tax is estimated by multiplying a hospital's net income as reported through the Hospital Transparency program by the state corporate tax rate of 4.55%
- Property tax is estimated by visiting county assessor websites and finding parcels that have known hospital facilities and finding parcels that list hospitals or health systems as owner. The Department reviewed to make sure that the parcels or values included were only those that were listed as tax exempt.[12] County websites include market value, assessed value, and the property's mill levies.
    - Some of the county assessor websites validated this methodology by providing a property tax liability (before exemption) that matched Department estimates.

Estimates were performed as the hospital-level then aggregated by health system.

Taxes that the Department did not attempt include an estimate of sales tax and an estimate of equipment taxes. A sales tax estimate was not attempted because there are medical supplies that are already exempt from sales tax. This added a complexity and uncertainty to the valuation. Some county assessor sites indicated that equipment was included in property values, so the Department did not attempt to estimate to ensure there wasn't double counting.

The Department used the state of Montana's audit of community benefit spending as a reference for how to estimate the value of tax exemption.[13] The Department diverged from the Montana methodology in the following ways:

- Montana sourced net income from 990s while the Department source net income from the Hospital Transparency dataset.
- Montana applied a single estimated rate for mill levies to the taxable value for hospitals to determine an estimated property tax. The Department used data from all

[12] There are office buildings owned by hospitals that are not tax exempt. Some parcels have a mix of exempt and non-exempt values.
[13] State of Montana, Department of Public Health and Human Services, Legislative Audit Division. September 2020. Community Benefit and Charity Care Obligations at Montana Nonprofit Hospitals. leg.mt.gov/content/Committees/Administration/audit/2019-20/Meetings/Oct-2020/18P-07.pdf

the hospital's county assessor websites per hospital owned parcel to estimate what a hospital would be liable for in taxes.

- Montana's methodology allowed for an estimate for equipment taxes, while the Department's did not because the risk of double counting.

Limitations

Income Tax

- Organizations have an incentive to lower their taxable include. Hospitals would likely include as many legal deductions as possible to lower their taxable income for income tax returns. The Department acknowledges that, by using net income, corporate taxes may be overstated.
- Some or part of certain expenses would *not* be included in income tax returns. The Department did not make any adjustments to net income to address adding back expenses for these additions. For example, entertainment expense may only be tax deductible in certain circumstances.

Property Tax

- The Department attempted to capture all properties owned by a hospital or health system but may have mistakenly included or excluded parcels.
- The Department was limited to publicly available information.
- Campuses with multiple hospitals were challenging to split up.
- There were cases were a known hospital was located, but the parcel's tax exempt status was not listed as exempt. These parcels were assumed to be tax exempt.

XI. Appendix E Investments Reported by Hospital

Avista Adventist Hospital

- Community Education
- Family Life Education Center
- OB Post-Partum classes
- Childbirth training and education classes
- Behavioral health stigma reduction

Boulder Community Health

- Community outreach coordinator
- Sexual Assault Nurse Examiners
- Community education programs
- Stop the Bleed education program
- Walk with a Doc program
- Beacon Infectious Disease Clinic

Castle Rock Adventist Hospital

- Transportation services
- Community based clinical services
- Behavioral health stigma reduction
- SNAP outreach

Children's Hospital Colorado

- Community health education
- Home based asthma education
- After hours nurse line
- Partnership with Aurora Public Schools to address food insecurity
- Pediatric clinical translational research
- Support community-based organizations that address identified needs
- Support organizations focused on community building

Children’s Hospital Colorado, Colorado Springs

- Injury prevention
- After hours nurse line
- Boosting access to comprehensive physical education in schools

- Neonatal care, cancer care, respiratory care services
- Pediatric clinical translational research
- Support community-based organizations that address identified needs

Community Hospital

- Laryngology screening
- County fair first aid station
- Sports physicals
- Lifestyle medicine and health coaching
- Community transformation group

Delta County Memorial Hospital

- COVID-19 vaccination clinics

Denver Health and Hospital Authority

- Denver CARES detox
- Tobacco cession clinics
- 24-hour nurse line
- Psychosocial support for pediatric patients
- Refugee health screenings
- Healthy eating program
- Injury prevention program
- Substance abuse treatment, education, and prevention program
- Programs to address gap between clinical care and community services

East Morgan County Hospital

- Community blood drives
- Patient and community education for prenatal, mental health, diabetes, palliative care
- Community food and nutrition education classes
- Enrollment assistance to the vulnerable and underserved
- Post-discharge services to the vulnerable and underserved
- Support local agencies that support Veteran wellness, Alzheimer's, Cancer prevention and cures, suicidal awareness and prevention

Fort Collins Medical Center

- Patient and community education for prenatal, wellness, women's health
- Enrollment assistance to the vulnerable and underserved
- Support local breast cancer organizations.
- Post-discharge services to the vulnerable and underserved
- Elderly day care

Good Samaritan Medical Center

- Community health education
- Clinical training
- Infusion center, dialysis, OB/newborn services
- Support partner programs addressing access to healthcare, SDOH needs, disease prevention, and clinical services
- Emergency preparedness/disaster readiness

Littleton Adventist Hospital

- Health education for prenatal and early childhood care
- Transportation services
- Behavioral health stigma reduction
- Mental Health First Aid training and education

Longmont United Hospital

- Transportation support services
- Community health education
- Health professions education

Lutheran Medical Center

- Community health education
- Cardiac rehab, pulmonary rehab, dialysis, hospice, OB/newborn, infusion center services
- Community outreach
- Community grants focused on CHIP priorities

McKee Medical Center

- Patient and community education for prenatal, wellness, behavioral health

- Oncology research
- Elderly day care
- Palliative care
- Heart clinic
- Women’s services
- Post-discharge services to the vulnerable and underserved

Mercy Regional Medical Center

- Food insecurity initiative
- Community health clinic
- Community outreach
- Access to specialized services
- Sexual Assault Nurse Examiner program
- Support non-profits that promote health and wellness

Montrose Memorial Hospital

- Education for women's health and family planning
- Clinic services
- Support non-profits providing programs and support to community health
- Physician recruitment

National Jewish Health

- Access to specialty care programs
- Access to specialty care programs
- Clinical training
- Inner city Asthma program
- Pediatric Asthma program extended clinic hours
- Research on air quality, Asthma, COPD

North Colorado Medical Center

- Enrollment assistance to the vulnerable and underserved
- Post-discharge services to the vulnerable and underserved
- Community blood drives
- Patient and community education for prenatal, sports medicine, wellness
- Palliative care

- Women's clinic
- Oncology research

Parker Adventist Hospital

- Workforce development for students in the community
- Injury prevention education
- Mental health first aid training and education
- Behavioral health stigma reduction
- Emergency medical services
- Support organizations that focus on social determinants of health

Parkview Medical Center

- Immunization clinics
- Community health fairs
- Community health education
- Sexual Assault Nurse Examiners program

Penrose-St Francis Health Services

- Cancer Center Women's Services outreach
- Cancer Center Latino Community outreach
- Outreach and clinical assistance, prevention, and treatment for unhoused neighbors
- Free meals donated to the community

Platte Valley Medical Center

- Community health education
- Infusion center, OB/newborn, NICU, ED, wound care services
- Community grants focused on CHIP priorities
- Donations to community-based organizations
- Collective impact initiatives with community stakeholders

Porter Adventist Hospital

- Charity prescriptions
- Support groups for mental health and substance abuse
- Behavioral health stigma reduction

- Kids Alive Oncology services
- Mental health first aid training and education

Saint Joseph Hospital

- Community health education
- Healthcare support services
- Community based clinical services
- Mobile mammography
- Infusion center
- Psychiatry services
- Disease prevention and clinical services

San Luis Valley Health

- Health fairs
- Support groups
- Athletic trainers
- Internships
- Orthopedic and ear, nose, throat clinics
- Food banks and adopt a family
- Physician health program
- Career fairs

St Anthony Hospital

- Medical and preventative services provided at public events
- Nurse family partnership program
- Behavioral health stigma reduction
- Health education in the community
- Integrative healing services
- Support groups for mental health and substance abuse
- Student ambassador program

St Anthony Hospital North Health Campus

- Support groups and integrative healing services
- Transportation services
- Sexual Assault Nurse Examiner program

- Community education on COVID-19 prevention
- Coalition building to address community health needs

St Anthony Summit Medical Campus

- Community based clinical and prevention services
- Community health improvement activities, violence prevention, food access
- Emergency and trauma services
- Support disaster preparedness activities

St Mary-Corwin Hospital

- Education and training for patients and the community
- Residency programs
- Support for programs and events that support community identified needs

St Mary's Regional Medical Center

- Health education
- Healthcare support services
- Collective impact initiatives with community stakeholders
- Health library
- Mammography, infusion center, cardiac rehab, dialysis, wound care services
- Community grants focused on CHIP priorities

St Thomas More Hospital

- Child birth education
- Community education focused on rural health outreach
- Free sports physicals and screenings
- Community classes

Sterling Regional Medical Center

- Community blood drives and screenings
- Patient and community education for wellness, diabetes, Cancer, Alzheimer's
- Safe sitter program
- Provide enrollment assistance to the vulnerable and underserved
- Disaster preparedness training

UCHealth Broomfield Hospital

- Access to care and physician network development
- Support development of the Colorado Center for Personalized Medicine
- Support community organizations dedicated to the prevention and treatment of specific health needs
- Support non-profit and community-based organizations that promote the health and wellbeing of the community

UCHealth Grandview Hospital

- Access to care and physician network development
- Support development of the Colorado Center for Personalized Medicine
- Support community organizations dedicated to the prevention and treatment of specific health needs
- Support non-profit and community-based organizations that promote the health and wellbeing of the community
- Support the Independence Center

UCHealth Greeley Hospital

- Access to care and physician network development
- Support development of the Colorado Center for Personalized Medicine
- Support community organizations dedicated to the prevention and treatment of specific health needs
- Support non-profit and community-based organizations that promote the health and wellbeing of the community

UCHealth Highlands Ranch Hospital

- Access to care and physician network development
- Support development of the Colorado Center for Personalized Medicine
- Support community organizations dedicated to the prevention and treatment of specific health needs
- Support non-profit and community-based organizations that promote the health and wellbeing of the community

UCHealth Longs Peak Hospital

- Access to care and physician network development

- Support development of the Colorado Center for Personalized Medicine
- Support community organizations dedicated to the prevention and treatment of specific health needs
- Support non-profit and community-based organizations that promote the health and wellbeing of the community
- Post-partum lactation support program
- Community health programs that serve people ages 50 and above

UCHealth Medical Center of the Rockies

- Access to care and physician network development
- Support development of the Colorado Center for Personalized Medicine
- Support community organizations dedicated to the prevention and treatment of specific health needs
- Support non-profit and community-based organizations that promote the health and wellbeing of the community
- Post-partum nurse home visit and lactation support program
- Support for health care research for the development of new therapies and scientific discovery
- Support Food Bank of Larimer County

UCHealth Memorial Hospital

- Access to care and physician network development
- Support development of the Colorado Center for Personalized Medicine
- Support community organizations dedicated to the prevention and treatment of specific health needs
- Support non-profit and community-based organizations that promote the health and wellbeing of the community
- HealthLink nurse advice line
- Partnership with Peak View Behavioral Health
- Support for the Ronald McDonald House
- Support for The Independence Center

UCHealth Poudre Valley Hospital

- Access to care and physician network development
- Support development of the Colorado Center for Personalized Medicine

- Support community organizations dedicated to the prevention and treatment of specific health needs
- Support non-profit and community-based organizations that promote the health and wellbeing of the community
- Healthy Hearts School and Family program
- Post-partum nurse home visit and lactation support program
- Injury prevention programs
- Partnership with local schools to provide health education to students

UCHealth University of Colorado Hospital

- Support development of the Colorado Center for Personalized Medicine
- Support community organizations dedicated to the prevention and treatment of specific health needs
- Support non-profit and community-based organizations that promote the health and wellbeing of the community

UCHealth Yampa Valley Medical Center

- Support development of the Colorado Center for Personalized Medicine
- Support non-profit and community-based organizations that promote the health and wellbeing of the community
- Clinical program support
- Transportation support for patients
- Support for local health fairs
- Community health education programs
- Nurse telephone consultation services

Vail Health

- Health fairs
- Fitness, exercise, nutrition, weight management
- Cancer education
- Consumer health library
- Heart disease education
- Mental health education
- Sports injury prevention
- Car seat safety education programs

Valley View Hospital

- Athletic trainers for local schools
- Calaway Young Cancer Center
- Support local non-profits that specialize in mental health, education, and community wellness
- Rent abatement to Mountain Family Health
- Member of the Valley Health Alliance focused on improving access to quality care, population health management and reduce waste in the healthcare system

XII. Appendix F Definitions

Community - the community that a hospital has defined as the community that it serves pursuant to 26 CFR § 1.501(r)-(b)(3).

Community Benefit Implementation Plan - a plan that satisfies the requirements of an implementation strategy as described in 26 CFR § 1.501(r)-3(c).

Community Health Center - a federally qualified health center as defined in 42 U.S.C. sec. 1395x(aa)(4) or a rural health clinic as defined in 42 U.S.C. sec. 1395x (aa)(2).

Community Health Needs Assessment - a community health needs assessment that satisfies the requirements of 26 CFR § 1.501(r)-3(b).

Community Identified Health Need - a health need of a Community that is identified in a Community Health Needs Assessment.

Financial assistance policy (FAP) - a written policy that meets the requirements described in § 1.501(r)– 4(b).

Free or Discounted Health Care Services - health care services provided by the hospital to persons who meet the hospital's criteria for financial assistance and are unable to pay for all or a portion of the services, or physical or behavioral health care services funded by the hospital but provided without charge to patients by other organizations in the Community. Free or Discounted Health Care Services does not include the following:

1. Services reimbursed through the Colorado Indigent Care Program (CICP),
2. Bad debt or uncollectable amounts owed that the hospital recorded as revenue but wrote off due to a patient's failure to pay, or the cost of providing care to such patients,
3. The difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived therefrom,
4. Self-pay or prompt pay discounts, or

5. Contractual adjustments with any third-party payers.

Health System - a larger corporation or organizational structure that owns, contains, or operates more than one hospital.

Medicaid Shortfall - is the difference between a hospital's cost of care for Medicaid eligible patients and the payments that the hospital receives for these services.

Net Patient Revenue - Net patient revenue approximates the payments a hospital receives for patient services. Net patient revenue is calculated by totaling all charges the hospital billed to patients, subtracting contractual allowances and then subtracting bad debt and charity care.

Programs that Address Health Behaviors or Risk - programs funded by the hospital and provided by the hospital or other Community organizations that provide education, mentorship, or other supports that help people make or maintain healthy life choices or manage chronic disease, including addiction prevention and treatment programs, suicide prevention programs and mental health treatment, programs to prevent tobacco use, disease management programs, nutrition education programs, programs that support maternal health, including screening, referral and treatment for perinatal and postpartum depression and anxiety, and healthy birth outcomes, and programs that help seniors and people with disabilities live as independently as possible in the Community.

Programs that Address the Social Determinants of Health - funding or in-kind programs or services that improve social, economic, and environmental conditions that impact health in the Community. Social and economic conditions that impact health include education; employment; income; family and social support; and Community safety. Environmental conditions that impact health include air and water quality, housing, and transit. Programs that Address the Social Determinants of Health include but are not limited to the following:

1. Job training programs,
2. Support for early childhood and elementary, middle, junior-high, and high school education,

3. Programs that increase access to nutritious food and safe housing,
4. Medical Legal Partnerships, and
5. Community-building activities that could be included in Part II of Schedule H of the Form 990.

Reporting Hospital

1. A hospital licensed as a general hospital pursuant to Part 1 of Article 3 of Title 25 of the Colorado Revised Statutes and exempt from Federal taxation pursuant to Section 501(c)(3) of the Federal Internal Revenue code, but not including a general hospital that is federally certified or undergoing federal certification as a long-term care hospital pursuant to 42 CFR § 412.23(e) or that is federally certified or undergoing federal certification as a critical access hospital pursuant to 42 CFR § 485 Subpart F,
2. A hospital established pursuant to § 25-29-103 C.R.S., or
3. A hospital established pursuant to § 23-21-503 C.R.S.

Safety Net Clinic - a Community clinic licensed or certified by the Department of Public Health and Environment pursuant to Section § 25-1.5-103 (1)(a)(I) or (1)(a)(II), C.R.S.