

Diamond State Hospital Cost Review Board Meeting

Delaware Department of Health and Social Services
(DHSS)

Herman M. Holloway Sr. Health and Social Services
The Chapel Building
1901 N. DuPont Highway
New Castle, DE 19720

October 20, 2026



Agenda

- I. Welcome/Call to Order
- II. Approval of September 8, 2026, and October 5, 2026, Meeting Minutes
- III. Timeline & Guidance for Regulation 5003: Hospital Information Review
- IV. Review Feedback from October 5th Hospital Working Session : Charity Care/Financial Assistance Program
- V. Board Guidance: Informing the Plain Language Draft of the Charity Care/Financial Assistance Program Administration Regulation
- VI. Introduction to Hospital IRS Form 990
- VII. Upcoming Meeting Topics
- VIII. Public Comment
- IX. Next Steps & Adjourn





Diamond State Hospital Cost Review Board — October 20, 2026 Meeting:

Diamond State Hospital Cost Review Board
October 20, 2026

Meeting Agenda

Agenda Item	Time
Welcome and Approval of Meeting Minutes	10:00 AM – 10:05 AM
Timeline & Guidance for Regulation 5003: Hospital Information Review	10:05 AM – 10:10 AM
Review Feedback from October 5th Hospital Working Session Re: Charity Care/Financial Assistance Program	10:10 AM – 10:30 AM
Board Guidance: Informing the Plain Language Draft of the Charity Care/Financial Assistance Program Administrative Regulation	10:30 AM – 11:30 AM
Introduction to Hospital IRS Form 990	11:30 AM – 12:10 PM
Upcoming Meeting Topics	12:10 PM – 12:15 PM
Public Comment	12:15 PM – 12:20 PM
Next Steps & Close	12:20 PM – 12:30 PM



Feedback and Recommendations after October 5th Hospital Working Session

DECISION. Establish the categories of information and documentation a hospital may request from an applicant. The categories may not exceed what is reasonably necessary to verify income and household size, and a hospital may not request anything outside them.

REFINED RECOMMENDATION: Categories of Information

Identification: patient, and guarantor if different

- Only what is needed to identify the patient and contact the guarantor, such as name, date of birth, address and phone number.
- Social Security number only if the person has one.

Income: patient or guarantor, and spouse

- Most recent federal tax return (Form 1040, W-2s, 1099s), or
- Two most recent pay stubs or a benefit award letter, such as SSI.
- Signed attestation when there is no income or no documents are available: “I certify that all the information I have provided is accurate and complete.”

WHAT CHANGED AND WHY

Added a short identification category.

Hospitals need to know who applied and how to reach them.

Social Security number only if the person has one.

Not everyone has one, and it isn't needed to verify income.

A short, ordered list of income documents.

Tax return first, then pay stubs or a benefit letter. No bank statements or catch-all, to keep applying simple.

Attestation when no documents exist.

DECISION. Establish the categories of information and documentation a hospital may request from an applicant. The categories may not exceed what is reasonably necessary to verify income and household size, and a hospital may not request anything outside them.

REFINED RECOMMENDATION: Categories of Information

Household: the federal tax definition

- The patient or guarantor, a spouse, and everyone claimed as a dependent.
- Signed attestation of household members when no tax return is available.

Insurance status and Medicaid enrollment: for coordination only (§ 9964(4))

- Hospitals may coordinate Medicaid enrollment during screening, but may not deny or delay assistance over possible Medicaid eligibility unless they have screened the patient, helped with enrollment and documented the result.
- Medicaid screening is not required for assistance, and enrollment help may not delay assistance.

WHAT CHANGED AND WHY

Household follows the federal tax definition.

A known definition is clear for patients and hospitals.

Attestation when there is no tax return.

Covers people who don't file taxes.

Added the law's Medicaid coordination rules.

Hospitals asked about insurance. The law allows coordination, but not delay.

DECISION

Establish the categories of presumptive eligibility, such as enrollment in income-based public benefits, subsidized housing, receipt of homeless services, or other income indicators.

REFINED RECOMMENDATION

Presume eligibility based on the following:

- **Enrollment in an income-based program.** Program is administered by the State of Delaware and has an eligibility threshold at or below the free care or discounted care FPL thresholds.
 - A list of State of Delaware income-based programs will be developed and published with the Charity Care Application and updated as necessary.
- **Prior/Continuous eligibility:** Any Delaware hospital approval for free or discounted care in the past 12 months.
- **Homelessness:** experiencing homelessness.
- **Use of a predictive tool to estimate income.** See Presumptive Eligibility Methodology.

WHAT CHANGED AND WHY

A test replaces the named program list.

Any Delaware program with an income limit at or below the charity care limits could qualify. The Board will maintain a list

The program list is published and kept current.

Program limits change, so a posted list stays accurate.

Homelessness stays, with no proof of services.

Prior approval covers free or discounted care.

Any approval at a Delaware hospital in the past year carries over.

§ 9962(f)(1) “A patient deemed financially qualified is considered eligible for financial assistance for a minimum of 1 year from the date of the eligibility determination.”

EXAMPLE: Delaware Income-Tested Programs and Eligibility Thresholds

Program	Agency	Income limit (% of FPL)	Charity care tier
Medicaid	DMMA	Adults 138%; children 138–142%; pregnant women and infants 212%	Free care
Delaware Healthy Children Program (CHIP)	DMMA	212%	Free care
Medicare Savings Programs	DMMA	100%, 120% and 135%	Free care
Chronic Renal Disease Program	DMMA	300%	Free care
Prescription Assistance Program	DMMA	200%, or drug costs above 40% of income	Free care
Supplemental Nutrition Assistance Program (SNAP)	DSS	200% gross income	Free care
Temporary Assistance for Need Families (TANF)	DSS	185% of the standard of need, well below 100%	Free care
General Assistance	DSS	\$79 a month for one person, well below 100%	Free care
Women Infants and Children (WIC)	DPH	185%, or enrollment in Medicaid, SNAP or TANF	Free care
Screening for Life (free or low-cost cancer screening)	DPH	139% to 250%	Free care

DECISION

Establish the methodologies for identifying presumptively eligible patients, such as historical data and predictive modeling. The Board may **require, permit, or restrict** specific methods.

REFINED RECOMMENDATION

- **Employ presumptive screening before first bill.**
 - Presumptive eligibility screening of every uninsured patient and patient responsibility balance equal to or greater than \$500, before the first bill; hospital chooses its presumptive screening approach.
 - No referral, sale, or suit until the screening result has been recorded.
- **Employ the following restrictions related to historical data and predictive modeling:**
 - Restrict screening to income only.
 - Restrict use of Propensity to Pay (P2P) tools that could indicate likelihood that bill will be paid instead of eligibility for financial assistance.
 - Models approve, never deny. Predictive scores or eligibility criteria may qualify a patient; unmet criteria should trigger an invitation to apply.
 - “No Data” cannot result in denial.

WHAT CHANGED AND WHY

Screen uninsured patients and balances of \$500 or more, not every balance.
Screening every bill could be too burdensome. \$500 matches the law's screening trigger.

Hospitals choose how they screen.
Some use vendors and some screen by hand.

Added: no data cannot mean denial.
Vendors return “not eligible” when they simply lack data.

DECISION

Establish by regulation that recipients of financial assistance must be **Delaware residents**, and how residency is shown.

REFINED RECOMMENDATION

Employ the following residency requirements:

- **Automatic:** Delaware benefit enrollment proves residency; unhoused patients qualify by attestation.
- **Lives in Delaware at the time of service.**
- “I was living in Delaware at the time I or my legal dependent received medical services subject to my financial assistance application.”

Floor, not ceiling: hospitals may provide charity care for non-residents.

WHAT CHANGED AND WHY

Added a signed statement of residency.
Gives hospitals something verifiable without extra documents.

Covers the patient or a legal dependent.
Minors and dependents take the guarantor's residency.

Still no minimum stay.
A 183-day test would shut out new Delawareans, and the law does not require one.

State Residency Requirements for Financial Assistance

SS1 for SB13

State	Residency required?	Basis	Notable features
Colorado	Yes; Self-attestation only	C.R.S. § 25.5-3-501(5)	Patient attests to CO residency; lawful presence not required; undocumented residents qualify
California	No	H&S Code §§ 127400/127405	Eligibility is purely income-based; explicitly available regardless of residency or immigration status
Oregon	Not clearly	ORS 442.610	“Resident of this state” appears only re: limits on info collection, not as an eligibility gate; no definition given
North Carolina	Not codified	HASP (Medicaid directed-payment agreement, not a standalone statute)	No statewide statutory test; some hospitals use “NC resident” in their own policies, but that's hospital-level
Washington	No; affirmatively barred	RCW 70.170; DOH guidance	DOH has told hospitals they may not restrict eligibility by zip code, city, county, or state of residence
Vermont	Optional for facility to require; if required, broadly defined	18 V.S.A. § 9481(12); § 9482(d)	Live, work, or attend school in VT (or lack stable housing there); includes undocumented immigrants; no durational requirement allowed

Three states (CA, OR effectively, WA) impose no residency bar; Colorado uses a self-attested test; only Vermont statutorily defines residency in detail.



Additional Work for the Full Plain Language Regulation

Additional Components to include in Regulation

MUST BE ESTABLISHED BY REGULATION

§ 9963(b) — “shall establish by regulation”

- § 9963(b)(1) Information and documentation categories
- § 9963(b)(2) Presumptive eligibility categories
- § 9963(b)(3) Methodologies for identifying presumptively eligible patients
- § 9963(b)(4) Delaware residency requirement for recipients

Covered in section 1 of this deck. Association input is required on all four.

MUST BE PRESCRIBED

§ 9963(c) and § 9964 — “shall prescribe,” with no “by regulation”

- § 9963(c)(1) Standard financial assistance application, and the standard for approving a hospital's modified application
- § 9963(c)(2) Standardized list of acceptable forms of income verification
- § 9963(c)(3) List of qualifying public assistance programs and their verification forms
- § 9964(3)e Patient appeals process for a denied eligibility determination

Not yet drafted. Regulation is optional here: § 9963(a) rulemaking is permissive (“may”), so the Board could prescribe these by vote, form or bulletin instead.

The prescribed items could be issued by vote or bulletin. **We recommend writing the process into the regulation.** Writing the process for creating, publishing and updating each required item into the regulation keeps all parts of the Financial Assistance Program in one place, while the forms and lists themselves can still change, within parameters, without new rulemaking.



Options for the Plain Language Draft

Option: Standard Application

Option	Explanation	Consideration
A. Put the form in the regulation § 9963(c)(1)	The application itself is an appendix to the regulation.	Every change to the form needs a new rulemaking. The form cannot be final until the regulation is.
B. Regulation sets the process § 9963(c)(1)	The regulation says the Board prescribes the form, limited to the (b) categories, and posts it on its website. Hospitals have six months from publication to adopt it. The Board updates the form only to keep pace with new state or federal requirements or simpler ways to collect information, and gives notice before any change.	The Board can build the form and website after the regulation is final, and transition time is accounted for.

TRANSITION TIMELINE

January 1, 2027
Income tiers take effect. Hospitals use their own applications.

February 15, 2027
Target for Board approval of regulation; submitted to the Registrar for March 1 publication and 30-day comment.

May 11, 2027
Earliest final regulation: published May 1, effective May 11. Rest of the law takes effect with the Board's notice.

July 1, 2027
Law takes effect if the regulation is not final. Website and uniform application launch.

January 1, 2028
Hospitals must use the uniform application, six months after launch.

Option: Approving a Modified Application

Option	Explanation	Consideration
A. Board votes on each request § 9963(c)(1)a–c	The hospital submits its form with a side-by-side comparison to the standard application. The Board votes at its next meeting.	Fully public, but approval waits on the meeting calendar.
B. Staff review, Board ratifies § 9963(c)(1)a–c	Staff check the form against the (b) categories and a short checklist of burden reductions, such as fewer questions. Checklist is posted to website. Staff decide within 30 days, the Board ratifies at its next meeting.	More consistent, approval still requires Board to meet to approve, consistent with law.

“The Board shall approve a modified application that reduces applicant burden” and “may not approve a modified application that requires information or documentation beyond the categories established under subsection (b).” § 9963(c)(1)b–c.

Option: How Complaints Reach the Board

Option	Explanation	Consideration
A. Board receives credible complaints, then routes § 9963(e)(1)	Simple web form for complaint, plus phone and email, listed on the Board website and on every hospital notice. The Board logs each direct complaint and refers credible complaints of noncompliance to the Division of Health Care Quality, the same path as any other oversight trigger. Hospital reporting to the Board includes appeals. Partner agencies asked to share any direct complaint counts with Board.	Simplest for patients. Consistent with the Board having Financial Assistance Program oversight. The Board sees every complaint, which it needs as a review trigger, without investigating each one.
B. Existing channels only No Board intake	Patients file with the Division of Health Care Quality or other existing state complaint lines. Partner agencies share complaint counts with the Board.	Least Board work, but less clear to patients as reporting of complaints would not be with the entity that has oversight of the financial assistance program. Board relies on others for its data.

16 Del. C. § 9963(e): “The Board may initiate reviews for hospital compliance with this subchapter on the occurrence of any of the following: (1) A credible complaint alleging noncompliance. (2) Outlier patterns in reporting under this section, including unusually high denial or closure rates, unusually long determination times, or unusually low presumptive eligibility usage. (3) Evidence of lack of written communication about financial assistance eligibility during billing or collection activity taken during a pending determination. (4) Any other risk indicators as the Board may establish by regulation.”

Option: How the Board Carries Out Oversight

Option	Explanation	Consideration
A. Board investigates § 9963(e); § 9965(a)	Board staff pull records, sample accounts and make findings, then notify the Division of Health Care Quality.	Most staff and expertise. Duplicates work the Division already does.
B. Board screens, Division investigates § 9963(e); § 9965(a)	The Board checks reports and complaints against set triggers. When one is met, including a credible complaint, it refers the matter to the Division of Health Care Quality, which investigates and may penalize.	Uses the agency that already holds licensure and penalty authority.
C. Periodic outside audit § 9963(e)	The Board contracts an auditor to sample each hospital's accounts every two to three years and refers findings to the Division.	Thorough and predictable, but requires budget and findings arrive late.
D. Combine B and C § 9963(e); § 9965(a)	The Board screens and refers as in Option B, and may contract an auditor, if necessary.	Lighter day-to-day oversight, with audit capacity available if needed.

EXAMPLE TRIGGERS

Set by statute, § 9963(e)(1)–(3)

- A credible complaint alleging noncompliance
- Unusually high denial or closure rates
- Unusually long determination times
- Unusually low presumptive eligibility use
- No written notice to the patient during billing or collection while a decision is pending

Board could add by regulation, § 9963(e)(4)

- A § 9962(j) report that is late or incomplete
- Median time to decision over 21 days
- Denial rate well above other Delaware hospitals
- Assistance at cost falling sharply from the prior year
- Repeated complaints about collection during a pending application

Option: Keeping the Program and Income Lists Current

Option	Explanation	Consideration
A. Lists in the regulation § 9963(c)(2), (c)(3)	The regulation names each program and each acceptable income document.	Any change to a program or its income limit needs rulemaking. Lists go out of date.
B. Regulation sets the categories; Board keeps the lists § 9963(c)(2), (c)(3)	The regulation states the categories of information the hospitals shall use. The Board posts both lists on its website, with each program's income limit and the tier enrollment grants. It reviews them each year after new poverty guidelines come out and gives 30 days' notice of changes, on a set cycle.	Lists stay current without rulemaking, and hospitals get notice before anything changes.
C. Add a request process (optional, with Option B) § 9963(c)(2), (c)(3)	Hospitals or the public may ask the Board to add a program or document. The Board decides at its next meeting.	Open and simple. Hospitals may already add programs that are no more restrictive.

New federal poverty guidelines come out each January, so a spring review keeps the lists in step with the income tiers.

Option: Hospital Report Schedule

Option	Explanation	Consideration
A. Annual, with the financial submission § 9962(j); Regulation 5003	One annual report, filed with the hospital's annual financial submission to the Board and covering the same fiscal year. Components of annual report to be specified as an exhibit made available to hospitals and posted to Board's website.	One calendar for hospitals. Dollar figures come from the same financial data. The statute already ties these reports to other required reports.
B. Counts twice a year, dollars yearly § 9962(j)	Application counts, decisions, presumptive screenings and time to decision every six months. Dollar figures once a year, with the financial submission.	Earlier warning of outliers for compliance triggers, but two filings a year.
C. Annual, on a separate date § 9962(j)	Every hospital reports the calendar year by a set date, such as March 31.	Same period for every hospital makes comparisons easy, but adds a second deadline.

Reporting starts when § 9962(j) takes effect, no later than July 1, 2027. Decide whether the first report covers a partial year.

Option: The Patient Appeals Process

Option	Explanation	Consideration
A. Board prescribes one process § 9964(3)e	Every hospital follows the same steps, for example 60 days to appeal, a reviewer not involved in the first decision, and a written result within 21 days.	Same rights at every hospital. Collections stay paused while an appeal is pending.
B. Minimum standards only § 9964(3)e	The Board sets deadlines and notice rules. Each hospital writes its own process.	More hospital flexibility, but rights differ from one hospital to the next.

16 Del. C. § 9964(3)e requires each hospital's financial assistance policy to include “An appeals process for a patient deemed ineligible for financial assistance in accordance with the process prescribed by the Board. A patient must have the ability to provide additional documentation supporting the patient’s appeal.” Under § 9964(3)d, the denial notice must tell the patient of the opportunity to appeal. The 21-day decision period in Option A matches the 21 days hospitals have to decide an application.

Recommended Options at a Glance

Topic	Recommended option	Timing
Standard application § 9963(c)(1)	Regulation sets the process; Board publishes the form.	Launch July 1, 2027; hospitals adopt within six months (January 1, 2028).
Modified applications § 9963(c)(1)a–c	Staff review against a checklist; Board ratifies.	Requests accepted once the uniform application launches.
Complaints § 9963(e)(1)	One simple front door; Board refers credible complaints to the Division of Health Care Quality.	Complaint form live July 1, 2027.
Oversight § 9963(e); § 9965(a)	Board screens triggers and refers to the Division of Health Care Quality; auditor as needed.	Triggers defined in the regulation.
Program and income lists § 9963(c)(2), (c)(3)	Test in the regulation; Board keeps the lists, reviewed each year.	First lists published July 1, 2027 with the application.
Report schedule § 9962(j)	Annual, filed with the financial submission.	First report after § 9962(j) takes effect.
Patient appeals § 9964(3)e	One process prescribed by the Board.	Effective with the regulation.
Public website § 9963(d)	One home for the application, lists, complaint form, hospital policies and reports.	Live July 1, 2027; policies and reports posted within 30 days of receipt.



Introduction to IRS Form 990

Public Financial Information

There is no one data source that has complete information about hospitals or health systems.

Today's focus: **Internal Revenue Service Form 990**

Data source	How it informs the Board's duties	Scope
Audited Financial Statements	"Gold standard" of an organization's financial position, including expenses, revenues, assets, and debt.	Entire reporting entity (i.e., more than Delaware hospitals)
Medicare Cost Reports	Annual, standardized report required by Medicare, which includes costs allocated by cost center, staffing, utilization, discharges, and revenue.	Hospital
Internal Revenue Service Form 990	Provides information about compensation, community benefit, charity care, and workforce investment.	Tax-exempt employer
Bond disclosures	Continuing disclosure filings include more timely information about debt coverage, days cash on hand, leverage, operating margin, and capital plans.	Obligated group for those issuing municipal bonds.

Components of the Form 990

Part I	• Summary of revenue, expenses, and net assets for the whole tax-exempt organization
Part VII	• Officers, directors, key employees, and highest-paid employees, with reportable compensation
Part X	• Balance sheet: assets, liabilities, and net assets at the beginning and end of the year
Schedule H	• Hospital schedule: community benefit at cost, bad debt and Medicare shortfall, and IRC 501(r) compliance for each hospital facility
Schedule J	• Compensation detail for the highest-paid people, and how the organization sets pay

Domains of Form 990 Analysis

Community Benefit

What does the organization provide to the community, measured at cost?

Charity Care & Bad Debt

How much free or discounted care is provided, and how does it compare with unpaid bills written off?

Executive Compensation

How are leaders paid, and how is pay set?

Tax-Exemption Requirements

Does each hospital meet the IRC 501(r) requirements for needs assessments and financial assistance?

Financial Context

How large is the filer, and how do its 990 totals line up with audited financial statements?

Overview of Delaware Form 990 Filers

Filer	Hospitals in the extract	FY25 total expense	Notes
CC Health Services	Christiana Care Health System	\$2,947 M	
Bayhealth	Bayhealth Hospital Kent Campus Bayhealth Hospital Sussex Campus	\$1,121 M	One return covers the Kent and Sussex campuses
Beebe	Beebe Medical Center	\$636 M	
Nanticoke Memorial	Nanticoke Memorial Hospital	\$234 M	
St. Francis	St. Francis Hospital Wilmington	\$148 M	CEO pay reported by related organizations (Trinity Health)
Nemours Foundation (national)	Nemours Children's Hospital Delaware	\$2,112 M (FY24)	One national return (Delaware and Florida); left out of Delaware totals

Total expense from Form 990 Part I line 18, for the whole filing organization.



Form 990 vs Audited Financial Statements

- The 990 is filed by the tax-exempt organization (EIN). One return can cover several hospitals (Bayhealth's Kent and Sussex campuses) or operations outside Delaware (Nemours Foundation files one return for Delaware and Florida).
- Returns are often released more than a year after submission.
- Schedule H reports community benefit at cost and in standard IRS categories, which audited statements do not.
- Part I "revenue less expenses" includes investment income, so it is not comparable to the operating margin from audited statements.

Bad Debt and Form 990 Filings

Due to changes in accounting principles established in Financial Accounting Standards Board, Accounting Standards Codification Topic 606, "Revenue from Contracts with Customers" (FASB ASC 606), treatment of bad debt expense changed. The change required payments the hospital did not expect to collect to be treated as an implicit price concession (instead of treating the expected lack of payment as a bad debt expense).

As a result, the Form 990 provides flexibility to filers for how to report bad debt expense on Schedule H:

Health Finance Management Association's Statement 15 (generally based off charges)

- Beebe
- ChristianaCare
- Nanticoke Memorial
- St. Francis

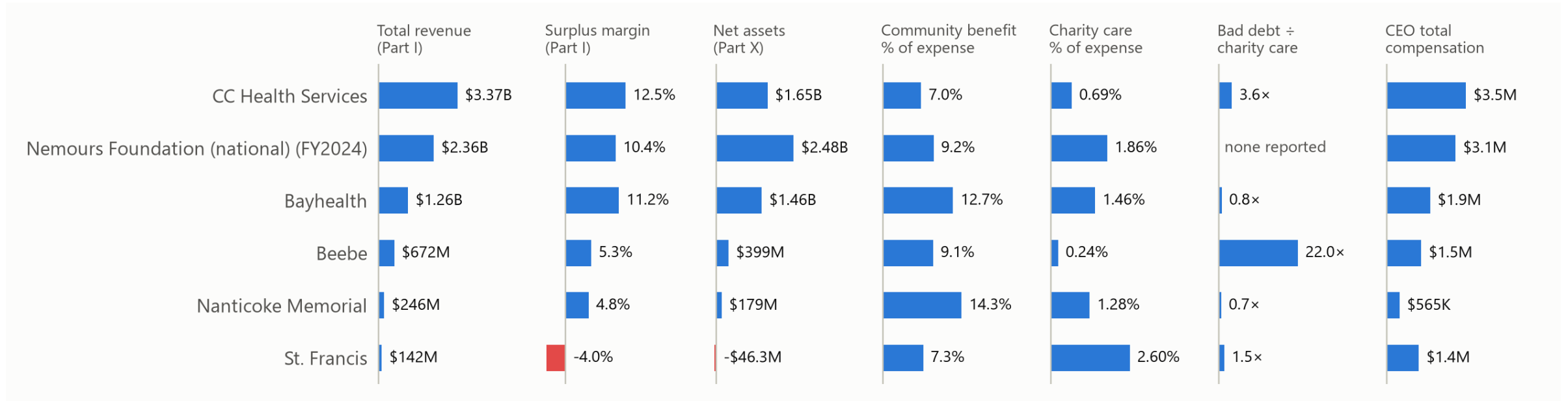
Other methods

- Bayhealth – uses ratio of charges to cost from their cost accounting system
- Nemours – reports none (\$0), applying the implicit price concession accounting principles.

Key Takeaways

- In aggregate, Delaware filers reported net community benefit of **8.8%** of total expense in FY25, down from 8.9% in FY24 (7.8% average over 4 years).
- Charity care was **0.9%** of total expense for Delaware filers in FY25, up from 0.8% in FY22.
- 3 of 5 Delaware filers wrote off more as bad debt than they provided as charity care in FY25 (Beebe, CC Health Services, St. Francis). Bad debt is reported at cost by Bayhealth and at charges by Beebe, CC Health Services, and St. Francis; Nanticoke Memorial does not state a basis. Charity care is always at cost, so **ratios for filers reporting at charges overstate bad debt relative to charity care.**
- Median CEO total compensation was \$1.54 million in FY25. Among filers with a CEO identified in both FY22 and FY25, pay rose 54% at CC Health Services, 43% at Beebe, 28% at Bayhealth, and 27% at Nanticoke Memorial.
- 6 of 6 filers report a CHNA within the three-year cycle in their latest return.

Overview of Form 990 Results (FY25)



Form 990 Part I, Part X, Schedule H, and Schedule J for the same filer and fiscal year. Nemours files one national return (Delaware and Florida).

Community Benefit Measures

What does the organization provide to the community?

Nonprofit hospitals are exempt from federal income tax and report the community benefit they provide on Schedule H.

Measures highlighted:

- **Net community benefit (% of total expense):** financial assistance at cost, Medicaid and other means-tested shortfalls, community health improvement, health professions education, subsidized services, research, and contributions, net of offsetting revenue (Part I line 7k).
- **Charity care (% of total expense):** free or discounted care under the financial assistance policy, at cost (line 7a).

Medicare shortfall and bad debt are reported on Schedule H Part III but are not counted as community benefit.

Community Benefit Results: Net community benefit (%)

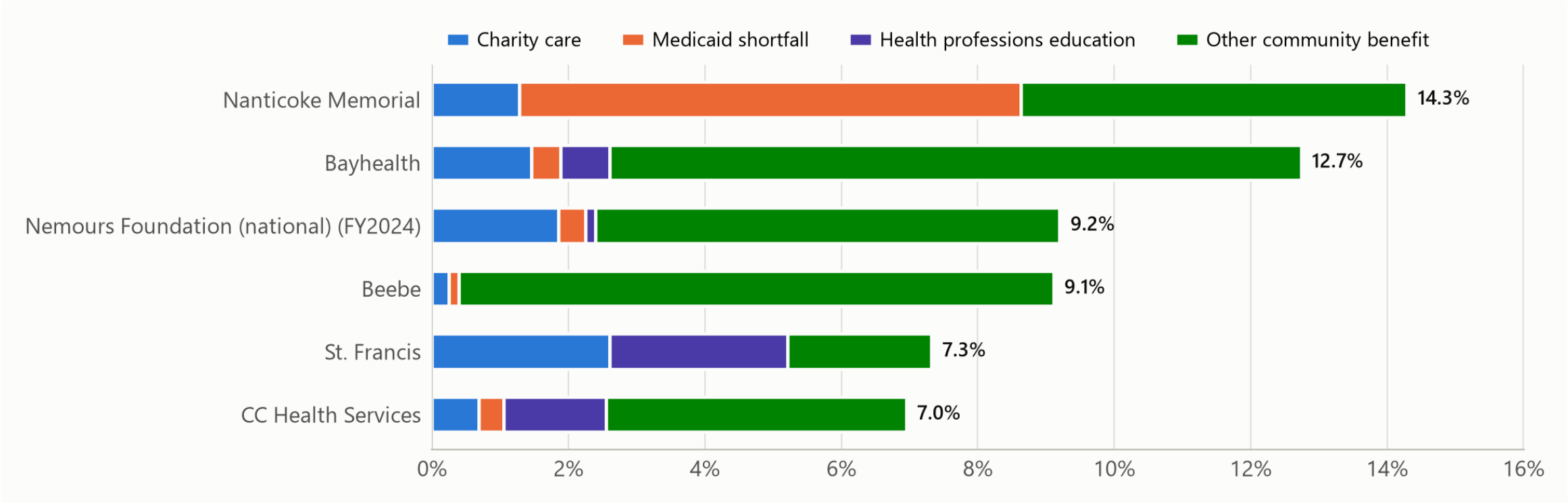
- In aggregate, Delaware filers reported net community benefit of **8.8%** of total expense in FY25, down from 8.9% in FY24 (7.8% average over 4 years).
- Highest in FY25: Nanticoke Memorial (14.3%); lowest: CC Health Services (7.0%).
- Other community benefit is the largest component for 3 of 5 filers; Medicaid shortfall for Nanticoke Memorial; health professions education for St. Francis.

Filer	4-year average (FY21–FY24)	FY24	Change since FY21
Overall – DE filers	7.2	8.9	+2.3 pts
Nemours Foundation (national)	11.3	9.2	-1.9 pts
Nanticoke Memorial	11.2	12.2	-0.9 pts
Bayhealth	9.3	11.0	+3.5 pts
Beebe	8.2	8.6	+0.5 pts
CC Health Services	6.1	8.1	+2.7 pts
St. Francis	5.4	5.9	-0.7 pts

Percent of total expense, filer's Schedule H basis (excludes bad debt). Source: Schedule H Part I line 7k, column (f). Overall excludes Nemours Foundation.

Community Benefit Results: Components (FY25)

- Other community benefit is the largest component for 3 of 5 filers; Medicaid shortfall for Nanticoke Memorial; health professions education for St. Francis.



Community Benefit Results: Charity care (%)

- Charity care held at about **1.0%** of total expense for Delaware filers in both FY21 and FY24, after a dip to 0.8% in FY22.
- Highest in FY24: St. Francis (2.20%); lowest: Beebe (0.46%).
- Charity care is 5% to 37% of each filer's net community benefit in FY24; the rest is Medicaid shortfall and other categories.

Filer	4-year average (FY21–FY24)	FY24	Change since FY21
Overall – DE filers	0.9	1.0	0.0 pts
Nanticoke Memorial	2.3	1.4	-1.4 pts
St. Francis	1.7	2.2	+0.6 pts
Bayhealth	1.5	1.8	+0.5 pts
Nemours Foundation (national)	1.2	1.9	+0.7 pts
Beebe	0.7	0.5	-0.2 pts
CC Health Services	0.6	0.6	-0.1 pts

Percent of total expense, filer's Schedule H basis (excludes bad debt). Source: Schedule H Part I line 7a, column (f). Overall excludes Nemours Foundation (national).

Charity Care and Bad Debt Measures

How does free care compare with unpaid bills written off?

Patients who qualify for financial assistance should receive charity care rather than a bill that is later written off.

Measures highlighted:

- **Bad debt expense:** amounts billed and not collected (Schedule H Part III line 2). Filers also estimate the share attributable to patients eligible for financial assistance (line 3).
- **Bad debt to charity care (ratio):** dollars of bad debt per dollar of charity care. Above 1.0x, more is written off than given as free care.

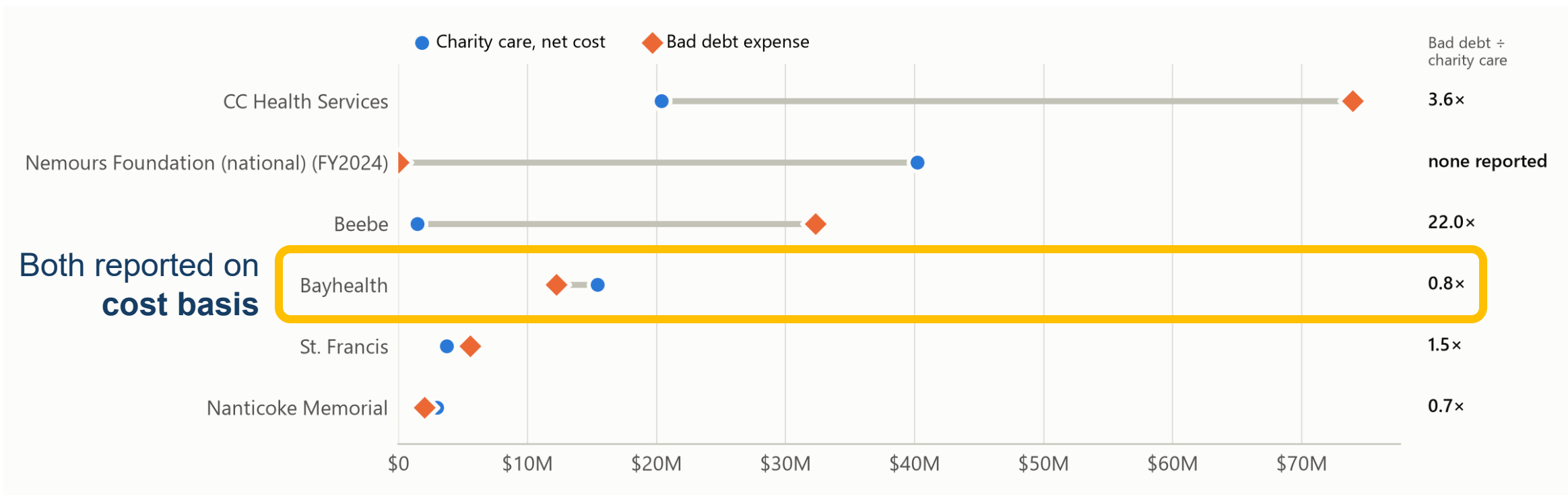
Results: Bad debt to charity care (ratio)

- In aggregate, Delaware filers reported **2.9 dollars of bad debt** for every dollar of charity care in FY25.
- 3 of 5 Delaware filers wrote off more as bad debt than they provided as charity care in FY25 (Beebe, CC Health Services, St. Francis).
- Bad debt is reported at cost by Bayhealth and at charges by Beebe, CC Health Services, and St. Francis; Nanticoke Memorial does not state a basis. Charity care is always at cost, so ratios for filers reporting at charges overstate bad debt relative to charity care.

Filer	4-year average (FY22–FY25)	FY25	Change since FY22
Overall – DE filers	2.5x	2.9x	+1.0x
Beebe	9.5x	22.0x	+18.3x
CC Health Services	3.4x	3.6x	+2.0x
St. Francis	2.5x	1.5x	-1.5x
Nanticoke Memorial	1.8x	0.7x	-1.6x
Bayhealth	0.9x	0.8x	-0.4x
Nemours Foundation (national)	none reported	none reported	n/a

Source: Form 990 Schedule H Part III line 2 and Part I line 7a. Overall excludes Nemours Foundation (national).

Results: Charity Care and Bad Debt by Filer (FY25)



Schedule H Part I line 7a and Part III line 2. Ratio above 1x means more unpaid bills written off than free care given.

Executive Compensation Measures

How are leaders paid, and how is pay set?

Part VII lists pay for officers, directors, and key employees; Schedule J adds detail for anyone paid over \$150,000.

Measures highlighted:

- **CEO total compensation (\$M):** base, bonus, other reportable, deferred, and nontaxable benefits for the chief executive, including pay from related organizations (Schedule J column (F)).
- **Pay-setting practices:** yes/no answers on compensation committees, independent consultants, comparability surveys, severance, supplemental retirement plans, and incentive pay (Schedule J Part I).

Pay approved by an independent body, using comparability data and documented, is presumed reasonable under IRS rules.

Results: CEO total compensation (Millions of \$)

- Median CEO total compensation for Delaware filers was **\$1.54 million** in FY25.
- Among filers with a CEO identified in both FY22 and FY25, pay rose 54% at CC Health Services, 43% at Beebe, 28% at Bayhealth, and 27% at Nanticoke Memorial.
- CEO pay follows organization size: in FY25 the filers rank in nearly the same order by total expense and by CEO pay.

Filer	4-year average (FY22–FY25)	FY25	Change since FY22
Median – DE filers	1.37	1.54	+34%
CC Health Services	2.89	3.55	+54%
Nemours Foundation (national)*	2.75	n/a	n/a
Bayhealth	1.72	1.94	+28%
Beebe	1.26	1.54	+43%
St. Francis*	0.98	1.43	+178%
Nanticoke Memorial	0.50	0.57	+27%

Source: Schedule J column (F), otherwise Part VII. Median excludes national filers; its change uses filers with data in both years. *Years without current CEO identified are skipped.

Results: How Executive Pay Is Set

	Compensation committee	Independent consultant	Comp survey or study	Severance or change-of-control	Supplemental retirement plan	Incentive (non-fixed) pay	Pay tied to net earnings
CC Health Services	—	—	—	●	●	●	○
Bayhealth	●	●	●	○	●	●	○
Beebe	●	●	●	●	○	●	○
Nanticoke Memorial	—	—	—	○	●	○	○
St. Francis	—	—	—	●	●	○	○
Nemours Foundation (national) (FY2024)	●	●	●	●	●	●	○
● Yes ○ No — Blank in extract							

Schedule J Part I, latest year answered.

Tax-Exemption Requirements (IRC 501(r))

Does each hospital meet the requirements for tax exemption?

Since 2010, tax-exempt hospitals must meet four requirements, reported facility by facility on Schedule H Part V.

Measures highlighted:

- **Community health needs assessment:** conducted at least every three years, with an adopted implementation strategy.
- **Financial assistance and billing:** a written policy with eligibility criteria, limits on charges to patients who qualify (amounts generally billed), and reasonable efforts before extraordinary collection actions.

Results: CHNA and Financial Assistance Policy

- 6 of 6 filers report a CHNA within the three-year cycle in their latest return.
- 5 of 6 filers use federal poverty guidelines to set discount eligibility; CC Health Services reports otherwise.
- The extract has no usable answer on limiting charges to amounts generally billed (AGB); confirm from the returns.

	CHNA within 3-year cycle	CHNA conducted	CHNA made public	Implementation strategy adopted	Community input taken	FPL used to set discount eligibility
CC Health Services	●	●	●	●	●	○
Bayhealth	●	●	●	●	●	●
Beebe	●	●	●	●	●	●
Nanticoke Memorial	●	●	●	●	●	●
St. Francis	●	●	●	●	●	●
Nemours Foundation (national) (FY2024)	●	●	●	●	●	●

● Yes ○ No — Blank in extract

Schedule H Part V, latest year answered. CHNA within 3-year cycle is derived from the CHNA year reported (IRC 501(r)(3)). FPL = federal poverty guidelines.

Upcoming Meeting Topics

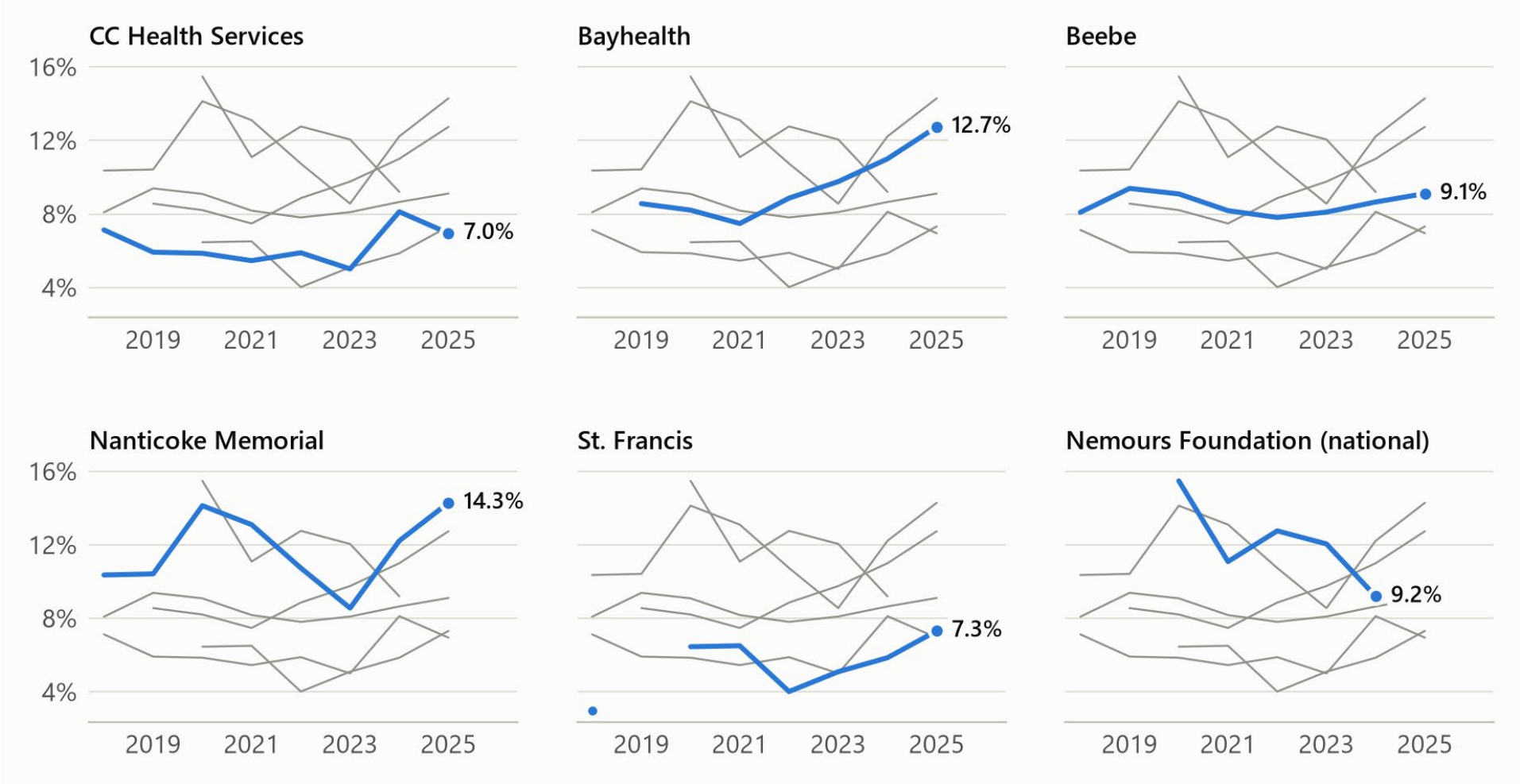
Board Meeting	Topics
November 2026	• Hospital Panel • Review/Discuss plain language draft Charity care regulation • Introduce Medicare Cost Reports
December 2026	• Finalize plain language draft of Charity Care regulation • Outline process for reviewing annual hospital data submissions
February – April 2027	• Review hospital submissions and conduct hearings
February 2027	• Target date for Board approval of Charity care regulation





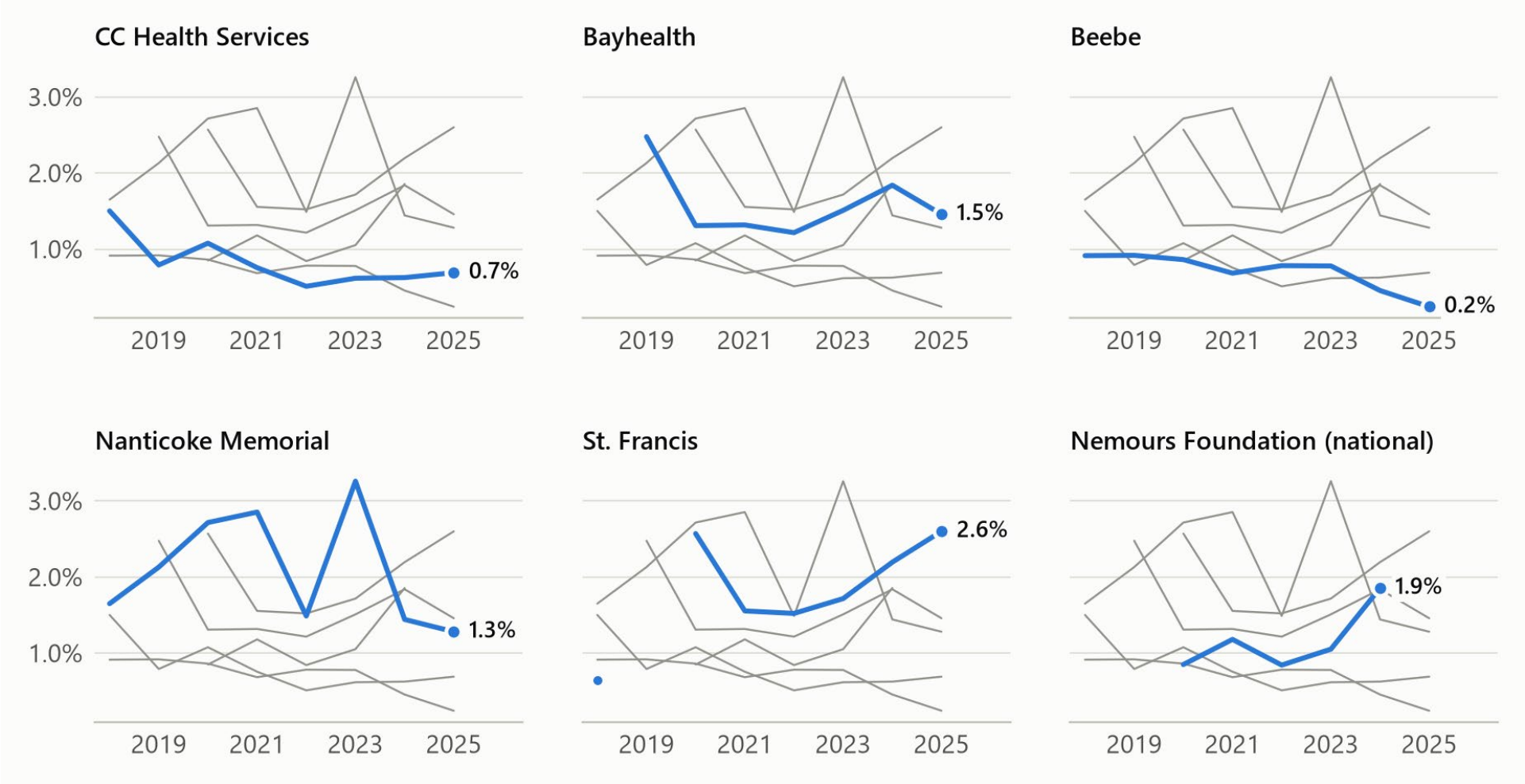
Appendix: Form 990 Trends by Filer

Trends: Net community benefit (%)



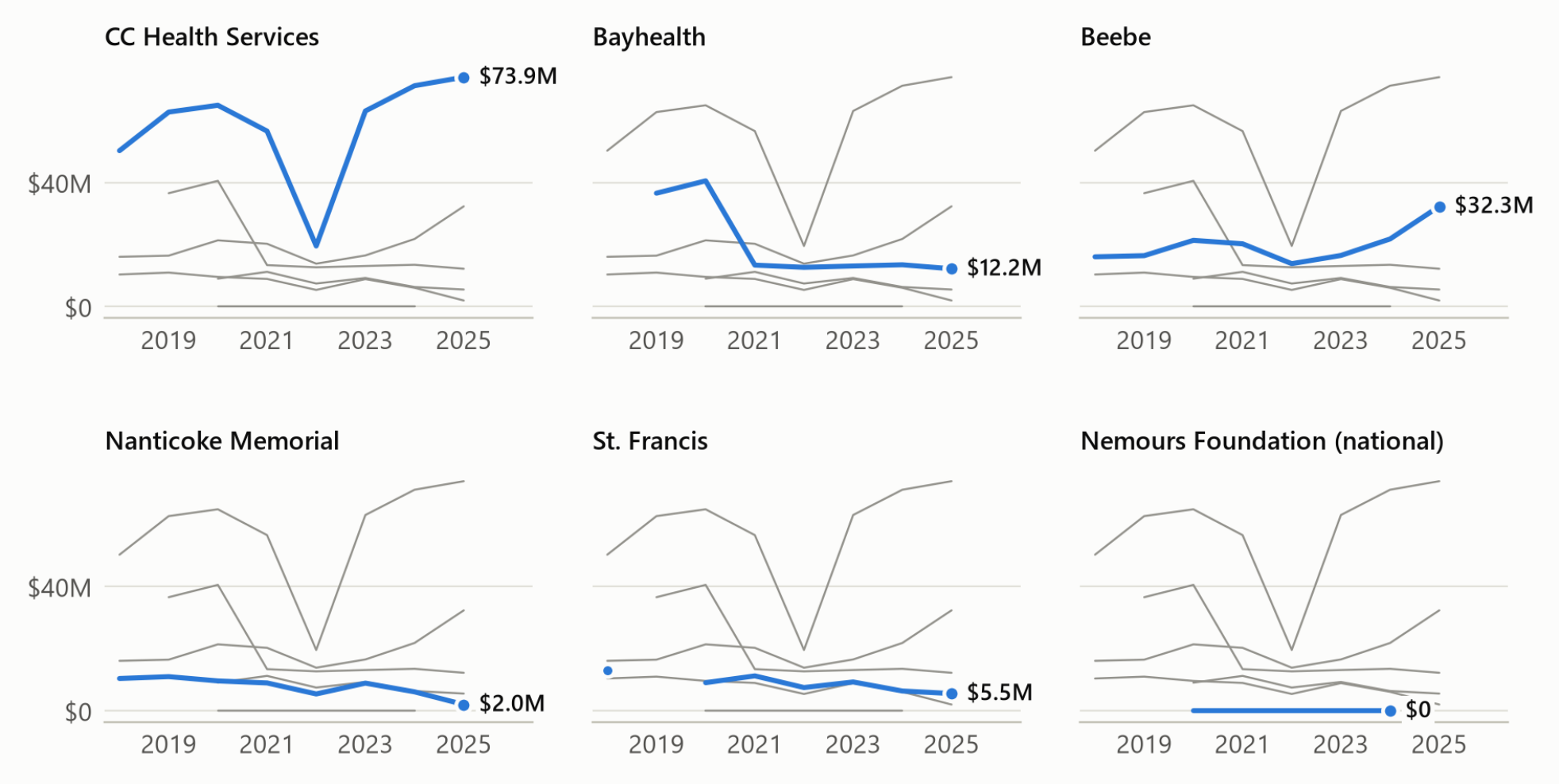
Schedule H Part I line 7k, column (f). Excludes Medicare shortfall and bad debt, which Schedule H does not count as community benefit.

Trends: Charity care (%)



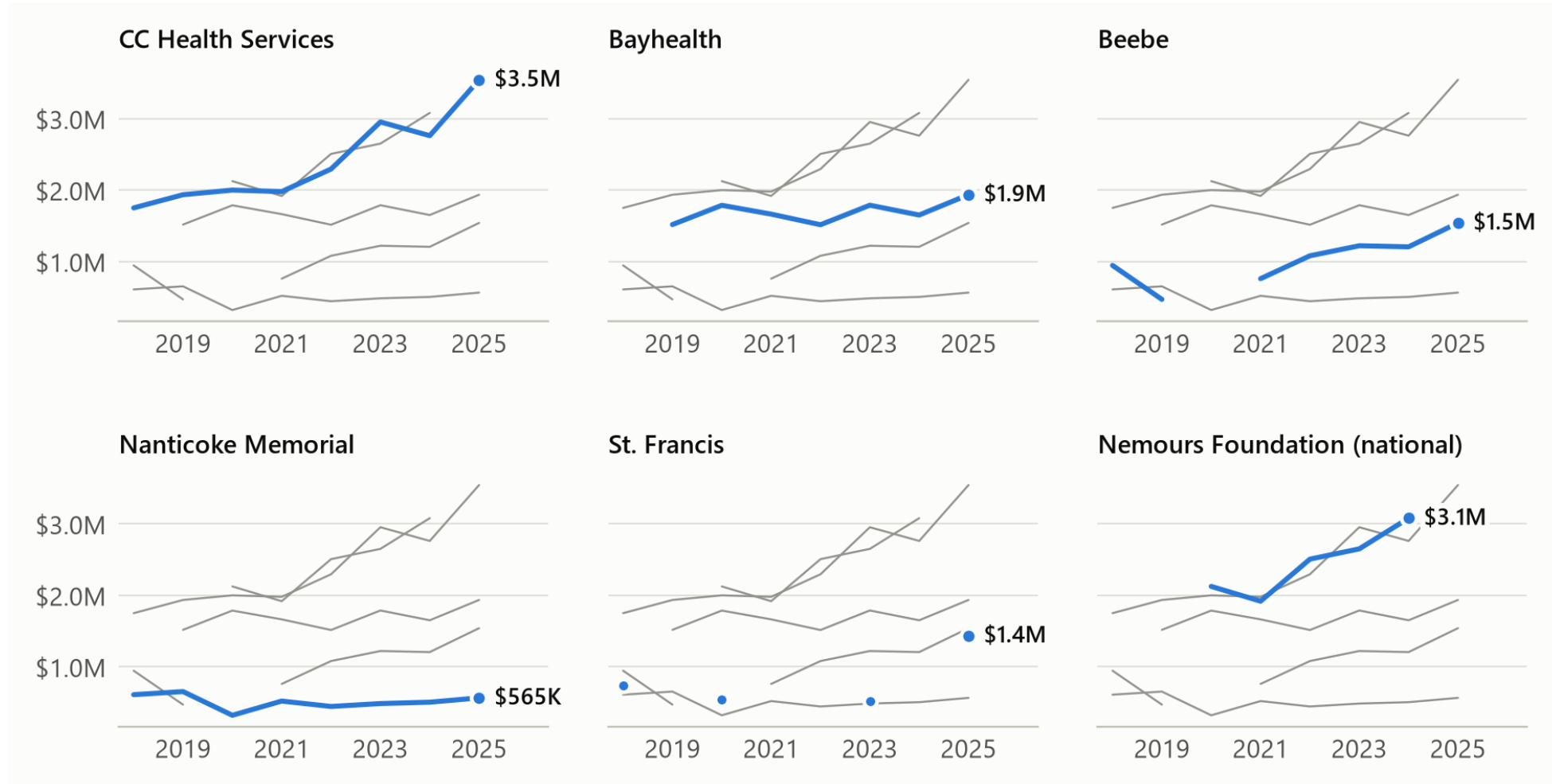
Schedule H Part I line 7a, column (f) as a percent of total expense.

Trends: Bad debt expense (\$M)



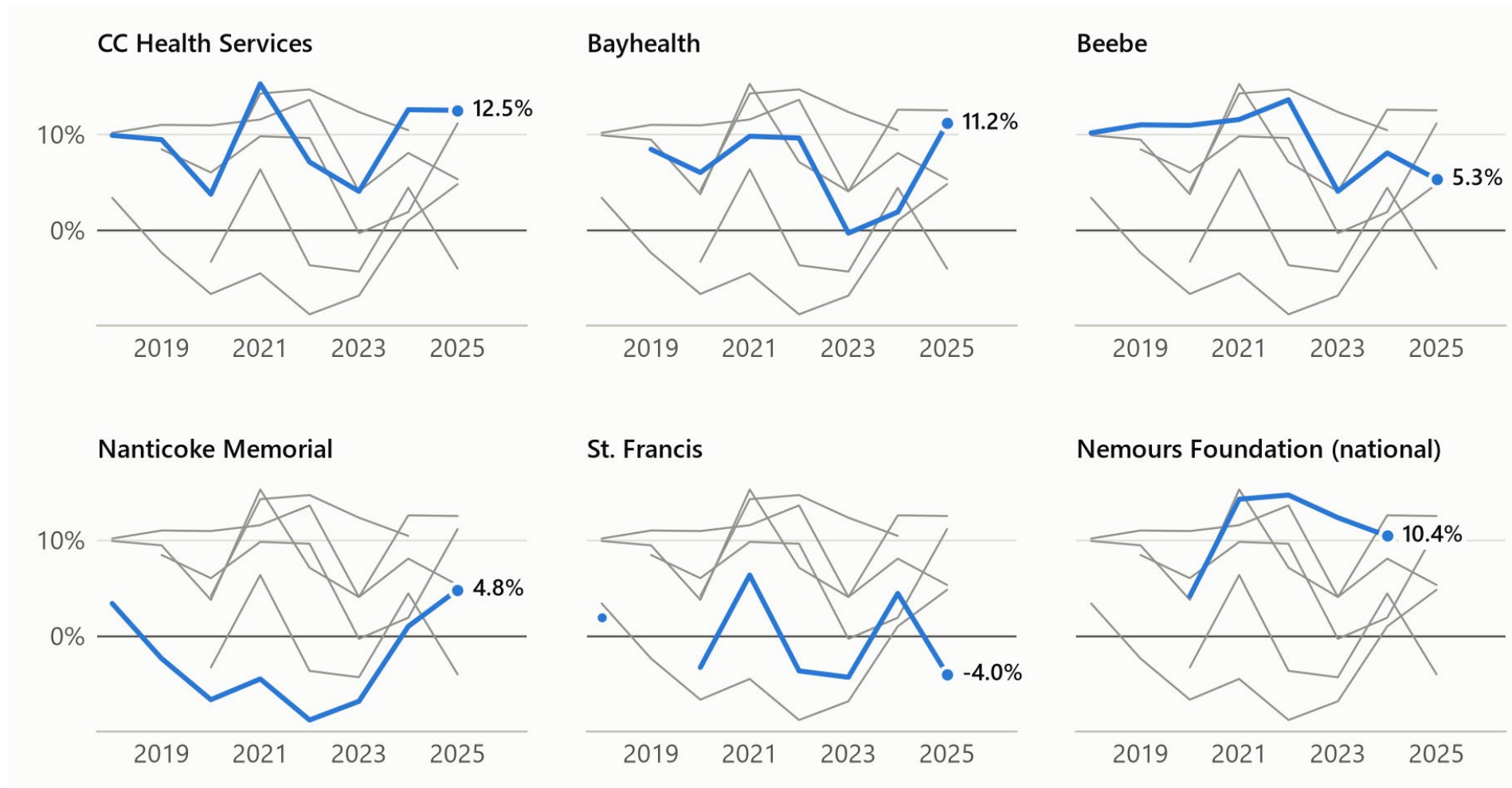
Schedule H Part III line 2. No break at ASC 606 adoption where the data spans it (Beebe, CC Health Services, Nanticoke Memorial). Drops to confirm against audited statements: Bayhealth in FY21, CC Health Services in FY22, Nanticoke Memorial in FY25.

Trends: CEO total compensation (\$M)



Schedule J column (F) where reported, otherwise Part VII reportable compensation. Breaks in a line are years with no current CEO identified. St. Francis CEO pay is reported by related organizations (Trinity Health).

Trends: Surplus margin, Part I (%)



Form 990 Part I line 19 divided by line 12. A total margin, not an operating margin: investment gains and other non-operating items are included.



Thank you.

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Public Comment

Adjourn

