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Diamond State Hospital Cost Review Board — August 11, 2026 Meeting: Final Draft Administrative Regulation, Hospital Submission Guidance, and Audited Financial Statements

Diamond State Hospital Cost Review Board
August 11, 2026

Meeting Agenda

Agenda Item	Time
Welcome and Approval of Meeting Minutes	10:00 AM – 10:05 AM
Review Final Draft Administrative Regulation and DHA Comments	10:05 AM – 10:20 AM
Board Vote on Draft Administrative Regulation	10:20 AM – 10:25 AM
Review Draft Guidance for Hospital Information Submissions	10:25 AM – 11:15 AM
Potential Vote to Post Guidance on DSHCRB Website	11:15 AM – 11:20 AM
Health Care Finance Background and Introduction to Delaware Hospitals' Audited Financial Statements	11:20 AM – 12:15 PM
Public Comment	12:15 PM – 12:20 PM
Next Steps & Close	12:20 PM – 12:30 PM



Review Final Draft Administrative Regulation: Changes Between 7/21/26 and 8/11/26

Incorporation of Feedback from July 21 Discussion of Draft Administrative Regulation

Section	Draft 1 (7/21/2026)	Feedback	Draft 2 (8/11/2026)
Applicability and Computation of Time: 2.2	Extends a deadline falling on a Saturday, Sunday, or State holiday to the next business day.	Add language addressing deadline calculations when State offices are closed due to a declared emergency or similar state action.	Adds: “or a day on which State government offices are closed by order of the Governor.”
Submission of Audited Financial Statements: 3.1.2	Includes, “Any accompanying letter or report issued in connection with the audit, regardless of how titled”.	Clarify the definition of audit-related documents, especially the phrase ‘in connection with the audit,’ and consider revising it to reference documents issued with the audited financial statements or required under applicable auditing standards.	Rewritten. Ties the requirement to documents “issued in connection with the audited financial statements submitted under subsection 3.1.1,” and to describe the three categories functionally (matters communicated to the governing body/audit committee; management's written representations; and communicated internal-control deficiencies, including significant deficiencies or material weaknesses).

Incorporation of Feedback from July 21 Discussion of Draft Administrative Regulation

Section	Draft 1 (7/21/2026)	Feedback	Draft 2 (8/11/2026)
Submission of Hospital Information: 4.0-4.10	4 separate interim deadlines requiring Board to complete final review no later than May 15.	Revise Section 4 timeline dates to give the Board and staff more time for review, hearings, recommendations, and findings.	Consolidated/Extended. 4 separate interim dates (Mar 30, Apr 30, May 1, May 15) are replaced by 2 dates (Jun 1 hearing, Jun 30 findings).
Uniform Reporting Manual: 5.1	Contains the full set of Uniform Reporting Manual definitions.	Clarify that the URM is a menu of possible reporting categories.	Clarified. URM definitions moved to Section 1.0. Short introductory statement notes that definitions are in Section 1.0 and indicates URM provides, “the full potential set of annual submission requirements.”
Uniform Reporting Manual: 5.3.3.6	The Board may require labor costs to be reported by units of service.	Clarify Section 5.3.3.6 regarding labor costs reported by units of service, including whether the intended measure is more accurately framed as FTEs or cost-report-based information.	Removed. Review will be limited to information available through Medicare Cost Reports.

Incorporation of Feedback from July 21 Discussion of Draft Administrative Regulation

Section	Draft 1 (7/21/2026)	Feedback	Draft 2 (8/11/2026)
Posting of Public Records: 6.0	Silent on Chair's role in redaction requests.	Develop a process for hospital redaction requests (confidentiality), including submission to the Board Chair, Chair review with counsel, and reporting to the full Board on approved or denied redactions.	New: 6.2.3 and 6.2.4 the Board Chair, or the Chair's designee, decides each redaction request before the records are posted and reports each decision to the Board at its next meeting. While a redaction request or review is pending, the Board may post the proposed public (redacted) version of the submission.
Extensions of Deadlines: 7.1-7.4	The Board may extend a deadline under Section 3.0 or Section 4.0, on hospital request or the Board's own initiative.	Ensure Section 7 extension authority applies to deadlines across the regulation, including guidance-related deadlines in Section 5, not only Sections 3 and 4. Ensure extension authority may be exercised by the Chair, or designee. With reporting back to the Board.	Revised. A deadline under Section 3.0, Section 4.0, or subsection 5.4 may be extended by the Chair of the Board (or the Chair's designee) on hospital request, or by the Board on its own initiative. Adds subsection 5.4 (guidance deadlines) to the sections eligible for extension. Requires Chair to report decision to Board at Board's next meeting.

Draft 1 to Draft 2 Refinements (Not Tied to July 21 Feedback)

Section	Draft 1 (7/20/2026)	Draft 2 (8/5/2026)
Front Matter	Summary of Proposal left as a placeholder: “[To be prepared by DHCC Staff].”	Fully drafted narrative summary describing the statutory basis and Sections 1.0–7.0.
Definitions: 1.0 / 5.1	Split into two sets: a short Section 1.0 list and a separate, longer Section 5.1 list for Uniform Reporting Manual terms.	Consolidated into a single Section 1.0. New terms added (Inpatient, Outpatient, Payer, Purchaser, Reporting entity, Ancillary services); several definitions tightened to tie directly to audited financials or statute (e.g. Capital expenditure, Cash and cash equivalents, Long-term debt, Hospital information). Per DHA Letter (7/31/26), “Other Uncompensated Care” replaced with “Other Adjustments.”
Uniform Reporting Manual: 5.2–5.4	5.2.5 subitems mislabeled 5.2.3.x; 5.3.2 included a cost-center prohibition clause; 5.3.4 listed “ambulatory care” as a separate category.	Numbering corrected; 5.3.2 simplified; “ambulatory care” folded into inpatient/outpatient/ancillary categories; guidance-posting language reworded and moved into a standalone subsection (5.4.4).
Posting of Public Records: 6.1.1	Original word order.	Reworded for clarity; no substantive change.



Review of Delaware Healthcare Association Written Feedback

DHA Comment Letter Feedback and Recommendations for Incorporation

Section	DHA Comment Summary	Recommendation to Board
Submission of Audited Financial Statements: 3.1.2	Remove Section 3.1.2, Reports in Connection with the Audit. Hospitals already submit audited financial statements (auditor's opinion, notes, supplemental schedules). DHA comment indicates this should be sufficient for Board review. DHA argues the additional auditor-prepared statements Section 3.1.2 requires are internal, proprietary/confidential documents not disclosed publicly or to bond rating agencies, and that the section lacks confidentiality protections and exceeds the Board's statutory authority (not necessary to assess benchmark compliance). DHA requests the section be removed entirely.	Do not remove section. • 16 Del.C. §9953(a)(9) authorizes Board to request "other information the Board determines to be relevant to the Board's obligations under this section," thereby committing any determination of what's relevant to the Board. • §9953(d)(2) requires the Board to "analyze and consider" the information submitted by the hospital. • Letters are relevant to future compliance plan work. §9954(b) directs the Board to consider "a hospital's financial condition" among compliance plan factors, and internal control deficiencies bear directly on that. • Section 6.0 requires the Board to post the records that are public records under 16 Del.C. §9958(b)(2) and establishes a process for a hospital to request that the Board withhold information that is not deemed public under 29 Del.C. §10002(o). This process has been refined in Draft 2/Final Draft of the Administrative Regulation. • Annual Submission Guidance will provide clarification about questions of confidentiality and specify the components of the submission are deemed public records per Statute. • The 3.1.2 letters are not within any §9958(b)(2) public posting category (budgets, spending and revenue data, utilization info), so they are nonpublic by default under §9958(b)(1) without any designation by hospital. Protection is automatic by statute.

DHA Comment Letter Feedback and Recommendations for Incorporation

Section	DHA Comment Summary	Recommendation to Board
Uniform Reporting Manual: 5.2.3, 5.2.4, 5.3.2, 5.3.3.1, 5.3.5	Remove excessive payer-specific and disaggregation requirements. • 5.2.3: Requires insurer-specific payment data beyond what's publicly disclosable under 45 C.F.R. Part 180; DHA says this exceeds statutory scope given Section 5.3.6 already relies on existing federal price transparency data — requests removal. • 5.2.4: Requires attributing utilization to a single payer beyond existing Medicare Cost Report categories; DHA requests removal or limiting to existing Medicare Cost Report categories. • 5.3.2: Appears to let the Board require disaggregation of virtually any data element; DHA calls this administratively burdensome and inconsistent with existing reporting — requests removal. • 5.3.3.1: Lets the Board require standardized expense categories beyond audited financial statements; DHA requests clarification of intent and removal if it goes beyond existing categories. • 5.3.5: Requires further disaggregation of financial/utilization data by payer type; DHA requests removal on the same grounds as above.	Do not remove payer-specific and disaggregation requirements. • Choosing to remove the categories of information identified here, and removing the ability of the Board to request finer granularity on various data elements, is inconsistent with the Statutory intent for the Board to be able to request information from hospitals that is not in the public domain. • 9952(g) directs the Manual to provide uniform definitions and submission criteria. Standardizing definition/submission criteria is the Manual's statutory function.

DHA Comment Letter Feedback and Recommendations for Incorporation

Section	DHA Comment Summary	Recommendation to Board
Uniform Reporting Manual: 5.2.5	Eliminate or significantly reduce Section 5.2.5, Workforce Development Investment Requirements DHA notes Section 5.3.7 already lets hospitals describe workforce investments in narrative form. They say Sections 5.2.5.1, 5.2.5.2, 5.2.5.3, and 5.2.5.5 create new, non-standardized reporting requirements exceeding statutory scope, requiring new data collection/tracking processes. DHA is particularly concerned with 5.2.5.5's requirement to disclose signing and retention bonuses, calling it competitively sensitive and not relevant to benchmark assessment. DHA requests Section 5.2.5 be removed.	Do not remove this section. §9953(d)(4) makes review of workforce development investments a mandatory Board duty. Under §9952(g), Board has the authority to require this information in a standardized format and in a format the Board determines is appropriate.

DHA Comment Letter Feedback and Recommendations for Incorporation

Section	DHA Comment Summary	Recommendation to Board
Posting of Public Records: 6.0	Public versus private information (confidentiality / FOIA) DHA asks the Board to clarify whether information submitted will be subject to disclosure under Delaware's FOIA, and what protections would apply to confidential business information. DHA also flags Section 6.2.1.2's requirement that hospitals justify the basis for each redaction, asking for confirmation that only a reference to the non-public-record categories in 29 Del. C. Ch. 100 is required — and requests the section be removed or modified if it demands more than FOIA itself requires.	Hospital submissions are not public records for FOIA purposes. §9958(b)(1) is the default. There is a narrow exception for the three categories of information listed at §9958(b)(2): spending and revenue data and utilization information are public and posted. For the posted categories, hospitals may request withholding of information (pursuant to draft regulation 6.2). The redaction statement must simply identify the reason for the exclusion asserted. 29 Del.C. §10002(o) sets out exclusions from the definition of “public record.” Recommend retaining 6.2.1.2: Chair can't make a decision under 6.2.3 without understanding the hospital's asserted basis for withholding the info. A detailed justification or a line-by-line discussion about the information for which confidential treatment is requested is not required or expected. Annual Submission Guidance will provide clarification on issues of nonpublic vs. public and requests for confidential treatment.

DHA Comment Letter Feedback and Recommendations for Incorporation

Section	DHA Comment Summary	Recommendation to Board
Definitions: 1.0	Definitional consistency DHA asks the Board to align regulation definitions with existing federal reporting/accounting standards and standard healthcare financial terminology. Specific example given: replacing “Other Uncompensated Care” with “Other Adjustments,” since the category includes write-offs that are neither charity care nor bad debt.	Implement replacement provided in example. Standard financial terminology can/may change over time—this is why annual guidance for reporting will be issued.

DHA Comment Letter Feedback and Recommendations for Incorporation

Section	DHA Comment Summary	Recommendation to Board
General: Initial Reporting Timeline	DHA reiterates concern (raised verbally in June and in a June 5 letter) about the feasibility of hospitals submitting complete, audited, hospital-level financial statements for FY2026 under the proposed timeline. DHA “strongly urges” the Board to begin the new reporting structure with FY2027 data, citing delays in the rulemaking process and the work hospitals need to do to come into compliance.	Proceed with initial review of FY2026 hospital information. • Under 16 Del.C. §9954(a)(1): “Beginning in 2027” the Board must begin to determine whether a hospital has exceeded the spending benchmark. A 2027 benchmark determination cannot be made without FY2026 data, and beginning with FY2027 reporting would push the Board's first statutory determination to 2028. • The submission requirement is for the hospitals’ system-level statements, as already submitted for FY2025 and expected to be complete in accordance with the timeline for FY2026. The Administrative Regulation now includes a definition of reporting entity to clarify. • The Administrative Regulation and Draft Annual Submission Guidance do not specify that hospitals must submit hospital-level financial statements.



Board Vote on Draft Administrative Regulation

For Reference: Regulatory Adoption Process

- Submit the proposed regulation to the Registrar of Regulations by the 15th of the month (NOTE: the 15th of August falls on a Saturday, so effectively must be submitted by August 14th)
- Proposed regulation and public notice are published in the Register of Regulations on the 1st of the following month
- Public comment period remains open no less than 30 days after publication.
- Board will review any public comments received.
 - If there are substantive changes, the Board must republish the proposed regulation with the changes, which resets the public comment period to 30 days.
 - If there are no substantive changes, the Board can submit their final regulation for publication (process continues below).
- Submit the final regulation by the 15th of the month after the close of public comment
- Final regulation and Order are published in the Register of Regulations on the 1st of the following month
- Regulation effective 10 days after publication (unless delayed effective date)
- Adopted regulation updated in the Administrative Code after the 11th of the month or delayed effective date

Source: Delaware Administrative Procedures Act: The Regulatory Process. Training for State Agencies Submitting regulations for publication in the *Register of Regulations*. Office of the Register of Regulations. 2024



Review Draft Guidance for Hospital Information Submissions

Annual Guidance Overview

The guidance is designed to inform hospitals of exactly what information the DSHCRB will be collecting each year, applicable standards and definitions, and prescribes certain formats for the information.

In the initial year, the idea is to keep the submission as straightforward as possible. Since the treatment of Benchmark Compliance Plans has been deferred to future rulemaking, the first cycle will help introduce the Board to the material available and how it compares with the Spending Benchmark.

The comparison will depend on the hospital’s fiscal year:

Fiscal Year End	Spending Benchmark	Calculation
December 31, 2025	4.2%	n/a
June 30, 2026	4.55%	Average of 4.2% and 4.9%

Types of Exhibits

There are 2 main types of exhibits envisioned in the draft guidance:

- **Standard exhibits** mean a requirement to submit the most recent version of materials already prepared for existing filings and
- **DSHCRB exhibits** mean completing a set of templates developed for use in the filing.

Standard

1. Audited Financial Statement (AFS) (including consolidating statements)
2. *AFS Explanatory Statement (optional)*
3. Letters accompanying the AFS (e.g., management letters)
4. Hospital Price Transparency file (per CMS standards)
5. IRS Form 990 series
6. Medicare Hospital Cost Report

DSHCRB

7. Narrative
8. Standardized AFS
9. Utilization summary
10. Revenue summary
11. *Redaction statement and proposed public version of submission with proposed redactions (optional)*
12. Certification

Public Posting of Exhibits

For any information that is public because it falls within the three categories of information listed at §9958(b)(2), hospitals may request withholding of information by utilizing process at draft regulation 6.2. Specifically, hospitals should submit the brief statement along with the redacted/unredacted versions. The redaction statement must simply identify the reason for the exclusion asserted.

§9958(b)(2) lists:

1. Original and modified budgets (none required under the regulation)
2. Spending and revenue data
3. Utilization information

For the information submitted in the initial cycle all exhibits would be considered public records **except the letters accompanying the AFS (exhibit 3), which are not considered public records and therefore would not be posted.**

If there are exhibits or elements of the remaining exhibits that fulfill a FOIA exemption under 29 Del.C. §10002(o), filers may submit a redacted and unredacted version. A brief statement asserting the basis of the redaction must then be completed (exhibit 11), which would be included in the postings.

DSHCRB Exhibit Overview

Exhibit	Description
7. Narrative	A set of standard questions to allow hospitals to provide context to their information and provides the Board an avenue for specific inquiry.
8. Standardized AFS	Provides a more apples-to-apples comparison of AFS information in a common format.
9. Utilization summary	Provides summary statistics for inpatient, outpatient, emergency, surgical, and maternal care by payer subtype.
10. Revenue summary	Provides summary of distribution of charges by payer subtype with total reconciliation to net patient revenue.
11. Redaction statement with proposed public version of submission (optional)	Optional summary of material redacted with assertion of relevant exemption for public posting, along with the proposed public version of the submission that includes the hospital's proposed redactions.
12. Certification	Attestation that the information provided is accurate and legally compliant.



Narrative (1 of 2)

The draft guidance includes 6 questions:

1. What material information is important for the Board to consider when reviewing your Audited Financial Statement? Examples include one-time or other non-recurring events, service line changes, changes to key personnel, or financial restructuring.
2. Were there any material changes in the restatement of the prior-year figures? If so, explain why.
3. Summarize the top expenses affecting hospital operations in Delaware and any measures that have been taken to address or otherwise mitigate them.
 - a) Describe the primary drivers of pharmaceutical expenses and the specific strategies used to manage or mitigate these costs (e.g., formulary management, biosimilar adoption, group purchasing arrangements, 340B utilization, or site-of-care optimization).



Narrative (2 of 2)

4. Summarize the hospital's investments in workforce development initiatives, including the objective(s) associated with the investments.
5. Explain how the hospital approaches establishing and monitoring employee compensation, including any benchmarking techniques.
6. Explain how the hospital approaches establishing and monitoring its prices for medical services, including any benchmarking techniques.

Standardized AFS: Balance Sheet

ASSETS			LIABILITIES		
Current Assets			Current Liabilities		
Cash and investments	\$	-	Current portion of long-term debt and finance lease liability	\$	-
Current assets - limited use	\$	-	Current portion of operating lease liability	\$	-
Net patient accounts receivable	\$	-	Accounts payable and other accrued liabilities	\$	-
Current assets with donor restrictions	\$	-	Accrued payroll, payroll taxes and amounts withheld	\$	-
Other current assets	\$	-	Other current liabilities	\$	-
Total Current Assets - Fill from Balance Sheet	\$	-	Total Current Liabilities - Fill from Balance Sheet	\$	-
Non-Current Assets			Non-Current Liabilities		
Board designated and undesignated investments	\$	-	Long-term debt and finance lease liability, less current portion	\$	-
Trustee-held assets	\$	-	Long-term operating lease liability, less current portion	\$	-
Property, plant, and equipment - net	\$	-	Accrued retirement benefits	\$	-
Right of use assets	\$	-	Self-insurance reserves, less current portion	\$	-
Assets with donor restrictions	\$	-	Other liabilities	\$	-
Other non-current assets	\$	-	Total Liabilities - Fill from Balance Sheet	\$	-
Total Assets - Fill from Balance Sheet	\$	-			
EQUITY (Net Assets)					
Donor-restricted	\$	-			
Unrestricted	\$	-			
Total Liabilities and Net Assets - Fill from Balance Sheet	\$	-			

Standardized AFS: Income Statement

Operating Revenue

Net patient service revenue	\$	-
Research revenue	\$	-
Other revenue	\$	-
Total Operating Revenue - Fill from Income Statement	\$	-

Operating Expenses

Income Taxes	\$	-
Interest	\$	-
Depreciation and amortization	\$	-
Employee Salaries and Benefits	\$	-
Supplies	\$	-
Other operating expenses	\$	-
Total Operating Expenses - Fill from Income Statement	\$	-
(Loss) Income From Operations	\$	-

Non-Operating Gains (Losses)

Unrestricted gifts and donations - net of related expenses	\$	-
Realized gains (losses) on investments	\$	-
Unrealized gains (losses) on investments	\$	-
Pension-related expenses	\$	-
Other	\$	-
Total Non-Operating Gains (Losses) - Fill from Income Statement	\$	-
(Deficiency) Excess of Revenue and Nonoperating - Fill from Income Statement	\$	-

Changes in net assets without donor restrictions

Net assets released from restriction for PPE	\$	-
Pension-related changes in net assests	\$	-
Transfers to other entities	\$	-
Dividend payment	\$	-
Other changes in net assets without donor restrictions	\$	-
(Decrease) Increase in Net Assets without Donor Restrictions - Fill from Income Statement	\$	-

Standardized AFS: Cash Flow Statement and Footnotes

Accumulated depreciation and amortization	\$	-
Capital expenditure (purchases of property plant and equipment)	\$	-
Non-Recurring Revenue or Financial Assistance	\$	-
Non-Recurring Operating Expenses	\$	-

Utilization Summary

Requests an all-payer measure of the hospitals **case mix index** to get a sense of the resource intensity of the care provided. For example, the removal of a skin tag requires fewer resources than an organ transplant.

Utilization for the following services is requested by payer subtype: Medicare Fee-for-Service (FFS), Medicare Advantage, Medicaid FFS, Medicaid Managed Care, Commercial, Self-Pay, and Other:

Unit of measurement	Type of services	
Inpatient discharges and days	- Acute (Medical / Surgical) - Psychiatric Distinct-Part Unit	- Rehabilitation Distinct-Part Unit - Skilled Nursing Subprovider
Outpatient and Emergency	- Outpatient Visits (excluding ED) - Emergency Department Visits <i>subset resulting in admission</i>	Observation Cases
Surgical cases	- Inpatient - Outpatient	
Obstetric	Deliveries	
Newborn	Newborn / nursery discharges	

Revenue summary

Requests a summary of *charges* by payer subtype: Medicare Fee-for-Service (FFS), Medicare Advantage, Medicaid FFS, Medicaid Managed Care, Commercial, Self-Pay, and Other for the following cost centers:

- Inpatient routine
- Ancillary
- Outpatient service
- Other reimbursable
- Special purpose
- *TOTAL* net patient revenue

The second section requests a total step down from charges to net patient revenue:

Total Gross Patient Revenue	
Less: Contractual Adjustments	
Less: Charity Care	
Less: Implicit Price Concessions	
Net Charge-Based Patient Revenue	
Add / (Less): Capitation and Risk-Based Revenue	
Add / (Less): Value-Based and Incentive Payments	
Net Patient Revenue (reconciled)	

Redaction statement

Hospitals may request withholding of information that is otherwise public under the statute: spending and revenue data, utilization information. To do so, hospitals must submit a redaction statement briefly asserting the reason for the proposed withholding, along with a copy of the proposed public version of the submission.

This statement serves to identify proposed redactions in the submissions, including the asserted basis for each redaction. The statement must include:

- 1. a general description of the information;
- 2. the document(s) where the information appears; and
- 3. the asserted basis for withholding, with a brief explanation of why the information falls within that provision.

Redactions of the same type may be addressed together; a line-by-line discussion of individual redactions is not required.

Attach the public version of each redacted submission with proposed redactions for public posting.

A. List of proposed redacted submissions (add additional rows as needed):

Count	Proposed Public Submission File Name
1	Example-Document-Name.pdf
2	

B. Redaction statement:

Provide the statement here, addressing elements 1 - 3 above. Use as much space as is needed.



Certification

The certification is a simple attestation by an appropriate representative of the hospital:

I hereby certify, to the best of my knowledge, information, and belief, that the information submitted herewith is accurate, complete, and truthful.

I understand that this information will be used for purposes of compliance with the duties of the Diamond State Hospital Cost Review Board and any deliberate omission, misrepresentation, or falsification of this data may subject the facility and/or the signatory to legal, regulatory, or financial penalties under applicable law.



Potential Vote to Post Guidance on DSHCRB Website



Health Care Finance Background

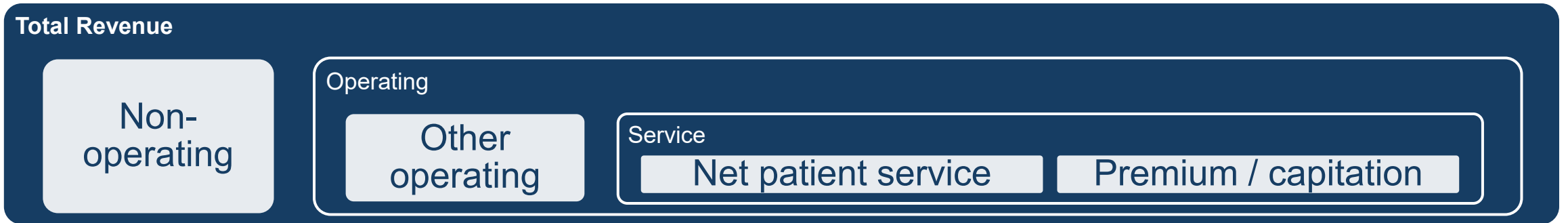
Public Financial Information

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

Today's focus: **Audited Financial Statements**

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

Revenue Categories in Health Care Finance



Total revenue for a health care provider includes:

- **Net patient service revenue (NPSR or NPR)**, which is collected from insurers and patients for the care delivered and represents the bulk of revenue.
- **Other operating revenue**, which is collected from services supporting direct care, such as parking fees or cafeteria sales.
- **Non-operating revenue**, which is related to investments and other financial activity not directly supporting patient care.

Patient Service Revenue

Gross Patient Service Revenue (GPR or GPSR)

Full **charges** billed, which are the same for all payers.

LESS

Contractual allowances

Negotiated price between payer and provider or **allowed amount**.

LESS

Charity care

Services or parts of provided without cost to patient “written off.”

LESS

Implicit price concessions

Amounts owed to the provider that are not expected to be collected.

EQUALS

Net Patient Service Revenue
(NPR or NPSR)

The amount the provider expects to collect after adjustments, often ranging from 25 to 40% of GPSR.

Revenue and Expense Categories in Health Care Finance

	Revenue	Expense
Operating	Net Patient Service	Salaries and benefits
	Premium / capitation	Supplies and drugs
	Other operating	Purchased services
		Depreciation and amortization
		Interest
		Other operating
Non-operating items	Net investment return (realized and unrealized)	
	Philanthropy / contributions	
	Equity method earnings	
	Gain / loss on debt extinguishment	
	Other non-operating	

Above the line operating revenue and expenses associated with the health care business

Below the line non-operating items related to financing, investing, and other non-core activities



Introduction to Hospital Audited Financial Statements

Components of Audited Financial Statements

Balance sheet		• Point in time snapshot of assets, liabilities, and fund balance (or equity)
Income statement		• Annual summary of revenues, expenses, and profit / loss
Cash flow		• Tracks cash and cash equivalents moving in and out over the year
Notes		• Disclosures and explanations to provide context for how numbers were derived (e.g., accounting methods, debt)
Letters		• Includes the independent auditor's opinion as to the accuracy and compliance with generally accepted accounting principles, as well as letter to management and those charged with governance

Domains of Financial Analysis

Profitability

Does an organization cover its costs? Indicators are comparisons of revenue and expense based on operations and for the whole organization.

Liquidity

Is the organization able to pay its bills? How much money does it have on hand and how quickly does it collect revenue?

Solvency & Debt Capacity

How much debt is an organization carrying and how well can it fulfill those obligations, in the short and longer term?

Capital Investment

Is there evidence of adequate reinvestment to maintain equipment and facilities?

Cash Flow

How is real cash moving? How do reported earnings compare with those generated from operations?

Additional Domains of Financial Analysis

These additional metrics can be reviewed in part through Audited Financial Statements. However, additional data sources provide important context, namely more detailed information about how much and what types of services are being provided, as well as the staff who are providing the services.

These additional domains will be revisited in connection with Medicare Cost Reports and IRS 990 data.

Efficiency

How well does an organization use its assets and labor?

Growth

How are revenue, market share, and volume changing over time?

Payer Mix

Which types of payers does the organization tend to serve?

Overview of Delaware Hospital Entities

Entity	FY25 operating revenue (% of total)	Parent (if different)	Notes
Christiana Care Health Services	\$3,106.6 M (50%)	ChristianaCare	~94% of parent; ~\$2.3 B in investments were transferred to parent in FY25
Bayhealth	\$1,109.1 M (18%)		
Nemours (DE)	\$942.0 M (15%)	Nemours Foundation	Endowed by the duPont trust; calculations adjusted to move investment returns below the line to match other entities
Beebe	\$682.3 M (11%)		
Nanticoke Memorial	\$241.0 M (4%)	TidalHealth	~20% of TidalHealth
St. Francis	\$119.0 M (2%)	Trinity Health Mid-Atlantic (THMA)	~12% of THMA; limited information available for Delaware, as THMA is a regional slice of Trinity's ~\$24 B national system
TOTAL	\$6,200.0 M (100%)		

Overview: Rating Criteria

[S&P Global publishes its framework for assigning ratings to U.S. and Canadian Not-For-Profit Acute Care Health Care Organizations](#) based on their methodology for assessing creditworthiness for potential lenders.

No one factor determines the entire rating, which blends enterprise risk and financial risk into a final rating, ranging from aaa to b-. Factors include complex blends of qualitative and quantitative inputs with dozens of underlying measures.

For the underlying measures, S&P classifies results into 6 tiers, which are used in the subsequent analysis. **The tiers do not reflect financial condition.**

S&P Global Tier	Numeric Assessment Levels
Strong	1, 2, 3
Adequate	4
TBD*	5, 6

* Terminology adaptation under development

Parent vs Delaware Entity Considerations

- **Delaware entities** may be reviewed for high-level **operational results**.
 - All 4 hospitals with corporate parents show **stronger average operating margins in Delaware** as compared with the parent entity.
 - Nemours Delaware raw operating results would show losses without endowment. Since it is contracted to be a permanent and recurring it is included as operating income (but investment returns are reapportioned below the line to match the other systems).
- **Solvency** and **capital capacity** are best measured at the **parent level**.
 - These Delaware entities send cash to the parent entity, which is also where debt is generally held.
 - This means the Delaware entities are operationally healthy, but financially reliant on funding from the parent organization.
 - The share of parent entity associated with Delaware varies among organizations ranging from Christiana Care Health Services representing nearly all of ChristianaCare's operating revenue to St. Francis's tiny share of Trinity Health.

Key Takeaways

- Average operating margins vary from TBD (Beebe, Nanticoke) to strong (Bayhealth, Nemours) with ChristianaCare Health Services the only entity showing an adequate average result.
- Balance sheets are strong, collectively showing ~9 months of operating expenses in cash and unrestricted investments (269 days). Reserves cover long-term debt about 3.5 times over and there is relatively little reliance on debt (16% of capitalization) suggesting recent operating losses are being absorbed by reserves.
- In aggregate, operating margins were stronger in FY24 and FY25 (6.5% and 4.9%), but recovery is uneven with 2 entities in the red in FY25 (St. Francis at -4.3% and Beebe at -3.6%) and only 2 showing strong averages over the 4 years (Bayhealth at 2.8% and Nemours DE at 19.6%).
- Capital reinvestment is emerging as a factor with capital spending relatively low (~103% vs 105-115% benchmark). Coupled with an increasing average age of plant (growing from 12.2 to 15.5 years from FY22 to FY25), deferred investment may help explain the strength of balance sheets.
 - ChristianaCare and TidalHealth show increased capital spending in FY25 (136% and 164%), which may indicate early signs of systemwide reinvestment.



Notable One-Time transactions

- These non-recurring transactions will distort some financial calculations:
 - Bayhealth (FY25): + \$40 M (inpatient rehabilitation operations sale recognized)
 - TidalHealth (FY25): + \$59 M (Atlantic General Hospital acquisition)
 - THMA (FY22): + \$117 M (sale of stake in Gateway Health Plan L.P.)

Overview of Health System Financial Position

Health System	Performance Summary	Profitability	Liquidity	Solvency & debt	Capital Investment
Bayhealth	Healthiest stand-alone hospital in every domain.	Strong	Strong	Strong	Adequate
Beebe	Thinnest cushion of stand-alone hospitals with recovery of reserves lagging in comparison with other hospitals.	TBD	Adequate	TBD	Adequate
ChristianaCare	Strong reserves and assets with modest operating profit. Signs of delayed capital investment (oldest age of plant). Reinvestment appears to have begun in FY25. Delaware operations are slightly stronger than the system.	Strong	Strong	Strong	Adequate
Nemours	Strongest system, but results are driven by endowment – patient care operates at ~ -5%.	Strong	Strong	Strong	Adequate
TidalHealth	Nanticoke Memorial shows improving profitability (-6.8% in FY23 to 3.6% in FY25). System shows recent operating losses and lower debt coverage.	TBD	Adequate	TBD	TBD
Trinity Health Mid-Atlantic (THMA)	Part of a large national system with limited information about Delaware operations. Exhibits least strong system profitability.	TBD	Unknown		

Profitability Measures

How well does the organization cover its costs?

Organizations require some profit to replace equipment and absorb shocks.

Two measures are highlighted:

- **Operating margin:** revenue and expenses associated with patient care and supporting functions. [S&P Global](#) assesses an adequate system margin as 0.5 to 2.0% (1.0 to 2.5% for stand-alone hospitals).
- **EBIDA total margin:** complete accounting of revenue and expense, including investment earnings. System adequacy is assessed as 8.5 to 10.0% (10.5 to 12.0% for stand-alone hospitals).

The gap between the measures assesses how much an organization depends on its investment portfolio rather than its core business.

EBIDA stands for Earnings Before Interest, Depreciation, and Amortization which makes profits more apples-to-apples by adjusting for non-cash accounting expenses. Since all organizations are not-for-profit, this measure is equivalent to EBITDA, which also adds taxes back into earnings.

Profitability Results: Operating margin (%)

- In aggregate margins appear **strong**, largely due to the influence of Nemours and Bayhealth.
- Delaware entities consistently show stronger operating results than parent organizations.

System	4-year average	Tier ¹	FY25
Overall – DE entities consolidated	4.3 <i>1.4</i>	Strong	4.9 <i>1.9</i>
Nemours DE consolidated ²	19.6 <i>8.0</i>	Strong	21.4 <i>8.0</i>
Bayhealth	2.8	Strong	5.1
CC Health Services consolidated	1.9 <i>0.9</i>	Adequate	2.2 <i>1.1</i>
St. Francis consolidated	0.6 <i>-5.5</i>	TBD	-4.3 <i>-4.7</i>
Nanticoke Memorial ³ consolidated	-1.2 <i>-4.6</i>	TBD	3.6 <i>-3.4</i>
Beebe	-1.2	TBD	-3.6

¹Assessment based on [S&P Global criteria](#); ²Reclassifies reported investment returns as non-operating revenue; ³3-year average due to missing FY22 information

Profitability Results: EBIDA margin (%)

- In aggregate Earnings Before Interest Depreciation and Amortization (EBIDA) margins are on the upper range of TBD. However, the 4-year average is affected by substantial investment losses in FY22. As a result, FY25 may provide a better picture of financial position (strong).
- Results for Bayhealth (FY25), TidalHealth (FY25), and THMA (FY22) include significant one-time gains.

System	4-year average	Tier ¹	FY25
Overall	8.4	TBD	11.3
Nemours ²	14.5	Strong	13.9
Bayhealth	10.7	Adequate	20.1
ChristianaCare	7.3	TBD	10.8
Beebe	6.5	TBD	5.6
TidalHealth	3.4	TBD	11.1
THMA	1.8	TBD	1.0

¹Assessment based on [S&P Global criteria](#); ²Reclassifies reported investment returns as non-operating revenue

Liquidity Measures

How long could the organization pay its bills with cash on hand?

This domain looks at how much “cushion” an organization has at its disposal.

Two measures are highlighted:

- **Days Cash on Hand (DCOH):** estimates how many days the organization could operate without additional revenue, with adequacy assessed as adequate at 100 to 150 days for hospital systems (110 to 160 days for stand-alone hospitals) by S&P Global.
- **Unrestricted reserves to long-term debt:** measures if a hospital could repay its debt from reserves with systems deemed adequate at 80 to 100% (85 to 120 for stand-alone hospitals).

Liquidity Results: Days Cash on Hand (# days)

- Systems operating in Delaware almost all demonstrate **strong** DCOH with consistent results over time.
- Beebe shows the lowest relative amount of cash on hand with more variability over time. The 4-year average is influenced by a relatively higher result in FY22 (164 DCOH). Without that observation the average would be 117 days.
- THMA results could not be calculated as their condensed statements do not include a balance sheet.

System	4-year average	Tier ¹	FY25
Overall	269	Strong	270
ChristianaCare	350	Strong	351
Bayhealth	348	Strong	369
TidalHealth	218	Strong	213
Nemours ²	181	Strong	189
Beebe	129	Adequate	111

¹ Assessment based on [S&P Global criteria](#); ² Reclassifies reported investment returns as non-operating revenue

Liquidity Results: Unrestricted reserves to long-term debt (%)

- The strong cash position translates to **strong** reserves when compared with long-term debt.
- Most hospitals show reserves growing more steadily than debt, whereas Beebe shows a flatter trajectory despite proportionate borrowing reflecting its more modest cash position relative to peers.
- THMA results could not be calculated as their condensed statements do not include a balance sheet.

System	4-year average	Tier ¹	FY25
Overall	354	Strong	413
ChristianaCare	604	Strong	706
Nemours ²	310	Strong	401
Bayhealth	302	Strong	370
TidalHealth	216	Strong	216
Beebe	104	Adequate	103

¹ Assessment based on [S&P Global criteria](#); ² Reclassifies reported investment returns as non-operating revenue

Solvency & Debt Capacity Measures

How reliant is the organization on debt and how capable is it to make the associated payments?

This domain looks at 2 related indicators to see how much of an organization's funding comes from borrowing and its ability to pay back the loans based on operating profit.

Two measures are highlighted:

- **Long-term debt to capitalization (LTD/Cap):** shows the share of debt to net worth with lower reliance on debt consider more favorable. [S&P Global](#) assesses an adequate value in the range of 45-55% (42-50% for stand-alone hospitals).
- **Debt service coverage (DSC):** compares EBIDA with annual debt payments. For this measure, [Milbank](#) summarizes 3-4x EBIDA to debt as typical per Moody's and Fitch.

Solvency & Debt Capacity Results: LTD to Cap (%)

- Systems operating in Delaware all demonstrate **strong** lack of reliance on debt. This means that most are not highly leveraged and have capacity to borrow, if necessary. Beebe is nearing the adequate assessment threshold (42% for stand-alone hospitals).
- THMA results could not be calculated as their condensed statements do not include a balance sheet.

System	4-year average	Tier ¹	FY25
Overall	16.4	Strong	14.1
ChristianaCare	11.6	Strong	9.9
Nemours ²	14.2	Strong	11.2
TidalHealth	25.9	Strong	25.2
Beebe	37.2	Strong	35.3

¹ Assessment based on [S&P Global criteria](#); ² Reclassifies reported investment returns as non-operating revenue

Solvency & Debt Capacity Results: DSC (factor of debt)

- Systems operating in Delaware in aggregate demonstrate **strong** Debt Service Coverage (DSC) ratios, with all but one strong in FY25. Beebe and TidalHealth show lower average DSC for the period due to lower operating margins (and more relative borrowing).
- THMA results could not be calculated as their condensed statements do not include a balance sheet.

	4-year average	Tier ¹	FY25
Overall	6.5x	Strong	6.8x
Nemours ²	11.9x	Strong	11.9x
ChristianaCare	8.3x	Strong	7.0x
Bayhealth	5.8x	Strong	7.0x
Beebe ³	1.6x	Adequate	7.0x
TidalHealth ³	0.9x	Adequate	0.6x

¹Assessment based on [S&P Global criteria](#); ²Reclassifies reported investment returns as non-operating revenue; ³ Only 3 years of data available

Capital Investment Measures

How well are organizations maintaining equipment and buildings?

Purchasing, building, or upgrading physical assets and equipment help ensure hospitals maintain safe, effective treatment options. Continuing reinvestment and preventative maintenance can be less costly than urgent or emergent repairs.

Two measures are highlighted:

- **Capital expenditures to depreciation (CapEx/Dep):** compares what a hospital invests each year with the amount of value its assets have lost over the same time. [S&P Global](#) assesses an adequate value of 90 to 110% (100 to 120% for stand-alone hospitals).
- **Average age of plant:** measures how dated facilities are by comparing how much value assets have lost in their life to date with how much value they lose each year. S&P Global assesses an adequate age of plant as 11.5 to 12.5 years (11 to 12 years for a stand-alone hospital).

Capital Investment Results: CapEx / Dep (%)

- In aggregate, systems operating in Delaware demonstrate **strong** investment influenced by high ratios by Beebe in FY22 and Nemours every year. Note that Nemours investments are systemwide with lack of specificity about what projects are occurring in Delaware. Most hospitals show increases in capital investment in FY25. Beebe's latest expansion is underway and expected to increase their ratio in FY26.
- THMA results could not be calculated as their condensed statements did not include a balance sheet nor statement of cash flow.

System	4-year average	Tier ¹	FY25
Overall	114	Strong	152
Nemours ²	144	Strong	226
Beebe	135	Strong	94
ChristianaCare	98	Adequate	136
TidalHealth	90	Adequate	164

¹Assessment based on [S&P Global criteria](#); ²Reclassifies reported investment returns as non-operating revenue

Capital Investment Results: Average Age of Plant (years)

- In aggregate, systems operating in Delaware showed TBD ratings in average age of plant. Three of the hospitals were adequate or better on average. Both Nemours and ChristianaCare showed significant upticks in FY25 due to fully depreciated assets and asset retirement. Most organizations are showing increased capital spending in FY25, but construction in progress will not be visible in this measure until the new assets go into service.
- THMA results could not be calculated as their condensed statements do not include a statement of cash flow.

System	4-year average	Tier ¹	FY25
Overall	13.4	TBD	15.5
Bayhealth	10.1	Strong	11.4
Beebe	11.5	Adequate	12.0
Nemours ²	12.4	Adequate	14.3
TidalHealth	14.1	TBD	16.9
ChristianaCare	15.9	TBD	19.1

¹Assessment based on [S&P Global criteria](#); ²Reclassifies reported investment returns as non-operating revenue

Thank you.

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