

GEORGIA STATE OFFICE OF RURAL HEALTH
AN OFFICE OF GEORGIA DEPARTMENT OF COMMUNITY HEALTH



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Executive Summary Critical Access Hospital Financial Analyses

2011

Charles F. Owens
Executive Director

Patsy Whaley
Director

Brittany S. Brown
Program Specialist

Analysis Performed by:
Draffin and Tucker, LLP



Funded by the Medicare Rural Hospital Flexibility Grant C7DA: 93.241

502 SOUTH 7TH STREET CORDELE, GA 31015

Table of Contents

PROCEDURES.....	3
GENERAL CHARACTERISTICS.....	3
Table 1: CAHs Characteristics.....	4
PROFITABILITY	5
Figure 2: Operating Margin	6
LIQUIDITY	7
Figure 3: Return on Equity.....	7
Figure 4: Days Cash on Hand	8
Figure 5: Current Ratio	9
Figure 6: Net Days Revenue in Accounts Receivable	10
CAPITAL STRUCTURE	10
Figure 7: Long-Term Debt to Capitalization	11
REVENUE INDICATORS.....	13
Figure 8: Debt Service Coverage	12
Figure 9: Patient Days Percentage by Payer	13
Figure 10: Outpatient Revenues to Total Revenue	14
Figure 11: Medicare Acute Days as Percentage of Total Days.....	15
Figure 12: Average Salaries per FTEs	16
Figure 13: FTE’s per Average Daily Census	17
Figure 14: Average Age of Plant	18
UTILIZATION	18
Figure 15: Average Daily Census	19
Figure 16: Average Length of Stay (Swing Bed and Acute Beds)	20
CONCLUSION.....	21
Table 2: 2009 Median Indicator Values for Georgia and the United States	22
Appendix.....	22
DATA SOURCES	23
2009 Almanac of Hospital Financial and Operating Indicators published by Ingenix	24

Summary of Findings

PROCEDURES

The Georgia Department of Community Health (DCH), State Office of Rural Health (SORH) contracted with Draffin & Tucker CPAs LLP to perform analyses on the fiscal sustainability of critical access hospitals (CAHs) in Georgia. An on-site visit was made to each of the 32 participating CAHs to assess their financial health. The latest (2007) audited financial statements, statistics, and Medicare cost reports, as well as interviews with key management personnel, were analyzed. The data was collected and analyzed across six CAH financial indicator dimensions. These dimensions as suggested by the Flex Monitoring Team include: profitability, liquidity, capital structure, revenue, expenses, and utilization.¹ Financial data from each hospital was then compiled to present comparative financial information. The financial analyses were performed in three phases between 2007-2009. Eleven hospitals were evaluated in 2007 and in 2008, and the remaining 10 in 2009.

This report provides a summary of the comparative financial findings of the participating CAHS. CAHs are identified in

this report by a unique alpha character to maintain facility confidentiality.²

GENERAL CHARACTERISTICS

According to George Pink et al, “Significant differences in financial performance and condition exist among CAH peer groups.”³ Variations exist in the types and number of services provided by CAHs across the country.¹ This fact is believed to contribute to the variability in facility revenue and fiscal sustainability among CAHs.

Georgia’s CAHs mirror the operational trend of the CAHs throughout the nation in that they do not conform to a universal operating model. The 32 Georgia CAHs can be characterized by several factors, including but not limited to ownership and management type, system affiliation, and the diversification of services provided.

Research and data suggests that diversification of the services provides an additional source of revenue¹. Thirty-one of the 32 Georgia CAHs operated swing bed programs; however, the utilization of these programs varied greatly by hospital. More than half (59 percent) of the

¹ Pink, G. H., Holmes, G. M., D’Alpe, C., Strunk, L. A., McGee, P. and Slifkin, R. T. (2006), Financial Indicators for Critical Access Hospitals. *The Journal of Rural Health*, 22: 229–236.

² Draffin & Tucker, LLP June 2010 “Critical Access Hospital Financial Analyses-2008-2009”

³ Pink, G. H., Holmes, G. M., Thompson, R.E., Slifkin, R.T. (2007) Variations in Financial Performance Among Peer Groups of Critical Access Hospitals. *Journal of Rural Health*, 23(4), 299-305

hospitals also operated skilled nursing facilities and/or rural health clinics. Six of the 32 CAHs operated Emergency Medical Services (EMS) and 29 percent operated physician practices.

The ownership and management types of the 32 CAHs included those hospitals that are independent hospital authorities and

those managed or owned by larger tertiary care facilities or private corporations. The classification of the 32 Georgia CAHs are as follows:

- 50 percent (16/32) independent hospital authorities
- 38 percent (12/32) owned/leased
- 9 percent (3/32) affiliated
- 3 percent (1/32) other

Table 1: CAHs Characteristics

CAHs	Swing Bed	Rural Health Clinic	Emergency Medical Services	Skilled Nursing Facility	Physician Practice	Other
Bacon County Hospital	✓	✓		✓	✓	
Effingham Hospital	✓			✓	✓	
Morgan Memorial Hospital	✓			✓		
Peach Regional Medical Center	✓				✓	
Putnam General Hospital	✓					
Calhoun Memorial Hospital	✓	✓	✓	✓		✓
Jeff Davis Hospital						
Monroe County Hospital	✓					
Warms Spring Medical Center	✓			✓		
Miller County Hospital	✓	✓		✓		
Jenkins Memorial Hospital	✓	✓				
Candler County Hospital	✓					
Liberty Regional Medical Center	✓		✓	✓	✓	
Screven County Hospital	✓				✓	
Wills Memorial Hospital	✓					
Lower Oconee Community Hospital	✓	✓			✓	
Chatuge Regional Hospital	✓			✓	✓	
Higgins General Hospital	✓	✓				
Phoebe Worth Medical Center	✓	✓				
Bleckley Memorial Hospital	✓					
Brooks County Hospital	✓	✓				
Charlton Memorial Hospital	✓		✓		✓	
Optim Medical Center of Tattnall	✓	✓				
Jasper Memorial Hospital	✓			✓		✓
Early Memorial Hospital	✓	✓	✓	✓		
Mitchell County Hospital	✓	✓		✓		
Mountain Lakes Medical Center	✓				✓	
St. Joseph's at East Georgia	✓					
Polk Medical Center	✓					
SW GA Regional Medical Center	✓	✓		✓	✓	
Louis Smith Memorial Hospital	✓		✓	✓		
Clinch Memorial Hospital	✓		✓			

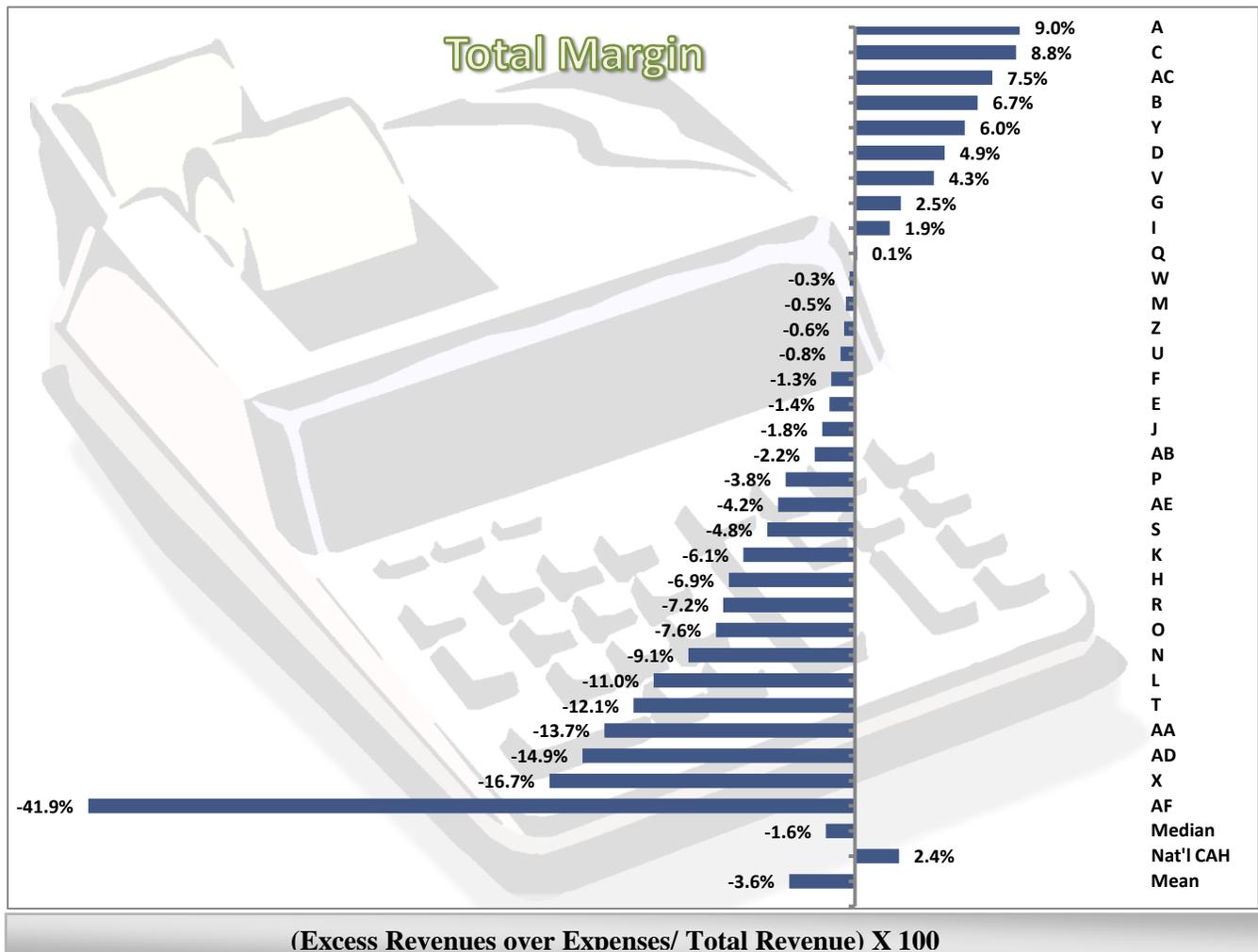
● Independent/Authority- 50% ● Affiliated - 10%
● Owned/Leased - 38% ● Other- 2%

PROFITABILITY

Although Medicare reimburses qualified CAHs at 101 percent of allowable cost, the majority of these designated facilities are struggling to breakeven. In order to determine Georgia CAHs' profitability, Total Margin, Operating Margin and Return on Equity were analyzed. According to the *Almanac of Hospital Financial & Operating Indicators*, "Total Margin defines the percentage of total revenue that has been realized in the form of net income, or excess revenues over expenses."⁴ The Operating Margin measures the revenue and costs that are

solely related to patient-care activities.

Of the 32 hospitals included in the analyses only 10 had a positive Total Margin, while only 5 had a positive Operating Margin. Sixty-nine percent (22/32) of Georgia CAHs are operating with a negative Total Margin. Georgia's median Total Margin, -1.6 percent, is significantly below the national median, 2.4 percent. Georgia CAHs' Total Margin ratios ranged from a -41.9 percent to a 9.0 percent, with the mean Total Margin of -3.6 percent.

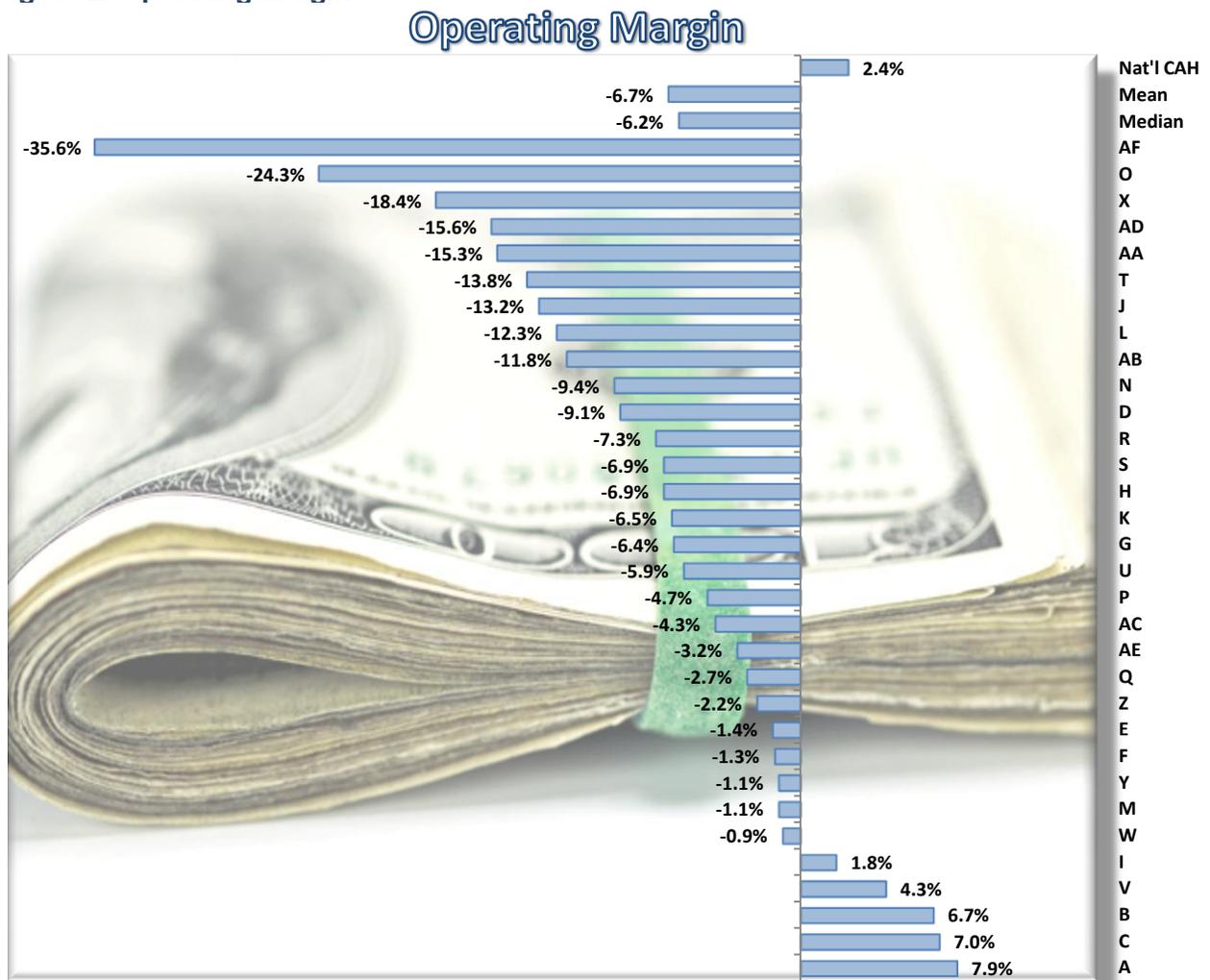


⁴ Center for Healthcare Industry Performance Studies (CHIPS), *Almanac of Hospital Financials and Operating Indicators*, 2009 ed. (Ingenix Publishing Group, 2000).

Eighty-four percent (27/32) of CAHs are operating with a negative Operating Margin. Operating Margins ranged from -35.6 percent to 7.9 percent with a median Operating Margin of -6.7 percent compared to the national median Operating Margin of 2.4 percent. These

negative margins greatly affect the ability of CAHs to generate the financial return required to replace assets, meet increases in service demands, and compensate investors. A negative Operating Margin is usually an early sign of financial difficulties.

Figure 2: Operating Margin

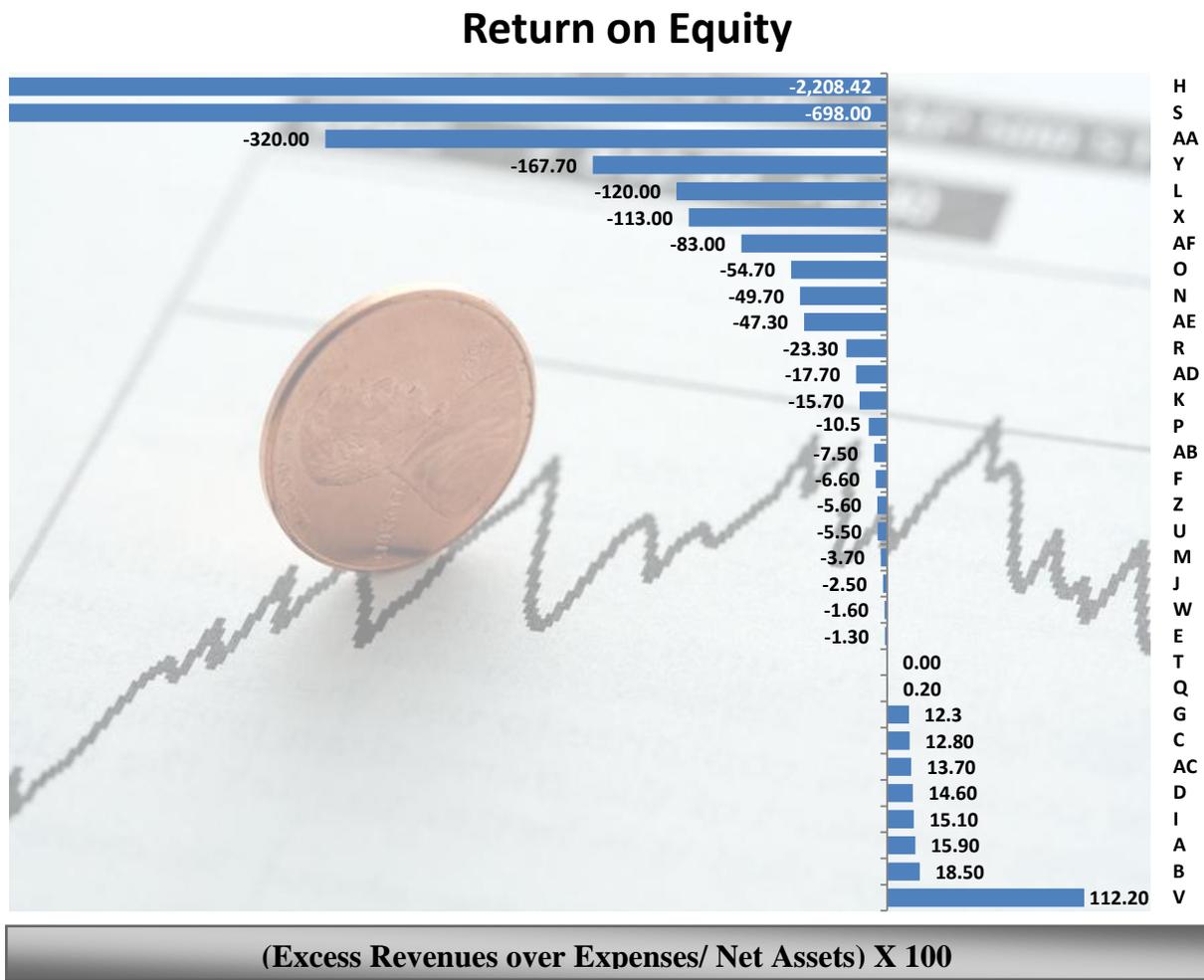


$$\frac{((\text{Operating Revenue} - \text{Total Operating Expenses}) / \text{Operating Revenue}) \times 100}{}$$

The Return on Equity ratio was used to determine Georgia CAHs' ability to add new investments in plant and equipment without adding excessive levels of new debt. Only 24 percent (8/32) of the participants experience a positive return on equity, while 75 percent (24/32) of the

participants experienced a negative return. Of those with a negative Return on Equity, 22 also experienced net losses for the fiscal year. Return on Equity ratios ranged from a low of -2,208.42 percent to a high of 112.20 percent. An increasing trend is viewed positively.

Figure 3: Return on Equity



LIQUIDITY

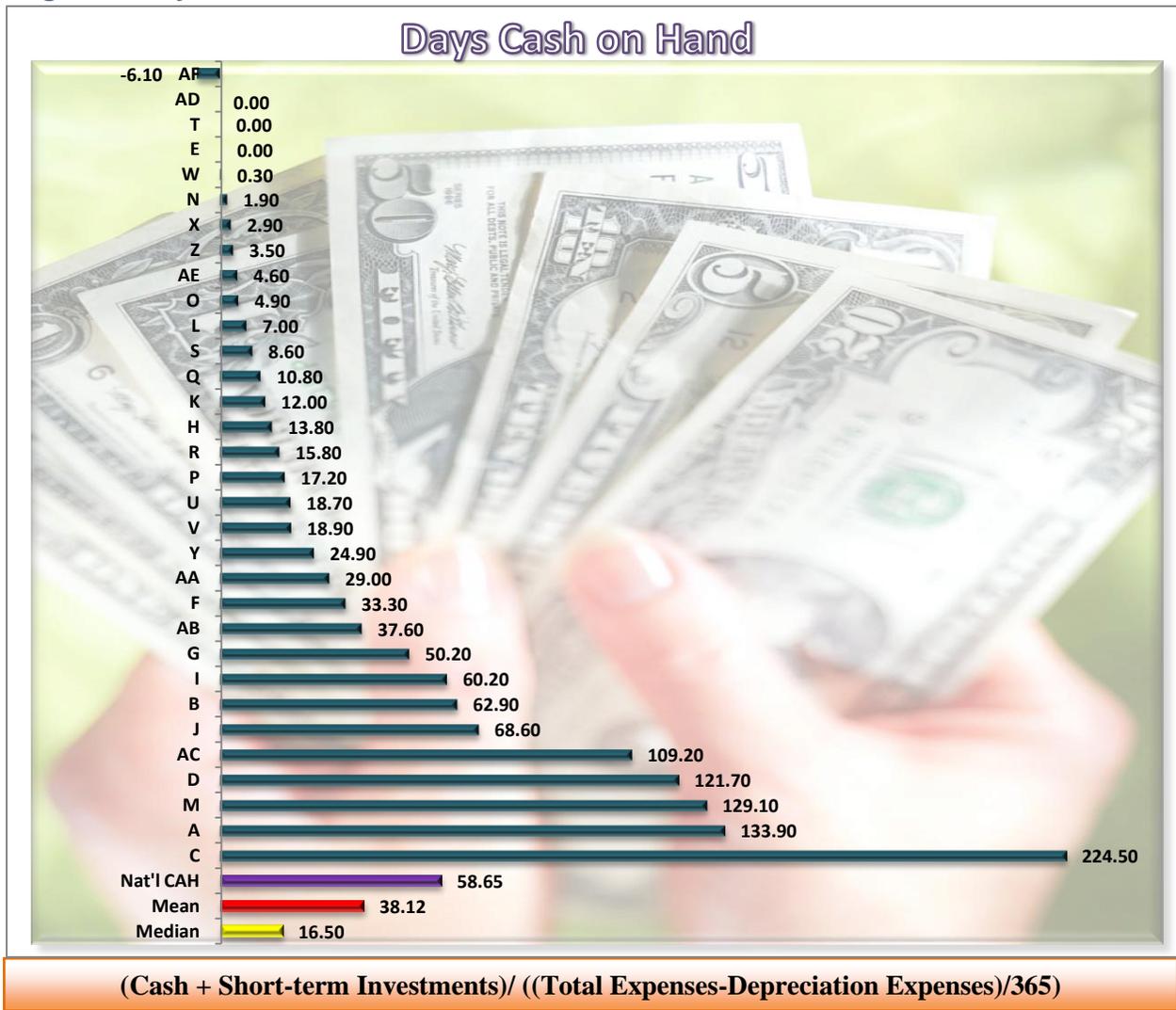
Liquidity indicators: Days Cash on Hand, Current Ratio, and Days in Accounts Receivable were analyzed to measure the ability of the 32 participating CAHs to

meet cash obligations in a timely manner and to pay off debts on a short-term basis. Medians for two of the three indicators of liquidity (Days Cash on Hand Short-Term,

and Current Ratio) were lower than the median values for the national CAHs; while the Net Average Days in Accounts Receivable was greater than the national median. The median Days Cash on Hand for Georgia CAHs was 16.50 days compared to the national median of 58.65 days. Median Days Cash on Hand ranged

from -6.10 days to 224.50 days. On average CAHs in Georgia could operate for approximately 38.12 days if no cash was collected or received. An increasing trend in Days Cash on Hand is desired in all health care organizations.

Figure 4: Days Cash on Hand



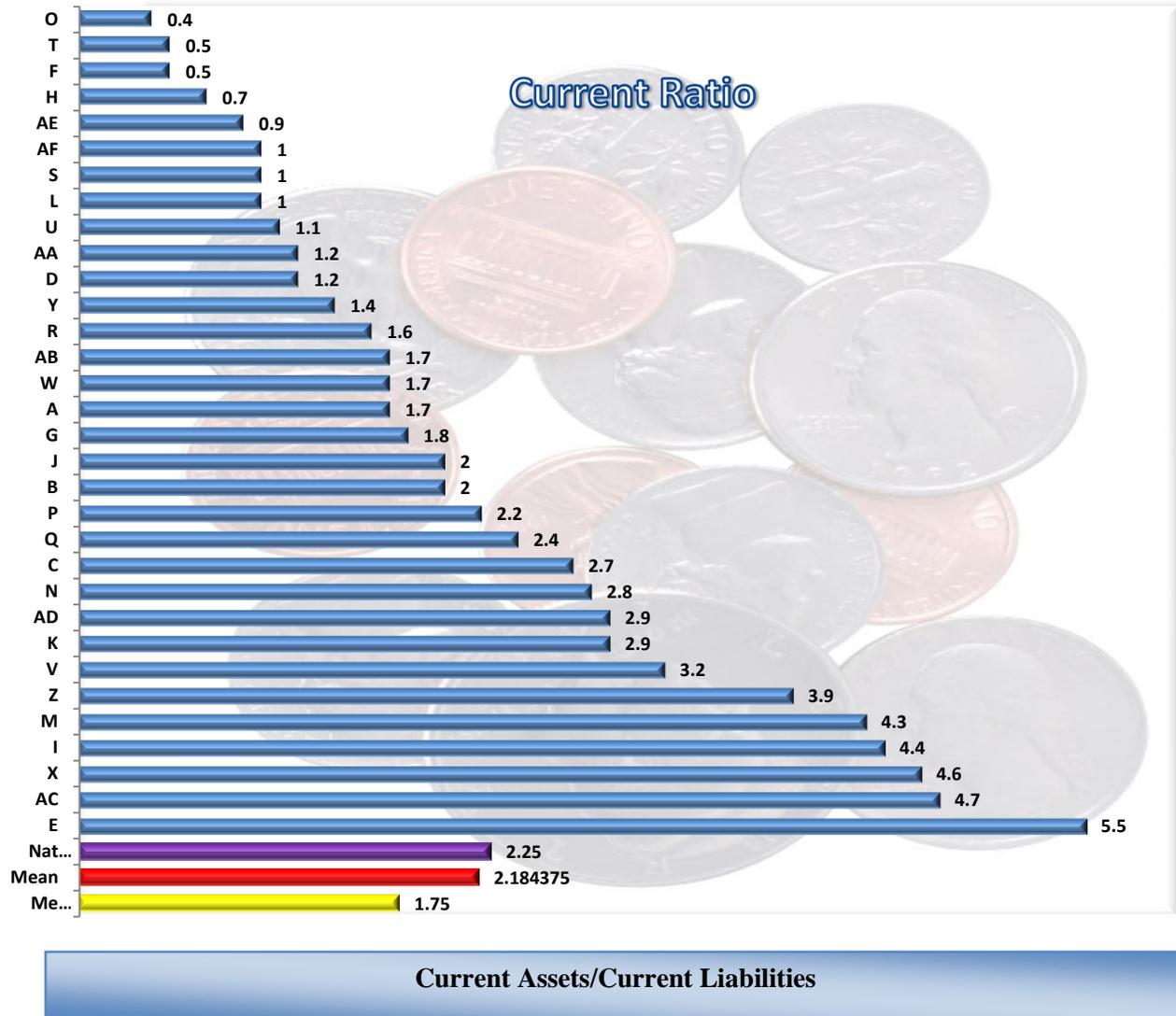
Current Ratio measures the number of times short-term obligations can be paid

using short-term assets. This is the most widely used measure of liquidity.

A higher value for the Current Ratio implies that a hospital is in a good position to pay short-term obligations; their assets are greater than their liabilities. The median Current Ratio for Georgia CAHs was 1.75 compared to the

median national Current Ratio of 2.25. There were significant variances in Current Ratio among participants. Current ratios for Georgia CAHs ranged from 0.4 to 5.5.

Figure 5: Current Ratio



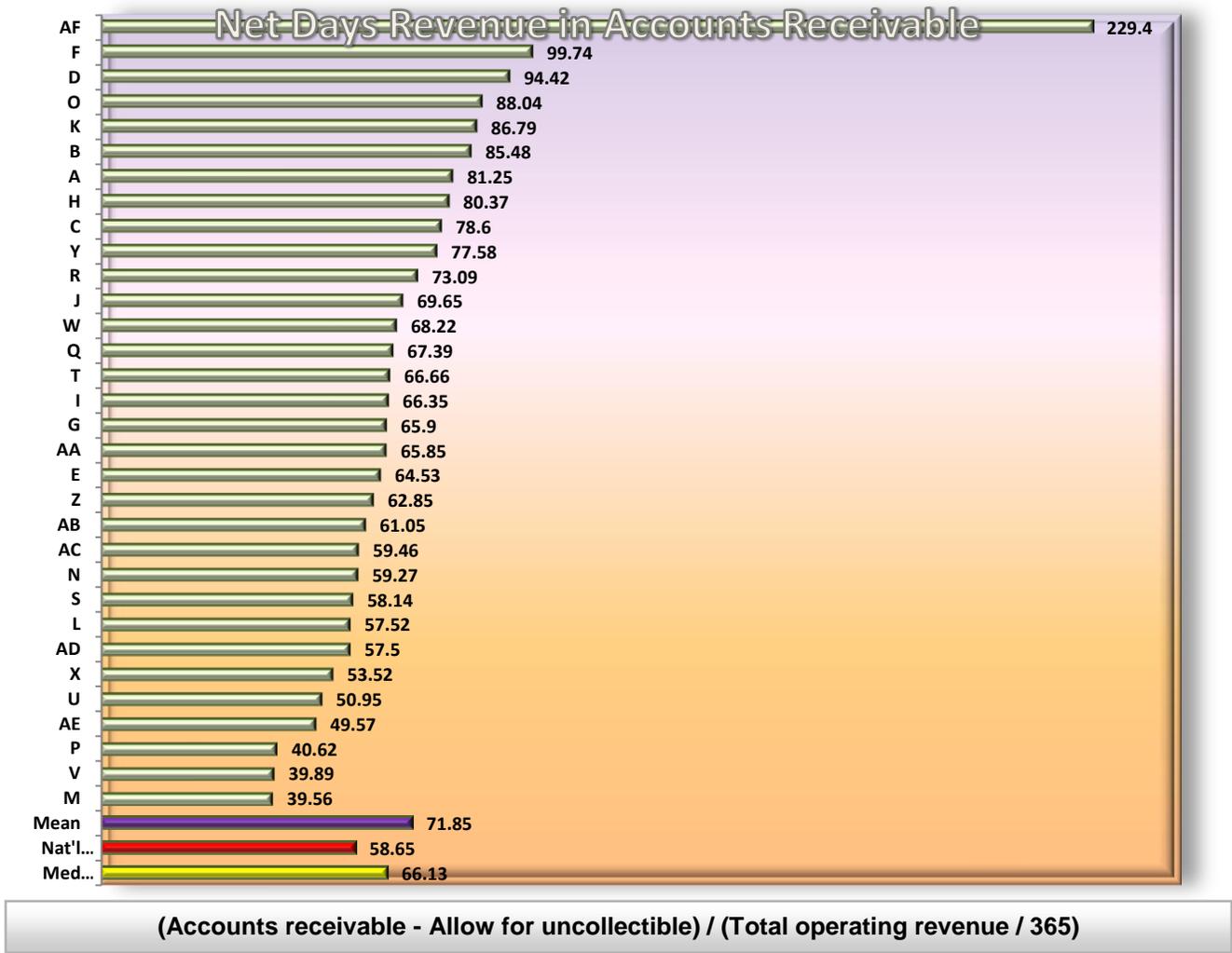
Net Days in Accounts Receivable is based on the latest audited fiscal year end and

the accounts outstanding at the time of the on-site visit.

The number of days required for Georgia CAHs to collect receivables ranged from 39.56 days to 229.4 days, with a median of 66.13 days. The national median Net Days in Accounts Receivable was 58.65. The report suggests that variability in Net

Days in Accounts Receivable may be attributable to varying bad debt policies. Greater days in accounts receivable places hospitals at higher risk by decreasing their ability to meet short-term obligations.

Figure 6: Net Days Revenue in Accounts Receivable



CAPITAL STRUCTURE

Capital Structure was evaluated to determine the extent of debt and equity financing. Long-Term Debt to Capitalization and Debt Service Coverage were used to access capital structure. Long-Term Debt to Capitalization

measures the percentage of total capital that is debt. This ratio is used to identify the amount of long-term funds supplied by creditors to access financial leverage utilized by the CAH. This is used to quantify and analyze risk exposure. Higher values indicate a greater

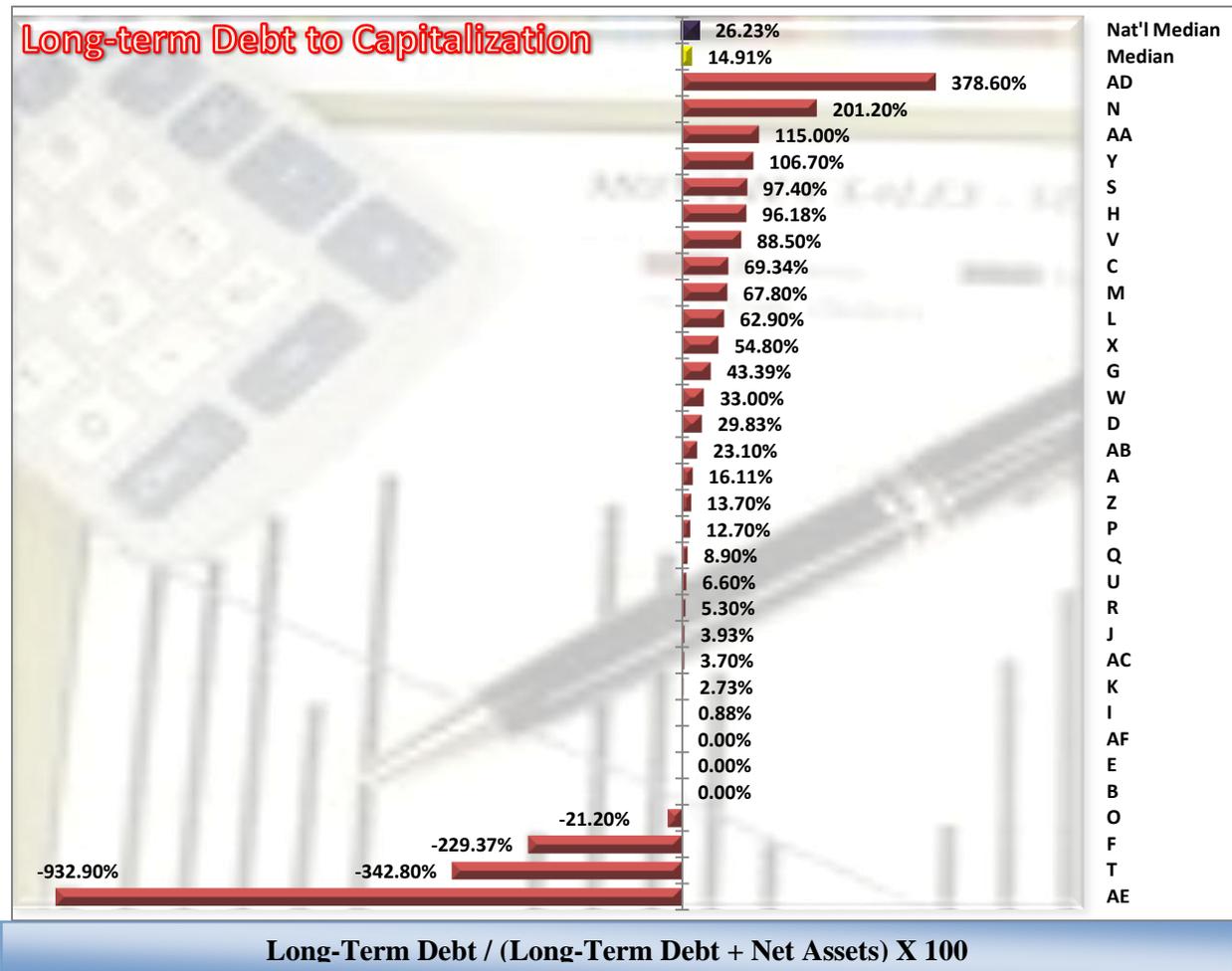
percentage of capital is shown as debt as opposed to equity. Debt allows not-for-profit organizations to provide more services than it could if it were financed only by contributed capital and retained earnings.⁵

Hospitals that have a leverage ratio greater than 50 percent are generally considered a greater risk than those with lower Long-Term Debt to Capitalization

ratios. This is generalized because the ratio implies the CAHs' ability to carry debt is lowered. A declining trend is positive. On the other hand, CAHs with very low ratios may indicate opportunities for debt financing.

The Long-term Debt to Capitalization ratio for the participating CAHs ranged from -932.90 percent to 378.60 percent. The national median Long-term to Debt Capitalization ratio is 20.7 percent. The median for the 32 GA CAHs is 14.91 percent.

Figure 7: Long-Term Debt to Capitalization



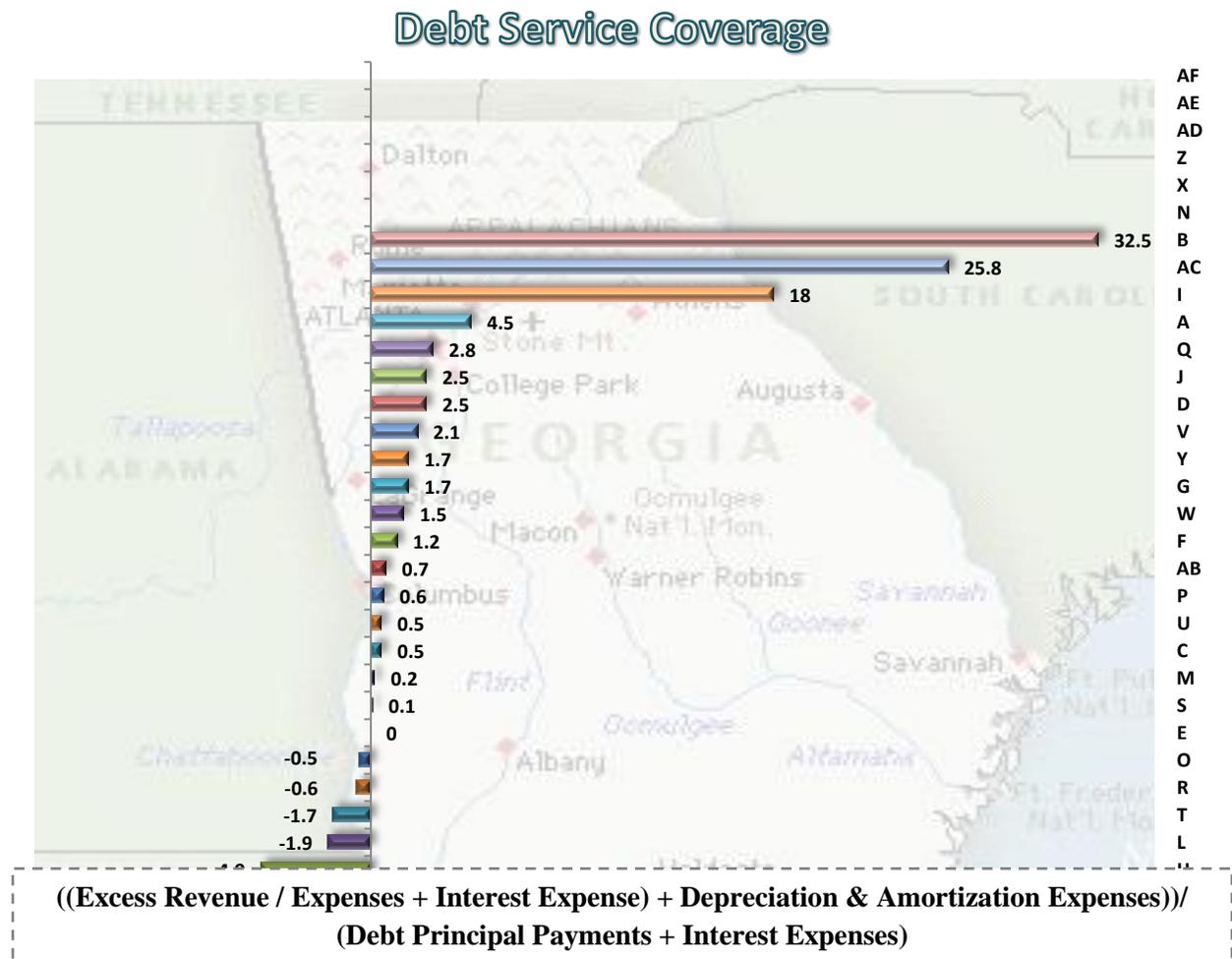
CAHs AF, B, and E did not indicate long-term debt on their financials. Hospitals X, Z, AD, and AE indicated long-term debt is comprised of intercompany payables.

⁵ Unland, J.; Ponton, K; Not-For-Profit Hospitals Face New Challenges Accessing Capital, March 3, 2003 <accessed> 09/31/2011. <http://www.capitalexerts.com/UnlandPontonArticleCapNeeds1.prn.pdf>

Debt Service Coverage measures the ability to meet debt service payments from cash flow. The measure does not take into account positive or negative cash flow associated with balance sheet changes. A higher ratio is favorable and an increasing trend is desirable.⁴ Higher values are viewed positively by creditors. The Debt Service Coverage ratio for the

hospitals ranged from -10.3 to 32.5. Hospitals X, Z, AD, AE, and AF had no long-term debt principal payments. Hospital N's long-term debt is due to intercompany expenses with no fixed principal payments.¹

Figure 8: Debt Service Coverage



² Draffin & Tucker, LLP June 2010 “Critical Access Hospital Financial Analyses-2008-2009”

⁴ Center for Healthcare Industry Performance Studies (CHIPS), Almanac of Hospital Financials and Operating Indicators, 2009 ed. (Ingenix Publishing Group, 2000).

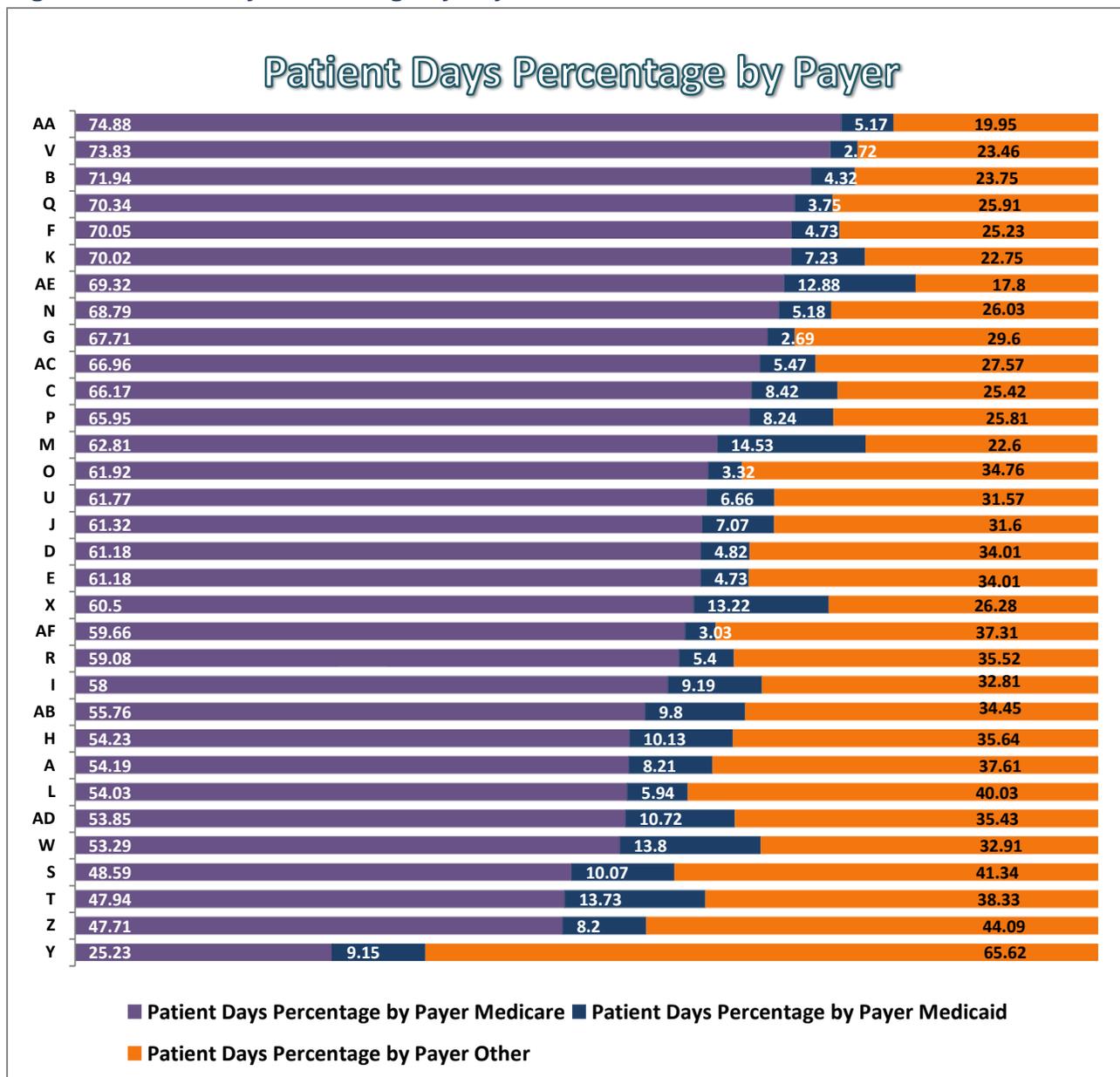
REVENUE INDICATORS

Analyses were performed to evaluate and compare revenue and costs among the participating CAHs. Revenue indicators measure the amount and mix of different sources of revenue. The Patient Days Percentage by Payer, Outpatient Revenues to Total Revenues Ratio and Medicare Days as a Percentage of Total

Days measures were used to analyze the revenue of the participating CAHs.

Expense/cost indicators measure the amount and mix of different types of costs. The expense/cost indicators that were measured were Average Salaries per FTEs, FTEs per Average Daily Census, and Age of Plant.

Figure 9: Patient Days Percentage by Payer

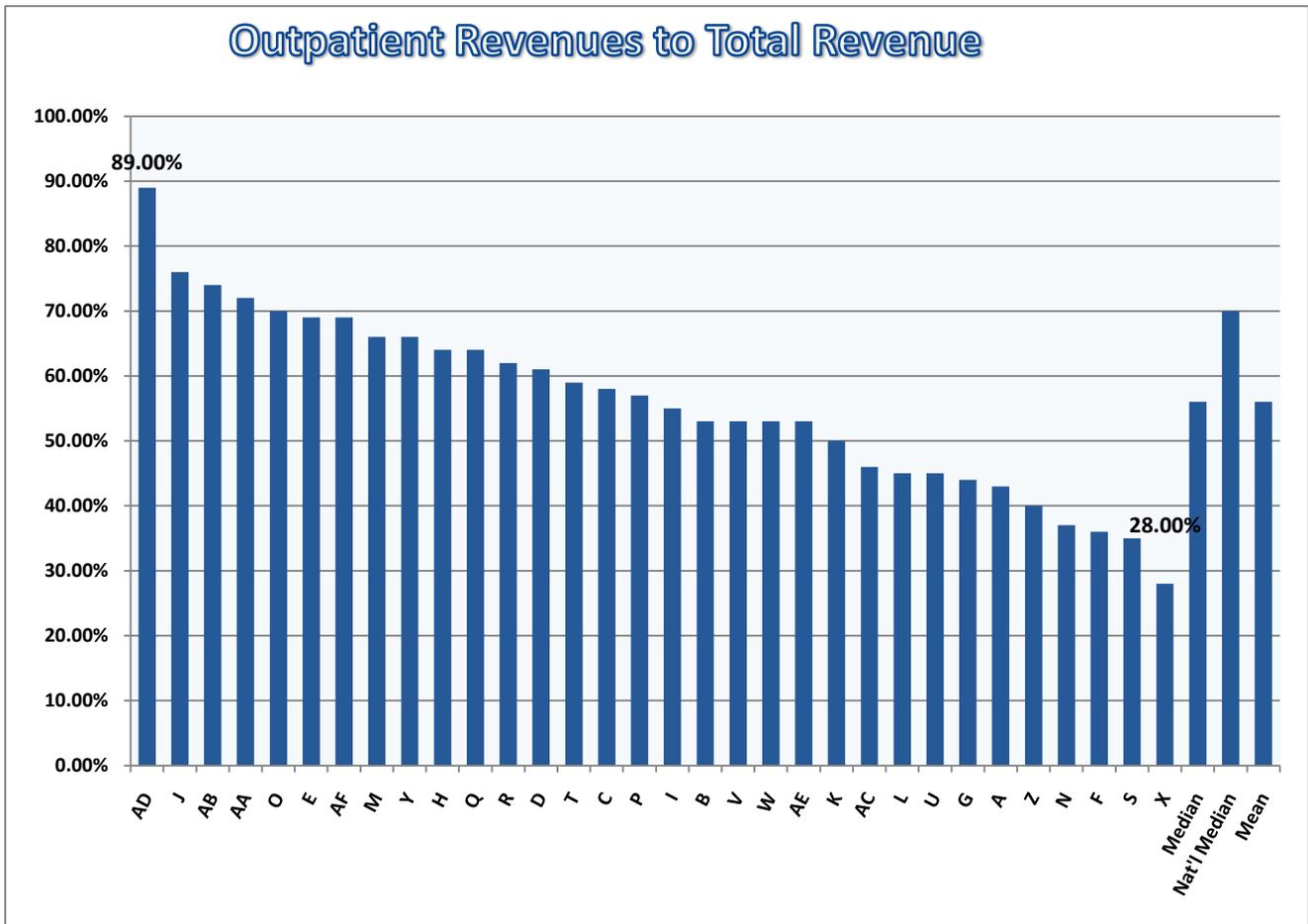


More than half of acute patient days for 28 of the 32 CAHs in Georgia are attributed to Medicare patients. This payer percentage is significantly higher than that experienced in prospective payment system (PPS) hospitals. Medicare patient days ranged from 74.88 days to 25.23 days. The second largest payer group was classified as Other. This group is comprised of the commercial, self-pay and other payers. According to the latest audited financial statements, the largest component of this group was

self-pay. Medicaid patients were the smallest percentage of payers amongst all of the participants.

Outpatient services comprise the majority of many hospitals' revenue base. Outpatient Revenues to Total Revenues measures the percentage of total revenues that are for outpatient services. Outpatient revenues for the participating hospitals ranged from 28 percent to 89 percent. The median outpatient revenue to total revenue for the 32 Georgia Critical

Figure 10: Outpatient Revenues to Total Revenue

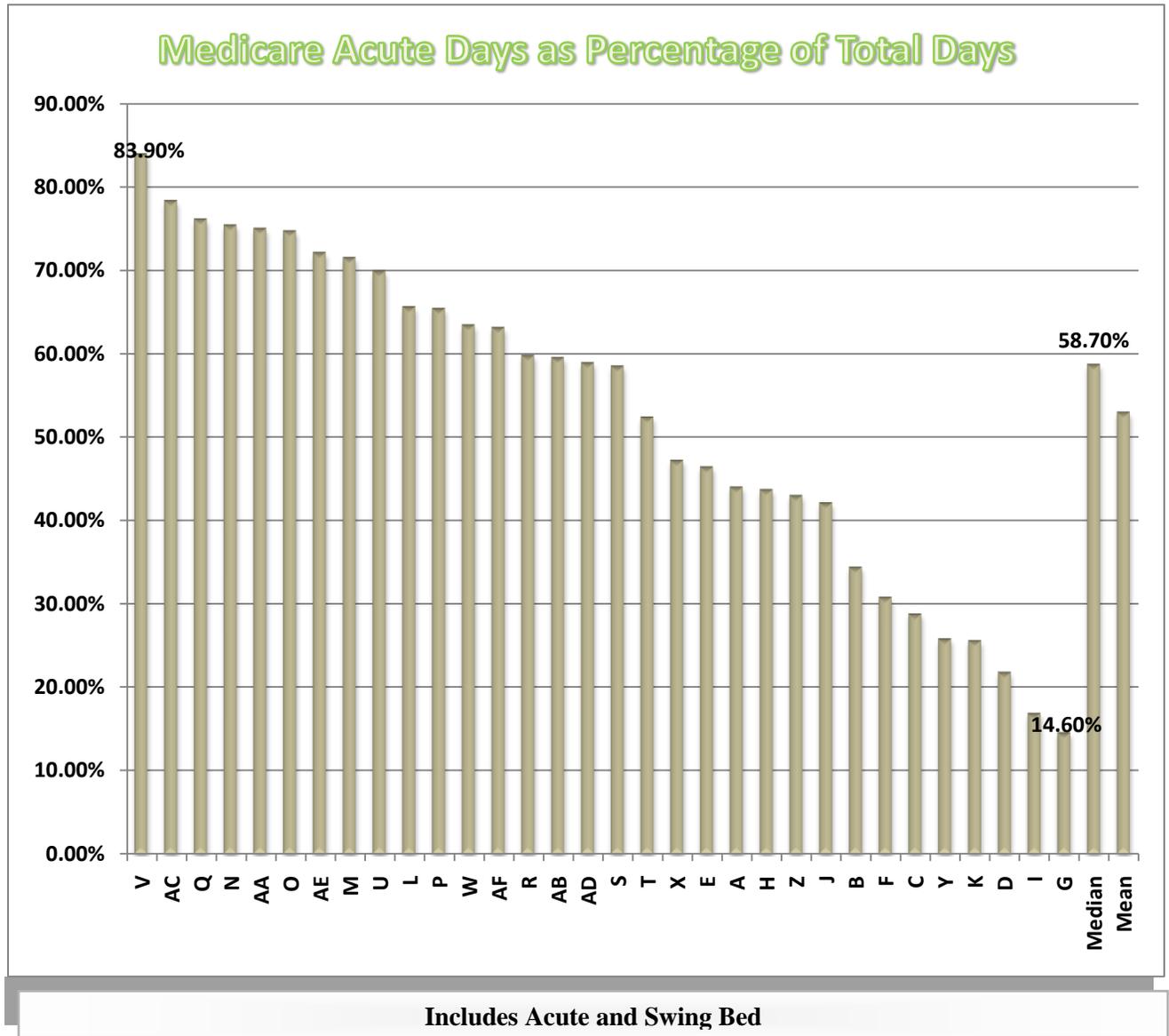


Total Outpatient Revenue/ Total Patient Revenue

Access Hospitals was 56 percent compared to the national median of 70 percent. The higher the Medicare utilization, the more difficult it is for a CAH to generate a profit. Medicare will reimburse 101 percent of its share of allowable cost; therefore profits must come from other payer sources. Hospital

G had the lowest combined percentage of Medicare days for acute and swing bed at 14.6 percent, while Hospital V had the highest combined percentage at 83.90 percent. The median Medicare Acute Days as Percentage of Total Days for participating CAHs was 58.70 percent.

Figure 11: Medicare Acute Days as Percentage of Total Days

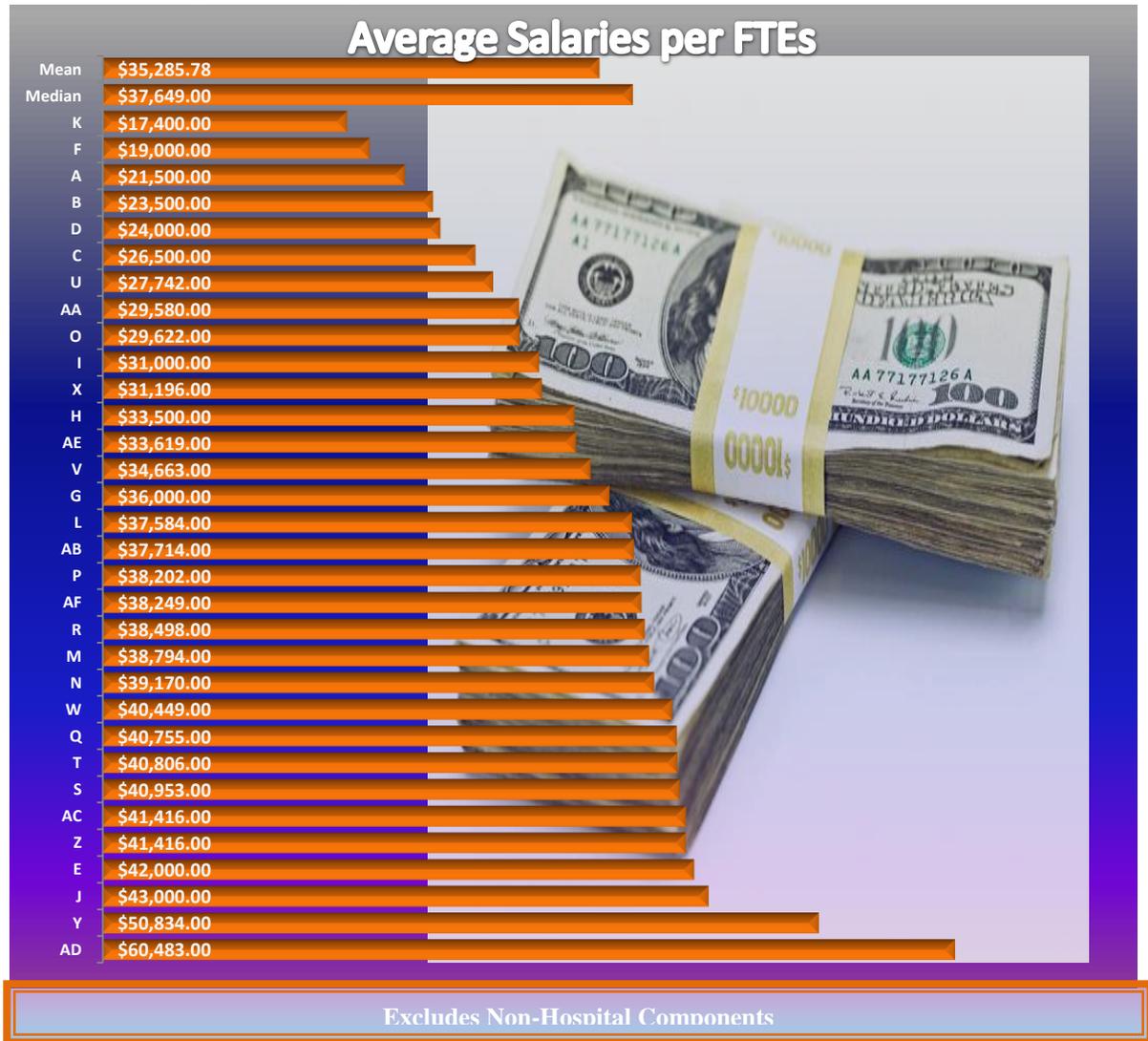


The majority of CAHs' administrators would agree that staff retention is consistently of major concern. A study conducted as a part of the CAH/FLEX National Tracking Project in 2003 suggested that competitive salaries was the third most important factor in

recruitment and retention.⁶

Average Salaries per Full Time Equivalent (FTE) ranged from a low of \$17,400.00 to a high of \$60,483.00. The median of the average salary per FTEs was \$35,285.78.

Figure 12: Average Salaries per FTEs



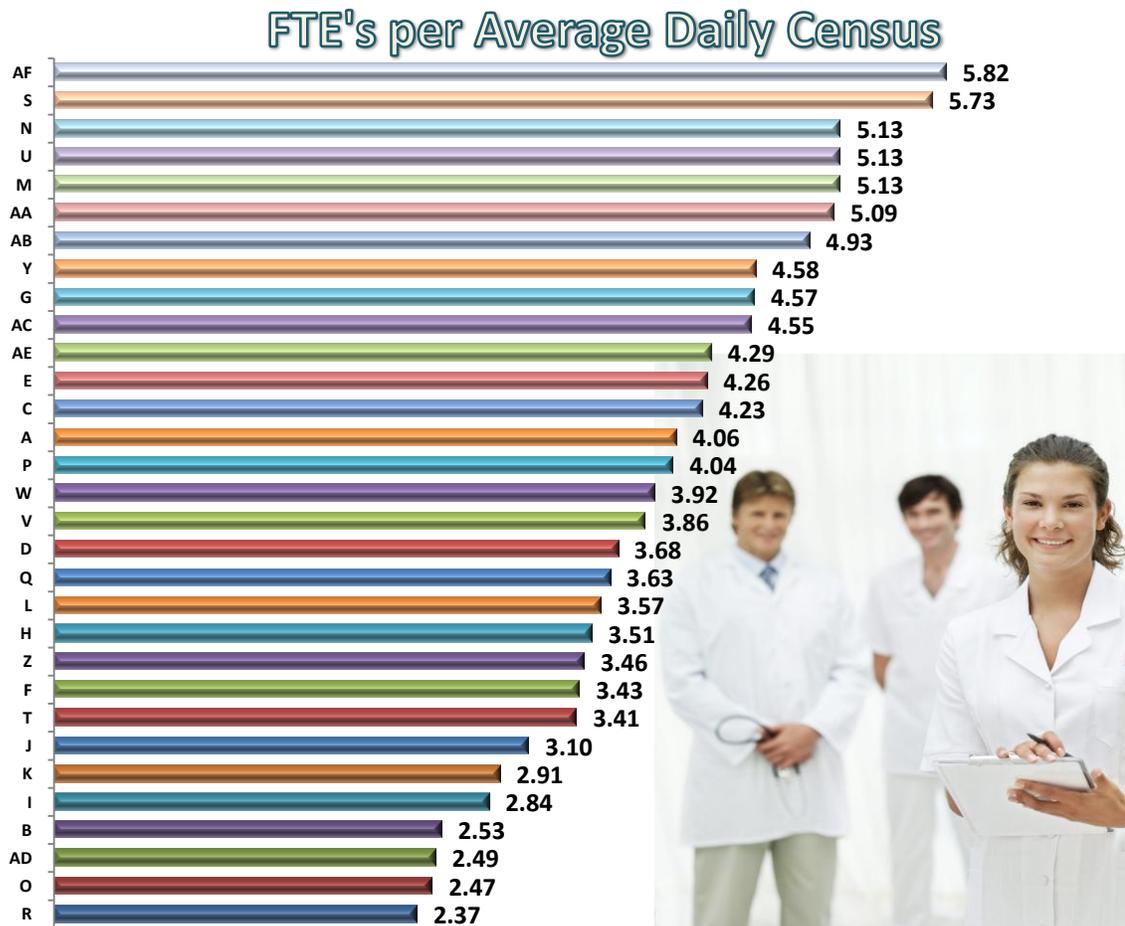
The use of shared staffing in hospitals with Skilled Nursing Facilities (SNF) components may distort the average salary comparisons. Use of contract services, rather than employed staff will also affect comparability. The SNF Component and contract staff were excluded from the average salaries calculations.¹

⁶ CAH/FLEX National Tracking Project, "Findings from the Field" Volume 3, Number 6 November 18, 2003.

FTEs per Average Daily Census measures the number of full-time employees per each average occupied patient bed. Very high values may indicate low volume and a potential opportunity to evaluate staff productivity. Very low values may

indicate high volume or a high level of staff productivity. FTEs per Average Daily Census ranged from a high of 5.82 FTEs to a low of 2.37 FTEs. The median FTEs per Average Daily Census for the 32 participants was 3.98 FTEs.

Figure 13: FTEs per Average Daily Census

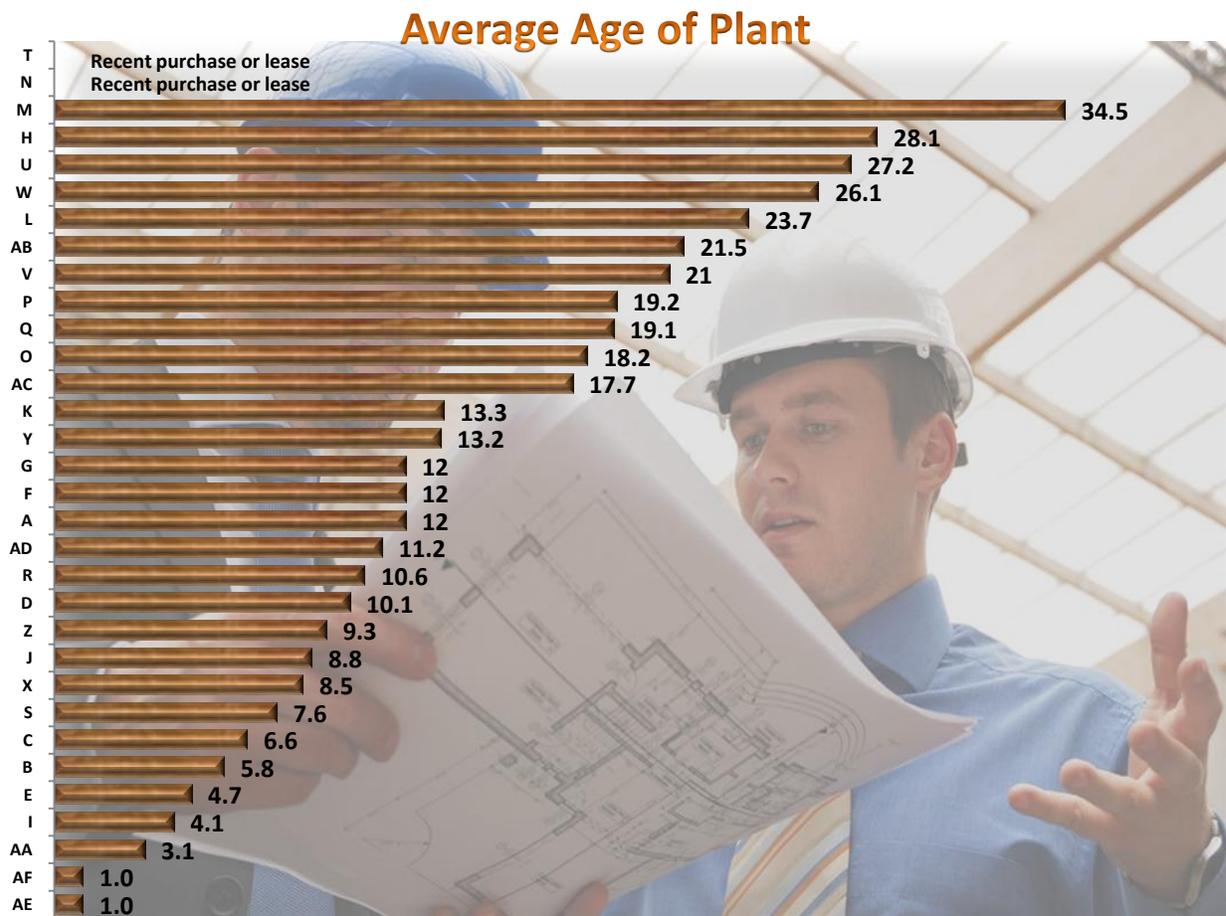


Many participants use contract services, rather than employed staff to perform certain functions. The use of contract staff will affect the FTE comparisons. There are also participants that, as a component of a hospital system, benefit from consolidated billing functions.¹

The Average Age of Plant ratio provides a rough estimate of the age of Georgia’s CAHs fixed assets. This includes the average age of property, plant and equipment owned by the hospital. The average age of plant ratio for the 32 CAHs spans from 1.0 years to 34.5 years. The average age is directly affected by

ongoing renovations to the facility. Lower values indicate new facilities and equipment, whereas higher values indicate greater amounts of older assets. Very high values may indicate a need for fixed-asset replacement.

Figure 14: Average Age of Plant



Accumulated Depreciation/ (Depreciation + Amortization Expense)

UTILIZATION

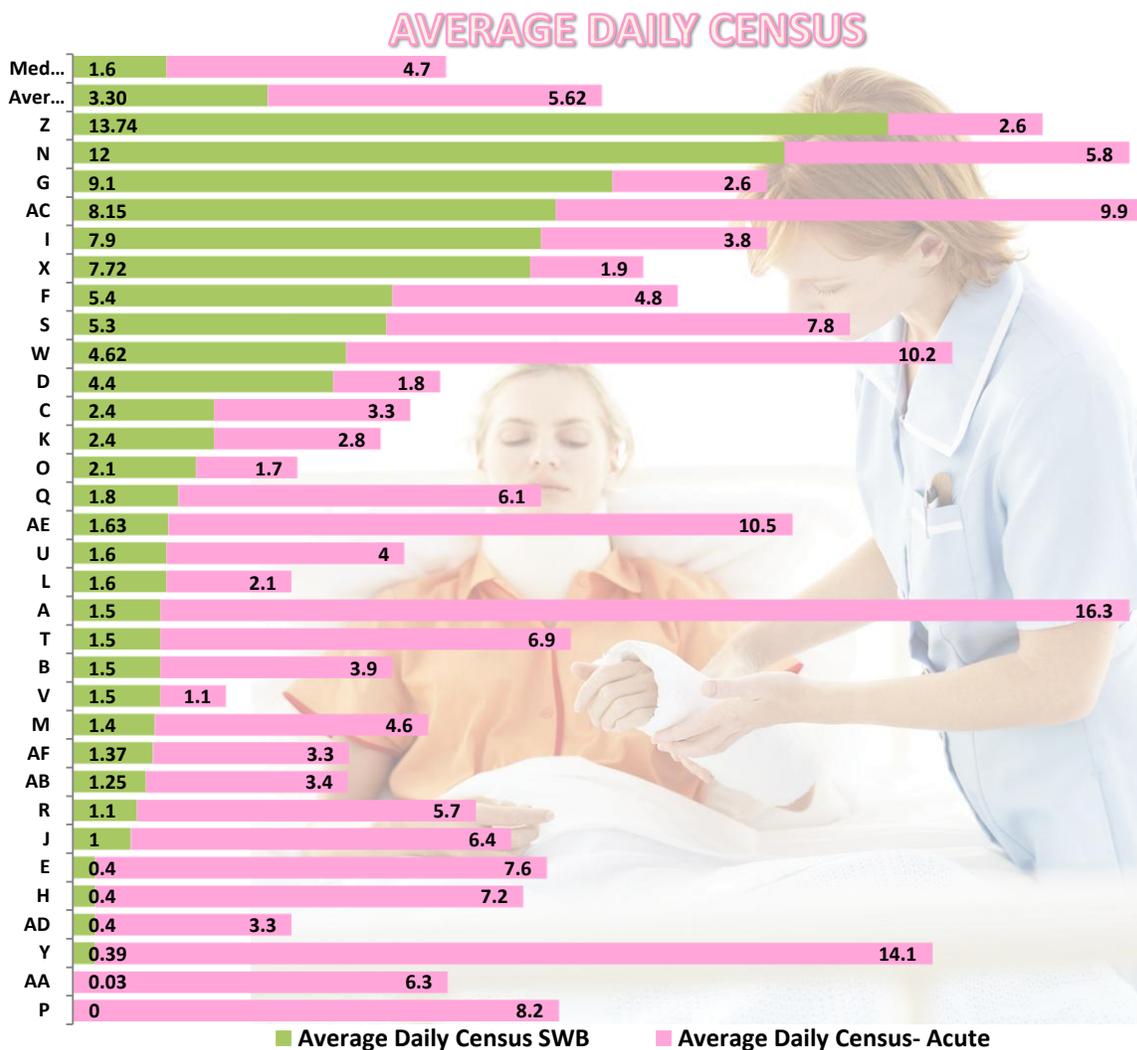
Draffin & Tucker analyzed the Average Daily Census (swing beds and acute beds)

and the Average Length of Stay (swing beds and acute beds) for the 32

participating CAHs. These utilization indicators measure the extent to which fixed assets are fully occupied. Under federal legislation, CAHs are limited to 25 beds. Consistent with their bed size, CAHs historically have a low average daily census; the Average Daily Census for the 32 CAHs acute beds is 5.63 patients. When swing patients are included in the

calculation, the average CAH daily census increased by 12 percent to 6.3 patients per day. Average Daily Census for acute beds ranged from 16.3 patients to 1.1 patients a day. Average Daily Census for swing bed patients ranged from a low of 0 to a high of 13.74 patients.

Figure 15: Average Daily Census

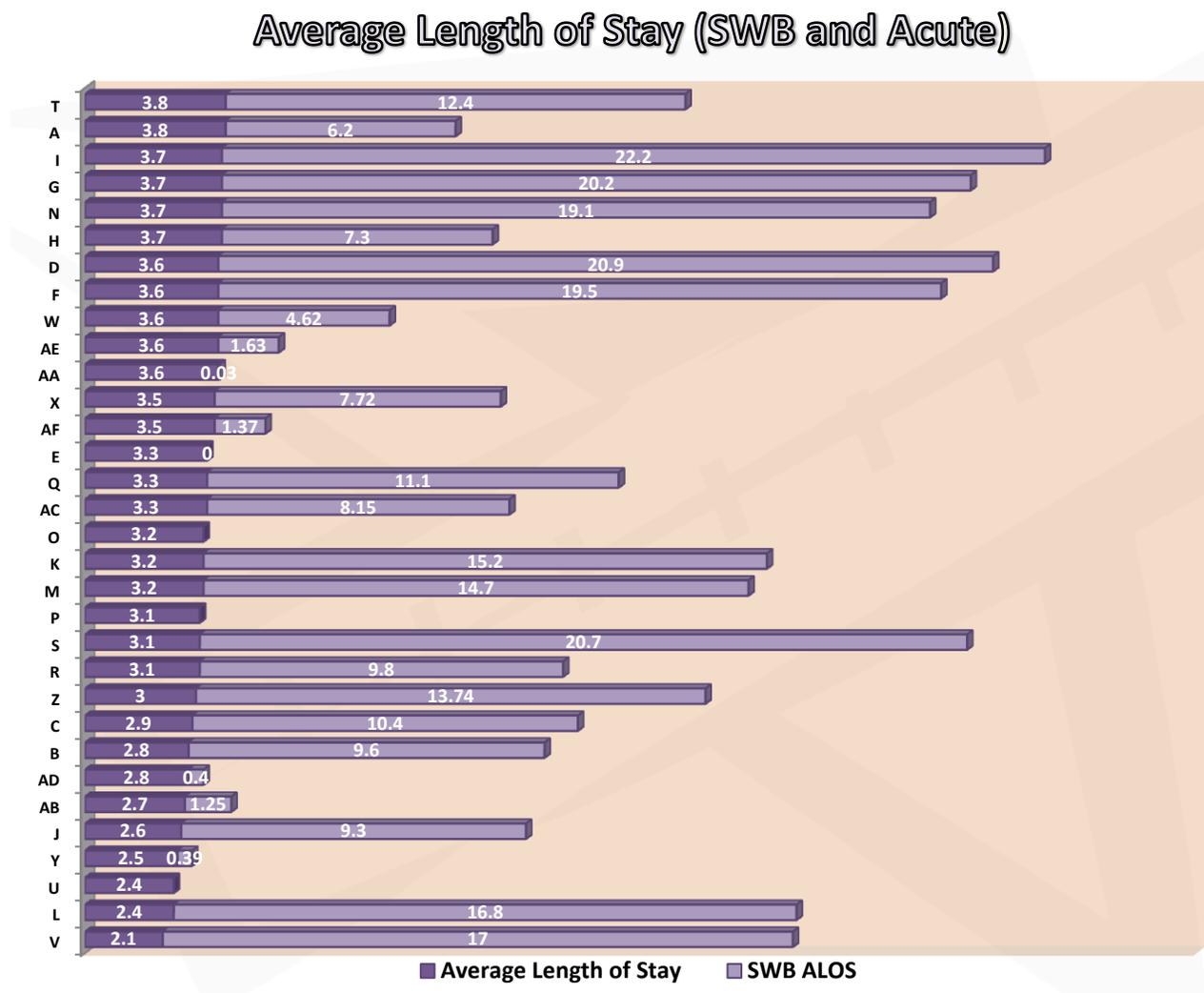


I/P Swing Bed SNF Days/ Days in Period = Average Daily Census SWB
 I/P Acute Care Bed Days/ Days in Period = Average Daily Census Acute

CAHs must maintain an annual average length of stay of 96 hours or less for their acute care patients. There is no length of stay limit for swing bed patients. The average length of stay acute days for the 32 participating CAHs ranged from a low of 0 days to a high of 22.2 days. The median average length of stay for acute care was 3.25 days. The average length of stay swing bed ranged from 2.1 days to 3.8 days. There were significant differences in both average daily census (SWB) and average length of stay (SWB)

among the participants. Swing beds are highly utilized by Georgia CAHs; however, their models of utilization greatly differ. Hospitals D, G, and I provided high volumes of therapy services to the SWB patients, which would indicate that a majority of the SWB patients were admitted for rehabilitative services. Some CAHs are providing post-orthopedic and stroke aftercare to the patients, while others are using the swing beds as an interim level of care between the acute and Skilled Nursing Facility (SNF) settings

Figure 16: Average Length of Stay (Swing Bed and Acute Beds)



Total Inpatient Days, Swing Bed / Total Discharges, Swing Bed = Average Daily Census SWB
 Total Inpatient Days, Acute Care / Total Discharges, Acute Care = Average Length of Stay Acute

CONCLUSION

Nationally, Critical Access Hospitals vary substantially from one another in organizational structure, ownership and management type, the diversification of services provided, and the method of delivery of services. These key differences have a large impact on the variances in the financial health of these hospitals.

There is also evidence to justify that geographical location may also contribute to financial variances amongst CAHs. Those located in the western and Mid-Western regions of the US are less impacted by the external forces that cause a greater concern for those located in the Southeastern region. External forces as recognized by the Southeastern states include poverty rates, payer mix, health status and provider availability. These and other forces weigh heavily on the financial outcomes of CAHs. A comparison of the overall financial health of Georgia CAHs and the National CAHs standards can be seen in Table 2.

Following the trend of financial variability among CAHs in the United States, Georgia CAHs showed great variations in many of the financial indicators that were accessed through this review. Each CAH was found to be unique. They differ in ownership and management type, the amount of financial support given by the community, and the services provided. It

has been suggested that diversification of services will provide additional revenue sources; this is necessary to offset shrinking inpatient volumes.

Poverty levels are higher in areas where some CAHs are located, greatly contributing to decreased profitability. The second largest payer group consisted of self-pay and commercial insurance, with self-pay comprising the majority of this group. This greatly impacts the amount of bad debt and charity care write-offs. Critical Access Hospitals in Georgia are heavily influenced by the external force of Medicare. More than 50 percent of inpatients seen by Georgia CAHs are Medicare patients. As a result, the slightest change in Medicare regulations has the potential to greatly alter the bottom line of Georgia's CAHs.

Table 2: 2009 Median Indicator Values

2009 Median Indicator Values for Georgia and the United States CAH Financial Indicators Report Issue 8		
Indicator	GA	US
Total Margin	-0.45	1.89
Cash Flow Margin	-1.16	5.65
Return on Equity	7.55	4.55
Operating Margin	-6.20	0.66
Current Ratio	1.73	2.26
Days Cash on Hand	19.91	65.94
Net Days Revenue in Accounts Receivable	51.80	53.45
Equity Financing	52.24	60.55
Debt Service Coverage	1.34	2.42
Long-Term Debt to Capitalization	27.18	26.52
Outpatient Revenues to Total Revenues	66.04	70.33
Patient Deductions	47.11	36.02
Medicare Inpatient Payer Mix	67.32	73.09
Medicare Outpatient Payer Mix	33.13	35.80
Medicare Outpatient Cost to Charge	0.41	0.48
Medicare Revenue per Day	1309	1762
Salaries to Net Patient Revenue	43.95	44.66
Average Age of Plant	13.21	9.88
FTEs per Adjusted Occupied Bed	4.98	5.75
Average Daily Census Swing-SNF Beds	1.58	1.61
Average Daily Census Acute Beds	4.11	4.20
Number of Included CAHs	33	1261

Source: Flex Monitoring Team Data Summary Report No. 6. (October 2009) CAH Financial Indicators Report: Summary of Indicator Medians by State. Retrieved from <http://www.flexmonitoring.org/getit.php?productid=129>

Appendix

DATA SOURCES

Unless otherwise note, data used in the Draffin& Tucker, LLP Critical Access Hospital Financial Analyses was taken from the hospitals' latest audited financial statements and/or the latest filed Medicare cost reports.

CAH	Fiscal Year End	CAH	Fiscal Year End
A	2007	Q	2007
B	2007	R	2007
C	2007	S	2007
D	2007	T	2007
E	2007	U	2007
F	2007	V	2007
G	2007	W	2008
H	2007	X	2009
I	2007	Y	2009
J	2007	Z	2009
K	2007	AA	2008
L	2007	AB	2009
M	2008	AC	2009
N	2008	AD	2009
O	2007	AE	2008
P	2007	AF	2008

National CAH averages included in various charts were obtained from the *2009 Almanac of Hospital Financial and Operating Indicators* published by Ingenix.

The 2009 Almanac of Hospital Financial and Operating Indicators was used to analyze the desired trend of the key financial indicators used to assess Georgia Critical Access Hospital’s financial health. The chart summarizes the desired position of a hospital in terms of trends and medians.

PROFITABILITY RATIOS	Desired Position	
	Trend	Median
Operating Margin	Up	Above
Total Margin	Up	Above
Return on Equity	Up	Above
LIQUIDITY RATIOS	Desired Position	
	Trend	Median
Current Ratio	Up	Above
Days Accounts Receivable	Down	Below
Days Cash On Hand	Up	Above
CAPITAL STRUCTURE RATIOS	Desired Position	
	Trend	Median
Debt to Service	Up	Above
Long-Term Debt to Capitalization	Down	Below

2009 Almanac of Hospital Financial and Operating Indicators published by Ingenix