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The Financial Effects of Wisconsin Critical Access Hospital Conversion

Prepared by:

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Rural Wisconsin Health Cooperative
Dale Guillickson, FHFMA
Richard Donkle, CPA

2013

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EXECUTIVE SUMMARY

Critical Access Hospital (CAH) designation was introduced through the Medicare Rural Hospital Flexibility Program (Flex Program) as part of the Balanced Budget Act (BBA) of 1997. Many low-volume rural hospitals were finding it difficult to recover their Medicare costs under the prospective payment system (PPS) rates. As a result, policymakers created the new designation of CAH, under which small facilities would be paid 101% of their Medicare costs for inpatient services, outpatient services (including laboratory and therapy services), and post-acute services in swing beds. The first Wisconsin CAH hospitals were certified in 1999. This study is the sixth since the CAH program was implemented. As with the prior Wisconsin CAH study financial performance studies completed in 2003, 2005, 2007, 2009, and 2011, the purpose of this study is to analyze the financial condition of Wisconsin's CAHs. There have been many recent changes in Medicare and Medicaid and many more related to healthcare reform are imminent.

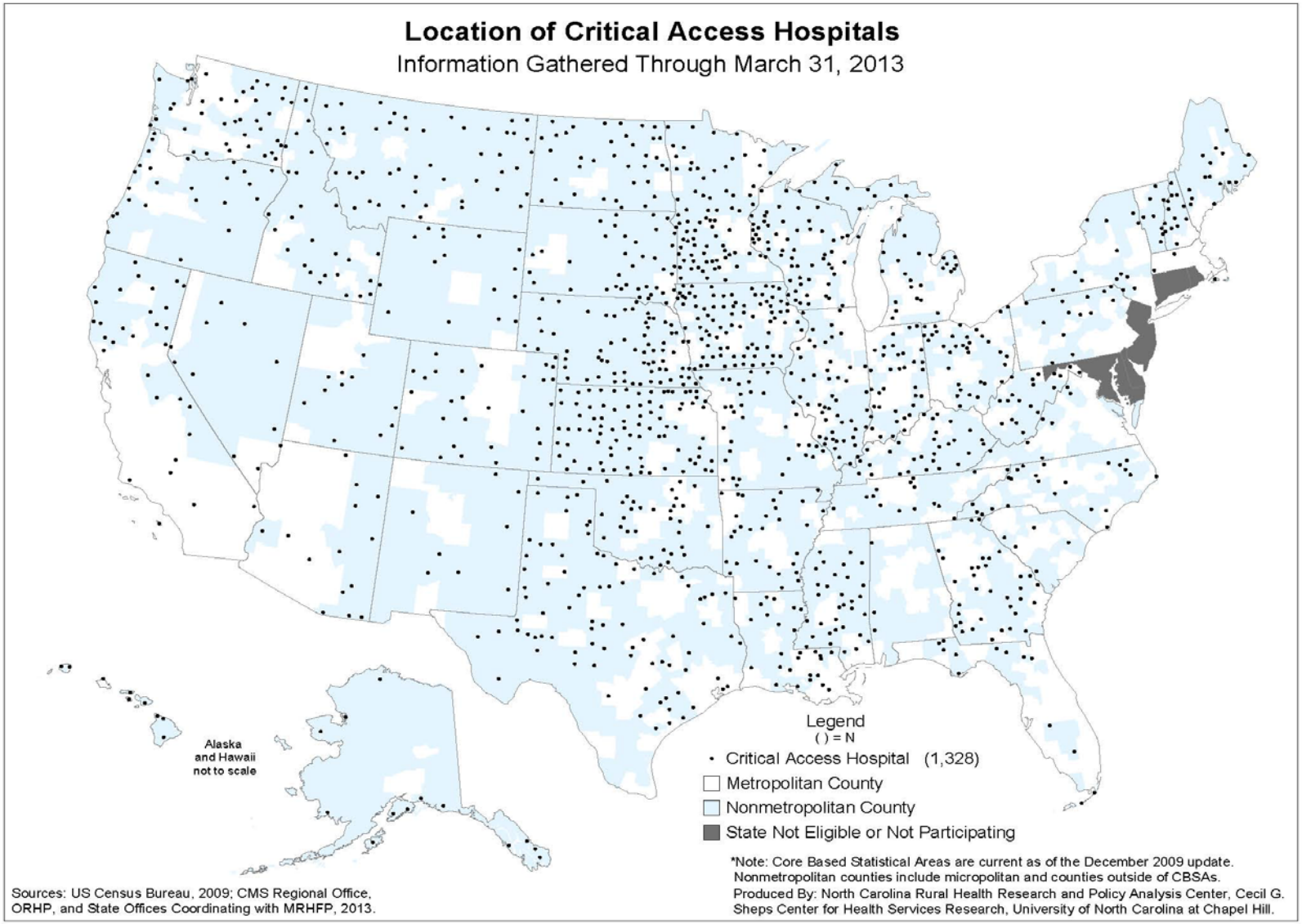
For Wisconsin hospitals (PPS & CAH, both Urban & Rural) this study shows that:

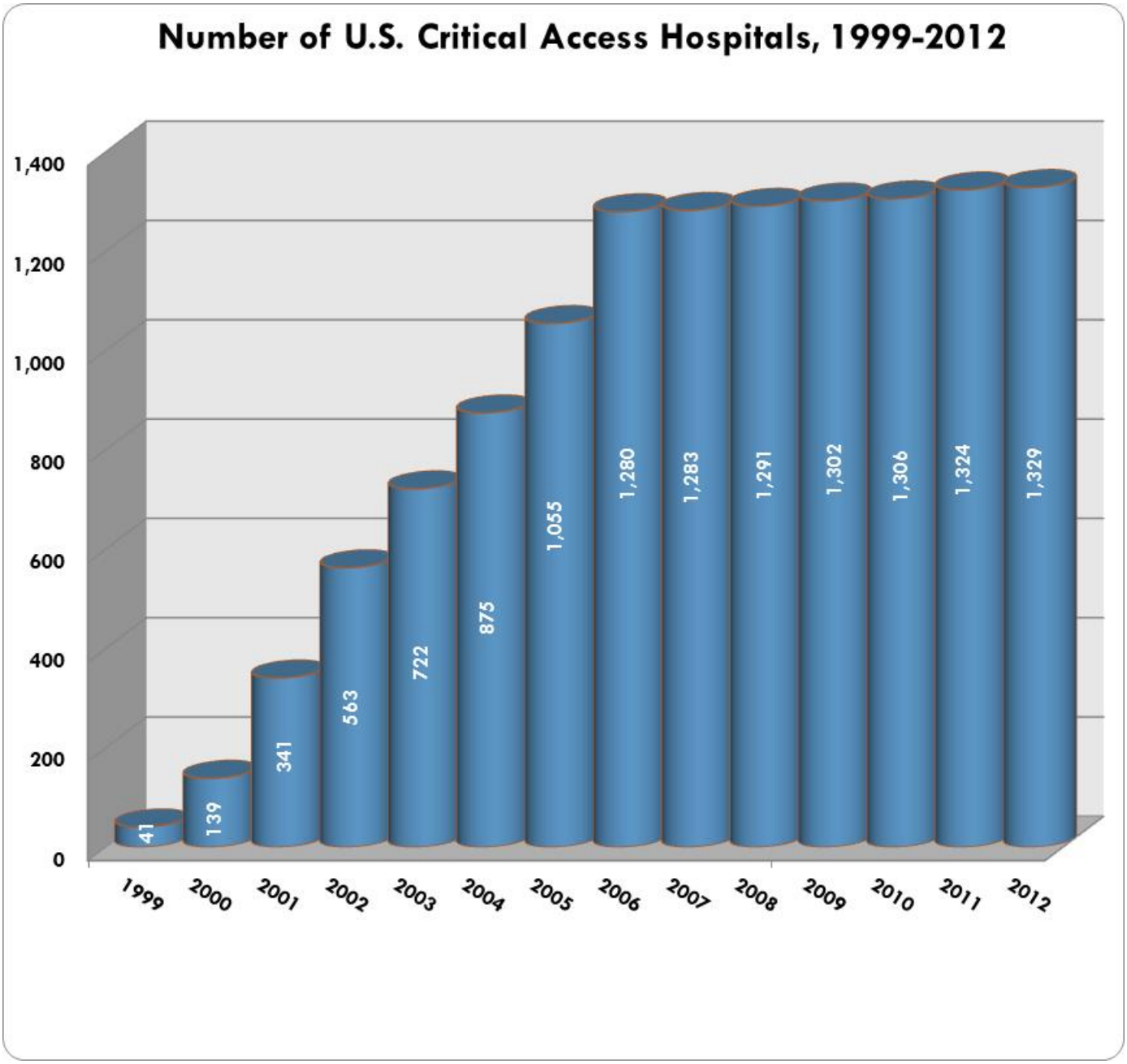
- The Total Margin for CAHs was 7.23% in 2010 and 7.30% in 2012 while the Total Margin for PPS hospitals was 9.32% in 2011 and 9.25% in 2012.
- Although CAHs Operating Margins improved in 2011 and 2012, they continue to experience lower Operating Margins than PPS hospitals.
- Average Age of Plant increased for PPS hospitals and decreased for CAHs in 2011. In 2012, CAH Age of Plant stayed the same while PPS hospitals Age of Plant increased slightly. CAH Age of Plant was less than PPS hospitals for both 2011 and 2012.
- Net Days in Accounts Receivable increased for PPS hospitals in 2011. This ratio decreased for CAHs and stayed about the same for PPS hospitals in 2012.
- Overall strength as measured by the Financial Strength Index increased in 2011 and 2012 for both CAHs and PPS hospitals. The improvement in Financial Strength was higher for CAH hospitals for both years than for PPS hospitals.
- There have been changes in services provided for both CAH and PPS hospitals. The reason for these changes may be related to financial considerations.
- Several key utilization statistics such as inpatient days, surgical operations, births, and emergency visits showed less growth or more rapid decline since 2000 for CAHs than experienced by PPS hospitals.
- CAHs outpatient revenue as a % of total revenue has increased since 2000 and CAHs have higher outpatient % revenue to total revenue than PPS hospitals.
- The % of Wisconsin Medicare beneficiaries covered by Medicare Advantage plans continues to rise.

- The % of Uncompensated Care increased slightly in 2011 and 2012 for both groups.
- The pending transition from ICD-9 code sets to ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) (ICD-10) code sets was to occur on October 1, 2013. In August, 2012, CMS announced the transition was being delayed one year to October 1, 2014. This transition could have major implications on cash flow.
- It is important to note that the Hospital Fiscal Survey does not include nursing home financial information. More CAHs have nursing homes than PPS facilities (see Changes in Services). Nursing homes typically generate lower contribution margins than hospital operations. Therefore, the study may overstate the strength of CAH facilities compared to the PPS group.
- The presence of EHR incentive payments and the method used to record their financial impact may have material effects on several ratio calculations.
- The impact of the reduction to the Medicare Bad Debt % for 2013 through 2015 is approximately $10M for CAHs, $4M for PPS facilities for a total of about $14M.
- The annual 2% sequestration reduction to Medicare inpatient, outpatient, and swing bed payments for CAHs about $9.5M, for PPS facilities $47M, for a total of about $56.5M. This does not include the impact of other types of Medicare payments that are subject to sequestration. See further discussion in the "Medicare" section of this study.
- A report issued in August, 2013 by the HHS Office of Inspector General (OIG) recommends that CMS reassess and decertify many CAH facilities for failing to fulfil location requirements. The OIG proposal would eliminate CAH status for as many as 53 Wisconsin CAH facilities.
- The Patient Protection and Affordable Care Act (PPACA) is discussed more extensively in the "Recent Legislation" section of this study.

The number of CAHs nationally has grown steadily over the last ten years. As of March 2013, there were 1,329 CAHs in the United States (see following graph). Most CAHs are located geographically in the central part of the U.S. (see following map). The increase in CAHs is in part due to a series of legislative changes that made conversion to CAH status possible for more facilities to consider and, therefore, expanded the services that qualify for cost-based reimbursement. Prior to 2006, hospitals could convert to CAH status if they were (1) 35 miles by primary road or 15 miles by secondary road from the nearest hospital, or (2) their state declared them to be a necessary provider under criteria established by each state and approved by CMS. Starting in 2006, hospitals could no longer use the state necessary provider criteria to apply for CAH status. While many existing CAHs do not meet the distance test, they were

grandfathered into the program based on their necessary provider status. Among small rural hospitals that have not converted, most do not meet the distance requirement. Therefore, the number of CAHs since 2006 has remained fairly constant.


Location of Critical Access Hospitals
Information Gathered Through March 31, 2013
Alaska
and Hawaii
not to scale
Legend
( ) = N
Critical Access Hospital (1,328)
Metropolitan County
Nonmetropolitan County
State Not Eligible or Not Participating
*Note: Core Based Statistical Areas are current as of the December 2009 update.
Nonmetropolitan counties include micropolitan and counties outside of CBSAs.
Produced By: North Carolina Rural Health Research and Policy Analysis Center, Cecil G.
Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
Sources: US Census Bureau, 2009; CMS Regional Office,
ORHP, and State Offices Coordinating with MRHFP, 2013.



Currently, Wisconsin has 58 CAHs which means roughly 40% of all Wisconsin facilities were CAHs. Critical Access Hospitals are located in 41 of Wisconsin's 72 counties (see following map). Two facilities did not exist prior to 2005 and were not included in this or prior studies due to lack of historical financial data. One CAH facility closed in 2011 and was not included in this study. Of the 56 facilities in this study, 17 were certified in 1999, 2000, or 2001 (see Table 1).

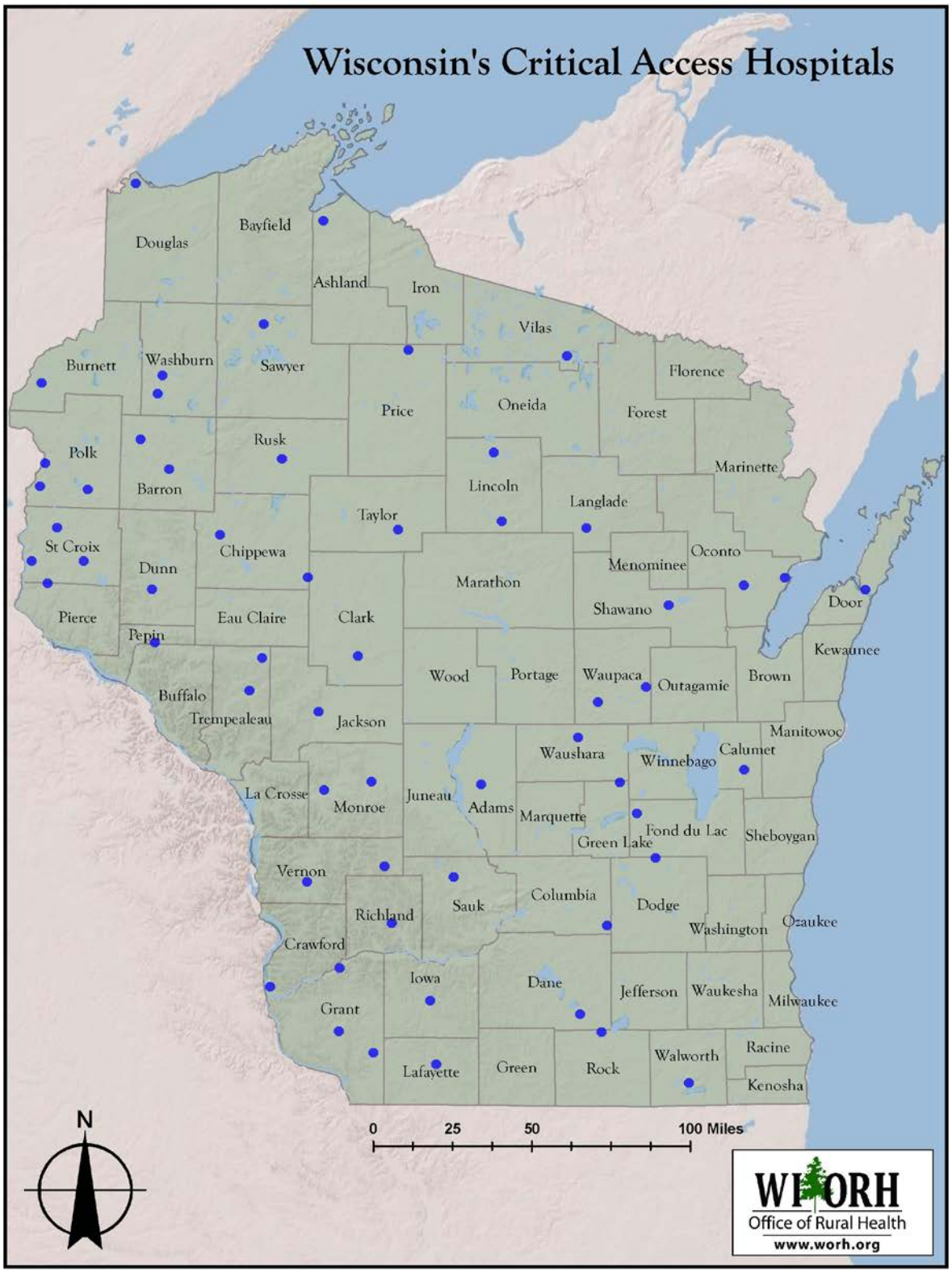

Wisconsin's Critical Access Hospitals
Douglas
Bayfield
Ashland
Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Polk
Barron
Rusk
Marinette
Lincoln
Langlade
Taylor
St Croix
Dunn
Chippewa
Menominee
Oconto
Marathon
Door
Pierce
Pepin
Eau Claire
Clark
Shawano
Kewaunee
Wood
Portage
Waupaca
Outagamie
Brown
Buffalo
Trempealeau
Jackson
Manitowoc
Waushara
Winnebago
Calumet
La Crosse
Monroe
Juneau
Adams
Marquette
Green Lake
Fond du Lac
Sheboygan
Vernon
Richland
Sauk
Columbia
Dodge
Washington
Ozaukee
Crawford
Iowa
Dane
Jefferson
Waukesha
Milwaukee
Grant
Lafayette
Green
Rock
Walworth
Racine
Kenosha
N
0
25
50
100 Miles
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Table 1: Wisconsin CAHs by Year of Certification

YEAR	Certified	TOTAL FOR STUDY
1999	2	2
2000	6	6
2001	9	9
2002	8	8
2003	6	6
2004	17	17
2005	9	7
2006	1	1
2007	1	1
2008	0	0
2009	0	0
2010	0	0
2011	-1	-1
2012	0	0
Total	58	56

- The facilities that converted to CAH status early were generally smaller and not as financially strong as the later converters. The largest group (31 facilities) received critical access certification during 2002, 2003, and 2004. The remaining nine study facilities converted in 2005, 2006, and 2007. One CAH facility closed in 2011 and was not included in this study.

Financial and services data were analyzed for thirteen years (from 2000 through 2012). The 56 study facilities are categorized as CAHs. Table 2 shows if the study facility was paid as a CAH or under the Medicare PPS. It also shows if the facility converted during its fiscal year (PPS/CAH).

Table 2: Study Hospitals by Year and Medicare Payment Type

YEAR	PPS	PPS/CAH	CAH	ALL STUDY
2000	50	5	2	57
2001	42	7	8	57
2002	34	6	17	57
2003	29	3	25	57
2004	16	12	29	57
2005	11	14	32	57
2006	1	6	50	57
2007	1	0	56	57
2008	0	0	57	57
2009	0	0	57	57
2010	0	0	57	57
2011	0	0	56	56
2012	0	0	56	56

- Most charts graph CAH study facilities, all other hospitals, and both groups combined. Psychiatric, Children's, Veterans, and Rehabilitation hospitals were excluded from the study.
- The source of most of the study data was the Wisconsin Hospital Fiscal Survey and the Wisconsin Annual Survey of Hospitals. These surveys are completed annually by all Wisconsin hospitals and returned to the Wisconsin Hospital Association (WHA) Information Center.
- The Financial Strength Index (FSI) is a ratio that combines several key performance indicators (see further discussion in the Financial Performance section of this study). This ratio increased for both groups in 2011. In 2012, the PPS FSI stayed about the same but increased for CAHs. The FSI ratio shows both groups in the "Good" range in the FSI Rating Guide (see Table 6).
- For the first time, the Average Age of Plant in 2011 for CAHs was lower than for PPS facilities. Both CAHs and PPS facilities Age of Plant stayed approximately the same in 2012 (see further discussion in the Average Age of Plant Ratio section.)
- The Debt-to-Capitalization ratio is a new ratio added to the 2013 Critical Access Hospital study. This ratio measures the utilization of long-term sources of debt financing. This ratio may be used as a covenant in capital financings. This ratio is calculated by dividing Long-Term Debt by Long-Term Debt plus Fund Balance. Both PPS and CAHs show a decreasing trend in Debt-to-Capitalization from 2006 through 2012. CAHs have a higher Debt-to-Capitalization than PPS facilities (see further discussion in the Debt-to-Capitalization Ratio section)

INTRODUCTION

The purpose of this study is to report on the financial impact of Wisconsin hospitals designated as CAHs. Similar reports were conducted in 2003, 2005, 2007, 2009, and 2011.

As of August, 2013, Wisconsin had 58 CAH facilities. The first Wisconsin hospital received CAH designation on October 1, 1999. As noted in the Executive Summary, Table 2 shows when Wisconsin hospitals received CAH status and the number of facilities included in this update.

This study primarily uses the information from the Wisconsin Hospital Fiscal Survey and the Annual Survey of Hospitals. Both of these surveys are submitted annually to the WHA Information Center. The information is reviewed for accuracy. The Hospital Fiscal Survey is designed to closely follow the hospital's audited financial statements. For these reasons, the source for most of the study data is the Fiscal and Annual Survey. It is important to note, however, that the annual Wisconsin Hospital Fiscal Survey does not include nursing home financial information. More CAHs in Wisconsin have nursing homes than do PPS facilities (see Changes in Services). Nursing homes typically generate lower contribution margins than hospital operations. Therefore, the study probably overstates the strength of CAH facilities compared to the PPS group. The years included in this study are from 2000 through 2010. Financial ratios were calculated and are shown in graphs to provide the user with a visual aid to measure trends.

REIMBURSEMENT METHODOLOGIES

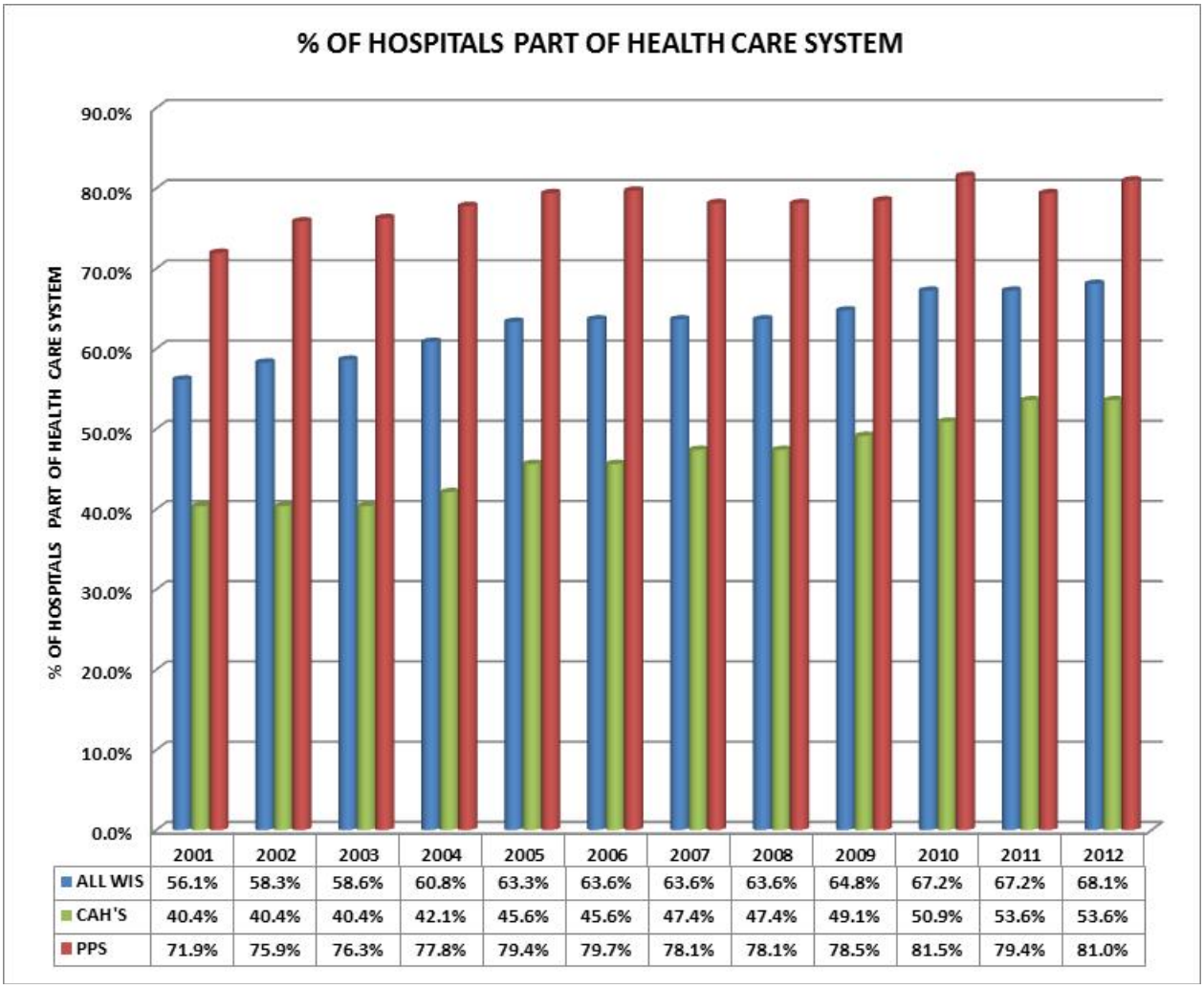
CAH Medicare reimbursement is generally the same as presented in prior studies. Under PPS, inpatient reimbursement was based on diagnosis related groups (DRGs). Swing bed reimbursement was based on a combination of skilled nursing facility per diems for the nursing care and the Medicare program ancillary costs until July 1, 2001. At that time, swing bed reimbursement became based on the prospective resource utilization group (RUG) methodology. Prior to August 1, 2000, outpatient reimbursement was based on a combination of costs and fee schedules. Outpatient reimbursement is now based on ambulatory payment categories (APCs) and fee schedules. CAHs are paid costs for acute care, swing bed and outpatient services. Cost reporting methodology for CAHs splits nursing care costs between acute and swing bed services based on patient days. The resulting nursing cost per diems are equal. The per diem is multiplied by Medicare program acute and swing bed days. A decrease in acute or swing bed patient days will increase the cost per diem and increase Medicare payments. For CAH cost reports beginning on or after January 1, 2004, there is

a 1% add-on to allowable Medicare costs, making Medicare CAH reimbursement 101% of allowable costs.

The Wisconsin Medical Assistance Program (Medicaid) CAH reimbursement used to be based on costs similar to Medicare reimbursement. Medicaid funding for CAHs no longer involves retrospective cost settlements. Major changes to the Wisconsin Medicaid State plan have been implemented recently. The new Medicaid hospital Outpatient rates effective April 1, 2013 involve a new reimbursement methodology called Enhanced Ambulatory Patient Groups (EAPGs). Under EAPGs, hospital outpatient services will be based upon the quantity and type of services provided. The base rate for CAHs is a prospective cost-based base rate, established using the most recently audited Medicare Cost Report and total adjusted EAPG weights for each provider. The base rate for all other hospitals paid under the EAPG reimbursement methodology was calculated from the remaining Department of Health Services (DHS) OP hospital budget and the total adjusted EAPG weights for all other providers. DHS has decided to limit the fiscal impact to individual providers during the first year of implementation to a +/- 5% corridor, of the projected payments the provider would have otherwise received under the historical per visit reimbursement methodology. Therefore, the rates effective April 1, 2013 are based upon this fiscal corridor adjustment to the Wisconsin statewide base rate. For Medicaid inpatient payments, the rate per inpatient discharge is calculated for and assigned to each hospital for the rate year. This calculation determines a unique "hospital-specific DRG base rate" for each hospital. This hospital-specific DRG base rate includes an adjustment for differences in wage levels between rural and metropolitan areas throughout the state. This rate also includes an amount for capital costs and, for qualifying hospitals, additional amounts for serving a disproportionate share of low-income persons, for direct and indirect costs of a medical education program, or for the hospital being located in a rural area. Payment to a hospital for the stay is determined by multiplying the hospital's specific DRG base rate by the weight assigned to the DRG into which the stay is classified by the grouper. As discussed in the 2011 study, Wisconsin implemented a 1.4 percent assessment on hospitals' and ambulatory surgical centers' gross revenue. Because Medicaid funding is a joint Federal and State program, this measure was intended to increase the state's Medicaid reimbursement by $300 million a year. Most of the revenues will be returned to the hospitals, but some of the revenue will be used to expand health coverage to low-income, childless adults. Most states have already implemented a similar provider assessment.

HOSPITAL ORGANIZATION CHANGES

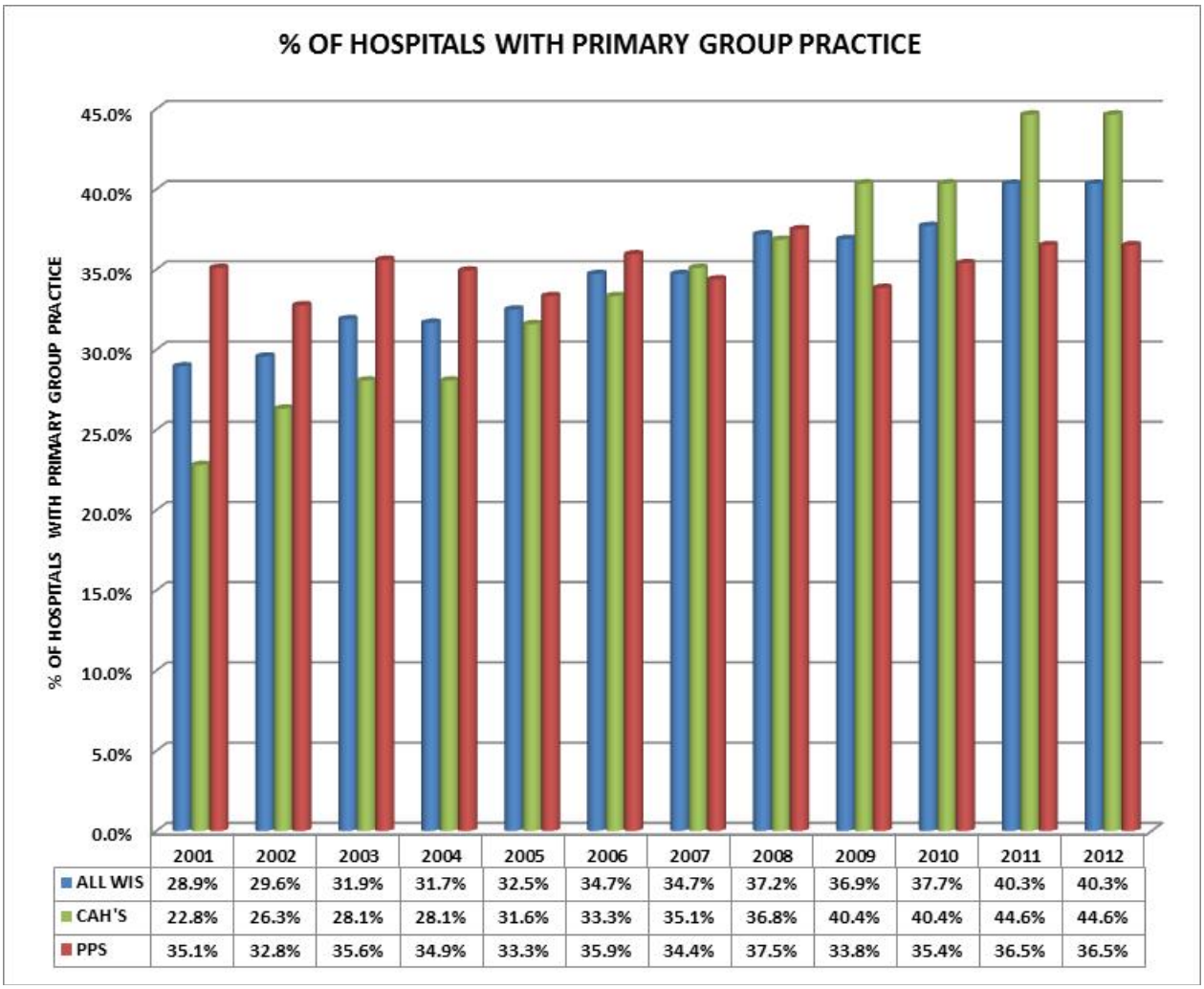
Wisconsin hospitals' organizational structure has changed in the last 12 years. The Annual Survey collects data on whether the hospital is part of a health care system. The following chart shows what percent of Wisconsin CAHs, PPS facilities and both groups combined belong to a health care system.



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	56.1%	58.3%	58.6%	60.8%	63.3%	63.6%	63.6%	63.6%	64.8%	67.2%	67.2%	68.1%
CAH'S	40.4%	40.4%	40.4%	42.1%	45.6%	45.6%	47.4%	47.4%	49.1%	50.9%	53.6%	53.6%
PPS	71.9%	75.9%	76.3%	77.8%	79.4%	79.7%	78.1%	78.1%	78.5%	81.5%	79.4%	81.0%

The chart indicates about 68% of Wisconsin hospitals belonged to a health care system in 2012. This is 12% higher than in 2001. 81% of PPS hospitals in 2012 belonged to a system while only about 54% of CAHs are part of a group. CAHs showed about a 13% increase since 2001.

Another Annual Survey question examines the relationship of Wisconsin hospitals with primary group practices. The survey response to whether or not the hospital owns or operates a primary group practice is graphed in the following chart.



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	28.9%	29.6%	31.9%	31.7%	32.5%	34.7%	34.7%	37.2%	36.9%	37.7%	40.3%	40.3%
CAH'S	22.8%	26.3%	28.1%	28.1%	31.6%	33.3%	35.1%	36.8%	40.4%	40.4%	44.6%	44.6%
PPS	35.1%	32.8%	35.6%	34.9%	33.3%	35.9%	34.4%	37.5%	33.8%	35.4%	36.5%	36.5%

The chart shows that in 2001, the % of CAHs who owned or operated a primary group practice was below 23% while the % for PPS facilities was about 35%. In 2012, a higher % of CAHs (44%) own or operate a primary group practice than PPS hospitals (36%). The % of hospitals with primary group practices for both groups combined has increased from 28.9% to 40.3% in 2012. One reason CAHs may have a higher percentage of primary group practices is physician reimbursement concerns. Physicians with large Medicare populations are more likely to want to move to hospital-employed positions.

FINANCIAL PERFORMANCE ANALYSIS

As with the prior studies, ratio analysis will be used to evaluate financial performance. The reader should be aware of the following disclaimer. The financial information for the most recent years for many of the CAH and PPS hospitals included in this study reflects EHR incentive payments. Another factor regarding EHR incentive payments is financial statement presentation. The Hospital Financial Management Association (HFMA) in December 2011 issued guidance for financial statement presentation of EHR Incentive payments. The guidance had recommendations but allowed some options to facilities on how to present these payments in their financial statements. This means not all EHR incentive payments are classified the same. In addition, the source of the study financial data does identify either the amount or how EHR payments were recorded. Therefore it is not possible to quantify the impact of removal of the payments on the ratios presented in this study. This obviously makes for inconsistent comparisons of financial performance. The presence of EHR incentive payments and the method used to record their financial impact may have material effects on several ratio calculations.
Also new in this study is the Debt-to-Capitalization ratio. A discussion of key ratios selected for this project follows.

Table 3: Financial Ratios and Description

RATIO	DESCRIPTION
Days in Accounts Receivable (net)	This ratio measures the average number of days in the collection period. A larger number of days represent cash that is unavailable for use in operations.
Days Cash on Hand	The number of days of expenses that the hospital can currently cover with its available cash.
Operating Margin	This ratio defines the % of operating income to total operating revenue.
Total Margin	This ratio evaluates the overall profitability of the hospital using both operating surplus (loss) and non-operating surplus (loss).
Average Age of Plant	Age of plant is the average age of property, plant and equipment owned by the hospital.
Deduction Ratio	The deduction percentage measures the proportion of total patient charges that are given up as discounts and allowances.
Financial Strength Index	Composite of four components of entity's financial condition that reflects an organization's overall financial condition.
Debt-to-Capitalization	The Debt-to-Capitalization ratio is a new ratio added to the 2013 Critical Access Hospital study. This ratio measures the utilization of long-term sources of debt financing. This ratio is many times used as a covenant in capital financings.

Table 4 describes how each financial ratio is calculated.

Table 4: Financial Ratio Calculation

RATIO	CALCULATION
Days in Accounts Receivable (net)	Net accounts receivable/Net patient revenue per day
Days Cash on Hand	Cash/(Operating expenses less depreciation/365)
Operating Margin	Total operating revenue-Total operating expenses/Total Operating revenue
Total Margin	Excess of revenue over expenses/Total revenue
Average Age of Plant	Accumulated depreciation/Depreciation expense
Deduction Ratio	Total patient revenue-net patient revenue/Total patient revenue
Financial Strength Index	See discussion below
Debt-to-Capitalization	Long-Term Debt/Long-Term Debt plus Fund Balance

The FSI is a financial measure that reflects an organization's overall financial condition. The FSI encompasses four major components of an entity's financial condition: liquidity, profitability, capital structure, and physical plant age. The formula for the FSI uses four financial ratios from an organization's balance sheet and income statement.

Table 5: Financial Strength Index Dimensions and Measures

Dimensions of Financial Strength	Measured by
Profits	Total margin
Liquidity	Days cash on hand
Debt expense	Debt financing %
Age of physical facilities	Average age of plant

Each of the four measures is "normalized" around a predefined average for the measure. Adding the four measures creates a composite indicator of total financial strength. Thus, the formula for calculating the FSI is as follows:

FSI = [(Total Margin - 4.0) / 4.0] + [(Days Cash on Hand - 50) / 50] + [(50 - Debt Financing Percent) / 50] + [(9.0 - Average Age of Plant) / 9.0]

Organizations that have high margins, lots of cash, little debt, and new facilities are in better financial condition and have higher FSI. On the other hand, entities with losses, little cash, lots of debt, and old physical facilities have lower ratios. Table 6 is a suggested guide to rate FSI.

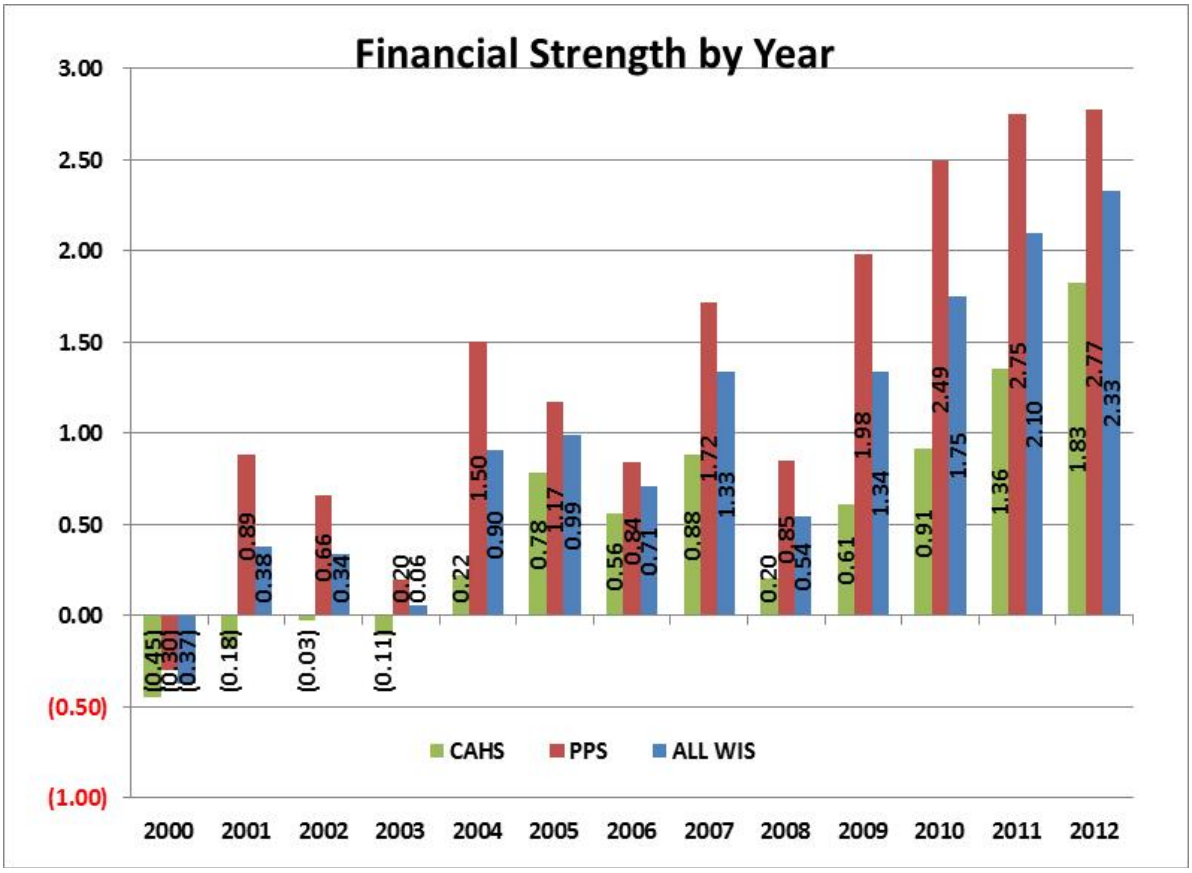
Table 6: Financial Strength Index Rating Guide

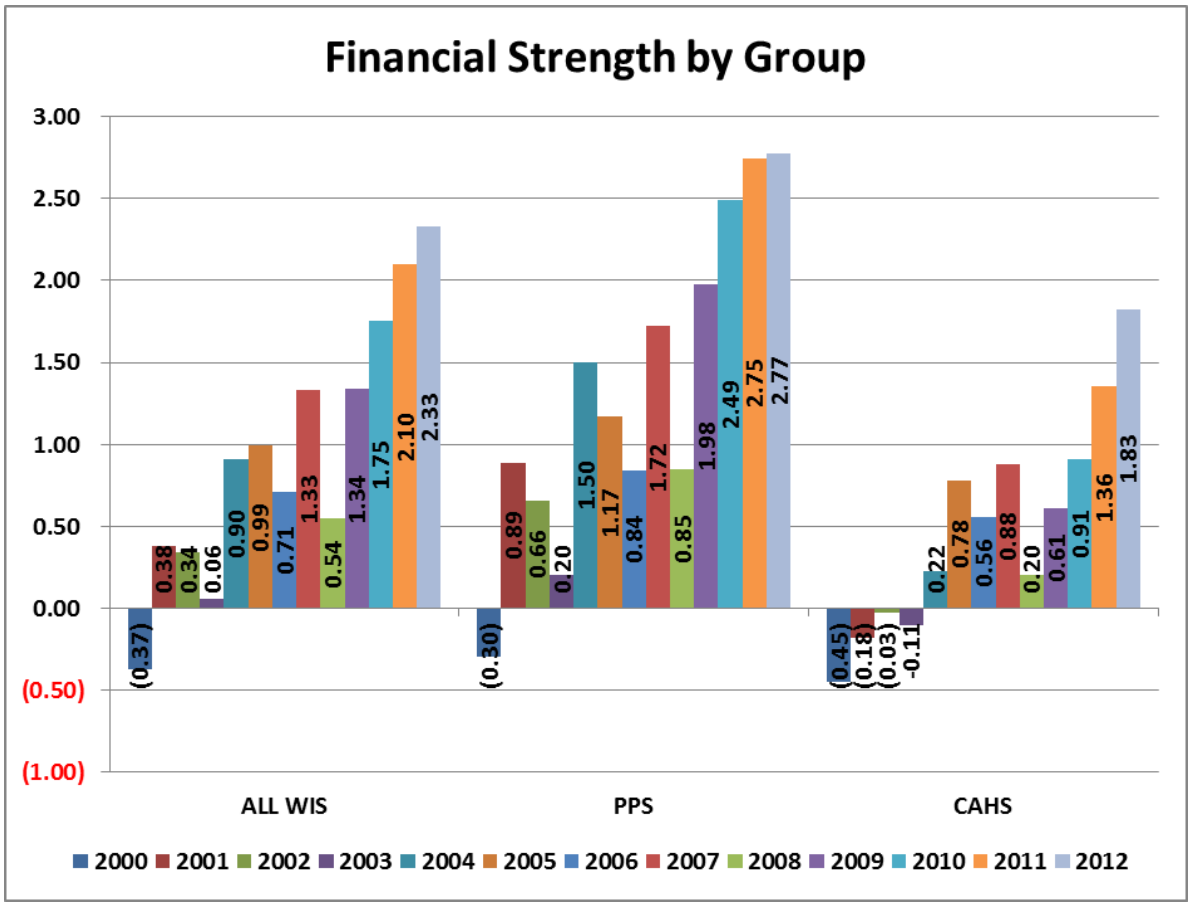
Score	Financial Health
Greater than 3	Excellent
0 to 3	Good
-2 to 0	Fair
Less than -2	Poor

FSI seeks to combine the effects of four financial performance ratios in order to reveal the impact of changes in the organization. If one area of the organization's finances improves but others regress, the FSI will properly reflect the tradeoff. For example, if an entity increased its cash position simply by issuing additional debt, the improvement in cash on hand will be offset by the increase in debt financing percent. No single financial measure, however, is capable of assessing the financial health of an organization.[1]

Prior studies showed an improvement in the FSI for CAHs and PPS facilities in 2004, decreasing in 2005 and 2006 and increasing again in 2007. The FSI for both groups decreased in 2008. The following graph shows improvement in the FSI in 2009, 2010, 2011 and 2012. While the FSI for PPS continues to be higher than for CAHs, CAH FSI increased more than PPS facilities in 2011 and 2012. The 2012 FSI for both groups is "Good" according the FSI rating guide (See Table 6).

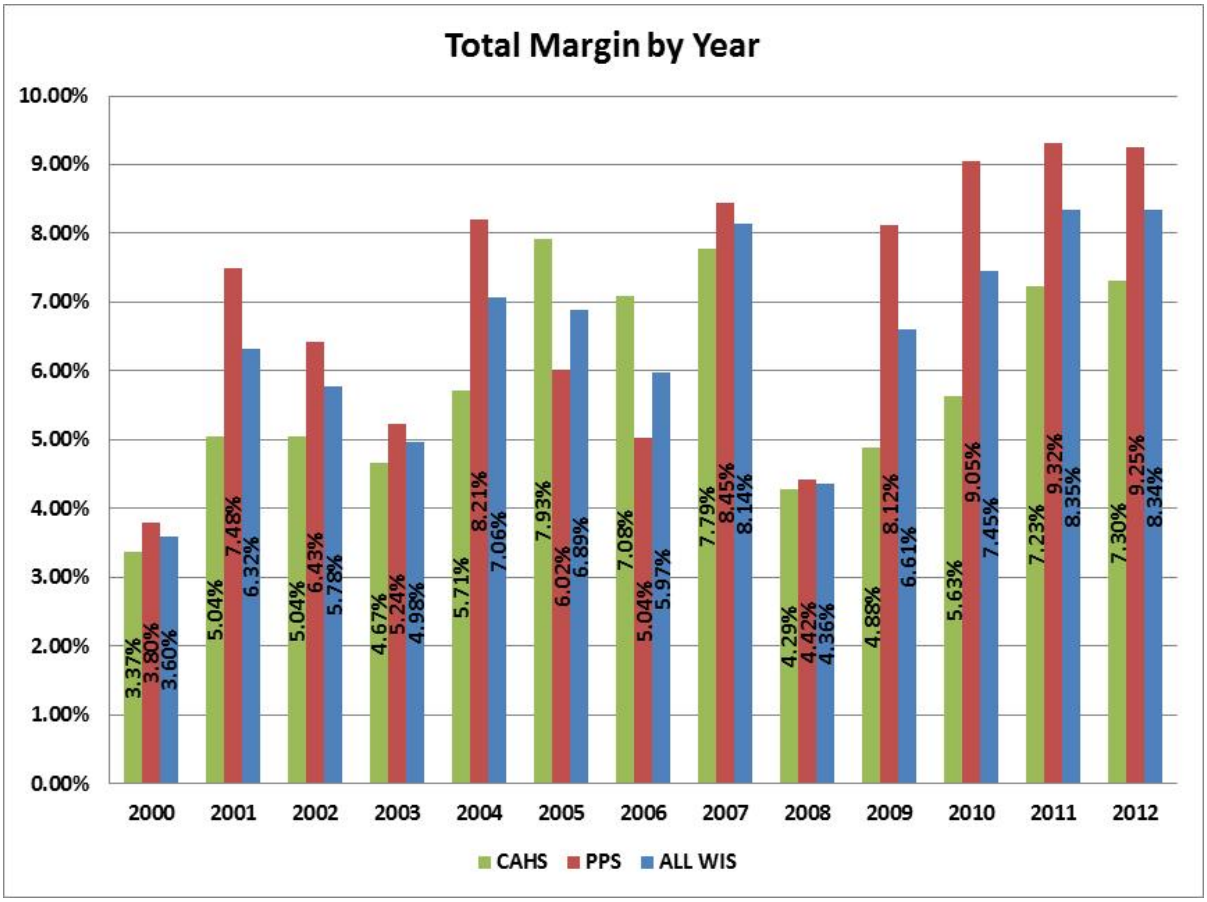
[1] SOURCE: "The Financial Strength Index: A Measure of a Firm's Overall Financial Health," by William O. Cleverley, Ph.D., President, Cleverley & Associates, and Andrew E. Cameron, Ph.D., MBA, Assistant Professor, Ohio State University. Published in the January 2003 issue of HFMA's newsletter, *Executive Insights*.

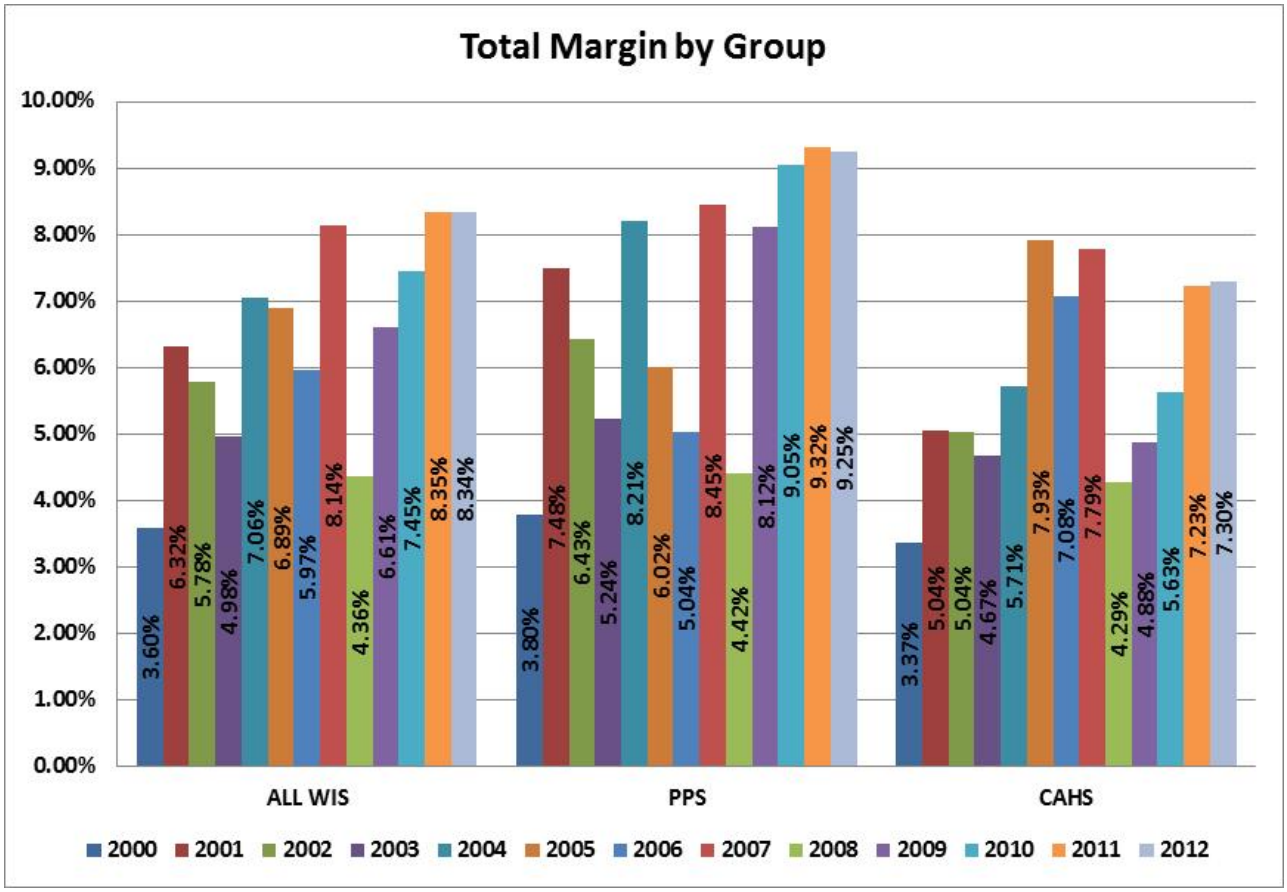

Financial Strength by Year
3.00
2.50
2.00
1.50
1.00
0.50
0.00
(0.50)
(1.00)
CAHS
PPS
ALL WIS
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
(0.45)
(0.30)
(0.37)
(0.18)
0.89
0.38
(0.03)
0.66
0.34
(0.11)
0.20
0.06
0.22
1.50
0.90
0.78
1.17
0.99
0.56
0.84
0.71
0.88
1.72
1.33
0.20
0.85
0.54
0.61
1.98
1.34
0.91
2.49
1.75
1.36
2.75
2.10
1.83
2.77
2.33


Financial Strength by Group
3.00
2.50
2.00
1.50
1.00
0.50
0.00
(0.50)
(1.00)
(0.37)
0.38
0.34
0.06
0.90
0.99
0.71
1.33
0.54
1.34
1.75
2.10
2.33
(0.30)
0.89
0.66
0.20
1.50
1.17
0.84
1.72
0.85
1.98
2.49
2.75
2.77
(0.45)
(0.18)
(0.03)
-0.11
0.22
0.78
0.56
0.88
0.20
0.61
0.91
1.36
1.83
ALL WIS
PPS
CAHS
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012

TOTAL MARGIN

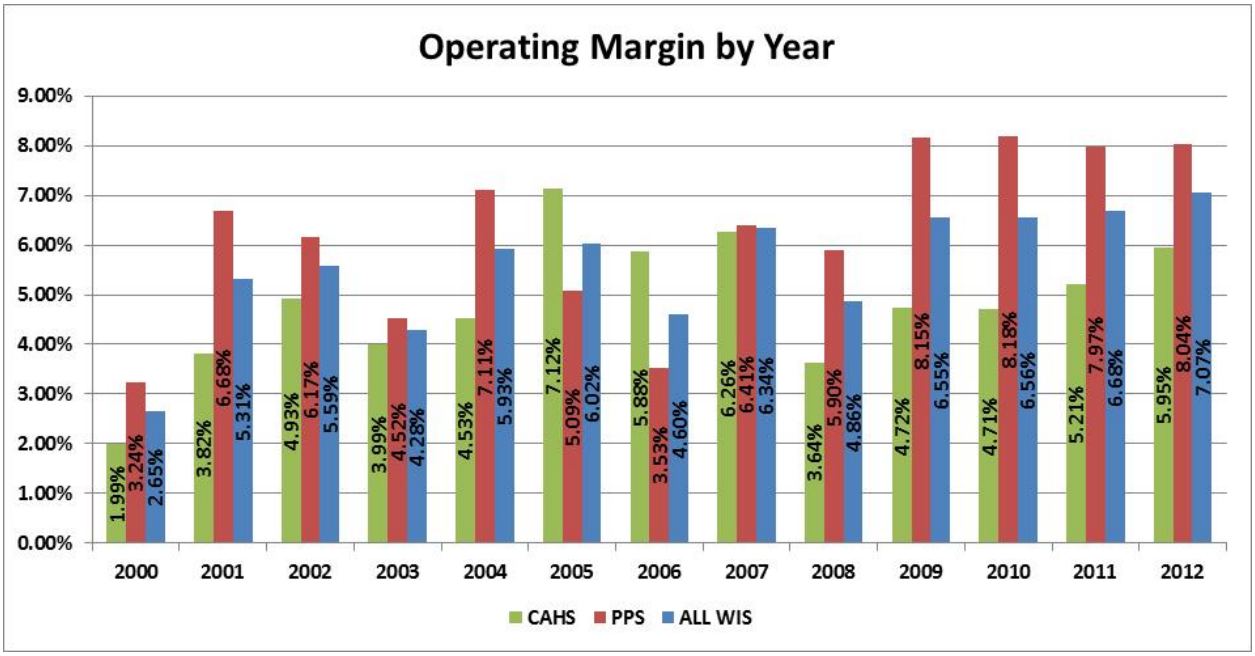
As indicated in Table 4, Total Margin represents the percent of Net Income to Net Patient Revenue. Total Margin ratio includes both operating and non-operating income. Increasing trends are favorable financial indicators. From 2000 through 2004, CAHs Total Margin lagged behind PPS facilities. In 2005 and 2006, Total Margin for CAHs was higher than for PPS hospitals. In 2007 and 2008, CAHs fell slightly below PPS but still had a Total Margin of approximately 8%. In 2009, Total Margin for CAHs increased slightly over 2008 to 4.88% while PPS facilities experienced a more dramatic increase to just over 8%. In 2010, CAHs Total Margin continued to improve to 5.63% and PPS facilities also showed a small increase to 9.05%. For 2011 and 2012, CAH Total Margin increased to slightly over 7% which was about 2% less than PPS facilities.

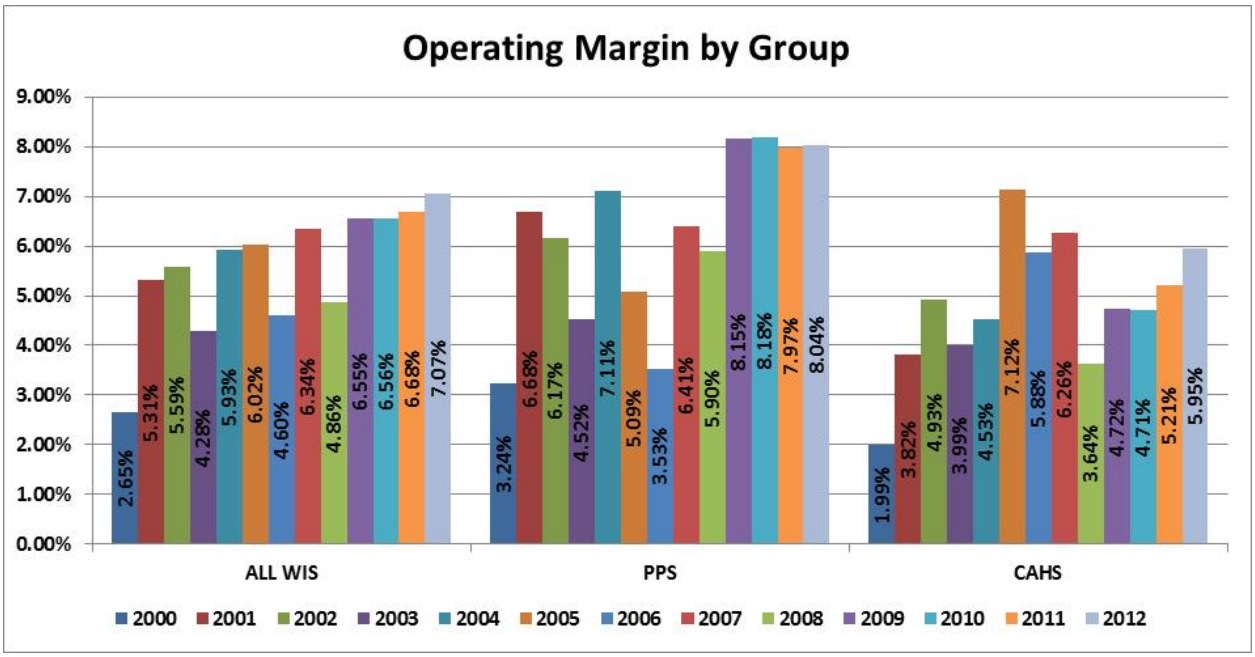




OPERATING MARGIN RATIO

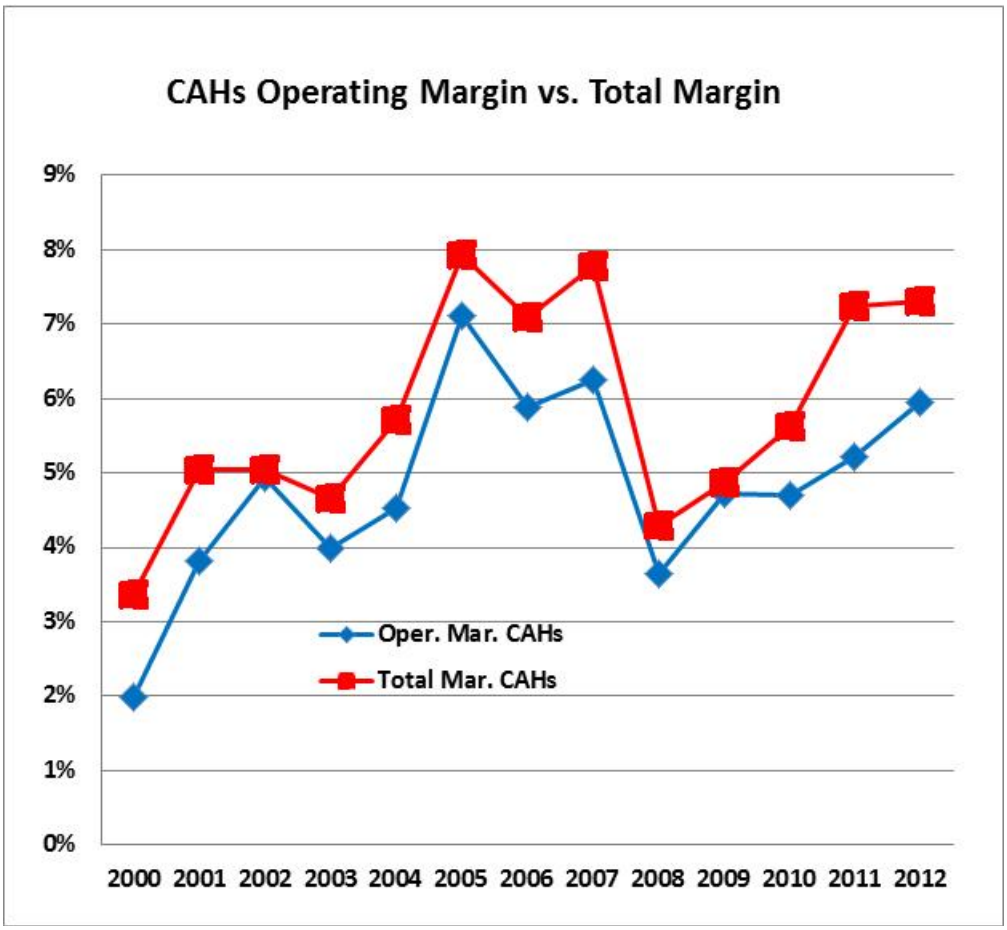
The Operating Margin ratio measures the percent of operating income to total operating revenue. It is used by many analysts as a primary measure of operating profitability. The Operating Margin ratio does not reflect investment income or losses. The following graphs indicate that PPS facilities since 2009 continue to have Operating Margins at about 8%. Operating Margins' for CAHs increased in 2011 and 2012. CAH Operating Margin in 2012 was just under 6%.

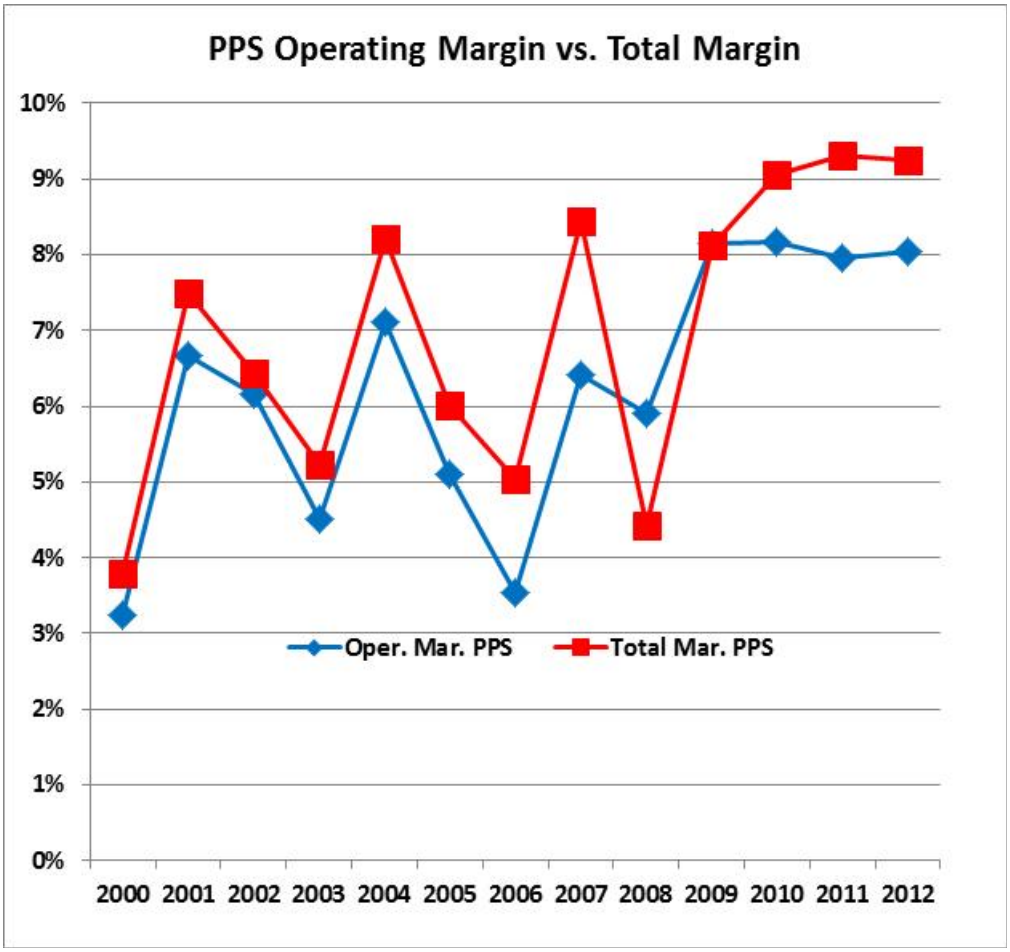

Operating Margin by Year
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
1.99%
3.24%
2.65%
3.82%
6.68%
5.31%
4.93%
6.17%
5.59%
3.99%
4.52%
4.28%
4.53%
7.11%
5.93%
7.12%
5.09%
6.02%
5.88%
3.53%
4.60%
6.26%
6.41%
6.34%
3.64%
5.90%
4.86%
4.72%
8.15%
6.55%
4.71%
8.18%
6.56%
5.21%
7.97%
6.68%
5.95%
8.04%
7.07%
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
CAHS
PPS
ALL WIS


Operating Margin by Group
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
2.65%
5.31%
5.59%
4.28%
5.93%
6.02%
4.60%
6.34%
4.86%
6.55%
6.56%
6.68%
7.07%
3.24%
6.68%
6.17%
4.52%
7.11%
5.09%
3.53%
6.41%
5.90%
8.15%
8.18%
7.97%
8.04%
1.99%
3.82%
4.93%
3.99%
4.53%
7.12%
5.88%
6.26%
3.64%
4.72%
4.71%
5.21%
5.95%
ALL WIS
PPS
CAHS
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012

OPERATING/TOTAL MARGIN COMPARISON

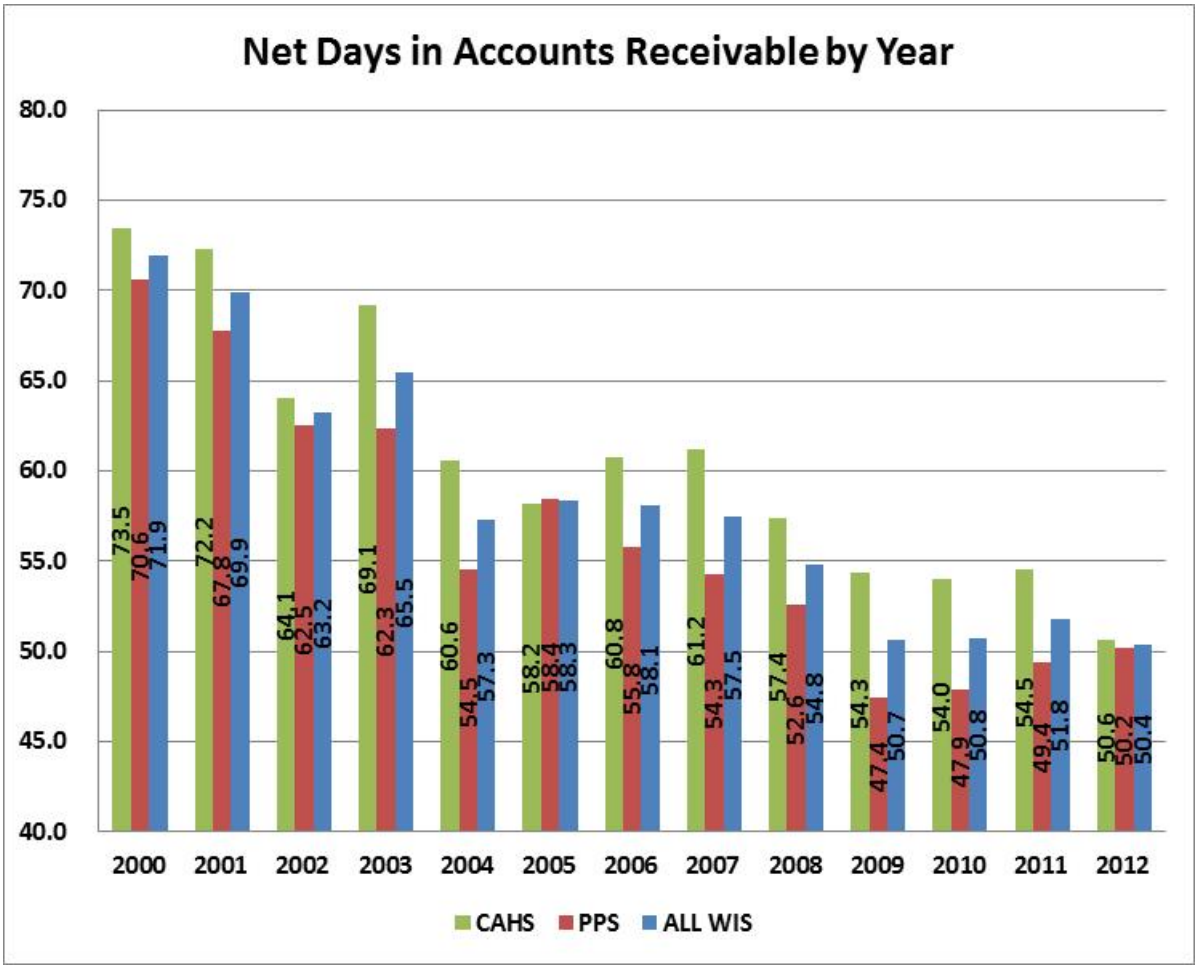
Even though Operating Margins remained relatively flat for 2009 through 2012, because of improved non-operating investment performance, PPS and CAH facilities Total Margins increased during the most recent four year timeframe. CAH Total Margin was slightly over 7% in 2011 and 2012 while PPS Total Margin for the same two year period was just over 9%.

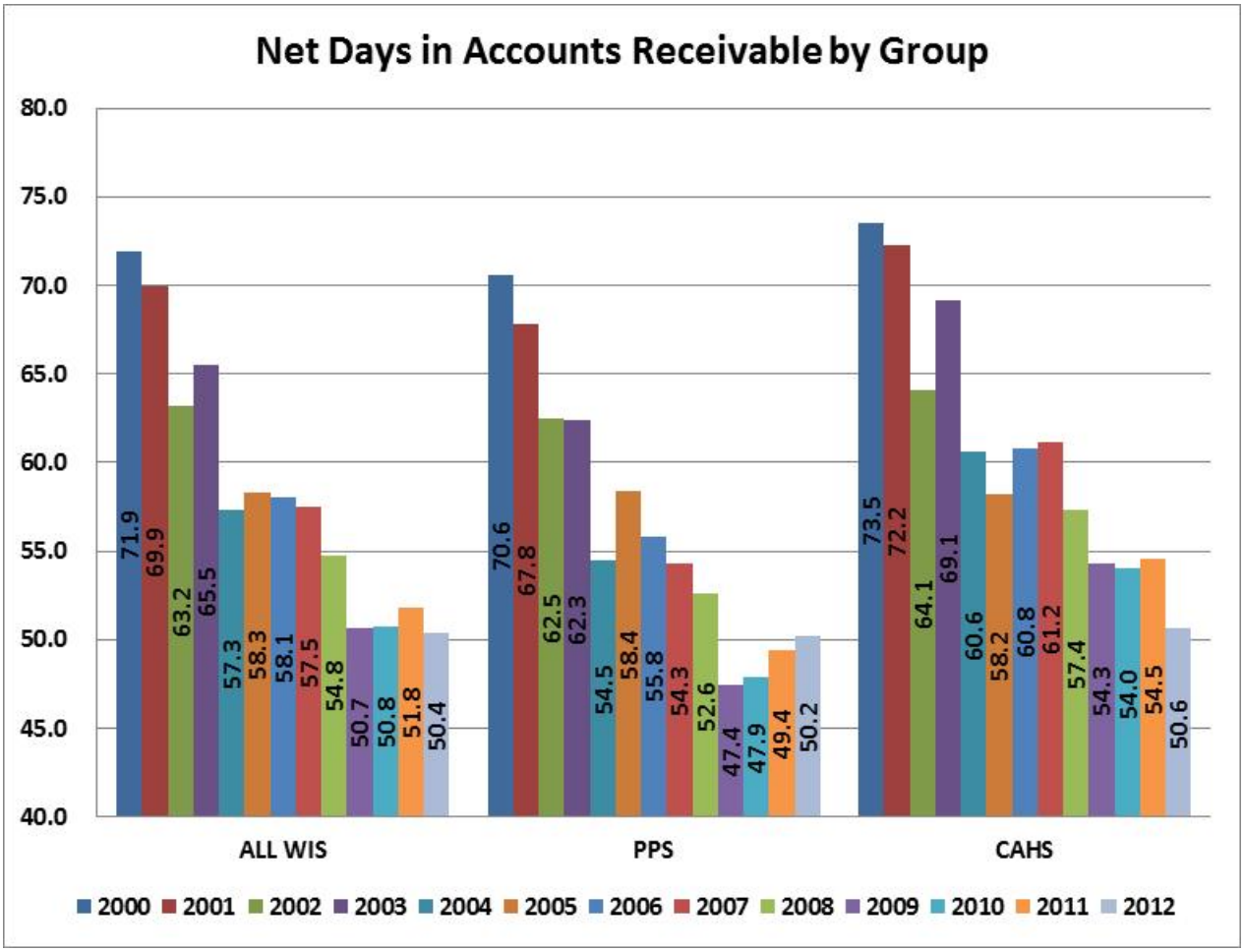




NET DAYS IN ACCOUNTS RECEIVABLE

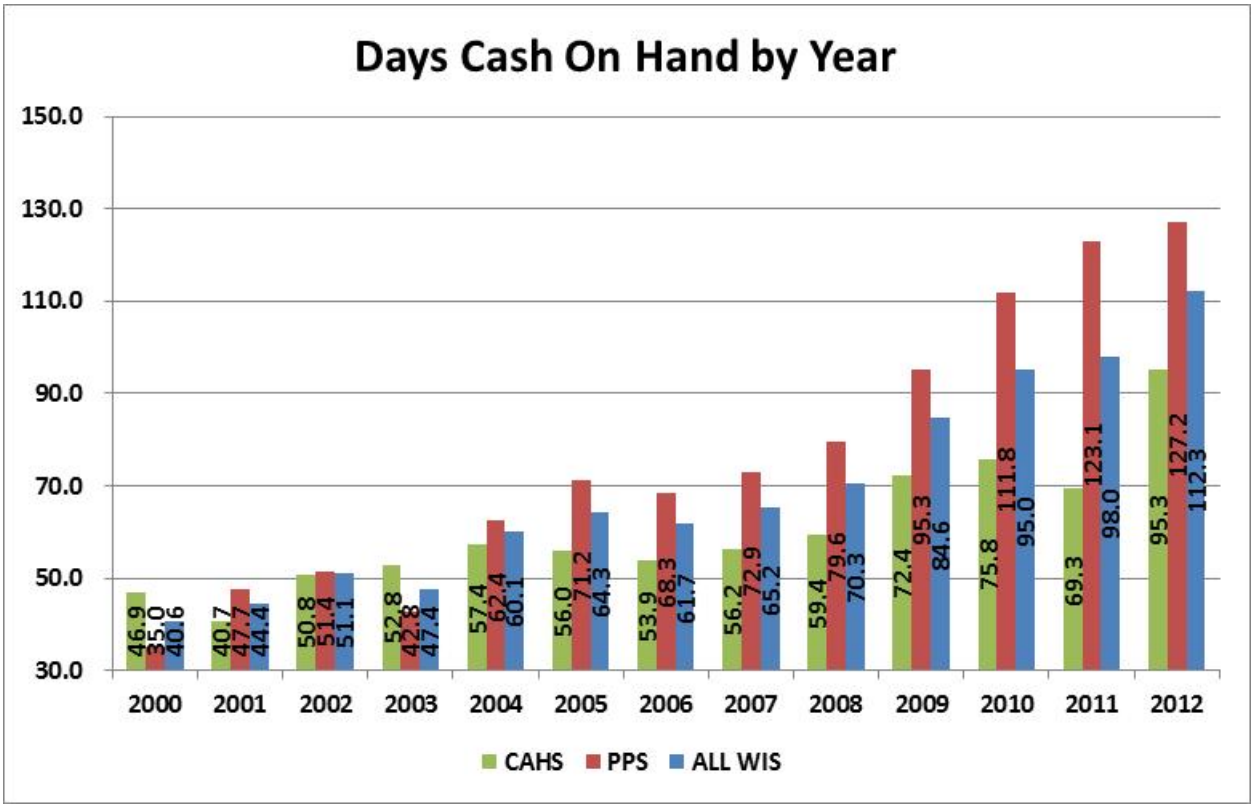
Net Days in Accounts Receivable is a ratio that indicates how quickly services are billed and paid. Generally, low numbers for this ratio are favorable. Decreasing trends show improvement in the collection process. Lower Net Days in Accounts Receivable is a positive trend that usually translates into higher cash account balances. Both groups have shown a general improvement in collecting accounts receivable from 2000 through 2012. CAHs Net Days decreased in 2008, 2009, and 2012. Net Days for both groups remained about the same from 2010 to 2011. CAHs Net Days in Accounts Receivable for 2012 decreased by approximately four days. CAH and PPS facilities both had about 50 Net Days in Accounts Receivable in 2012. The challenge for all facilities will be to maintain low Days in Accounts Receivable during the approaching transition to the ICD-10 coding system (discussed in the "ICD-10-CM/PCS" section of this study.

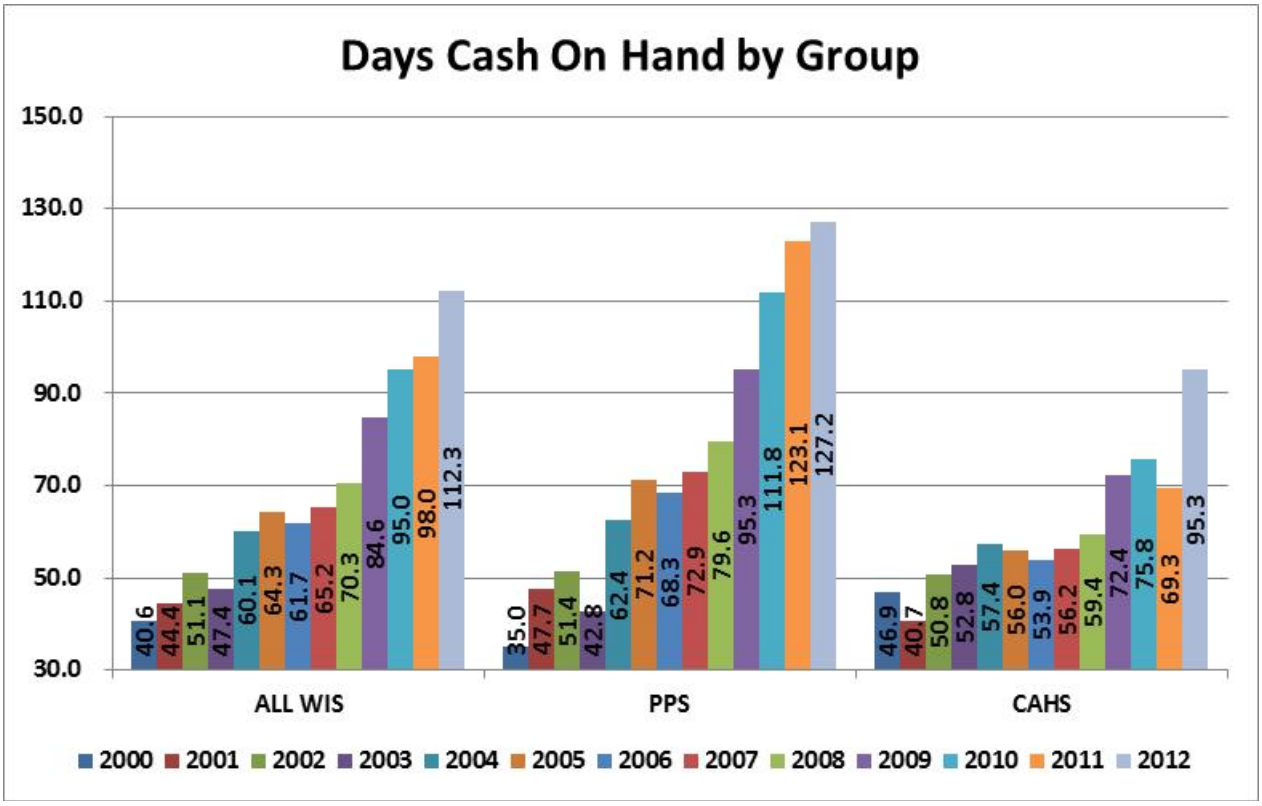

Net Days in Accounts Receivable by Year
80.0
75.0
70.0
65.0
60.0
55.0
50.0
45.0
40.0
73.5
70.6
71.9
72.2
67.8
69.9
64.1
62.5
63.2
69.1
62.3
65.5
60.6
54.5
57.3
58.2
58.4
58.3
60.8
55.8
58.1
61.2
54.3
57.5
57.4
52.6
54.8
54.3
47.4
50.7
54.0
47.9
50.8
54.5
49.4
51.8
50.6
50.2
50.4
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
CAHS
PPS
ALL WIS



DAYS CASH ON HAND

The Days Cash on Hand ratio indicates how many days' cash the facility has based on the average daily cash expenditures. High ratios are favorable and an increasing trend in this ratio is also favorable. The following graphs show a substantial increase for both groups in 2012. However, Days Cash on Hand showed a higher increase in 2012 for CAH facilities than for PPS. As mentioned previously, Days in Accounts Receivable impacts Days Cash on Hand. The major imminent change to ICD-10 coding system discussed in this study could potentially increase Accounts Receivable Days and decrease Days Cash on Hand.


Days Cash On Hand by Year
150.0
130.0
110.0
90.0
70.0
50.0
30.0
46.9 35.0 40.6
40.7 47.7 44.4
50.8 51.4 51.1
52.8 42.8 47.4
57.4 62.4 60.1
56.0 71.2 64.3
53.9 68.3 61.7
56.2 72.9 65.2
59.4 79.6 70.3
72.4 95.3 84.6
75.8 111.8 95.0
69.3 123.1 98.0
95.3 127.2 112.3
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
CAHS PPS ALL WIS

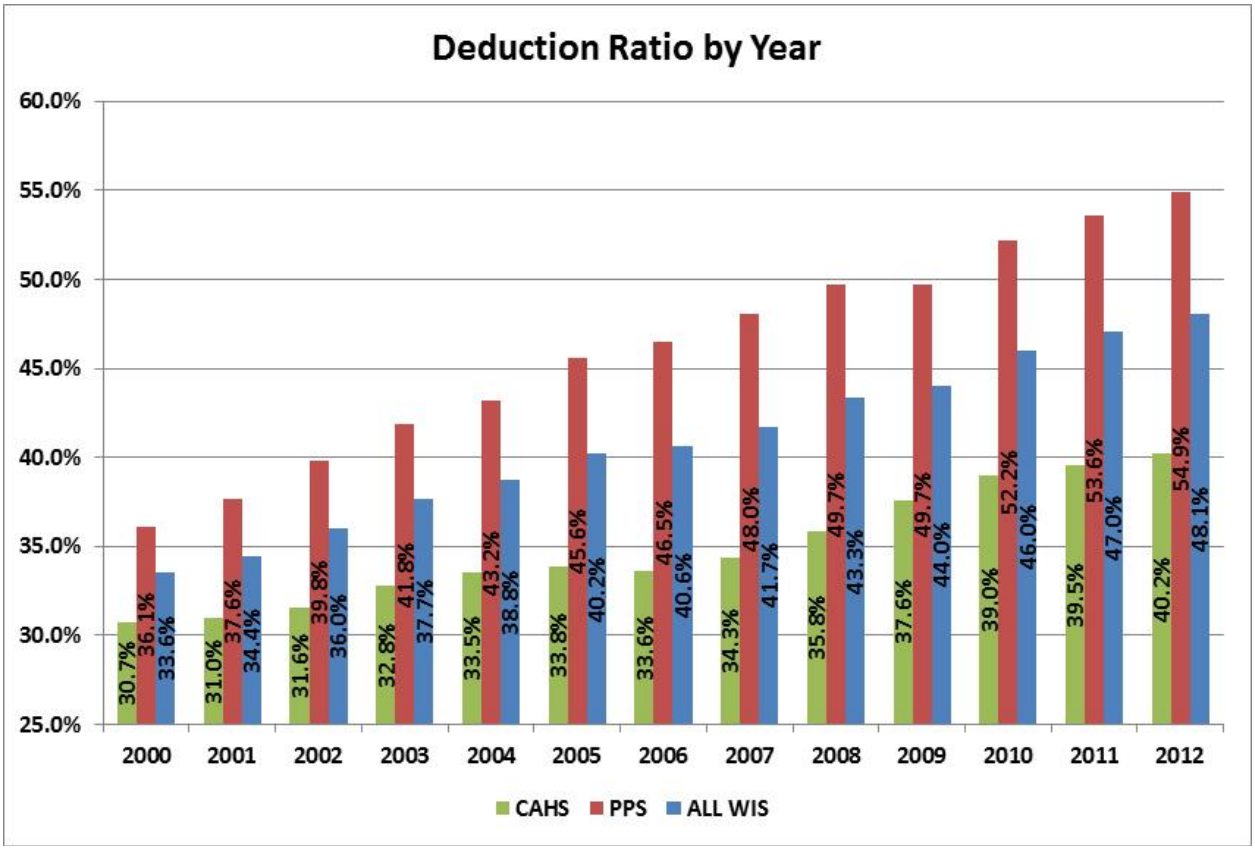

Days Cash On Hand by Group
150.0
130.0
110.0
90.0
70.0
50.0
30.0
40.6 44.4 51.1 47.4 60.1 64.3 61.7 65.2 70.3 84.6 95.0 98.0 112.3
35.0 47.7 51.4 42.8 62.4 71.2 68.3 72.9 79.6 95.3 111.8 123.1 127.2
46.9 40.7 50.8 52.8 57.4 56.0 53.9 56.2 59.4 72.4 75.8 69.3 95.3
ALL WIS
PPS
CAHS
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012

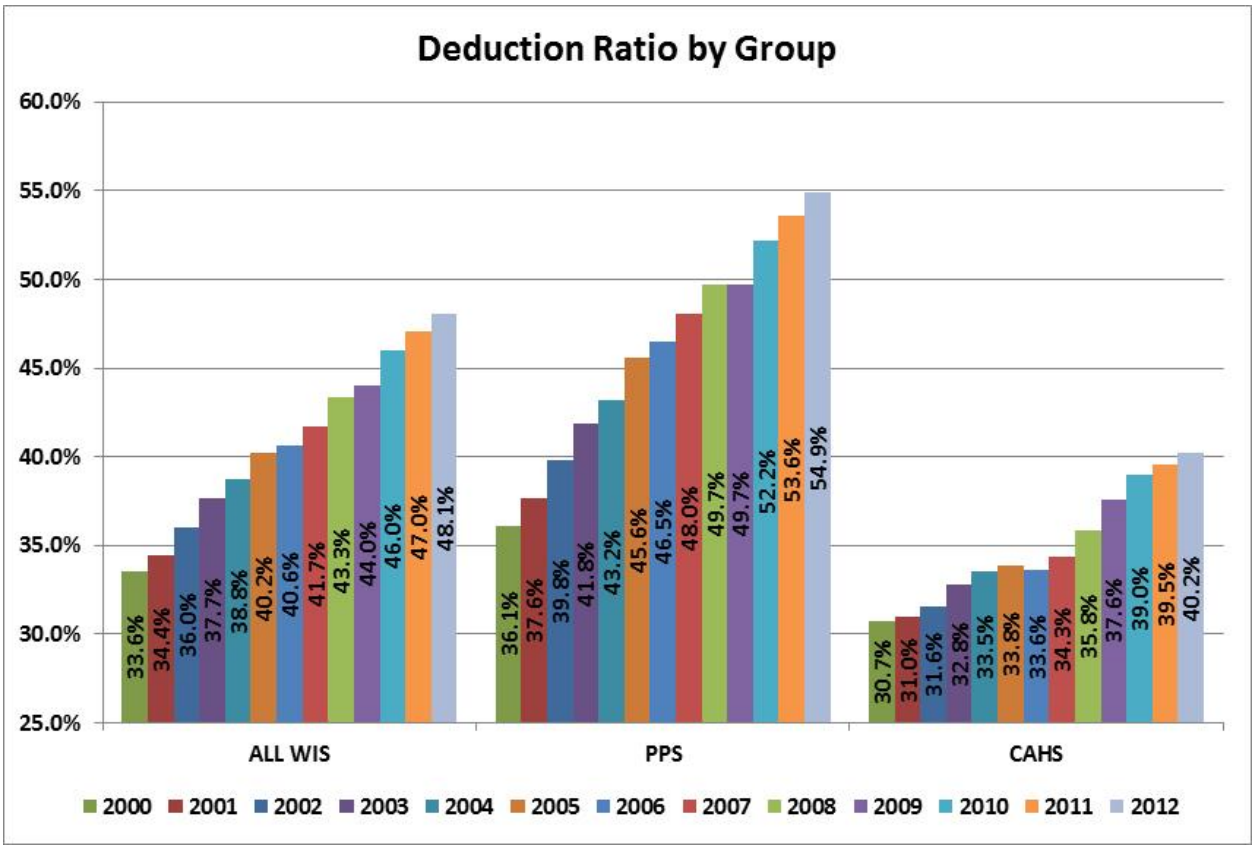
DEDUCTION RATIO

The deduction ratio shows the percent difference between hospital charges and actual cash paid for services provided. The deductions include government payers such as traditional Medicare and Medicaid, Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Medicare Advantage plans, Medicaid HMO plans, and private pay discounts including charity care. During the study period, bad debts are considered expenses and are not included in the deduction ratio. However, in July 2011, the Financial Accounting Standards Board (FASB) published an Accounting Standards update for Healthcare Entities entitled “Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities”. The amendments in this update require certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from operating expense to deduction from patient service revenue (net of contractual allowances and discounts). This change to the treatment of bad debts will affect future financial statements and related financial rations. Although all periods covered in this report treat bad debts as an expense, future financial analysis will need to address this change.

The gap in increases in hospital prices over increases in in Medicare inpatient prospective payments contributes to the rise in the deductible ratio. For CAHs, average charges increase typically more than cost-based reimbursement for traditional Medicare and potentially Medicare Advantage plans.

The following graph indicates a steady increase in the deduction ratio for all groups from 2000 through 2012. It also shows a much higher ratio for PPS than for CAHs. Payer mix, managed care penetration, and charge structure are three reasons the deduction ratio may be higher for some facilities.


Deduction Ratio by Year
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
30.7% 36.1% 33.6%
31.0% 37.6% 34.4%
31.6% 39.8% 36.0%
32.8% 41.8% 37.7%
33.5% 43.2% 38.8%
33.8% 45.6% 40.2%
33.6% 46.5% 40.6%
34.3% 48.0% 41.7%
35.8% 49.7% 43.3%
37.6% 49.7% 44.0%
39.0% 52.2% 46.0%
39.5% 53.6% 47.0%
40.2% 54.9% 48.1%
CAHS
PPS
ALL WIS

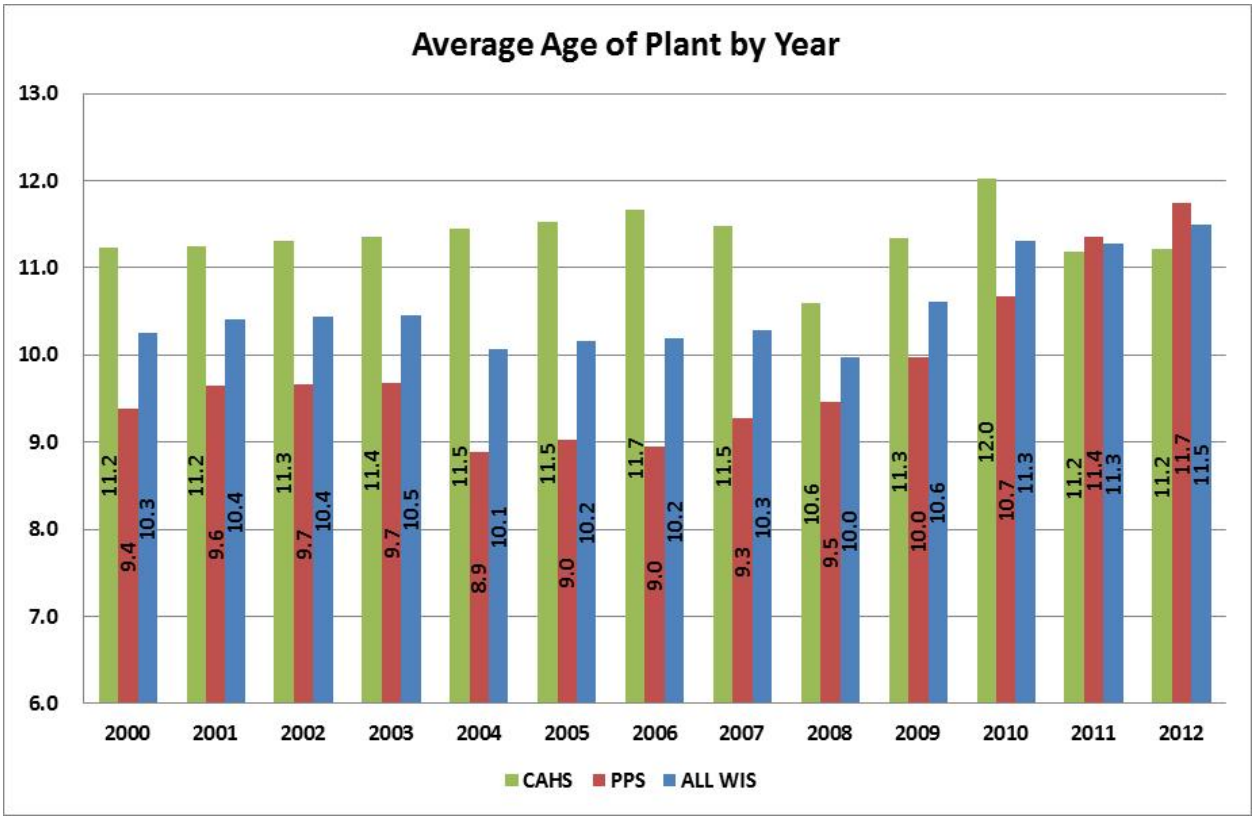

Deduction Ratio by Group
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
33.6% 34.4% 36.0% 37.7% 38.8% 40.2% 40.6% 41.7% 43.3% 44.0% 46.0% 47.0% 48.1%
36.1% 37.6% 39.8% 41.8% 43.2% 45.6% 46.5% 48.0% 49.7% 49.7% 52.2% 53.6% 54.9%
30.7% 31.0% 31.6% 32.8% 33.5% 33.8% 33.6% 34.3% 35.8% 37.6% 39.0% 39.5% 40.2%
ALL WIS
PPS
CAHS
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012

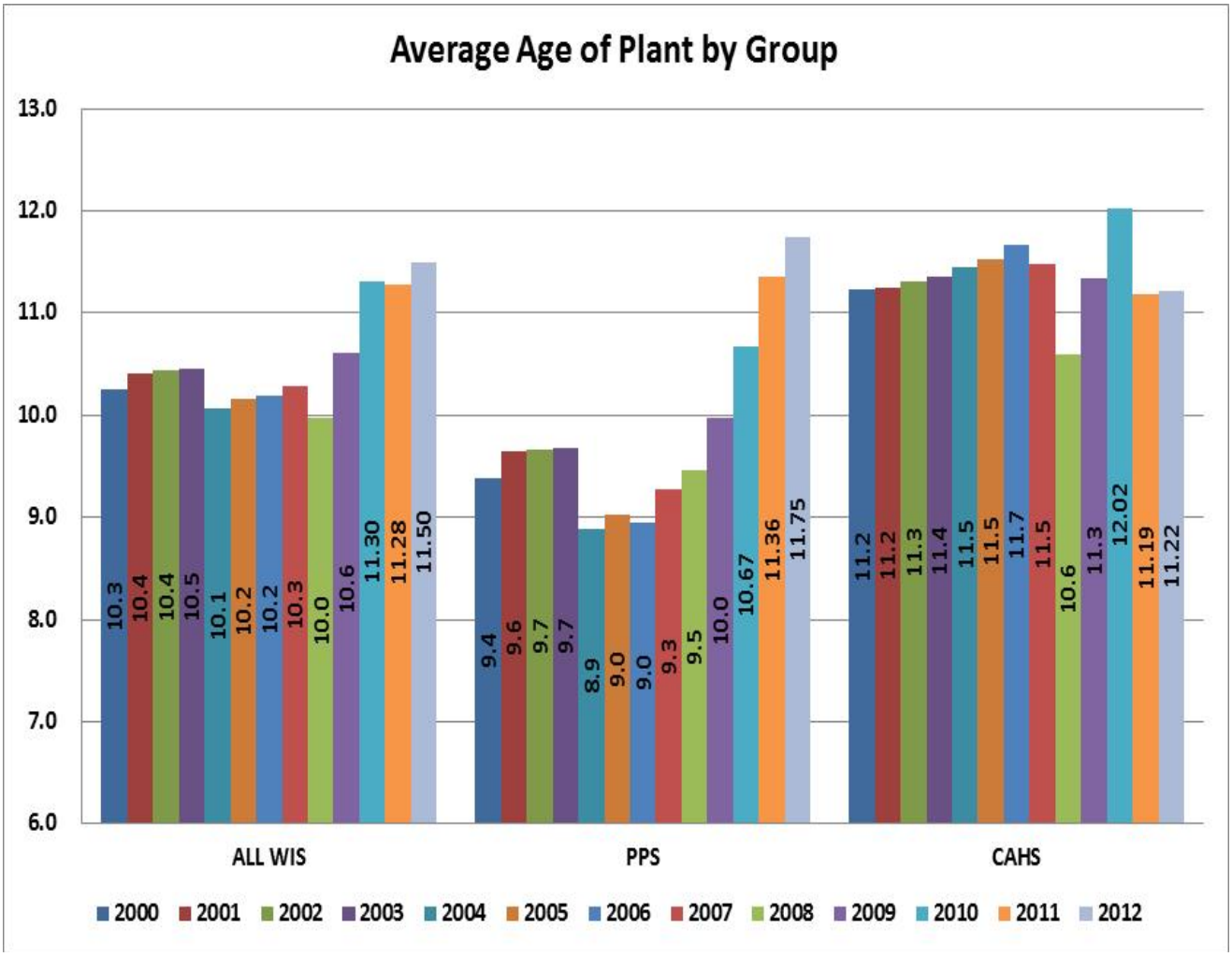
AVERAGE AGE OF PLANT

Many hospitals, both PPS and CAHs, struggle to replace outdated facilities and equipment. Average Age of Plant is typically used as a benchmark to measure capital improvements. It is generally felt that the Average Age of Plant should be less than 10.0, and some financial analysts feel that it should be closer to 7.5. Average Age of Plant is calculated by dividing Accumulated Depreciation by Depreciation Expense. Lower ratios and decreasing trends are usually associated with financially strong organizations. The following graphs show a decrease in Average Age of Plant for CAHs in 2011 to 11.2. PPS facilities showed an increase in Age of Plant in 2011 to 11.4 years. Average Age of Plant for both groups remained about the same in 2012. This is the first study that shows Age of Plant is higher in PPS hospitals than CAHs. Although many factors determine how much money hospitals invest in capital, the graph would seem to indicate that CAH status may be helping rural hospitals modernize plants and equipment.

One factor which may affect future capital investment and the resulting Average Age of Plant ratio is the American Recovery and Reinvestment Act of 2009 (ARRA). This legislation helps provide hospitals the funding and incentives to implement systems such as Nurse Documentation, Electronic Medication Administration Records, Bedside Medication Verification Systems, or Computerized Practitioner Order entry. Utilized correctly, these systems can improve efficiency and the quality of patient care. This program is further discussed in the Health Information Technology section of this study.

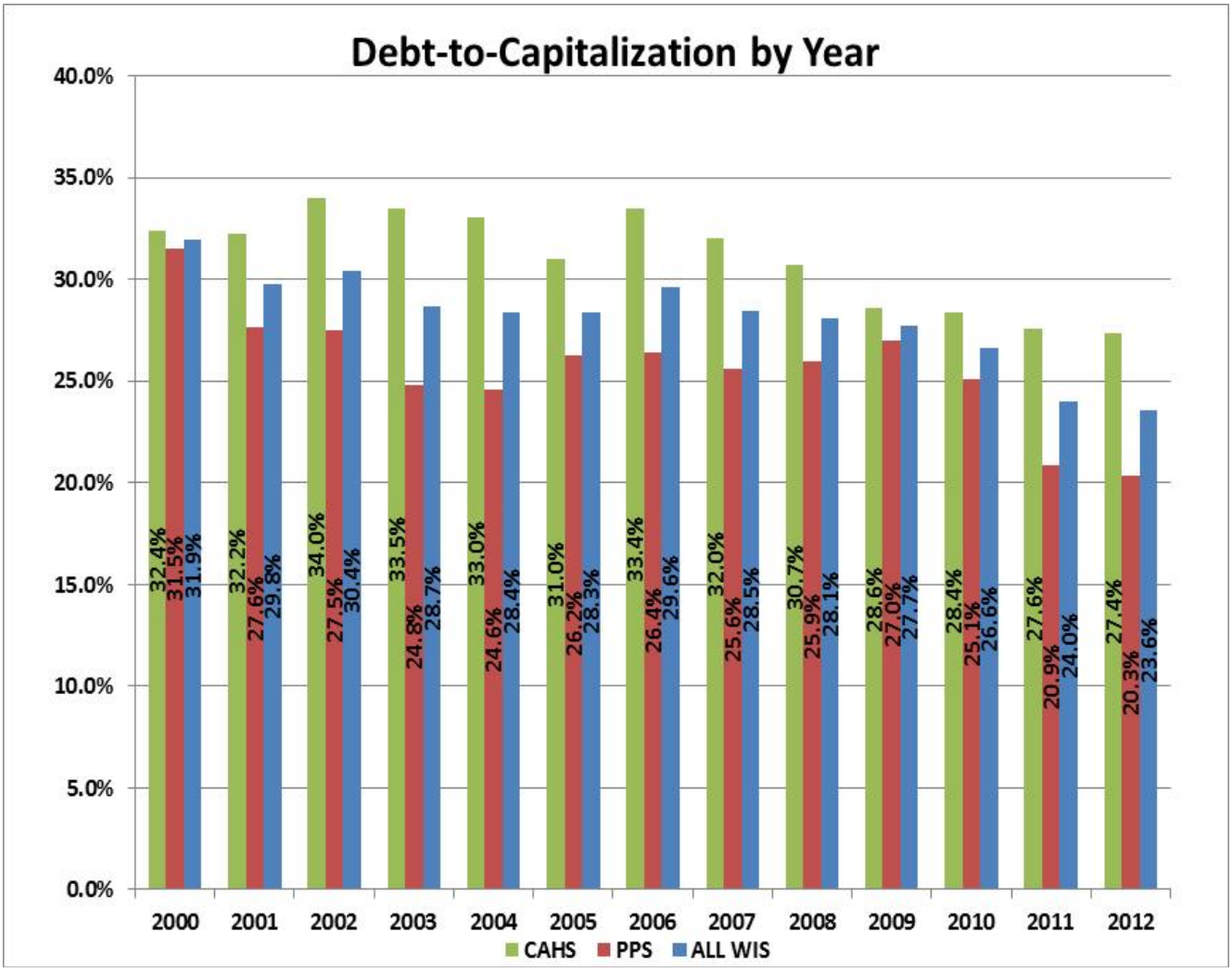
Access to capital will continue to be one a top priority of all hospitals. Smaller hospitals usually find it more difficult to access capital than larger organizations. Some rural hospitals are due for major renovation or replacement. Aged facilities can become very inefficient and affect quality of care and patient safety. Even financially strong hospitals have more limited borrowing options, higher cost of capital, and more restrictive debt terms. Capital needs continue to be near the top of the list of priorities for rural hospitals. Hospitals that cannot obtain capital may even need to secure partners or merge with larger organizations to access needed capital resources. Another factor that will affect Average Age of Plant is the potential impact of PPACA health care reform. Facilities may decide due to the financial uncertainties of healthcare reform to wait on major investments in capital projects.

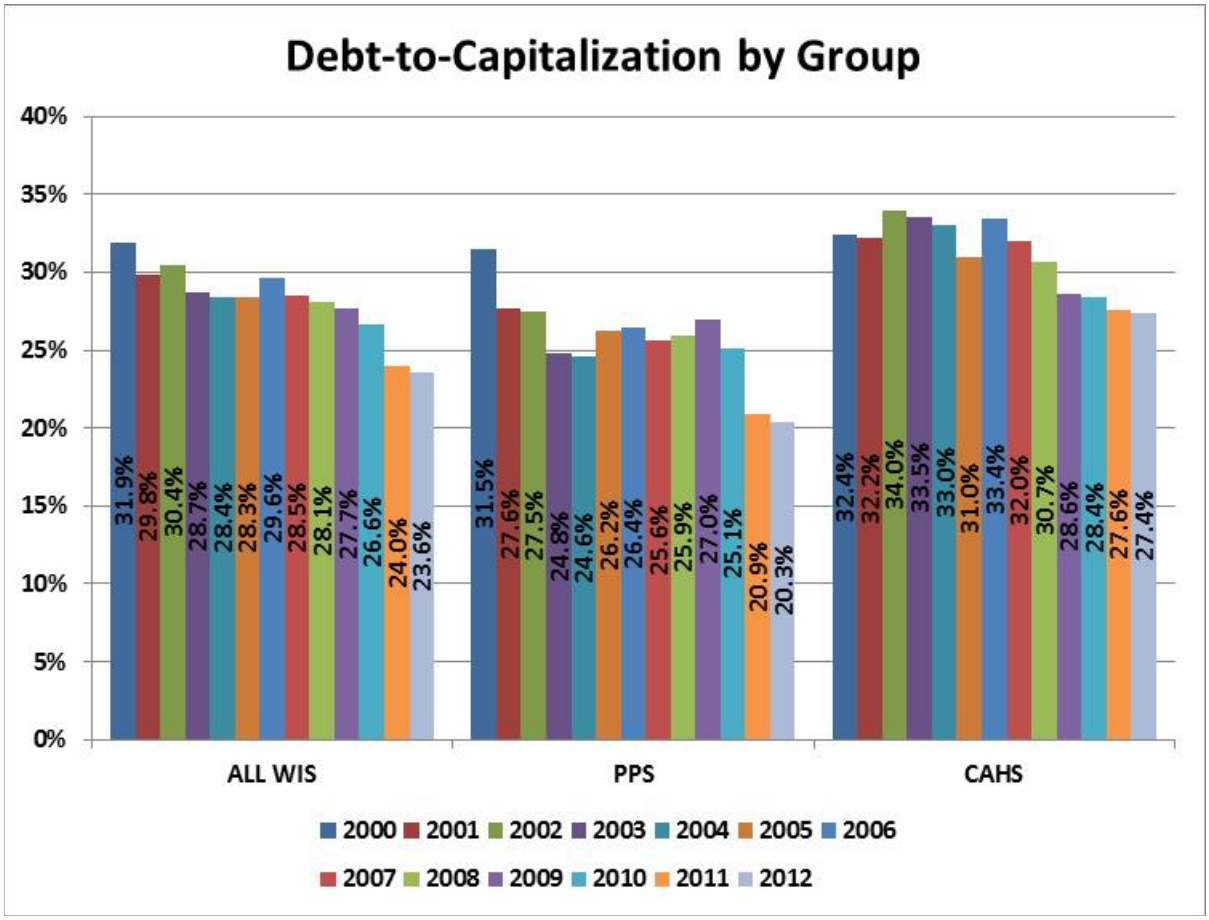

Average Age of Plant by Year
13.0
12.0
11.0
10.0
9.0
8.0
7.0
6.0
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
11.2 9.4 10.3
11.2 9.6 10.4
11.3 9.7 10.4
11.4 9.7 10.5
11.5 8.9 10.1
11.5 9.0 10.2
11.7 9.0 10.2
11.5 9.3 10.3
10.6 9.5 10.0
11.3 10.0 10.6
12.0 10.7 11.3
11.2 11.4 11.3
11.2 11.7 11.5
CAHS
PPS
ALL WIS



DEBT-TO-CAPITALIZATION

The Debt-to-Capitalization ratio is a new ratio added to the 2013 Critical Access Hospital study. This ratio measures the utilization of long-term sources of debt financing. This ratio is many times used as a covenant in capital financings. A commonly used maximum debt-to-capitalization covenant is 60%. The Debt-to-Capitalization ratio is affected by the patterns of long-term borrowing, debt retirement, and changes in Fund Balance. It is especially important to maintain favorable debt-to-capitalization ratios when new financing is being completed. The ability to attract debt capital on favorable terms may be related to debt-to-capitalization experience. The Debt-to-Capitalization ratio is calculated by dividing Long-Term Debt by Long-Term Debt plus Fund Balance. Decreasing values for this ratio is favorable. Low values are also favorable. The following two graphs show a decreasing trend in Debt-to-Capitalization for both PPS and CAHs from 2006 through 2012. CAHs have a higher Debt-to-Capitalization than PPS facilities.


Debt-to-Capitalization by Year
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
32.4%
31.5%
31.9%
32.2%
27.6%
29.8%
34.0%
27.5%
30.4%
33.5%
24.8%
28.7%
33.0%
24.6%
28.4%
31.0%
26.2%
28.3%
33.4%
26.4%
29.6%
32.0%
25.6%
28.5%
30.7%
25.9%
28.1%
28.6%
27.0%
27.7%
28.4%
25.1%
26.6%
27.6%
20.9%
24.0%
27.4%
20.3%
23.6%
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
CAHS
PPS
ALL WIS

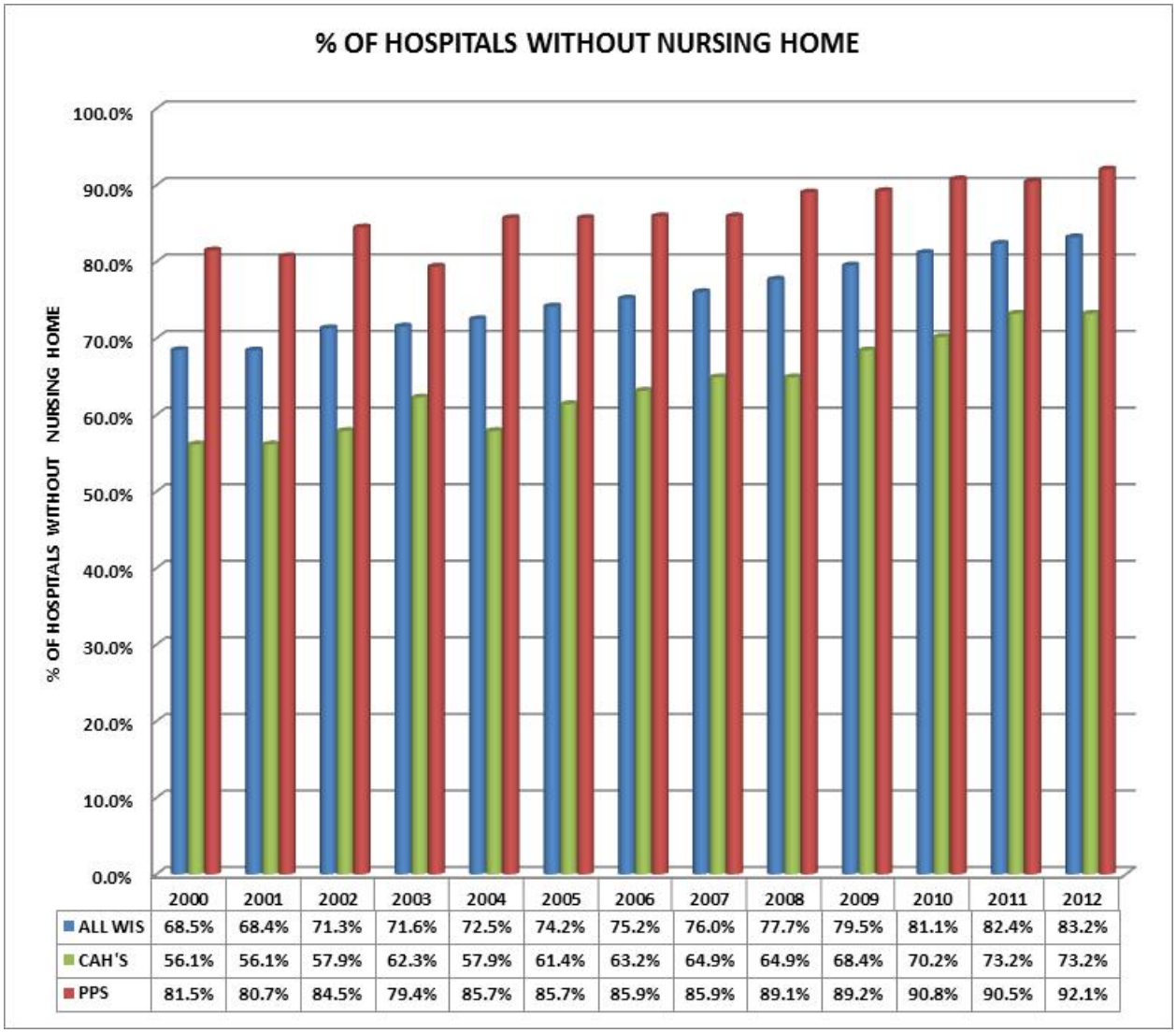

Debt-to-Capitalization by Group
40%
35%
30%
25%
20%
15%
10%
5%
0%
31.9%
29.8%
30.4%
28.7%
28.4%
28.3%
29.6%
28.5%
28.1%
27.7%
26.6%
24.0%
23.6%
31.5%
27.6%
27.5%
24.8%
24.6%
26.2%
26.4%
25.6%
25.9%
27.0%
25.1%
20.9%
20.3%
32.4%
32.2%
34.0%
33.5%
33.0%
31.0%
33.4%
32.0%
30.7%
28.6%
28.4%
27.6%
27.4%
ALL WIS
PPS
CAHS
2000 2001 2002 2003 2004 2005 2006
2007 2008 2009 2010 2011 2012

CHANGES IN SERVICES

The first Wisconsin hospital converted to critical access status in 1999. We now have thirteen years of data from the Annual Survey of Hospitals. This is sufficient time to determine if there are trends in services Wisconsin hospitals are provide. The Fiscal and Annual Surveys for the last several years have been submitted to the WHA Information Center. The Annual Survey of Hospitals requires hospitals to report on a very comprehensive list of services. Typically, hospitals must indicate by a code number is the service is provided or not. The possible codes are from 1 to 5. The first 4 codes indicate how and where the service is provided or if the service is available through a contractual arrangement with another provider. Code 5 indicates the service is not available either by the hospital or through a formal contractual arrangement with another hospital or provider. As in the prior study, this report will determine the % of CAH or PPS facilities that do not provide the service (code 5).

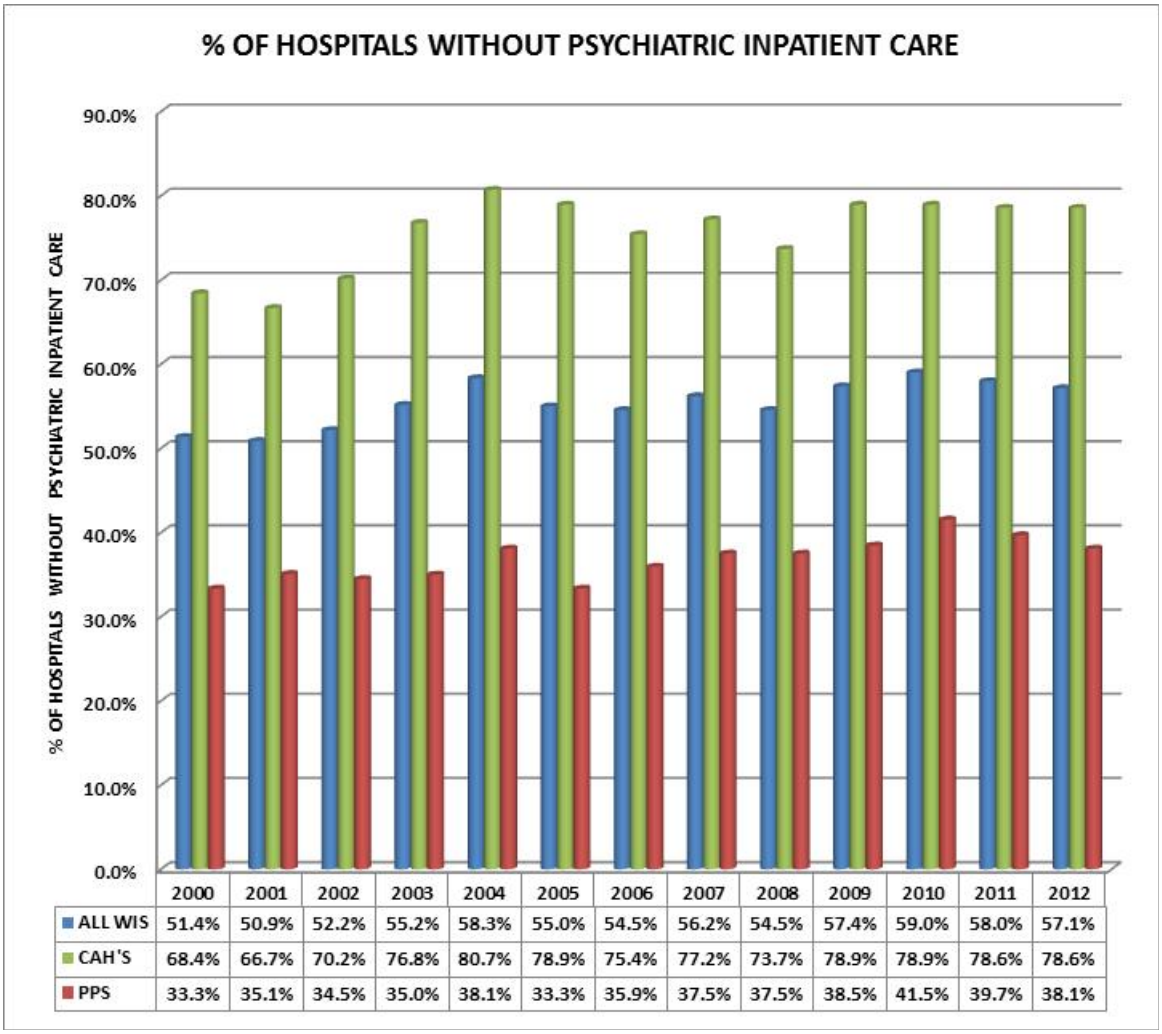
As mentioned, CAHs are reimbursed 101% of the cost they incur for covered hospital inpatient, outpatient, and swing bed services provided to Medicare beneficiaries. Medicare cost-finding reimbursement principles require that all services be subjected to the allocation of overhead costs such as depreciation, utilities, and housekeeping. For example, if a hospital provides long-term care, direct and indirect costs are allocated to Skilled Nursing Facility (SNF). Medicare does not pay for all services and their share of the services varies. For example, if a facility provides “Meals-On-Wheels” to members of their community, Medicare does not participate in the costs because this service is not covered by Medicare. Additionally, Nursery and Obstetric services are provided by almost all facilities but because Medicare beneficiaries are almost exclusively over 65, Medicare utilization is minimal. Another example of how financial considerations may affect which services CAHs provide is SNF. Although the SNF may be Medicare-certified, SNF’s are not cost reimbursed. The SNF Medicare payment system is based on prospective Resource Utilization Groups (RUGS). CAHs may face low RUG rates and relatively low volume, the same problems they confronted when they were paid under the Medicare prospective payment system for hospital services. The following graphs show the % of hospitals that do not provide services by CAHs, PPS, and both groups combined.

The % of CAHs that do not provide long-term care services has increased from 56% in 2000 to 73% in 2012. The % of CAHs providing long-term care services is still higher than for PPS facilities. In 2012, over 92% of PPS hospitals did not provide this service.



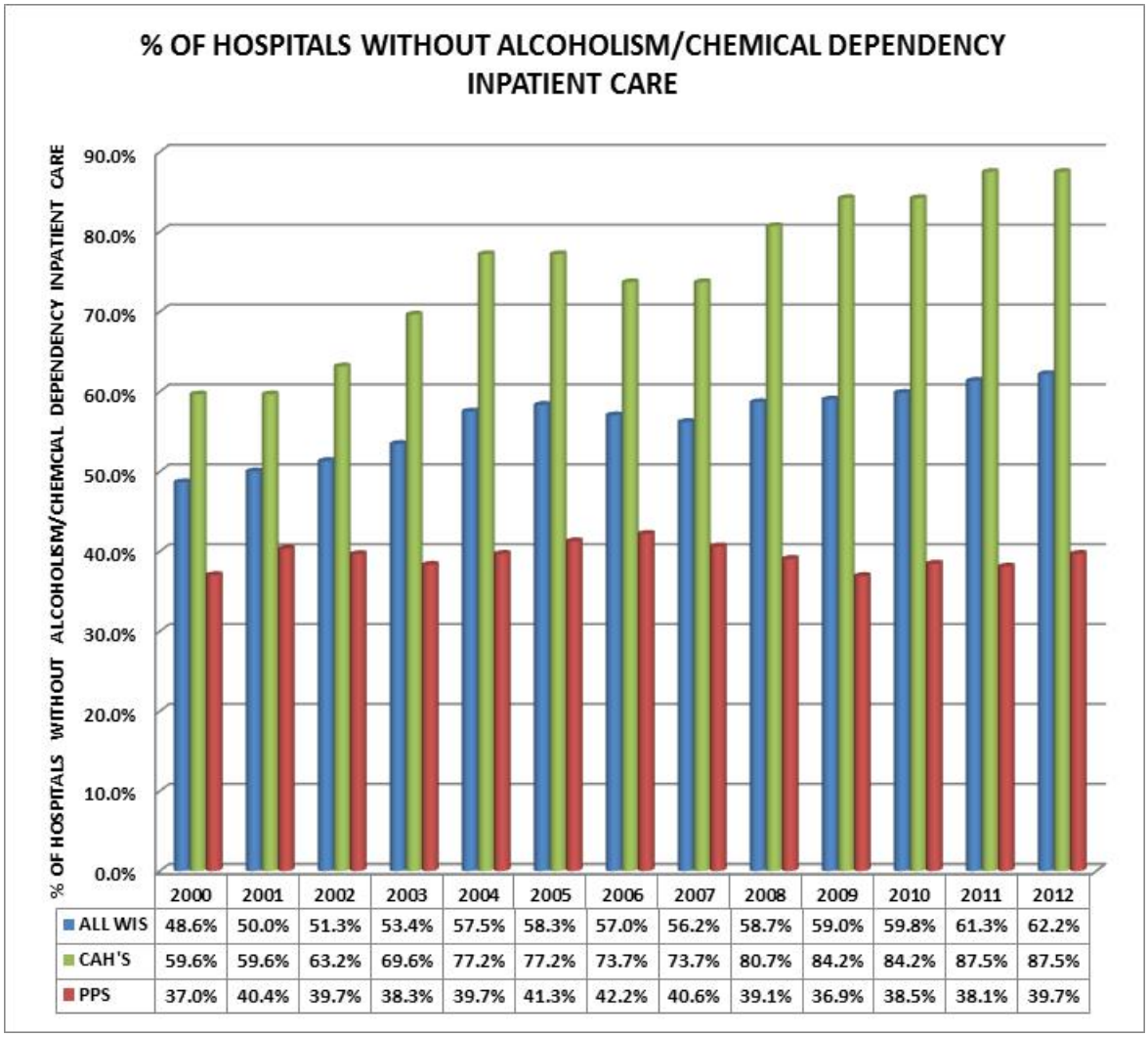
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	68.5%	68.4%	71.3%	71.6%	72.5%	74.2%	75.2%	76.0%	77.7%	79.5%	81.1%	82.4%	83.2%
CAH'S	56.1%	56.1%	57.9%	62.3%	57.9%	61.4%	63.2%	64.9%	64.9%	68.4%	70.2%	73.2%	73.2%
PPS	81.5%	80.7%	84.5%	79.4%	85.7%	85.7%	85.9%	85.9%	89.1%	89.2%	90.8%	90.5%	92.1%

In spite of the fact that the % of PPS facilities that do not provide Psychiatric inpatient care services has increased from slightly over 33% in 2000 to about 38% in 2012, a much higher % of CAHs do not provide this service than PPS hospitals (78% for CAHs in 2012 versus 38% for PPS).



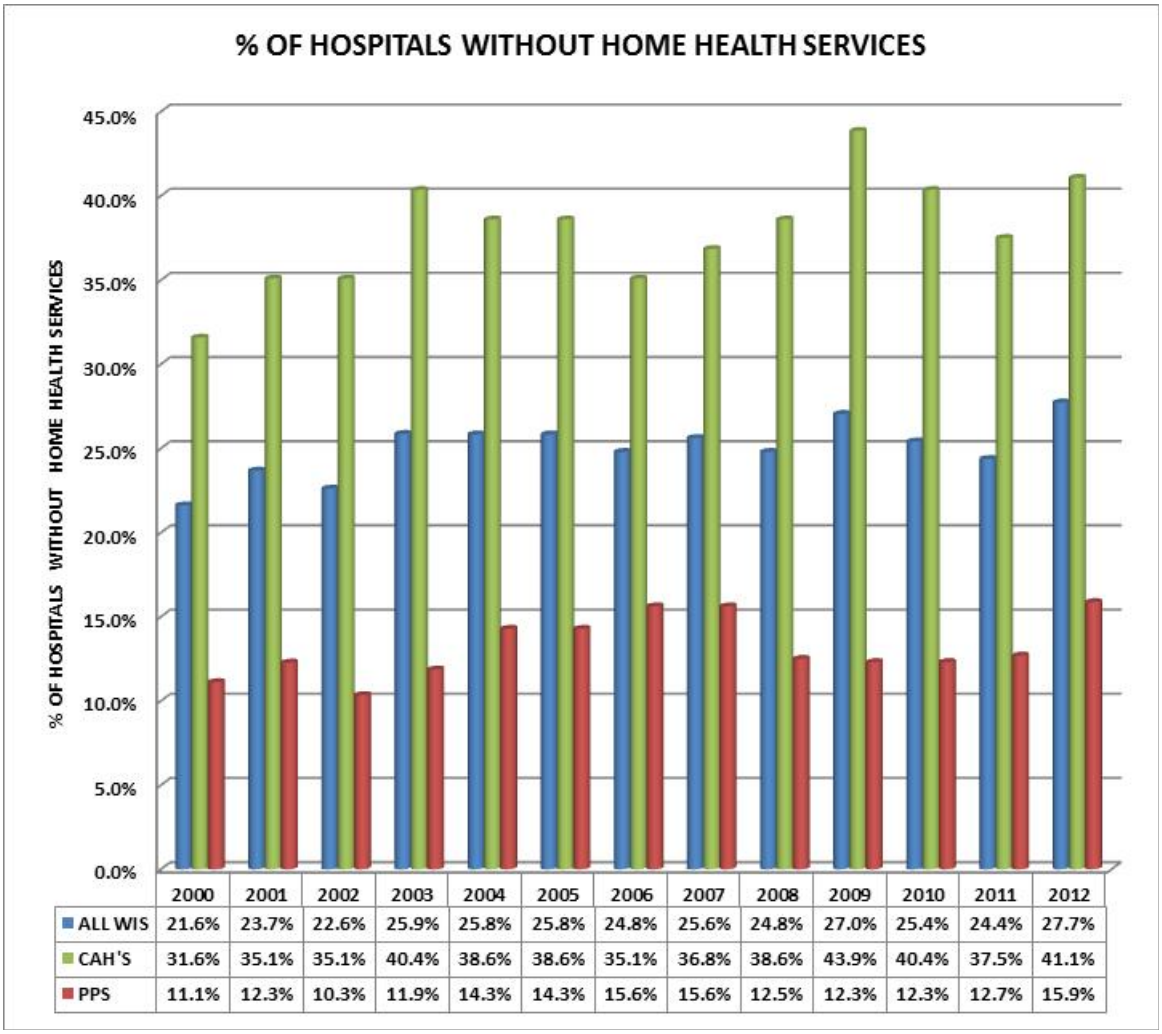
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	51.4%	50.9%	52.2%	55.2%	58.3%	55.0%	54.5%	56.2%	54.5%	57.4%	59.0%	58.0%	57.1%
CAH'S	68.4%	66.7%	70.2%	76.8%	80.7%	78.9%	75.4%	77.2%	73.7%	78.9%	78.9%	78.6%	78.6%
PPS	33.3%	35.1%	34.5%	35.0%	38.1%	33.3%	35.9%	37.5%	37.5%	38.5%	41.5%	39.7%	38.1%

The % of PPS facilities that do not provide Alcoholism and Chemical Dependency Inpatient Care has remained relatively unchanged from 2000 to 2012 (approximately 40%). However, there has been a substantial increase in the % of CAHs that do not provide this service. The % of CAHs that do not provide Alcoholism and Chemical Dependency Inpatient Care has risen from just under 60% in 2000 to over 87% in 2012.



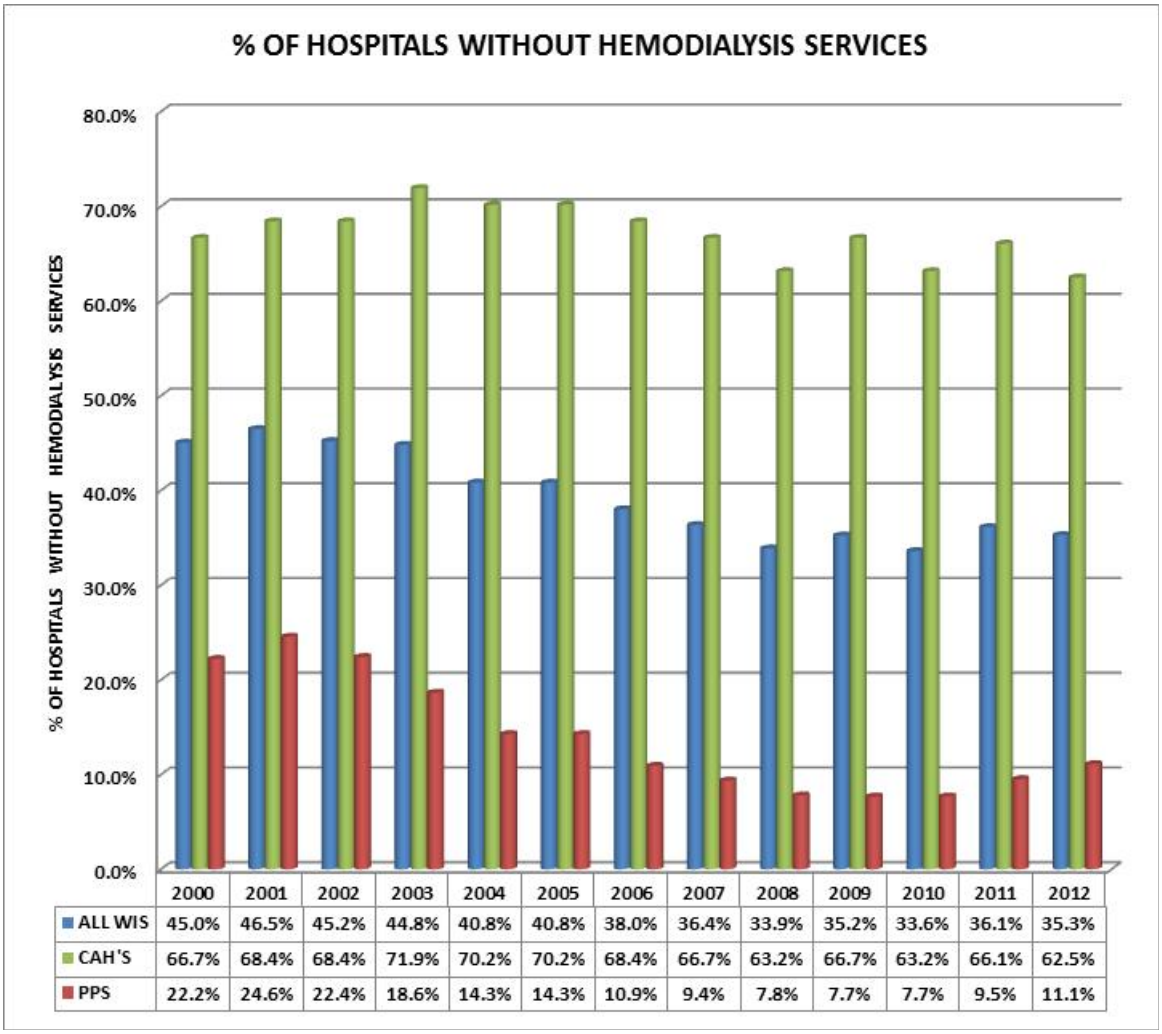
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	48.6%	50.0%	51.3%	53.4%	57.5%	58.3%	57.0%	56.2%	58.7%	59.0%	59.8%	61.3%	62.2%
CAH'S	59.6%	59.6%	63.2%	69.6%	77.2%	77.2%	73.7%	73.7%	80.7%	84.2%	84.2%	87.5%	87.5%
PPS	37.0%	40.4%	39.7%	38.3%	39.7%	41.3%	42.2%	40.6%	39.1%	36.9%	38.5%	38.1%	39.7%

The analysis of Home Health Services shows a similar trend to the prior graph of Alcoholism and Chemical Dependency Inpatient Care service. More CAHs are deciding not to provide Home Health services as the % that do not provide this service has increased from 31% in 2000 to over 41% in 2012. The % of PPS facilities that do not provide Home Health Services remained relatively stable at about 12% from 2000 through 2011. The % of PPS facilities not providing Home Health Services increased to almost 16% in 2012.



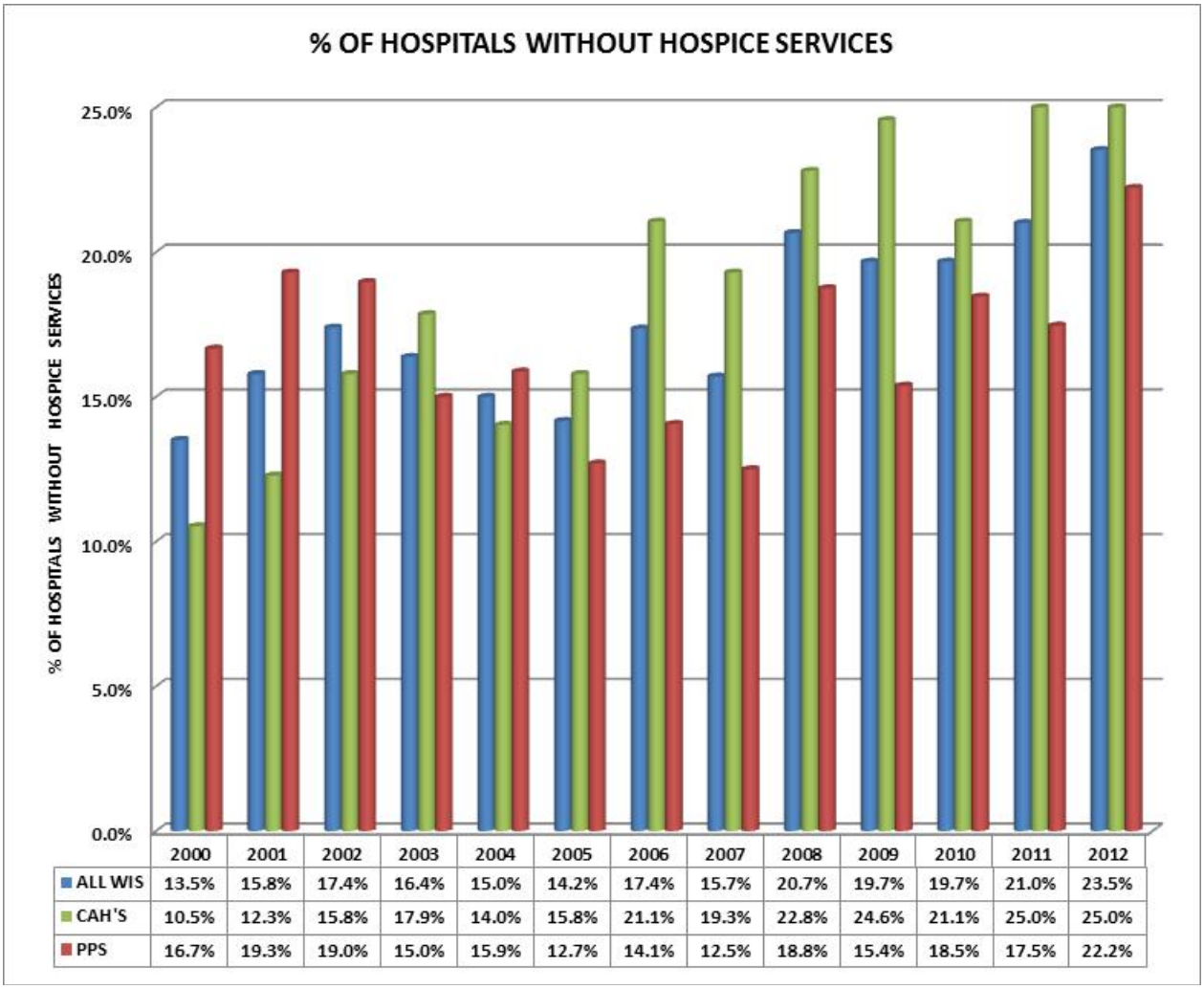
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	21.6%	23.7%	22.6%	25.9%	25.8%	25.8%	24.8%	25.6%	24.8%	27.0%	25.4%	24.4%	27.7%
CAH'S	31.6%	35.1%	35.1%	40.4%	38.6%	38.6%	35.1%	36.8%	38.6%	43.9%	40.4%	37.5%	41.1%
PPS	11.1%	12.3%	10.3%	11.9%	14.3%	14.3%	15.6%	15.6%	12.5%	12.3%	12.3%	12.7%	15.9%

The % of PPS hospitals not providing Hemodialysis Services increased from 7.7% in 2011 to about 10% in 2011 and slightly over 11% in 2012. In contrast, a much higher % of CAH facilities do not provide Hemodialysis (62.5% in 2012). The % of CAHs that do not provide Hemodialysis has remained about the same since 2000.



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	45.0%	46.5%	45.2%	44.8%	40.8%	40.8%	38.0%	36.4%	33.9%	35.2%	33.6%	36.1%	35.3%
CAH'S	66.7%	68.4%	68.4%	71.9%	70.2%	70.2%	68.4%	66.7%	63.2%	66.7%	63.2%	66.1%	62.5%
PPS	22.2%	24.6%	22.4%	18.6%	14.3%	14.3%	10.9%	9.4%	7.8%	7.7%	7.7%	9.5%	11.1%

The analysis of Hospice Services shows more CAHs are deciding not to provide this service as the % not providing Hospice Care has increased from 10% in 2000 to 25% in 2012. The % of PPS facilities that do not provide Hospice Services increased from 17% in 2011 to 22% in 2012.



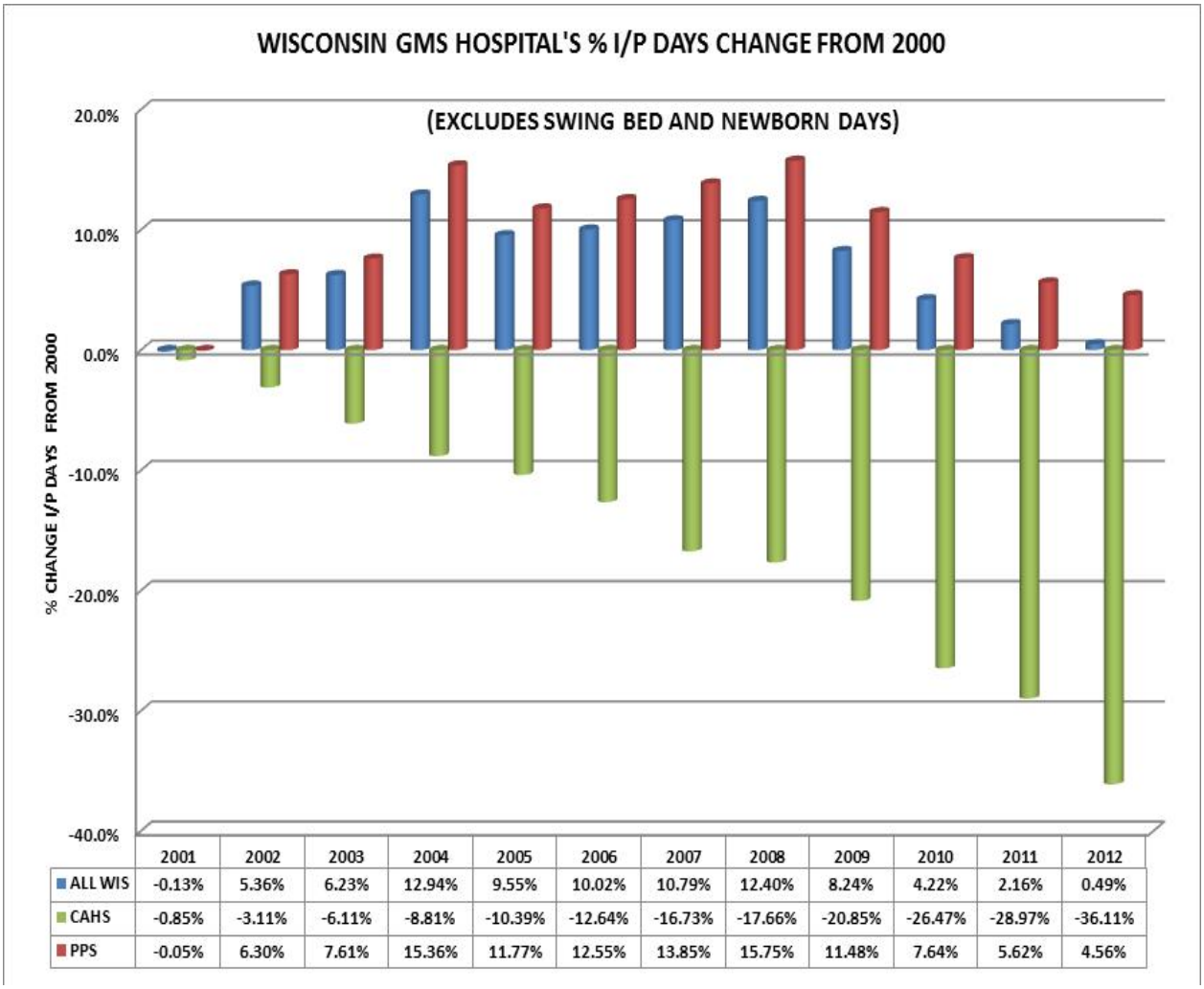
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	13.5%	15.8%	17.4%	16.4%	15.0%	14.2%	17.4%	15.7%	20.7%	19.7%	19.7%	21.0%	23.5%
CAH'S	10.5%	12.3%	15.8%	17.9%	14.0%	15.8%	21.1%	19.3%	22.8%	24.6%	21.1%	25.0%	25.0%
PPS	16.7%	19.3%	19.0%	15.0%	15.9%	12.7%	14.1%	12.5%	18.8%	15.4%	18.5%	17.5%	22.2%

Hospitals decide what services to provide based on a number of factors such as community need, make-up of the medical staff, impact on overall financial performance or to gain advantage over competitors. Each facility must determine which services contribute to the health of their communities as well as their own financial health. Hospitals, either PPS or CAHs, may determine the net financial loss of providing a particular service outweighs any advantages. The financial impact on Medicare cost-based payments of providing certain services can be a factor for CAHs in deciding what services to provide. CAHs may decide that because of the cost report methodology for allocating cost to non-reimbursable service, the service cannot be provided without risking the financial health of the overall organization. PPS facilities may be able to continue to provide some services paid prospectively because their higher volumes help to cover fixed costs. Some services may also have a total positive financial impact on the organization.

UTILIZATION

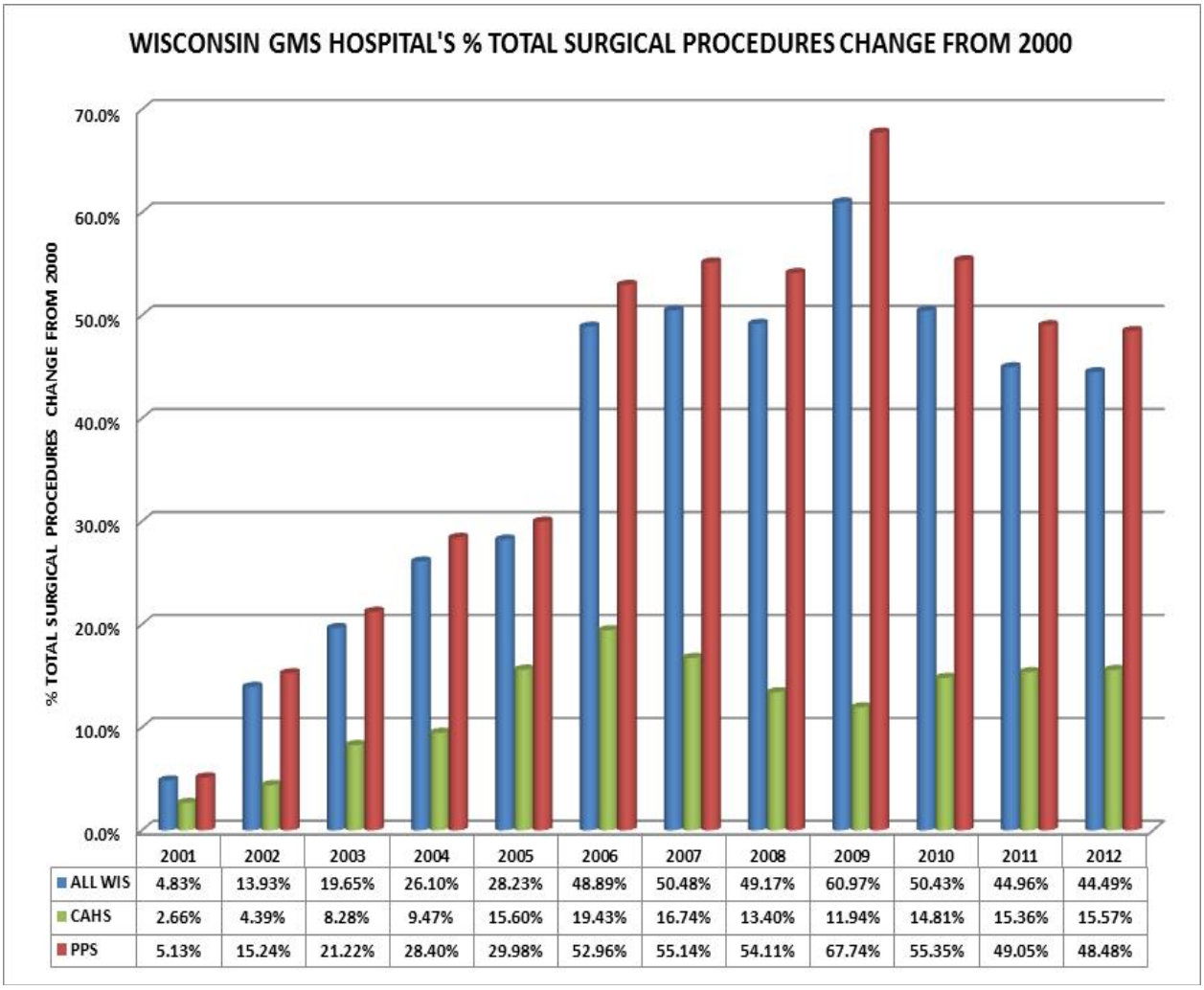
The following charts show the percentage change from the year 2000 through 2012 for several key services.

CAHs inpatient days (excluding Swing Bed and Newborn Days), have decreased 36% from 2000 to 2012. Inpatient days increased for PPS facilities over the same period by 4.56%.



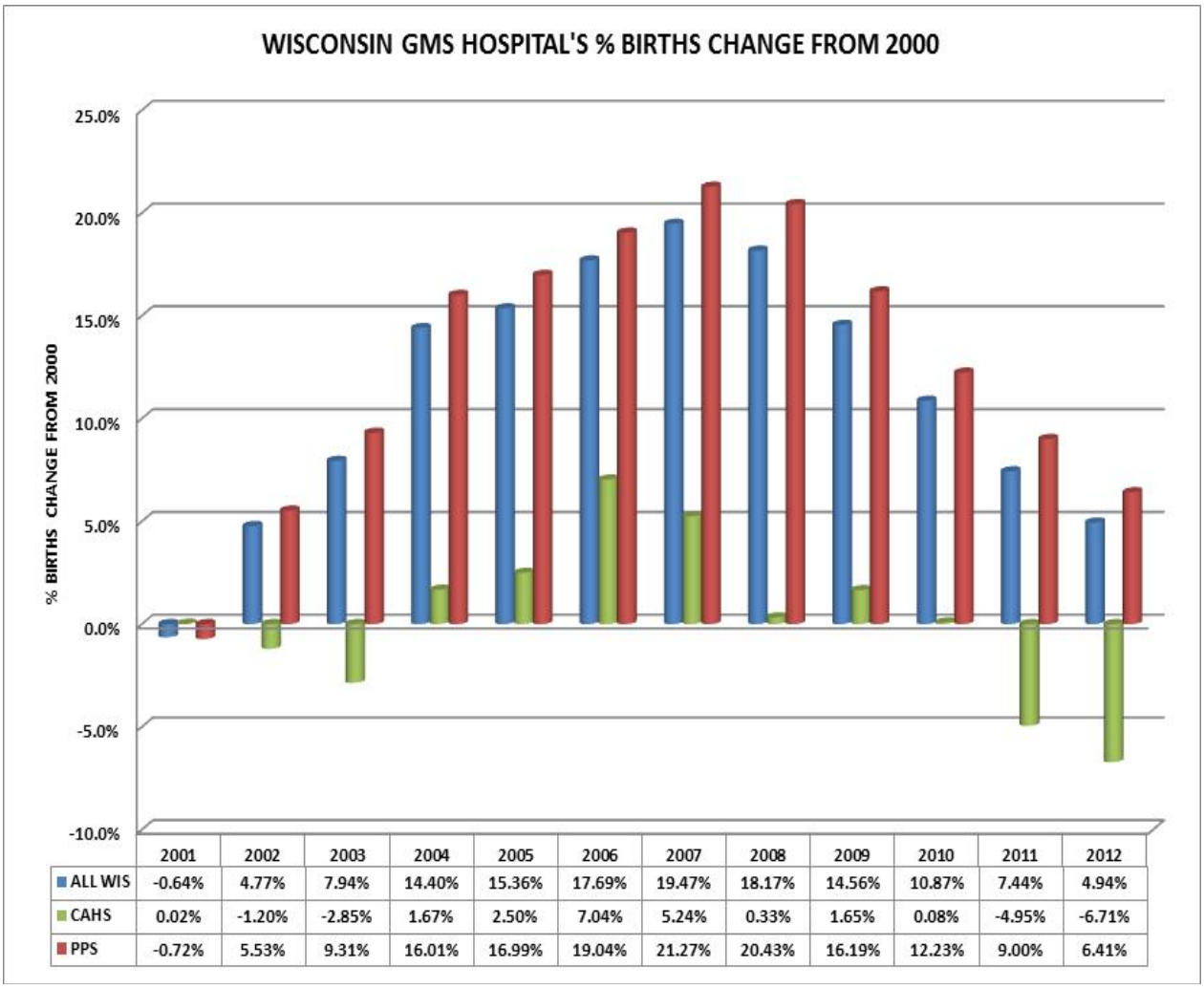
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	-0.13%	5.36%	6.23%	12.94%	9.55%	10.02%	10.79%	12.40%	8.24%	4.22%	2.16%	0.49%
CAHS	-0.85%	-3.11%	-6.11%	-8.81%	-10.39%	-12.64%	-16.73%	-17.66%	-20.85%	-26.47%	-28.97%	-36.11%
PPS	-0.05%	6.30%	7.61%	15.36%	11.77%	12.55%	13.85%	15.75%	11.48%	7.64%	5.62%	4.56%

The number of surgical procedures for CAHs has increased by over 15% since 2000 while the number of surgical procedures for PPS facilities increased by over 48%.



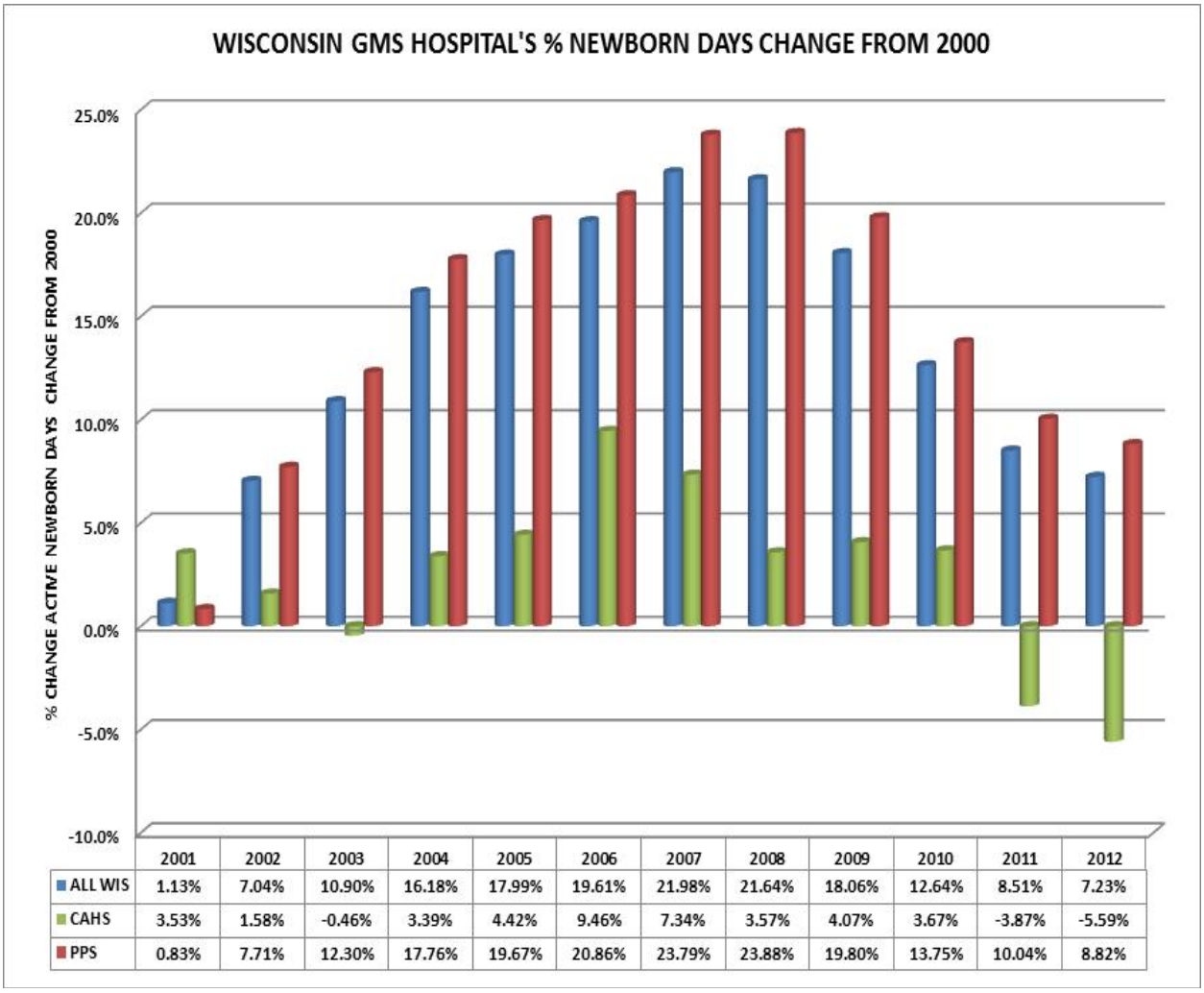
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	4.83%	13.93%	19.65%	26.10%	28.23%	48.89%	50.48%	49.17%	60.97%	50.43%	44.96%	44.49%
CAHS	2.66%	4.39%	8.28%	9.47%	15.60%	19.43%	16.74%	13.40%	11.94%	14.81%	15.36%	15.57%
PPS	5.13%	15.24%	21.22%	28.40%	29.98%	52.96%	55.14%	54.11%	67.74%	55.35%	49.05%	48.48%

The number of births at CAHs has decreased by slightly below 7% since 2000 while the number of births for PPS facilities increased by over 6%.



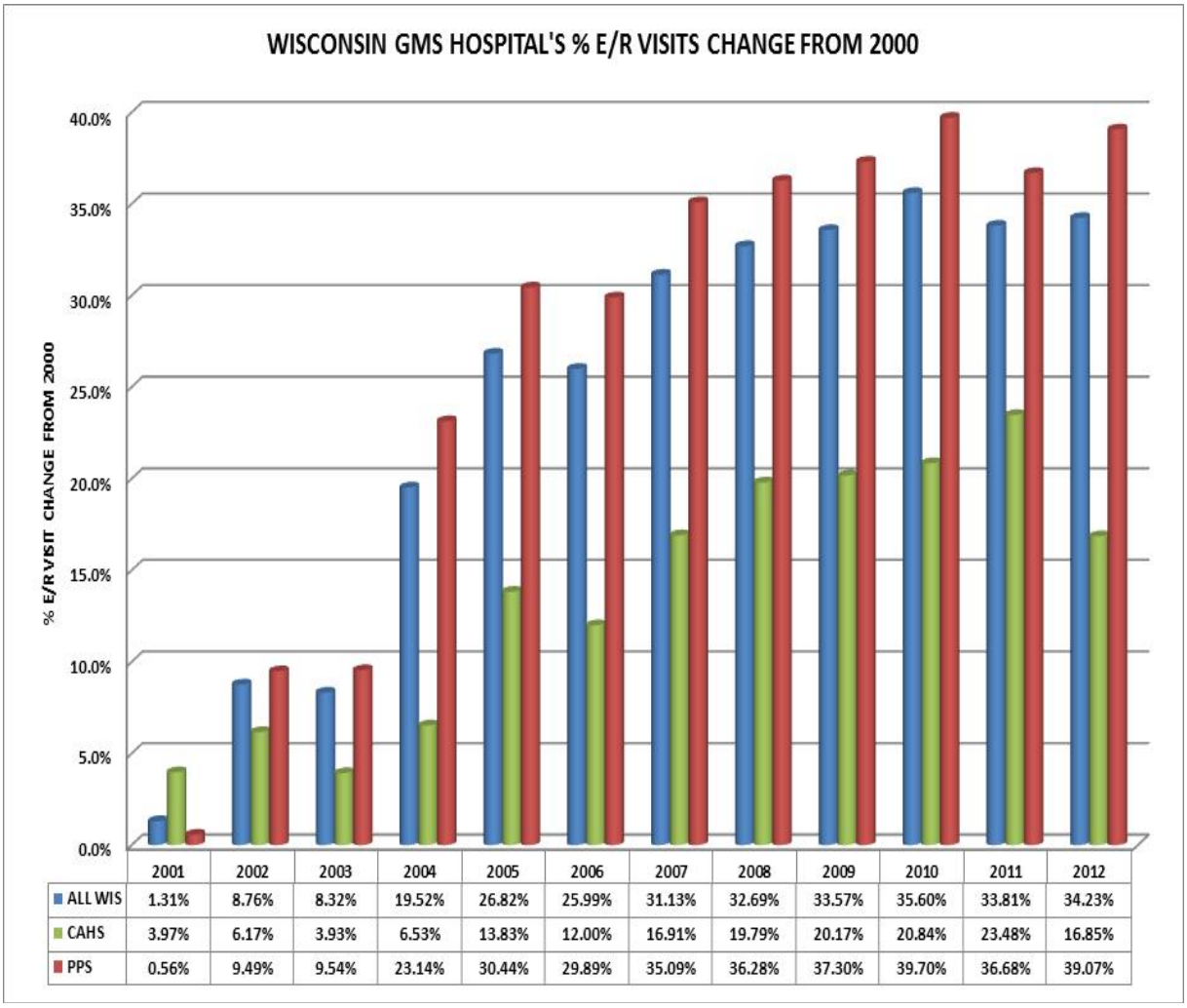
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	-0.64%	4.77%	7.94%	14.40%	15.36%	17.69%	19.47%	18.17%	14.56%	10.87%	7.44%	4.94%
CAHS	0.02%	-1.20%	-2.85%	1.67%	2.50%	7.04%	5.24%	0.33%	1.65%	0.08%	-4.95%	-6.71%
PPS	-0.72%	5.53%	9.31%	16.01%	16.99%	19.04%	21.27%	20.43%	16.19%	12.23%	9.00%	6.41%

Newborn Days at CAHs have decreased by 5.59% from 2000 to 2012. The % increase in Newborn Days at PPS facilities over the same time period is 8.82%.



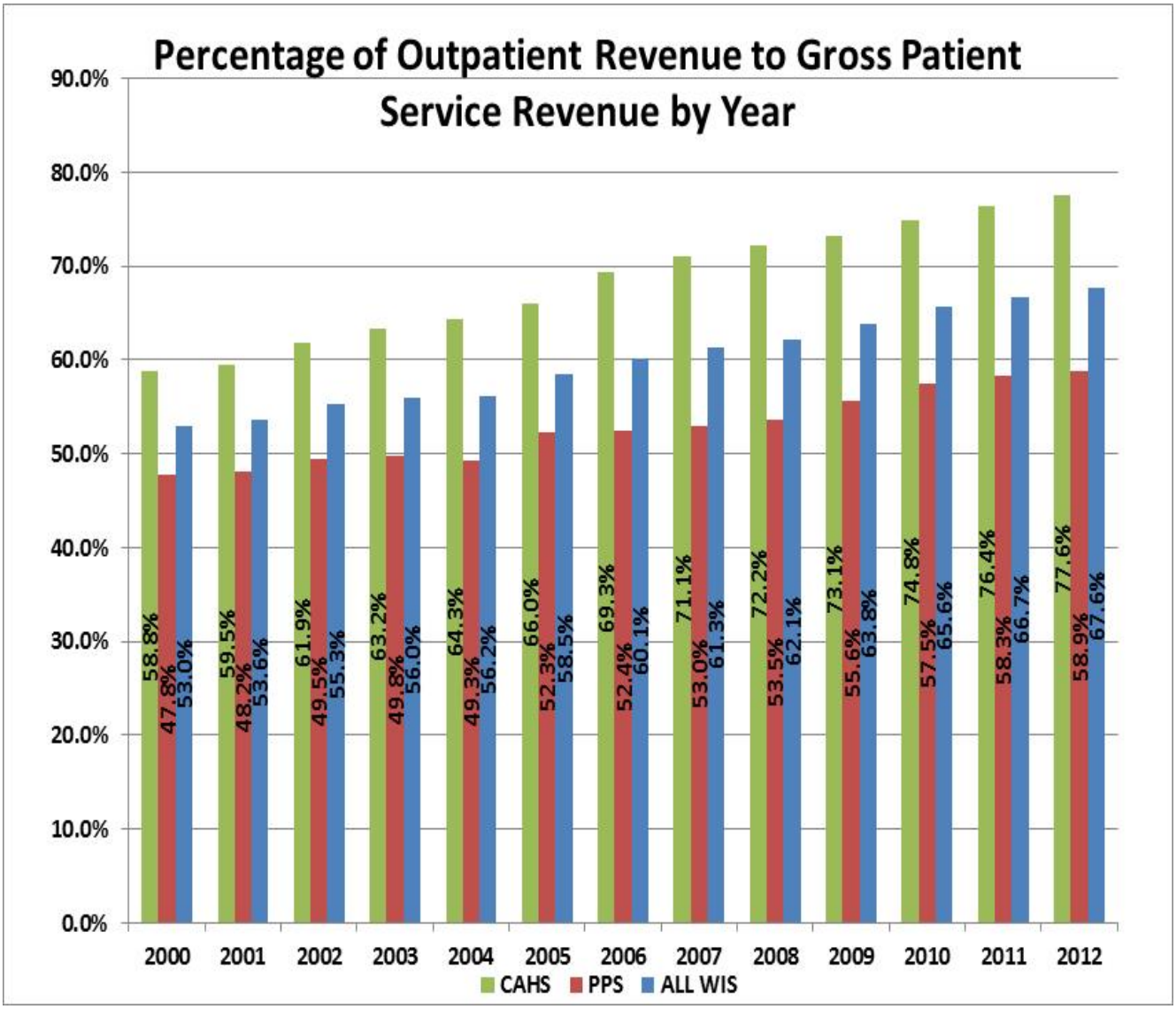
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	1.13%	7.04%	10.90%	16.18%	17.99%	19.61%	21.98%	21.64%	18.06%	12.64%	8.51%	7.23%
CAHS	3.53%	1.58%	-0.46%	3.39%	4.42%	9.46%	7.34%	3.57%	4.07%	3.67%	-3.87%	-5.59%
PPS	0.83%	7.71%	12.30%	17.76%	19.67%	20.86%	23.79%	23.88%	19.80%	13.75%	10.04%	8.82%

The % change in Emergency Room visits for PPS facilities from 2000 to 2012 is 39%. CAHs showed a % change over the same time period of almost 17%.



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ALL WIS	1.31%	8.76%	8.32%	19.52%	26.82%	25.99%	31.13%	32.69%	33.57%	35.60%	33.81%	34.23%
CAHS	3.97%	6.17%	3.93%	6.53%	13.83%	12.00%	16.91%	19.79%	20.17%	20.84%	23.48%	16.85%
PPS	0.56%	9.49%	9.54%	23.14%	30.44%	29.89%	35.09%	36.28%	37.30%	39.70%	36.68%	39.07%

The Utilization graphs show a decline for the CAH facilities over the 12 years for key statistics like Patient Days. Some of decrease in Patient Days can be attributed to the CAH rules regarding the 96 hour length-of-stay rule and the 25-bed limitation. However, even services that have increased like Surgical Procedures and Emergency Room Visits have not kept pace with the volumes at PPS facilities. One reason CAH's are experiencing a higher drop in inpatient activity than PPS hospitals is the shift to outpatient services. As the following charts show, even though Outpatient Revenue as a % of Gross Revenue for both PPS and CAHs is increasing, CAHs consistently have a much higher percentage of revenue from outpatient services than their PPS counterparts.


Percentage of Outpatient Revenue to Gross Patient Service Revenue by Year
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
58.8%
47.8%
53.0%
59.5%
48.2%
53.6%
61.9%
49.5%
55.3%
63.2%
49.8%
56.0%
64.3%
49.3%
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2000
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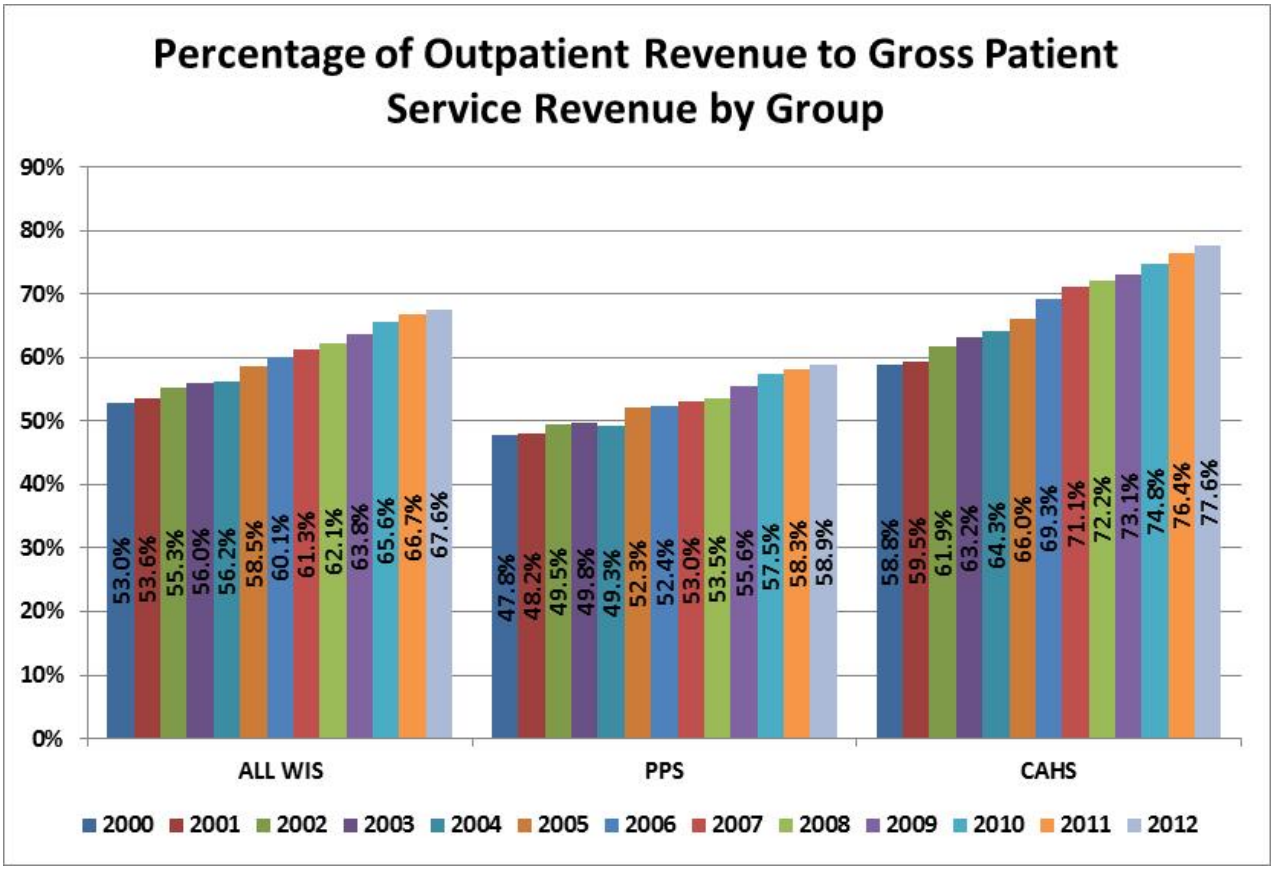
CAHS
PPS
ALL WIS



ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) CD-10

ICD-9-CM (International Classification of Diseases, 9th edition, Clinical Modification) (ICD-9) is a set of codes currently used by physicians, hospitals, and allied health workers to indicate diagnosis for all patient encounters. ICD-9 has been in use since the 1970's. The 2011 Critical Access Hospital study discussed the pending transition from ICD-9 code sets to ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) (ICD-10) code sets. At the time the 2011 study was released the transition to ICD-10 codes was to occur on October 1, 2013. In August, 2012, CMS announced the transition was being delayed one year to October 1, 2014. In announcing the delay, CMS stated "By delaying the compliance date of ICD-10 from October 1, 2013, to October 1, 2014, we are allowing more time for covered entities to prepare for the transition to ICD-10 and to conduct thorough testing."

ICD-10 consists of two parts: ICD-10-CM captures diagnosis coding and will be used for all U.S. health care settings. ICD-10-PCS captures procedure coding and will be used only for inpatient procedure claims. One reason for the transition is because ICD-10 produces additional information about patients' medical conditions and hospital inpatient procedures. This additional detail will be useful, for we are

entering into a world of data analytics – where our data is being utilized for a multitude of functions and reimbursement related initiatives. Having ICD-10 details will add to the kind of intelligence that is needed to support these initiatives. Diagnosis coding under ICD-10-CM uses 3 to 7 alphanumeric characters instead of the 3 to 5 digits used with ICD-9-CM. ICD-10-PCS uses 7 alphanumeric characters instead of the 3 or 4 numeric digits used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding, as it will capture the body system and part, the approach and devices used. This will help to account for the length of stay, risks, utilization of ancillary services, as well as surgeon's skill.

Many providers, payers, and software vendors developed a business plan early on for effectively completing the transition to ICD-10. They also have adequately budgeted for the substantial costs of the implementation of ICD-10. Health Information Managers have and continue to educate coders, clinicians, physicians, billers, Information Technology staff, and Finance Staff. They are working with their software vendors, clearinghouses, third-party billing services, and payers to ensure all affected parties are ready for this major transition. When CMS announced grounds for the delay, they indicated extensive internal as well as external testing of the new coding system would be vitally important to validate readiness and process claims accurately. Some surveys indicate many hospitals, especially smaller facilities, will not be ready for ICD-10. This is concerning, as hospitals risk delays in payments and will incur additional costs to resubmit claims if incorrect codes are used. Disruption of payment flow with resulting increase in receivables could result if claims are rejected. Payments could be affected for all code-based services. For PPS facilities, failure to use correct codes could negatively affect their Medicare case-mix index. Although some "unspecified" ICD-10 codes will be available for use, their frequent use may jeopardize payment and unjustly reports the acuity of the patient's condition. Clinical documentation improvement strategies will promote and support the ICD-10 data elements. Quality reporting could also be affected due to lack of adequate documentation.

Because of the magnitude of the transition and the consequences of delays in billing and resulting payments, some providers have developed plans for the financial implications of decreased cash flow. The plans may include managing inventory levels, renegotiating payment terms with suppliers, and having contingency plans with financial institutions for working capital needs. CMS has indicated there will be no further delay in ICD-10 implementation, so a focused and disciplined effort towards ICD-10 transition will be essential as we move into 2014.

ELECTRONIC HEALTH RECORDS

The 2011 study discussed the American Recovery and Reinvestment Act of 2009 (ARRA). The major goal of ARRA is to modernize health care through the use of information technology. To encourage adoption of electronic health records by 2015, the federal government is investing $36 billion in Medicare and Medicaid providers. To receive an Electronic Health Record (EHR) incentive payment, the provider (eligible professional (EP), eligible hospital or CAH must demonstrate meaningful use of certified EHR technology. As of June 2013, CMS reports that over $15 billion in EHR incentive payments have been distributed to eligible providers. Of that amount, almost $10 billion has been distributed to hospitals in Medicare and Medicaid payments. While some CAHs are struggling to meet meaningful use standards, many have already received Medicare and Medicaid EHR incentive payments. The accounting for these incentive payments in discussed further in the "Financial Performance Analysis" section of this study. Sequestration is also discussed separately in this study. It is noted here that Medicare EHR Incentive Payments will be reduced due to sequestration for reporting periods that end on or after April 1, 2013. Medicaid EHR Incentive Payments are exempt.

RECENT LEGISLATION

Although most legislation challenges health care providers, many healthcare experts would argue that the Patient Protection and Affordable Care Act (PPACA) could potentially change the entire health delivery system. Over the next several years, major changes in the health insurance market, federal incentives and tax changes for businesses and individuals, cost reduction programs, quality initiatives and the related issues of providing services to the newly insured will create many problems but also opportunities. Following is a discussion of the major healthcare initiatives since 2011.

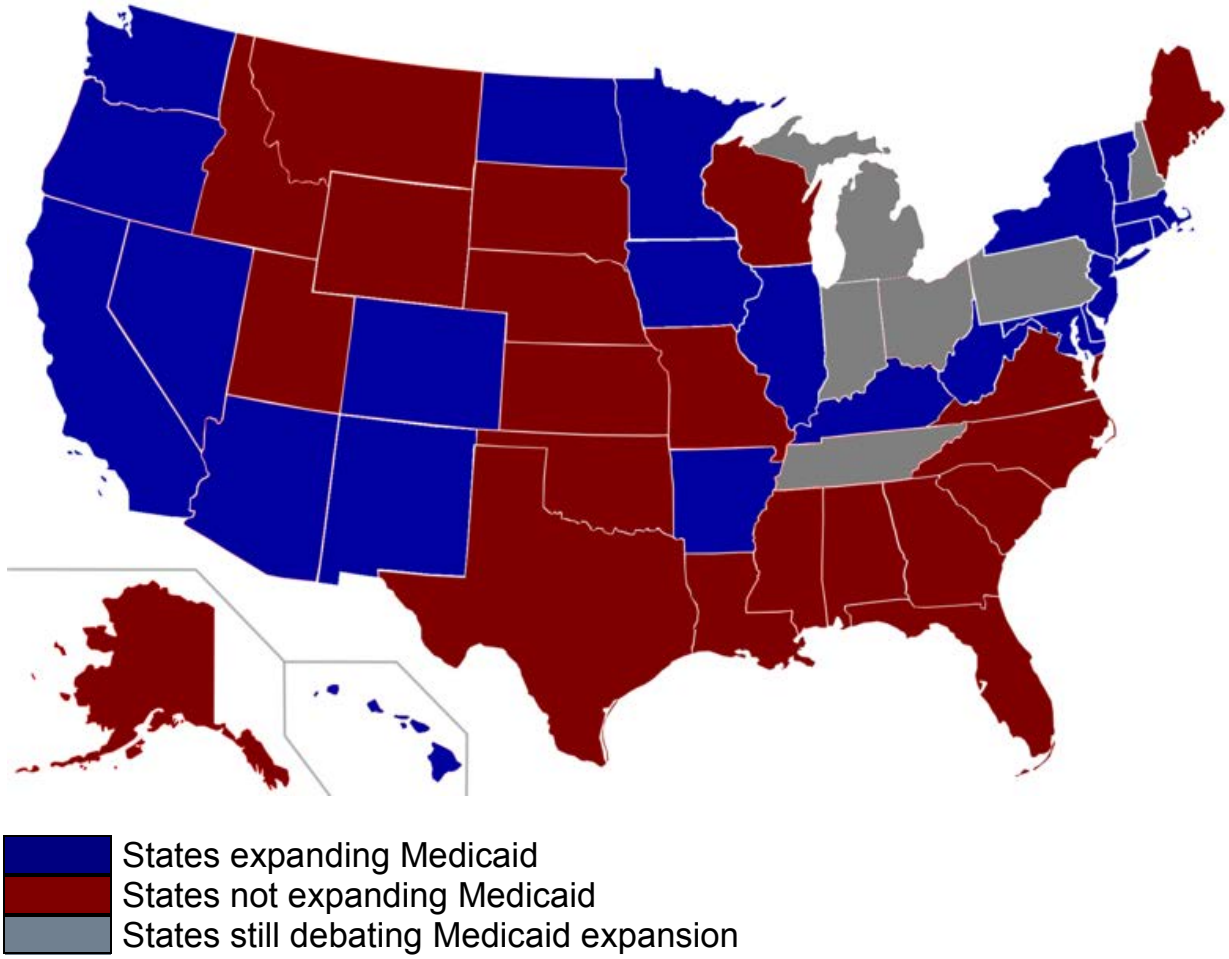
PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) was enacted March 23, 2010 and the related Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was enacted March 30, 2010. Since the 2011 study, implementation of PPACA has taken several turns. Following is a discussion of some of the federal and state developments since 2011.

SUPREME COURT DECISION

Opponents of PPACA turned to the federal courts to challenge the constitutionality of the legislation. On June 28, 2012, the Supreme Court upheld most of the law, ruling the individual mandate (see following additional discussion) (5-4) is constitutional on the basis that is a tax rather than being authorized by the Commerce Clause. The court also determined that States could not be forced to participate in the Medicaid expansion, effectively allowing states to opt out of this provision. As of the date of this study, Wisconsin has chosen this option (see map below). The impact of opting out of Medicaid expansion is further discussed in the "Medicaid" section of this study. PPACA originally would have withheld all Medicaid funding from states declining to participate in the expansion. The Supreme Court decision ruled that this withdrawal of funding was unconstitutionally coercive, and that states have the right to opt out of the Medicaid expansion without losing existing Federal Medicaid funding. The Court decision meant all other provisions of PPACA would continue in effect or would take effect as scheduled (subject to States determination on Medicaid expansion).

Medicaid Expansion by State, July 1, 2013



HEALTH INSURANCE EXCHANGES

A Health Insurance Exchange is a set of government-regulated and standardized health care plans from which individuals may purchase health insurance eligible for federal subsidies. Under PPACA the individual mandate requires that all individuals purchase health insurance, at the risk of incurring a fine that grows every year. Within the exchanges, insurance plans are to be offered in four tiers designated from lowest premium to highest premium: bronze, silver, gold, and platinum. The four levels of coverage, which vary depending on how much the insurer pays, include:

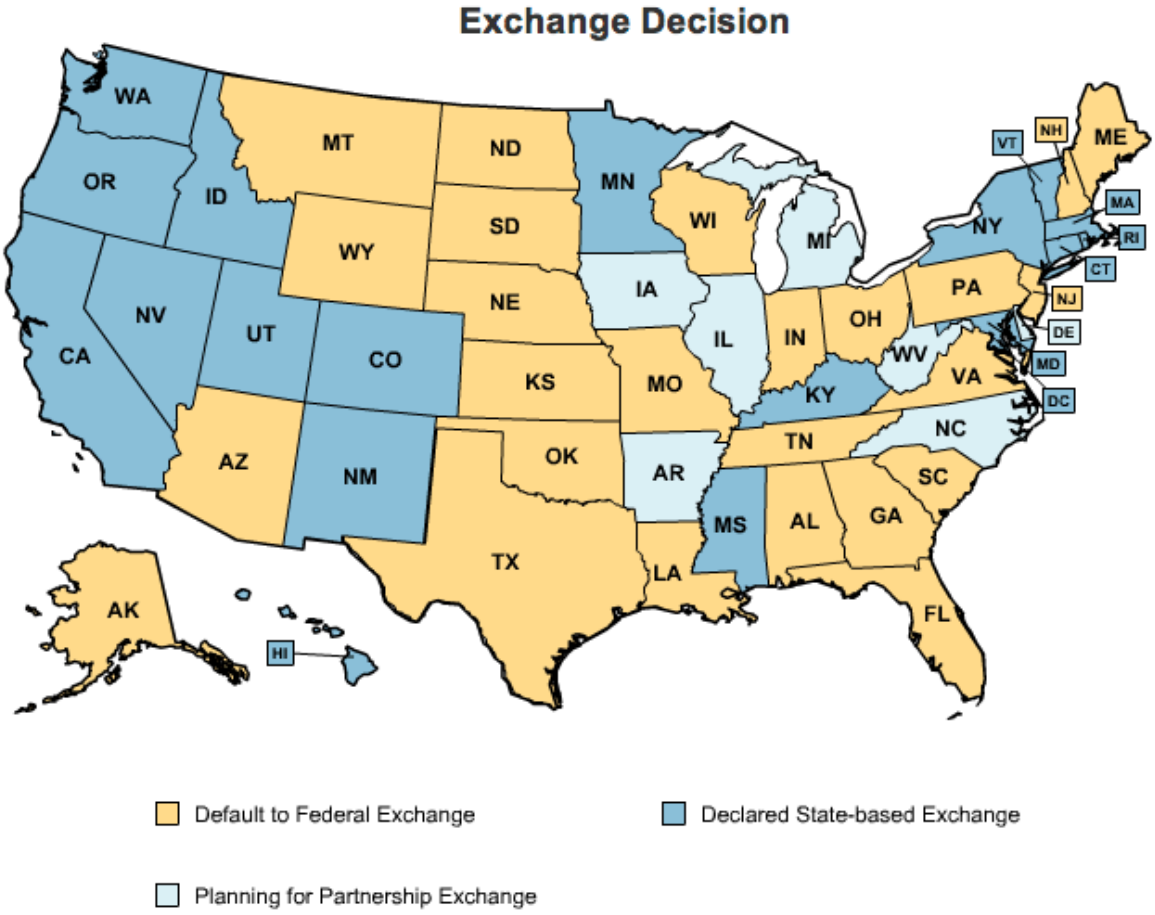
- Bronze: benefits equivalent to 60% of the full actuarial value of plan benefits,
- Silver: benefits actuarially equivalent to 70% of full value,
- Gold: benefits actuarially equivalent to 80% full value, and
- Platinum: benefits actuarially equivalent to 90% of full value.

Low to moderate income individuals and families who purchase coverage through the Exchanges may be eligible for premium subsidies in the form of tax credits starting in 2014. Generally, subsidies will not be available to people with access to health coverage through an employer.

PPACA prohibits denying coverage for pre-existing conditions starting in 2014. PPACA requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches the age of 26.

PPACA requires every state to have an Insurance Exchange. While the law requires each state to have an Insurance Exchange, states have the option of running their own Exchange or handing that authority over to the federal government. On November 16, 2012, Wisconsin notified federal officials that it would default to a federally-facilitated health insurance exchange. The federal government will assume full responsibility for running a health insurance exchange in Wisconsin beginning in 2014.

The following map shows which States have chosen to default to the federal health insurance exchange:



DELAY IN EMPLOYER MANDATE

On July 2, 2013 the Department of Treasury announced that it would provide an additional year before the PPACA mandatory employer and insurer reporting requirements begin. PPACA imposes penalties on applicable employers that do not offer minimum essential coverage to full-time employees and dependents. The Obama Administration stated the reason for the delay was to allow time for it to consider ways to simplify the new reporting requirements consistent with the law.

INDIVIDUAL MANDATE

As previously discussed in the “Supreme Court Decision” section, the Supreme Court ruled the individual mandate is constitutional on the basis that is a tax rather than being authorized by the Commerce Clause. Beginning in 2014,

PPACA requires most citizens to have qualifying health insurance coverage (public or private) or pay a tax for not carrying insurance. “Qualifying” is broadly defined by the law. Government programs like Medicare, Medicaid, and CHIP automatically qualify. Taxes begin in 2014 and rise in years following. In each year, the tax consists of the higher of a dollar amount or a percentage of household income. For a given household, the tax applies to each individual, up to a maximum of three. Following is the schedule of taxes:

- 2014: The higher of $95 per person (up to 3 people, or $285) OR 1.0% of taxable income.
- 2015: The higher of $325 per person (up to 3 people, or $975) OR 2.0% of taxable income.
- 2016: The higher of $695 per person (up to 3 people, or $2,085) OR 2.5% of taxable income.
- After 2016: The same as 2016, but adjusted annually for cost-of-living increases.

The individual mandate tax requires insurance or tax in lieu of insurance coverage. Subsidies, called “health insurance premium tax credits” may be available to eligible households.

QUALITY AND PATIENT SAFETY MEASURES

The challenge prior to the PPACA was to improve quality while reducing costs. PPACA made quality improvement and measurement an even higher priority for all healthcare providers, not just hospitals. There are more than 40 sections of the law that affect how to improve, measure, and pay for quality of care. It is beyond the scope of this study to analyze all the sections of PPACA related to quality issues but following is a general discussion of some of the changes. It must be noted that some Medicare penalties and provisions of PPACA affect prospective-payment providers and not cost-based payments to CAHs. However, regardless of financial class, many consumers will review and consider quality and patient safety measures when they select a healthcare provider for their own or family member’s care.

One area PPACA strongly addresses is readmission rates. PPACA will penalize hospitals with high readmission rates. The general definition of a readmission is a hospital admission 30 days from the date of discharge from the initial hospitalization hospital. Hospitals with high readmission rates could lose Medicare reimbursement of 1% in 2013, 2% in 2014, and 3% in 2015. The penalty will be in addition to other Medicare cuts. Other provisions of the PPACA, such as Medicare's Value-Based Purchasing Program (VBP) also

encourage providers to reduce readmissions. PPACA requires CMS to implement a VBP program that rewards hospitals for the quality of care they provide. Under the VBP program, CMS will evaluate hospitals' performance during a performance period based on both achievement and improvement on selected measures. Hospitals will receive points on each measure based on the higher of their level of achievement relative to an established standard or their improvement in performance from their performance during a prior baseline period. Their combined scores on all the measures will be translated into value-based incentive payments for discharges occurring on or after October 1, 2012. PPACA requires CMS to fund the aggregate VBP incentive payments by reducing the base operating diagnosis-related group (DRG) payment amounts that determine the Medicare payment for each hospital inpatient discharge. The law sets the reduction at 1 percent in FY 2013, rising to 2 percent by FY 2017. For the FY 2013 VBP program, CMS will measure hospital performance using two criteria: the clinical process of care criteria, which is comprised of 12 clinical processes of care measures, and the patient experience of care criteria, which is comprised of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measure. Hospitals are using several techniques to minimize avoidable readmission rates. One technique is improving communication and following up with discharged patients. Another technique that has become is the use of post-discharge clinics where the patient receives assistance until the primary care physician assumes responsibility for their care. A third technique is to provide a "transition coach" who monitors and educates the patient. One of the main goals of these techniques is to develop an effective readmission plan and avoid the penalties.

Another goal of PPACA is to reduce Hospital-Acquired Conditions (HAC). Hospitals will be penalized for having a high incidence of HACs, and the 25 percent worst performing hospitals with respect to HACs will only be paid 99 percent of what they would otherwise receive from Medicare. Starting in FY 2015, hospitals will have to report on two domains of measures related to HACs. Payments may be affected starting in FY 2015.

As mentioned, true to the "Patient Protection" part of the name, there are many provisions in PPACA related to quality and patient safety. Over the next several years, the emphasis will be to develop systems to accurately measure and reward quality and less on the quantity of services provided.

One model that is being tested to accomplish the goals of higher quality and less cost is an accountable care organization (ACO). An ACO is a payment and care delivery model that seeks to tie provider reimbursements to quality cost savings for an assigned population of patients. ACOs are composed mostly of hospitals, physicians, and other healthcare professionals. Section 3022 of the PPACA

allowed for the establishment of ACO contracts with Medicare by January 2012. CMS recently reported early results of an accountable care organization (ACO) model called Pioneer. The Pioneer ACO model was specifically designed by CMS for organizations experienced in coordinated care and risk-sharing. CMS recently released the results from the first performance year of the Pioneer ACO model. The early results from the Pioneer ACO program show that a majority of participating health systems indicated improvement in care delivery and promise in the area of cost savings, including the ability to participate in those cost savings. More testing of ACO's will determine if this model consistently generates savings while improving quality. At this early stage, the long-term impact on providers is also unclear.

AMERICAN TAXPAYER RELIEF ACT OF 2012

Although the American Taxpayer Relief Act of 2012 (the Act) enacted January 2, 2013, did not receive as much attention as PPACA, this law had many health-related provisions that providers must be aware of. The Act prevented scheduled Medicare payment cuts for physicians and other practitioners from taking effect on January 1, 2013. The Act provided for a zero percent update for physician services through December 31, 2013. The Act extended several provisions of the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act) as well as provisions of the Affordable Care Act (see Patient Protection and Affordable Care Act (PPACA), discussed in the "Recent Legislation" section of this study. Section 603 extends the exceptions process for outpatient therapy caps through December 31, 2013. Section 603 extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department, and counts outpatient therapy services furnished in a Critical Access Hospital towards the cap and threshold. Section 604 extends several Job Creation Act ambulance payment provisions. Section 605 allows qualifying low-volume hospitals to receive add-on payments based on the number of Medicare discharges. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This provision extends the payment adjustment through September 30, 2013, retroactive to October 1, 2012. Section 606 extends the Medicare-Dependent Hospital (MDH) Program. The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program until October 1, 2013, and is retroactive to October 1, 2012. The Act also postponed implementation of the majority of sequestration until March 1, 2013, and Medicare cuts until April 1, 2013.

MEDICARE

BAD DEBTS

Starting in Federal Year 2013, Medicare bad debt payments will be reduced. Among the providers affected by this change will be PPS hospitals, skilled nursing facilities (SNFs), and CAHs. The Center for Medicare & Medicaid Services (CMS) expects the change in bad debt reimbursement to save Medicare almost $11 billion over 10 years.

Until the end of fiscal year 2012 (September 30, 2012), CMS reimbursed 70% of the bad debt incurred by PPS hospitals and 100% of CAH bad debts. PPS bad debt reimbursement will decrease to 65% starting in FY 2013. CAH bad debt reimbursement will drop to 88% in FY 2013, 76% in FY 2014, and 65% in FY 2015. CMS noted in the Final rule that the reduction in bad debt reimbursement will have a "significant impact on the operations of a substantial number of small entities and small rural hospitals."

The following table from the November 9, 2012, Federal Register shows the percent of Medicare Bad Debt reimbursement by provider type for Federal Year 2013, 2014, and 2015.

TABLE 7—SUMMARY OF MEDICARE BAD DEBT REIMBURSEMENT BY PROVIDER TYPES FOR COST REPORTING PERIODS THAT Begin During FY 2013, 2014, 2015 AND SUBSEQUENT YEARS

Provider type	Allowable bad debt amount during FY 2012 (percent)	Allowable bad debt amount during FY 2013 (percent)	Allowable bad debt amount during FY 2014 (percent)	Allowable bad debt amount during FY 2015 & subsequent FYs (percent)
Hospitals	70	65	65	65
SNFs: Non-Full Dual Eligibles	70	65	65	65
Swing Bed Hospitals: Non-Full Dual Eligibles	100	65	65	65
SNFs: Full Dual Eligibles	100	88	76	65
Hospital Swing Beds: Full Dual Eligibles	100	88	76	65
CAHs	100	88	76	65
ESRD Facilities	100	88	76	65
CMHCs	100	88	76	65
FQHCs	100	88	76	65
RHCs	100	88	76	65
Cost Based HMOs	100	88	76	65
Health Care Pre-Payment Plans	100	88	76	65
Competitive Medical Health Plans	100	88	76	65

Source: Federal Register/Vol. 77, No. 218/Friday, November 9, 2012 (67519)

The following table shows the estimated impact of the reduction in the Medicare Bad Debt reimbursement % on CAH, PPS, and All Study hospitals for 2013, 2014, and 2015:

Table 8-ESTIMATED IMPACT OF REDUCTION IN BAD DEBT %	2013	2014	2015	TOTAL
CAH	$1,685,000	$3,371,000	$4,916,000	$9,972,000
PPS	$1,341,000	$1,341,000	$1,341,000	$4,023,000
ALL STUDY HOSPITALS	$3,026,000	$4,712,000	$6,257,000	$13,995,000

SEQUESTRATION

Sequestration began because of the 2011 legislative struggle to raise the debt limit. The American Taxpayer Relief Act of 2012 briefly postponed Medicare cuts until April 1, 2013. The 2% reduction to Medicare fee-for-service payments resulting from the sequestration order applies to all payments for services furnished in the one-year period after the reductions begin. For Medicare, the reductions began on the first day of the first month after the order was issued, meaning they began on April 1, 2013. Accordingly, the sequestration order covers all payments for services with dates of service or dates of discharge from April 1, 2013, through March 31, 2014. The estimated net impact on Wisconsin hospitals of sequestration is summarized in the following table:

Table 9-ESTIMATED 2% SEQUESTER IMPACT (ANNUAL BASED ON MOST RECENT FILED COST REPORT)	PART A	PART B	SWING BED	TOTAL
CAH	$3,253,240	$5,040,900	$1,131,840	$9,425,980
PPS	$32,784,280	$14,361,140	$6,360	$47,151,780
TOTAL STUDY HOSPITALS	$36,037,520	$19,402,040	$1,138,200	$56,577,760

The estimated calculated impact on the study hospitals only includes Part A, Part B, and Swing Bed sequestration. It does not include SNF's, Renal Dialysis, Hospice, Home Health, Rural Health Clinics, Psychiatric and other Medicare sub-providers, EHR Medicare incentive payments, or any professional services paid on the Medicare Physician Fee Schedule. The Wisconsin Hospital Association (WHA) estimates that total sequestration will cost state hospitals $2 million a week in Medicare payments.

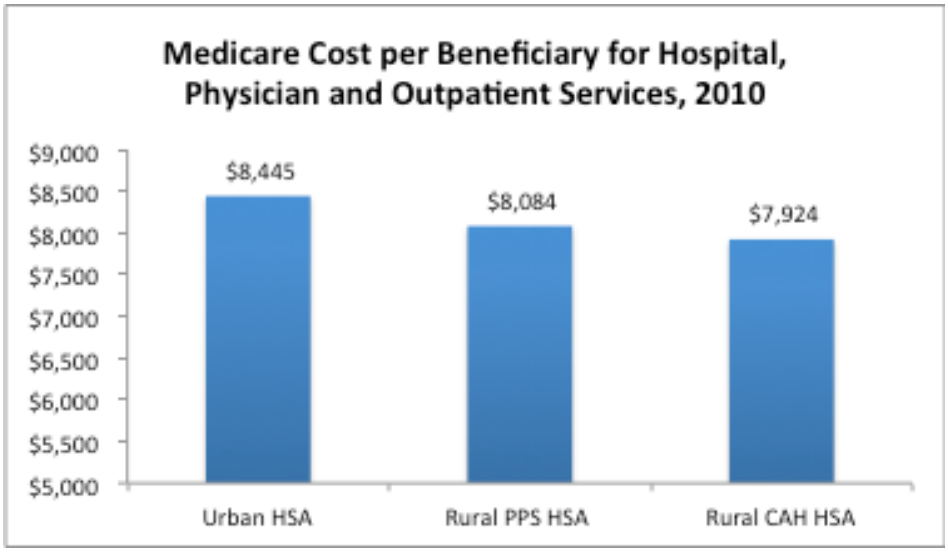
CURRENT DEVELOPMENTS

Although volumes of data and many studies, including this one, conclude that the Critical Access program has been successful in improving the financial condition of many rural hospitals, the challenges to the program continue. Some challenges may be attributed to misinterpretation or lack of reliable and complete data. Other challenges may be attributed to competition for limited resources. Often, the quality of care of CAHs is compared to other hospitals. One example is the Journal of the American Medical Association study released in April, 2013 which concluded that adjusted death rates among Medicare patients in CAHs rose from 2002 to 2010 whereas mortality in other hospitals declined. The three conditions studied were acute myocardial infarction (MI), congestive heart failure, and pneumonia. However, another JAMA study reported patients undergoing eight commonly performed surgical procedures at CAHs are no more likely to die in a CAH hospital than patients undergoing the same surgeries at non-CAHs.

Another challenge to the Critical Access program was issued by the HHS Office of Inspector General (OIG) in August, 2013. The OIG report stated Medicare spent an extra $449 million in 2011 reimbursing facilities that do not meet the location requirements for critical access hospital status. The American Hospital Association, the National Rural Health Association, the Wisconsin Hospital Association (WHA) and the Rural Wisconsin Health Cooperative (RWHC) are among those who have objected to the OIG recommendation that CMS reassess and decertify many critical access hospitals for failing to fulfil location requirements. The OIG proposal would eliminate CAH status for as many as 53 Wisconsin CAH facilities. In a joint statement on the OIG proposal, WHA and RWHC stated:

CAH status was enacted under the Balanced Budget Act of 1997 as Congress sought to address the closure of hundreds of rural hospitals across the country, which, due to their small size and care for disproportionately older, sicker and poorer patients, could not financially survive under Medicare's traditional payment system. Since that time the CAH program has operated efficiently, represents less than five percent of Medicare's total hospital budget, and has provided more than 60 million rural Medicare beneficiaries in the U.S. with access to health care that is close to home.

Also, a recent analysis by Stroudwater Associates based on data provided by Dartmouth Atlas of Healthcare (2010), the costs per Medicare beneficiary is lower for Rural PPS and Rural CAH Hospital Service Areas (HSA) than for urban service areas (see chart below):



On a positive note, iVantage Health Analytics, a privately held company providing comprehensive and objective information and analytic solutions to help hospitals and health systems, released a report in March, 2013 of the Top 100 CAHs. The company rates hospitals on market condition, clinical and operational performance, and financial and qualitative outcomes. The Top 100 CAHs perform as well or better at the median overall than the full census of all U.S. general acute care hospitals and their Quality is near the Top Quartile when compared to all U.S. general acute care hospitals. Wisconsin led the nation by placing 13 hospitals in the Top 100. The hospitals are:

HOSPITAL NAME	CITY	STATE
Red Cedar Medical Center - Mayo Health	Menomonie	WI
Tomah Memorial Hospital	Tomah	WI
The Richland Hospital	Richland Center	WI
River Falls Area Hospital	River Falls	WI
Door County Memorial Hospital	Sturgeon Bay	WI
Waupun Memorial Hospital	Waupun	WI
Ministry Good Samaritan Health Center	Merrill	WI
Upland Hills Health	Dodgeville	WI
Memorial Health Center	Medford	WI
Hudson Hospital	Hudson	WI
Prairie du Chien Memorial Hospital	Prairie du Chien	WI
Hayward Area Memorial Hospital	Hayward	WI
Black River Memorial Hospital	Black River Falls	WI

Also, the National Rural Health Association (NRHA) recently announced Stoughton Hospital as one of the 20 highest ranked critical access hospitals (CAHs) in the country for patient satisfaction. CAHs named have achieved success in patient satisfaction, based on iVantage Health Analytics tabulation. To measure patient satisfaction hospitals send a patient satisfaction survey to patients asking about their experiences during a recent hospital stay. Stoughton Hospital was rated in the 99th percentile based on two of those measures – "overall rating" and "highly recommend.

TRADITIONAL GOVERNMENT PROGRAM UTILIZATION

After several years of declines, Wisconsin hospital traditional or fee-for-service Medicare program utilization in 2011 and 2012 remained relatively flat. Table 10 shows traditional Medicare utilization based on program revenue to total revenue increased only slightly in 2011 and 2012. Traditional Medicare utilization continues to be higher in CAHs than in PPS facilities. For PPS hospitals, Medicaid fee-for service continued to decline the last two years. CAHs had higher Medicaid FFS utilization than PPS facilities but also experienced a decrease for 2011 and 2012. Total FFS government program utilization remained about the same for PPS facilities for 2011 and 2012 but CAH's utilization increased slightly.

Table 10 Government Program Utilization Based On Revenue

	YEAR												
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
MEDICARE UTILIZATION*													
ALL WIS	44.8%	43.7%	43.3%	42.5%	41.8%	41.6%	40.8%	38.5%	37.2%	36.3%	35.2%	35.6%	35.7%
PPS	42.1%	40.7%	41.2%	40.6%	39.5%	39.6%	39.2%	37.3%	36.3%	35.0%	34.5%	34.8%	34.4%
CAH	47.8%	46.9%	45.6%	44.7%	44.6%	44.0%	42.6%	39.8%	38.2%	37.7%	36.0%	36.5%	37.1%
MEDICAID UTILIZATION*													
ALL WIS	4.9%	5.6%	6.5%	6.8%	7.8%	7.6%	7.0%	7.1%	6.8%	6.3%	6.4%	6.2%	5.9%
PPS	4.6%	5.5%	6.2%	6.6%	7.7%	7.5%	6.7%	6.6%	6.4%	5.6%	6.2%	6.1%	5.6%
CAH	5.2%	5.6%	6.8%	7.1%	7.9%	7.8%	7.4%	7.7%	7.3%	7.0%	6.5%	6.4%	6.2%
TOTAL GOV. PROGRAM UTILIZATION*													
ALL WIS	49.6%	49.2%	49.7%	49.3%	49.6%	49.2%	47.8%	45.6%	43.9%	42.5%	41.6%	41.8%	41.6%
PPS	46.7%	46.2%	47.4%	47.1%	47.2%	47.1%	45.9%	43.9%	42.6%	40.6%	40.8%	40.9%	40.1%
CAH	53.0%	52.5%	52.4%	51.8%	52.4%	51.8%	50.1%	47.5%	45.5%	44.7%	42.5%	42.9%	43.3%
*BASED ON PROGRAM REVENUE/TOTAL REVENUE													

MEDICARE ADVANTAGE UTILIZATION

The utilization of Medicare Advantage Plans continues to be higher in Wisconsin than for the entire United States (see Table 11). Wisconsin Medicare Advantage utilization also increased in 2011 to 32% of Medicare beneficiaries and to 33% for the 2013 enrollment period.

Table 11 Wisconsin vs. National Medicare Advantage Plan Penetration

MEDICARE ADVANTAGE PLAN PENETRATION*														
	YEAR													
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
US	16.8%	15.0%	13.2%	12.2%	12.1%	12.7%	16.3%	19.0%	21.0%	22.5%	23.6%	25.6%	27.0%	28.0%
WI	5.1%	5.0%	2.6%	3.1%	4.7%	7.0%	15.0%	20.4%	23.3%	26.1%	29.0%	30.1%	32.0%	33.0%

*Penetration % is number of Medicare Advantage Enrollees/Medicare Beneficiaries

SOURCE: KAISER FAMILY FOUNDATION

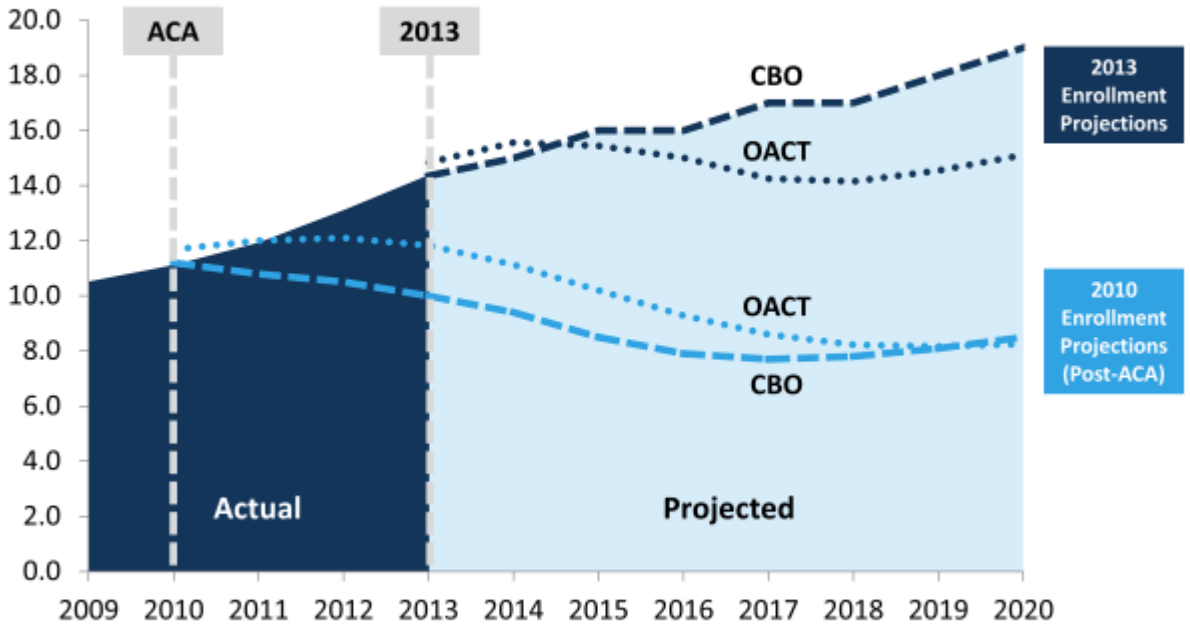
The PPACA includes many changes to the Medicare Advantage plans. The changes revolve around three areas to save costs. They are:

- Rewards for quality: CMS will provide incentive payments based on how plans rate on measures including how many members are up-to-date on screenings, vaccines, and members' satisfaction with the plan. Over $2 billion has been allocated for quality payments.
- Most of the cost-savings will come from changing the way Medicare sets the private plan payment rates. Each county will be ranked based on their per capita health care spending for traditional Medicare. Plans will receive 95% of traditional Medicare costs for their county. The new rate-setting plan is estimated to annually save over $12 billion.
- The rebate paid to Medicare Advantage plans will be reduced from 75% of the difference between the set benchmark rate and the plan's bid to provide coverage to Medicare enrollees to 50%. It is estimated this change will yield about $640 million in savings per year.

It remains to be seen what the future impact of PPACA will be on Medicare Advantage enrollment. The following graph, however, shows enrollment may level off or decrease slightly for several years before continuing to rise. Obviously, Medicare Advantage enrollment will be influenced by how the plans structure benefits and cost sharing.

What is the future outlook for Medicare Advantage?

Actual and projected enrollment (in millions)

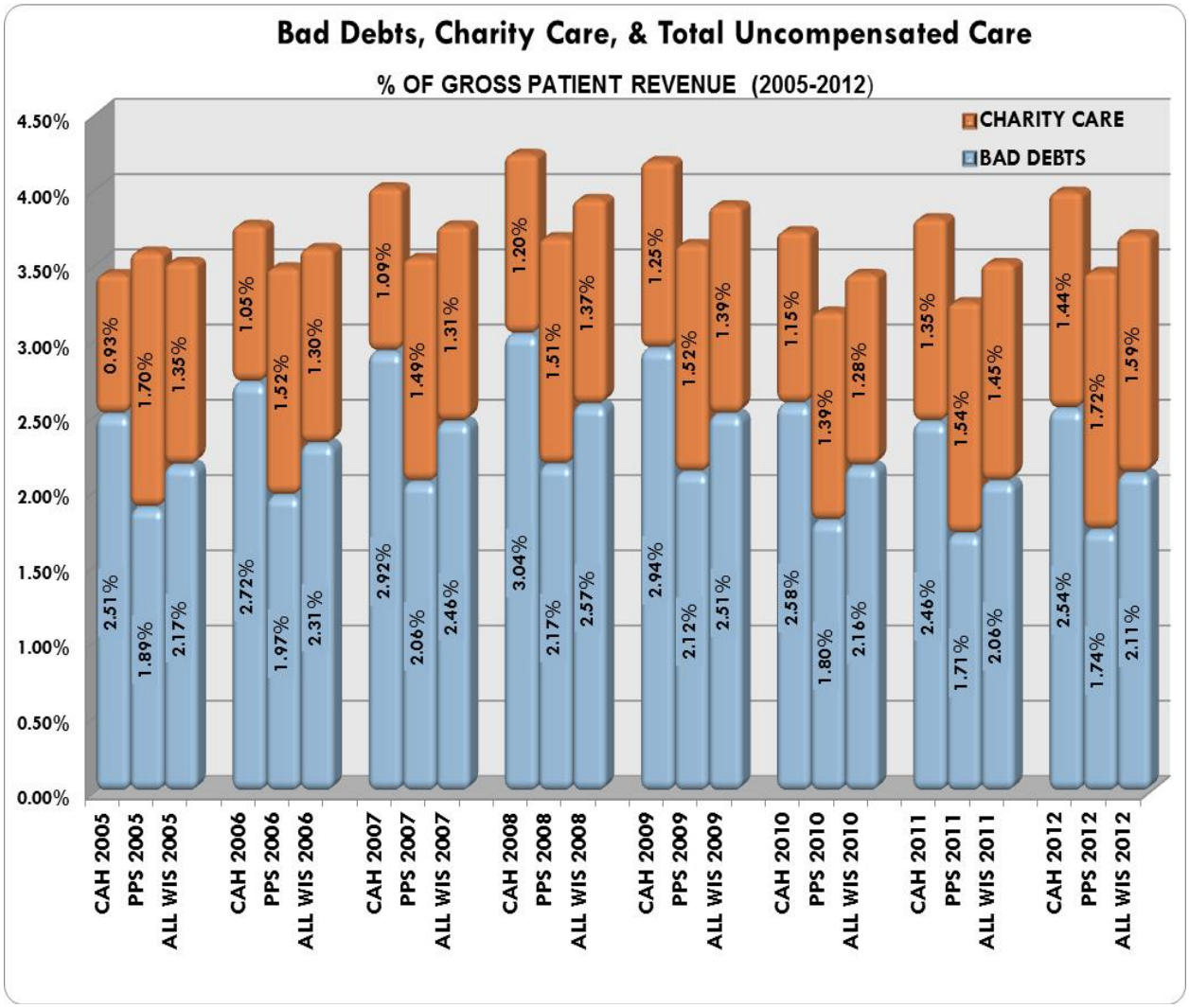


NOTE: CBO is Congressional Budget Office; OACT is CMS Office of the Actuary.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2009-2013. CBO, "Medicare Baseline," August 2010 and May 2013. Report of the Medicare Board of Trustees, 2010 and 2013.

UNCOMPENSATED CARE

Uncompensated Care is defined as the total of Bad Debts and Charity Care (sometimes referred to as community care or indigent care). The term "uncompensated health care" is used to encompass charity care and bad debt. Both represent services for which the hospital does not receive payment. Charity care is care for which a hospital does not expect payment because the patient cannot afford to pay. Bad debt, however, is care for which payment is expected, but the hospital is unable to collect. Distinguishing charity care from bad debt has been complex because of the way hospitals defined and reported these components for accounting purposes. For example, one hospital may write off charges as bad debt, while another hospital may call such charges charity care. In the past, some hospitals did not account separately for charity care and bad debts. The distinction, however, between charity care and bad debt is becoming even more important. The PPACA discussed in "Recent Legislation" requires non-profit hospitals to conduct community health needs assessments every three years and adopt an implementation strategy to meet the needs of the community identified through the assessment. This requirement is effective during tax years beginning after March 23, 2012. Charity services are an important indicator of a hospital's fulfillment of its charitable obligations.

The following graph is a stacked bar graph which shows the average Bad Debts and Charity Care % of Total Revenue for CAHs, PPS, and both groups combined from 2005 through 2012.



After a steady increase in the average uncompensated care from 2005 through 2008, both groups experienced a leveling off in 2009, a slight decline in 2010, and increasing uncompensated care in 2011 and 2012. The numbers of patients who are uninsured or underinsured obviously affect Uncompensated Care as does changes in health insurance plans coverage and beneficiary deductibles and coinsurance. Coverage under tax-advantaged private plans, employer based plans, or government programs will also affect Uncompensated Care. One trend in the graph is that since 2006, CAHs provide higher levels of uncompensated care compared to PPS hospitals. The graph indicates this is a result of higher bad debts. The economic strength of the communities CAHs serve may contribute to the trend. In 2011, Uncompensated Care for CAHs increased while PPS hospitals remained relatively flat. In 2012, Uncompensated

Care increased slightly for both groups. In spite of the projected increase in patients with insurance due to PPACA, most experts predict only modest decreases in Charity Care and Bad Debts over the next several years.

SUMMARY

The first Wisconsin hospital obtained critical access status in 1999. This study is the sixth in a series of reports on the financial status of Wisconsin CAH hospitals. The first CAH study was completed in 2003 and has been updated every two years since then. This study includes 56 Wisconsin facilities or slightly less than half of all Wisconsin General Medical Surgical hospitals. EHR meaningful use payments affected the financial data in this study. Because of various methods of accounting for these payments and the inability to identify the payment amounts, the affect was indeterminate. On the positive side, CAHs have shown improvement in several key financial ratios. The Financial Strength Index, a composite of four financial ratios, has improved from a negative in 2000 to positive 1.83 in 2012. The Average Age of Plant ratio has improved to the point that for the first time, in 2011 and 2012 CAH Average Age of Plant is lower than for their PPS counterparts. The American Recovery and Reinvestment Act of 2009 (ARRA) has helped CAHs fund some of their information technology needs. CAHs have improved their revenue cycle process resulting in Days Revenue in Accounts Receivable approximately the same as PPS facilities. As a result, Days Cash On Hand, although lower than for PPS facilities, has improved from 2000. CAH Operating and Total Margin ratios increased in 2011 and 2012 but are still lower than for PPS facilities. A new ratio was added to the 2013 study. The Debt-to-Capitalization ratio measures the utilization of long-term sources of debt financing. The Debt-to-Capitalization ratio is calculated by dividing Long-Term Debt by Long-Term Debt plus Fund Balance. CAHs have a higher Debt-to-Capitalization than PPS facilities. However, both types of facilities showed improvement in the ratio since 2006. On the utilization side, CAHs outpatient revenue as a percentage of total revenue continues to increase and is higher than for PPS facilities. Services hospitals provide to their communities continue to evolve. The percentage of facilities that do not own and operate a Nursing Home has steadily increased since 2000. Over 70% of CAHs did not provide SNF, Psychiatric, or Alcoholism/Chemical Dependency inpatient care in 2012. The percentage of CAHs that own or operate a primary group practice has doubled from 22% in 2001 to over 44% in 2012. The percentage of CAHs that are part of a health care system was over 50% in 2012. There are many reasons for the changes in services provided by CAHs. However, it would be reasonable to assume that each CAHs management, Board of Directors, and Medical Staff's consider the financial impact when deciding what services to provide. Because of Wisconsin's rural demographics, CAH reimbursements for the Medicare and Medicaid programs will have a major impact on future financial performance. Sequestration and reductions in the percent of Medicare bad debts, discussed in this study, will be challenges enough to overcome. As Federal and State governments struggle with budgets problems, cost-based reimbursement itself may be in jeopardy. The recent OIG proposal to possibly eliminate CAH status

for as many as 53 Wisconsin necessary- providers threatens the gains many of these facilities have made. Major question marks for all providers revolve around the impact of the Patient Protection and Affordable Care Act (PPACA). CAHs will be challenged to provide high quality services at less cost. The challenges to rural CAHs at the present time may seem overwhelming, but these words from Abraham Lincoln's Annual Message to Congress, December 1, 1862 provide guidance:

> **The dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty, and we must rise with the occasion. As our case is new, so we must think anew and act anew.**

OTHER RESOURCES

Here are several websites that have more information:

Administration on Aging www.aoa.gov
Agency for Healthcare Research and Quality www.ahrq.gov
American Hospital Association http://www.aha.org/
AHA Critical Access Hospital Center http://www.aha.org/advocacy-issues/cah/index.shtml
American Health Information Management Association http://www.ahima.org/
Centers for Medicare & Medicaid Services:
  Critical Access Hospital Information http://www.cms.hhs.gov/center/cah.asp
  Federally Qualified Health Centers Information http://www.cms.hhs.gov/center/fqhc.asp
  ICD-10 http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10
Electronic Health Record Incentive Program http://www.cms.gov/ehrincentiveprograms/
Affordable Care Act Information http://www.cms.gov/Affordable-Care-Act/
Health Resources and Services Administration www.hrsa.gov
Hospital Compare http://www.hospitalcompare.hhs.gov/
Native American Health Service www.ihs.gov
National Association of Community Health Centers www.nachc.org
National Rural Health Association www.nrharural.org
Rural Assistance Center http://www.raconline.org/
Rural Wisconsin Health Cooperative www.rwhc.com
United States Department of Agriculture www.usda.gov
Wisconsin Department of Health Services http://www.dhs.wisconsin.gov/
Wisconsin Hospital Association http://www.wha.org/
Wisconsin Office of Rural Health http://www.worh.org/
Wisconsin PricePoint http://www.wipricepoint.org/
WHA Information Center http://www.whainfocenter.com/
WHA Checkpoint http://www.wicheckpoint.org/index.aspx
US Census Bureau http://www.census.gov/