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# Questions around finance, staff cuts, Long Term Care, overall financial direction of the hospital

The Board evaluates the financial status at its meetings as well as monthly finance committee meetings. In addition, the auditors visit with the Board at least yearly on the financial status of the hospital. The formula for Critical Access Hospitals (CAH) is detailed, but the short answer is that only services that are cost-based (per Medicare and Medicaid, called CMS) are reimbursable through the cost report. In addition, the formula involves square footage delegated to each service area. Some services are not cost-based—such as Long Term Care. In essence, other services of the hospital that are part of the cost-basis formula subsidize those services that are not cost-based.

Using Long Term Care (LTC) as an example---for many years the Board has known that this service has lost money—back as far as 2001 in the numbers we use. At yearly meetings with our auditors, they have also told us that it was losing money. As a Board, we purposely decided to absorb those costs because we felt it was important to have the unit available. As the economy has taken a dip over the last few years and as the health care industry has had major changes in order to reduce costs, the Board has scrutinized those areas that are not cost-based. Starting with figures from 2001, LTC has had a loss every year; 2001 was a loss of $233,376; 2006 was $695,657; 2010 was $402,608; 2012 was $484,459. Using the formula for CAH that involves square-footage, not having Long Term Care (having it as empty space), would have added an overall average of +400,000 to the bottom line. We have found through researching other CAH, that a number of other critical access hospitals are no longer providing the LTC service. This same concept applied to Home Health—also not part of the cost-base formula. Because of that formula (square footage), it was more economical to house that service off campus. The public health is part of the formula. That is why the public health service that was retained is now housed in the facility.

One of the questions the Board asked was availability of beds elsewhere for residents if the LTC were to be closed. On a survey of nursing homes locally and in towns surrounding Davis County, those institutions were running at about 50% occupancy.

In November, the Board discussed the financial situation of Long Term Care. As a result of that discussion, families of residents became concerned, which was totally understandable. As a result of that discussion, some families made arrangements to move family members. This added to the urgency of making a decision.

Another area that the Board routinely looks at is reimbursements received not only from Medicare, but Medicaid and insurance companies. Over the last few years, insurance companies have reduced the amount that they pay on claims across the United States. In addition, the amount of charity care and write offs have increased substantially.

While every Board member would like to be able to offer every service to the community, we know we can’t. In addition, we have to make sure the hospital has funding to purchase equipment as needed and maintain operations. As the trend in national health care has gone from the inpatient

side to outpatient (clinics), the hospital has increased the number of specialty clinics as well as starting its own medical clinic.

This is a brief explanation of why the decision was made for Long Term Care as well as the 5% reduction in operating costs. The responsibilities from those positions reduced were absorbed by other employees. The hospital has a healthy ‘cash on hand’ figure as well as a good financial outlook. But without making adjustments as needed, this would not be true.