Community questions responses.

#9 Finance: What caused the negative debt ratio that necessitates cutting staff hours and positions?

#10 Finance: Why are we $400,000 short?

Some patient volumes have decreased over the past three fiscal years which decreased revenue.

1. Acute inpatient days decreased over the past three fiscal years as follows:
    a. FY 2012 monthly average was 97
    b. FY 2013 monthly average was 67 a decrease of 30.28% from prior year
    c. FY 2014 monthly average is 58 a decrease of 13.22% from prior year
2. Swing Bed patient days decreased over the past three fiscal years as follows
    a. FY 2012 monthly average was 86
    b. FY 2013 monthly average was 50 a decrease of 42.25% from prior year
    c. FY 2014 monthly average is 51 an increase of 3.26% from prior year
3. Emergency Room Visits decreased over the past three fiscal years as follows:
    a. FY 2012 monthly average was 291
    b. FY 2013 monthly average was 285 a decrease of 2.20% from prior year
    c. FY 2014 monthly average is 263 a decrease of 7.77% from prior year

Although outpatient volumes have increased over the past three years as follows, the increase isn't as significant as the decrease in acute inpatient days, swing bed days and ER visits.

1. Outpatient visits increased over the past three years as follows:
    a. FY 2012 monthly average was 1,087
    b. FY 2013 monthly average was 1,291 an increase of 18.70% from prior year
    c. FY 2014 monthly average is 1,339 an increase of 3.77% from prior year

Deductions from revenue, which consist of bad debt, charity, contractual allowances, discounts and write-offs, have steadily increased in percentage over the past three years as follows:

a. FY 2012 average deduction from revenue percentage was 32.39%
b. FY 2013 average deduction from revenue percentage was 34.11%
c. FY 2014 average deduction from revenue percentage is 36.27%

The increase in deductions has a direct affect on the net income or net loss. As the percentage increases we have less net revenue to use for wages, benefits, interest, principal payments, and other expenses.

With the implementation of an electronic health record our expenses in information technology have increased over the past four years as follows:

a. FY 2011 total Information Technology direct expenses were $458,172
b. FY 2012 total Information Technology direct expenses were $699,709
c. FY 2013 total Information Technology direct expenses were $906,108
d. FT 2014 total Information Technology direct expenses are trending to $847,626

We went live with the electronic health record in June 2011. As we add more modules to meet the Medicare/Medicaid guidelines for Meaningful Use our fixed annual fees increase due to maintenance and support of the modules. The Meaningful Use Guidelines established by Medicare and Medicaid specify what we have to have in place to meet each stage of meaningful use. We are ready to complete our 90 day attestation period for Meaningful Use Stage Two. With the attestation we have to be able to prove we meet the specified guidelines and submit the information to Medicare and Medicaid.

We are cost based reimbursed from Medicare and Medicaid for the expenses related to the electronic health record but only for the amount related to the Medicare and Medicaid patients. Over the past three years approximately 62% of our revenue is from Medicare and Medicaid patients. This leaves approximately 38% of our revenue that is either commercial insurance or self-pay patients. Wellmark Blue Cross and Blue Shield is approximately 20% of our patient revenue. The reimbursement fee schedules established by the commercial insurance have not included additional funds to help offset our expenses related to the electronic health record. We need to have a greater volume of patients to help offset our increased fixed costs.

The increase in fixed costs and decrease in patient volumes necessitated the reduction in staff. At the end of December 2013, half way through FY 2014, we had a year-to-date net loss of $869,514. Employee wages and benefits are approximately 46% of the total expenses of the hospital. Of the remaining 54% of total expenses there are many expenses that are fixed and do no fluctuate as patient volumes increase or decrease. With the reduction in patient volumes we needed to reduce staff not only in patient care areas but also in non-patient care departments. This was done to help minimize the loss we were trending towards after the first six months of the fiscal year.

Long Term Care

Long Term Care also affected the debt service coverage ratio. Long Term Care was a fee schedule reimbursed service. This means we received a set amount per day per resident which did not change as our expenses increased. Almost all other areas of the hospital are cost based reimbursed by Medicare and Medicaid with a few exceptions such as ambulance and public health.

Each year we have to complete a cost report for Medicare and Medicaid which determines what our reimbursement will be for inpatient, swing bed and outpatient services. Each department has direct expenses and is also allocated overhead expenses to determine our reimbursement rate. Overhead expenses are allocated to the patient services cost centers by a method determined by Medicare and Medicaid. Some methods of allocating overhead expenses to departments are by percentage of total expenses, square footage, laundry pounds, meals served, time studies, etc.

Long Term Care is also allocated overhead expenses on the cost report but did not change what we were paid per day per resident. With the closing of Long Term Care this allows the overhead expenses that would have been allocated to Long Term Care to be allocated to cost centers that are cost based reimbursed. Increasing the cost in cost based reimbursed departments decreases our contractual allowance write-offs as our payment from Medicare and Medicaid increases thus increasing our net income.

Long Term Care did have an affect our net income by reducing the amount of reimbursement we would received for cost based services. The estimated additional reimbursement in FY 2013 was calculated at an annual increase of $373,000 by our external Auditors, Seim Johnson, LLC. Using this annual estimation for FY 2013, Long Term Care would have affected the first six months of FY 2014 by approximately $186,000. The affect of Long Term Care would have reduced the net loss for the first six months to approximately a $683,514 loss. Additional expense reductions were necessary in addition to closing Long Term Care.

#11 Finance: To what extent has this been caused by expensive building additions, renovations, and off campus home purchases?

The formula for calculating the debt service coverage ratio is as follows:

$$\frac{\text{Net Income (Loss)} + \text{Interest} + \text{Depreciation} + \text{Loss on Disposal of Equipment}}{\text{Past 12 months Bond Debt Service Principal} + \text{Capital Lease Payments Principal} + \text{Interest Payments}}$$

The numerator of the equation has the net income or loss which would include the depreciation expense on the building additions, renovations and off campus home purchases. The depreciation expense is then added back to the net income or loss which zeros out the effect of the depreciation expense. Thus the depreciation expense does not affect the debt service coverage ratio.

The denominator consists of the principal and interest payments for the bond payments and other capital debt. The total interest expense for FY 2014 is approximately $549,000. Of this amount the two bond issues amount to approximately $487,000 of the interest expense. The

remaining $62,000 in interest expense is related to the Electronic Health Record software, MRI, Bladder Scanner, and Cardiac monitoring equipment purchases.

In FY 2014 the total principal payments are approximately $1,257,473. Of this amount $685,000 relates to the principal amount due on the two bond issues. The remaining $572,473 is due to the other capital equipment purchases as stated above.

In Fiscal Year 2014 we have not financed any of the capital purchases. All purchases have been made using general fund cash, which is approximately $1,300,000.

#12 Finance: To what extent has this been caused by expensive building additions, renovations, and off campus home purchases?

We have always made all interest and principal payments each month on time from the general fund cash account for both bond issues and all other debt.

#13 Finance: Was the physician recruitment property paid for in cash? If so, where did this cash come from? How much cash do we have on hand for hospital operations and purchases such as this?

The physician recruitment property at 418 Goode Street, Bloomfield, Iowa was paid for in cash from the general fund cash account. Absolutely no additional debt was incurred because of this purchase.

At the end of May 2014 we have the following general fund cash and cash equivalents:

General fund checking and savings accounts	$1,057,149
General fund 5-Star money market account	$2,862,734
General fund Certificates of Deposit	$704,452
Swab estate funds	$562,192
Total General Fund cash and cash equivalents	$5,186,527

We also have debt service sinking fund and interest fund accounts that are not included in the above cash listing. We deposit monthly into the sinking fund and interest fund accounts, which are held at Banker's Trust in Des Moines, Iowa according to the bond covenants. The payments due on March 1st and September 1st each year are made from these accounts that we have pre-funded throughout each fiscal year.