# HELPING ARKANSAS'
## GOVERNMENT-OWNED COMMUNITY HOSPITALS

### Achieve Their Full Potential

Proactively evaluating your situation and preserving access to high quality healthcare services in your local community

STATE OF YOUR HOSPITAL

stateofyourhospital.com

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# INTRODUCTION

Hospital leaders across the country are at a crossroads. While each community and its hospital is unique, all U.S. hospitals – particularly standalone, general acute care facilities – face many similar challenges, including decreasing inpatient census, decreasing revenues, a move toward a value-based business model, and capital-intensive needs, such as physician recruitment, information technology and facility improvements. In light of the growing challenges standalone community hospitals face, the expectations for boards, management teams, and elected officials have grown significantly.

We know that as a hospital and community leader you have the difficult task of evaluating your hospital's future and taking strategic action so you can:

- Ensure the continued availability of high-quality healthcare services to the residents of your community;
- Provide those services as close to patients' homes as possible;
- Create efficiencies to allow for the delivery of higher-quality, lower-cost care;
- Preserve jobs in your community;
- Preserve and maximize the value of your hospital for your citizens; and
- Enable the resulting healthcare service structure to continue to provide quality service in a financially self-sustaining manner (i.e., without direct taxpayer support).

Together, Healthcare Management Partners (HMP), Waller Lansden Dortch & Davis (Waller), Taggart, Rimes & Graham (Taggart) and Jarrard Phillips Cate & Hancock have studied the financial and legal status of government-owned community hospitals across the nation. This report covers the findings for Arkansas, the particular issues standalone, government-owned hospitals face, and what lies ahead for them. Our purpose is to educate hospital leaders and fiduciaries on the current status of Arkansas' standalone government-owned hospitals and analyze their options for providing quality healthcare in their communities for years to come. This report is based on rigorous data analysis and on our collective knowledge – along with some anecdotal evidence and observations – based on working with hundreds of hospitals and healthcare organizations across the country for the past 50 years.

# EXECUTIVE SUMMARY

***This study includes a quantitative and qualitative assessment of all short-term general acute and critical access hospitals across the United States with an in-depth analysis of Arkansas' 13 community-based, government-owned hospitals.[1] Our quantitative analysis has been prepared using data reported and certified in over 30,000 Medicare Cost Reports[2] filed by more than 5,000 hospitals for fiscal years 2008 to 2013. The performance of all hospitals in Arkansas was compared to national data for key metrics that are useful indicators of an organization's financial health. Then, the authors compared the performance of hospitals that are part of multihospital "systems"[3] to those that are "standalone"[4] (or non-system) hospitals. Finally, we analyzed performance by ownership type (Government, Investor (for-profit), Charitable (nonprofit)), and hospital type (University, General Acute Care, Critical Access).***

***The quantitative analysis has been complemented with qualitative analysis describing healthcare market factors and trends based upon both independent research and the authors' extensive experience in managing and advising hospitals and local governments over the last 50 years. A summary of the authors' background and experience is included at the end of this report.***

For decades, county-owned short-term general acute care and critical access hospitals[5] have been the primary source of healthcare services for rural Arkansans. Today, Arkansas' 13 community based government-owned general acute care and critical access hospitals[6] have combined annual net patient revenues of more than $150 million, directly employ nearly 2,000 full-time equivalent staff (FTE), and generate on average, the indirect employment of another 1,100 non-healthcare jobs in their local communities.

**MORE THAN 80%**

*of all government-owned hospitals in Arkansas have reported an operating loss in each of the past two years.*

For the last available reporting period (a single year), the 13 non-university government-owned hospitals in Arkansas had an aggregate net loss from hospital operations of nearly $30 million. More than 80% of all Arkansas government-owned hospitals have reported an operating loss in each of the past two years. As challenging as the news is in Arkansas, government- hospitals across the nation are experiencing even greater financial losses. Absent effective strategic changes, these negative trends are likely to intensify for these hospitals and accelerate their financial decline.

In the body of this paper, we attempt to describe the major forces affecting the ability of government-owned hospitals both to meet the healthcare needs of their communities and to remain financially self-sustaining without direct taxpayer funded operating subsidies. Based upon our analysis, we believe that the key drivers of the current financial and operating challenges are the following:

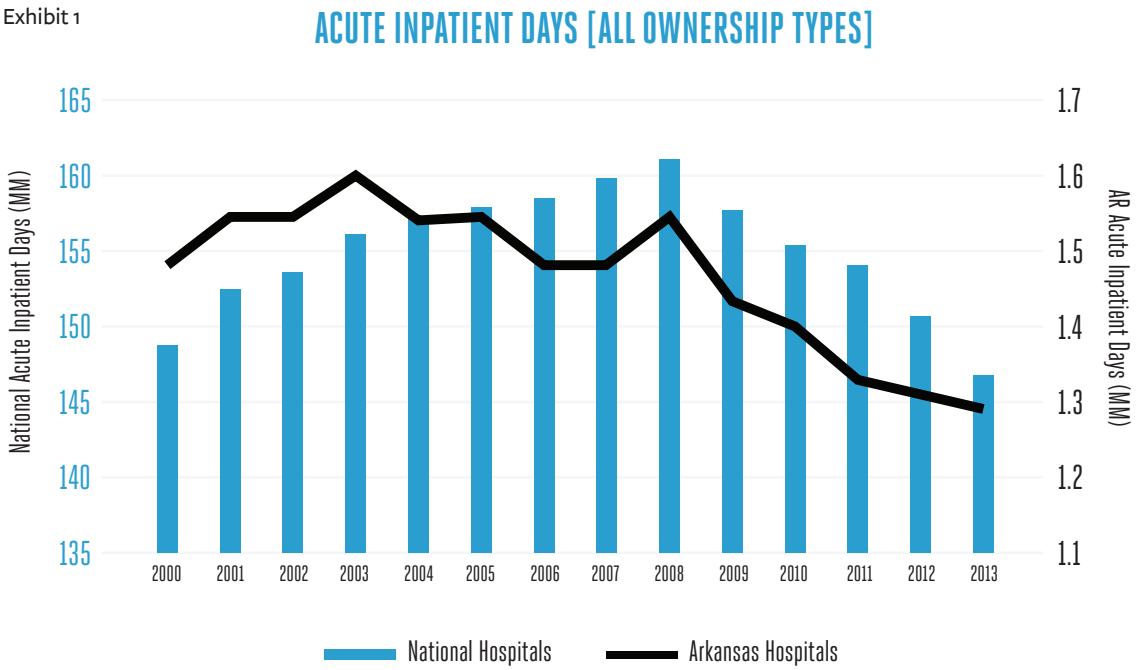
## Decline in Demand for Inpatient Services

Scientific advances in the diagnosis and treatment of disease means a further decline in demand for inpatient services. Hospital use rates, as measured by the number of inpatient days per 1,000 population, have been declining for decades and are expected to continue to decline into the future.

The rate of decline in inpatient services is currently projected at approximately four times the rate of growth of the population. Based on this factor alone, average occupancy rates in communities with a growing population can be

expected to decline by 1% to 2% per year. This problem is compounded in rural areas where the population is often declining. Hospitals are largely a fixed-cost business, with most operating expenses associated with creating the ability to provide care at any time, even if not actually providing it. Declining revenues because of declining inpatient occupancy always translate into significant loss of marginal profits.

Exhibit 1




*Source: Medicare Cost Reports or reports filed with the Center for Medicare and Medicaid Services (CMS) and reported in the Hospital Cost Report Information System (HCRIS)*

## Significant and Growing Excess Inpatient Capacity

Arkansas currently has nearly 2,000 more inpatient beds than conventional bed need formulas would indicate are necessary. In spite of declines in the number of hospitals and hospital beds, national inpatient occupancy rates are at historic lows. The average occupancy rate of all general acute care hospitals in the United States is approximately 61%. In Arkansas, the average hospital occupancy rate is 52%.[7] If its use rates were adjusted downward to the national average, the average occupancy of Arkansas hospitals would drop to 49%.

*Arkansas currently has*
**NEARLY 2,000**
*more inpatient beds than conventional bed need formulas would indicate are necessary.*

## Healthcare Has Become a Knowledge Business

Assembling and maintaining the stream of knowledge or skills necessary to successfully operate a modern general acute care hospital has become extremely complex and expensive. In addition to recruiting and retaining the necessary medical, nursing and clinical skills, hospitals must master increasingly complex clinical and information technologies, together with revenue cycles and supply chain management. It is a practical impossibility for most small standalone, government-owned hospitals with an average of 61 inpatient beds to meet this challenge effectively.

## The Hospital Payment System is Largely Based on National Average Cost

The Medicare payment methodology, which serves as a model for most other health insurance programs, is based on the national average cost for all hospitals and is thoughtfully designed so that the average hospital will produce a sufficient

profit margin from all patients to enable the hospital to make necessary investments in buildings and equipment to maintain its ability to provide care. Hospitals with costs below the computed average or with rapidly increasing patient volumes (those in the first and second quartiles, in the analysis that follows) will be generally profitable and thrive. Those with above average costs or declining patient volumes will find it increasingly difficult to maintain their ability to provide quality care which, in turn, will drive their volumes lower and the average unit costs higher.

## National Payment Policies Favor Hospitals in Multihospital Systems

Approximately 50% of all hospitals are owned and operated by multihospital systems.[8] But only 16% of government-owned hospitals in the United States are part of a multihospital system. Except for government-owned hospitals, hospitals that are part of a system are consistently larger and more profitable than their non-system competitors. Based on current data, multihospital systems currently account for over 60% of all inpatient beds and patients. Further, when combined with the economies of scale that systems can produce for their hospitals and a national hospital payment system based on average cost, these factors make it increasingly difficult for standalone hospitals to remain independent.

**APPROXIMATELY 50%**

*of all hospitals are owned and operated by multi-hospital systems. But only 16% of government-owned hospitals in the U.S. are part of a multi-hospital system.*

## Government-Owned Hospitals Are Structurally Disadvantaged in their Ability to Compete Effectively with Large Multihospital Systems

Government-owned hospitals are the only hospital ownership type which cannot select the geographic markets which they choose to serve. In addition, unlike private for-profit and nonprofit hospitals, government-owned hospitals are generally restricted by statute from organizing into multihospital systems across jurisdictional lines or entering into various types of entrepreneurial ventures. Finally, government ownership carries unique fiduciary duties and levels of public accountability and scrutiny that often inhibit their ability to compete effectively in a highly competitive national market for healthcare services.

Standalone hospitals in general, and particularly government-owned hospitals in regional and rural areas with declining populations, are structurally unable to cope with the scale and pace of change the hospital sector is experiencing. Unless fundamentally reorganized from the ground-up and combined with a larger sustainable delivery system, we believe that the vast majority of these hospitals and their associated healthcare services will ultimately become financially unsustainable and unable to meet an acceptable standard of care.

*In 2013, the average operating loss for a standalone government hospital in Arkansas was just under*

**$1.5 MILLION.**[9]

Our analysis indicates that standalone government-owned hospitals are struggling to reach the operating performance required to be financially self-sustaining in the long term. In 2013, the average operating loss for a standalone government hospital in Arkansas was just under $1.5m.[9]

When a hospital experiences significant operating losses, particularly over consecutive years, the quality of clinical care is put at risk due to an inability to recruit physicians, retain nurses, invest in the facility and purchase the equipment required to keep up to date with standards of modern medicine.

There are some tactical solutions that might buy time. But, where there are consecutive years of declining patient volumes and the associated financial losses, unless strategic action is taken quickly to reposition the hospital in the

emerging healthcare delivery system, a hospital's cash reserves can and will be quickly exhausted. Ultimately, as the financial distress continues, it is likely, that the hospital will be forced to limit access to critical health services.

Many providers are opting to form or join large healthcare networks or systems, so they may gain the physical and intellectual infrastructure and scale of operations needed for financial sustainability in this market context.

To thrive in the changing healthcare environment, many hospitals and health systems are implementing a range of strategies, from population health management and retail clinics to partnerships and alliances with other hospitals and health systems, insurers and physicians. Almost nine out of 10 hospitals in the country are evaluating some form of partnership or alignment, according to a recent survey.

*Almost*

**NINE OUT OF 10**

*hospitals in the country are evaluating some form of partnership or alignment, according to a recent survey.*

While the challenges may be different for each hospital, the mission and goals of community hospital boards of trustees are the same: to maintain access to high-quality care. With this and other objectives in mind, the strategic options available to hospitals facing uncertainty generally include: (1) sell; (2) merge; (3) affiliate; (4) transform into an alternative (non-hospital) care delivery mode; or (5) close. The best option for each hospital will depend on its unique market and circumstances.

Government-owned hospital boards and county supervisors that respond quickly to these rapidly emerging market forces will experience the best outcome for the residents of their communities. The option, however, to "play defense" may indeed pose the greatest risk to the long-term availability of quality of healthcare services for the community, and the existing enterprise value of the institution.

## Taking Strategic Action Will Not Be Easy.

Reconfiguring local healthcare services is a highly emotional and difficult political undertaking. The local community hospital holds a dear place in the hearts of many people and is often one of the largest employers in the county. It is important for hospital and county leaders to consider thoughtfully their strategies for obtaining the best long-term outcome for all of their constituents. As described later in this paper, hospital trustees in particular have specific duties when it comes to mapping out the future direction of the hospital and meeting the healthcare needs of the community well into the future.

Another certainty is that the implementation of a strategic action plan to preserve healthcare services within the community will involve the understanding and unravelling of complex legal and financial structures, many of which are unique to each jurisdiction and institution. As such, the legal framework within which Arkansas county-owned hospitals operate has been analyzed separately.

Most of the hospital's constituents, including its medical and nursing staffs, have a limited understanding of the full scope of the external forces that impact healthcare service delivery within the community. Accordingly, it is imperative that county and hospital leadership agree upon and communicate a well-planned, consistent and truthful series of messages to all affected parties that accurately describes the hospital's operating environment and condition, the available alternatives being considered and ultimately the actions to be taken to accomplish the hospital's goals.

In this paper, you will find:

- An overview of the industry dynamics that are forcing hospitals to address market forces;
- Quantitative analysis of the performance of Arkansas' standalone, government- owned, acute care hospitals;
- An assessment of the various strategic alternatives available;
- A discussion of the specific duties of hospital boards in evaluating strategic options;
- Help in understanding the legal challenges unique to government-owned Arkansas hospitals; and
- A summary of the different approaches that can be taken to address constituent communications while evaluating and implementing a strategic plan.

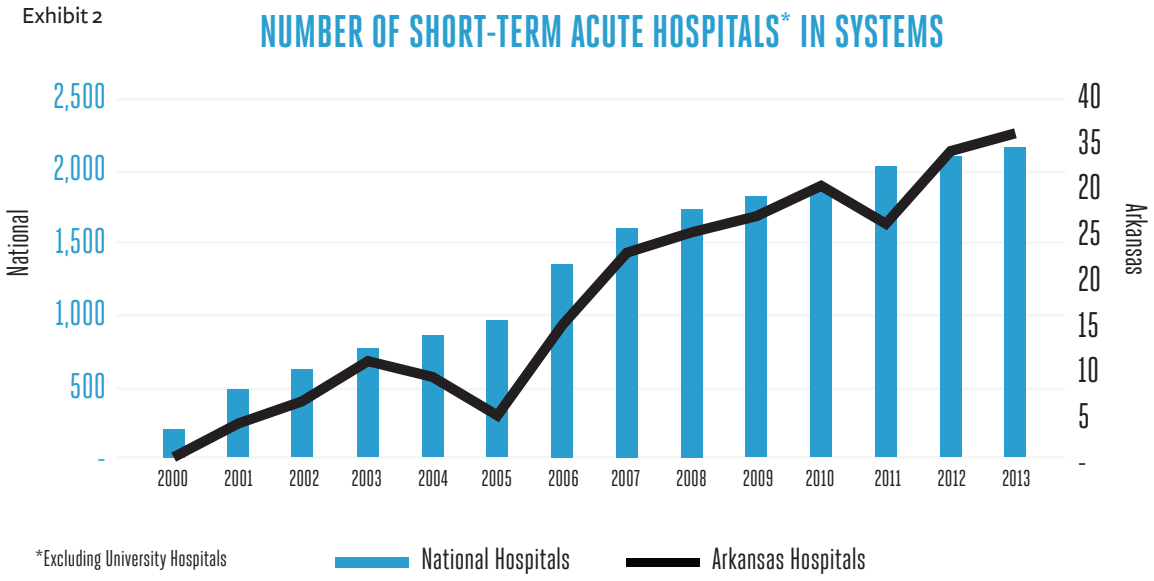
In conjunction with preparing this document, the authors have developed provider-specific performance data, customized peer group benchmarks and an extensive online resource, which may be found at StateofYourHospital.com (Case sensitive password: soyh2015).

# THE SHIFTING LANDSCAPE FOR STANDALONE GOVERNMENT HOSPITALS

**To thrive in the changing healthcare environment, many hospitals and health systems are implementing a range of strategies, from population health management and retail clinics to partnerships with other hospitals, health systems, insurers and physicians.**

It is clear that hospitals and health systems in the state and across the country are exploring ways to work together. Organizations that are not open to collaborating with others will be at a disadvantage.

Exhibit 2




*Source: Medicare Cost Reports or reports filed with the Center for Medicare and Medicaid Services (CMS) and reported in the Hospital Cost Report Information System (HCRIS)*

It is important for hospital leaders not only to be aware of how healthcare is changing and how others are adjusting to the changes, but to continue to examine their hospital and their market to identify the next best steps to ensure long-term success. In doing so, a board is duty bound to consider every option, including a restructure, partnership or close alliance.

Significant factors make it increasingly difficult for standalone general acute care and critical access hospitals to achieve financial stability. Those factors include the following:

## Changes in the Way Hospitals Are Paid

**Macroeconomics Drive Healthcare Spending Policies**

Because of a rapidly aging population combined with better-informed consumers, the demand for healthcare services has historically grown at rates 3%-5% greater than either the population or the American economy. In 2013, total healthcare spending grew at 3.6%, one of the smallest increases on record, to a total of $2.9 trillion or $9,255 per person.[10] According to the U.S. Census Bureau, the population of the country grew by 0.7% that year.[11] Total healthcare spending in 2013 was 17.4% of GDP.[12] The federal government is aggressively pursuing approaches to reduce the rate of growth in aggregate healthcare spending because more than 40% of total lifetime healthcare spending occurs in the last two years of life.

**How the Current Medicare Payment Structure Works**

Medicare currently accounts for more than 40% of all hospital patient revenues. At standalone, rural hospitals, because the elderly are less mobile than younger commercially insured patients, it is not uncommon for Medicare to account for 50% or even 60% of total patient revenues. Additionally, because of the scope and scientific validity of the Medicare rate-setting process for hospitals combined with the fact that most major insurance plans also offer Medicare Advantage plans, most commercial insurance or state Medicaid programs, incorporate or "piggyback" on the Medicare rate-setting methodology. Stated differently, on a national basis Medicare rate-setting policies drive hospital rate setting for all payors.

*Almost*

**THREE OUT OF FOUR**

*government-owned standalone hospitals were in the bottom 50% of all hospitals nationally.*

The Medicare payment methodology for hospitals is conceptually very simple. Annually, CMS computes an average cost for each inpatient and outpatient payment classification using the cost data it receives in approximately 5,000 hospital cost reports and allocates the cost based on approximately one billion processed and paid Medicare claims for the same period. There are some additional technical adjustments and then the computed average historical cost per diagnosis-related group (DRG) or ambulatory payment classification (APC) is adjusted upward for medical inflation less 2%. The 2% reduction in the medical inflation adjustment is an imposed productivity measure to help contain the rise in total expenditures. In theory, it also reflects that hospitals are a fixed-cost business and that all costs do not increase perfectly with volume.

The payment methodology is based on average cost for all hospitals and is thoughtfully designed so that the average hospital will produce a sufficient profit margin from all patients to enable it to make necessary investments in buildings and equipment to maintain its ability to provide care. Hospitals with costs below the computed average or rapidly increasing patient volumes (those in the first and second quartiles, in the analysis that follows) will be generally profitable and thrive. Those with above average cost or declining patient volumes will find it increasingly difficult to maintain their ability to provide quality care which in turn will drive their volumes lower and the average unit costs higher. The system is mechanically designed to put hospitals with high cost structures out of business. For the last reporting period, the reported operating profit margins of almost three out of four government-owned standalone hospitals were in the bottom 50% of all hospitals nationally.[13] Further, 64% of government-owned hospitals in government-owned systems were also in the bottom 50% of all hospitals. These results contrast sharply with non-government-owned hospitals in multihospital systems where less than a third of their hospitals were in the bottom 50% for operating profit margin.

The concept that most hospital payment systems are based on a national average cost that is increasingly dominated by more cost-efficient system-owned hospitals is fundamental to evaluating the strategic choices to be made by standalone community hospitals. As will be shown in the section titled, "Comparative Data on Arkansas Hospitals," standalone government hospitals have a cost structure that makes it increasingly difficult for them to operate in a financially self-sustaining manner.

**Evolving Payment Structures**

Post-war "baby boomers" are now in their 60s and 70s and they are expected to put an increasingly significant burden on the Centers for Medicare and Medicaid Services (CMS) in its funding of elderly care.

*Because more than 40% of total lifetime healthcare spending occurs in the last two years of life, the government is desperate to get healthcare spending under control before it "breaks the bank."*

New and developing payment structures, which involve providers assuming the risk to manage population health, favor health systems that can cover thousands of lives in an actuarially balanced way. Standalone hospitals with small and concentrated populations cannot as easily spread the economic risk of treating very critically ill patients.

Recently, CMS announced it established a target to have 50% of provider payments risk-based or weighted by the beginning of FY 2018. ***This step is a refinement of the "average cost" methodology described above and not a blanket replacement. It will, however, further increase the complexity of an already complex payment system.*** Hospitals must develop plans to assess their financial capability to operate in this new risk-based world and take action, as needed, to preserve community health services if survival in the current structure is not possible under future payment methodologies.

Additionally, for quality of care reasons, commercial insurance carriers that also provide Medicare Advantage and Medicaid managed care plans are increasingly refusing to contract with standalone or small hospitals for medical procedures that the hospitals perform at low volumes. The result is a decline in local community procedure-based medical specialties (surgeons, obstetricians, etc.) and a corresponding loss of marginal revenues.

As the reimbursement and regulatory structures become more complex, standalone facilities will find it more difficult to sustain the level of skill required to manage the business risk associated with the new and increasingly complex payment systems. The level of skill and knowledge required to properly provide and bill for healthcare services is challenging and expensive to sustain, but failure to do so can result in RAC audits or compliance litigation which can be devastating for a hospital's reputation and cash flow.

## Being a Healthcare Provider Requires Acquiring and Mastering New Skills

Healthcare services in general and hospitals in particular have become the consummate "knowledge business" rather than the service business generally perceived by consumers or patients. Service, however, remains a critically important part of the patient and family experience and is generally the criteria that families and patients use to evaluate hospitals.

*Delivery of state-of-the-art acute care requires hospitals to acquire, integrate and continuously maintain a current base or streams of knowledge in diverse and technically complex subject areas to compete successfully in today's very complex and rapidly changing healthcare marketplace.*

The following are the most critical subject areas that today's hospitals must master.

## Medical and Clinical

The effective diagnosis and treatment of acutely ill patients requires the organization, development and maintenance of effective medical, nursing and allied health staffs. It takes the combined knowledge of the medical and clinical staffs,

working closely together, to provide cost-effective, high-quality care. Maintaining this knowledge base is the single biggest challenge for a standalone hospital.

A demographic shift of the population away from regional and rural areas toward more heavily populated towns and cities means not only is the patient population declining in rural communities, but most standalone hospitals have an aging physician workforce and struggle with physician succession planning. In many cases, when a physician retires or dies, specific medical services can no longer be safely provided by the hospital unless expensive alternatives are employed. It is particularly difficult to recruit young newly trained physicians under these circumstances. Young physicians overwhelmingly favor employment in large practice groups. They generally do not want to start a practice of their own and are reluctant to take over the practice of a retiring physician.

Further, exponential growth in medical knowledge and technological innovation means that each new generation of physicians is more likely to join a physician group than to be the sole provider of a medical specialty.

As standalone hospitals struggle with physician recruitment and retention, regional and national systems have a myriad of options to recruit, retain and efficiently utilize their most expensive resource (physicians) not available to a standalone hospital. Most particularly, health systems can assemble stable, single-specialty, multi-physician practices that are designed to serve multiple locations. For example, whereas a small critical access hospital is unlikely to successfully recruit and retain a qualified general surgeon or cardiologist because it only has demand sufficient for one or two days per week, a large multihospital system can rotate physicians among multiple locations to increase their utilization.

## Corporate and Legal Compliance

The delivery of healthcare, particularly by hospitals, is perhaps the most regulated, complex business in the United States. In addition to the usual business requirements (state and local taxes, corporate and employment law, etc.), hospitals must also comply with diverse legal and operating requirements which range from licensing and accreditation requirements, patient privacy and protection, to highly complex billing requirements and hazardous chemical and nuclear waste disposal.

For instance, Natchez Regional Medical Center in Natchez, Miss. had more than $2.4 million in Medicare receipts withheld by CMS in just 8-10 months as part of a RAC audit. Natchez Regional was forced to file for bankruptcy in the middle of a process to sell the hospital, because, among other reasons, cash became suddenly so short that the hospital could not pay its regular operating expenses.

## Business Management and Revenue Cycle

As much as 20% of a hospital's total administrative staff effort is associated with billing and collecting payment for medical and hospital services. The collection, processing and storage of personal and financial patient information, as well as coding medical records to reflect the millions of possible combinations of procedures and diagnoses presents an extremely difficult and complex challenge for a small or standalone hospital to master.

**MOST STANDALONE HOSPITALS**

*have an aging physician workforce and struggle with physician succession planning.*

Due to the complexity, it is common for large hospital systems to consolidate their billing and collecting functions on a regional or

national basis. The next few years will be particularly difficult for hospitals as the government has set an implementation date of October 1, 2015 for implementation of a new ICD-10 coding system. Even with an effective training program for ICD-10 implementation, experts predict substantial cash flow delays to accompany implementation. Lack of an effective ICD-10 implementation strategy will create long-term cash flow issues. The transition will be difficult for standalone hospitals without dedicated resources.

Additionally, many standalone hospitals have outdated budgeting and financial reporting systems. Boards, particularly county boards of supervisors, frequently must rely on the year-end audit for a reasonable picture of the financial condition of the hospital enterprise. In the current and future healthcare environment, information received three to six months after the end of the year is far too late to inform critical decision making. Most standalone hospitals, however, do not have the resources to update their reporting systems.

For hospitals that are part of a system, this problem along with its technological challenges is largely eliminated through the creation of a consolidated corporate or regional business office.

## Information Technology

The information systems now required for hospitals are dramatically more complex than their commercial business counterparts. Hospitals are required to have electronic health record systems that are used to record and manage their patient's care. Lab results, x-rays and other diagnostic studies are transferred securely to doctors to enable them to remotely manage patient care. Mastering information management is extremely expensive and one of the leading reasons standalone hospitals consider joining a system. The industry is full of examples where a failed information system installation has cost a hospital as much as 10%-20% of its total annual revenues in lost billing. Additionally, hospitals have new information management needs as information systems of the future will need to provide hospitals with tools to implement population management and risk-based contracting.

*The industry is full of examples where a failed information system installation has cost a hospital as much as*

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*of its total annual revenues in lost billing.*

## Resource Management

Managing human resources, supplies, equipment and facilities in a hospital is very complex. A typical 100-bed general acute care hospital will employ 500-700 full-time equivalent staff, occupy 150,000 to 200,000 square feet of space, and stock 10,000 to 20,000 distinct drugs and supply items. Additionally, this typical hospital will own several hundred separate pieces of sophisticated electronic medical equipment ranging from patient beds, IV pumps, heart monitors and ventilators to surgical robots, MRIs and linear accelerators. The equipment will have a replacement value of $25 to $35 million. Effectively managing these resources requires significant and continuous specialized knowledge. Those hospitals that are part of a larger system gain the benefits of:

- **Consolidated Treasury Management:** By consolidating cash and treasury management systems, hospitals can lower the amount and cost of borrowing as well as improve investment yields.
- **Facilities Management and Maintenance:** Corporate facilities management teams provide system hospitals with sophisticated project management expertise; lower the cost and improve the quality of maintenance service contracts; provide the foundation for sophisticated approaches to energy management, biomedical engineering and waste disposal.
- **Centralized Employee Benefits Administration:** There is little additional cost associated with the

administration of employee benefit plans for one location or multiple locations.

» **Self-Insurance and Risk Management Programs:** Multihospital systems with seven or more hospitals typically self-insure malpractice, workers compensation and employee health insurance, usually at great savings over market-based risk financing programs.

## Management and Governance

Well-trained and experienced management and boards of directors or trustees are essential to ensure the continuous provision of cost-effective, quality healthcare services. Effective boards and management teams that work well together take years to build and require trust, reliable operating and financial reporting, clear lines of authority and responsibility and enforced accountability.

WELL-TRAINED

*and experienced management and boards of directors or trustees are essential to ensure the continuous provision of cost-effective, quality healthcare services.*

While the management team is tasked with carrying out day-to-day hospital operations, boards of directors or trustees exist to supervise the hospital's management team. The directors or trustees have a fiduciary duty to the hospital's stakeholders, including the management team, employees, physicians, patients, the community and elected officials - all of whom have their own unique interests and priorities. The board's fiduciary duties reflect the stakeholders' expectations that board members will prudently oversee the hospital's management team and business affairs.

In light of the growing economic challenges facing standalone government-owned hospitals, the expectations for boards have recently grown significantly. Today, board members are expected to be more involved and better informed in order to ensure the long-term viability of healthcare services within the community they serve. Ironically, a board's efforts to maintain a hospital in a community beyond the time of the hospital's financial viability may actually harm the hospital's ability to continue to provide within the community the essential healthcare services and jobs that could otherwise be maintained with an orderly restructuring of the community's healthcare offerings. Trustees must ask if the old ways still work in new times. Could alternatives be more effective? Have other organizations found better ways? An energetic and focused board is essential to tackling the challenges hospitals face today. The decisions made in the board room are as important to maintaining quality healthcare as those made in the operating room.

*The most effective approach to policy makers is a demonstration of how the access to community-based, high-quality healthcare can be achieved by taking affirmative action now, if needed, to prevent the inevitable decay caused by the economics of traditional hospital models.*

Unlike their counterparts at better-capitalized or large health systems, the trustees and senior managers of community hospitals, which typically are smaller and more dependent on public payments and subsidies, have little margin for error in planning and operating their organizations. Time, human resources and capital are scarce; determining when and how resources are deployed in the post-reform environment requires informed decisions based on concepts that may not yet be proven. Given the thin or negative margins at which many nonprofit and public hospitals operate, leadership teams must not only determine how to operate with less, but how to realistically position the organization for financial stability in a very uncertain environment. For these providers, a proactive and honest assessment of operational and strategic options is recommended.

## Politics

Most public officials tasked with overseeing healthcare facilities know their institutions are under intense pressure. It is challenging, however, for some officials to see the evolution of these hospitals to other hospital systems or healthcare models in a positive light. The most effective approach to policy makers is a demonstration of how access to community-based, high-quality healthcare can be achieved by taking affirmative action now, if needed, to prevent the inevitable decay caused by the economics of traditional hospital models. Conversely, if the local community is subsidizing the hospital's operating losses, some policy makers may be enthusiastic about freeing up revenue for other purposes and avoiding additional taxes. The sale of a hospital may not only preserve healthcare in the community but may result in significant proceeds, often resulting in a foundation, which can be used by the municipality for other worthy purposes.

Of course, the more existing jobs that can be preserved in the evolution to a self-sustaining model, the better. To the extent that some jobs are lost, others may be created in the ramp up of a new healthcare delivery system. In any event, it is a near certainty that all current hospital-based jobs are at risk if hospitals in the bottom 50% of reported profit margins try to maintain the *status quo.*

## Geographic Location

Government-owned hospitals, in general, and critical access hospitals, in particular, tend to serve rural communities. These communities are some of the most economically and demographically stagnant communities in America. Many, if not most, of these communities are experiencing population declines. This, in turn, translates into declining demand for hospital services.

> *This demographic shift of the population away from regional and rural areas toward more heavily populated towns and cities also means physician recruitment is increasingly difficult and costly. Because hospitals are largely fixed-cost businesses, a decline in patient volume or marginal revenues is extremely difficult to compensate for through the reduction in operating expenses.*

Unprofitable or declining hospitals are poor candidates for a merger or sale into a larger more efficient multihospital system.

Government-owned hospitals are also unable to choose the markets in which they operate. One of the reasons that investor-owned hospitals tend to be more profitable than their government and nonprofit counterparts is that they can choose the markets in which they invest.

*In Arkansas, the 10 government-owned CAHs have net patient revenue per adjusted occupied bed of*

**LESS THAN 80%**

*of their GACH counterparts.*

## Unique Circumstances of Critical Access Hospitals

Twenty-eight percent (or 1,310) of all short-term general acute care hospitals are classified as Critical Access Hospitals (CAH).[15] Typically, CAHs must be located in a rural area and be more than a 35-mile drive from any hospital or other CAH, maintain no more than 25 inpatient beds, and have an annual average length of stay of 96 hours or less per patient for acute care. CAHs must also furnish 24-hour emergency care services seven days a week, using either on-site or on-call staff.[16]

Historically, CAHs were often the only reasonably accessible providers of acute care services for very rural populations. Most residents in rural communities,

however, now bypass their local CAH and self-refer to doctors on staff at regional general acute care hospitals (GACH) due to a number of factors, including better transportation systems, patient choice, improved emergency medical transport and the inability of rural communities to recruit and retain an array of medical and nursing skills. In Arkansas, the 10 government-owned CAHs have net patient revenue per adjusted occupied bed (AOB) of less than 80% of their GACH counterparts ($962 Vs $1,228). Effectively, certain CAHs are operating nursing homes that also provide certain diagnostic and therapeutic services.

Nationally, less than 30% of all CAHs meet the requirement that they be located more than 35 miles from a GACH or another CAH. None of Arkansas' 30 CAHs currently meet the 35-mile criteria. Traditionally, this criteria has been liberally waived by CMS. In an effort to reduce expenditures for Medicare, the current definition of CAH is under challenge by CMS.

Cost-based reimbursement, provides CAH hospitals with a payment rate that is generally 6% to 10% greater than they would have received if they were paid on a prospective basis. Still locally and nationally on average, these facilities lose money from operations and require substantial non-operating revenue (often in the form of local tax subsidies or other government funds) to stay in business.

No one would dispute the need for rural communities to have access to high-quality health services. The issue is whether CAHs continue to offer the highest quality and most cost-effective way to provide those services in light of technological advances, reimbursement changes, and changes in the patterns of physician practice and employment. For some communities, replacement of the CAH with a regional delivery system with limited or no inpatient services, which in turn relies on local primary care physicians supplemented with rotating specialists and tele-health technology, may provide superior healthcare services at a much lower cost.

# COMPARATIVE DATA ON ARKANSAS HOSPITALS

**HMP Metrics: Measuring Peer Group Adjusted Performance**

HMP Metrics is a tool enabling the measurement of peer group adjusted performance for a diverse range of healthcare providers. Utilizing publicly available hospital Medicare cost report data, we have used the HMP Metrics to conduct an extensive study comparing performance within various hospital peer groups, including hospital type, ownership, system membership and bed size.

Using proprietary filters, data contained in the HMP Metrics database has been "scrubbed" to exclude partial period or statistically aberrant data elements for individual hospitals or health systems. This data validation process produces highly accurate and defensible peer group comparisons for dozens of standard industry metrics, many of which are analyzed in detail in the exhibits and text which follow.

The industry terms or descriptors used to evaluate relative performance are defined below:

## Key Hospital Descriptors

| | |
|---|---|
| **Average Total Bed Size** | Includes acute and sub-acute beds (usually nursing home beds) |
| **Average Acute Bed Size** | Excludes sub-acute beds but includes all types of acute beds (medical, surgical, ICU, obstetrics, pediatrics, etc.) |
| **Average Occupancy Rate (AOR)** | Percentage of available acute patient beds that are filled on any given day |
| **Average Daily Census (ADC)** | Average number of actual inpatients occupying acute patient beds on any given day |
| **Adjusted Occupied Beds (AOB)** | An industry standard measure which uses total gross patient revenues to equate inpatient and outpatient revenues in a uniform manner |
| **Net Patient Revenue Per AOB** | Total Net Patient Revenue divided by the computed Adjusted Occupied Beds (this is an aggregate indicator of the relative complexity of patient services provided) |
| **Average Markup on Cost** | Total Gross Patient Charges (retail patient revenue based on retail prices) divided by total operating cost (Patients rarely actually pay the retail price for services. Contrary to common thinking, a lower markup is usually an indication of under management as opposed to price gouging.) |
| **Full-Time Equivalent Staff (FTE)** | Term is used to compute measures of labor productivity (one FTE is equal to 2080 paid staff hours) |
| **Total FTEs** | Total equivalent full-time employees for a hospital or ownership type for a given sector (For example, the 30 critical access hospitals in Arkansas directly employed the equivalent of 3,939 full-time employees.) |

## Key Hospital Descriptors

| | |
|---|---|
| **Average Full-Time Equivalent Staff** | Average total equivalent full-time employees for a hospital or ownership type for an individual (For example, the 30 critical access hospitals in Arkansas directly on average employed the equivalent of 131 full time employees.) |
| **Net Patient Revenue Per FTE** | Average total net patient revenue per FTE employee (this is a composite indicator of labor efficiency and the relative market value of services provided) |

In the exhibits that follow, hospitals by type and ownership are stratified further into quartiles in order to illustrate the benchmarks for poor to exceptional performance for each metric used, allowing for easy comparison within peer groups. The first quartile contains the top 25% of the best performing hospitals in an applicable peer group, the second quartile contains those hospitals falling in the 26% to 50% range, the third quartile contains those hospitals falling in the 51% to 75% range, and finally the fourth quartile contains those hospitals falling below 76%.

Using HMP Metrics, we were able to construct peer group performance reports from publicly available data and extract valuable comparative information across national, state and local benchmarks which is presented and analyzed in exhibits 3 through 13. All data in the exhibits was derived from the most recent (Fiscal Year 2013) Medicare Cost Reports filed with the federal government by almost 5,000 individual hospitals. Only one cost report was used for each hospital and all of the short-term acute care hospitals in Arkansas were included. By law, hospitals must file an electronic cost report within 150 days of the close of their fiscal year. Typically filed cost reports are electronically available to the public within 90 days of their receipt by CMS.

The individual metrics and the statistical measures or terms used in the exhibits are defined on the next page.

## Key Hospital Metrics or Statistical Measure

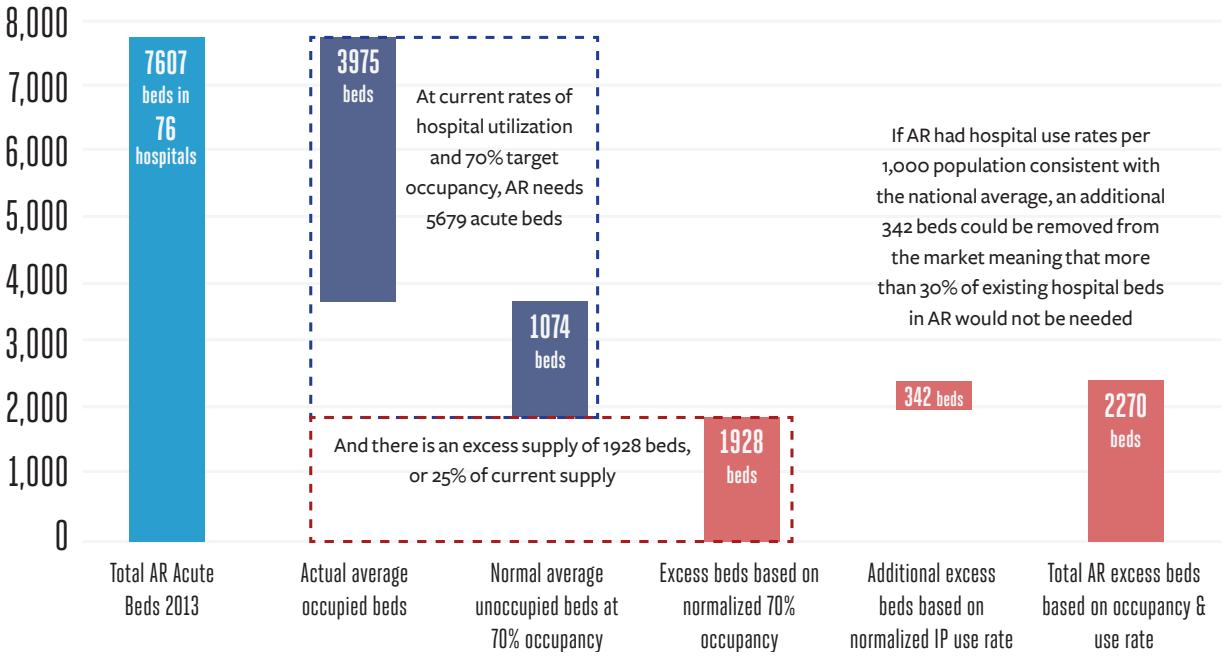
| | |
|---|---|
| **Hospital Metrics** | |
| **Operating Profit Margin** | Expressed as a percentage, it is computed by dividing total operating profit by total operating revenues (A negative percentage would indicate a loss from operations.) |
| **Total Labor Cost as a Percentage of Total Operating Revenue** | This is a percentage calculated by dividing the sum of the cost of employee salaries, benefits and contract labor; by total operating revenues (A lower percentage indicates better labor cost efficiency.) |
| **Full-Time Equivalent (FTE) Staff Per Adjusted Occupied Bed (AOB)** | This ratio is computed by dividing total full-time equivalent staff by total computed adjusted occupied beds (It is an indicator of workforce productivity. A lower ration indicates greater relative productivity.) |
| **Average Days Net Patient Revenue in Patient Accounts Receivable** | This is a measure of how many days of net patient revenue is on average uncollected (It is used to measure the efficiency of the hospitals revenue cycle or billing operations. A lower number would indicate greater revenue cycle efficiency.) |
| **Statistical Measures Used** | |
| **Weighted Average Mean** | The mathematical average of all of the required data elements for all of the hospitals included in the analysis. For example the weighted average mean operating margin was computed as follows: [(Total Operating Revenues for all included hospitals/Total Operating Expenses for all included hospitals) – 1]/(Total Operating Revenues for all included hospitals) |
| **Median** | The number separating the higher half of a data sample, or distribution from the lower half. In our exhibits it is the value for the middle hospital included in the analysis (e.g., half have a higher value and half have a lower value). |
| **Percent (%) in the Bottom 50% of all Hospitals** | Percent of the hospitals of a hospital or ownership type which are in the bottom 50% of ALL short term acute care hospitals |
| **Percent (%) with an Operating Loss for the Past Two Consecutive Years** | Percent of the hospitals of a hospital or ownership type which have experienced a net loss from operations for at least the last two consecutive reporting periods. |
| **Mean for the Top 50% of all Hospitals in the Sector or Type** | Mean value (average) for the metric for all hospitals of a hospital or ownership type which are in the first or second quartile for that metric. |
| **Mean for the Bottom 50% of all Hospitals in the Sector or Type** | Mean value (average) for the metric for all hospitals of a hospital or ownership type which are in the third or fourth quartile for that metric. |

## Declining Demand for Inpatient Services

Since 1980, the number of hospital inpatient surgical procedures per 1,000 population has declined by almost 75% and because of advances in technology, evermore healthcare services are provided at home or in sub-acute or non-hospital ambulatory settings. These trends are not expected to reverse. Based on 2012 data, the international actuarial firm Milliman, Inc. projected total inpatient utilization to decline by an additional 15% by 2021.[17]

Exhibit 3

### ACUTE CARE BED NEED AND EXCESS ACUTE CARE BEDS IN ARKANSAS, 2013




*Source: Medicare Cost Reports or reports filed with the Center for Medicare and Medicaid Services (CMS) and reported in the Hospital Cost Report Information System (HCRIS); Kaiser State Health Facts, Hospital Inpatient Days per 1,000 Population by Ownership Type 2013*

Based upon a generally accepted industry standard of an ideal target average occupancy rate (AOR) for a general acute care hospital of between 65% and 75%, similar Arkansas hospitals have nearly 2000 beds in excess of this AOR target optimum rate.[18]

This excess capacity or over-bedding will continue to grow in the future as total patient days per 1,000 (demand for hospital inpatient services) continues to decline. Based on Milliman's projected 15% decline in inpatient demand through 2021, AOR in Arkansas will decline further from 52% to 44.2%.

Surprising as this may sound, this is likely the "best case" scenario. Arkansas hospitals face significant challenges in terms of total inpatient days per 1,000 population. Twenty states have use rates higher than Arkansas' 614 days per 1,000 population. The national average is 577 days per 1,000 population and thirteen states have rates below 500 days per 1,000 population, including five states with rates below 400 days per 1,000 population. If Arkansas was operating at the national average, more than 30% of existing hospital beds in the state would not be needed. Future payment methodologies will force Arkansas to operate closer to the national average.

Hospitals are largely a fixed-cost business, with most operating expenses associated with creating the ability to provide care not actually providing it. Declining revenues associated with declining inpatient occupancy will translate into significant financial losses.

Our analysis of government hospitals nationally and in Arkansas indicates that many hospitals in this category are already experiencing signs of severe financial distress, and, in many cases, the situation has already reached the point where consistent access to quality clinical care is likely being impaired.

## System -vs- Non-System Hospitals

As shown in Exhibit 4 below, approximately half of all short-term general acute care hospitals are corporate subsidiaries of multihospital systems. However, there is great disparity between system membership and ownership type. Only 16% of government-owned hospitals are configured as multihospital systems whereas 70% of investor-owned and 55% of nonprofit hospitals are part of national or regional hospital chains or systems.[19] Similarly only 31% of critical access hospitals are part of a system. Over fifty-five percent of all non-system hospitals are either owned by government or are critical access hospitals.

Exhibit 4 - Number of Short-term General Acute Care Hospitals by Type and System Affiliation

| | National | | | | Arkansas | | | |
|---|---|---|---|---|---|---|---|---|
| | System | | Non-System | | System | | Non-System | |
| Ownership Type | Hospitals | Percent | Hospitals | Percent | Hospitals | Percent | Hospitals | Percent |
| Government Owned | 175 | 16% | 892 | 84% | 2 | 14% | 12 | 86% |
| For Profit (Investor Owned) | 685 | 69% | 312 | 31% | 12 | 75% | 4 | 25% |
| Not-For-Profit (Charitable) | 1,473 | 55% | 1,223 | 45% | 22 | 48% | 24 | 52% |
| All Short-term Hospitals | 2,333 | 49% | 2,427 | 51% | 36 | 47% | 40 | 53% |

| | National | | | | Arkansas | | | |
|---|---|---|---|---|---|---|---|---|
| | System | | Non-System | | System | | Non-System | |
| Hospital Type | Hospitals | Percent | Hospitals | Percent | Hospitals | Percent | Hospitals | Percent |
| University | 147 | 56% | 115 | 44% | - | 0% | 1 | 100% |
| General Acute Care | 1,781 | 56% | 1,391 | 44% | 25 | 56% | 20 | 44% |
| Critical Access | 405 | 31% | 921 | 69% | 11 | 37% | 19 | 63% |
| All Short-term Hospitals | 2,333 | 49% | 2,427 | 51% | 36 | 47% | 40 | 53% |

Source: Hospital Cost Report Information System (HCRIS) using the most recent cost report on file.

As shown in Exhibits 5 to 7, non-system hospitals are on average smaller and less profitable, with the exception of investor-owned hospitals, on average, all other non-system hospitals lose money from hospital operations whereas their system-owned counterparts, except for government-owned systems, make money from recurring operations. Similarly, on average, critical access hospitals which are part of an investor-owned or nonprofit system make money and those which are not part of a system or are owned by a government system lose money from recurring hospital operations. Nationally the profit margins of all ownership and hospital types are 2% to 6% better than their non-system counterparts.

## Exhibit 5 - Average Acute Bed Size Per Short-term General Acute Care Hospital

| Ownership Type | National | | Arkansas | |
|---|---|---|---|---|
| | System | Non-System | System | Non-System |
| Government | 179 | 80 | 87 | 63 |
| Government Excluding University | 127 | 61 | 87 | 28 |
| For Profit | 155 | 68 | 119 | 50 |
| For Profit Excluding University | 151 | 68 | 119 | 50 |
| Not-For-Profit | 190 | 140 | 137 | 85 |
| Not-For-Profit Excluding University | 160 | 112 | 137 | 85 |

| Hospital Type Regardless of Ownership Type | National | | Arkansas | |
|---|---|---|---|---|
| | System | Non-System | System | Non-System |
| University (Regardless of Ownership) | 529 | 543 | N/A | 439 |
| All Short-term Including University | 179 | 109 | 128 | 75 |
| General Acute Excluding Univ. and CAH | 185 | 131 | 175 | 104 |
| Critical Access Hospitals (CAH) | 22 | 22 | 23 | 24 |

Source: Hospital Cost Report Information System (HCRIS) using the most recent cost report on file.

## Exhibit 6 - Average Annual Operating Profit Margin Per Short-term General Acute Care Hospital

| Ownership Type | National | | Arkansas | |
|---|---|---|---|---|
| | System | Non-System | System | Non-System |
| Government | -4.4% | -7.6% | -46.9% | -2.3% |
| Government Excluding University | -3.6% | -8.3% | -46.9% | -16.8% |
| For Profit | 7.5% | 1.8% | 3.7% | 4.5% |
| For Profit Excluding University | 7.8% | 1.8% | 3.7% | 4.5% |
| Not-For-Profit | -0.3% | -3.1% | -11.7% | -12.5% |
| Not-For-Profit Excluding University | 0.4% | -2.3% | -11.7% | -12.5% |

| Hospital Type Regardless of Ownership Type | National | | Arkansas | |
|---|---|---|---|---|
| | System | Non-System | System | Non-System |
| University (Regardless of Ownership) | -2.4% | -4.9% | | Note 1 |
| All Short-term Including University | 0.8% | -3.8% | -7.0% | -7.3% |
| General Acute Excluding Univ. and CAH | 2.1% | -3.0% | -6.7% | -9.5% |
| Critical Access Hospitals (CAH) | -3.7% | -5.9% | -13.7% | -16.2% |

Source: Hospital Cost Report Information System (HCRIS) using the most recent cost report on file.
Note 1: Institution-specific information is not presented where there is only one institution reporting.

## Exhibit 7 - Average Annual Operating Profit/(Loss) Per Short-term General Acute Care Hospital

| Ownership Type | National | | Arkansas | |
|---|---|---|---|---|
| | System | Non-System | System | Non-System |
| Government | $ (9,193,319) | $ (5,829,151) | $ (8,984,813) | $ (1,359,606) |
| Government Excluding University | $ (4,342,039) | $ (4,291,824) | $ (8,984,813) | $ (2,044,541) |
| For Profit | $ 9,324,445 | $ 929,585 | $ 3,334,329 | $ 2,487,686 |
| For Profit Excluding University | $ 9,321,841 | $ 929,585 | $ 3,334,329 | $ 2,487,686 |
| Not-For-Profit | $ (652,704) | $ (5,289,258) | $ (12,078,802) | $ (6,164,591) |
| Not-For-Profit Excluding University | $ 654,303 | $ (2,745,463) | $ (12,078,802) | $ (6,164,591) |

| Hospital Type Regardless of Ownership Type | National | | Arkansas | |
|---|---|---|---|---|
| | System | Non-System | System | Non-System |
| University (Regardless of Ownership) | $ (18,109,612) | $ (44,991,899) | | Note 1 |
| All Short-term Including University | $ 1,578,121 | $ (4,778,362) | $ (6,705,900) | $ (3,857,868) |
| General Acute Excluding Univ. and CAH | $ 3,835,257 | $ (4,000,676) | $ (8,643,224) | $ (6,315,117) |
| Critical Access Hospitals (CAH) | $ (882,885) | $ (1,225,947) | $ (1,862,593) | $ (1,799,319) |

Source: Hospital Cost Report Information System (HCRIS) using the most recent cost report on file.
Note 1: Institution-specific information is not presented where there is only one institution reporting.

Hospitals are ***very capital intensive*** businesses. In order to maintain its clinical and technological capacity, a hospital typically must on average annually invest, on average, a minimum average 9-13%[20] of revenues each year in new technology and the routine replacement of its buildings and equipment.

Stated differently, in order to make the needed investment, hospitals must on average produce annual total profit margins of 3-4%. As seen in Exhibits 6 and 7 above, the greater profitability of system-owned hospitals provides them with a distinct competitive advantage over non-system hospitals in their ability to internally generate the capital required to make the necessary investments. Based on a national average annual revenue of $77.1 million for non-system government-owned hospitals, the 8.5% to 16% spread in operating margins between them and their nonprofit and for-profit system competitors translates to an average difference in annual profits or cash generated from operation of $6.5 to $12.3 million.[21] These sums are sufficient to pay the debt service on $100 to $190 million in tax-exempt bonds.[22] Today the average non-system government hospital with 61 acute care beds could be newly built and equipped with state-of-the-art medical technology for less than $100 million.[23]

***In our opinion, in today's marketplace, system membership is the single most important factor currently contributing to a hospital's long-term programmatic and financial success.***

Significant additional factors which we believe will make it increasingly difficult for standalone general acute care and critical access hospitals to achieve financial stability are summarized on the next page.

## Key Operating Metrics

### Hospital Operating Profits

Key Findings:[24]

- Nationally and in Arkansas, government-owned hospitals have the lowest profit margins and patient revenue per adjusted occupied bed.
- Between 66% and 77% of all government hospitals rank in the bottom 50% of all hospitals.
- Nationally, system hospitals have consistently higher profit margins than non-system hospitals.
- Nationally 71% and in Arkansas 100% of Critical Access Hospitals are located within 35 miles of a general acute care hospital.
- Nationally non-system hospitals had 88% Net Patient Revenue per AOB of that of their System Counterparts ($2,105 –v- $2,400) in Arkansas it was 94% or ($1,682 –v- $1,796)

Exhibit 8 - General Acute Care Hospitals Operating Profit by Ownership Type

| | National | | | | Arkansas | | | |
|---|---|---|---|---|---|---|---|---|
| Metric | Gov't | Not-for-profit | For profit | Total | Gov't | Not-for-profit | For profit | Total |
| **Average Hospital Profile** | | | | | | | | |
| Number of Hospitals (before any exclusions) | *464* | *1,805* | *903* | *3,172* | *3* | *28* | *14* | *45* |
| Average Bed Size (total beds) | 180 | 211 | 150 | 189 | 87 | 191 | 126 | 164 |
| Average Bed Size (acute only) | 129 | 183 | 135 | 161 | 79 | 165 | 114 | 143 |
| Average Occupancy Rate (acute only) | 53.0% | 60.1% | 53.6% | 57.7% | 17.7% | 55.3% | 47.9% | 51.9% |
| Average Daily Census (acute only) | 68 | 110 | 72 | 93 | 14 | 91 | 54 | 74 |
| Adjusted Occupied Beds (AOB) | 198 | 243 | 141 | 206 | 46 | 188 | 117 | 157 |
| Average Annual Operating Revenue | $ 115,259,492 | $ 195,378,573 | $ 107,956,447 | $ 160,203,976 | $ 20,651,605 | $ 115,026,059 | $ 90,847,114 | $ 101,212,090 |
| Revenue Per AOB (weighted avg) | $ 1,532 | $ 2,230 | $ 2,114 | $ 2,126 | $ 1,228 | $ 1,708 | $ 2,139 | $ 1,795 |
| Average Annual Operating Expense | $ 122,856,277 | $ 196,325,553 | $ 100,488,621 | $ 159,812,178 | $ 26,392,678 | $ 128,494,995 | $ 87,134,935 | $ 108,820,600 |
| **Operating Profit Margin** | | | | | | | | |
| Number of Hospitals (after any exclusions) | *421* | *1,722* | *797* | *2,942* | *3* | *28* | *14* | *45* |
| 1st Quartile (Top) | 5.2% | 9.8% | 18.0% | 12.2% | | 5.1% | 16.5% | 7.9% |
| 2nd Quartile | -4.0% | 0.8% | 8.4% | 1.8% | -7.6% | -7.0% | 6.5% | -3.6% |
| 3rd Quartile | -14.2% | -4.9% | -0.1% | -4.9% | -35.2% | -14.8% | 0.6% | -13.9% |
| 4th Quartile (Bottom) | -41.8% | -17.0% | -14.4% | -19.2% | -46.9% | -27.6% | -13.8% | -27.9% |
| Mean | -6.6% | -0.5% | 6.9% | 0.2% | -27.8% | -11.7% | 4.1% | -7.5% |
| Median | -8.7% | -2.2% | 4.0% | -1.7% | -35.2% | -10.9% | 1.7% | -8.6% |
| % in Bottom 50% of all Hospitals | 66.3% | 45.0% | 29.2% | 43.8% | 66.7% | 46.4% | 14.3% | 37.8% |
| % with Operating Loss last 2 Yrs | 67.7% | 46.9% | 26.2% | 44.3% | 100.0% | 78.6% | 21.4% | 62.2% |
| Mean Top 50% | -2.4% | 2.7% | 10.0% | 3.7% | -19.2% | -7.9% | 5.7% | -3.8% |
| Mean Bottom 50% | -23.0% | -9.9% | -5.5% | -10.4% | -41.2% | -19.3% | -1.7% | -18.5% |
| Average Markup on Cost (Weighted Average) | 288% | 296% | 448% | 325% | 280% | 337% | 423% | 362% |

Notes:

1. For Average Bed Size, the Total Beds figure includes Specialty Hospitals
2. Daily Occupancy rate is based on Acute Inpatient Days
3. Revenue Per AOB is based on Average Total Operating Revenue Per AOB
4. All figures contained in this table use weighted average

All data contained in the table is sourced from the annual CMS cost reports.

Exhibit 9 - Critical Access Hospitals Operating Profit by Ownership Type

| | National | | | | Arkansas | | | |
|---|---|---|---|---|---|---|---|---|
| Metric | Gov't | Not-for-profit | For profit | Total | Gov't | Not-for-profit | For profit | Total |
| **Average Hospital Profile** | | | | | | | | |
| Number of Hospitals (before any exclusions) | 536 | 707 | 83 | 1,326 | 10 | 18 | 2 | 30 |
| Average Bed Size (total beds) | 35 | 37 | 28 | 35 | 27 | 32 | 21 | 29 |
| Average Bed Size (acute only) | 21 | 23 | 21 | 22 | 25 | 24 | 21 | 24 |
| Average Occupancy Rate (acute only) | 32.9% | 36.5% | 33.7% | 34.9% | 32.1% | 32.5% | 35.7% | 32.5% |
| Average Daily Census (acute only) | 7 | 8 | 7 | 8 | 8 | 8 | 7 | 8 |
| Adjusted Occupied Beds (AOB) | 65 | 75 | 36 | 69 | 28 | 48 | 22 | 39 |
| Average Annual Operating Revenue | $ 17,261,319 | $ 25,584,775 | $ 15,525,516 | $ 21,690,481 | $ 9,733,274 | $ 13,041,357 | $ 10,600,352 | $ 11,775,929 |
| Revenue Per AOB (weighted avg) | $ 702 | $ 947 | $ 1,186 | $ 861 | $ 962 | $ 768 | $ 1,328 | $ 837 |
| Average Annual Operating Expense | $ 18,773,901 | $ 26,568,466 | $ 15,250,417 | $ 22,807,814 | $ 11,416,133 | $ 15,072,114 | $ 11,604,262 | $ 13,622,263 |
| **Operating Profit Margin** | | | | | | | | |
| Number of Hospitals (after any exclusions) | 506 | 700 | 76 | 1,283 | 10 | 18 | 2 | 30 |
| 1st Quartile (Top) | 1.5% | 6.5% | 16.0% | 5.2% | -1.1% | -5.5% | | -4.2% |
| 2nd Quartile | -6.6% | -2.2% | 3.0% | -3.7% | -12.3% | -14.7% | | -14.3% |
| 3rd Quartile | -13.3% | -8.3% | -6.9% | -10.3% | -18.6% | -18.2% | -5.4% | -18.6% |
| 4th Quartile (Bottom) | -31.0% | -20.6% | -24.4% | -25.1% | -35.6% | -28.7% | -19.8% | -31.4% |
| Mean | -8.8% | -3.8% | 1.8% | -5.2% | -17.3% | -15.6% | -9.5% | -15.7% |
| Median | -9.7% | -4.9% | -4.5% | -6.7% | -17.2% | -16.1% | -12.6% | -16.1% |
| % in Bottom 50% of all Hospitals | 77.1% | 58.6% | 51.3% | 65.5% | 70.0% | 77.8% | 50.0% | 73.3% |
| % with Operating Loss last 2 Yrs | 76.1% | 61.4% | 44.7% | 66.3% | 90.0% | 94.4% | 50.0% | 90.0% |
| Mean Top 50% | -4.9% | -1.0% | 5.0% | -2.0% | -11.1% | -13.1% | -5.4% | -12.3% |
| Mean Bottom 50% | -20.4% | -12.8% | -12.1% | -15.9% | -26.9% | -21.4% | -9.5% | -23.3% |
| Average Markup on Cost (Weighted Average) | 146% | 157% | 244% | 157% | 169% | 199% | 205% | 191% |

Notes:

1. For Average Bed Size, the Total Beds figure includes Specialty Hospitals
2. Daily Occupancy rate is based on Acute Inpatient Days
3. Revenue Per AOB is based on Average Total Operating Revenue Per AOB
4. All figures contained in this table use weighted average

All data contained in the table is sourced from the annual CMS cost reports.

Exhibit 10 - Short-term Hospitals Operating Profit by System Ownership

| Metric | Governmental (Inc. University) System | Governmental (Inc. University) Non-System | All Short-term (Inc. University) System | All Short-term (Inc. University) Non-System | All Short-term (Inc. University) Total |
|---|---|---|---|---|---|
| National | | | | | |
| Average Hospital Profile | | | | | |
| Number of Hospitals (before any exclusions) | *175* | *892* | *2,333* | *2,427* | *4,760* |
| # of GACs within 35-miles of a Critical Access | 44 | 325 | 312 | 628 | 940 |
| Average Bed Size (total beds) | 213 | 114 | 201 | 137 | 169 |
| Average Bed Size (acute only) | 179 | 80 | 179 | 109 | 143 |
| Average Occupancy Rate (acute only) | 68.0% | 53.2% | 61.1% | 59.5% | 60.5% |
| Average Daily Census (acute only) | 121 | 43 | 109 | 65 | 86 |
| Adjusted Occupied Beds (AOB) | 267 | 126 | 220 | 161 | 189 |
| Average Annual Operating Revenue | $ 208,394,826 | $ 77,061,172 | $ 190,288,309 | $ 124,570,745 | $ 156,789,851 |
| Revenue Per AOB (weighted avg) | $ 2,123 | $ 1,748 | $ 2,400 | $ 2,105 | $ 2,283 |
| Average Annual Operating Expense | $ 217,546,793 | $ 82,906,793 | $ 188,751,736 | $ 129,336,490 | $ 158,465,782 |
| Operating Profit Margin | | | | | |
| Number of Hospitals (after any exclusions) | *160* | 820 | *2,191* | 2,278 | 4,469 |
| 1st Quartile (Top) | 6.4% | 2.8% | 13.5% | 5.9% | 10.3% |
| 2nd Quartile | -1.9% | -6.0% | 3.8% | -2.5% | 0.2% |
| 3rd Quartile | -13.9% | -13.3% | -3.5% | -8.9% | -6.8% |
| 4th Quartile (Bottom) | -30.4% | -36.9% | -18.6% | -23.7% | -21.6% |
| Mean | -4.4% | -7.6% | 0.8% | -3.8% | -1.1% |
| Median | -9.1% | -9.4% | -0.1% | -5.5% | -3.1% |
| % in Bottom 50% of all Hospitals | 64.4% | 73.3% | 39.8% | 59.9% | 50.0% |
| % with Operating Loss last 2 Yrs | 65.0% | 73.0% | 39.2% | 61.8% | 50.7% |
| Mean Top 50% | 0.6% | -3.9% | 5.0% | -0.5% | 2.6% |
| Mean Bottom 50% | -23.0% | -21.6% | -10.0% | -15.1% | -13.1% |
| Average Markup on Cost (weighted average) | 276% | 243% | 330% | 262% | 302% |
| Arkansas | | | | | |
| Average Hospital Profile | | | | | |
| Number of Hospitals (before any exclusions) | *2* | *12* | *36* | *40* | *76* |
| # of GACs within 35-miles of a Critical Access | 1 | 9 | 11 | 19 | 30 |
| Average Bed Size (total beds) | 87 | 66 | 142 | 90 | 114 |
| Average Bed Size (acute only) | 87 | 63 | 128 | 75 | 100 |
| Average Occupancy Rate (acute only) | 13.6% | 63.9% | 54.9% | 47.6% | 52.3% |
| Average Daily Census (acute only) | 12 | 40 | 71 | 35 | 52 |
| Adjusted Occupied Beds (AOB) | 29 | 89 | 143 | 88 | 114 |
| Average Annual Operating Revenue | $ 12,863,847 | $ 58,259,737 | $ 93,472,424 | $ 52,709,292 | $ 72,018,144 |
| Revenue Per AOB (weighted avg) | $ 1,235 | $ 1,800 | $ 1,796 | $ 1,682 | $ 1,761 |
| Average Annual Operating Expense | $ 18,644,776 | $ 59,619,343 | $ 100,063,634 | $ 56,567,160 | $ 77,170,753 |
| Operating Profit Margin | | | | | |
| Number of Hospitals (after any exclusions) | *2* | 12 | *36* | 40 | 76 |
| 1st Quartile (Top) | | 1.1% | 9.4% | 2.2% | 4.5% |
| 2nd Quartile | | -8.2% | -4.7% | -9.2% | -8.1% |
| 3rd Quartile | -39.1% | -16.3% | -16.2% | -16.3% | -16.3% |
| 4th Quartile (Bottom) | -46.9% | -32.4% | -26.0% | -31.9% | -28.5% |
| Mean | -44.9% | -2.3% | -7.1% | -7.3% | -7.2% |
| Median | -43.0% | -14.4% | -12.7% | -14.1% | -13.3% |
| % in Bottom 50% of all Hospitals | 100.0% | 58.3% | 50.0% | 52.5% | 51.3% |
| % with Operating Loss last 2 Yrs | 100.0% | 83.3% | 66.7% | 77.5% | 72.4% |
| Mean Top 50% | -39.1% | -0.3% | -4.1% | -3.1% | -3.8% |
| Mean Bottom 50% | -44.9% | -25.8% | -19.4% | -26.6% | -21.4% |
| Average Markup on Cost (weighted average) | 453% | 235% | 372% | 285% | 338% |

Notes:

1. For Average Bed Size, the Total Beds figure includes Specialty Hospitals
2. Daily Occupancy rate is based on Acute Inpatient Days
3. Revenue Per AOB is based on Average Total Operating Revenue Per AOB
4. All figures contained in this table use weighted average

All data contained in the table is sourced from the annual CMS cost reports.

## Labor Cost

**Key Findings:**

- Nationally and in Arkansas, government-owned hospitals have the highest labor cost as a percentage of net patient revenue.
- Nationally, government hospitals have comparable FTEs per AOB with the national average. Arkansas government hospitals are 10% above the national average.
- Government and non-system hospitals have revenue per FTE that is consistently lower (6% to 22%) than their counterparts.

Exhibit 11 - General Acute Care Hospitals Total Labor Cost by Ownership Type

| | National | | | | Arkansas | | | |
|---|---|---|---|---|---|---|---|---|
| Metric | Gov't | Not-for-profit | For profit | Total | Gov't | Not-for-profit | For profit | Total |
| **Average Hospital Profile** | | | | | | | | |
| Number of Hospitals (before any exclusions) | *464* | *1,805* | *903* | *3,172* | *3* | *28* | *14* | *45* |
| Average Bed Size (total beds) | 180 | 211 | 150 | 189 | 87 | 191 | 126 | 164 |
| Average Bed Size (acute only) | 129 | 183 | 135 | 161 | 79 | 165 | 114 | 143 |
| Average Occupancy Rate (acute only) | 53.0% | 60.1% | 53.6% | 57.7% | 17.7% | 55.3% | 47.9% | 51.9% |
| Average Daily Census (acute only) | 68 | 110 | 72 | 93 | 14 | 91 | 54 | 74 |
| Adjusted Occupied Beds (AOB) | 198 | 243 | 141 | 206 | 46 | 188 | 117 | 157 |
| Average Annual Operating Revenue | $ 115,259,492 | $ 195,378,573 | $ 107,956,447 | $ 160,203,976 | $ 20,651,605 | $ 115,026,059 | $ 90,847,114 | $ 101,212,090 |
| Revenue Per AOB (weighted avg) | $ 1,532 | $ 2,230 | $ 2,114 | $ 2,126 | $ 1,228 | $ 1,708 | $ 2,139 | $ 1,795 |
| Average Annual Operating Expense | $ 122,856,277 | $ 196,325,553 | $ 100,488,621 | $ 159,812,178 | $ 26,392,678 | $ 128,494,995 | $ 87,134,935 | $ 108,820,600 |
| Total FTEs | 382,835 | 2,138,751 | 499,250 | 3,020,837 | 668 | 23,091 | 6,559 | 30,318 |
| Average Full Time Equivalent Staff (FTE) | 827 | 1,190 | 557 | 957 | 223 | 825 | 469 | 674 |
| Revenue per FTE | $ 131,380 | $ 162,974 | $ 193,495 | $ 164,014 | $ 92,683 | $ 139,483 | $ 193,905 | $ 150,225 |
| FTE (Inc. Contract Labor) per AOB (Mean) | 4.3 | 4.4 | 3.8 | 4.3 | 4.8 | 4.5 | 3.9 | 4.4 |
| **Labor Cost as a % of Revenue** | | | | | | | | |
| Number of Hospitals (after any exclusions) | *404* | *1,713* | *785* | *2,904* | *3* | *27* | *13* | *43* |
| 1st Quartile (Top) | 39.5% | 34.2% | 28.7% | 32.4% | | 42.0% | 28.3% | 30.9% |
| 2nd Quartile | 49.8% | 42.9% | 34.5% | 41.1% | 64.2% | 51.8% | 30.4% | 43.3% |
| 3rd Quartile | 57.9% | 50.9% | 40.8% | 49.7% | 65.6% | 57.3% | 32.6% | 53.7% |
| 4th Quartile (Bottom) | 69.9% | 62.6% | 51.7% | 62.3% | 73.9% | 66.2% | 37.5% | 64.3% |
| Mean | 49.9% | 45.1% | 37.6% | 44.2% | 67.5% | 49.4% | 31.6% | 45.0% |
| Median | 53.7% | 47.0% | 37.5% | 45.3% | 65.6% | 54.0% | 32.1% | 52.3% |
| % in Bottom 50% of all Hospitals | 68.8% | 46.8% | 19.1% | 42.4% | 100.0% | 59.3% | 0.0% | 44.2% |
| Mean Top 50% | 46.6% | 41.6% | 34.4% | 40.6% | 64.8% | 47.4% | 30.7% | 42.2% |
| Mean Bottom 50% | 63.4% | 55.7% | 45.6% | 54.7% | 69.6% | 61.6% | 34.0% | 57.8% |

Notes:
1. For Average Bed Size, the Total Beds figure includes Specialty Hospitals
2. Daily Occupancy rate is based on Acute Inpatient Days
3. Revenue Per AOB is based on Average Total Operating Revenue Per AOB
4. All figures contained in this table use weighted average

All data contained in the table is sourced from the annual CMS cost reports.

Exhibit 12 - Critical Access Hospitals Total Labor Cost by Ownership Type

| | National | | | | Arkansas | | | |
|---|---|---|---|---|---|---|---|---|
| Metric | Gov't | Not-for-profit | For profit | Total | Gov't | Not-for-profit | For profit | Total |
| **Average Hospital Profile** | | | | | | | | |
| Number of Hospitals (before any exclusions) | *536* | *707* | *83* | *1,326* | *10* | *18* | *2* | *30* |
| Average Bed Size (total beds) | 35 | 37 | 28 | 35 | 27 | 32 | 21 | 29 |
| Average Bed Size (acute only) | 21 | 23 | 21 | 22 | 25 | 24 | 21 | 24 |
| Average Occupancy Rate (acute only) | 32.9% | 36.5% | 33.7% | 34.9% | 32.1% | 32.5% | 35.7% | 32.5% |
| Average Daily Census (acute only) | 7 | 8 | 7 | 8 | 8 | 8 | 7 | 8 |
| Adjusted Occupied Beds (AOB) | 65 | 75 | 36 | 69 | 28 | 48 | 22 | 39 |
| Average Annual Operating Revenue | $ 17,261,319 | $ 25,584,775 | $ 15,525,516 | $ 21,690,481 | $ 9,733,274 | $ 13,041,357 | $ 10,600,352 | $ 11,775,929 |
| Revenue Per AOB (weighted avg) | 702 | 947 | 1,186 | 861 | 962 | 768 | 1,328 | 837 |
| Average Annual Operating Expense | $ 18,773,901 | $ 26,568,466 | $ 15,250,417 | $ 22,807,814 | $ 11,416,133 | $ 15,072,114 | $ 11,604,262 | $ 13,622,263 |
| Total FTEs | 86,840 | 129,158 | 9,855 | 225,852 | 1,293 | 2,439 | 207 | 3,939 |
| Average Full Time Equivalent Staff (FTE) | 162 | 183 | 120 | 171 | 129 | 135 | 104 | 131 |
| Revenue per FTE | $ 102,332 | $ 139,642 | $ 125,877 | $ 124,696 | $ 75,277 | $ 96,253 | $ 102,211 | $ 89,682 |
| FTE (Inc. Contract Labor) per AOB (Mean) | 3.0 | 3.1 | 3.4 | 3.1 | 4.6 | 4.5 | 4.7 | 4.6 |
| **Labor Cost as a % of Revenue** | | | | | | | | |
| Number of Hospitals (after any exclusions) | *501* | *693* | *79* | *1,274* | *9* | *18* | *2* | *29* |
| 1st Quartile (Top) | 43.1% | 38.8% | 33.3% | 39.8% | 51.8% | 42.1% | | 42.9% |
| 2nd Quartile | 52.0% | 48.9% | 43.9% | 49.9% | 54.8% | 50.5% | | 52.8% |
| 3rd Quartile | 59.4% | 55.7% | 54.0% | 57.1% | 59.3% | 58.0% | 35.5% | 58.8% |
| 4th Quartile (Bottom) | 70.9% | 64.7% | 67.9% | 67.2% | 65.8% | 64.9% | 59.6% | 65.2% |
| Mean | 54.1% | 51.2% | 45.8% | 51.9% | 58.0% | 54.6% | 42.3% | 54.7% |
| Median | 55.8% | 52.3% | 48.2% | 53.4% | 57.5% | 55.7% | 47.5% | 56.8% |
| % in Bottom 50% of all Hospitals | 78.2% | 66.4% | 51.9% | 70.2% | 77.8% | 61.1% | 50.0% | 65.5% |
| Mean Top 50% | 50.8% | 47.6% | 41.6% | 48.5% | 55.0% | 50.9% | 35.5% | 51.2% |
| Mean Bottom 50% | 64.0% | 59.8% | 60.0% | 61.3% | 62.9% | 61.4% | 42.3% | 62.0% |

Notes:
1. For Average Bed Size, the Total Beds figure includes Specialty Hospitals
2. Daily Occupancy rate is based on Acute Inpatient Days
3. Revenue Per AOB is based on Average Total Operating Revenue Per AOB
4. All figures contained in this table use weighted average

All data contained in the table is sourced from the annual CMS cost reports.

Exhibit 13 - Short-term Hospitals Total Labor Cost by System Ownership

| Metric | Governmental (Inc. University) System | Governmental (Inc. University) Non-System | All Short-term (Inc. University) System | All Short-term (Inc. University) Non-System | All Short-term (Inc. University) Total |
|---|---|---|---|---|---|
| **National** | | | | | |
| **Average Hospital Profile** | | | | | |
| Number of Hospitals (before any exclusions) | *175* | *892* | *2,333* | *2,427* | *4,760* |
| # of GACs within 35-miles of a Critical Access | 44 | 325 | 312 | 628 | 940 |
| Average Bed Size (total beds) | 213 | 114 | 201 | 137 | 169 |
| Average Bed Size (acute only) | 179 | 80 | 179 | 109 | 143 |
| Average Occupancy Rate (acute only) | 68.0% | 53.2% | 61.1% | 59.5% | 60.5% |
| Average Daily Census (acute only) | 121 | 43 | 109 | 65 | 86 |
| Adjusted Occupied Beds (AOB) | 267 | 126 | 220 | 161 | 189 |
| Average Annual Operating Revenue | $ 208,394,826 | $ 77,061,172 | $ 190,288,309 | $ 124,570,745 | $ 156,789,851 |
| Revenue Per AOB (weighted avg) | $ 2,123 | $ 1,748 | $ 2,400 | $ 2,105 | $ 2,283 |
| Average Annual Operating Expense | $ 217,546,793 | $ 82,906,793 | $ 188,751,736 | $ 129,336,490 | $ 158,465,782 |
| Total FTEs | 240,041 | 541,528 | 2,496,784 | 1,972,521 | 4,469,304 |
| Average Full Time Equivalent Staff (FTE) | 1,380 | 607 | 1,075 | 816 | 943 |
| Revenue per FTE | $ 149,104 | $ 130,026 | $ 176,560 | $ 149,699 | $ 164,705 |
| FTE (inc Contract Labor) per AOB (Mean) | 4.7 | 4.6 | 4.5 | 4.6 | 4.5 |
| **Total Labor Cost as a % of Revenue** | | | | | |
| Number of Hospitals (after any exclusions) | *159* | 801 | *2,187* | 2,238 | 4,425 |
| 1st Quartile (Top) | 34.9% | 41.0% | 31.6% | 38.6% | 33.8% |
| 2nd Quartile | 45.7% | 51.6% | 39.1% | 49.3% | 43.6% |
| 3rd Quartile | 51.7% | 60.1% | 46.2% | 57.4% | 52.0% |
| 4th Quartile (Bottom) | 73.6% | 70.6% | 58.1% | 68.5% | 64.8% |
| Mean | 46.3% | 51.0% | 41.6% | 49.9% | 44.9% |
| Median | 49.3% | 55.7% | 42.6% | 53.4% | 48.0% |
| % in Bottom 50% of all Hospitals | 54.1% | 76.3% | 31.8% | 67.9% | 50.0% |
| Mean Top 50% | 41.4% | 47.5% | 38.2% | 46.2% | 41.4% |
| Mean Bottom 50% | 62.6% | 65.1% | 51.3% | 62.7% | 57.4% |
| **Arkansas** | | | | | |
| **Average Hospital Profile** | | | | | |
| Number of Hospitals (before any exclusions) | *2* | *12* | *36* | *40* | *76* |
| # of GACs within 35-miles of a Critical Access | 1 | 9 | 11 | 19 | 30 |
| Average Bed Size (total beds) | 87 | 66 | 142 | 90 | 114 |
| Average Bed Size (acute only) | 87 | 63 | 128 | 75 | 100 |
| Average Occupancy Rate (acute only) | 13.6% | 63.9% | 54.9% | 47.6% | 52.3% |
| Average Daily Census (acute only) | 12 | 40 | 71 | 35 | 52 |
| Adjusted Occupied Beds (AOB) | 29 | 89 | 143 | 88 | 114 |
| Average Annual Operating Revenue | $ 12,863,847 | $ 58,259,737 | $ 93,472,424 | $ 52,709,292 | $ 72,018,144 |
| Revenue Per AOB (weighted avg) | $ 1,235 | $ 1,800 | $ 1,796 | $ 1,682 | $ 1,761 |
| Average Annual Operating Expense | $ 18,644,776 | $ 59,619,343 | $ 100,063,634 | $ 56,567,160 | $ 77,170,753 |
| Total FTEs | 259 | 5,172 | 20,583 | 17,144 | 37,727 |
| Average Full Time Equivalent Staff (FTE) | 130 | 431 | 572 | 429 | 496 |
| Revenue per FTE | $ 99,220 | $ 135,180 | $ 163,483 | $ 122,982 | $ 145,079 |
| FTE (inc Contract Labor) per AOB (Mean) | 4.8 | 4.8 | 4.1 | 4.8 | 4.4 |
| **Total Labor Cost as a % of Revenue** | | | | | |
| Number of Hospitals (after any exclusions) | *2* | 11 | *35* | 38 | 73 |
| 1st Quartile (Top) | | 35.7% | 31.4% | 39.7% | 34.4% |
| 2nd Quartile | | 54.2% | 40.4% | 54.5% | 48.5% |
| 3rd Quartile | 62.2% | 62.0% | 48.8% | 60.2% | 56.3% |
| 4th Quartile (Bottom) | 65.6% | 70.5% | 60.0% | 69.2% | 66.1% |
| Mean | 64.7% | 40.1% | 42.6% | 47.6% | 44.6% |
| Median | 63.9% | 57.5% | 45.3% | 58.5% | 54.0% |
| % in Bottom 50% of all Hospitals | 100.0% | 72.7% | 25.7% | 76.3% | 52.1% |
| Mean Top 50% | 62.2% | 38.4% | 39.8% | 45.8% | 42.4% |
| Mean Bottom 50% | 64.7% | 65.8% | 52.9% | 63.1% | 60.5% |

Notes:

1. For Average Bed Size, the Total Beds figure includes Specialty Hospitals
2. Daily Occupancy rate is based on Acute Inpatient Days
3. Revenue Per AOB is based on Average Total Operating Revenue Per AOB
4. All figures contained in this table use weighted average

All data contained in the table is sourced from the annual CMS cost reports.

## Free Online Resource

Additional hospital metrics covering the last six years by bed size hospitaland ownership type is available online at StateofYourHospital.com (password: soyh2015).

# REVIEW OF STRATEGIC OPTIONS AVAILABLE TO ARKANSAS HOSPITALS

The traditional message of a community to its local government and board members is "save our hospital at all costs." Unless informed about other options, the community is unable to fathom any other option. This is a worthy goal if the hospital is sustainable in the long term. If saving the current hospital model is not realistic in the long-term, however, delay in developing an alternative plan may actually deprive the community of the essential healthcare services needed to preserve quality of life and economic stability. For communities that cannot financially sustain a hospital in the new reimbursement climate, exploring a sale, a merger, an affiliation, or a re-designed system (such as a free-standing emergency room coupled with telemedicine) may be a viable options for preserving access to care.

There are some tactical solutions that may buy time for a financially distressed government- owned hospital or system, but where there are consecutive years of declining patient volumes and the associated financial losses the hospital's or system's cash reserves can and will be quickly exhausted unless strategic action is taken to reposition the hospital. Ultimately, the hospital will likely be forced to begin limiting access to critical health services and face the prospect of insolvency.

Because of the long-term structural disadvantages faced by government-owned hospitals and systems, even a currently profitable organization should conduct an evaluation of changing reimbursement methodologies and other external market forces to determine if one of the strategic options summarized here can be employed to preserve healthcare services on a long-term basis.

## Sell the Hospital or System

By selling the hospital or health system to a for-profit or nonprofit multihospital system, the hospital accomplishes the goals of preserving healthcare access and hospital jobs and optimizes the value of the assets to the county or state. Importantly, a sale can also eliminate the risk of future financial obligations by the current government sponsors. Even financially healthy government-owned hospitals or health systems should perform an assessment to consider this option. Sale of currently profitable or particularly desirable facilities would monetize the assets for the sponsoring government body without impairing (and most likely improving) access to health services or eliminating jobs.

## Merge with Another System

This approach may or may not involve the sale of the existing government-owned hospital(s) or system. The focus of this strategy is to create a new, self-supporting and governing hospital system which is legally and financially independent of its current government sponsors.

## Create a Free Standing ED

Free-standing emergency departments operate 24 hours a day and typically provide pharmacy, laboratory and radiology services. Specialty care may be provided through telemedicine. Patients with more serious health conditions must be stabilized and transferred to hospitals more equipped to care for them.

Free-standing emergency departments with access to specialty physicians and appropriate transfer agreements can offer quality care in rural communities. Some states require a Certificate of Need (CON) for free-standing emergency departments and certain ancillary services. Some states do not allow free-standing emergency departments at all, but the legislature may be willing to change the law if they understand how many of the state's hospitals are likely to fail. Redesigning the healthcare system in communities that cannot sustain a hospital not only saves some well-paying healthcare jobs in the community, but non-healthcare jobs as well. While some healthcare jobs will inevitably be lost

with an organized transition from a hospital model to an alternative, far fewer jobs will be lost than if a hospital is suddenly closed due to insolvency.

## Transform into an Ambulatory Care Delivery Model

This strategy is particularly attractive for existing critical access hospitals. CAHs could be transformed into Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) with much more favorable reimbursement structures than traditional physician offices and without the high fixed cost associated with the operation of an acute care hospital. The FQHC or RHC could be affiliated with a large hospital (FQHCs may not be owned or controlled by a hospital) for physician coverage and focus all their efforts to meet all of the primary healthcare needs of their communities.

- **Rural Health Centers:** RHCs use mid-level providers, such as nurse practitioners (NP), physician assistants (PA), or certified nurse midwives (CNM) with physician supervision to provide primary care. CMS pays RHCs using a prospective payment system (PPS) rather than a cost-based reimbursement system. RHCs receive an interim payment from Medicare, and at the end of the year, this payment is reconciled by using the clinic's cost reporting. RHC conversion can increase reimbursement by 25-75% over fee-for-service reimbursement where the patient population equals or exceeds 50% Medicare and Medicaid combined. RHCs are authorized to serve as an originating site for telehealth services.
- **Federally Qualified Health Centers:** FQHCs are community-based, safety net providers. Federal 330 grants for new FQHCs may be available in amounts up to $650,000.[25] Effective October 1, 2014, Medicare pays FQHCs a single encounter-based rate per beneficiary per day for FQHC services, with some adjustments. Payment is 80% of either the PPS rate of $158.85 (to be adjusted annually with the MEI) (est.), or the total charges for services furnished, whichever is less. In addition to enhanced reimbursement, some of the primary advantages of FQHCs include participating in the 340B Drug Discount Pricing Program for purchasing prescription drugs at steep discounts, granting access to National Health Service Corp. providers and resources, the right to have out-stationed Medicaid eligibility workers on-site, and access to the Federal Vaccine for Children program. FQHCs that are funded under Section 330 also have access to free medical malpractice insurance under the Federal Tort Claims Act program and may be eligible for a myriad of grant and loan opportunities for both service and capital expansions.

## Affiliations and Non-Control Transactions

A non-control transaction is a hospital affiliation that does not involve the sale of a majority interest in the hospital or a transfer of a majority of governance control over the hospital. While many names and variations exist, some of the more common non-control transactions include:

- **Special member models**, in which a larger hospital or system takes a minority interest in a smaller one, in exchange for financial and programmatic investments.
- **Branding arrangements**, which are designed to leverage the name, clinical expertise, or physician platform of a system or academic medical center on behalf of an unaffiliated hospital or system.
- **Management and joint operating arrangements (JOAs)**, either for discrete service lines or whole hospitals. JOAs are sometimes referred to as "virtual mergers." JOAs allow hospitals to pool resources and expertise and benefit from joint purchasing power. The hallmark of the JOA type of affiliation is that participating hospitals retain their separate identities, boards of directors and a certain amount of autonomy even though considerable management and financial authority is shifted to the governing body of the JOA.

- **Shared Service Organizations (SSOs) or Clinically Integrated Networks (CIN)**: A SSO or CIN spanning multiple organizations, or super CIN, can be an alternative to merger for organizations that want to retain their independence yet not go it alone in creating the infrastructure and capabilities to participate in shared savings contracting.

Affiliation agreements can be successful if the community hospital is receiving or will receive substantial and immediate financial benefits that will assist it to meet its strategic goals. Affiliation agreements that are easily canceled, not legally binding on both parties or do not have well-defined measurable objectives, run the risk of doing little more than documenting an agreement to work together in the future.

## Short-Term Strategies to Increase Profitability

There are numerous additional strategies that an underperforming hospital may adopt to increase profitability. In most cases, these strategies do not provide a long-term solution for free-standing community hospitals. Focusing on such initiatives to prolong the life of a hospital that will not ultimately survive may, however, be detrimental to creating a transition plan that will preserve long-term healthcare services in the community.

These strategies may be an effective part of the long-term solution for some hospitals and may be part of an interim strategy for others. Potential purchasers of hospitals are more selective of their acquisition targets than they were several years ago. The strategies may be part of an interim plan for a hospital to increase financial performance to a level that will make it an attractive acquisition target by a hospital system that will ultimately maintain services in the community.

## Strategies Undertaken at the Hospital or Community Level

- **Telemedicine:** Medicare reimbursement for telemedicine services was recently increased. Telemedicine may provide the ability for expanded specialty services to be offered in the community.
- **340B Drug Pricing Program:** 340B drug pricing allows participants to enjoy significantly reduced drug prices.
- **Urgent Care Centers (with RHC designation):** Urgent care centers deliver ambulatory care outside of a hospital emergency department on an unscheduled or walk-in basis. In order to increase reimbursement, many urgent care centers located in qualifying areas seek RHC designations. Urgent care centers present an attractive and cost-efficient model for providing community health services in areas where it is unlikely the community hospital will survive. They provide services such as mammography, ultrasounds, echocardiography, bone density, arterial brachial indices, x-ray, chemical analyses and lab services, physical therapy services, primary care services, specialist services and a number of other services that are provided close to home for community residents.
- **Management Services Agreements:** Management Services Agreements allow smaller hospitals without specific expertise to obtain needed management services from larger hospitals or systems.

## Strategies to Increase Profitability that Would Require State Action

- **Medicaid Expansion:** Additional federal funding is available pursuant to the Affordable Care Act to expand Medicaid programs to cover adults under 65 with income up to 133% of the federal poverty level.
- **1115 Wavier/DSRIP Payments:** "Delivery System Reform Incentive Payment" or DSRIP initiatives are part of

broader Section 1115 Waiver programs and provide states with significant funding that can be used to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries. California, New York, and Texas each expect to receive several billion dollars from their DSRIP initiatives over a five-year period.

## Close

If it is determined that the communities healthcare service needs cannot be met without further government ownership or support, the hospital could be closed or liquidated. Since 2010, a total of 48 rural hospitals have been closed.[26]

# WHY ACT NOW?

The best option for each hospital will depend on its unique market and circumstances. In the case of most standalone government-owned hospitals, however, a "right-sizing" or "reimagining" of operations should be undertaken for the facility to successfully meet the changing healthcare needs of the community it serves. Maintaining the status quo may indeed pose the greatest risk to the long-term availability of quality of healthcare services for the community and the existing enterprise value of the institution. Hospitals that delay may lose the ability to make the transformation or attract a suitable buyer or partner. As a result, delay may cause a loss of a majority of healthcare services for the community. Boards and community leaders carry a more challenging burden than ever before to preserve healthcare services in the face of such external pressures.

The organizational goals which require prompt strategic action by government-owned hospital boards and their government sponsors are to:

- Ensure the continued availability of high-quality healthcare services to the residents of your community;
- Provide those services as close to patients' homes as possible;
- Create efficiencies to allow for the delivery of higher-quality, lower-cost care;
- Preserve jobs in your community;
- Preserve and maximize the value of your hospital for your citizens; and
- Enable the resulting healthcare service structure to continue to provide quality service in a financially self-sustaining manner (i.e., without direct taxpayer support).

Government-owned hospital boards and counties that respond quickly to these rapidly emerging market forces will experience the best outcome for the residents of their communities. Activity levels in their hospital may still be high enough to attract the interest of a qualified strategic buyer or merger partner. Any existing cash reserves likely can be retained by the county instead of expended to fund recurring operating losses. The county or hospital acting from a position of relative strength, as the seller, will have an improved ability to dictate the terms of any sale or partnership, including the mix of critical services to be provided within the community. Community leaders need to determine if the value of their hospital assets will increase or decrease in the future and, based on that assessment, take appropriate action to maximize value and preserve healthcare services for the community.

# EFFECTIVE CONSTITUENT COMMUNICATIONS

Communicating significant change for any community's hospital is a tremendous challenge. The task requires a different way of working and thinking.

As a hospital leadership team considers a change in its strategy – in its future direction – the way it delivers care, its financial objectives and its ownership structure, it is important for it to remember that every hospital faces its own unique situation. There are some common, yet incredibly challenging scenarios in a restructure or a partnership, including: financial obligations and concerns, pension issues, debt restructuring path, publicly owned to privately owned conversion, nonprofit to for-profit conversion, name change, antitrust concerns, public referendum, facility repurposing, union contracts, and others. Every communication plan must be finely tailored to meet each organization's specific needs and address its specific issues.

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To build an effective communications campaign, leadership needs to know how a hospital's change of strategy will progress and how to think about the strategy as a whole rather than simply a series of disconnected, event-driven milestones. If you know that, you can ask the right questions to build your plan.

The architecture of today's hospital change strategies has become increasingly creative as organizations work to customize their future plans to meet their community's needs. Depending on the debt structure, legal and regulatory restraints, community needs, relationships with physicians, cultural needs – any number of factors – change strategies are as unique as the hospitals and healthcare organizations they bring together.

Navigating change is nothing new for hospital leaders tasked with communicating. Change is the new normal – shifting federal regulations, competitive pressures and ever-evolving communications tools. However, a strategic shift discussion elevates all of this usual, day-to-day work and adds emotional, political, operational and financial elements to the mix.

Traditionally, hospital boards and leadership teams have a laser focus on the financial, operational, regulatory and clinical elements of a transaction. That makes sense. Communicators know, however, that a hospital restructure or partnership is much more than numbers and rules and charts. It's more than the timelines and the deal terms.

A hospital change of the magnitude of a restructure or partnership is an emotional, political event in the life of an organization. In fact, a strategic direction that makes financial, operational and clinical sense can die a quick death if it doesn't make political sense to a community or cultural sense inside the walls of the hospital.

Leaders know the unique and powerful emotional connection people have with their hospital. Nurses fulfill a mission through their care for their patients and for each other. Physicians have an emotional and economic relationship to the hospital that is vital to their livelihood and the hospital's success. Patients and their families experience life-changing events inside the hospital's doors. The sense of ownership by the community can be strong: *It's my hospital.* The emotions felt by patients, physicians and staff are powerful political forces.

This can all work for leadership and the board (or decidedly against, too) as it leads an organization to a new future. Managing these political forces is at the heart of the work of hospital communications.

In a time of change, the cost of ignoring the value of communications is high. The plans of the board and leadership to restructure, buy, sell or partner can fail if the message – the story – is not well-crafted or delivered in the right way by the right people at the right time.

Done correctly, a well-orchestrated, assertive campaign can energize the hospital's team and excite the patients and the general community. It puts the hospital's political strength to work for you and your organization when you need it most.

A strategic shift is a defining moment for an organization. It is a holistic event – everything and everyone matters because everything and everyone is impacted.

It is, in short, a big deal that will capture the attention of your key audiences – internal and external – from the first rumor through the change management and strategic integration process. Success in this hothouse environment requires relentless and comprehensive communication.

Throughout a major change, the hospital's key audiences must be engaged assertively, steadily and as transparently as possible, using a variety of communication tools (existing tools, social media, news media, personal interaction, etc.) with a smart and consistent core message that advances the cause and counters objections.

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It is not just advertising, press releases, a Twitter feed or a special event, though the work may include all or none of those. Those are just tools, after all. A different way to approach this work is to think of changing communications as a political campaign to be waged and won. The political campaign analogy captures the comprehensive and intense work that successful change management needs.

Every successful political campaign has a crystal-clear goal: to win the most votes on Election Day. To get there, good campaigns run a tightly disciplined communication effort that mobilizes, unites and focuses a host of resources toward the single goal of winning. That is the task of a hospital's leadership team as well.

Courts apply the "business judgment" rule to determine whether directors have satisfied their duty of care. If applicable, the business judgment rule generally provides strong protections for directors regarding their good-faith decisions, even if they are ultimately proven to be in error. Simply put, the historical foundation of the business judgment rule is that businesspeople, rather than courts, are better qualified to make decisions in the best interests of an organization. This concept is critical to the board's duty of care, particularly with respect to the board's ability to recruit qualified members and limit the board members' exposure to individual liability. In an increasingly complex regulatory environment, the business judgment rule has grown significantly more important, and board members must recognize the heightened need for both preparation for and participation in the decision-making process of the hospitals they serve. Especially where an organization is at financial risk, the failure to demonstrate the exercise of good faith business judgment may result in directors being exposed to personal liability, removal from the board and damage to reputation.

Even if a board member enjoys full or limited governmental immunity or quasi-immunity for his or her actions under state statutes, the standard for the duty of care is not reduced. In today's complex regulatory, legal and reimbursement environment, board members must, more than ever, take steps to demonstrate the exercise of their duty of care and good faith business judgment in the oversight of the hospital's operations or by implementing a plan to maintain essential healthcare services in the community through non-hospital services.

Board members must demonstrate the exercise of their fiduciary duties in order to take advantage of the business judgment rule. The fiduciary duties of directors require that board members take an active role in obtaining the information necessary to satisfy their duty of care. In order to make the proper inquiries of management, a director must be knowledgeable about the business of the hospital he or she is serving. This knowledge includes the rules and regulations that regulate the hospital's operation(s) and the hospital's financial condition.

Finally, a director or trustee must become knowledgeable about what the managers of the organization are doing to conduct the business of the hospital, how they are addressing the hospital's financial needs and the steps that are being taken to ensure that the hospital complies with applicable rules and regulations. Satisfaction of these duties requires board members to educate themselves continually about their organization. Once they have obtained this knowledge, board members have a duty then to provide strategic input into the organization's affairs. Doing both will likely demonstrate that a director is entitled to the protections of the business judgment rule.

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## Red Flags and the Zone of Insolvency

Under certain circumstances, the board's fiduciary duties can expand. When a director is presented with a warning or a "red flag," the duty to make a reasonable inquiry of the facts increases. Financial distress is a "red flag" that not only increases the director's duties, but broadens the number of constituencies the director has a duty to protect. When a board member is a director of a financially distressed hospital, a wide range of parties – the hospital's employees, the state attorney general, patients or the hospital's creditors – may seek to hold the board members personally liable for disruptions in business operations or patient care. When a hospital's assets

are less than its liabilities or when it cannot pay its debts as they come due, it has entered the "zone of insolvency." In the zone of insolvency, a director's duties change, and a director may also take on a duty of care with regards to the hospital's creditors.[27]

The exposure to individual liability for decisions that are made in the zone of insolvency is more acute for members of nonprofit boards. Even where board members have statutory immunity, however, they may find themselves defendants in a lawsuit in which they have to assert their statutory immunity. Therefore, board members of government-owned hospitals can profit from understanding the rationale of certain courts which have recognized deepening insolvency as a tort. On January 26, 2015, the United States Court of Appeals for the Third Circuit issued a ruling in the case of In re Lemington Home for the Aged,[28] recognizing the individual liability of officers and directors of a nonprofit nursing home for "deepening insolvency."[29] Before filing a Chapter 11 bankruptcy proceeding ,the nursing home had been 'beset with financial troubles' for decades, but had remained afloat with help from the City of Pittsburgh, Allegheny County and donations from private foundations."[30] In that case, two former officers and 14 former directors of the nursing home were found personally liable to the nursing home's creditors for breach of fiduciary duty and the tort of deepening insolvency.

In affirming the judgment against the members of the board for breach of their duty of care, the Court of Appeals considered the following factors:

- The board of directors was responsible for the hiring and firing of management;
- The directors had information demonstrating that the nursing home's administrator should be replaced; and
- The board of directors knew that the nursing home was not maintaining proper financial records.

The court went on to describe the tort of deepening insolvency, "defining it as 'an injury to the [enterprise's] corporate property from the fraudulent expansion of corporate debt and prolongation of corporate life."[31] In affirming the judgment against the members of the board for the tort of deepening insolvency, the Court of Appeals cited the following evidence:

- The directors concealed a decision to close the nursing home from creditors;
- The directors knew its actions would further deteriorate the nursing home's finances to the detriment of creditors;
- Through their silence, the directors consciously defrauded the nursing home's creditors; and
- The directors delayed filing bankruptcy.[32]

A consultant for the plaintiffs told the court that the directors' decisions resulted in a "slow death" of the nursing home's ability to generate revenue, and that the directors failed to disclose facts that would have increased the nursing home's chances of finding a buyer.[33] The Court of Appeals noted that the directors failed to oversee management, whose conduct hurt the value and financial viability of the nursing home.[34] All of this, the Court of Appeals concluded, supported a judgment against the directors for the tort of deepening insolvency.[35]

## Corporate Responsibility and Corporate Governance in the Zone of Insolvency

If a hospital is in the zone of insolvency, its board members should take action to shore up the hospital's financial condition, and be certain to document their efforts to identify and combat the hospital's financial distress. Courts generally find that when exercising their business judgment, directors are entitled to rely on information, opinions,

reports or statements prepared by legal counsel and other professionals.

When a hospital nears the zone of insolvency, board members can demonstrate their effort to carry out their fiduciary duties to all constituencies by engaging turnaround managers and legal counsel. A turnaround manager is a consultant who has experience and expertise in examining an organization's operations in times of financial stress and making recommendations to improve the organization's operations and finances. Turnaround counsel are attorneys with experience advising organizations in the zone of insolvency, and they can assist an organization in restructuring its debt and in its efforts to deal with its vendors and other creditors during a restructuring or turnaround. Bringing in this outside expertise can evidence the board's effort to carry out its fiduciary duties.

Turnaround counsel can also advise the board about options available to it if the hospital is unable to reach a consensual restructuring of its operations and finances. Those options may include filing a Chapter 9 bankruptcy proceeding. Chapter 9 proceedings are similar to Chapter 11 proceedings. A Chapter 11 proceeding is generally used by businesses who plan to continue to operate and maintain control of their business as a way to restructure their finances and operations. Unlike a Chapter 11 proceeding, however, because the municipality is a sovereign entity Chapter 9 limits the bankruptcy court's ability to exercise control over the municipality, and its affairs during the bankruptcy proceeding. The Bankruptcy Code sets forth eligibility requirements necessary to be a debtor in a Chapter 9 proceeding. Determining whether an entity is eligible to proceed with a Chapter 9 bankruptcy proceeding can require a fact-intensive analysis.

The analysis requires an examination of state law. The Bankruptcy Code defines a "municipality" as a "political subdivision or public agency or instrumentality of a State."[36] Public agencies or instrumentalities of a State generally "refers to independent corporations, boards, districts, authorities and commissions that are organized to construct or operate public projects."[37] These would include public utilities, public improvement districts, and bridge and highway authorities that may raise revenues through taxes or user fees.[38] The answer to whether your hospital meets the Bankruptcy Code's definition of a municipality will lie in the details of its incorporation, funding and control. If your hospital qualifies as a municipality, generally, the next eligibility issue to address is whether the hospital is authorized to file a Chapter 9 petition.

A government-owned hospital must also be authorized by state law to be a Chapter 9 debtor. "Some states have very broad statutes that give municipalities almost blanket authority to file [for bankruptcy.] Some place conditions on the right to file, such as approval by the governor. Approximately half the states do not permit municipalities to file at all: Municipalities in these states must ask the state legislature to pass a law authorizing Chapter 9 before they are allowed to file [for bankruptcy.]"[39]

Arkansas has specifically authorized taxing agencies and instrumentalities named in § 14-74-102 to institute Chapter 9 proceedings.[40] In Arkansas, it is the taxing agency and instrumentality's governing board that has the power to institute the Chapter 9 proceeding.[41] Turnaround counsel can determine whether your hospital qualifies as a taxing agency or instrumentality under § 14-74-102.

The breadth of Arkansas's authorization statute was discussed by the United States Bankruptcy Court for the Western District of Arkansas in the case of *In re Ozark Mountain Solid Waste District*. In that case, the Bankruptcy Court examined two factors. First, whether the entity was a taxing agency or its payable out of taxes or assessments. Second, whether it is specifically named in § 14-74-102(D).[44] Interestingly, when examining whether the Ozark Mountain Solid Waste District was specifically authorized to file a Chapter 9 proceeding, the Bankruptcy Court also examined whether the District met the requirement of filing its bankruptcy case in good faith pursuant to § 921(c) of the Bankruptcy Code.

The Bankruptcy Court determined that the bankruptcy case was filed in bad faith because the District's board members failed to impose what the board members' considered a politically unpopular service fee available to the District that may have resolved the District's financial distress before filing bankruptcy.

The Bankruptcy Court stated: "[T]he Court finds that the District did not meet the requirement of filing this case in good faith pursuant to § 921(c). Despite being authorized to collect a service fee from residences and businesses within the District, the District never imposed the service fee even though the tipping fee was being exhausted on a monthly basis in an effort to contain the leachate problem. The service fee would have afforded the District an influx of revenue each month, but it opted not to exercise its statutory right to collect the fee - largely because the board members believed that imposing the service fee would be unpopular with the counties in the district and would result in the board members failing to be reelected to their respective county positions. Good faith required that the District access the service fee to attempt to resolve its financial straits prior to seeking Chapter 9 protection."[45]

The Bankruptcy Court's decision in *In re Ozark Mountain Solid Waste District*, alerts board members to the fact that the courts may consider whether the board has taken steps to address the entity's financial distress, including politically unpopular steps, in determining whether it has proceeded with a bankruptcy filing in good faith.

Even if bankruptcy is not an appropriate strategy, there are other actions board members can take to address financial stress when the hospital enters the zone of insolvency. Board members should require management to provide accurate and real-time financial reporting. A 13-week cash flow analysis is a tool used by many restructuring professionals that provides a snapshot of an organization's financial condition, that can reveal cash flow inadequacies.

Boards often wait too long to take action or fail to hire professionals with turnaround experience to advise them. The right time to engage a turnaround professional to assist you is at the beginning of a downward trend line, rather than when the organization has nearly run out of cash. Boards are generally not criticized for bringing in someone to address the organization's problems. Most often, boards are criticized when they are persuaded to believe that they cannot afford to engage turnaround professionals and either fail to timely bring in expert assistance or bring in assistance that does not have the experience to address today's complex healthcare environment.

## Director and Officer Liability

Many hospital board members and executives protect themselves from liability through director and officer liability insurance. Boards would be wise to evaluate their D&O policies to ensure that there is adequate protection, realizing that it might be impossible to increase coverage if the entity enters the zone of insolvency. While this caution might appear to have little relevance for hospital board members who may enjoy governmental immunity or immunity from liability, immunity does not protect board members against being sued and having to defend themselves or from public outcry directed at board members. Members of governmental hospital boards should analyze the limits of immunity that may be provided by state statute. If you are unsure of the extent of the immunity or if the immunity has limits, you might consider obtaining insurance to cover any acts that may potentially fall outside the immunity coverage provided by your state law.

## Arkansas Specific Issues

**State Licensure Issues (Arkansas)**

In Arkansas, a Certificate of Need ("CON") is not required for acute care hospitals, ambulatory surgery centers or free-standing radiology centers (including MRI). There are, however, licensing requirements for free-standing emergency departments. Currently, a free-standing emergency department can only be operated by an entity that

operates another acute care hospital in the state of Arkansas. The expansion of emergency department services to an off-campus location does not require an independent survey or inspection by the state because it is covered under the license of the primary acute care hospital location. However, approval of the construction/renovation of physical space requires approval by Health Facilities Services Division of the Department of Health. A hospital should allow two to three months to obtain approval of the construction/renovation of a free-standing emergency department.

**Ownership and Financing Structure (Arkansas)**

Amendment 32 to the Arkansas Constitution allows a county government, acting through the Quorum Court, to obtain tax to support hospitals not to exceed one (1) mill on the assessed value of real and personal property within the county for the purpose of "operation, maintenance, and support of any public hospital owned by the county or municipal corporation therein, whether operated by the court or municipal corporation or by a benevolent association as the agent or lessee of such county or municipal corporation." Upon petition of 100 or more electors to the county judge, the judge shall submit the question of obtaining a tax to support a hospital to the voters at a general election. If a majority of those voting on the question vote in support of a tax, it shall be continually levied until raised, lowered or abolished at a subsequent general election.

Arkansas law allows for the issuance and sale of bonds bearing interest in connection with the county's authority to own, acquire, construct, reconstruct, extend, equip, improve, maintain, operate, sell, lease, contract concerning, or otherwise deal in or dispose of any land, buildings or facilities of any and every nature that can be used for a hospital, nursing home or rest home in the county. Issuance of the bonds shall be by order of the county court and referral to the voters is not required. A statutory mortgage lien on the property will exist in favor of the bondholders. It is unclear whether such bonds could be used for a free-standing Emergency Department or other hospital type services that comprise less than an acute care hospital.

Revenues may be derived from lease or sale of a county hospital located within the county where there is no outstanding bonded indebtedness. The quorum court must approve the conditions of a lease and a sale requires voter approval. The revenues received may be used to support all purposes of county government.[47]

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Healthcare Management Partners (HMP), LLC is a firm led by a team of C-Level healthcare executives that quickly identify, define and solve problems to produce exceptional results for healthcare organizations and their stakeholders.

With its extensive experience, financial modeling and data analysis tools and action-based model, HMP provides senior executive led management, financial advisory, and litigation support services to hospitals and other healthcare organizations and their creditors, investors and business partners. **hcmpllc.com**


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Jarrard Phillips Cate & Hancock is the premier strategic communications and public affairs team for any healthcare provider in the nation experiencing a time of significant change, crisis or opportunity.

Based in Nashville, with an office in Chicago, our team of journalists, political operatives and former hospital marketing executives develops and manages successful campaigns throughout the United States — from clearing the way for mergers and acquisitions, to building, protecting and using an organization's reputation, to navigating issues and change, to launching (or repositioning) a service or business, to harnessing political power through building and maintaining strong relationships with elected officials to retooling communications departments to be savvy and successful in this new era of healthcare. **Jarrardinc.com**

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# NOTES

1 Includes all state and local government owned short-term general acute care hospitals and critical access hospitals. Excludes university hospitals and all federal or specialty hospitals.

2 All hospitals that accept and bill for services to patients enrolled in Medicare are required by the terms contained in their Provider Agreement to file a complete and correct Medicare Cost Report within 150 days of the end of each fiscal year. Depending on the size and complexity of the individual hospital, its Medicare Cost Report can contain over 3,000 items of financial and statistical data. Upon receipt and processing of the Cost Report by the Federal Centers for Medicare and Medicaid Services (CMS), the data is electronically entered into the Healthcare Cost Report Information System (HCRIS) file.

3 Common corporate ownership of two or more hospitals with separate Medicare provider agreements.

4 A hospital that is not corporately owned or legally controlled by a multihospital system.

5 A special Medicare payment designation for hospitals that apply and have 25 or fewer beds and are located in rural areas. Critical access hospitals are paid by Medicare at 101% of Medicare cost, in lieu of participation in the prospective payment system.

6 Data is derived from Medicare Cost Reports or reports filed with the Center for Medicare and Medicaid Services (CMS) and reported in the Hospital Cost Report Information System (HCRIS). The data has been "scrubbed" to exclude partial period or statistically aberrant data elements for individual hospitals or health systems.

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10 Centers for Medicare & Medicaid Services (CMS), *National Health Expenditures continued slow growth in 2013,* (December 3, 2014), http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-12-03-2.html

11 United States Census Bureau

12 Centers for Medicare & Medicaid Services (CMS), *National Health Expenditures continued slow growth in 2013,* (December 3, 2014), http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-12-03-2.html

13 Data is derived from Medicare Cost Reports or reports filed with the Center for Medicare and Medicaid Services (CMS) and reported in the Hospital Cost Report Information System (HCRIS). The data has been "scrubbed" to exclude partial period or statistically aberrant data elements for individual hospitals or health systems.

14 Recovery Audit Contractor, a contractor of CMS which audits hospital bills on a contingent fee basis.

15 Data is derived from Medicare Cost Reports or reports filed with the Center for Medicare and Medicaid Services (CMS) and reported in the Hospital Cost Report Information System (HCRIS). The data has been "scrubbed" to exclude partial period or statistically aberrant data elements for individual hospitals or health systems.

16 Centers for Medicare & Medicaid Services (CMS), *Critical Access Hospitals* (April 9, 2013), http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CAHs.html

17 Robert York at al, *Where Have All The Inpatients Gone?* A Regional Study With National Implications, Health Affairs

(January 6, 2014) http://healthaffairs.org/blog/2014/01/06/where-have-all-the-inpatients-gone-a-regional-study-with-national-implications/

[18] Based on 7,607 statewide Short-term general acute care beds at an average occupancy rate of 52% as compared to the Target AOR noted in Exhibit 3.

[19] Data is derived from Medicare Cost Reports or reports filed with the Center for Medicare and Medicaid Services (CMS) and reported in the Hospital Cost Report Information System (HCRIS). The data has been "scrubbed" to exclude partial period or statistically aberrant data elements for individual hospitals or health systems.

[20] Capital investment would include money set aside for the periodic replacement of facilities and/or the payment of debt service on long term debt incurred to finance capital expenditures

[21] Data is derived from Medicare Cost Reports or reports filed with the Center for Medicare and Medicaid Services (CMS) and reported in the Hospital Cost Report Information System (HCRIS). The data has been "scrubbed" to exclude partial period or statistically aberrant data elements for individual hospitals or health systems.

[22] Based on 30-year bonds with a 5% coupon

[23] Based upon an average cost of $1.5 million per bed to acquire the site, construct and equip a primary care general acute care hospital.

[24] Data is derived from Medicare Cost Reports or reports filed with the Center for Medicare and Medicaid Services (CMS) and reported in the Hospital Cost Report Information System (HCRIS). The data has been "scrubbed" to exclude partial period or statistically aberrant data elements for individual hospitals or health systems

[25] Peter C. Damia et al, *Federally Qualified Health Centers: Impact of the ACA and Health System Change on the Iowa Safety Net*, The University of Iowa Public Policy Center (September 27, 2013), http://ppc.uiowa.edu/sites/default/files/fqhc_report.pdf

[26] University of North Carolina Cecil G. Sheps Center for Health Services Research Center, "Rural Hospital Closures: 2010 to Present"

[27] 5 Norton Bankr. L. & Prac. 3d § 96:3.

[28] *In re Lemington Home for the Aged*, No. 13-2707, 2015 WL 305505 (3rd Cir. Jan. 26, 2015).

[29] *In re Lemington Home for the Aged*, No. 13-2707, 2015 WL 305505, at *5-6 (3rd Cir. Jan. 26, 2015).

[30] Id. at *1.

[31] Id. at *6.

[32] Id. at *6

[33] Id. at *6

[34] Id. at *7.

[35] Id. at *7

[36] 11 U.S.C. § 101(40).

[37] H. Slayton Dabney, Jr., et. al., Municipalities in Peril, The ABI Guide to Chapter 9, at 10 (2nd ed. 2012).

[38] Id.. at 10.

[39] Id. at 11.

[40] A.C.A. § 14-74-103.

[41] Id.

[42] In re Ozark Mountain Solid Waste Dist., No. 3:14-bk-70015, 2014 WL 7494926, at *4-5 (Bankr. W.D. Ark. Aug. 5, 2014).

[43] Id. at *6.

[44] Id. at *6. Section 14-74-102(D) includes among others: local improvement districts, cities, towns, villages, boroughs, townships, or other municipalities. See A.C.A. § 14-74-102.

[45] 2014 WL 7494926 at *8.

[46] A.C.A. § 14-265-101 through § 14-265-111

[47] A.C.A. § 14-16-105, §14-16-108 and §14-263-106.

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