Appendix 2 of Rural Hospital Closures

"The ambulance is our emergency room!"—The voices of rural Tennessee

HOW TO ASSESS THE HEALTH OF YOUR HOSPITAL

In the course of the THCC Rural Health Equity Project, our volunteer team has been learning more than we ever thought we would know about hospital and health system financing, and what health economists are predicting for the future of rural hospitals in our nation.

A recent example of one of these predictions is the ***2020 Rural Hospital Sustainability Index: Trends in Rural Hospital Financial Viability, Community Essentiality, and Patient Outmigration***. The model looked at all 50 states, and Tennessee had the most hospitals at risk. **The model concluded that 19 of Tennessee's 25 remaining essential access rural hospitals**, **that's 75%**, **are at high risk of closure in the next few years if current healthcare policies and practices remains the same**.

Many of these economic models rely on data that is not easily available to the public. However there are some data elements that every model had in common that ***are*** accessible to the public, and this tool will help communities access and interpret that data.

1. **Trends in a hospital's "bottom line"**. At the end of each fiscal year, is a hospital in **"the red"** [loosing money after all revenues were accounted for and all expenses were paid], **breaking even**, or in **"the black"** [ending the year with a surplus that could be reinvested in hospital personnel and services, or, if a hospital is "for-profit", distributed to shareholders].

One or two years of losses are not always a cause for concern, because hospital administrators and boards often have some flexibility to make changes in services or staffing patterns or marketing strategies that can make a positive difference. Some hospitals also have assets that they can tap into to cover some of the losses in the short term. *But if there is a consistent trend of expenses exceeding revenue, especially if a hospital must consistently dip into its assets to pay its expenses, that is a clear sign of trouble ahead for the survival of the hospital.*

2. **The hospital's "payer mix"**? From the hospital's point of view there are three main buckets of patient health coverage:

- ***private or commercial insurance plans***, such as employer-based insurance or Affordable Care Act Marketplace plans [which negotiate with in-network hospitals for discounted rates, but are the highest paying of the three buckets]
- ***government sponsored coverage*** such as Medicare [which usually pays hospitals at a lower rate than private insurance payers] and TennCare [Tennessee's Medicaid program which usually pays at an even lower rate than Medicare]
- ***self-pay***, persons who are uninsured [those with no insurance can seldom pay the full cost of a serious hospitalization, resulting either in bad debt or charity care].

3. **Uncompensated care.** The payer mix is correlated with a hospitals' **burden of uncompensated care**, or the amount of hospital care for which no payment was received from patient or insurer. Uncompensated care is the total of the amount of **financial assistance or charity care** provided by the hospital to patients who meet certain low income guidelines, plus the amount of **bad debt** that results from patients, both insured and uninsured, who are unable to pay their hospital bills in full. A hospital is

at risk if can not cover its burden of uncompensated care with revenue from privately insured patients or other sources.

4. **Average daily patient census rates** over time. The census rate is the average number of beds occupied daily over the year. It provides both a measure of how well the services offered by the hospital match the health needs in the community, and whether patients are continuing to use their local hospital as a source of care, or going elsewhere.

5. **Changes in utilization of services.** When patient's go elsewhere for care that could be provided at their community hospital, it is called **patient out-migration**. While it is difficult for a hospital to know where else its former patients are going or why, a downward trend in numbers of patients using in-patient or out-patient services is a concern.

JOINT ANNUAL REPORTS.

Every hospital in Tennessee reports its annual **expenses and revenues, assets and liabilities, payer mix, uncompensated care, average daily census, and service utilization** patterns in a **Joint Annual Report** or **JAR.** These JARs are submitted to the Tennessee Department of Health and available to the public on its website at: https://www.tn.gov/health/health-program-areas/statistics/health-data/jar.html.

Citizens who have concerns about their hospital's financial health can review these reports to create a profile of how their hospital is doing. The rest of this guide will walk you through the Joint Annual Report for Hospitals (JARs) section by section, focusing on those sections that are most helpful for assessing the sustainability of your hospital.

The JARs, though filed and posted annually, usually lag about a year behind, so it is possible that the picture painted by last year's report may not reflect the current status of the hospital. For that reason we recommend looking at the past 3 to five years of reports to establish a trend. We will discuss this more later.

[NOTE: Joint Annual Reports are also filed by assisted living and nursing home facilities, home health agencies, ambulatory surgical treatment centers, outpatient diagnostic centers and birthing centers, but this resource only describes the hospital reports].

The Department of Health used to prepare annual summaries of the Joint Annual Reports which provided a cumulative picture of how hospitals across the state were doing. ***We recommend that the Department of Health (DOH) annually summarize JAR data for monitoring and planning purposes, particularly related to availability and utilization of services. The DOH should proactively report their findings to county and regional governing bodies so that these entities can be better informed and more engaged in finding ways to support hospitals that are at-risk before closure is the only option.***

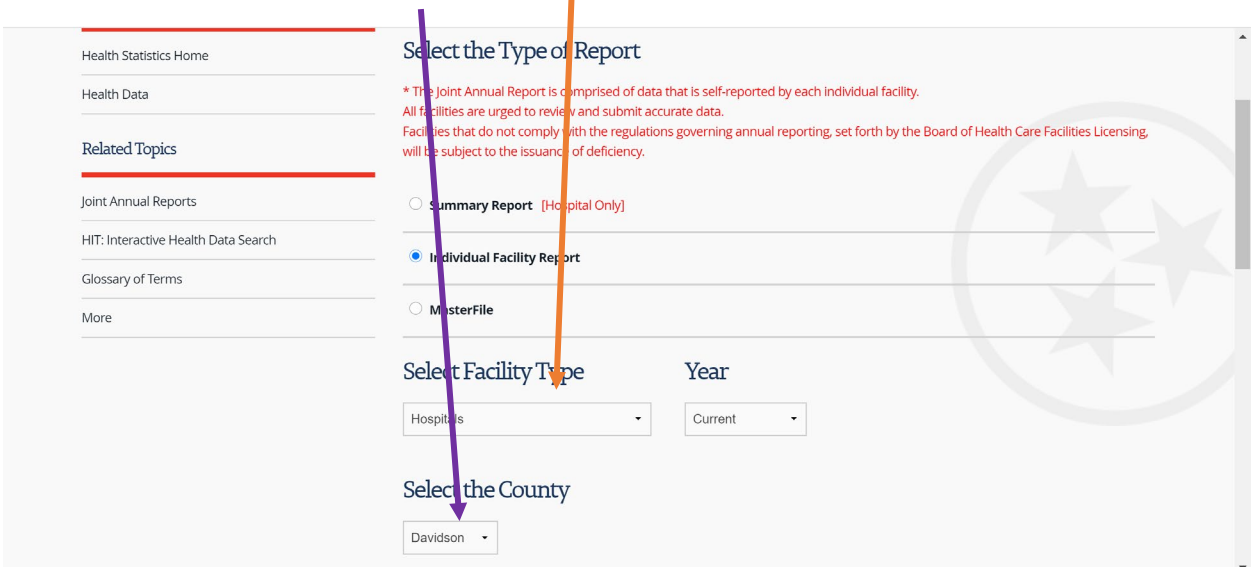
Where to Find a Hospital Joint Annual Report

Go to the Tennessee Department of Health Data homepage:

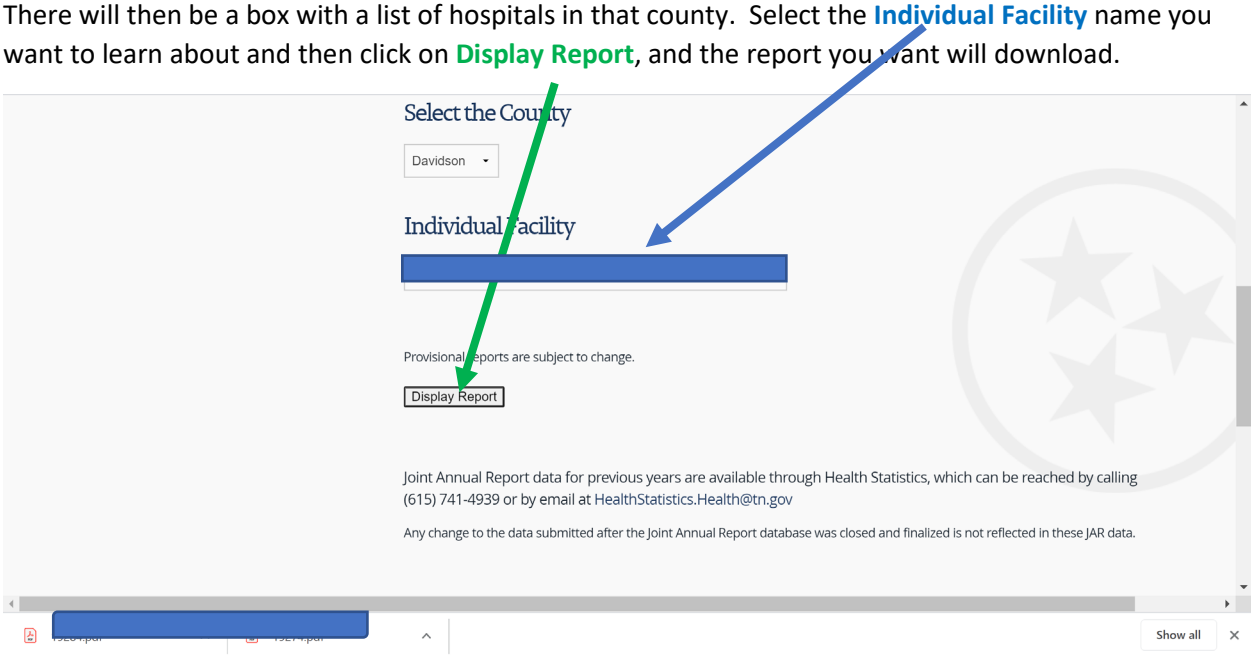
https://www.tn.gov/health/health-program-areas/statistics/health-data/jar.html

Click on the Joint Annual Report JAR Search button

Then select Hospital from the menu of **Facility Types**, and the current year or any previous year of the report you want to review, the **County** in which the hospital is located…



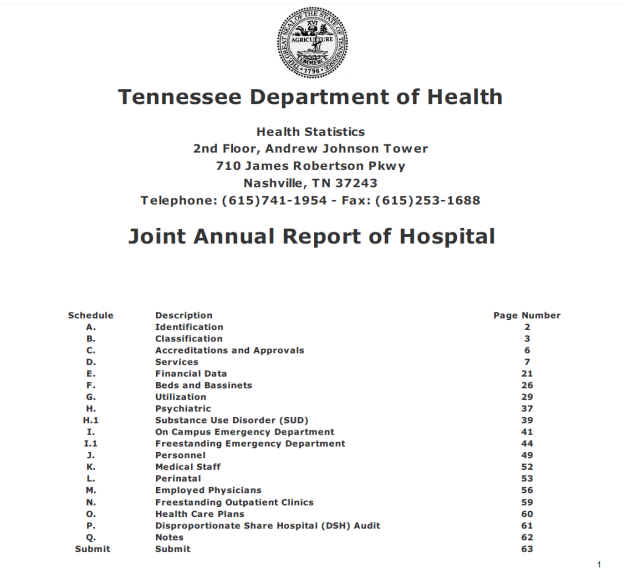
There will then be a box with a list of hospitals in that county. Select the **Individual Facility** name you want to learn about and then click on **Display Report**, and the report you want will download.



How to Read a Joint Annual Report [JAR]

Below is the screen shot of the first page of a JAR from 2018 to illustrate the content. The format of the different sections may vary somewhat from year to year, but the section categories remain basically the same. This resource will examine some sections, called 'Schedules" such as **E. the Financial Data**, and **G. the Utilization** sections, in more detail than others because of the information they provide about the sustainability of the hospital.

NOTE: screen shots used throughout this resource are for illustration purposes only and are taken from JARS of different years and different hospitals to maintain anonymity of any individual hospital.



Tennessee Department of Health

Health Statistics
2nd Floor, Andrew Johnson Tower
710 James Robertson Pkwy
Nashville, TN 37243
Telephone: (615)741-1954 - Fax: (615)253-1688

Joint Annual Report of Hospital

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Schedule A. Identification. This section includes:

- name and address of the hospital and contact information for the Chief Executive Officer (CEO), and the person completing the form.
- whether your hospital is operated as part of a larger system of hospitals (which may indicate that decisions might be made based on the needs of the system rather than of an individual hospital).
- whether your hospital is affiliated with a Centers for Medicare and Medicaid (CMS)-approved hospital network or Accountable Care Organization. (which may enable the hospital to participate in new Value Based Care payment models being developed by Medicare and Medicaid. These new payment models reward quality of care over quantity of care and are intended to benefit patients, but do not always take into account the limited resources of small rural hospitals).

Schedule B. This section describes the ownership of the hospital, the type of licensure the hospital has, and the financial relationship between the medical staff and the hospital administration.

1.Classification of ownership. There are three basic categories of ownership:

- ***Government owned*** (state, county, city, city/county, hospital district or authority, Veterans Administration, Armed Services, or other). All government owned hospitals are non-profit. They often serve special populations like veterans, or uninsured citizens living in designated counties or cities. They receive their basic operating funds through a public budgeting process. Any additional revenues generated by government-owned facilities are usually returned to a general fund. As discussed below, it is important to note that although the hospital building may be owned by a city or county, the management of the hospital is often contracted out to for-profit hospital management corporations. Similarly, physicians who staff rural hospitals do not work on a city or county payroll, but for practice management firms that work under contract as well.
- ***Non-government non-profit*** (church-operated, other non-profit corporation, or other non-profit, such as a hospital affiliated with a private university's medical school). These hospitals make their budgeting decisions through boards of directors and reinvest additional revenues they generate in new staff, equipment or programs.
- ***Investor-owned for-profit*** (individually-owned, partnership-owned, or corporation-owned) which have an obligation to their investors to generate profits on a yearly basis. Breaking even, which may be acceptable for non-profits, is not a sustainable long-term option for for-profits.

This information is relevant to understanding how critical the 'bottom-line' is to the sustainability of your hospital and where the decisions about your hospital are being made. Recent national studies have shown that for-profit rural hospitals are more at risk of closing than government or non-profit hospitals. [need citation].

2.Type of hospital. Hospitals are usually classified as general medical and surgical, pediatric, psychiatric, obstetrical, rehabilitation, orthopedic, or long-term care. In this report we have focused mainly on the impact of the closure of a ***general medical and surgical hospitals***, which includes emergency department services. Several of the hospitals that have closed in recent years have been converted to psychiatric hospitals that treat mental health and substance use disorders, but may maintain an emergency department as well.

A general medical and surgical hospital may be licensed to operate "swing beds" which can be used for more than one purpose provided qualified staffing is available—e.g. general medicine one week and rehabilitation the next, depending on demand. The COVID epidemic illustrates the need for this kind of flexibility, as so many hospitals have been required to convert general medical suites to intensive care units or units where patients with COVID can recover before discharge home.

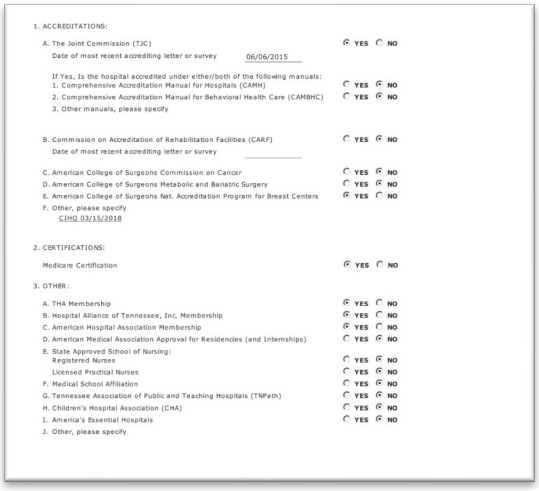
Tennessee recently approved licensure of **Free-Standing Emergency Rooms** to be set up in communities that lack a hospital. These Emergency Rooms need to be affiliated with a hospital system for back-up and their data is now reported in a separate section of the JAR for their affiliated hospital.

3. Financial relationship between the hospital administration and the medical staff. Very few rural hospitals have physicians on their staff payrolls any more but instead contract with physician groups to provide needed services. Negotiating contracts between physicians and hospitals, and between physicians and private insurance companies, federal Medicare and state Medicaid programs is a difficult and time-demanding task, and many physicians chose to contract in turn with groups that can do that negotiating for them. The JAR lets you know whether medical staff negotiate as *independent practices*, through a larger third party *physician hospital organization*, or through a third party *management services organization* which also assists physicians with hiring, credentialing, training and managing office staff, providing coding, billing and collection services, and risk management.

Schedule C: Accreditations and Approvals.

While achieving national accreditation is voluntary, it is essential in order to receive funding from the Centers for Medicare and Medicaid. Accreditation is also necessary for a hospital to gain entry into many health insurance networks. Accreditation also lets potential patients know that their hospital is focused on delivery quality care and meets national safety standards.

There are several national professional bodies that conduct intensive inspections and confer accreditation. The most widely known is called The Joint Commission that was created in 1951 by the American Hospital Association, the American Medical Association, and the American College of Surgeons. Additional recognition is offered for specialty services by other professional bodies, such as overall cancer care or specific care such as breast cancer care. These additional accreditations will be listed in this section.



1. ACCREDITATIONS:

A. The Joint Commission (TJC) — YES / NO
Date of most recent accrediting letter or survey: 06/06/2015

If Yes, Is the hospital accredited under either/both of the following manuals:
1. Comprehensive Accreditation Manual for Hospitals (CAMH) — NO
2. Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC) — NO
3. Other manuals, please specify

B. Commission on Accreditation of Rehabilitation Facilities (CARF) — NO
Date of most recent accrediting letter or survey:

C. American College of Surgeons Commission on Cancer — NO
D. American College of Surgeons Metabolic and Bariatric Surgery — NO
E. American College of Surgeons Nat. Accreditation Program for Breast Centers — YES
F. Other, please specify
CIHQ 03/15/2018

2. CERTIFICATIONS:

Medicare Certification — YES

3. OTHER:

A. THA Membership — YES
B. Hospital Alliance of Tennessee, Inc. Membership — YES
C. American Hospital Association Membership — YES
D. American Medical Association Approval for Residencies (and Internships) — NO
E. State Approved School of Nursing:
Registered Nurses — NO
Licensed Practical Nurses — NO
F. Medical School Affiliation — NO
G. Tennessee Association of Public and Teaching Hospitals (TNPath) — NO
H. Children's Hospital Association (CHA) — NO
I. America's Essential Hospitals — NO
J. Other, please specify

Schedule C also provides information on whether the hospital participates in organizations such as the American Hospital Association and Tennessee Hospital Association that provide ongoing training and technical support to health care quality, patient safety and satisfaction, and improve operations efficiency.

[NOTE: A hospital must usually be operational for several months before an accreditation inspection can be scheduled and there is a cost to the hospital for each inspection in the range of $10,000-$45,000, which can be expensive for a smaller hospital with thin operating margins. Hospitals must also update their accreditation status through surveys every 3 years. ***We recommend that state funds and technical support be made available to assist smaller hospitals in maintaining accreditation***. To learn more about The Joint Commission standards go here: https://www.jointcommission.org/en/standards/.]

Schedule D. Services.

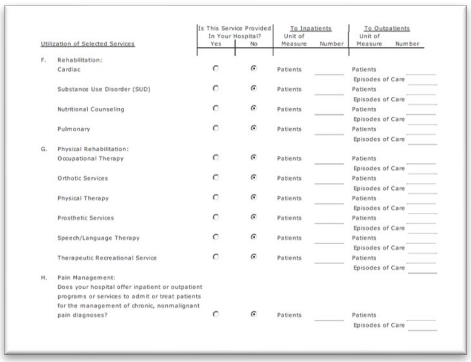
Types of services offered by the hospital to the community. These services include ambulance services, helipad services, free-standing emergency rooms, urgent care centers, primary care clinics, birthing centers, long-term care services, home health services, psychiatric services, laboratory services, diagnostic and treatment services. It even contains specific information about the types of imaging services available. [This detail reflects in part the original purpose of Certificate of Need legislation, which was to control unnecessary and costly over-investment in excess technology in a given service area].

Numbers of diagnostic, treatment and minor surgical procedures provided to both in-patients *and out-patients*

Utilization of various medical visits or admissions by specialty (such as neurology, cardiology, gastroenterology, obstetrical, gynecological, orthopedic, rehabilitation, psychiatric, substance abuse treatment, pain management etc.) by in-patients and out-patients.

Too often, we focus on the acute in-patient care services lost to a community by a hospital closure, but often the ambulatory out-patient specialty services also disappear, making it more difficult for patients to achieve diagnostic and follow up care in their own communities. This section helps get a sense of the

magnitude of the services that would be lost by a closure and that need to be absorbed by other hospitals and specialty practices that can often be 30-50 miles away.



Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
F. Rehabilitation:						
Cardiac	○	◉	Patients		Patients Episodes of Care	
Substance Use Disorder (SUD)	○	◉	Patients		Patients Episodes of Care	
Nutritional Counseling	○	◉	Patients		Patients Episodes of Care	
Pulmonary	○	◉	Patients		Patients Episodes of Care	
G. Physical Rehabilitation:						
Occupational Therapy	○	◉	Patients		Patients Episodes of Care	
Orthotic Services	○	◉	Patients		Patients Episodes of Care	
Physical Therapy	○	◉	Patients		Patients Episodes of Care	
Prosthetic Services	○	◉	Patients		Patients Episodes of Care	
Speech/Language Therapy	○	◉	Patients		Patients Episodes of Care	
Therapeutic Recreational Service	○	◉	Patients		Patients Episodes of Care	
H. Pain Management: Does your hospital offer inpatient or outpatient programs or services to admit or treat patients for the management of chronic, nonmalignant pain diagnoses?	○	◉	Patients		Patients Episodes of Care	

Examining this data as a community might also provide a sense of whether the services offered by the hospital match the needs of the community. A serious mismatch may result in poor utilization and patients seeking care elsewhere. [Please see companion tool in this toolkit on ***Community Health Needs Assessments***]. Although the opioid crisis is epidemic in rural Tennessee, and was a deep concern in each of the listening sessions we conducted, none of the hospitals that closed in the communities we visited offered substance abuse treatment at the time of their closure. ***THCC recommends that the state provide incentives to smaller hospitals to work more closely with communities and state health planning agencies to create services that align with community need and improve health outcomes.***

Schedule E. Financial Data.

The data to diagnose whether a hospital's bottom line is a healthy black one or a sickly red one, and the stability of its operating margin is found here. We can also get a sense of whether the hospital has assets to carry it through a rough year or two. Lastly, we can calculate a hospital's uncompensated care costs. payer mix, and ascertain whether, given current circumstances, it is a sustainable one.

Section A Charges. The three columns in the screenshots below—Charges, Adjustments, and Revenue—reveal the complexity of hospital finance.

- ***Gross Patient Charges*** are what the hospital calculates it should be reimbursed for the facilities, nursing care, diagnostic work, supplies and equipment needed in caring for patients. [Note: Physician fees charged by emergency room physicians, specialists, hospitalists, radiologists and pathologists are usually billed separately, particularly when these specialists are on contract rather than on staff. Such bills often come as unwanted surprises to many patients].
- ***Adjustments*** are discounts negotiated by private insurance companies, offered to self-pay patients, or required by Medicare and Medicaid.
- ***Patient Revenue*** is the amount actually received from the payers.

Patient charges are reported in two categories reflecting the dual public/private nature of how the health system in this country is funded.

Government charges include Medicare, Medicaid/TennCare, Cover Kids and insurance covering military families.

- Medicare is the federal government program for persons over 65 years of aga and some younger adults who are severely disabled. There are currently two types of Medicare coverage available:
    - Original Medicare, which enables enrollees to see any doctor and use any hospital but pays providers according to cost-based funding formulas. Medicare covers 80% of hospitalizations (Part A), but enrollees contribute to the costs of regular physician care (Part B) and medications (Part D) and often elect to get supplemental insurance to help with the remaining 20% of costs.
    - Medicare Advantage plans, which are commercially administered plans that roll Part A, Part B and Part D into one package and that use defined networks of doctors and facilities. Medicare Advantage plans are not responsible for payment to out-of-network providers.
- TennCare, our state Medicaid program, is jointly funded by federal and state funds, currently at a ratio of approximately 65% federal to 35% state match. TennCare covers:
    - low income children,
    - low-income pregnant women and
    - low-income women who have breast or cervical cancer
    - low income seniors and disabled Tennesseans who need assistance paying for some of their Medicare services.
    - some low-income adult care-givers of minor children.

  Our state government chose NOT to expand TennCare to other low income adults (those without minor children) although the federal government agreed to cover 90% of the expansion population costs as part of the Affordable Care Act.

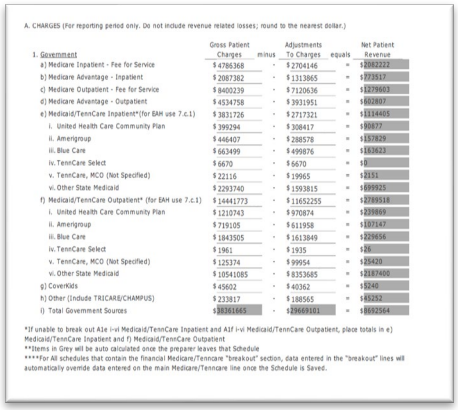
  TennCare is somewhat unique among Medicaid programs in that it depends almost exclusively on private insurance carriers to manage care for enrollees and is experimenting with new value-based care reimbursement strategies. However, TennCare reimburses at rates lower than Medicare for most services.

  [Currently there are three major Managed Care Organizations (MCOs) in our state—BlueCrossBlueShield (BlueCare), United Health Care, and Amerigroup, but JARs from previous years will be set up somewhat differently to reflect previous MCO arrangements].

Non-Government charges include **commercial** plans that are offered by employers to employees, or individual plans purchased on either the Affordable Care Act Marketplace or private marketplace by persons not offered or eligible for employer-based insurance. Commercial payers negotiate payment rates with in-network hospitals. Care paid for by Workers Compensation insurers and other private programs is included here too.

Self-Pay charges reflect the cost of care billed to uninsured patients. In Tennessee, that has not taken advantage of the Affordable Care Act's Medicaid expansion program for low-income adults, it is estimated that there are well over 300,000 uninsured adults, with higher rates of uninsurance in rural areas of the state.

A key problem for Tennessee rural hospitals is that of these payer groups, only non-government commercial payers are currently reimbursing hospitals at levels that do not result in financial losses, provided that commercially insured patients are able to afford their deductibles and co-payments.



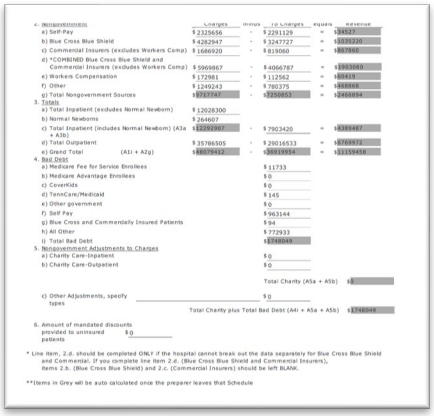
A. CHARGES (For reporting period only. Do not include revenue related losses; round to the nearest dollar.)

	Gross Patient Charges	minus	Adjustments To Charges	equals	Net Patient Revenue
1. Government					
a) Medicare Inpatient - Fee for Service	$ 4786368	-	$ 2704146	=	$ 2082222
b) Medicare Advantage - Inpatient	$ 2087382	-	$ 1313865	=	$ 773517
c) Medicare Outpatient - Fee for Service	$ 8400239	-	$ 7120636	=	$ 1279603
d) Medicare Advantage - Outpatient	$ 4534758	-	$ 3931951	=	$ 602807
e) Medicaid/TennCare Inpatient*(for EAH use 7.c.1)	$ 3831726	-	$ 2717321	=	$ 1114405
i. United Health Care Community Plan	$ 399294	-	$ 308417	=	$ 90877
ii. Amerigroup	$ 446407	-	$ 288578	=	$ 157829
iii. Blue Care	$ 663499	-	$ 499876	=	$ 163623
iv. TennCare Select	$ 6670	-	$ 6670	=	$ 0
v. TennCare, MCO (Not Specified)	$ 22116	-	$ 19965	=	$ 2151
vi. Other State Medicaid	$ 2293740	-	$ 1593815	=	$ 699925
f) Medicaid/TennCare Outpatient* (for EAH use 7.c.1)	$ 14441773	-	$ 11652255	=	$ 2789518
i. United Health Care Community Plan	$ 1210743	-	$ 970874	=	$ 239869
ii. Amerigroup	$ 719105	-	$ 611958	=	$ 107147
iii. Blue Care	$ 1843505	-	$ 1613849	=	$ 229656
iv. TennCare Select	$ 1961	-	$ 1935	=	$ 26
v. TennCare, MCO (Not Specified)	$ 125374	-	$ 99954	=	$ 25420
vi. Other State Medicaid	$ 10541085	-	$ 8353685	=	$ 2187400
g) CoverKids	$ 45602	-	$ 40362	=	$ 5240
h) Other (Include TRICARE/CHAMPUS)	$ 233817	-	$ 188565	=	$ 45252
i) Total Government Sources	$ 38361665	-	$ 29669101	=	$ 8692564

*If unable to break out A1e i-vi Medicaid/TennCare Inpatient and A1f i-vi Medicaid/TennCare Outpatient, place totals in e) Medicaid/TennCare Inpatient and f) Medicaid/TennCare Outpatient

**Items in Grey will be auto calculated once the preparer leaves that Schedule

***For All schedules that contain the financial Medicare/Tenncare "breakout" section, data entered in the "breakout" lines will automatically override data entered on the main Medicare/Tenncare line once the Schedule is Saved.



	Charges	minus	To Charges	equals	Revenue
2. Nongovernment					
a) Self-Pay	$ 2325656	-	$ 2291129	=	$ 34527
b) Blue Cross Blue Shield	$ 4282947	-	$ 3247727	=	$ 1035220
c) Commercial Insurers (excludes Workers Comp)	$ 1686920	-	$ 819060	=	$ 867860
d) *COMBINED Blue Cross Blue Shield and Commercial Insurers (excludes Workers Comp)	$ 5969867	-	$ 4066787	=	$ 1903080
e) Workers Compensation	$ 172981	-	$ 112562	=	$ 60419
f) Other	$ 1249243	-	$ 780375	=	$ 468868
g) Total Nongovernment Sources	$ 17727747	-	$ 11250853	=	$ 6476894
3. Totals					
a) Total Inpatient (excludes Normal Newborn)	$ 12028300				
b) Normal Newborns	$ 264607				
c) Total Inpatient (includes Normal Newborn) (A2a + A3b)	$ 12292907	-	$ 7903420	=	$ 4389487
e) Total Outpatient	$ 35786505	-	$ 29016533	=	$ 6769972
e) Grand Total (A1i + A2g)	$ 48079412	-	$ 36919954	=	$ 11159458
4. Bad Debt					
a) Medicare Fee for Service Enrollees			$ 11733		
b) Medicare Advantage Enrollees			$ 0		
c) CoverKids			$ 0		
d) TennCare/Medicaid			$ 145		
e) Other government			$ 0		
f) Self Pay			$ 963144		
g) Blue Cross and Commercially Insured Patients			$ 94		
h) All Other			$ 772933		
i) Total Bad Debt			$ 1748049		
5. Nongovernment Adjustments to Charges					
a) Charity Care-Inpatient			$ 0		
b) Charity Care-Outpatient			$ 0		
			Total Charity (A5a + A5b)		$ 0
c) Other Adjustments, specify types			$ 0		
			Total Charity plus Total Bad Debt (A4i + A5a + A5b)		$ 1748049

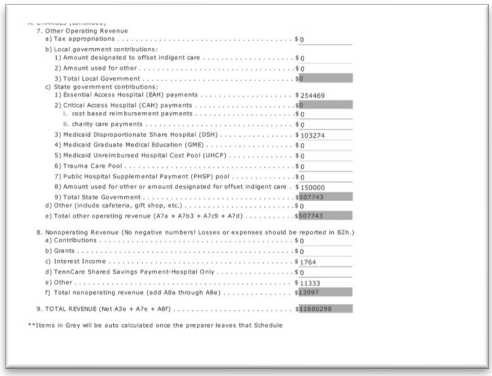
6. Amount of mandated discounts provided to uninsured patients $ 0

* Line item, 2.d. should be completed ONLY if the hospital cannot break out the data separately for Blue Cross Blue Shield and Commercial. If you complete line item 2.d. (Blue Cross Blue Shield and Commercial Insurers), items 2.b. (Blue Cross Blue Shield) and 2.c. (Commercial Insurers) should be left BLANK.

**Items in Grey will be auto calculated once the preparer leaves that Schedule

Uncompensated Care. *Uncompensated Care* is calculated by combining the amount of financial assistance provided by the hospital to patients who meet certain low income guidelines [Section A.5. *Charity Care*] with the amount of lost revenue that results from patients, ***both insured and uninsured***, who are unable to pay their hospital bills in full [Section A.4. *Bad Debt*]. These amounts are not added into the Total Revenue, but provide an estimation of additional revenue that might be available if all patients were insured.

Other Operating Revenue [Section A.7] shows additional supplemental payments made to hospitals usually by local, state or federal governments. The categories of these supplemental payments have changed over the past decade.



7. Other Operating Revenue	
a) Tax appropriations	$ 0
b) Local government contributions:	
1) Amount designated to offset indigent care	$ 0
2) Amount used for other	$ 0
3) Total Local Government	$ 0
c) State government contributions:	
1) Essential Access Hospital (EAH) payments	$ 254469
2) Critical Access Hospital (CAH) payments	$ 0
i. cost based reimbursement payments	$ 0
ii. charity care payments	$ 0
3) Medicaid Disproportionate Share Hospital (DSH)	$ 103274
4) Medicaid Graduate Medical Education (GME)	$ 0
5) Medicaid Unreimbursed Hospital Cost Pool (UHCP)	$ 0
6) Trauma Care Pool	$ 0
7) Public Hospital Supplemental Payment (PHSP) pool	$ 0
8) Amount used for other or amount designated for offset indigent care	$ 150000
9) Total State Government	$ 507743
d) Other (include cafeteria, gift shop, etc.)	$ 0
e) Total other operating revenue (A7a + A7b3 + A7c9 + A7d)	$ 507743
8. Nonoperating Revenue (No negative numbers! Losses or expenses should be reported in B2h.)	
a) Contributions	$ 0
b) Grants	$ 0
c) Interest Income	$ 1764
d) TennCare Shared Savings Payment-Hospital Only	$ 0
e) Other	$ 11333
f) Total nonoperating revenue (add A8a through A8e)	$ 13097
9. TOTAL REVENUE (Net A3e + A7e + A8f)	$ 11680298

**Items in Grey will be auto calculated once the preparer leaves that Schedule

In the example above, the state of Tennessee provided additional payments to hospitals that met the CMS criteria for Critical Access Hospital (CAH) and Essential Access Hospitals in recognition of the important role they play.

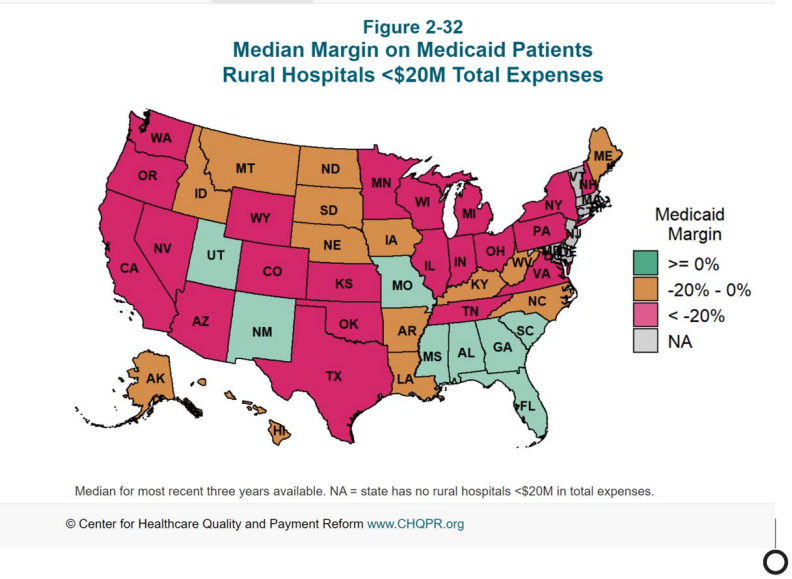
- **Critical Access Hospitals** are a designation created by Congress in 1997 for rural hospitals that have 25 acute care beds or less, are located more than 35 miles from another hospital or more

than a 15 mile drive from another hospital in an area with mountainous terrain or only secondary roads, maintain an average in-patient length of stay of 96 hours or less, and provide 24/7 emergency care services.

- **Essential Access Hospitals** include larger hospitals that are also meet similar geographical isolation criteria, provide needed emergency and acute care services, and serve a majority of Medicare patients in their service area. Some urban hospitals may also be considered Essential Access Hospitals if they are serving as a referral center for large numbers of Medicare and Medicaid patients from adjacent rural areas.

Critical Access and Essential Access Hospitals are also reimbursed at higher rates by Medicare for their services. Rural hospitals in Tennessee, which have much smaller revenue streams and lower assets to start with than the urban hospitals, are often very dependent on these supplemental "back end" payments to make ends meet. Most rural hospitals also need to attain either an CAH or EAH designation to survive.

Another source of *Other Operating Revenue* comes from TennCare, which provides additional **supplemental payments** to hospitals that serve a high proportion of TennCare patients and uninsured patients, or that provide supervision to medical students receiving training. Because TennCare has historically reimbursed hospitals at rates that result in negative financial margins (see map below a recent report on ***The Crisis in Rural Health Care*** report from the Center for Healthcare Quality and Payment Reform, https://ruralhospitals.chqpr.org) these supplemental payments can also be key to a small hospital's survival.

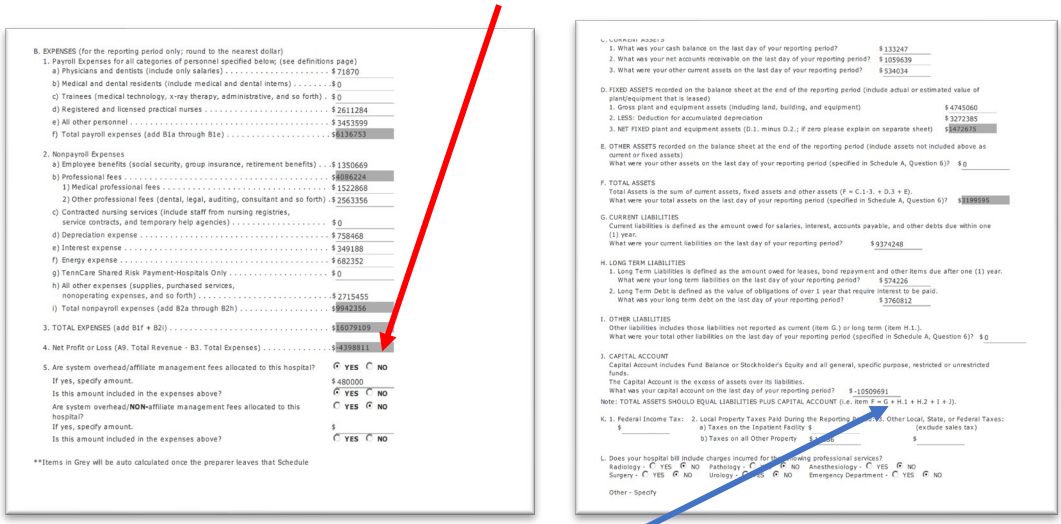


THCC recommends that a careful review be made of how these funds are allocated and whether changes to the distribution of these funds could better sustain rural health systems.

Non-operating revenue, the last revenue category in Schedule E, includes what is collected from the Gift Shop or the Cafeteria, as well as from charitable contributions from the community, and grants from foundations.

Section B. EXPENSES—personnel salaries and benefits, professional services fees, other contracted services costs, depreciation, etc.

Net profit or loss (i.e, "**the bottom line**") is then calculated by subtracting total expenses from total revenues and can be found on line 4 in section B of Schedule E.



B. EXPENSES (for the reporting period only; round to the nearest dollar)

1. Payroll Expenses for all categories of personnel specified below; (see definitions page)
   - a) Physicians and dentists (include only salaries) . . . $ 71870
   - b) Medical and dental residents (include medical and dental interns) . . . $ 0
   - c) Trainees (medical technology, x-ray therapy, administrative, and so forth) . $ 0
   - d) Registered and licensed practical nurses . . . $ 2611284
   - e) All other personnel . . . $ 3453599
   - f) Total payroll expenses (add B1a through B1e) . . . $ 6136753
2. Nonpayroll Expenses
   - a) Employee benefits (social security, group insurance, retirement benefits) . . . $ 1350669
   - b) Professional fees . . . $ 4086224
     - 1) Medical professional fees . . . $ 1522868
     - 2) Other professional fees (dental, legal, auditing, consultant and so forth) . $ 2563356
   - c) Contracted nursing services (include staff from nursing registries, service contracts, and temporary help agencies) . . . $ 0
   - d) Depreciation expense . . . $ 758468
   - e) Interest expense . . . $ 349188
   - f) Energy expense . . . $ 682352
   - g) TennCare Shared Risk Payment-Hospitals Only . . . $ 0
   - h) All other expenses (supplies, purchased services, nonoperating expenses, and so forth) . . . $ 2715455
   - i) Total nonpayroll expenses (add B2a through B2h) . . . $ 9942356
3. TOTAL EXPENSES (add B1f + B2i) . . . $ 16079109
4. Net Profit or Loss (A9. Total Revenue - B3. Total Expenses) . . . $ -4398811
5. Are system overhead/affiliate management fees allocated to this hospital? ○ YES ○ NO
   - If yes, specify amount. $ 480000
   - Is this amount included in the expenses above? ○ YES ○ NO
   - Are system overhead/**NON**-affiliate management fees allocated to this hospital? ○ YES ○ NO
   - If yes, specify amount. $
   - Is this amount included in the expenses above? ○ YES ○ NO

**Items in Grey will be auto calculated once the preparer leaves that Schedule

C. CURRENT ASSETS
1. What was your cash balance on the last day of your reporting period? $ 133247
2. What was your net accounts receivable on the last day of your reporting period? $ 1059639
3. What were your other current assets on the last day of your reporting period? $ 534034

D. FIXED ASSETS recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased)
1. Gross plant and equipment assets (including land, building, and equipment) $ 4745060
2. LESS: Deduction for accumulated depreciation $ 3272385
3. NET FIXED plant and equipment assets (D.1. minus D.2.; if zero please explain on separate sheet) $ 1472675

E. OTHER ASSETS recorded on the balance sheet at the end of the reporting period (include assets not included above as current or fixed assets)
What were your other assets on the last day of your reporting period (specified in Schedule A, Question 6)? $ 0

F. TOTAL ASSETS
Total Assets is the sum of current assets, fixed assets and other assets (F = C.1-3. + D.3 + E).
What were your total assets on the last day of your reporting period (specified in Schedule A, Question 6)? $ 3199595

G. CURRENT LIABILITIES
Current liabilities is defined as the amount owed for salaries, interest, accounts payable, and other debts due within one (1) year.
What were your current liabilities on the last day of your reporting period? $ 9374248

H. LONG TERM LIABILITIES
1. Long Term Liabilities is defined as the amount owed for leases, bond repayment and other items due after one (1) year.
What were your long term liabilities on the last day of your reporting period? $ 574226
2. Long Term Debt is defined as the value of obligations of over 1 year that require interest to be paid.
What was your long term debt on the last day of your reporting period? $ 3760812

I. OTHER LIABILITIES
Other liabilities includes those liabilities not reported as current (item G.) or long term (item H.1.).
What were your total other liabilities on the last day of your reporting period (specified in Schedule A, Question 6)? $ 0

J. CAPITAL ACCOUNT
Capital Account includes Fund Balance or Stockholder's Equity and all general, specific purpose, restricted or unrestricted funds.
The Capital Account is the excess of assets over its liabilities.
What was your capital account on the last day of your reporting period? $ -10509691
Note: TOTAL ASSETS SHOULD EQUAL LIABILITIES PLUS CAPITAL ACCOUNT (i.e. item F = G + H.1 + H.2 + I + J).

K. 1. Federal Income Tax: $
2. Local Property Taxes Paid During the Reporting Period: a) Taxes on the Inpatient Facility $ b) Taxes on all Other Property $
3. Other Local, State, or Federal Taxes: $ (exclude sales tax)

L. Does your hospital bill include charges incurred for the following professional services?
Radiology - ○ YES ● NO Pathology - ○ YES ● NO Anesthesiology - ○ YES ● NO
Surgery - ○ YES ● NO Urology - ○ YES ● NO Emergency Department - ○ YES ● NO

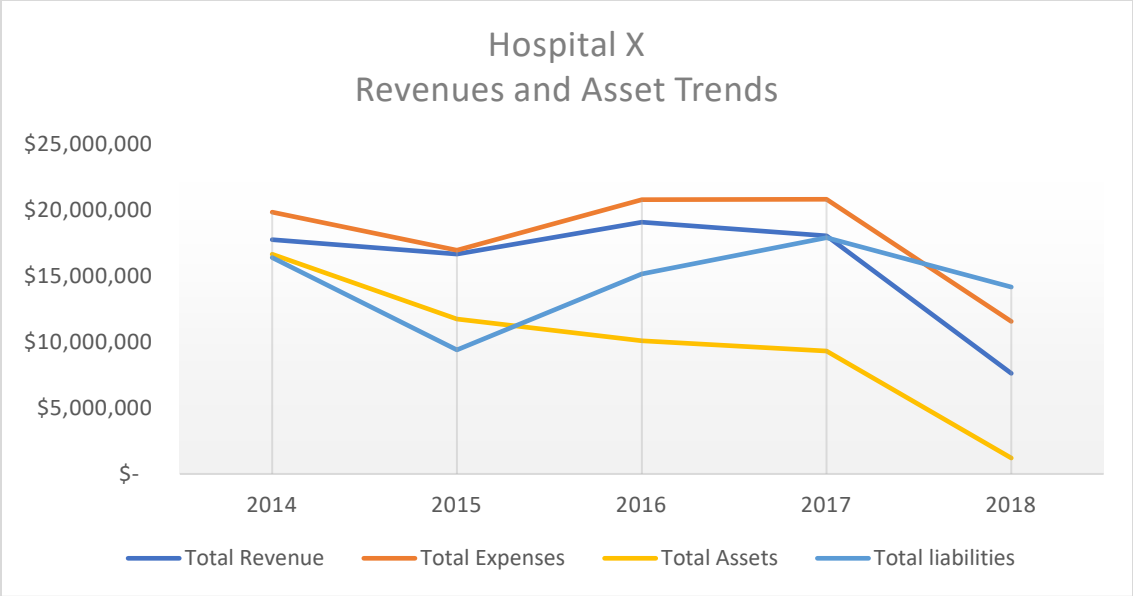
Other - Specify

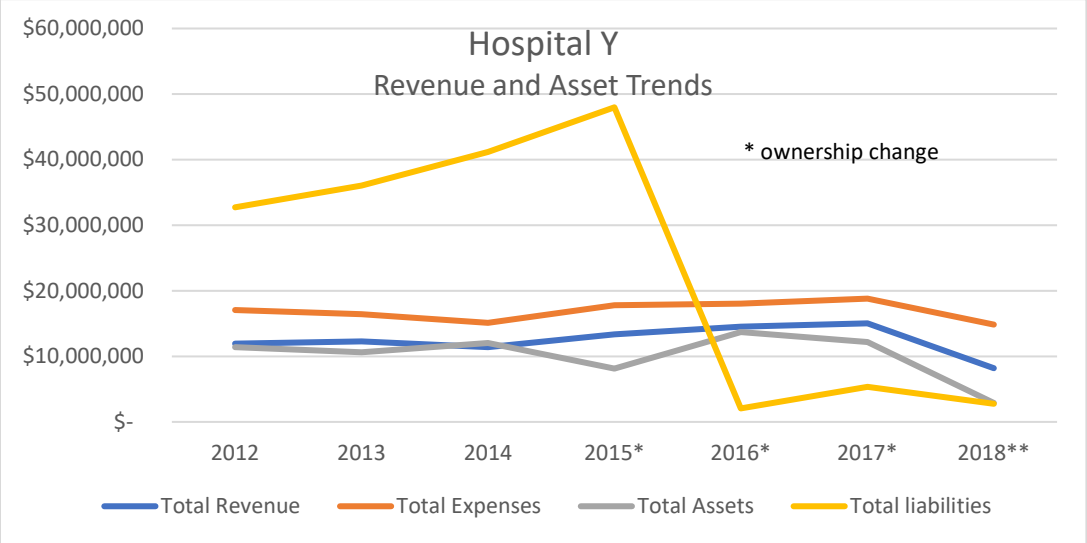
Sections C,D,E, and F: **Assets** includes cash on hand, accounts receivable, fixed facility and equipment a

Sections G, H, and I: **Liabilities** includes total short term and long term **liabilities** (such as loans that need repayment).

Section J: **Capital account** equals Total Assets minus Total Liabilities, sort of a long-term "bottom line". A strong, positive capital account indicates an ability to weather temporary losses. A capital account that is negative or approaching zero is another warning sign of financial instability.

The graphs that follow illustrate five year trends in revenues vs. expenses and assets vs. liabilities for several rural Tennessee hospitals that recently closed. While these closures came as a surprise to most in their communities, if community leaders been made aware of the downward trend lines in hospital profits and assets, there may have been opportunities to intervene and perhaps prevented total closure.

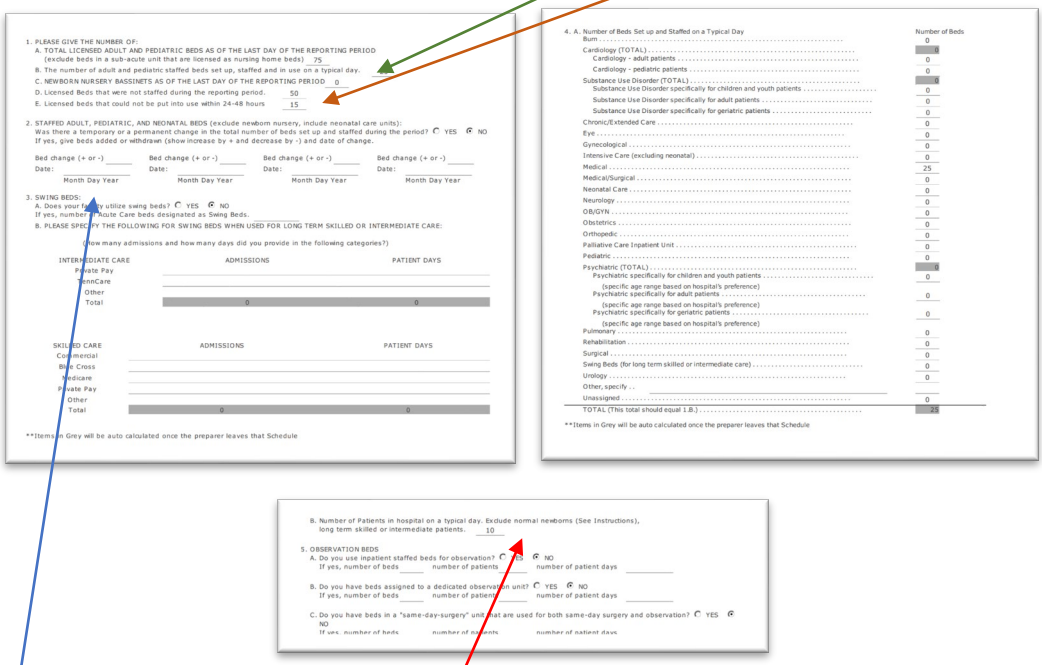




THCC recommends that the Tennessee Department of Health pro-actively review and report on Joint Annual Reports to identify problematic trends and develop stronger mechanisms for intervention to help communities mitigate or reverse negative trends.

Schedule F: Beds and Bassinets

Total beds available in the hospital, as well as the number that are typically **staffed beds** on a daily basis are reported. Also reported are the additional number that could be staffed in 24-48 hours in a crisis, and whether the beds are in rooms equipped for special services. This is information that health planners might look at in a time of crisis if additional capacity were needed.



Excess capacity is common for the many rural hospitals in Tennessee that were built or renovated with funding provided the federal Hill-Burton Act between 1946 and 1976. In fact one-third of all US hospitals were constructed using those funds. Rural populations have shrunken significantly over the past 70 years. CMS policy of providing cost + reimbursement to smaller-sized hospitals (Critical Access Hospitals are required to be no larger than 25 beds, and other Essential Access Hospitals no larger than 50 beds) acknowledges that reality, but also recognizes that rural communities need beds for essential emergency and acute care needs of rural residents.

Swing beds are beds approved by the Centers for Medicare and Medicaid that can be converted from acute care needs to provide for skilled nursing care and rehabilitative services provided by physical, occupational and speech therapists. Swing beds enable a smaller rural hospital the flexibility they might need to accommodate community residents who might need to be close to family during rehabilitation following a stroke, readjusting to a colostomy, or recovering from a serious injury.

Average daily census count is the number of patients on average who are actually being cared for in the hospital on a given day, and one of the key predictors of the health of the hospital, is also reported here. The closer the alignment between the number of regularly staffed beds and number of in-patients, the better the chances of the hospital maintaining a positive bottom line.

Schedule G. Utilization

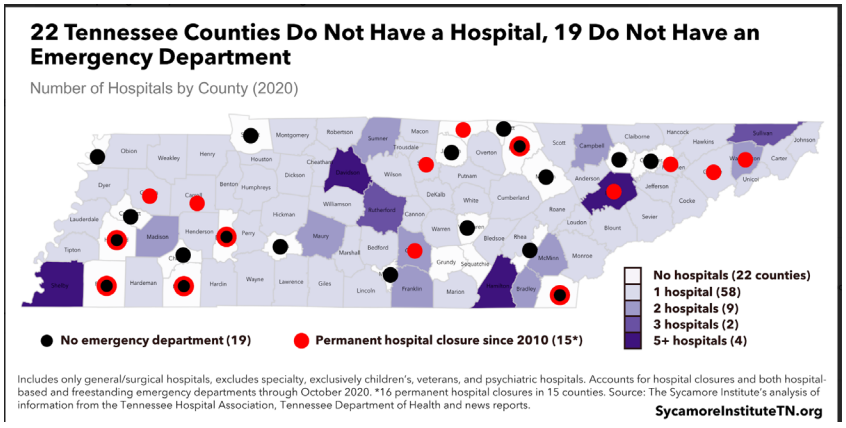
This schedule provides:

- **Diagnostic categories of illnesses** (for example, respiratory illnesses or heart problems or endocrine conditions like diabetes) for patients using the hospital's inpatient services (measured by admissions or discharges) and out-patient services (measured by visits). This is information that could be used to assess alignment of hospital services with identified community needs, and where a hospital might want to invest in additional preventive, diagnostic, treatment, and support services
- **Payer mix** for both inpatient or outpatient services, another of the key predictors of hospital financial health.
- **Ages of patients** seen at the hospital are, again information that can be used for making staffing and training decisions
- **County of patient residence.** When looked at in the context of other hospitals in a geographic area, this can be used to assess **patient out-migration patterns** (another predictor of sustainability) over time

Schedule H provides data specific to **Psychiatric Hospitals**, with a specific section devoted to Substance Abuse Disorder treatment. None of the rural hospital closures since 2010 have been of psychiatric hospitals, and several closed Tennessee hospitals were successfully converted to psychiatric hospitals in our state.

Schedule I is devoted revenue and utilization data specific to **Emergency Departments**—both those on the hospital campus and any free-standing emergency departments that hospital might operate. Developing Free-standing Emergency Rooms in rural counties that currently lack a hospital would enable stabilization of rural residents experiencing trauma, stroke, and acute cardiac events is an important policy option to explore. As of October 2020 there were 19 Tennessee rural counties that lacked any emergency room services. State regulations require that Free-Standing Emergency Rooms be affiliated with a hospital system.

We recommend that our state consider incentivizing the strategic development of Free-Standing Emergency Rooms to ensure that no Tennessean is at risk of missing the life-saving treatment that needs to be administered within the "golden hour" of the onset of cardiac events, stroke, and trauma.



Schedule J provides detailed information on the **number of employees on the hospital payroll** at the end of the reporting period and those providing contracted services. Aggregate payroll expenses are provided, which makes it possible to assess the economic impact of the hospital on the community.

Schedule K lists **Employed Medical Staff**, their departments and number of full-time-equivalent staff employed.

Schedule L: Perinatal service data. One of the most costly services to provide is obstetric services, and this tends to be one of the first services cut when a rural hospital is struggling.

Schedule M reports how much inpatient and outpatient revenue physicians on the hospital payroll generate in the aggregate.

Schedule N reports data for any Federally Qualified Health Centers operated by the hospital.

Schedule O lists the **Health Plans Accepted**. This is significant for understanding how insurance networks might impact rural residents' utilization and costs. It is important to note that even if a rural hospital is considered in-network by an insurance carrier, the contracted physician services may not have agreed to those networks. This is significant for patients at rural hospitals because they are more likely to be subjected to higher costs from balance billing practices.

Schedule P: Disproportionate Share Audit data. The number of uninsured patients reported here is used to calculate supplemental payments from TennCare to hospitals that treat a high number of uninsured.

Increasing supplemental payments to rural hospitals is another strategy that other states have used to help sustain their rural hospitals and one that might be considered for Tennessee. As already noted, THCC recommends that the current system be made more transparent and carefully reviewed.

We hope this tool has been helpful in introducing you to the information available in the Joint Annual Report of Hospitals. Please let us know how this tool can be improved and what other tools would be helpful. You can share your thoughts with us at info@tnhealthcarecampaign.org.