MISSION

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Providing the right care, at the right time, in the right setting – Close to home.

Gove County Medical Center

Committed to Others. Always.

1¢ Sales Tax Community Forum

October 14, 2024

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Objectives and Agenda

Objective 1: Define what the sales tax is (and isn't), the source of the sales tax revenue, how much funding it provides to GCMC and when Gove County residents will vote on the sales tax

Objective 2: Differentiate between the mill levy and the sales tax

Objective 3: Clearly outline GCMC's ongoing need for public funding, including a review of our current financials

Objective 4: Explore the challenges of the state and federal healthcare industry and economy

Objective 5: Discuss the impact that the sales tax has on GCMC's ability to provide vital healthcare services to Gove County and beyond

Objective 6: Identify the importance of health care services in rural communities, including Gove County

Objective 7: Address questions and concerns from the community

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1¢ Sales Tax Overview

1. What is the sales tax and how does it work?
2. New tax or tax renewal?
3. How much funding does the sales tax provide to GCMC?
4. Sales tax vs. Mill Levy

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What is the 1¢ Sales Tax?

The 1¢ sales tax represents a tax of 1¢ on every $1 of purchased goods and services in Gove County.

The revenue generated from the 1¢ tax is then distributed to GCMC for the purpose of assisting with financial stability and provision of healthcare services.

> Ex: A semi truck driver passing through Gove County stops at Mittens and purchases $100 of snacks and services. The driver will pay $101. The extra $1 generated from the tax is distributed to GCMC.

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Is the 1¢ Sales Tax New?

<u>NO</u>. THE SALES TAX IS NOT NEW.

- The sales tax has been in place since Gove County voters voted yes in 2015
  - The sales tax has always been for the sole purpose of assisting GCMC
- The vote taking place on **November 5th** during the general election is for a **<u>RENEWAL</u>** of the sales tax
- The 1¢ sales tax has already been renewed by Gove County voters on two separate occasions: 2018 and 2021

<u>GOVE COUNTY RESIDENTS WILL SEE NO INCREASE IN THEIR SALES TAX AS A RESULT OF THE RENEWAL.</u>

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How much Revenue Does the Sales Tax Generate?

The amount of sales tax revenue that GCMC receives varies by year:

GCMC receives anywhere from $600,000 - $900,000 in sales tax revenue each year.

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Sales Tax vs. Mill Levy

Sales Tax:

- Paid for by a mix of Gove County residents, workers that commute to Gove County and travelers down the interstate
- Evaluated every three years

Mill Levy:

- Paid for solely by Gove County property owners
- Evaluated each year

The Mill Levy has a greater financial impact on Gove County residents

- Currently, both tax dollar sources are crucial to the longevity of GCMC
- However, because of its greater impact on Gove County residents, the Mill Levy is the preferred tax source to reduce (when feasible)
- Eliminating the sales tax now will greatly reduce the likelihood of being able to lower the mill levy
- Because the mill levy is annually reviewed, having the security of the sales tax in future years provides the GCMC Board of Trustees flexibility in determining how much tax burden can be reduced or raised each year based on the ongoing financial performance of GCMC

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Financial Overview

1. What does the sales tax do for GCMC and our community?
2. GCMC's current financial performance – Why does GCMC still need the sales tax?

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Why is Health Care so Difficult?

A recent article in Becker's Hospital Review cited quoted a CFO explaining the challenges of Hospital finances:

"Hospitals' biggest challenge in the revenue cycle is that we provide services to anyone who walks through our front door. I don't know of any other industry that has a business model in which they don't know when, if or how much they will get paid, and the customer is not the person paying. It's one of the hardest business models to try to figure out, and we're subject to a whole other industry, the insurance industry, and all of the shifts a consumer might go through throughout their lifetime."

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What Does the Sales Tax Help GCMC Fund?

GCMC receives a significant amount of revenue from the sales tax.

Overall, the purpose of the sales tax is to provide funding necessary to provide health care services in Gove County.

This sales tax assists in absorbing the costs and financial losses of:

- Vital health care services, such as Labor and Delivery
- Required charity care
- Unavoidable bad debt through non-payment of services
- Underpayments by insurance companies

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How Much Uncompensated Care Does GCMC Provide?

Uncompensated care refers to healthcare services provided by hospitals or providers that are not reimbursed by any source, including insurance or government programs. This typically includes care given to uninsured patients, as well as services for which the patient cannot pay or for which reimbursement is insufficient. Uncompensated care can be classified into two main categories:

1. **Charity Care**: Services provided to patients who are unable to pay due to financial hardship and for which the provider absorbs the cost.

2. **Bad Debt**: Services provided to patients who have the ability to pay but do not fulfill their financial obligations, resulting in unpaid bills.

Uncompensated care can significantly impact a healthcare provider's financial stability, as it represents lost revenue that must be absorbed by the organization.

	Uncompensated Care	August 2024 Year To Date
1	Charity	(117,428)
2	Bad Debt	(400,853)
	Total Uncompensated Care	**(518,280)**

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How does the Sales Tax Impact GCMC Financials?

		August 2023 Year to Date	August 2024 Year to Date	August 2024 Year to Date No Sales Tax
1	**Total Operating Revenue**	**9,507,758**	**11,491,984**	**11,491,984**
2	**Total Operating Expense**	**13,090,836**	**13,377,569**	**13,377,569**
3	**Net Inc (Loss) From Operating**	**(3,362,308)**	**(1,708,834)**	**(1,708,834)**
4	Sales Tax Revenue	813,950	539,886	0
5	Property Tax Mil Levy	766,667	886,746	886,746
6	**Total County Revenue**	**1,580,617**	**1,426,631**	**886,746**
7	**Net Income (Loss)**	**(1,781,691)**	**(282,203)**	**(822,088)**

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Financials: Detailed Overview

Financial Overview

1.Non-Reimbursable Expenses:

1. 2022: $4,481,468
2. 2024: $41,045

2.Projected Revenue:

1. Estimated 340B net revenue for 2024: $350,000

3.Sales Tax Impact:

1. Estimated annual sales tax revenue: $600,000 - $900,000
    1. This revenue does not impact the cost report at all

4.Cost Savings Analysis:

1. For every $1 saved on expenses, the actual savings amount is only $0.60 due to the cost report implications.
2. To offset $800,000 in sales tax, the hospital would need to reduce expenses by approximately $1,335,000 (calculated as $1,335,000 * 0.60 = $800,000).

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Financials: Detailed Overview

Financial Overview (continued)

5.Potential Areas for Expense Reduction:

1. Considerations for expense cuts could include:
    1. Reduction of services
    2. Reduction of workforce
    3. Switching to REH (Band-Aid station – loss of OB, Inpatient, Swing bed, Loss of 340b)

6.Implications of Expense Reduction:

1. Such cuts would merely return the hospital to its current financial status:
    1. No growth in cash reserves
    2. No reinvestment in hospital equipment or facilities
    3. Reduction in hospital services

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Does GCMC Still Need the Sales Tax?

YES

- Despite significant financial improvement, GCMC is not yet in a stable financial position.
- The removal of the sales tax will make overcoming our financial deficit nearly impossible without significant – and likely consequential – changes.
- Sales tax assistance allows GCMC to continue to provide care in our community by countering the financial difficulties that accompany:
  - Bad Debt write-offs from non-payment
  - Charity care requirements
  - Provision of Labor and Delivery services (OB)
  - Economic, industry and legislative transformation that has had severe financial consequences, especially in rural health

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Fighting to Survive: A Nationwide Problem

1. GCMC is not the only rural Hospital fighting to survive
2. What does the future have in store for hospitals?
3. Will GCMC adapt if the 1¢ sales tax is eliminated?

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Why Aren't Nearby Hospitals Struggling?

THEY ARE.

They are faced with the same decisions we have had to make and will have to continue to make.

According to 2023 data provided by CHQPR:

- Kansas has 98 remaining Rural Inpatient Hospitals
- 84 of the 98 (86%) posted a loss on services in 2022 **or** 2023
- 62 of the 98 (63%) are at Risk of Closing
- 31 of the 98 (32%) are at IMMEDIATE Risk of Closing

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More Kansas Hospital Financial Data

The Kansas Hospital Association (KHA) has recently released the following data to its members

In 2023:

- Average operating margins for Kansas Hospitals was -7% (compared to -4.7% in 2022)
- Average operating margins for Kansas Critical Access Hospitals (such as GCMC) was -13.6%
- Payroll expenses for Kansas Hospitals increased by 16% compared to the prior year
- 21% of Bad Debt came from patients **that had insurance**
- Combined **underpayments** from government programs totaled approximately $1.6 billion

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Kansas Hospitals: Stagnant Reimbursement, increased costs and inflation

KHA released the following data based on 2022 cost reports and 2023 survey data

National average of cash on hand is 265 days – in Kansas, it is 62 days

Medicare payments only cover 87% of costs

- 20% of Kansas will be eligible for Medicare by 2030

In 2022 (compared to 2021):

- U.S. inflations rose dramatically between 2021 (4.7%) and 2022 (8.0%)
  - The American Hospital Association (AHA) cites that from 2014 to 2023, Hospital employee compensations has outpaced U.S. inflation 45% to 28.7%
- Labor, supplies and drug costs comprise 70% of a hospital's budget
  - Drug costs increased 13%
  - Medical supplies increased 5%
  - Labor costs increased 16%

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Kansas is at the Highest Risk of Hospital Closures

According to the CHQPR, Kansas tops the list of states at the highest risk of losing it's rural healthcare providers

RURAL HOSPITALS AT RISK OF CLOSING

State	Hospital Closures Since 2015	Inpatient Service Closures (REH)[2]	Open Rural Inpatient Hospitals	Hospitals With Losses on Services[7]		Hospitals at Risk of Closing		Hospitals at Immediate Risk	
				Number	Percent	Number	Percent	Number	Percent
Kansas	8	2	98	84	86%	62	63%	31	32%
Texas	14	4	160	107	67%	80	50%	30	19%
Oklahoma	5	3	78	62	79%	39	50%	26	33%
Mississippi	5	5	67	43	64%	35	52%	25	37%
Alabama	1	0	52	34	65%	28	54%	24	46%
New York	3	0	52	37	71%	29	56%	20	38%
Tennessee	11	1	53	27	51%	19	36%	17	32%
Arkansas	0	4	46	35	76%	25	54%	13	28%
Louisiana	1	1	55	35	64%	24	44%	12	22%
Georgia	3	3	69	30	43%	22	32%	11	16%
California	1	0	58	30	52%	23	40%	10	17%

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This is a Nationwide Problem

A lack of financial resources has and will continue to result in a reduction of services and access to care in rural communities.

The risk of losing healthcare in GOVE COUNTY is as real as it is for the hundreds of rural communities in the U.S. that have already lost vital healthcare services.

- National Rural Health Association (NRHA):
  - "Since 2010, **170+ rural hospitals have closed or discontinued inpatient services**."
- Center for Healthcare Quality and Payment Reform (CHQPR):
  - "Over the past decade, **more than 100 rural hospitals have closed**. As a result, the millions of Americans who live in those communities no longer have access to an emergency room, inpatient care, and many other hospital services that citizens in most of the rest of the country take for granted."
  - "**Over two dozen hospitals eliminated inpatient services in 2023 and 2024** in order to qualify for federal grants that are only available for REHs (rural emergency hospitals)."
  - **"More than 700 rural hospitals – over 30% of all rural hospitals in the country – are at risk of closing** <u>because of the serious financial problems they are experiencing</u>. **Over half (360) of the rural hospitals are at immediate risk of closing.."**

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Will it Get Better?

Unfortunately, the future does not look bright for hospitals

According to a report published by the AHA in July 2024:

- According to the S&P, not-for-profit hospitals' ***negative*** financial outlooks are at their highest in over a decade, affecting 24% of the sector
- Fitch reported a downgrade-to-upgrade ratio of 3:1; alarmingly close to the ratio during the 2008 financial crisis
- More than 19 million Medicaid enrollees have been disenrolled through 2023 – Meaning more uncompensated care for hospitals such as GCMC
  - Not to mention, Kansas has not passed Medicaid expansion, only making matters worse
- Federal legislation threatens hospital revenues in areas of 340B and Medicare payments for hospital outpatient departments (i.e. sit-neutral payment cuts) – Both of which are massive revenue sources for GCMC
- Cybersecurity poses a very significant risk and requires hefty investments into IT infrastructure that many rural organizations cannot afford

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How can GCMC Overcome these Challenges?

GCMC cannot continue to operate in its current state if **BOTH** of the following things do not happen:

1. We must continue to receive both the sales tax and the mill levy
2. We must look internally as we continue to improve our financial situation by improving efficiencies, reducing expenses without sacrificing quality of care and improving patient revenue by investing in revenue generating services that provide value to our patients – this, however, first requires that we have the funds to invest.

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What Might Happen if GCMC Does Not Continue to Receive Sales Tax Revenue?

- Decisions will have to be made. If decisions are not made, GCMC will **NOT** continue to operate.
  - **Simple business concepts dictate that you must bring in more money than you spend or eventually you will run out of savings, and when you run out of savings you will have to close. Therefore, to avoid closure tough decisions would likely be required.**
- **BUT**, the good news is that we have been making these key decisions and will continue to do so.
  - Our financial position is much stronger than it was just one year ago.
  - Currently, becoming profitable is within reach, *BUT ONLY WITH CONTINUED LOCAL TAX DOLLARS*
- **The removal of the sales tax would make it difficult to overcome operational losses.**
- This in itself does not mean that GCMC will close! **Some health care is better than no health care.**
  - **Among other solutions, it may be that GCMC will have to evaluate the services we are able to continue to provide**

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What Service Would Have To Be Evaluated?

- GCMC provides both required and non-required services
- Required services cannot be cut even if they lose money
- Some non-required (or "luxury") services make money, while others lose money
- If GCMC tax funding is not enough to overcome the combined losses from required services and luxury services, the luxury services that are losing money cannot continue to be provided without the immanent and likely threat of hospital closure.
- While other solutions will be explored, the following possibilities are the worst case scenario:
  - Elimination of the Labor and Delivery Program
  - Elimination of Inpatient services (including Labor and Delivery) by changing to a Rural Emergency Hospital (REH)

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A Community Without Healthcare

1. What would happen to Gove County and its residents if GCMC was forced reduce its services or close due to financial collapse?

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What Happens in Rural Communities That Lose Their Health Care Services?

CHQPR:

Rural Hospital Closures Harm Patients and the Nation's Economy

Most at-risk hospitals are in isolated rural communities, where closure of the hospital would force residents of the community to travel a long distance for emergency or inpatient care. Moreover, in many cases, the hospital is the only place where residents can get laboratory tests or imaging studies, and it may be the principal source of primary care in the community. As a result, closure of the hospital would cause a loss of access to many essential healthcare services. In addition, rural hospital closures threaten the nation's food supply and energy production, because farms, ranches, mines, drilling sites, wind farms, and solar energy facilities are located primarily in rural areas, and they will not be able to attract and retain workers if health care isn't available in the community.

CHQPR: "Seriously ill individuals in their communities will have to be transferred to a hospital far from home in order to receive the services they need."

NRHA: "When a rural hospital closes, not only does the community lose access to vital health care, but a major employer and community lynchpin exits, affecting the larger community."

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What Happens in Gove County if Services are Reduced or the Hospital Closes?

The impact would be variable depending on the scale of the service reductions, but the final result would be a negative effect on the following:

1. Gove County Population
2. Gove County Businesses
3. Gove County Economy
4. Gove County Health and Safety

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How Could a Reduction in Services Impact the Gove County Population and Businesses?

GCMC employs approximately 150 employees, many of them specialize in healthcare and will seek jobs outside of the county to pursue their career.

Will they stay? What happens if they don't?

- If they don't specialize in healthcare, does Gove County have enough jobs to backfill to keep them in our community? Are these jobs ones that they would want?
- Many of these employees are married and rely on dual income in their household. Will their spouse continue to work in Gove County if the other must travel for work?
- Many of these employees have kids that go to our schools. Will they stay?
- Many of these employees shop for groceries, eat at restaurants, fill up their vehicles and change their oil in Gove County, among other things. Will they keep using Gove County services and businesses if they don't commute to or live in Gove County?

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What Does This Have to do With the Gove County Economy?

GCMC a significant contributor to the local Economy. The most recent Economic Impact report distributed by the Kansas Hospital Association (KHA) outlined this impact.

The loss of GCMC or any reduction in patient revenue through the loss of services and jobs will reduce the impact that we have on our local economy.

- For every $1 generated by GCMC, another 12¢ is generated in other county businesses
- For every job at GCMC, another 0.18 jobs are created in the county, leading to additional earned wages injected into the community
- The hospital has an estimated annual business income impact of over $12 million (GCMC wages and benefits + additional job and wage impact outside of GCMC)
- The report estimates that 34.49% of a health care worker's income is spent on taxable goods and services in the county
- **The conservative estimate is that the health care sector in Gove County contributes to $107,000 in generated SALES TAX REVENUE, thereby assisting in covering a portion of the 1¢ tax.**

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What Does This Have to do With the Gove County Economy?

Summary from the Economic Impact Report of the health care sector's economic contribution to Gove County – NOTE: Without GCMC, this contribution is massively reduced and other businesses suffer.

Economic contributions summary

In summary, the health care sector in Gove County generates significant employment and income for local residents and generous tax revenue for local governments. Health care businesses provide about 244 jobs and about $12.6 million in labor income. When the multiplier effect is included, the contributions rise to about 284 jobs and over $14 million in labor income in the county. The health care sector supports over $107,000 in local sales tax revenue.

The health care sector in the county may be constrained by the county's low level of income relative to the state, and by its high rate of uninsured people under age 65. Uninsured people affect hospital revenues, and the lack of insurance limits the ability of residents to access health care services.

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Closing Remarks

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Do Other Rural Hospitals Need Local Tax Revenues to Survive?

YES. WE ARE NOT ALONE.

CHQPR: "Many hospitals have managed to remain open despite losses on patient services because they receive local tax revenues..."

We are asking for the community's patience as we continue to find ways to improve our financial performance. We have made great strides and we will continue to do what needs to be done.

As a community, we ask that we choose to continue to provide financial support to our hospital while GCMC continues to weather the storm so that we will not be faced with making decisions that could jeopardize our breadth of healthcare services, access to care, jobs, our local economy and more.

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When is the Vote?

NOVEMBER 5th, 2024

Early Voting starts October 21st and ends on November 4th at noon

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Questions from the Community?

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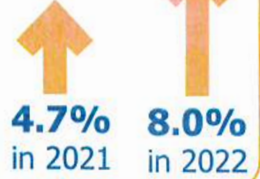
SIGNIFICANT FINANCIAL ISSUES AFFECTING KANSAS HOSPITALS

Stagnant reimbursement and increases in labor costs and inflation are creating financial stress.

20 percent
Kansans 65 and older that will be eligible for Medicare by 2030.

Medicare payments to hospitals **only cover about 87 percent** of costs.

U.S. inflation rose dramatically



4.7% in 2021
8.0% in 2022

Kansas' Population
2,937,150

82 of 105 counties in Kansas have experienced a **loss of population** in the **past 10 years**.

IN THE LAST THREE YEARS, HOSPITAL EXPENSES HAVE INCREASED BY MORE THAN 35%.

Top Three 2022 Expenses

Labor, supplies and drug costs comprise **70% of a hospital's budget.**

73 percent of hospitals in Kansas had a negative operating margin going into 2023.

National studies show **60 Kansas hospitals** are at **risk of closing**.

Margins Matter Margins allow hospitals to invest in services to meet growing demand, keep pace with the rapid changes in health care and subsidize access to community services.

National average of cash on hand is **265 days.**

Kansas average of cash on hand is **62 days.**

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SOCIAL TAGS
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Kansas Hospital Association

SOURCES

- KHA Survey Data Completed March 2023
- 2022 Cost Report Data, Centers for Medicare & Medicaid Services
- Census Bureau, 2022
- KaufmanHall March 2023, National Hospital Flash Report
- CHQPR Rural Hospitals at Risk Report, July 2023

How Can I Use this Data to Have Important Conversations about Financial Challenges and Make Positive Changes?

Local

- **Engage** local businesses about the importance of choosing their insurance payer.
- **Use** Economic Impact Report to encourage support for the local hospital.
- **Educate** the community on the impact of Medicare Advantage on hospitals.
- **Partner** with local health care organizations to educate them on financial challenges.
- **Understand** how local, city and county financial support impacts your hospital.
- **Know** your local percentage of population that is 65 and older.
- **Forecast** how many in your community will be eligible for Medicare by 2030.
- **Highlight** your specific labor, supply and drug costs, as well as solutions you are putting in place related to workforce, purchasing or other strategies.
- **Be** transparent and share your financial statistics.
- **Pull** data from other sources such as Kansas Health Matters or the QHi Benchmarking tool to expand on the challenges.
- **Speak** with your local radio/newspaper to share what these numbers mean and the impact to your hospital.

State

- **Communicate** to insurance payers about challenges and opportunities.
- **Champion** Medicaid (KanCare) Expansion.
- **Encourage** your leadership team, board members and staff to participate in KHA advocacy efforts.
- **Schedule** your state representatives to visit your hospital to discuss challenges and solutions.
- **Leverage** contacts with the Kansas Insurance Department and the Kansas Department of Health and Environment.
- **Share** patient stories that impact financial condition of hospital.

Federal

- **Invite** your U.S. Congressmen to your hospital to discuss challenges and solutions.
- **Advocate** for legislative action to:
  - protect the DSH program;
  - reform 340B;
  - increase Medicare reimbursement;
  - provide additional oversight for Medicare Advantage; and
  - protect access to care.

Benchmarking Tools for Rural Hospitals and Clinics

Scan here:

Community Health-Related Statistical Data

Scan here:

Find Legislators and Advocacy Information

Scan here:

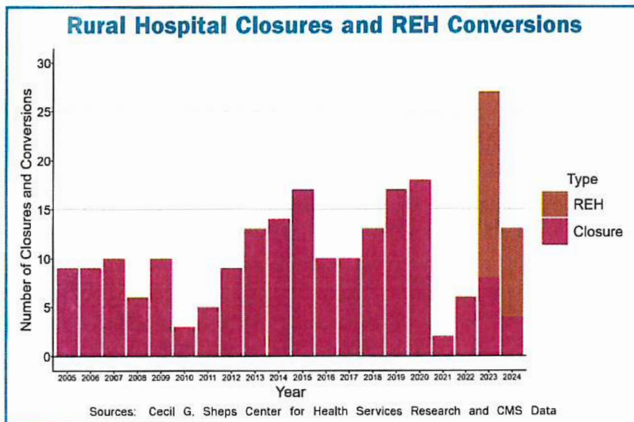
RURAL HOSPITALS AT RISK OF CLOSING

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

Millions of Americans No Longer Have Hospital Care in Their Community

Over the past decade, more than 100 rural hospitals have closed. As a result, the millions of Americans who live in those communities no longer have access to an emergency room, inpatient care, and many other hospital services that citizens in most of the rest of the country take for granted.

In addition, over two dozen hospitals eliminated inpatient services in 2023 and 2024 in order to qualify for federal grants that are only available for Rural Emergency Hospitals (REHs). Every year, more than 7,000 rural residents had received inpatient care in those hospitals, but now seriously ill individuals in their communities will have to be transferred to a hospital far from home in order to receive the services they need.

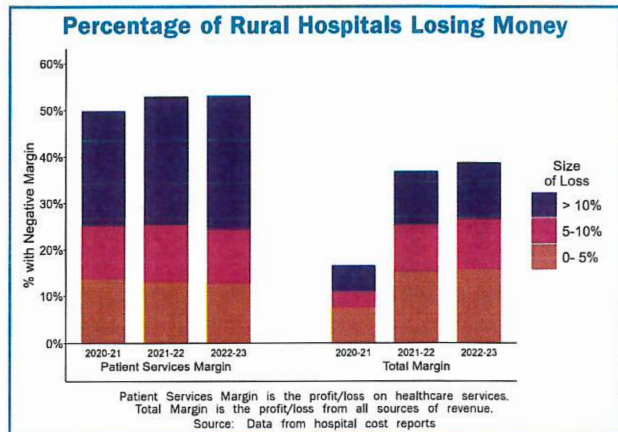


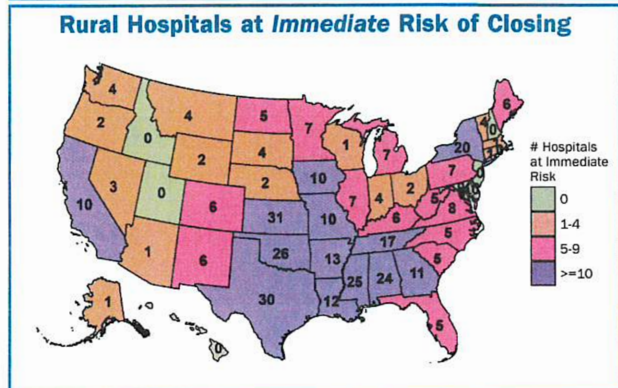
Hundreds More Rural Hospitals Could Close in the Near Future

More than 700 rural hospitals – over 30% of all rural hospitals in the country – are at risk of closing because of the serious financial problems they are experiencing. Over half (360) of these rural hospitals are at *immediate* risk of closing because of the severity of their financial problems.

- **Losses on Patient Services:** The majority of rural hospitals in the country lose money delivering patient services. It costs more to deliver health care in small rural communities than in urban areas, and many health insurance plans do not pay enough to cover these costs.
- **Insufficient Revenues From Other Sources to Offset Losses:** Many hospitals have managed to remain open despite losses on patient services because they receive local tax revenues or state government grants. However, there is no guarantee that these funds will continue to be available in the future or that they will be sufficient to cover higher costs. The special federal assistance many hospitals received during the pandemic has now ended. As a result, more than one-third of rural hospitals lost money overall in 2022-23.
- **Low Financial Reserves:** The hospitals at greatest risk of closing have more debts than assets, or they do not have adequate net assets (i.e., assets other than buildings & equipment, minus debt) to offset their losses on patient services for more than a few years.

There are hospitals at risk of closing in almost every state. In over half the states, 25% or more of the rural hospitals are at risk of closing, and in 9 states, the majority of rural hospitals are at risk.





Rural Hospital Closures Harm Patients and the Nation's Economy

Most at-risk hospitals are in isolated rural communities, where closure of the hospital would force residents of the community to travel a long distance for emergency or inpatient care. Moreover, in many cases, the hospital is the only place where residents can get laboratory tests or imaging studies, and it may be the principal source of primary care in the community. As a result, closure of the hospital would cause a loss of access to many essential healthcare services. In addition, rural hospital closures threaten the nation's food supply and energy production, because farms, ranches, mines, drilling sites, wind farms, and solar energy facilities are located primarily in rural areas, and they will not be able to attract and retain workers if health care isn't available in the community.

RURAL HOSPITALS AT RISK OF CLOSING

State	Hospital Closures Since 2015	Inpatient Service Closures (REH)[2]	Open Rural Inpatient Hospitals	Hospitals With Losses on Services[1]		Hospitals at Risk of Closing		Hospitals at Immediate Risk	
				Number	Percent	Number	Percent	Number	Percent
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Oklahoma	5	3	78	62	79%	39	50%	26	33%
Mississippi	5	5	67	43	64%	35	52%	25	37%
Alabama	1	0	52	34	65%	28	54%	24	46%
New York	3	0	52	37	71%	29	56%	20	38%
Tennessee	11	1	53	27	51%	19	36%	17	32%
Arkansas	0	4	46	35	76%	25	54%	13	28%
Louisiana	1	1	55	35	64%	24	44%	12	22%
Georgia	3	3	69	30	43%	22	32%	11	16%
California	1	0	58	30	52%	23	40%	10	17%
Iowa	1	0	94	72	77%	29	31%	10	11%
Missouri	9	0	58	30	52%	20	34%	10	17%
Virginia	2	0	30	9	30%	9	30%	8	27%
Illinois	3	0	74	19	26%	12	16%	7	9%
Michigan	2	1	64	25	39%	15	23%	7	11%
Minnesota	3	1	97	43	44%	19	20%	7	7%
Pennsylvania	3	0	43	23	53%	13	30%	7	16%
Colorado	0	0	43	18	42%	10	23%	6	14%
Kentucky	2	1	71	25	35%	13	18%	6	8%
Maine	2	0	25	16	64%	10	40%	6	24%
New Mexico	1	1	27	19	70%	7	26%	6	22%
Florida	5	0	22	12	55%	8	36%	5	23%
North Carolina	6	0	55	14	25%	6	11%	5	9%
North Dakota	0	0	39	29	74%	13	33%	5	13%
South Carolina	3	0	25	13	52%	10	40%	5	20%
West Virginia	2	0	31	14	45%	11	35%	5	16%
Indiana	3	0	54	15	28%	5	9%	4	7%
Montana	0	0	55	35	64%	14	25%	4	7%
South Dakota	0	0	49	16	33%	8	16%	4	8%
Vermont	0	0	13	10	77%	8	62%	4	31%
Washington	0	0	45	30	67%	16	36%	4	9%
Nevada	1	0	14	9	64%	5	36%	3	21%
Nebraska	1	1	71	34	48%	5	7%	2	3%
Ohio	1	0	71	13	18%	5	7%	2	3%
Oregon	0	0	33	11	33%	8	24%	2	6%
Wyoming	0	0	25	10	40%	6	24%	2	8%
Alaska	1	0	17	9	53%	2	12%	1	6%
Arizona	1	0	27	16	59%	2	7%	1	4%
Connecticut	0	0	3	3	100%	2	67%	1	33%
Massachusetts	0	0	6	3	50%	2	33%	1	17%
Wisconsin	0	0	79	24	30%	7	9%	1	1%
Delaware	0	0	2	0	0%	0	0%	0	0%
Hawaii	0	0	13	10	77%	8	62%	0	0%
Idaho	0	0	29	16	55%	7	24%	0	0%
Maryland	1	0	4	0	0%	0	0%	0	0%
New Hampshire	0	0	17	6	35%	2	12%	0	0%
New Jersey	0	0	0	0	0%	0	0%	0	0%
Rhode Island	0	0	0	0	0%	0	0%	0	0%
Utah	0	0	21	7	33%	0	0%	0	0%
U.S. Total	105	28	2,234	1,182	53%	703	31%	360	16%

[1] Rural hospitals that had a negative margin (loss) on patient services in the most recent year available (2022 or 2023).
[2] Conversion to Rural Emergency Hospital (REH) which requires closure of inpatient services.

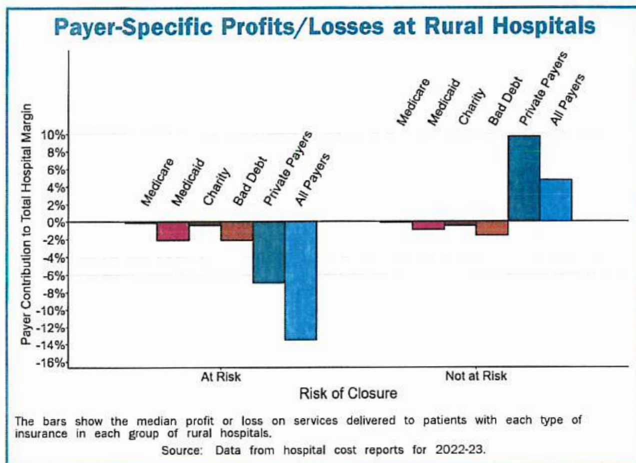
Data current as of July 2024

Closures Are Caused by Inadequate Payments from Private Health Plans

The primary reason hundreds of rural hospitals are at risk of closing is that private insurance plans are paying them less than what it costs to deliver services to patients. As shown below, although the at-risk hospitals are losing money on uninsured patients and Medicaid patients, **losses on private insurance patients are the biggest cause of overall losses.**

Conversely, many other rural hospitals are *not* at risk of closing because they make profits on patient services. They receive payments from private health plans that not only cover the costs of delivering services to the patients with private insurance, but those payments also offset the hospitals' losses on services delivered to uninsured and Medicaid patients.

Payer-Specific Profits/Losses at Rural Hospitals



The bars show the median profit or loss on services delivered to patients with each type of insurance in each group of rural hospitals.
Source: Data from hospital cost reports for 2022-23.

Most "solutions" for rural hospitals have focused on increasing Medicare or Medicaid payments or expanding Medicaid eligibility due to a mistaken belief that most rural patients are insured by Medicare and Medicaid or are uninsured. In reality, about half of the services at the average rural hospital are delivered to patients with private insurance (both employer-sponsored insurance and Medicare Advantage plans). In most cases, the amounts these private plans pay, not Medicare or Medicaid payments, determine whether a rural hospital loses money.

How to Prevent Rural Hospital Closures

Private insurance companies and public insurance programs need to make significant changes in both the amounts and methods they use to pay for rural hospital services in order to prevent more rural hospitals from closing in the future.

Require That Health Insurance Payments Cover the Cost of Services in Rural Communities

Payments that are sufficient to cover the cost of services at large hospitals will not be adequate at small rural hospitals because it costs more to deliver healthcare services in rural communities. This is not because rural hospitals are inefficient, but because of the smaller number of patients served relative to the fixed costs of the services. For example, a small rural community will have fewer Emergency Department (ED) visits than a larger community simply because there are fewer residents, but the minimum cost of staffing the ED on a 24/7 basis will be the same, so the average cost per visit will be higher.

Increasing payments to levels sufficient to prevent closures of the at-risk hospitals would only cost about $5 billion per year. This would represent an increase of only 1/10 of 1% in total national healthcare spending. Most of the higher spending would support primary care and emergency care, since the biggest causes of losses at most small rural hospitals are underpayments for primary care and emergency services. Spending would likely increase as much or more than this if hospitals close, because reduced access to preventive care and failure to receive prompt treatment will cause residents of the communities to be sicker and need more services in the future.

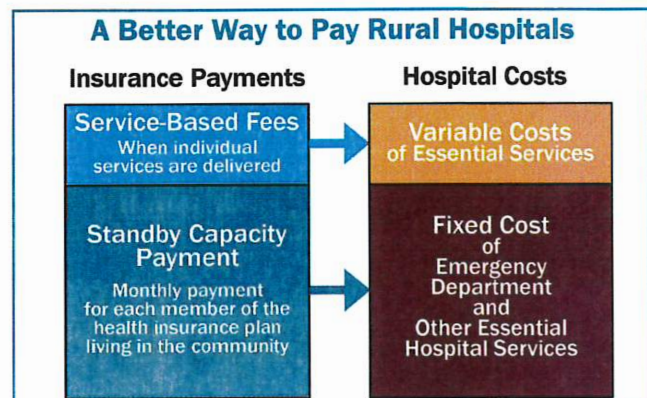
Rural hospitals should not be forced to eliminate inpatient care in order to receive higher payments for other services, as is required under the federal "Rural Emergency Hospital" program. Loss of inpatient services means that seriously ill individuals would no longer be able to receive prompt, high-quality care in their own community. Moreover, closure of the hospital's inpatient unit would also force the elimination of other important services such as maternity care, rehabilitation, and long-term care. Federal programs should preserve and expand rural healthcare services, not reduce them.

Create Standby Capacity Payments to Support the Fixed Costs of Essential Rural Services

The financial problems at small rural hospitals are caused not only by the inadequate *amounts* paid by private health insurance and Medicaid plans, but by the problematic *method* all payers use to pay for services. Small rural hospitals are paid nothing for what residents of a rural community would likely view as one of the most important services of all – the availability of physicians, nurses, and other staff to treat an injury or serious health problem quickly if the resident experiences an injury or problem. Having health insurance that pays fees for ED visits, laboratory tests, or treatments is of little value if there is no Emergency Department, laboratory, or treatment capability available in the community for the resident to use.

In order to preserve and strengthen essential hospital services in rural communities, small rural hospitals need to receive *Standby Capacity Payments* from both private and public payers in addition to being paid Service-Based Fees when individual services are delivered. The Standby Capacity Payment would support the fixed costs of essential services at the hospital, and the Service-Based Fees would cover the variable costs of those services. More details on this approach are available in *A Better Way to Pay Rural Hospitals*.

A Better Way to Pay Rural Hospitals



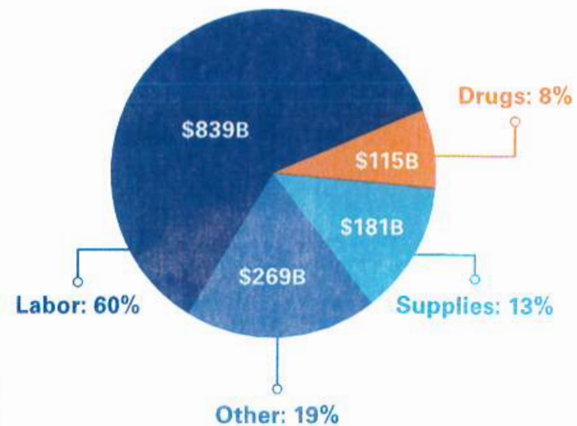
American Hospital Association™
Advancing Health in America

America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities

Introduction

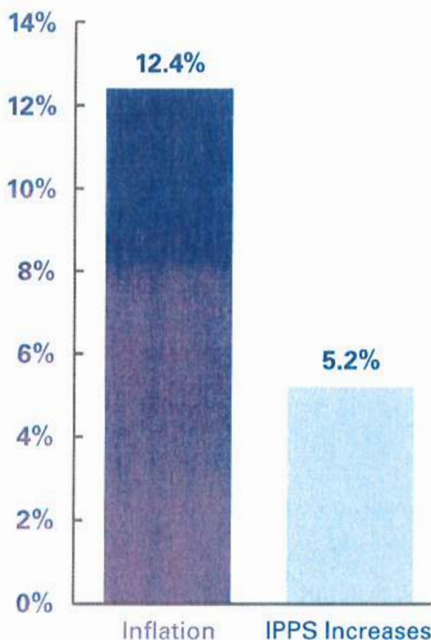
Hospitals and health systems have been at the forefront of a major transformation while at a crossroads of increasing demand for higher acuity care and deepening financial instability. Persistent workforce shortages, severe fractures in the supply chain for drugs and supplies, and high levels of inflation have collectively fueled hospitals' costs as they care for patients 24/7 (see Figure 1). At the same time, hospitals' costs have been met with inadequate increases in reimbursement by government payers and increasing administrative burden due to inappropriate commercial health insurer practices.

Figure 1. Labor constitutes largest percentage of hospital expenses.



Note: Average expenses estimated by Strata Decision Technology median 2023 values across all hospital spending. Labor is inclusive of purchased services and professional fees.

Figure 2. Inflation growth was more than double the growth in IPPS reimbursement, 2021 - 2023



Note: Inflation calculated using annual average CPI-U between 2021 and 2023 from BLS. IPPS increase from FY2020-2023 market basket increases net of other adjustments.

Taken together, these issues have created an environment of financial uncertainty where many hospitals and health systems are operating with little to no margin. While recent data suggest that some hospital and health system finances have experienced modest stabilization from historic lows in 2022, the hospital field is still far from where it needs to be to meet the demand for care, invest in new and promising technologies and interventions, and stand ready for the next health care crisis.

Fresh off a historically challenging year financially in 2022 in which over half of hospitals closed out the year operating at a loss, many hospitals spent much of 2023 simply struggling to break even.[1] Economy-wide inflation grew by 12.4% between 2021 and 2023 – more than two times faster than Medicare reimbursement for hospital inpatient care (see Figure 2).

Since the start of 2022, the number of days cash on hand for hospitals and health systems has declined by 28.3%, according to data from Strata Decision Technology, which provides data and cloud-based financial planning, decision support and performance analytics solutions.[2]

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Diverting dollars from their reserves to maintain access to care has required tradeoffs that have limited many hospitals and health systems from investing in updated infrastructure, new medical technology and equipment, and other clinical needs — particularly among those hospitals in severe financial distress.[3,4] For example, the average age of capital investments for medical equipment and infrastructure, after years of remaining relatively flat, increased by 7.1% for all hospitals in 2023, according to data from Strata Decision Technology. While the constraints and burdens of increasing plant age present serious challenges to hospitals and health systems in their own right, the inability to make needed capital investments has contributed to bond rating agencies issuing rating downgrades, making it harder for some hospitals and health systems to borrow money.[5] Ongoing reimbursement challenges, made worse by crises like the recent Change Healthcare cyberattack, and increased operating costs create an unsustainable financial environment.[6] While these challenges alone could cripple any organization, hospitals and health systems continue to face additional threats from ongoing Medicaid redeterminations increasing uncompensated care[7], regulatory changes that add operational burden, cyberattacks that threaten the health care infrastructure and potential legislation that would further cut Medicare payments to hospitals.

This report provides a snapshot of the current cost realities facing hospitals and health systems and how they impact their ability to care for patients and communities.

1. Costs of Providing Essential Services

Hospitals often play the critical — and sometimes only — role in providing access to essential health care services, such as emergency care and behavioral health, which are necessary for the health and well-being of the communities they serve. Further, oftentimes these are services that are not offered by other types of health care providers. In 2022, the most recent year for which data are available, hospitals admitted nearly 137 million patients in emergency departments and delivered over 3.5 million babies.[8] Many of these essential services are extremely resource intensive and costly to offer. Further compounding this issue are demographic trends such as an aging population and clinical factors such as higher patient acuity. This has driven a steady rise in the share of inpatient utilization among more clinically complex patients covered by Medicare and Medicaid.[9] Not only are inpatient services costlier to provide, but public payer payments for these services fall well below costs. In fact, underpayments from Medicare and Medicaid totaled nearly $130 billion in 2022, and Medicare paid just 82 cents for every dollar hospitals spent caring for patients — resulting in a shortfall of almost $100 billion.[10] Troublingly, cumulative underpayments in the second half of the last decade totaled more than half a trillion dollars — a nearly 40% increase compared to the first half even after adjusting for inflation (see Figure 3).

Figure 3. Cumulative Medicaid and Medicare underpayments

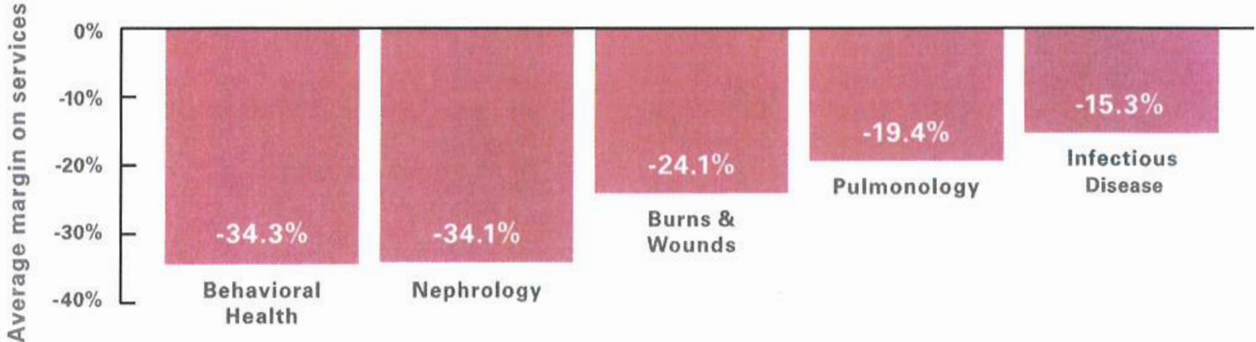
Note: AHA Annual Survey 2013 to 2022 all dollars inflation adjusted to 2022 values using CPI-U from the BLS.

However, the reimbursement challenges do not end with Medicare and Medicaid Reimbursement for some services consistently fall below costs across all payer types. For example, payments for inpatient behavioral health services were 34.3% below costs across all payers on average in 2023, according to data from Strata Decision Technology (see Figure 4). This is especially concerning given the increased utilization of behavioral health services over the last few years.

In the outpatient setting, average payments for costly burn and wound services were 42.9% below costs across all payers (see Figure 5). These shortfalls have been especially acute for government payers like Medicare. For example, average Medicare margins for behavioral health services were -38.9% in 2023.

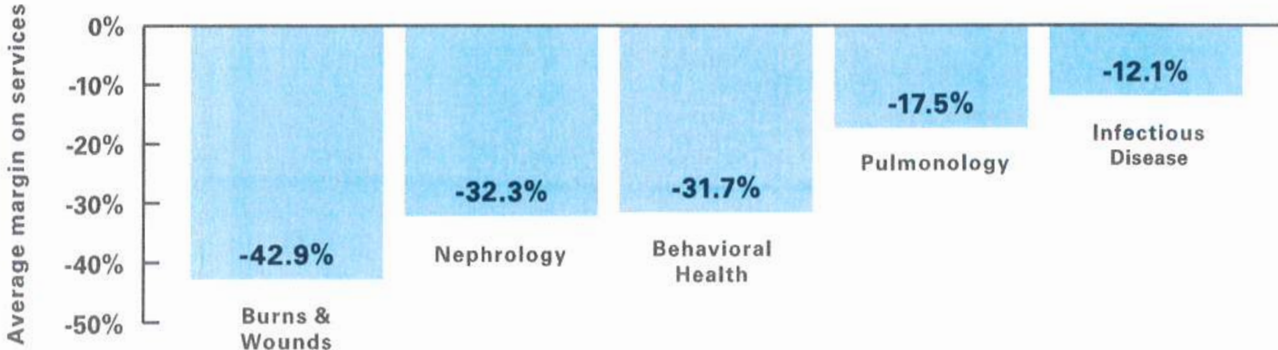
Taken together, these data highlight the challenges that hospitals and health systems face in providing essential services that communities need. This is particularly true for hospitals in rural areas, where the financial challenges can be even more severe.

Figure 4. Hospital payments do not cover the costs of providing vital inpatient services



Note: AHA analysis of 2023 average service line payment and cost across all payers from Strata Decision Technology. Does not include supplemental payments from Medicaid.

Figure 5. Hospital payments also fail to cover the costs of providing essential outpatient services



Note: AHA analysis of 2023 average service line payment and cost across all payers from Strata Decision Technology. Does not include supplemental payments from Medicaid.

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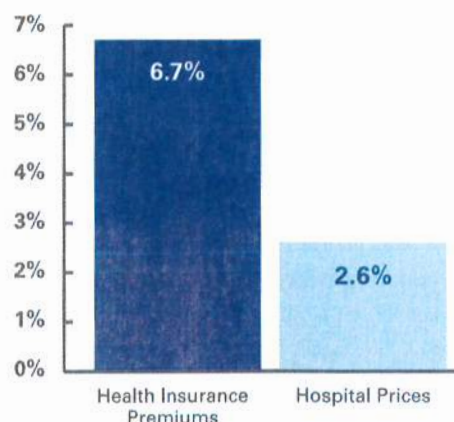
2. Hospital Administrative Expenses

Some commercial health insurer practices increase hospital costs and delay care to patients

Hospitals have seen significant growth in administrative costs due to inappropriate practices by certain commercial health insurers, including Medicare Advantage (MA) and Medicaid managed care plans.

In addition to increasing premiums, which grew twice as fast as hospital prices in 2023, commercial health insurers have overburdened hospitals with time-consuming and labor-intensive practices like automatic claims denials and onerous prior authorization requirements (see Figure 6).[11]

Figure 6. Premiums grew twice as fast as hospital prices in 2023



Note: Health insurance premiums represent premiums for a family of four, from KFF Employer Health Benefits Survey, 2023. Hospital Prices: BLS, annual average Producer Price index for hospitals.

A 2021 study by McKinsey estimated that hospitals spent $10 billion annually on dealing with insurer prior authorizations.[12] Additionally, a 2023 study by Premier found that hospitals are spending just under $20 billion annually in appealing denials — more than half which was wasted on claims that should have been paid out at the time of submission.[13] Denials issued by commercial MA plans rose sharply by 55.7% in 2023.[14] Notably, many of these denials were ultimately overturned, consistent with a study by the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) that found 75% of care denials were subsequently overturned.[15] These denials are particularly concerning because they often occur for medically necessary care, which can result in direct patient harm. In fact, a recent HHS OIG report found that nearly one in five MA denials met Medicare coverage rules, which meant that had they been paid via Medicare fee-for-service, they would have been paid without denial.[16] Even when denials are ultimately overturned, hospitals are not paid for the costs incurred to navigate that burdensome and resource-intensive process. Making matters worse, MA plans paid hospitals less than 90% of Medicare rates despite costing taxpayers more than traditional Medicare in 2023.[17,18] Although partly a function of lower rates, the worsening administrative overload is simply costing hospitals more and more.

Though these issues are often felt most acutely with MA and Medicaid managed care plans, it also is true for other commercial payers, where claims denials increased by 20.2% in 2023. Moreover, the time taken by commercial payers to process and pay hospital claims from the date of submission increased by 19.7% in 2023, according to data from the Vitality Index. For hospitals and health systems, these practices result in billions of dollars in lost revenue each year, which require hospitals to divert dollars away from patient care to instead focus on seeking payment from commercial insurers.[19] Without further intervention, these trends are expected to continue and worsen. National expenditures on the administrative costs of private health insurance spending alone are projected to account for 7% of total health care spending between 2022 and 2031 and are projected to grow faster than expenditures for hospital care.[20]

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Other expenses

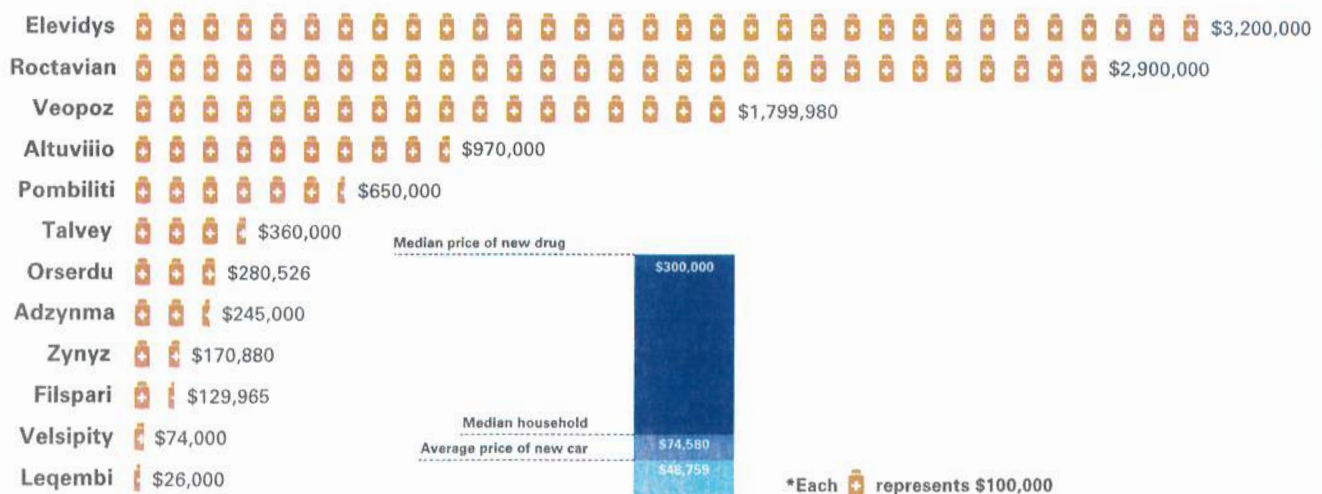
Hospitals also are spending more on things that are not direct patient care services but are still critical to delivering care and maintaining operations. For example, the costs associated with implementing, maintaining and upgrading information management systems and overall technology infrastructure, while critical to improving efficiency and quality of care, typically represent significant investments.

Additionally, given the confidential nature of patient data in these systems, hospitals have increasingly become targets for cyberattacks. As a result, the costs of defending against these attacks and protecting patient data has grown steadily.[21] Health care data breaches are by far the costliest of any other sector.[22] As cyberattacks and data breaches in health care have grown and regulators are requiring more robust protections, hospitals and health systems are finding themselves increasingly trying to invest in cybersecurity.[23] Protecting against cyberattacks and other vulnerabilities is important to patient care, but is increasingly costly. In 2022, hospitals spent nearly $30 billion on property and medical liability insurance, according to data from Lightcast.

3. Hospital Drug Expenses

An area of persistent cost pressure for hospitals and health systems has been the rapid and sustained growth in drug expenses. Hospitals spent $115 billion on drug expenses in 2023 alone. One of the factors fueling this growth is drug company decisions to impose large price increases on existing drugs. However, 2023 also saw a continuation of a long-standing trend of drug companies introducing new drugs at record prices. In 2023, the median annual list price for a new drug was $300,000, an increase of 35% from the prior year (see Figure 7).[24] A recent report by the HHS Assistant Secretary for Planning and Evaluation (ASPE) found that between 2022 and 2023, prices for nearly 2,000 drugs increased faster than the rate of general inflation, with an average price hike of 15.2%.[25]

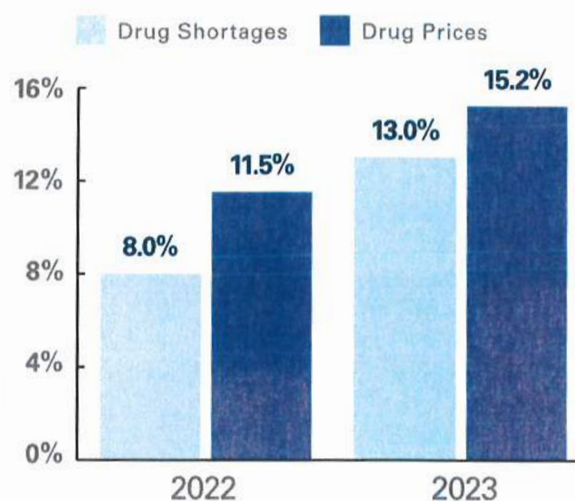
Figure 7. Annual List Prices of Novel Drugs Launched in 2023*



Source: Annual list prices of novel drugs launched in 2023 are from a Reuters survey of new drug costs. Median household income is from 2022 Census Bureau data. Average price of new car is from Kelly Blue Book new-vehicle transaction price in December 2023.

While high drug prices alone pose significant challenges for hospitals and health systems, it is compounded by the fact that many of these same drugs are in shortage. In fact, 2023 saw the most drug shortages in over a decade; there were an average of 301 drugs in shortage per quarter, an increase of 13.0% from the previous year (see Figure 8). These shortages added as much as 20% to hospital drug budgets, according to data from the American Society of Health System Pharmacists (ASHP). These shortages can occur for many reasons, including fractured global supply chains lack of available raw materials, and decisions by drug companies that lack incentives to produce low-margin generic medications.[26] An ASHP survey found that more than 99% of hospital and health system pharmacists experienced drug shortages in 2023, with 85% of respondents describing the severity of drug shortages as critically or moderately impactful.[27] While generic drugs comprised the majority of medications in shortage, estimated to make up as much as 83% of shortages, many of these drugs also were used to treat cancer and autoimmune diseases.[28]

Figure 8. Increase in drug shortages and drugs prices, 2022-2023



Note: Drug shortage data from Utah Drug Information System; Drug price data from ASPE.

Hospital pharmacy staff have limited options for navigating drug shortages. They can purchase the drug by going outside their traditional suppliers and group purchasing agreements, access alternate concentrations or package sizes of the drugs than what is needed or purchase a substitute drug with the same clinical indication. However, all three of these options mean hospitals pay higher prices to acquire the drugs. An ASPE report found up to a 16.6% increase in the prices of drugs in shortage; in many cases, the increase in the price of substitute drugs were at least three times higher than the price increase of the drug in shortage.[29] The costs incurred as a result of drug shortages are compounded by staff overtime needed to find, procure and administer alternative drugs, to manage the added challenges of multiple medication dispensing automation systems and changing electronic health records (EHRs), and to undergo training to ensure medication safety using alternative therapies.[30]

4. Hospital Supply Costs

Having adequate and up-to-date medical supplies, devices and equipment are necessary for hospitals to deliver high quality care to patients. These can include artificial joints used to treat patients with conditions such as arthritis, robotic surgery machines used to perform laparoscopic surgical procedures, and complex imaging machinery used for clinical diagnostics. Most of these items are expensive to acquire and maintain and rely on increasingly volatile global supply chains. Comprising approximately 10.5% of the average

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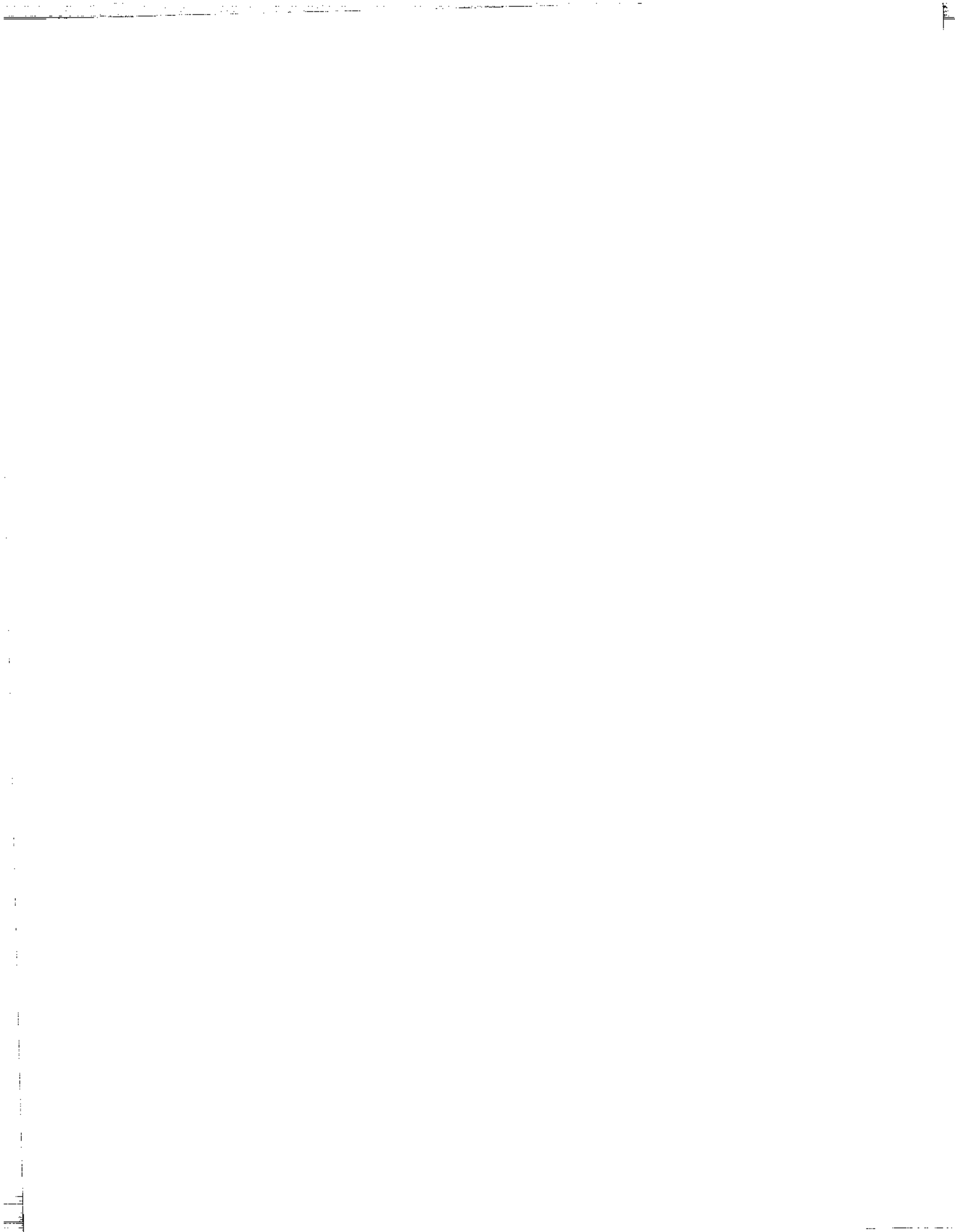


hospital's budget, medical supply expenses collectively accounted for $146.9 billion in 2023, an increase of $6.6 billion over 2022, according to data from Strata Decision Technology. As technology and science are constantly evolving, hospitals routinely need to purchase new supplies, devices and equipment that meet clinical care standards and ensure high quality care.

The upfront costs for critical equipment and device upgrades come at a significant cost (Table 1). For example, the advanced technology of cardiac magnetic resonance imaging (cMRI) machines, which have allowed doctors to develop a deeper understanding of cardiac pathologies and has led to improved diagnostics, costs hospitals on average $3.2 million. For some hospitals that have high demand for cardiac services, they may need to purchase multiple cMRI machines. The additional costs for ongoing maintenance, upgrades and staff training also add to the total costs hospitals must incur to deliver their patients with the high quality care.

Table 1. Medical Device and Equipment Market Prices

Cutting-edge innovation and technologies provide hospitals with the means to enhance patient outcome in their continuous commitment to delivering top-tier patient care. The featured equipment is intricately connected to advancements in diagnostics, heightened success rates in cardiovascular surgery, and more effective joint replacement procedures.

Medical Devices and Equipment	Average List Price
Point of Care ultrasound devices	
Pocket-sized handheld or tablet-based	$8,143
Compact ultrasound systems*	$73,797
Cardiovascular diagnostic and surgical equipment	
Cardiac magnetic resonance imaging (cMRI) machine	$3,230,728
Cardiopulmonary bypass system	$325,442
Joint implant proprietary software and equipment	
Image based planning software	$222,132
Navigation software system (guide surgeons in real-time)	$135,365

*Larger than handheld devices, but still portable. May have more advanced features.

Note: Market prices of medical devices and equipment are courtesy of ECRI, an independent not-for-profit corporation that provides a wide range of services dealing with health care technology.

5. Hospital Labor Costs

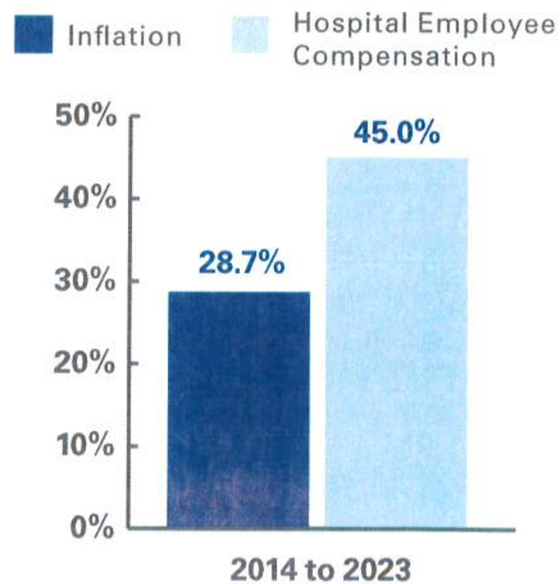
Hospitals' labor costs increased by more than $42.5 billion between 2021 and 2023 to a total of $839 billion, accounting for nearly 60% of the average hospital's expenses. Hospitals continue to turn to expensive contract labor to fill gaps and maintain access to care, spending approximately $51.1 billion on contracted staff in 2023.

Though expenditures on contract labor have moderated since pandemic highs, the spending remains elevated and has added to the financial challenges hospitals and health systems face. This is especially true for smaller, rural hospitals where the local workforce pool is smaller and it can be more difficult to recruit staff. Hospitals' labor costs also can be very sensitive to sudden fluctuations in the demand and supply of labor. Growth in wages and

benefits of hospital employees has vastly surpassed economy-wide inflation over the last decade (see Figure 9).

Yet, critical labor shortages persist, especially in the face of growing burnout among clinicians. Employee burnout hastened by the pandemic and further exacerbated by commercial insurer administrative burden and increase in violence against hospital employees, led to an unprecedented exodus of health care professionals in recent years.[31] Resignations per month among health care workers grew 50% between 2020 and 2023, according to data from McKinsey.[32] Additionally, hospitals have been forced to contend with record high turnover rates — fueling additional expenses for hospitals looking to recruit new workers.[33]

Figure 9. Growth in Total Hospital Employee Compensation Far Outpaces Inflation



Note: BLS, annual average Employee Cost Index, 2014 to 2023 for hospitals and CPI-U, 2014 to 2023.

Consequently, hospitals and health systems have invested more to attract and retain talent. Data from Lightcast indicates that advertised wage rates across all hospital jobs jumped by 10.1% during 2023. With a growing gap between supply and demand for health care workers over the next decade, labor costs will likely continue to be an issue for hospitals.

A Look Ahead to the Rest of 2024

Though 2024 is the first full year out of the most recent public health emergency period, hospitals and health systems continue to face many challenges. Credit ratings agencies have painted a bleak picture for the hospital sector in 2024.[34] According to the S&P, negative outlooks for not-for-profit hospitals are proportionally at their highest in over a decade, affecting 24% of the sector.[35] Similarly, Fitch reported a credit downgrade-to-upgrade ratio of 3:1 — alarmingly close to the ratio seen during the 2008 financial crisis — calling it a "make or break" year and highlighting the sector's struggles, particularly among smaller hospitals with annual revenues under $500 million.[36] While it is expected that hospitals and health systems will continue to face cost increases for labor, drugs, and medical supplies, there are additional headwinds to consider which include:

- Coverage losses due to Medicaid redeterminations: More than 19 million Medicaid enrollees have been disenrolled through 2023.[37] Though partially offset by record Marketplace enrollment and possible enrollment in employer-sponsored coverage, this has still resulted in a steady increase in uncompensated care costs throughout 2023 and will likely continue into 2024 – particularly for states that have not expanded Medicaid.[38]

- Potential legislative actions to cut hospital Medicare payments for patient care: Congress is considering several bills that would impose additional payment reductions to services provided in hospital outpatient departments. These proposals, referred to as "site-neutral" payment cuts, would exacerbate financial challenges for hospitals and threaten patients' access to quality care.
- Cybersecurity risks impact providers and patient care: The cyberattack on Change Healthcare in February 2024 has underscored the extensive repercussions such incidents can have on patient care and hospital operations. The disruptions stemming from that cyberattack have significantly hindered revenue cycle management, pharmacy services, select health care technologies, clinical authorizations, and more across multiple health systems, serving as an example of how an attack can reverberate across the entire health care sector when a business that provides numerous mission-critical services is compromised.[39]
- Ongoing and escalating hospital violence: There has been a significant uptick in violence against health care workers in recent years.[40] To address this issue, hospitals are making significant investments in violence prevention and preparedness efforts to support their employees.

Conclusion

America's hospitals and health systems are dedicated to providing high-quality 24/7 care to all patients in every community across the country. While the commitment to caring and advancing health never wavers, hospitals continue to face significant challenges making it difficult to ensure the care is always there.

The AHA continues to urge Congress and the Administration to support policies to make sure hospitals and health systems have the resources they need to continue providing 24/7 care to all patients and communities. These include:

- Rejecting Medicare and Medicaid cuts to hospital care, including harmful site-neutral proposals and forthcoming reductions to Medicaid Disproportionate Share hospitals.
- Supporting and strengthening the health care workforce.
- Protecting the 340B Drug Pricing Program from any harmful changes and reining in the increasing costs of drugs.
- Taking actions to hold commercial insurers accountable for practices that delay, deny and disrupt care.
- Bolstering support to enhance cybersecurity of hospitals and the entire health care system.

End Notes:

1 www.kaufmanhall.com/news/2022-worst-financial-year-hospitals-and-health-systems-start-pandemic

2 www.syntellis.com/sites/default/files/2023-11/aha_q2_2023_v2.pdf

3 fortune.com/well/2024/01/11/rural-hospitals-are-caught-in-an-aging-infrastructure-conundrum/

4 www.aha.org/guidesreports/2023-04-19-essential-role-financial-reserves-not-profit-healthcare

5 www.modernhealthcare.com/finance/hospital-2023-credit-rating-downgrade-fitch-ratings-sp-global-moodys

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Gove County Medical Center

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With the upcoming 1 cent sales tax vote in November, GCMC understands there are questions surrounding hospital's need for public funding. In an effort to address the most frequent questions the community may have, and the impact of this vote, a public informational piece has been developed below. Hospital finances can be difficult to understand and explain. We hope that that community finds this information helpful as we have broken it down into 4 different sections.

CONTENTS

Section 1: Overview of Public Funding Needs and Current Financial Position

a. After all the changes over the past year, why does GCMC still rely on the sales tax and mill levy?
b. For county residents, why is the sales tax a good source of public funding for GCMC?
c. What impact could the sales tax vote have on the future distribution of public funding sources to GCMC?
d. Why does GCMC still need both the sales tax and the mill levy?
e. How does public funding assist with the costs of charity care and bad debt write-offs?
f. What is GCMC's current financial position through the first 6 months of 2024 with and without public funding sources compared to this time last year?

Section 2: Cost Report Implications on Current Financial Position

a. Please explain why GCMC has not yet recognized all of the financial benefits from the closure of the Long Term Care (LTC) and the purchase of Bluestem Clinic?
b. How is GCMC subsidized by the federal government (i.e. Medicare)?
c. Can GCMC provide examples of how Medicare subsidizes GCMC based on the percentage of Medicare patients that a department provides services to?
d. Why do reimbursable and non-reimbursable expenses matter to GCMC and how do they impact our financial wellbeing?
e. How does Medicare pay out the subsidy to GCMC and how long does it take?

Section 3: Timeline of Major Changes and Expected Timing of Financial Impact

Section 4: GCMC Expense Management Questions

a. How does GCMC et its employee wages?
b. Does GCMC spend an excessive amount on Administration wages and expenses?
c. With wages and benefits being GCMC's largest operating expense, what measures have been taken to ensure that GCMC is competitive yet financially responsible in this area?
d. Does GCMC use an excessive amount of Consultants?

SECTION 1: OVERVIEW OF PUBLIC FUNDING NEEDS AND CURRENT FINANCIAL POSITION

As part of Gove County Medical Center's (GCMC) ongoing efforts to inform Gove County Voters of the significance of the sales tax and other public funding sources on the long-term sustainability of operating GCMC, we would like to provide our community with information that not only provides supporting facts for the ongoing need of the funds but also provides an explanation of our current financial standing and the primary efforts that GCMC has made over the past two years to improve our financial standing and be responsible with our public funds.

There are four sections to this document. This section (Section 1) is the high-level overview containing answers to frequently asked questions. Sections 2 and 3 are a detailed timeline of when financial results from the changes made over the past two years will be visible (Section 3) and why the federal subsidy process is causing delays in realizing the financial gains from these changes (Section 2). Section 4 is a brief overview of the positive financial impact resulting from decisions GCMC has made to optimize its workforce over the past two years. Workforce is our number one expense, as it is for the vast majority of healthcare organizations. Healthcare employment costs have skyrocketed across the country over the past five years. We feel it is important for the community to understand what has been done to manage costs while ensuring competitive wages to our remarkable employees.

GCMC wants to thank our community members for taking the time to respectfully ask questions. Please know that we have done our best to effectively communicate complex healthcare issues. We value our community and our staff and ask that as questions arise and conversations are held in the community that care is given to respect those that have chosen to pursue their careers with GCMC. We hope that this document provides you with the answers that you need to make an informed vote on the 1-cent sales tax this upcoming November.

After all of the changes over the past year, why does GCMC still rely on the sales tax and mill levy?

Our ultimate financial goal is to continue making the necessary business decisions that improve our financial stability, allowing us to potentially reduce future reliance on public funding and continue to provide healthcare services in our county. As you will see in the information below, the decisions we have made over the last two years have only been partially recognized in the current financials. As a result, we continue to operate at a financial loss even with the public funding we receive from the sales tax and the mill levy. Until we achieve a strong financial standing, public funding reliance will remain critical to keeping our hospital open.

For county residents, why is the sales tax a good source of public funding for GCMC?

The sales tax is in part subsidized by interstate travelers. Conversely, the mill levy is fully funded by property owners in Gove County. Because the sales tax secures funding for three year periods and is not solely subsidized by residents in our county, the sales tax provides GCMC with flexibility in how we utilize the mill levy in future years as our other source of public funding.

What impact could the sales tax vote have on the future distribution of public funding sources to GCMC?

The mill levy has been evaluated annually since 2016. Each year at the time in which the mill levy is approved, the amount of funding requested is based on (1) how GCMC has performed up to that point in the year, (2) where GCMC projects our financial margins to be at the end of the year, and (3) how we are projecting GCMC to perform in the following year. The reason that the mill levy has not been reduced since it was first approved in 2016 to be capped at 16.5 mills is because the organization has not been in a financial position to do so. This is the situation that the hospital continues to find itself in today. The hospital simply cannot afford to reduce the mill levy or any public funding including the sales tax at this point in time.

GCMC's financial performance is greatly improved by the contribution of the sales tax dollars that we receive. Without the sales tax, efforts toward reducing the mill levy in future years will be far more challenging for GCMC to achieve. While continuing to receive the sales tax revenue does not guarantee that the mill levy will be reduced in 2025 or in the coming years, it does have a significant impact on the decision making process.

Why does GCMC still need both the sales tax and the mill levy?

The decision to remove any public funding to the hospital has to be made with very careful consideration to the timing of such decisions relative to the financial strength of GCMC at that time. If public funding is pulled or reduced before the hospital's recent business decisions and any future business decisions come to fruition, the future of the hospital will be put at risk. GCMC will not have a full understanding of the financial impact of all the recent changes until we have at least one additional year's worth of financial data (estimated to be August 2025). As you will see in the table below, we are not yet financially sustainable and therefore it is too early to safely reduce or eliminate any source of GCMC's public funding without significant risk to the longevity of our community healthcare facility.

How does public funding assist with the costs of charity care and bad debt write-offs?

As a community hospital, GCMC provides a certain amount of uncompensated care each year. Sometimes this uncompensated care is a result of charity care, which is a mechanism that is in place to help low-income households afford healthcare when they do not otherwise qualify for Medicaid (i.e. the gap that Medicaid expansion would otherwise fill). As a result, GCMC ends up writing off the cost of care for those that meet the thresholds required to qualify for charity care, meaning we do not get paid for all or a portion of these services. Charity care is a mechanism that helps GCMC provide healthcare to those in our community that desperately need it but may not have the financial means to afford it.

Bad debt is the other form of uncompensated care that GCMC incurs. Unfortunately, this is the result of patients that are deemed to have the financial means to pay for their healthcare services but do not pay GCMC when they receive their statements. These unpaid statements are then sent on to our collection agency with the hopes, but not the guarantee, that we will recoup the amount owed.

For both charity care and bad debt, GCMC receives zero funding for the services provided but still incurs 100% of the cost to provide those services. In 2024 alone, GCMC provided $460,000 dollars in uncompensated care to people that receive healthcare services at GCMC, the majority of which are those that reside in our county. Sales tax revenue assists GCMC in absorbing this uncompensated care so that those who need services but cannot afford them and do not qualify for insurance coverage can receive needed services (which is done through charity), and assist in limiting the devastating impact of not being paid for services by those who do not qualify for charity care but still do not pay us for the services they receive. By the end of 2024, the revenue brought in by the sales tax is estimated to be nearly completely washed out by the cost of uncompensated care. While we take pride in taking care of our entire community and will continue to do so, it would be very difficult if not impossible for GCMC to take on the full financial impact of uncompensated care without the assistance of the sales tax.

What is GCMC's current financial position through the first 6 months of 2024 with and without public funding sources compared to this time last year?

GCMC Financial Summary	6/30/2023 YTD	6/30/2024 YTD
Net Inc (Loss) From Operating	**(2,948,754)**	**(2,218,938)**
Sales Tax Revenue	699,746*	399,882*
Property Tax Mill Levy	575,000**	665,059**
Interest Income	120,818	96,806
Interest (Expense)	(15,238)	(10,706)
Contributions (Donations)	12,152	5,400
Grants	3,444	2,470
Net Income (Loss)	**(1,552,832)**	**(1,060,027)**

*On average, the sales tax brings in roughly $600,000 to $700,000 per year. The reason that 2023 is so much higher than 2024 is the result of delayed payments from the year prior (2022).

**The 16.5 mill levy has been in place since March of 2016. Each year, the hospital has requested and received the full 16.5 mills. On average, the mill levy revenue to GCMC for a full calendar year ranges between $1,100,000 and $1,350,000.

We recognize that with the significant amount of public funding that GCMC secures, we must find ways to improve our financial performance. This is why GCMC has been making such large and impactful changes over the last two years and why we strive to continue to improve our financial position moving forward. Despite the amount of funding we have received in years past, we are not yet financially viable, with or without public funding. The public funding we receive plays a critical role in bridging this gap for GCMC as we continue to improve our financial performance and begin to recognize all of the financial benefits from the changes we have made over the last two years. Our Board of Trustees, administration and staff are dedicated to improving the financial performance of GCMC. For those interested in

knowing what GCMC has done over the past two years to curb the rising cost of employment, please refer to section 4. Healthcare finances are extremely complicated for Critical Access Hospitals and are not a straightforward, month-by-month profit/loss running balance. We sincerely hope that the information in this section has answered many of the questions surrounding our hospital, our current financial position, and the continued need for public funding.

SECTION 2: COST REPORT IMPLICATIONS ON CURRENT FINANCIAL POSITION

Please explain why GCMC has not yet recognized all of the financial benefits from the closure of the Long Term Care (LTC) and the purchase of Bluestem Clinic?

To understand how and when the full financial impact of the LTC closure and the purchase of GCMC Bluestem Clinic will take place, please see the frequently asked questions below.

How is GCMC subsidized by the federal government (i.e. Medicare)?

GCMC is designated as a Critical Access Hospital by the federal government. Because the government understands that expenses of providing rural health care greatly outpace the revenues generated, Critical Access Hospitals' expenses are subsidized by the federal government to provide healthcare services in rural communities. The way we are subsidized for our expenses by the federal government is based on three factors:

(1) What percentage of our patients are covered by Medicare?

(2) How much does GCMC spend each year to provide health care services (i.e. total expenses)?

(3) Out of our total expenses, how much is considered reimbursable, and how much is non-reimbursable?

To determine how much GCMC spends each year and whether or not the expenses are attributed to reimbursable or non-reimbursable departments, the government requires that we complete a cost report at the end of each calendar year.

The government takes the percentage of Medicare patients served by GCMC and multiplies it by GCMC's total reimbursable expenses to get the total amount of GCMC's operating expenses that Medicare expects to subsidize the hospital for over the course of the next year (i.e. the federal subsidy). This federal subsidy is then paid out to GCMC at 99% of the total calculated subsidized costs.

Can GCMC provide examples of how Medicare subsidizes GCMC based on the percentage of Medicare patients that a department provides services to?

Medicare Cost Report: Medicare will reimburse 99% (101% minus 2% Sequestration) of allowable cost to provide services to Medicare patients. The cost report is where GCMC provides

the allowable cost to provide the services to Medicare patients and Medicare pays us (or we pay them) the difference in what we were paid and what we should have been paid based on the cost. We will provide an explanation of reimbursable vs. non-reimbursable expenses later in this section.

Department with 100% Medicare Patients (Simplified): Department Direct Expenses ($10,000) plus allowable Administration and General Expense ($5,000) for a total of $15,000 to run that department. That means Medicare will pay $14,850 ($15,000*.99 = $14,850). If we have only been paid $9,000 (Billed to Medicare), Medicare will write us a check for the difference ($5,850).

Department with 50% Medicare Patients (Simplified): Department Direct Expense ($10,000) plus allowable Administration and General Expense ($5,000) for a total of $15,000 to run that department. The allowable cost will be $7,500 (50% Medicare $15,000*.50 =$7,500). That means Medicare will pay $7,425 ($7,500*.99 = $7,125). If we have already been paid $9,000 (Billed to Medicare), Medicare will request a check for the difference at the end of the year ($9,000 - $7,425= $1,575 Due to Medicare). If we have not been paid $7,425, Medicare will cut us a check at the end of the year to catch us up.

Department with 0% Medicare Patients (Simplified LTC example): Long Term Care Direct Expense ($2,200,000) plus allowable Administration and General ($2,400,000) for a total of $4,600,000 to run the Long Term Care. The allowable cost on the Long Term Care is 0% as Medicare does not allow long-term care costs. That means that in addition to not being subsidized on the $2,200,000 of direct LTC expenses, GCMC also loses the $2,400,000 of Admin and General Expense that could have been allocated to other departments that Medicare will allow for reimbursement.

Why do reimbursable and non-reimbursable expenses matter to GCMC and how do they impact our financial wellbeing?

As mentioned, the federal government does not simply set their subsidy based on our total expenses – they set it on total reimbursable expenses and remove the non-reimbursable expenses from the equation, which requires Critical Access Hospitals to carefully consider which services they can afford to keep due to financial constraints. Certain departments are deemed reimbursable by the federal government (such as Nursing, Clinic, Radiology), while others are not (such as the LTC and Independent Living).

The greater number of reimbursable services we provide during a given year, the more our reimbursable costs go up and the more the federal government expects to subsidize us on our expenses. As a result, they pay us higher reimbursement rates for the following year. As an example, it does not matter if GCMC's total expenses for 2023 are $20 million, $17 million or $16 million, if our reimbursable expenses are $15 million in 2023, then the federal government provides us a subsidy to our Medicare payment rates in 2024 as a percentage of $15 million.

The greater number of non-reimbursable services we provide (such as LTC and Independent Living), the more our reimbursable costs go down and the less the federal government expects to subsidize us the next year so they pay us at lower rates for the following year. So, if our reimbursable expenses for 2023

are only $12 million as opposed to $15 million in the previous example (regardless of total expenses), then the federal government will only provide us a subsidy to our Medicare payment rates in 2024 as a percentage of the $12 million.

Each department has their separate direct operating expenses that are attributed to them on the cost report, but the cost report also requires that we allocate overhead expenses to each department. These allocated overhead expenses are costs that are necessary for operating GCMC as a whole and therefore these expenses cannot be dedicated to just one department. When these overhead expenses are allocated to reimbursable departments, the federal subsidy will cover a portion of them. When they are allocated to non-reimbursable departments, the federal subsidy will not cover them. So, when a non-reimbursable department is closed (such as the LTC), the non-reimbursed costs are redistributed across the organization into other departments, including reimbursable departments (such as Nursing, Clinic and Radiology), and are then considered to be reimbursable and subsequently subsidized by the federal government. As a result, the fewer non-reimbursable departments that GCMC operates, the greater the amount of federal subsidy we receive.

This not only highlights how financially difficult it is to provide non-reimbursable services at GCMC, but it also serves to demonstrate why the timing of the cost report has resulted in GCMC not yet realizing the full financial impact of the decisions made over the last two years.

How does Medicare pay out the subsidy to GCMC and how long does it take?

Medicare uses our cost report from the prior year to forecast an expected subsidy amount for the next year. It is not a perfect calculation from Medicare as forecasting expenses for an entire year is an imperfect science. As a result, they may project the subsidy to be too high or too low. Regardless, the expected subsidy amount from Medicare for the upcoming year is not paid out to us in one lump sum at the beginning of the year or at the end of the year. Instead, Medicare simply adjusts how much they will pay us when we bill them for each service provided to Medicare patients throughout the course of the next 12 months. In other words, they pay us our subsidy through a rate adjustment so that it is spread out through the course of the year instead of paying it all at one time.

When setting the subsidized amount (i.e. the rate adjustment) based on our previous years cost report (i.e. the cost report year), they do so based on the cost report year's reimbursable expenses. If in that cost report year they had set the expected subsidy too low and therefore underpaid us for services provided through that year, they will write us a check approximately 6-9 months after the end of that cost report year and subsequently increase our rates moving forward until the next filed cost report starts the cycle over. If in that cost report year they overpaid GCMC because they projected a higher subsidy than was required and therefore overpaid us for services provided throughout that year, GCMC will write the government a check and Medicare will subsequently reduce our payment rates for the next year until the cycle starts over. It truly is a giant game of playing catch up for both GCMC and the federal government, but that game does have financial consequences on hospitals like ours.

In summary, why has the cost reporting process and federal subsidy structure resulted in not yet recognizing all of the financial benefits from the closure of the LTC and the purchase of GCMC Bluestem Clinic?

This method of subsidy payment from the federal government means that we are always 12 months behind in being paid our correct amount from Medicare. When we are being underpaid, this creates a hardship on our cash flow and decreases our profitability on our income statement. Eventually, we do catch up when Medicare finally makes the appropriate adjustments, but it lags behind significantly (12-23 months depending on the timing of the cost report filing and the finalized rates being set by Medicare). This is the same process that causes such a significant delay in GCMC recognizing the financial benefits of removing non-reimbursable costs from our operations (such as closing the LTC) or from increasing reimbursable costs from changes in our operations (such as adding the GCMC Bluestem Clinic).

Hopefully, this explanation helps improve the understanding of the complexities of our financial situation and why the changes we make are not reflected fully for a very long period of time. To see a timeline of the core changes made over the past two years and when we expect to see the financial changes, please continue on to Section 3.

SECTION 3: TIMELINE OF MAJOR CHANGES AND EXPECTED TIMING OF FINANCIAL IMPACT

June 2023: Closure of Long Term Care

Direct LTC Operating Expenses in 2023 (January – June 2023): $1,130,000. While every department has operating expenses (and revenues), the LTC operating expenses are considered non-reimbursable unlike the majority of other departments in the hospital, earning GCMC $0 on these expenses, making it extremely difficult to continue to operate the LTC.

Indirect Operating Impact: There is $1,240,000 that was allocated to the LTC from other departments still remaining on the 2023 cost report. These dollars are still non-reimbursable at $0 today and therefore continue to negatively affect our reimbursement from Medicare. When the 2024 interim cost report is final, the $1,240,000 will then be reallocated and reimbursable. The actual financial impact cannot begin to be recognized until that time.

August 2023: County Mill Levy Budget for 2024 Submitted

The mill levy budget was submitted in August 2023 for the year 2024. The requested amount was based on a combination of current financial needs at that time and future financial projections.

December 2023: Acquisition of Bluestem Clinic

The monthly average expenses have totaled roughly $250,000, which have not yet been recognized on the Medicare Cost Report as reimbursable. As of now, these expenses (approximately $1,500,000 through the first six months of 2024) are non-reimbursable at $0 until the 2024 interim cost report is submitted in August 2024 and subsequently finalized.

In addition, and similar to the LTC, prior to purchasing the clinic, the physical clinic space itself was considered a non-reimbursable department because it was being leased. All of the costs allocated to it while it was leased were reimbursed at $0 every year that the space was leased to Bluestem Medical. Once the 2024 interim cost report is final, these allocated costs will become reimbursable because we now own and operate the GCMC Bluestem Clinic.

December 2023: Ownership of Independent Living (ILA) Transferred to Gove County

Identical to the LTC, the ILA reimburses 0% of any overhead expenses that are required to be allocated to it when owned and operated or leased out by GCMC, which is why GCMC transferred ownership of the physical building and the operations to Gove County as opposed to leasing it. In this case, $251,000 was allocated in 2023 and will continue to be on our cost report until the 2024 interim cost report is submitted in August and subsequently finalized thereafter. Following that, the $251,000 will be shifted to reimbursable departments and we will receive reimbursement as a percentage of these dollars.

April 2024: 340B Program Starts

The 340B program is a source of revenue that is only possible as a result of the purchase of the Bluestem Clinic. These dollars are dedicated to providing the financial support necessary for keeping rural health care available in Gove County. The federal government sets parameters around how soon an organization can start their 340B program following an action that qualifies the organization to participate (in this case, the purchase of GCMC Bluestem Clinic in December 2023). For us, the earliest we could start the program was April of 2024, leaving January through March out of our current year-to-date financials. Based on financial results of the program in April-June, our 340B program should generate approximately $420,000 each year for GCMC, or $35,000 per month. 2024 will only see $325,000 of 340B dollars due to the start date being in April. GCMC has only recognized $105,000 of that $325,000 with the remaining $220,000 receivable expected to be realized in the second half of 2024.

May 2024: Cost Report of 2023 Submitted

GCMC has submitted and finalized the 2023 cost report. The 2023 cost report contains direct operating expenses for each department and indirect allocated expenses of each department for operations throughout the 2023 fiscal year.

The following areas will remain on our cost report until the 2024 interim cost report is finalized and therefore will continue to decrease our payments from Medicare until that point in time.

(1) Allocated overhead expenses into non-reimbursable departments that will be re-allocated across other reimbursable departments once the 2024 interim cost report is complete:

LTC: $1,240,000

ILA: $251,000

Leased Clinic Space: $110,000

(2) Operating expenses in non-reimbursable departments that will be removed completely once the 2024 interim cost report is complete:

LTC: $1,130,000

August 2024: County Mill Levy Budget for 2025 Submitted

The mill levy budget is submitted in August 2024 for the year 2025 (January – December 2025). Please note that while the 2024 interim cost report is expected to have a significant financial impact for GCMC, the extent of that impact is still to be determined and will not be known or realized for several more months. As a result, the financial impact will not be known at the time of the mill levy approval.

August 2024: 2024 Interim Cost Report

The 2024 interim cost report will be submitted at the end of August, but will not be settled for several months. This is the most important item in the timeline for beginning to recognize the full financial impact of all the changes made over the last two years. This cost report will take the first six months of 2024 and annualize for 12 months, effectively resulting in the following: (1) removing all remaining operating expenses from departments that no longer exist (such as LTC); (2) re-allocating overhead expenses from non-reimbursable departments and physical space that no longer exist (such as LTC and ILA, respectively); (3) begin to reimburse GCMC for operating and allocated expenses generated in 2024 by new services whose expenses are not currently being reimbursed because they were not on the 2023 annual cost report (such as the GCMC Bluestem Clinic).

These three changes will result in Medicare reimbursing us a one-time lump sum payment to make up the amount they underpaid GCMC and they will adjust our rates to pay us more over the course of the next year so that they don't fall behind on payments, thereby increasing our monthly revenue and improving our financial performance.

After the 2024 interim cost report is finalized, the following expenses will become reimbursable because the previously allocated costs to these non-reimbursable departments and space will now be redistributed to other areas that are reimbursable:

Overhead previously allocated to LTC: $1,240,000

Overhead previously allocated to ILA: $251,000

Overhead previously allocated to Leased Clinic Space: $110,000

The following non-reimbursable expenses (i.e. generates $0 of reimbursable expenses) will be removed from the interim cost report:

LTC direct operating costs: $1,130,000

The following expenses are current 2024 expenses that are not actively reimbursed but will be reimbursed following the completion of the interim cost report:

GCMC Bluestem Clinic operating expenses: $1,500,000

Summary: While GCMC has made a lot of progress in reducing our financial losses, the full impact of closing the LTC and purchasing of Bluestem Medical will not reflect in the financials until sometime after August of 2024. We are required to submit a finalized budget for the mill levy in August of 2024. While GCMC would like to reduce our tax burden on the county, that will have to be evaluated for the 2026 budget. Losing the sales tax (paid in part by out of county residents) would be extremely detrimental to any effort to lower the mill levy (paid only by county residents) for the 2026 budget.

SECTION 4: GCMC EXPENSE MANAGEMENT QUESTIONS

As it relates to the renewal of the sales tax, we believe it is important that any information provided to the general public is released with a description and explanation so that there is no confusion that could potentially lead to the belief that GCMC is being irresponsible in our expenditures and use of public funding. We hope that the answers to the questions below will be helpful.

How does GCMC set its employee wages?

First and foremost, we are grateful to employ such amazing caregivers. The work they do and the miracles they perform day-in and day-out is nothing short of remarkable and we are honored to be able to pay them competitive wages. We are grateful to those that dedicate their time to providing amazing healthcare services at GCMC. At the same time, GCMC is very careful not to exceed market wages for our positions. Each year, the Kansas Hospital Association (KHA) releases percentiles and wage/salary scales for healthcare positions across the state of Kansas. KHA provides separate percentile rankings depending on type of hospital, including designated Critical Access Hospital percentiles. GCMC is a Critical Access Hospital and therefore we do use these percentiles to set our wages because they best reflect our rural market and other similarly sized facilities across the state. GCMC uses this data to make informed decisions about our pay scales for every position in the organization. We feel this is the most objective way for GCMC to set their wages.

It is important to know that not every hospital is created equal. We all provide different services, care for different populations and care for a varying numbers of patients and we all have different needs. A higher or lower dollar amount attributed to employee salaries and benefits doesn't necessarily signify unwarranted pay or excessive spending. All hospitals have different staffing needs to care for the people they serve and the services they provide in order to conduct business in an efficient manner. Our dollars attributed to salaries and benefits means one thing: these are the dollars required to pay the people we need in order to provide the healthcare services that our patients need.

Does GCMC spend an excessive amount on Administration wages and expenses?

No, but as a whole, all employee salaries and benefits combined make up the single highest expense category at GCMC (as is the case at nearly all healthcare organizations). As mentioned previously, every position at GCMC uses the most current KHA market data to set our wage scales and there are no exceptions to this, administration or otherwise. Without understanding the different employee groupings that GCMC categorizes under "Admin Salaries," it is understandable why there has been some confusion. The first thing to know is that "Admin Salaries" is actually titled "Admin and General Salaries." It is a very large grouping of employees. The category of "Admin and General Salaries" consists of wages paid out to (but not limited to) a variety of: non-clinical administrative assistants, managers, directors and executives, human resources, marketing and other non-clinical support positions, all clinic and hospital business office, registration, billing and health information positions, among others. These positions make up a large portion of our workforce and contribute to a large part of GCMC's total wages and salaries.

The second thing to note is that every hospital has flexibility in how they recognize different positions across different salary categories on the cost report. GCMC chooses to put quite a few positions in this category where other hospitals may not. While we report these salaries in this manner on our cost report, we cannot speak to whether or not these categories are reported exactly the same by our competitors. The same can be said about how organizations may choose to report or not report their nursing admin salaries as well. At GCMC, we report each non-direct patient care nursing position in the category of "Nursing Admin Salaries" as opposed to separating them into other nursing categories or departments. This category is inclusive of many non-direct patient care nursing positions required to operate our hospital, including but not limited to: all nursing manager, director and executive positions, quality, infection control, pharmacy, utilization review and discharge planning, among others. Other organizations may choose to report many of these positions in other salary categories where GCMC has chosen to group them into this category.

There is a category on our cost report that is listed as "Admin & General Other", which is solely dedicated to business and supply expenses i.e. insurance, malpractice, internet services, business office equipment, etc. This category is not tied to salaries, wages or benefits.

GCMC provides a wide variety of healthcare services. These services require that we staff our departments with the appropriate number of qualified personnel. Understaffing often results in decreased quality of care and increased patient safety concerns. GCMC has evaluated our staffing models and has determined that our departments are currently staffed appropriately for the services we provide and the patient volumes that we see. The next question, supports the statement that current GCMC administration has been very diligent over the last three years in determining areas that may be overstaffed and made many necessary changes in order to be responsible stewards of our operating and public funding.

With wages and benefits being GCMC's largest operating expense, what measures have been taken to ensure that GCMC is competitive yet financially responsible in this area?

Over the last three years, GCMC has chosen to consolidate many positions as we have evaluated the true staffing needs of each department. We have adjusted many department staffing models and have been able to reduce our wages and benefits by an annual reoccurring amount of $847,175. Please keep in mind that this reduction in salaries and benefits is a year-over-year savings. You can see the breakout of these savings by department in the table below:

Expenses Saved		
Position	***Total reduction in staffed positions (full time and part time)***	***Total Annual Savings***
Dietary	**3.00**	**$ 166,697.62**
Housekeeping	**4.00**	**$ 148,599.36**
Transportation Van	**0.25**	**$ 21,607.56**
Accounts Representative	**1.00**	**$ 43,788.65**
Accounts Payable	**1.00**	**$ 44,310.24**
Risk/Quality Manager	**1.00**	**$ 95,752.80**
IT - Facilities Director	**1.00**	**$ 24,063.16**
Human Resources Department	**1.00**	**$ 113,022.00**
Administrative Assistant	**1.00**	**$ 57,564.00**
Laboratory Department	**1.05**	**$ 18,753.12**
Respiratory Department	**1.75**	**$ 113,017.25**
TOTAL	**16.05**	**$ 847,175.76**

Does GCMC use an excessive amount of Consultants?

It is important to understand the difference between consultants and contract fees. Consultants are routinely advisory in nature. Contract fees include companies and individuals that provide services to GCMC for patient care and revenue generating services. In 2023, we categorized $513,000 in consultant fees. Only $8000 of that amount was for true consultant fees, the remaining amount was for contract fees.

In closing, we want to reassure the residents of Gove County that GCMC is committed to spend responsibly and be good stewards of the dollars we earn through operations and the dollars provided to us by tax payers. We are hopeful that we have been able to successfully demonstrate how complex our environment is and that we have made amazing strides in the areas of revenue and expenses. We hope that we have answered the majority of questions surrounding our current financial position and as to why the sales tax is still so vital to our financial security for the time being. We want to sincerely thank you for all of your support and look forward to continue providing the right care, at the right time, in the right setting – close to home.

Your 1¢ tax

Keeping your care
CLOSE TO HOME

In consideration of the Special Question for Gove County Medial Center on the November 5th, 2024 election.

In 2015, Gove County residents committed to a 1% sales for the benefit of your local hospital. In 2020, Gove County residents recommitted to the 1% sales tax. For your community and hospital we respectfully as that you **VOTE** on November 5th, 2024 for the **CONTINUATION** of the current tax rate. There will be no increase and your tax will

NOT GO UP!

This tax represents 1¢ per every $1 spent in Gove County. These funds are used to assist the hospital in providing essential healthcare services. Without the generous support of the community, Gove County Medical Center would face additional financial challenges in continuing to provide quality healthcare.

A **YES** vote will continue to ensure the community the right care, at the right time, in the right setting - close to home and a continued sustainable hospital for

WHAT IT IS

- It **IS** a continuation of the 2015 county-wide sales tax.
- It **IS** funded in large part by non-Gove County residents by way of **I-70 travelers**.
- It **IS** a 1% sales tax that ensures the hospital will continue to meet the funding requirements for operations, maintenance, upgrading the facility, required technology, and employee retention.
- It **IS** the funding that commits the necessary dollars to preserve the OB program in Gove County.
- It **IS** an investment into the conservation of healthcare in Gove County.

WHAT IT IS NOT

- It is **NOT** solely paid by Gove County Residents.
- It is **NOT** a new increase to your taxes

WHY IS PUBLIC FUNDING IMPORTANT?

- National studies show Kansas is the **2nd** most vulnerable state for rural hospital closures at 56% (57 rural hospitals including GCMC).
- In 2023, **73%** of Kansas hospitals operated at a loss (including GCMC), with more than a **35%** increase in expenses over the past 3 years.
- GCMC contributes **$12.6 MILLION IN EARNED WAGES** for Gove County residents. Financial stability of GCMC directly affects the financial stability of many households in our county.

Gove County Medical Center
Committed to Others. Always.