



CRITICAL ACCESS HOSPITAL  
**GOLD STANDARD**  
PERFORMANCE SUMMARY

A LarsonAllen Gold Standard series of articles and research  
*2004 / 2005 report based on 2003 data*



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# ACKNOWLEDGEMENTS

LarsonAllen would like to express our appreciation to the CEOs, CFOs, and administrators of the Gold Standard Critical Access Hospitals (CAHs) for sharing their insights with us. We would also like to thank the Flex Monitoring staff at the University of Minnesota and the Federal Office of Rural Health. With their assistance, we were able to share perspectives beyond the numbers. Their insights were crucial to our findings, which we believe, will be valuable to the rural hospital community.

An electronic copy of this report is available at:  
[www.larsonallen.com/healthcare/cahgs.asp](http://www.larsonallen.com/healthcare/cahgs.asp)



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*“CAH designation is not a panacea.  
Creative strategy and performance-driven  
cultures make all the difference.”*

Matt Claeys, CPA, Principal, LarsonAllen

# INTRODUCTION

LarsonAllen (Larson, Allen, Weishair & Co., LLP), a certified public accounting, consulting, and advisory firm, has conducted an extensive review of the performance of the nation's Critical Access Hospitals (CAHs). Today over 1,000 hospitals are designated as CAHs, however, each takes advantage of the CAH designation in different ways, and the performance of these hospitals varies greatly. At the request of our clients, this report was developed to offer insights into the success of top performing CAHs.

## Methodology

This report examines public (Medicare Cost Report), financial, and service (MedPar) data for CAH hospitals from 2002 and 2003, which included information on over 750 CAHs, and highlights the financial and operational performance of 634 of them. The top 35 CAHs are identified by LarsonAllen as "Gold Standard Performers," based on their ability to achieve significantly above average financial performance.

This report specifically analyzes multiple financial and operational indicators such as profitability, cash and net asset position, utilization, staffing, cost performance, overall pricing, revenue and cost relationships, and non-Medicare discount rates. When studying these indicators, we evaluated several groups, including the median performance of all CAHs, large CAH hospitals (>\$11M net patient revenues), midsized hospitals (>\$5.5M and < \$11M net patient revenues), and small CAH hospitals (<\$5.5M net patient revenues).

To gain a better understanding of the meaning behind the data, we also interviewed select leaders of the Gold Standard Performers to explore a wide variety of topics, including:

- System affiliation
- Medical staff composition, working relationships, recruitment plans, and competition
- Array of programs and services offered and those being planned for both Medicare and non-Medicare
- Accreditation status
- Market service areas including demographics trends and competitor analysis
- Managed care and third party contracting strategies including the level of current volumes and anticipated changes
- Pricing methodologies and strategies
- Current and planned capital investments in facilities, both in technology and renovations/replacements of buildings
- Employee retention and recruitment strategies

## Implications

Many of the leaders of the 35 Gold Standard Performers have found practical strategies to leverage community support, create value from their physician relationships, generate sufficient revenues through assertive pricing and negotiations with non-Medicare payers, support and grow procedural and ancillary services, and effectively manage cost structures. CAH leaders, policy makers, and others in the industry can learn much from the Gold Standard Performers that could be applied to CAH organizations as well as other health care organizations. This report may help to answer some of the following questions:

- How do these top performers make a margin with so much of their revenue based on Medicare costs?
- How do Gold Standard Performers leverage the financial stability of strong CAH revenues to attract higher intensity clinical services and specialist physicians?
- How should CAH leaders enhance their roles in business planning to best balance the needs to operate physician clinics, skilled nursing facilities, swing-beds, ambulatory surgery, provide ER coverage, and make facility investments?
- How do the Gold Standard CAHs develop cultures with loyal employees that enthusiastically drive toward Gold Standard quality, safety, and financial results?

*Our common call to action is to enhance the performance of all CAHs. Exploring these questions and applying what we have learned through the experience of Gold Standard Performers is a step toward answering that call.*



## EXECUTIVE SUMMARY

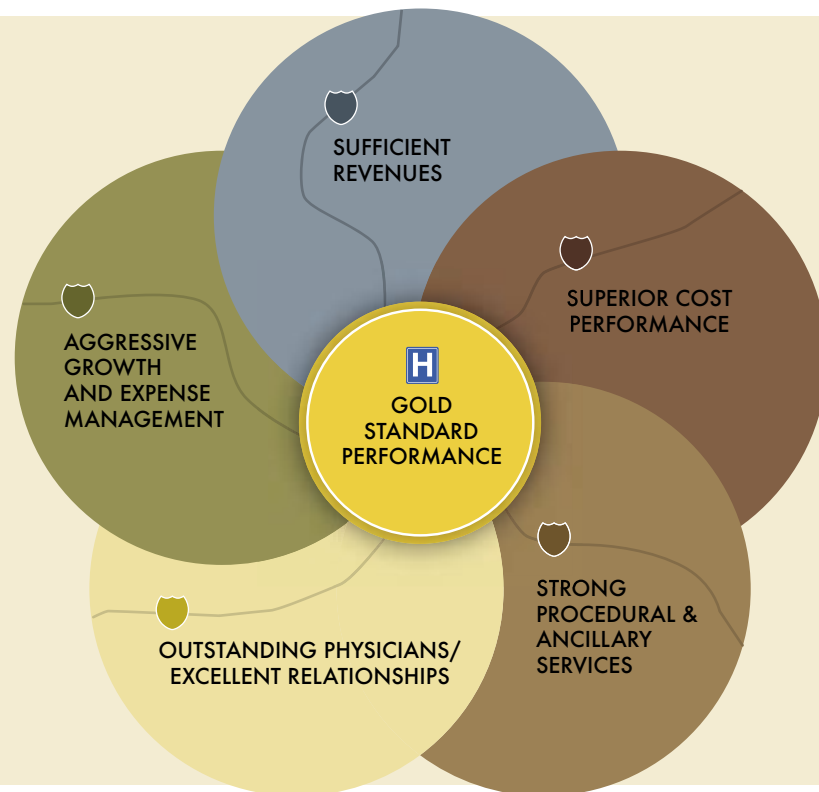
Critical Access Hospitals (CAHs) are small health care organizations, most often located in rural communities with a limited employment and economic base. Because of these limitations, many CAHs are financially fragile. Their managers, boards, and other community leaders have become interested in monitoring and improving the financial and operational performance of their CAH. LarsonAllen's *Critical Access Hospital Gold Standard Performance Summary* explores the key findings of this study and serves as a call to action. If CAHs are to remain financially viable, they must do the following:

- Build community confidence in their programs.
- Serve their communities collaboratively in order to meet the community needs and improve the quality of care provided.
- Provide a wide array of clinical services, recruit and retain physicians and other clinical staff, and garner community support and enthusiasm for their programs.
- Actively advocate for “rural smart” health policy initiatives that benefit the smallest Critical Access Hospitals. Without concerted effort and cooperation with community and state leaders the performance of small CAHs will continue to decline.
- Focus on their internal performance, actively assessing how they compare to similar facilities or Gold Standard Performers.
- Understand the value of strategic initiatives such as expanding service depth, investing in technology and facilities, and continued physician recruitment.
- Aggressively pursue improvements in the operational performance of the hospital, ER, affiliated medical practices, and nursing care facilities.

*“Focus on serving the needs of the community, and work with all stakeholders in the community to meet those needs.”*

CEO, Gold Standard Performer

## THE GOLD STANDARD ROAD MAP



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### The Road Map to Gold Standard Performance

Through the process of gathering and analyzing the data for this report LarsonAllen found that Gold Standard Performers tended to follow a similar road map to improved performance that included the following elements:

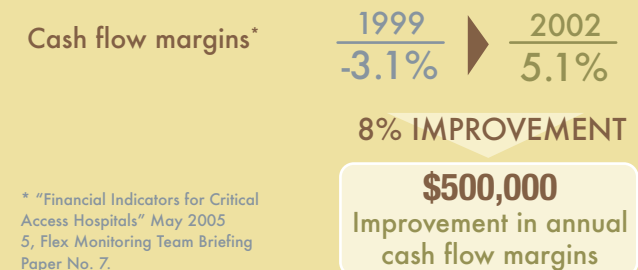
- Pricing that provides for financial success.
- Greater revenues from non-Medicare payers.
- Superior cost performance.
- Strong procedural and ancillary services.
- Outstanding physicians and excellent relationships with their medical staff and community.
- Initiatives to aggressively grow revenues and manage costs.



## The “Value” of CAH Status

In its May 2005 Briefing Paper No. 7, the Flex Monitoring Team presented the historical performance of CAHs from 1998 through 2003. The difference in cash flow margins of CAHs between 1998 and 2002 is particularly noteworthy. While the difference in cash flow margins between 1999 and 2002 could be explained by a variety of factors beyond conversion to CAH status, we believe that the number provides important insights into the “value” of CAH status. In assisting hospitals during the conversion process to CAH status, we found that CAH status provided a “typical” net revenue benefit of between 3 percent and 10 percent of net patient revenues. Translating an 8 percent difference in cash flow margins, on the Median CAH operating revenues in 2002 of approximately \$7.0 million, would result in an improvement of about \$500,000 in the annual operating margins for the “typical” CAH.

### ESTIMATING THE “VALUE” OF CAH STATUS



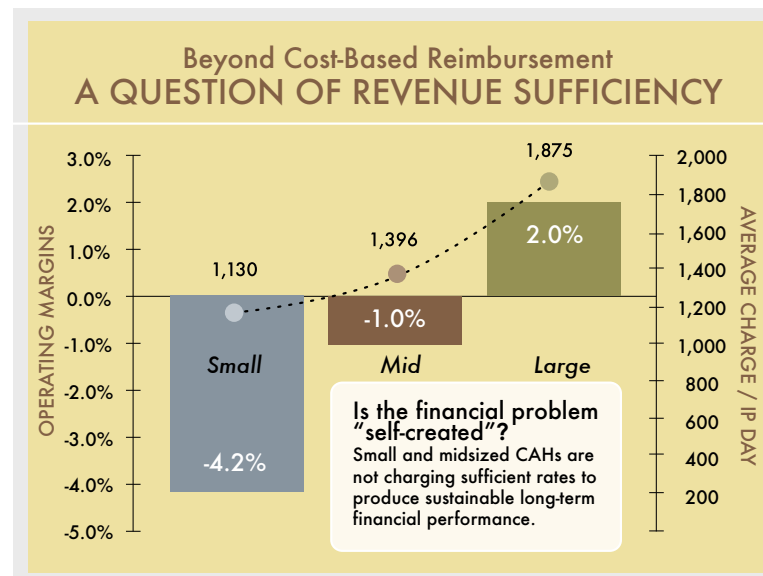
# INSIGHTS INTO INDUSTRY PERFORMANCE (continued)

## Current CAH Financial and Operating Performance

The table at the right depicts the median financial performance metrics based on YE 2003 performance for 634 CAHs, as well as the various size-based subgroups analyzed.

### Financial Insights:

- In terms of overall financial performance and strength, the median CAH, in general and in all size subgroups, lags behind the median U.S. hospital in several key areas, including:
  - Operating margins (-0.8 percent CAH vs. 1.6 percent U.S.<sup>2</sup>)
  - Days cash (62 days CAH vs. 80 days U.S.<sup>2</sup>)
  - Age of plant (11.5 years CAH vs. 9.8 years U.S.<sup>2</sup>)
- CAHs tend to rely on significant non-operating revenue sources to maintain profitability, including tax levies and contributions.
- In terms of size, large CAHs have significantly better financial performance and less aged facilities and equipment than small and midsized CAHs.
- The long-term viability of many small hospitals may be in jeopardy. Even with the infusion of additional revenues through the CAH program, small hospitals do not enjoy sufficient operating performance (break even margins, insufficient debt service coverage) and cash reserves (days cash) to fund much needed capital investment and regeneration (13 years average age of plant).
- A closer examination of the underlying revenue metrics of CAHs indicates that global charges (as measured by average inpatient charges per day) have a strong correlation to overall margin performance. Given the fact that many CAHs non-Medicare revenues are derived directly from global charges, this raises the question of whether the apparently conservative pricing policies of small and midsized CAHs produce sufficient revenues to maintain long-term viability.



## MEDIAN CAH FINANCIAL PERFORMANCE METRICS

	All	Small	Mid	Large
<b>Revenue indicators:</b>				
Operating revenues (\$ in thousands)	\$7,603	\$3,885	\$7,777	\$15,702
<b>Profitability indicators</b>				
Operating EBIDA margin	4.4%	-0.7%	4.6%	8.3%
Operating margin	-0.8%	-4.2%	-1.0%	2.0%
Total margin	2.4%	0.1%	2.4%	3.7%
Debt service coverage <sup>1</sup>	2.18x	-0.19x	2.02x	3.87x
<b>Liquidity indicators:</b>				
Net days in accounts receivable	59	57	59	60
Days cash on hand (all sources)	62	45	67	60
Cushion ratio <sup>1</sup>	7.1x	7.9x	6.7x	6.0x
Cash to debt	70%	100%	67%	71%
<b>Capital &amp; leverage indicators</b>				
Average age of plant	11.5	13.0	11.3	9.3
Debt to capitalization*	30%	23%	27%	30%
Facilities without long-term debt	87 (14%)	26(26%)	28 (11%)	7(7%)

\* for facilities with long-term debt



## CAH Status: A License to Spend?

Our experience with many CAHs suggests a general trend toward “investment” in staff, facilities, equipment, etc. following conversion. While in many cases these investments were considered necessary after years of deferral due to insufficient performance, this global “investment” appears to have had significant negative consequences on the long-term financial health of CAHs. Between 2002 and 2003, operating revenues showed a strong 9 percent increase; however, operating expenses increased by 12 percent, resulting in a decline in overall CAH margins by 28 percent. Clearly, this cost inflation trend is not sustainable.

## YE 2003 VS. 2002 MEDIAN FINANCIAL PERFORMANCE OF CRITICAL ACCESS HOSPITALS\*

(\$ in thousands)	2003	2002	% Change	
<b>Revenues &amp; expenses:</b>				
Operating revenues	\$7,734	\$7,100	8.9%	◀ Strong revenue growth
Operating expenses	\$7,868	\$7,028	12.0%	◀ Expense growth significantly exceeded revenue growth
<b>Key financial metrics profitability:</b>				
Operating margin %	0.0%	0.6%	-106.2%	} Significant margin erosion (expenses)
Excess margin %	2.5%	3.5%	-28.1%	
<b>Liquidity &amp; leverage:</b>				
Days cash (all sources)	67	63	7.6%	} Cash position stable
Cash to debt	79%	80%	-1.3%	
Debt to total cap	27%	26%	4.1%	
<b>Other:</b>				
Average age of plant	11.2	11.3	-1.4%	◀ Limited capital investment

\*Includes only facilities that were CAH for all of 2002 and 2003.

# INSIGHTS INTO INDUSTRY PERFORMANCE (continued)

## Operational Insights:

- Outpatient revenues drive the revenue streams and business volumes at CAHs. Inpatient revenues represent only 34 percent to 41 percent of a CAH's revenue base.
- Overall Medicare cost-based utilization (i.e. how much cost-based reimbursement per dollar of overall expense,) ranges from 31 percent to 42 percent, with small hospitals being the most dependent on CAH reimbursement.
- In terms of overall utilization, inpatient Medicare utilization at 72 percent to 84 percent is a poor proxy of cost-based reimbursement potential at a CAH. A better proxy is Medicare outpatient utilization, which ranges from 34 percent to 40 percent.
- Cost performance trends indicate that larger facilities, not unexpectedly, have lower overall cost profiles.
- From a pricing standpoint, larger CAHs tend to charge higher rates both in absolute terms (charges per day) as well as relative terms (overall Medicare cost to charge ratio is lower). While a portion of this charge differential relates to intensity and types of services offered, we believe it also reflects an overly conservative pricing philosophy in many smaller CAHs.
- Significant resources are expended by CAHs to provide 24-hour emergency services, with the Median CAH spending \$400,000+ annually.
- Larger CAHs tend to have more robust procedural and ancillary services.
- CAHs appear to have significant levels of contractual adjustments beyond just those derived through Medicare.

## MEDIAN CAH OPERATING AND COST-PERFORMANCE METRICS

	All	Small	Mid	Large
<b>Utilization indicators:</b>				
Medicare cost based utilization	33%	42%	34%	31%
Medicare utilization IP days (acute+swing)	77%	84%	78%	72%
Medicare acute days	742	430	731	1,437
Overall inpatient revenue % of total revenue	36%	41%	36%	34%
Medicare OP utilization %	37%	40%	37%	34%
Adjusted days	5,160	3,008	5,371	9,213
<b>Staffing and cost indicators:</b>				
FTEs per AOB	6.62	5.72	6.36	6.53
Acute FTEs	88	46	87	145
<b>Selected costs per day</b>				
Routine nursing per day (all days)	\$393	\$449	\$394	\$356
Routine costs per day (fully allocated)	\$731	\$773	\$741	\$711
Surgery cost per adjusted day	\$34	\$9	\$33	\$73
Emergency growth per adjusted day	\$86	\$49	\$84	\$113
Medicare ancillary costs per day	\$565	\$460	\$558	\$672
Medicare surgery costs PPD	\$37	\$3	\$34	\$107
Medicare ER costs PPD	\$68	\$39	\$64	\$102
Other ancillary cost PPD	\$460	\$418	\$459	\$467
Swing bed ancillary cost per day	\$213	\$182	\$217	\$238
<b>Charge and discount information:</b>				
Overall medicare CCR	74%	89%	76%	62%
Inpatient charges per day	\$1,435	\$1,130	\$1,396	\$1,875
CAH cost based discount %	26%	11%	24%	38%
Non-CAH cost based discount%	26%	27%	24%	28%
<b>Provider based entity information:</b>				
% of facilities with provider based SNFs	26%	20%	24%	36%
% of facilities with provider based clinics	53%	59%	49%	64%

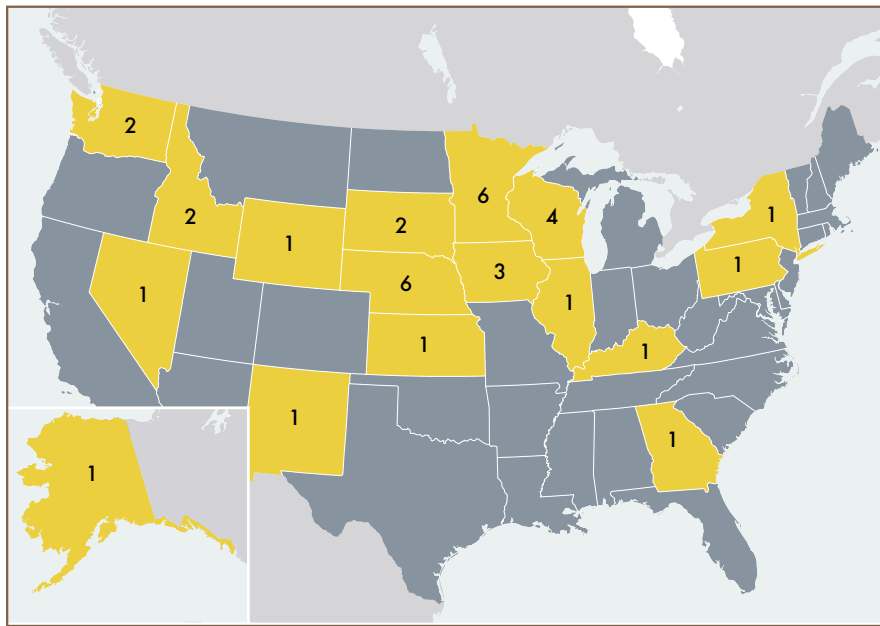


# INSIGHTS INTO GOLD STANDARD PERFORMANCE

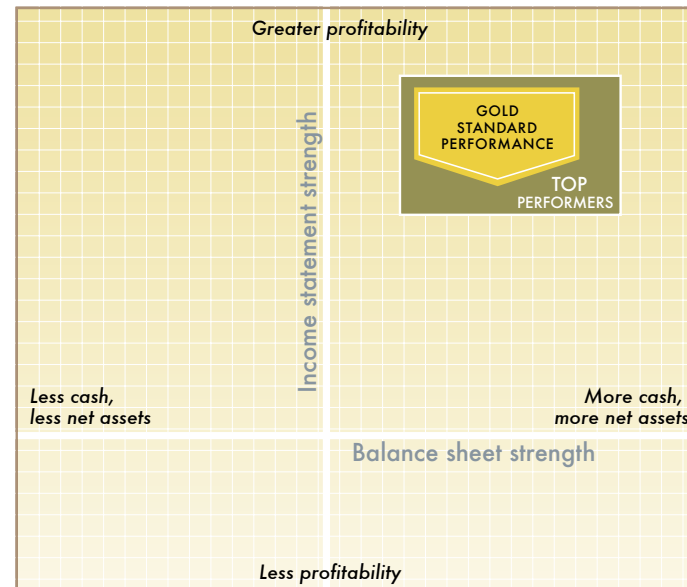
Gold standard performance is synonymous with success. A CAH is judged by LarsonAllen to achieve “Gold Standard Performance” when it generates top quartile financial performance. Top quartile financial performance would characteristically have strong current financial performance as well as strong balance sheets and robust cash reserves. (See the section “Measuring Financial Strength of CAHs” on page 17 for additional discussion on LarsonAllen’s process and methodology for assessing and ranking CAH financial strength.)

From top quartile performing CAHs, the performance of 58 facilities of all sizes and geographies were analyzed to gain insights into top performance. Finally, within these 58 top performing CAHs, 35 facilities were selected by LarsonAllen as Gold Standard Performers. These Gold Standard Performers included eight small, 14 mid-sized and 13 large CAHs from 17 different states.

## WHERE ARE THE GOLD STANDARD PERFORMERS?



## CAPTURING TOP PERFORMERS



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# INSIGHTS INTO GOLD STANDARD PERFORMANCE (continued)

## Gold Standard Financial Performance Highlights

An analysis and comparison of Gold Standard financial performance to median CAH performance reveals the vast difference in financial performance and strength. Key financial performance characteristics of Gold Standard Performers include:

- 1) Four times as much operating EBIDA as the median CAH. The Median CAH would have \$600,000–\$800,000 more profitability if it could achieve Gold Standard Performance.
- 2) Twice the cash reserve strength of the median CAH. The median CAH would have approximately \$1.7 million more cash if it could achieve Gold Standard Performance.
- 3) Newer plant assets.
- 4) Lower relative debt levels and less apparent reliance on long-term debt than the median CAH. Part of this could be due to their stronger financial performance and greater cash reserves.

## FINANCIAL PERFORMANCE METRICS

	Median CAH		Gold Standard Performer
<b>Profitability indicators:</b>			
Operating EBIDA margin	4.4%	<b>4x Profitability</b>	15.4%
Operating margin	-0.8%		9.4%
Total margin	2.4%		10.4%
<b>Liquidity indicators:</b>			
Days cash on hand	62	<b>2x Cash position</b>	146
Cash to debt	70%		124%
<b>Capital and leverage indicators:</b>			
Average age of plant	11.5	<b>Newer plant, lower debt</b>	9.8
Debt to capitalization*	30%		23%
Facilities without long-term debt	87 (14%)		16 (46%)

\* for facilities with long-term debt



## Gold Standard Operating Performance Highlights

A comparison of Gold Standard operating and cost performance to median CAH performance reveals a number of significant differences. Key operating and cost performance characteristics of Gold Standard Performers include:

- 1) Significantly better cost-based utilization than the median CAH. While some of this is due to lower levels of non cost-based services, this also suggests that Gold Standard Performers do a better job at optimizing cost-based reimbursement.
- 2) Higher global charge levels and significantly higher revenues from non-Medicare payers. The median CAH would have \$500,000 to \$750,000 (6–9 percent) more revenues from non-Medicare payers if it could achieve Gold Standard Performance.
- 3) Lower relative staffing levels. The median CAH would have 4–5 less FTEs (2–4 percent) if it could achieve Gold Standard Performance.
- 4) Substantially less costs to provide 24-hour emergency room services. The median CAH would have \$150,000 (35 percent) less emergency room costs if it could achieve Gold Standard Performance.
- 5) Less support and administrative costs. The median CAH would have \$140,000 (6 percent) less support and administrative costs if it could achieve Gold Standard Performance.
- 6) Greater levels of surgical (procedural) services.

## OPERATIONAL AND COST METRICS

	Median CAH	Gold Standard Performers
<b>Utilization indicators:</b>		
Medicare cost-based utilization	33%	40%
Medicare inpatient %	77%	76%
Medicare outpatient %	37%	40%
<b>Charge and discount information:</b>		
Average charge per inpatient day	\$1,435	\$1,586
Overall markup %	135%	143%
Non-CAH based realization %	74%	80%
<b>Staffing and cost indicators:</b>		
FTEs per adjusted occupied bed	6.62	6.36
Overall cost per adjusted day		
Acute nursing	\$138	\$132
Surgery	\$34	\$54
Emergency room	\$86	\$56
All other ancillaries	\$293	\$298
Support and administration*	\$463	\$436
Capital expense	\$70	\$72
All other services and costs	\$402	\$311
Medicare inpatient ancillary cost per day		
Surgery	\$37	\$86
Emergency room	\$68	\$50
All other ancillaries	\$460	\$508

\*including employee benefits

## Gold Standard Performance Beyond the Numbers

Beyond analyzing their financial, operating and cost performance characteristics, LarsonAllen also evaluated market and demographic data and interviewed a number of CEOs, CFOs, and administrators from select Gold Standard Performers to gain insights into their success that go beyond the numbers.

The ability to demonstrate solid financial performance seems more the result of outstanding physicians, excellent relationships between physicians, hospital, and community, and above average board and CEO leadership than the markets in which the Gold Standard CAHs operate. An assessment of Gold Standard Performers' market characteristics suggests that they face virtually the same market struggles as most other CAHs, including a limited and declining service area population, older and aging demographics, shrinking rural economies, limited economies of scale, and challenges in recruiting physician and allied health staff. Several common and important themes emerged from interviews with leaders of Gold Standard CAHs:

*continued on page 12*

### MARKET CHARACTERISTICS OF THE TYPICAL GOLD STANDARD CAH



Median population of home county  
**12,000** (7,100–16,700)

% change in median population  
of home county  
**-2.0%** (-4.0%–1.4%)

Age 65+ % of home county population  
**18.1%** (14.8%–20.5%)  
*National average= 14%*



*“We believe our commitment to our physicians, our patients, and our employees makes this a better community and a better place to live. We are proud of all we are able to achieve on behalf of our community.”*

CEO, Gold Standard Performer



*continued from page 11*

- 1) **Relationship with local medical staff:** An excellent medical staff and solid working relationships, including a strong physician role in the leadership and direction of the organization, was mentioned by all interviewees. Physicians were key members of the leadership team.
- 2) **Quality:** Many of the Gold Standard Performers mentioned quality as a key to their past, current, and future success. While recognizing the limitations in the array of services they could provide, most Gold Standard Performers indicated that the services they do (and should) provide to their communities were expected to meet or, in most cases, exceed the quality of surrounding health care providers.
- 3) **Innovation:** Many of the Gold Standard Performers talked about innovation—not in the sense of “ground-breaking” or “life-changing”—but in the sense of creatively and effectively responding to the needs of the communities that they served. Examples of innovative programs included:
  - Specialty clinics resulting in high ambulatory and inpatient surgery volumes, such as ENT, orthopedics, urology, etc.
  - Physician outreach clinics in near-by communities provided by the medical staff of the CAH.
  - Participation in networks that resulted in mobile technology, telemedicine, and partial ownership and management of managed care programs offered to the community.
- 4) **Committed and engaged employees:** Many Gold Standard Performers mentioned their commitment to providing a great work environment. Most of those interviewed also commented on their ability to recruit staff from a broad region around their facilities and their commitment to clinical training and continuing education for staff. Senior management from Gold Standard Performance organizations believe that these factors result in significantly lower staff turnover and higher clinical capabilities in staff.
- 5) **Community:** The rural leaders and Gold Standard Performers we talked with identified a number of other agencies and businesses that they work closely with to meet a broader range of community needs. These organizations take on larger roles in caring for some of the more vulnerable and frail community members both because the staffs have the capabilities, but also because of a sense of community and community pride. These additional services may include elaborative care coordination programs, community education services, and services as diverse as diaper services, day care services for both adults and children, and other services for those with developmental or physical disabilities. While some of these services diminished the Medicare reimbursement, hospital administrators believed these were activities that built community loyalty and confidence.

# A ROAD MAP TO GOLD STANDARD PERFORMANCE

From the intensive data analysis and results of interviews with select leaders of Gold Standard Performers, we believe six key areas emerge which provide a road map to Gold Standard performance.

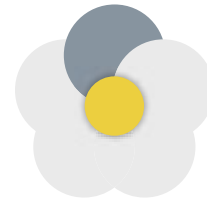


## Gold Standard Performers price for success.

In comparing the overall pricing across CAH facilities, the average Medicare inpatient charge per day was used as a proxy to compare overall charge structures. The analysis suggested that Gold Standard Performers overall charges are 11 percent higher than the median CAH.

This difference is particularly noteworthy as our experience suggests that many CAHs, particularly small CAHs, derive significant amounts of net revenues from non-Medicare sources based on a percentage of customary charges.

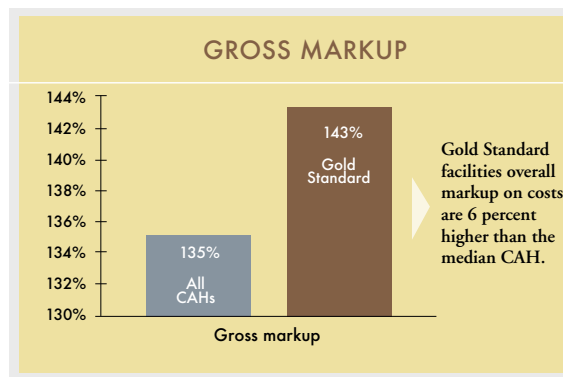
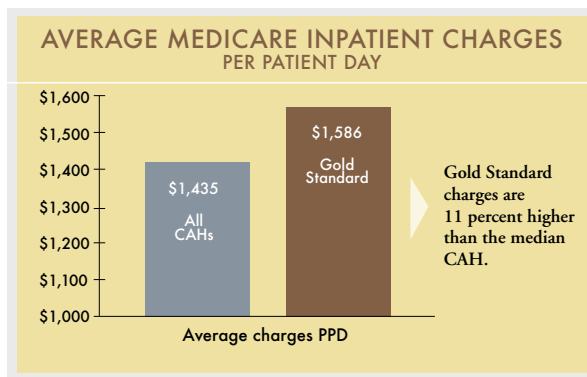
To further understand and evaluate comprehensive pricing across CAHs, we analyzed overall charges to costs (referred to as gross markup). This ratio compares a CAH's overall charge structure to its cost structure and can be useful in evaluating comparative margin potential across CAHs. The analysis suggested that Gold Standard Performers overall gross markups are 6 percent higher than the Median CAH. When coupled with the fact that CAHs derive significant amounts of non-Medicare revenues based on their overall charges, Gold Standard Performers by design are building in larger margins than Median CAHs. We believe this philosophy of "pricing for success" is a significant contributor to the financial health of Gold Standard Performers.



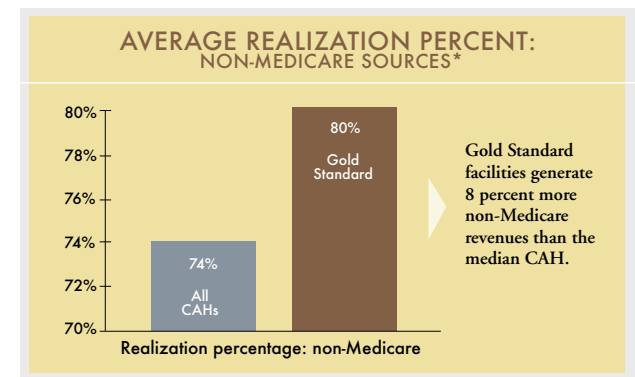
## Gold Standard Performers generate more revenues from non-Medicare payers.

In order to analyze the overall non-Medicare net revenue levels across CAH facilities, we compared net revenues from non-Medicare sources to gross charges to non-Medicare sources. The analysis revealed that Gold Standard Performers overall non-

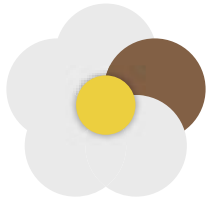
Medicare realization percentages are 8 percent higher than the median CAH. When combined with an 11 percent higher overall charge structure, Gold Standard Performers enjoy a 19 percent overall net revenue advantage from its non-Medicare payers. Considering that a typical CAH receives 60–65 percent of its net revenues from non-Medicare (and non-cost-based) sources, we believe this non-Medicare net revenue differential is a significant contributor to the financial health of Gold Standard Performers.



\*Based on 1 divided by the overall cost to charge ratio



\*Based on net patient revenues less Medicare cost-based reimbursement  
Gross patient revenues less Medicare revenues



## Gold Standard Performers have superior cost performance.

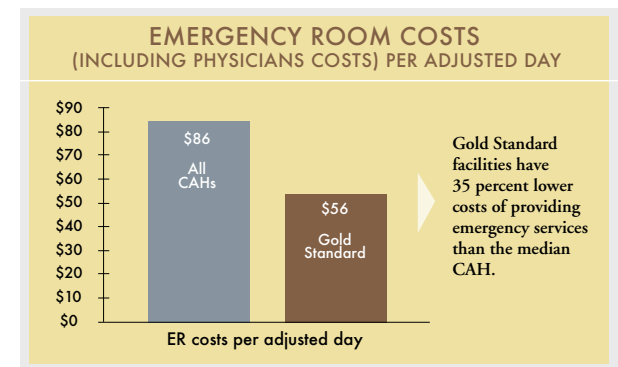
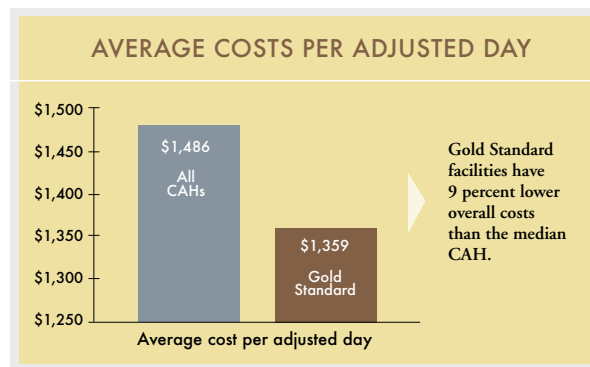
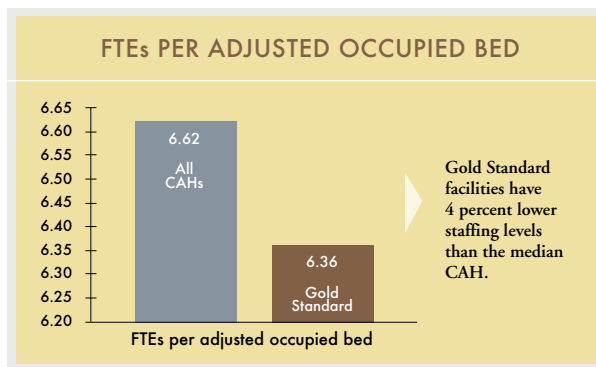
We evaluated the following indicators in order to understand the cost performance of CAHs:

- Staffing
- Overall costs
- Routine nursing costs
- Ancillary costs
- Emergency service expenses

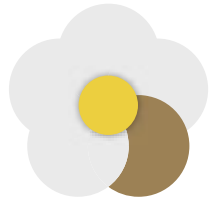
In all cost comparisons, Gold Standard Performers outperformed the median CAH.

- Gold Standard Performers have 4 percent lower overall staffing levels.
- Gold Standard Performers have lower overall costs per adjusted day, including:
  - 9 percent less overall costs
  - 6 percent less direct acute nursing costs
  - 6 percent less overhead and supports costs
  - 23 percent less costs related to non-CAH programs and services
- Gold Standard Performers have 35 percent less cost in providing 24-hour emergency services.

The cumulative impact of lower cost performance is a significant contributor to the financial health of Gold Standard Performers.



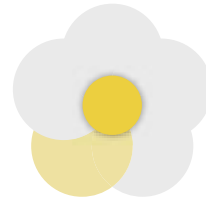
# A ROAD MAP TO GOLD STANDARD PERFORMANCE (continued)



## Gold Standard Performers have strong procedural and ancillary services.

In evaluating the cost performance metrics of CAHs, we noted that Gold Standard Performers had significantly higher procedural (surgery) and ancillary costs than the median CAH. We believe this difference in costs is a result of greater procedural and ancillary utilization and depth at Gold Standard Performers. Specifically, Gold Standard Performers provided significantly more overall procedural services to patients, particularly Medicare inpatients. This higher-than-average cost of inpatient Medicare services is indicative of a stronger local surgery program than a typical CAH.

We believe this stronger procedural and ancillary service profile and its related impacts contribute significantly to the financial health of Gold Standard Performers.



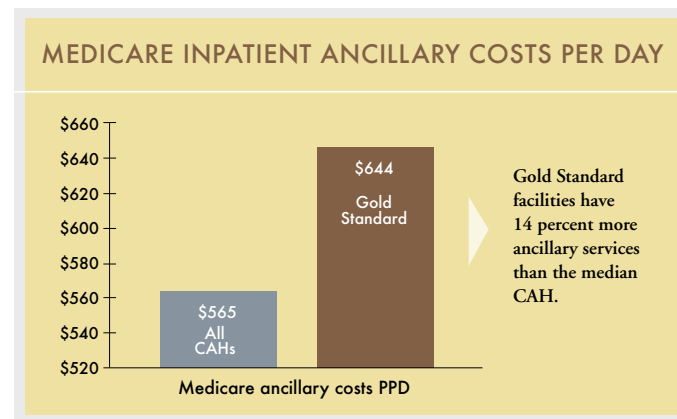
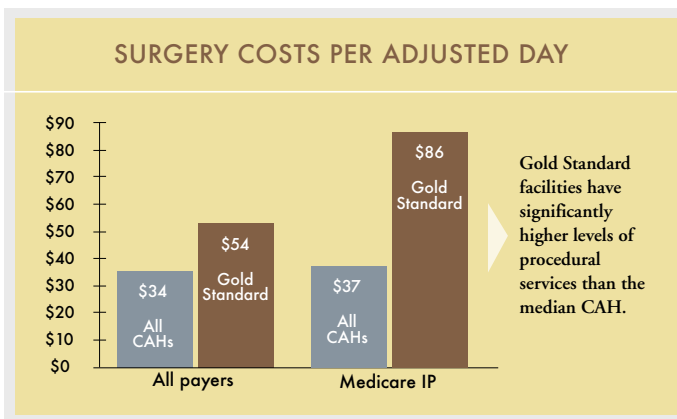
## Gold Standard Performers have outstanding physicians and excellent relationships with their medical staff and community.

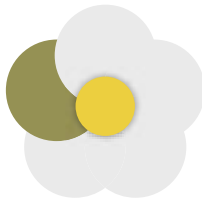
During the interviews with select leaders of Gold Standard Performers, they stressed two common themes: 1) the importance of outstanding local physicians, and 2) the value of developing excellent relationships with these physicians and with their communities.

Gold Standard leaders often described their physicians as excellent. Gold Standard Performers tended to include their physicians as an integral part of the leadership team, who actively participate in strategy and direction setting for the organization. Many highlighted the importance of a strong physician leader for the medical staff.

While difficult to directly quantify, we believe that outstanding physicians, combined with excellent physician and community relationships, is possibly the most important factor in the financial health of Gold Standard Performers.

*“The physicians in our community are really committed to the health of our area and have been very innovative in their efforts to improve the health of our region.”*  
CEO, Gold Standard Performer





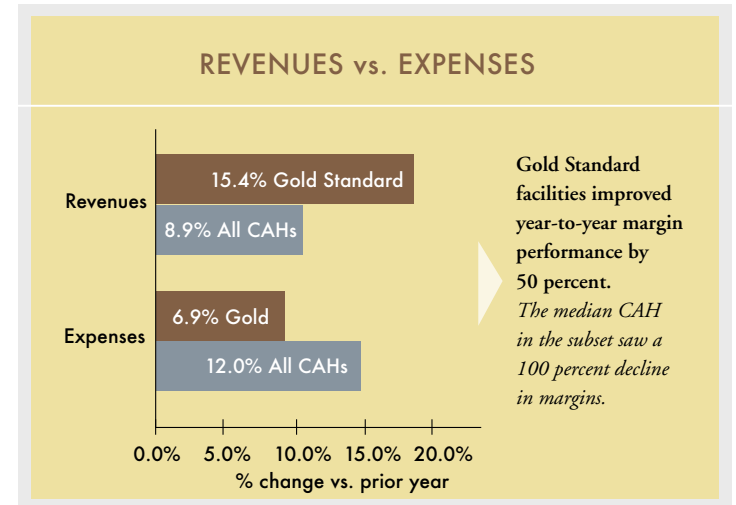
## Gold Standard Performers aggressively grow revenues and manage costs.

The preceding five points describe the current state and condition of operations at Gold Standard Performers. In order to evaluate Gold Standard and typical CAH performance beyond the current condition, we prepared a subset analysis which looked at year-over-year performance of Gold Standard Performers and the typical CAH. The results of this

analysis indicate that Gold Standard Performers aggressively grow revenues and manage costs.

The results of the analysis indicate that Gold Standard Performers grew revenues at twice the rate of the median CAH, while at the same time keeping expense increases to 50 percent of the median CAH. The result of this aggressive growth combined with strong cost management improved margins at Gold Standard Performers by 50 percent at the same time that the median CAH saw a 100 percent decline in margins.

The ability to produce excellent financial results on a year-over-year basis is a key reason for the superior financial health enjoyed by Gold Standard Performers.



# MEASURING THE FINANCIAL STRENGTH OF CAHs

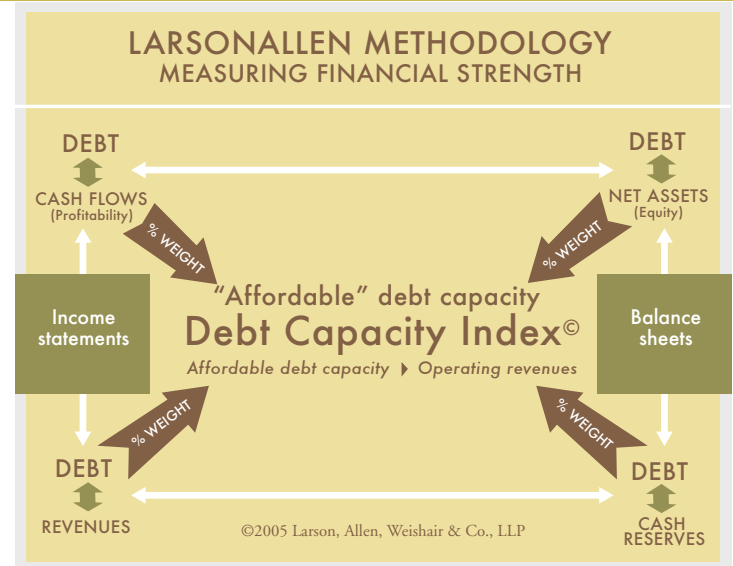
LarsonAllen has worked with hundreds of health care organizations in evaluating financial performance and assessing long-term financial vitality. A key output of these assessments is a core indicator of overall financial strength or “affordable” debt capacity. LarsonAllen’s methodology for sizing affordable debt capacity considers a variety of indicators, including profitability, revenues, cash position, and net assets.

In order to accurately compare and rank the relative financial strength of CAHs of varying sizes, the LarsonAllen Debt Capacity Index® (DCI) was used. This LarsonAllen metric is a function of an organization’s total affordable debt capacity to its operating revenue base. This metric allowed us to objectively rank the overall financial strength of CAHs of differing sizes. For the purpose of making the evaluation, each CAH’s total “affordable” debt capacity was calculated using the following financial performance guidelines:

- Debt service coverage of 2.5x
- Debt service percent of revenues of 6.0 percent
- Cash to debt of 75 percent
- Debt to capitalization of 50 percent

To determine top performers, all CAHs were ranked based on their overall DCI. Gold Standard and top performers were then selected from the upper quartile of financial performance based on the DCI. Other factors that were considered in selecting Gold Standard and top performers included completeness of available data, analytic consistency of available data, and levels of non-patient to patient revenues (<10 percent of patient revenues).

Based on the DCI analysis, Gold Standard and top performing CAHs have two times the debt capacity and, when combined with their significantly stronger cash reserves, have three times the overall capital spending capacity of typical CAHs.



**LARSONALLEN DEBT CAPACITY INDEX©: CAHs**

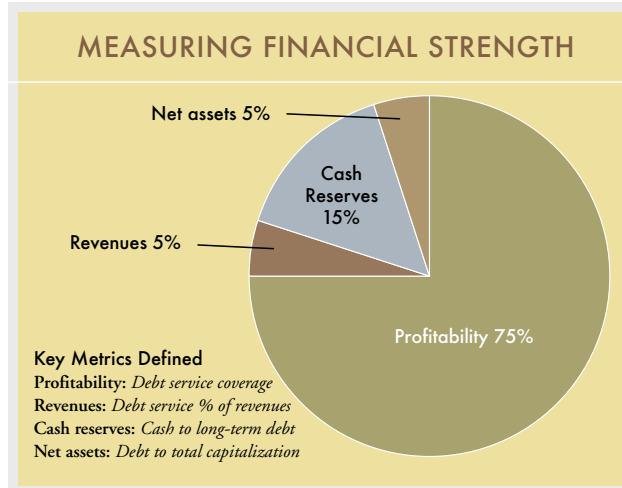
	Overall CAH Industry	Gold Standard and Top Performers
All CAHs	18% DCI	Gold Standard 37% DCI
Small	11% DCI	Top small 36% DCI
Mid	19% DCI	Top mid 42% DCI
Large	22% DCI	Top large 37% DCI

**"Value" of top performance**

Gold Standard and Top Performing CAHs  
 → 2x debt capacity  
 → 3x overall capital spending capacity

*"LarsonAllen's philosophy is that capital and debt capacity are the life blood of every health care organization. Measuring, monitoring, and managing this capacity is a sure way to assess and strengthen overall financial health."*

David Schuh, Principal, LarsonAllen





# FINANCIAL METRICS OF TOP PERFORMING CAHS

## MEDIAN FINANCIAL PERFORMANCE METRICS

	Small CAHs		Mid CAHs		Large CAHs	
	All Small	Top Performers	All Mid	Top Performers	All Large	Top Performers
<b>Revenue indicators:</b>						
Operating revenues (\$ in thousands)	\$3,885	\$4,016	\$7,777	\$8,070	\$15,702	\$17,163
<b>Profitability indicators:</b>						
Operating EBIDA margin	-0.7%	13.4%	4.6%	15.6%	8.3%	15.0%
Operating margin	-4.2%	8.1%	-1.0%	8.4%	2.0%	8.2%
Total margin	0.1%	10.3%	2.4%	10.0%	3.7%	9.8%
Debt service coverage*	-0.19x	5.60x	2.02x	7.52x	3.87x	4.58x
<b>Liquidity indicators:</b>						
Net days in accounts receivable	57	67	59	67	58	54
Days cash on hand (all sources)	45	193	67	195	60	157
Cushion ratio*	7.9x	9.7x	6.7x	18.8x	6.0x	6.1x
Cash to debt	100%	124%	67%	131%	71%	102%
<b>Capital and leverage indicators:</b>						
Average age of plant	13.0	11.3	11.3	10.4	9.3	9.3
Dept to capitalization*	23%	14%	27%	28%	30%	34%
Facilities without long-term debt	26 (26%)	5 (23%)	28	3 (17%)	7 (7%)	2 (10%)
Number of facilities	99	22	433	18	102	18

\* for facilities with long-term debt

# OPERATIONAL METRICS OF TOP PERFORMING CAHS

## MEDIAN OPERATING AND COST PERFORMANCE METRICS

	Small CAHs*		Mid CAHs		Large CAHs	
	All Small	Top Performers	All Mid	Top Performers	All Large	Top Performers
<b>Utilization indicators:</b>						
Medicare cost based utilization	42%	47%	34%	41%	31%	33%
Medicare utilization IP days (acute+swing)	84%	74%	78%	82%	72%	76%
Medicare acute days	430	474	731	835	1,437	1,599
Overall inpatient revenue % of total revenue	41%	36%	36%	39%	34%	31%
Medicare OP utilization %	40%	39%	37%	39%	34%	36%
Adjusted days	3,008	3,306	5,371	5,265	9,213	10,796
<b>Staffing and cost indicators:</b>						
FTEs per AOB	5.72	5.45	6.36	5.79	6.53	5.92
Acute FTEs	46	49	87	88	145	157
<b>Selected costs per day</b>						
Routine nursing per day (all days)	\$449	\$390	\$394	\$395	\$356	\$347
Routine costs per day (fully allocated)	\$773	\$749	\$741	\$753	\$711	\$699
Surgery costs per adjusted day	\$9	\$13	\$33	\$47	\$73	\$73
Emergency costs per adjusted day	\$49	\$46	\$84	\$67	\$113	\$92
Medicare ancillary per day	\$460	\$460	\$558	\$479	\$672	\$645
Medicare surgery cost PPD	\$3	\$25	\$34	\$65	\$103	\$126
Medicare ER cost PPD	\$39	\$41	\$64	\$45	\$102	\$79
Other ancillary costs PPD	\$418	\$394	\$459	\$369	\$467	\$440
Swing bed ancillary cost per day	\$182	\$213	\$217	\$199	\$238	\$261
<b>Charge and discount information:</b>						
Overall Medicare CCR	89%	85%	76%	72%	62%	62%
Inpatients charges per day	\$1,130	\$1,226	\$1,396	\$1,349	\$1,875	\$1,793
CAH cost based discount %	11%	15%	24%	28%	38%	38%
Non-CAH cost based discount %	27%	25%	24%	19%	28%	24%
<b>Provider based entity information:</b>						
% of facilities with provider based SNFs	20%	9%	24%	28%	36%	30%
% of facilities with provider based clinics	59%	36%	49%	22%	64%	55%
Number of facilities	99	22	433	18	102	18

\*Small = \$5.5M or less operating revenues, Mid = \$5.5 to \$11.0M operating revenues, Large = \$11.0M or more operating revenues



## LARSONALLEN HISTORY AND EXPERIENCE

LarsonAllen is a professional service firm that provides assurance, accounting, tax, consulting, and advisory services to organizations and individuals managing business ventures, and finance. Founded in 1953, LarsonAllen is dedicated to providing quality results to clients. We provide our clients with industry specialists and high quality business resources. With approximately 800 employees and regional offices based in Minneapolis, St. Louis, Philadelphia, Charlotte, Naples, and several Midwestern client service centers, we have a depth of talent, experience, and a national perspective.

LarsonAllen is the 16<sup>th</sup> largest accounting firm in the country (source: *Public Accounting Report*). In 2005, Vault Inc. ranked LarsonAllen 10<sup>th</sup> in the nation in overall prestige in its guide to the country's top accounting firms. The rankings are based on the opinions of industry leaders, the results of employee surveys, and on objective data, including firm size in terms of annual revenue.

We serve clients with quality and integrity and meet their needs with the highest levels of expertise. We stress open communication, efficiency, and a relationship grounded in fairness and trust as your accountants, consultants, and advisors.

### Our dedication to health care

*"We promise to transform complexity into opportunity for our health care clients."*

*- Health care mission*

LarsonAllen has developed one of the nation's largest health care practices. We devote approximately 150 people—including more than 30 principals—to serving over 3,000 health care clients. We serve hospitals and health systems, senior living providers, medical groups, physicians, dentists, home care and hospice agencies, and other health care entities nationwide.

Our team includes CPAs and a diverse range of experienced specialists with backgrounds and skill sets ranging from CEO and CFOs to RNs and certified coders. Represented by team members possessing up to 30 years of dedicated experience to the health care industry, we develop innovative responses and creative solutions for clients who demand specialized consultation and advice, as well as providers who require traditional CPA services. Our consulting and advisory services focus on finance, reimbursement, strategy, capital planning, risk management, operations and performance improvement, and facilities. Our independent and objective professionals are guided by your strategic vision and your unique environment.

### Our dedication to hospitals and health systems

LarsonAllen serves over 700 hospitals and health systems including more than 70 Critical Access Hospitals. Our range of hospital clients includes smaller rural hospitals, large academic health systems, and metropolitan area hospitals and health systems. Our national hospital practice consists of 14 principals and approximately 30 dedicated professionals.

Specialized services for hospitals and health systems:

- Audit, accounting, reimbursement and tax
- Critical Access Hospital reimbursement planning
- Strategic capital planning
- Strategic Financial and Capital Advisor™ software tool
- Risk management services
- Coding and compliance reviews
- Facility and service line planning
- Medical staff planning
- Hospital and physician affiliations
- Mergers/acquisitions/affiliations
- Post-acute network integration
- Feasibility studies
- Operations and performance improvement
- Managed care contracting strategy/analysis
- Price opportunity analysis

# ADDITIONAL INFORMATION

To engage CAH leaders and further assist you in your pursuit for Gold Standard Performance, we have provided some helpful downloadable tools. The Web address below includes a list of actions for stakeholder groups to take to strategically move toward success, a worksheet to build a sensible road map toward Gold Standard Performance, and ratio definitions. Please visit our Web site to access these documents.

[www.larsonallen.com/healthcare/cahgs.asp](http://www.larsonallen.com/healthcare/cahgs.asp)

*You can explore LarsonAllen's other Gold Standard initiatives, research, and resources at:*

[www.larsonallen.com/healthcare](http://www.larsonallen.com/healthcare)

*View the Skilled Nursing Facility Gold Standard Report at:*

[www.larsonallen.com/healthcare/costcomp/2003/GoldStandard.pdf](http://www.larsonallen.com/healthcare/costcomp/2003/GoldStandard.pdf)

## CAH Gold Standard Committee

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*(Listed in alphabetical order)*

*Matt Claeys, CPA*

Principal, Minneapolis, MN  
612/376-4736  
[mclaeys@larsonallen.com](mailto:mclaeys@larsonallen.com)

*Steve Rader, CPA*

Principal, Minneapolis, MN  
612/376-4531  
[srader@larsonallen.com](mailto:srader@larsonallen.com)

*Jim Rice, PhD*

Principal, Minneapolis, MN  
612/376-4571  
[jrice@larsonallen.com](mailto:jrice@larsonallen.com)

*David Schuh, CPA*

Principal, Minneapolis, MN  
612/376-4761  
[dschuh@larsonallen.com](mailto:dschuh@larsonallen.com)

*Dan Larsen, CPA*

Manager, Austin, MN  
507/434-7055  
[dlarsen@larsonallen.com](mailto:dlarsen@larsonallen.com)

*Nancy Rehkamp*

Principal, Minneapolis, MN  
612/376-4625  
[nrehkamp@larsonallen.com](mailto:nrehkamp@larsonallen.com)

*Rob Schile, CPA*

Principal, Minneapolis, MN  
612/376-4592  
[rschile@larsonallen.com](mailto:rschile@larsonallen.com)

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CPAs, Consultants & Advisors  
[www.larsonallen.com](http://www.larsonallen.com), 1-888-529-2648