



**SONOMA VALLEY HEALTH CARE DISTRICT
FINANCE COMMITTEE
REGULAR MEETING AGENDA
Monday, April 28, 2014, 5:00 p.m.**

**Location: Schantz Conference Room
Sonoma Valley Hospital – 347 Andrieux Street, Sonoma CA 95476**

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.		
1. CALL TO ORDER/ANNOUNCEMENTS	<i>Fogg</i>	
2. PUBLIC COMMENT SECTION At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.		
3. CONSENT CALENDAR: A. FC Meeting Minutes, 03.25.14	<i>Fogg</i>	Action
4. MARCH 2014 FINANCIALS	<i>Cox</i>	Inform
5. CASH FLOW FORECAST	<i>Cox</i>	Inform
6. RAC ANALYSIS	<i>Jensen</i>	Inform
7. FY2015 BUDGET ASSUMPTIONS	<i>Mather</i>	Inform
8. RESOLUTION No. 321 TO INCREASE UNION BANK LINE OF CREDIT FROM \$5,000,000 TO \$7,000,000	<i>Fogg</i>	Action
9. RESOLUTION No. 322 TO INCREASE CELTIC EQUIPMENT LEASE TO \$2,500,000	<i>Fogg</i>	Action
10. IMPACT OF SUSTAINABLE GROWTH RATE (SGR) FORMULA	<i>Mather</i>	Inform
11. CAPITATION IS THE FUTURE	<i>Cox</i>	Inform
12. ADJOURN Next meeting May 27, 2014	<i>Fogg</i>	

3.

CONSENT CALENDAR



**SONOMA VALLEY HEALTH CARE DISTRICT
FINANCE COMMITTEE
MEETING MINUTES
Tuesday, March 25, 2014
Schantz Conference Room**

Members Present	Members Present cont.	Staff/ Public/Other	Staff/ Public/Other cont.	Excused/Absent
Dick Fogg Kristina Gritsutenko Phil Woodward Peter Hohorst Sharon Nevins	Steve Barclay Shari Glago Subhash Mishra, M.D. (by phone)	Bernadette Jensen Kathryn Kyle Sam McCandless Gigi Betta Stephen Berezin		Keith Chamberlin, M.D. Mary Smith Kelly Mather

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
MISSION AND VISION STATEMENTS	<i>The mission of the SVHCD is to maintain, improve and restore the health of everyone in our community. The vision of the SVHCD is that SVH will be a nationally recognized, compassionate place of healing known for excellence in clinical quality. We serve as the guide and indispensable link in our community members' health care journey.</i>		
1. CALL TO ORDER	<i>Fogg</i>		
	Meeting was called to order at 5:03pm Mr. Fogg announced that Committee Member Richard Conley has resigned due to a conflict in his schedule. There will be an open application process to fill this voting position on the Committee.		
2. PUBLIC COMMENT SECTION	<i>Fogg</i>		
	None.		
3. CONSENT CALENDAR	<i>Fogg</i>	Action	
A. FC Minutes 2.25.14		MOTION by Nevins to approve 2.25.14 Minutes and 2 nd by Glago. All in favor.	
4. FEB 2014 FINANCIALS	<i>Gritsutenko</i>	Inform	

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
	<p>Ms. Gritsutenko presented the Financials for February 2014 and distributed three reports: Statement of Cash Flows, Statistical Analysis, and Days in A/P and A/R.</p> <p>Mr. Woodward asked that the first line item #1 (Net Income/Loss) be broken out into two sub-categories. Mr. Barclay suggested distinguishing between operating revenue, non-operating revenue and restricted revenue. Ms. Nevins and Ms. Gritsutenko will work together to incorporate suggested changes into the format.</p> <p>How SVH is capitalizing interest on the new ER is an unanswered question from the Committee. Ms. Nevins advised that there is an ongoing investigation being conducted by Mr. Fogg, two Board members, a Finance Committee member and one Hospital staffer. Their findings will be reported back to the FC at a future meeting.</p>		
5. BUDGET ASSUMPTIONS 2015	<i>Gritsutenko/Nevins</i>	Inform/Action	
	Ms. Gritsutenko presented 2015 budget assumptions and Ms. Nevins reviewed 2015 major strategies.		
6. PATIENT BILLING UPDATE	<i>Jensen/Kyle</i>		
	Ms. Jensen and Ms. Kyle presented a comprehensive, informative and engaging update on patient billing including vendor assignments, CBO activities, and efficiencies needed to improve collections,		
7. ADJOURN	Fogg		
	<p>Adjourn</p> <p>Meeting adjourned at 7:05pm</p> <p>Next FC meeting is April 22, 2014</p>		

4.

MARCH 2014 FINANCIALS



To: SVH Finance Committee
From: David Cox, CFO, MGH
Date: April 28, 2014
Subject: Financial Report for the Month Ending March 31, 2014

Overall Results for March 2014

SVH is reporting an operating profit of \$541,271 for March, which includes the favorable impact of recording \$1.3 million of LIHP funds, which are expected to be received in July. Without this entry, SVH would have reported an operating loss of about (\$800,000). The operating loss for the year is now (\$2.7 million), slightly behind budget. The year to date loss is offset by non-operating gains totaling \$2.9 million, and our Net Income is \$233,199, which is positive to budget. Also, in March we are recording a reserve for our receivable from Palm Drive Hospital due to their recent Chapter 9 filing.

Overall, we are experiencing lower inpatient activity and a poorer payer mix than expected, offset by a favorable expense variance and the benefit of State of California reimbursement programs. However, on a year over year basis, we are showing an increase in March on discharges, patient days, SNF days, surgical cases, and outpatient revenues and patient activity in March was relatively strong.

Patient Volumes - March

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
Acute Discharges	117	125	-8	88
Acute Patient Days	407	447	-40	315
SNF Patient Days	750	718	32	589
Home Care Visits	1,106	1,250	-144	1,101
OP Gross Revenue	\$9,999	\$9,168	\$831	\$8,906
Surgical Cases	156	139	17	115

Our payer mix is presented below and the significant issue is the increase in the Medi-Cal percent of charges this year, which is occurring nationally and is attributed to the recent increase in eligibility standards as a result of healthcare reform. Our collection ratio in March was 23.0%, below the budget of 24.6%. Year to date, the ratio is 24.3% compared to the budget of 25.2%. Although that doesn't sound like a lot, the impact on SVH year to date is about \$1.5 million of Net Revenue.

Overall Payer Mix - March

	ACTUAL	BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET	VARIANCE
Medicare	51.6%	49.8%	1.8%	51.1%	49.4%	1.7%
Medi-Cal	14.2%	10.6%	3.8%	12.0%	10.7%	1.3%
Self Pay	1.7%	3.7%	-2.0%	3.0%	3.8%	-.08%
Commercial	20.2%	28.9%	-8.7%	23.9%	29.0%	-5.1%
Managed MC	5.3%	2.8%	2.5%	4.4%	2.9%	1.6%
Workers Comp	3.2%	1.5%	1.7%	3.2%	1.5%	1.7%
Capitated	3.8%	2.7%	1.1%	2.4%	2.7 %	-0.3%
Total	100%	100%		100%	100%	

Expenses were \$5,005,960 on a budget of \$4,914,962 or (\$90,998) over budget for the month of March. Miscellaneous Revenue is over budget by (\$453,661) due the reserve of the Palm Drive Receivable of \$452,754, although we expect a good portion of this receivable to be eventually paid. The following is a summary of the operating expense variances:

- Total productivity FTE's were over budget at 292 on a budget of 286, or \$36,803 over budget. Registry was over budget by (\$61,963), due to the use of registry in OB, (\$29,537) and Surgery (\$16,458).
- Medical and Prof Fees are over budget by (\$52,013), (\$46,500) is due to additional Prima Physician call.
- Supplies are over budget by (\$43,654) due to Surgery supplies being over budget by (\$58,573) due to March's volumes.
- Purchase Services are over budget by (\$70,190) due to Patient Financial Services contracts for collection companies, (\$64,130).

The EBIDA prior to the restricted donations for the month was \$772,658 or 13.9%.

Cash Collections on Patient Receivables:

For the month of March the cash collection goal was \$3,209,323, the Hospital collected \$3,084,635 or under the goal by \$124,688. Year to date the Hospital patient collections goal was \$29,427,397 and had collection of \$29,913,085 or \$485,688 over the goal. We attribute the collection shortfall in March to lower revenues two months ago and normal variation. A recent review of our valuation of accounts indicated that collections have been better than expected on the June 2013 receivables and that we have been somewhat over reserved. Management will be gradually increasing the reserve through the end of our fiscal year.

Fiscal 2015 Budget Process

The Fiscal 2015 budget process is now well under way and management is attempting to implement significant cost reductions in all departments next year.



Sonoma Valley Hospital Sonoma Valley Health Care District March 2014 Financial Report

**Finance Committee
April 28, 2014**



March's Patient Volumes

	Actual	Budget	Variance	Prior Year
Acute Discharges	117	125	-8	88
Acute Patient Days	407	447	-40	315
SNF Patient Days	750	718	32	589
Home Health Care Visits	1,106	1,250	-144	940
Outpatient Gross Revenue (in thousands)	\$9,999	\$9,168	\$831	\$8,906
Surgical Cases	156	139	17	115

Summary Statement of Revenues and Expenses Month of March 31, 2014

	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Percentage</u>	<u>Prior Year</u>
1Total Operating Revenue	\$ 5,547,231	\$ 4,399,606	\$ 1,147,625	26%	\$ 4,201,578
2Total Operating Expenses	\$ 5,005,960	\$ 4,914,962	\$ (90,998)	-2%	\$ 4,577,334
3Operating Margin	\$ 541,271	\$ (515,356)	\$ 1,056,627	205%	\$ (375,756)
4NonOperating Rev/Exp	\$ (196,619)	\$ 248,712	\$ (445,331)	-179%	\$ 383,140
5Net Income before Restricted Cont.	\$ 344,652	\$ (266,644)	\$ 611,296	-229%	\$ 7,384
6Restricted Contribution	\$ 56,417	\$ 149,505	\$ (93,088)	-62%	\$ 136,471
Net Income with Restricted 7Contributions	\$ 401,069	\$ (117,139)	\$ 518,208	-442%	\$ 143,855
8EBIDA before Restricted Contributions	\$ 772,658	\$ 185,595	\$ 587,063		\$ 212,295
9EBIDA before Restricted Cont. %	14%	4%	10%		5%
10 Net Income without GO Bond Activity	\$ 329,244	\$ (189,815)	\$ 519,059		\$ (116,172)

Summary Statement of Revenues and Expenses Year to Date March 31, 2014 (9 months)

	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Percentage</u>	<u>Prior Year</u>
1Total Operating Revenue	\$ 38,269,798	\$ 39,309,127	\$ (1,039,329)	-3%	\$ 36,986,008
2Total Operating Expenses	\$ 40,933,257	\$ 41,865,908	\$ 932,651	2%	\$ 39,475,756
3Operating Margin	\$ (2,663,459)	\$ (2,556,781)	\$ (106,678)	-4%	\$ (2,489,748)
4NonOperating Rev/Exp	\$ 2,896,659	\$ 2,565,210	\$ 331,449	13%	\$ 3,171,817
5Net Income before Restricted Cont.	\$ 233,199	\$ 8,429	\$ 224,770	2667%	\$ 682,069
6Restricted Contribution	\$ 3,260,990	\$ 1,786,319	\$ 1,474,671	83%	\$ 524,163
Net Income with Restricted 7Contributions	\$ 3,494,189	\$ 1,794,748	\$ 1,699,441	95%	\$ 1,206,232
8EBIDA before Restricted Contributions	\$ 2,438,568	\$ 2,835,239	\$ (396,671)		\$ 2,831,714
9EBIDA before Restricted Cont. %	6%	7%	-1%		8%
10 Net Income without GO Bond Activity	\$ (762,693)	\$ (972,450)	\$ 209,757		\$ (429,935)

March's Operating Revenues

	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Percentage</u>	<u>Prior Year</u>
REVENUE					
NET PATIENT REVENUE					
1 Acute Inpatient	\$ 1,488,287	\$ 1,759,329	\$ (271,042)	-15%	\$ 1,345,965
2 Skilled Nursing Facility	\$ 425,376	\$ 486,848	\$ (61,472)	-13%	\$ 435,549
3 Outpatient and Emergency	\$ 1,887,421	\$ 1,826,511	\$ 60,910	3%	\$ 2,146,918
4 HomeCare	\$ 263,286	\$ 268,896	\$ (5,610)	-2%	\$ 250,883
5 Community Benefit (Charity)	\$ (2,500)	\$ (181,359)	\$ 178,859	99%	\$ (174,000)
6 Bad Debt Expense	\$ (230,000)	\$ (217,105)	\$ (12,895)	-6%	\$ (60,000)
7 Prior Period Adjustment	\$ 1,300,000	\$ -	\$ 1,300,000	100%	\$ -
8 TOTAL NET PATIENT REVENUE	\$ 5,131,870	\$ 3,943,120	\$ 1,188,750	30%	\$ 3,945,315
RISK CONTRACTS					
9 Capitation Revenue	\$ 174,028	\$ 164,178	\$ 9,850	6%	\$ 184,227
10 Napa State Hospital Revenue	\$ 158,074	\$ 157,739	\$ 335	0%	\$ 60,125
11 TOTAL RISK CONTRACTS	\$ 332,102	\$ 321,917	\$ 10,185	3%	\$ 244,352
12 OTHER OP. REVENUE	\$ 83,259	\$ 134,569	\$ (51,310)	-38%	\$ 154,770
13 TOTAL HOSPITAL NET REVENUE	\$ 5,547,231	\$ 4,399,606	\$ 1,147,625	26%	\$ 4,344,437

Revenue Variances

- Total Operating Revenue over budget by \$1,147,625
 - Overall inpatient volume was under budget by 8 discharges.
 - Skilled Nursing Home volume was over budget by 32 days
 - Outpatient was over budget in volume, but had higher Medicare patients and lower commercial insured patients.
 - Home Care volume was under budget by 144 visits.
 - Bad Debts and Charity Care were favorable to budget by \$165,964.
 - Prior Period Adjustment is for the County Medical Services Program, Low Income Health Program (LHIP).

March's Operating Expense

	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Percentage</u>	<u>Prior Year</u>
OPERATING EXPENSES					
1 Salary and Wages and Agency	\$ 2,178,672	\$ 2,151,869	\$ (26,803)	-1%	\$ 2,149,752
2 Employee Benefits	\$ 760,936	\$ 773,377	\$ 12,441	2%	\$ 775,206
3 Total People Cost	\$ 2,939,608	\$ 2,925,246	\$ (14,362)	0%	\$ 2,924,958
4 Medical and Prof Fees (excl'd Agency)	\$ 420,799	\$ 368,786	\$ (52,013)	-14%	\$ 431,316
5 Supplies	\$ 563,595	\$ 519,941	\$ (43,654)	-8%	\$ 575,860
6 Purchased Services	\$ 505,698	\$ 435,508	\$ (70,190)	-16%	\$ 300,002
7 Depreciation	\$ 248,464	\$ 277,142	\$ 28,678	10%	\$ 162,079
8 Utilities	\$ 89,720	\$ 132,354	\$ 42,634	32%	\$ 53,638
9 Insurance	\$ 18,888	\$ 18,699	\$ (189)	-1%	\$ 19,001
10 Interest	\$ 99,041	\$ 94,189	\$ (4,852)	-5%	\$ 12,821
11 Other	\$ 120,147	\$ 143,097	\$ 22,950	16%	\$ 97,659
12 TOTAL OPERATING EXPENSE	\$ 5,005,960	\$ 4,914,962	\$ (90,998)	-2%	\$ 4,577,334

Expense Variances

Total operating expenses were over budget by (\$90,998)

- Total productivity FTE's were over budget at 292, or (\$36,803) over budget, due to the use of registry in Labor and Delivery (\$29,537) and Surgery (\$16,458)
- Medical and Professional Fees were over budget by (\$52,013), (\$58,573) is due to additional Prima Physician call
- Supplies were over budget by (\$43,654) due Surgery supplies being over by (\$58,573) due to march's volume
- Purchase Services were over budget by (\$70,190) due to Patient Financial Services contracts for collection companies, (\$64,130)

March's Non-Operating Items

	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Percentage</u>	<u>Prior Year</u>
NON OPERATING					
1Miscellaneous Revenue	\$ (449,495)	\$ 4,166	\$ (453,661)	-10890%	\$ 20,266
2 Donations	\$ 1,359	\$ -	\$ 1,359	0%	\$ 59,930
3 Professional Center / Phys Recruitment	\$ -	\$ -	\$ -	0%	\$ -
4 Physician Practice Support - Prima	\$ (56,833)	\$ (65,630)	\$ 8,797	0%	\$ (65,630)
5 Tax Assessment Revenue-Parcel Tax	\$ 236,525	\$ 237,500	\$ (975)	0%	\$ 245,018
6 Tax Assessment Revenue - GO Bond	\$ 152,326	\$ 153,584	\$ (1,258)	-1%	\$ 153,567
7 GO Bond Interest	\$ (80,501)	\$ (80,908)	\$ 407	-1%	\$ (30,011)
8 NON-OPERATING REV/EXP	\$ (196,619)	\$ 248,712	\$ (445,331)	-179%	\$ 383,140
9Capital Campaign Contribution	\$ 56,417	\$ 149,505	\$ (93,088)	-62%	\$ 136,471
10Restricted Foundation Contribution	\$ -	\$ -	\$ -	0%	\$ -
11TOTAL NON-OPERATING REV/EXP	\$ (140,202)	\$ 398,217	\$ (538,419)	-135%	\$ 519,611

Balance Sheet

- Cash was stable at \$1.25 million, which is 11 Days Cash on Hand.
- Net Days in A/R are at 49, but there are recent system related issues that could delay claims somewhat next month.
- Trade accounts payable were paid down to \$4.5 million, a \$400,000 reduction.
- We have a verbal confirmation from Union Bank regarding an increase in the Line of Credit from \$5.0 to \$7.0 million.
- We are working to close the Celtic equipment financing, which will add \$700,000 to the lease.
- The remaining cost of the project is approximately \$3.5 million and, with the transaction above, we will have adequate cash to complete pending receipt of pledges.

**OPERATING INDICATORS
SONOMA VALLEY HOSPITAL**

For the month ended March, 2014

	CURRENT MONTH			YEAR-TO-DATE			
	Actual 03/31/14	Budget 03/31/14	Favorable (Unfavorable) Variance	Actual 03/31/14	Budget 03/31/14	Favorable (Unfavorable) Variance	Prior Year 03/31/13
Inpatient Utilization							
Discharges							
1 Acute	102	104	(2)	737	932	(195)	998
2 ICU	15	21	(6)	146	185	(39)	94
3 Total Discharges	117	125	(8)	883	1,117	(234)	1,092
4 Newborn	19	14	5	115	122	(7)	119
5 Total Discharges inc. Newborns	136	125	(3)	998	1,239	(241)	1,211
Patient Days:							
6 Acute	326	323	3	2,408	2,876	(468)	3,154
7 ICU	81	124	(43)	910	1,096	(186)	780
8 Total Patient Days	407	447	(40)	3,318	3,972	(654)	3,934
9 Newborn	36	30	6	227	268	(41)	272
10 Total Patient Days inc. Newborns	443	477	(34)	3,545	4,240	(695)	4,206
Average Length of Stay:							
11 Acute	3.2	3.1	0.1	3.3	3.1	0.2	3.2
12 ICU	5.4	5.9	(0.5)	6.2	5.9	0.3	8.3
13 Avg. Length of Stay	3.5	3.6	(0.1)	3.8	3.6	0.2	3.6
14 Newborn ALOS	1.9	2.2	(0.3)	2.0	2.2	0.2	2.3
Average Daily Census:							
15 Acute	10.5	10.4	0.1	8.8	10.5	(1.7)	11.5
16 ICU	2.6	4.0	(1.4)	3.3	4.0	(0.7)	2.8
17 Avg. Daily Census	13.1	14.4	(1.3)	12.1	14.5	(2.4)	14.4
18 Newborn	1.2	1.0	0.2	0.8	1.0	(0.1)	1.0
Long Term Care:							
19 SNF Patient Days	750	718	32	5,672	5,852	(180)	5,927
20 SNF Discharges	29	34	(5)	261	316	(55)	298
21 Average Daily Census	24.2	23.2	1	20.7	21.4	(1)	21.6
Other Utilization Statistics							
Emergency Room Statistics							
22 Total ER Visits	769	784	(15)	6,716	7,242	(526)	7,155
Outpatient Statistics:							
23 Total Outpatients Visits	4,516	4,212	304	37,957	37,655	302	36,036
24 IP Surgeries	43	38	5	296	347	(51)	328
25 OP Surgeries	113	101	12	887	838	49	811
26 Special Procedures	33	23	10	314	288	26	331
27 Home Health Visits	1,106	1,250	(144)	8,054	8,675	(621)	8,839
28 Adjusted Discharges	326	338	(11)	2,587	3,074	(487)	2,963
29 Adjusted Patient Days	2,587	2,476	111	20,328	21,064	(736)	21,021
30 Adj. Avg. Daily Census	83.4	79.9	3.6	74.2	76.9	(2.7)	76.7
31 Case Mix Index -Medicare	1.6250	1.4000	0.225	1.6412	1.4000	0.241	1.4714
32 Case Mix Index - All payers	1.4960	1.4000	0.096	1.5469	1.4000	0.147	1.4776
Labor Statistics							
33 FTE's - Worked	292	286	(5.7)	280	282	2.3	284
34 FTE's - Paid	318	313	(4.9)	313	316	3.4	320
35 Average Hourly Rate	38.81	38.81	(0.00)	36.76	36.01	(0.75)	35.25
36 Manhours / Adj. Pat Day	21.7	22.3	0.6	24.1	23.5	(0.6)	23.8
37 Manhours / Adj. Discharge	172.0	163.6	(8.4)	189.0	160.8	(28.2)	168.9
38 Benefits % of Salaries	22.2%	22.2%	0.0%	22.4%	23.2%	0.8%	23.2%
Non-Labor Statistics							
39 Supply Expense % Revenue	3%	3%	0%	3%	3%	0%	3%
40 Supply Exp. / Adj. Discharge	1,726.62	1,538.76	(188)	1,756.85	1,480.06	(277)	1,564.68
41 Total Expense / Adj. Discharge	15,756.91	12,633.39	(3,124)	16,170.90	13,944.28	(2,227)	13,612.71
Other Indicators							
42 Days Cash - Operating Funds	11.0						
43 Days in Net AR	48.8	50.0	(1.2)	51.8	50.0	1.8	53.6
44 Collections % of Net Revenue	94%			101%			
45 Days in Accounts Payable	67.5	60.0	7.5	67.5	60.0	7.5	-
46 % Net revenue to Gross revenue	23.0%	24.6%	-1.6%	24.3%	25.2%	-0.8%	24.9%
47 % Net AR to Gross AR	22.9%			22.9%			25.5%

Sonoma Valley Health Care District
Balance Sheet
For The Period Ended
As of March 31, 2014

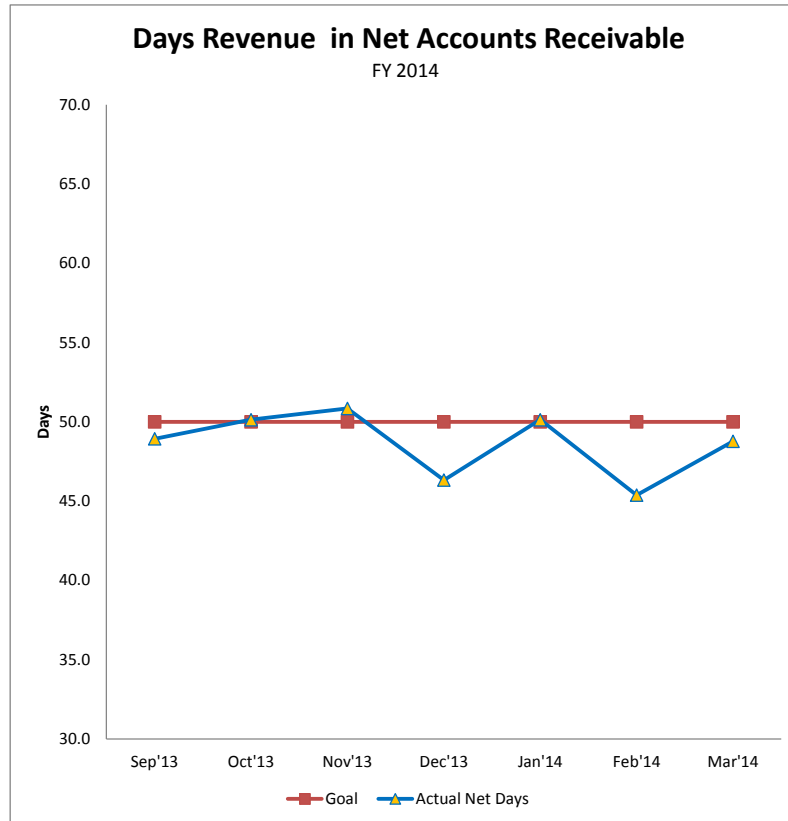
	<u>Current Month</u>	<u>Prior Month</u>	<u>Prior Year</u>
Assets			
Current Assets:			
1 Cash	\$ 1,255,535	\$ 1,226,962	\$ 2,168,776
2 Trustee Funds	762,010	762,010	479,531
3 Net Patient Receivables	7,888,038	7,341,202	8,394,847
4 Allow Uncollect Accts	(1,740,680)	(1,701,827)	(1,313,456)
5 Net A/R	6,147,358	5,639,376	7,081,391
6 Other Accts/Notes Rec	2,980,819	4,264,952	2,860,569
7 3rd Party Receivables, Net	1,937,910	539,077	536,404
8 Due Frm Restrict Funds	-	-	-
9 Inventory	743,867	766,416	916,924
10 Prepaid Expenses	909,717	1,191,341	1,047,371
11 Total Current Assets	\$ 14,737,216	\$ 14,390,134	\$ 15,090,966
12 Board Designated Assets	\$ 5,399	\$ 5,399	\$ 186,333
13 Property, Plant & Equip, Net	52,469,485	11,579,592	10,381,842
14 Hospital Renewal Program	-	41,058,751	23,209,142
15 Unexpended Hospital Renewal Funds	-	-	11,702,114
16 Investments	-	-	-
17 Specific Funds	565,239	1,068,395	766,528
18 Other Assets	436,558	431,217	266,767
19 Total Assets	\$ 68,213,897	\$ 68,533,489	\$ 61,603,692
Liabilities & Fund Balances			
Current Liabilities:			
20 Accounts Payable	\$ 4,471,747	\$ 4,876,954	\$ 4,122,329
21 Accrued Compensation	3,892,725	3,578,417	3,426,076
22 Interest Payable	285,340	142,670	285,705
23 Accrued Expenses	1,261,871	1,066,552	275,966
24 Advances From 3rd Parties	(191,739)	307,502	1,329,892
25 Deferred Tax Revenue	1,317,172	1,706,997	1,182,053
26 Current Maturities-LTD	910,496	909,807	1,173,343
27 Other Liabilities	4,204,540	4,197,540	2,041,107
28 Total Current Liabilities	\$ 16,152,152	\$ 16,786,440	\$ 13,836,471
29 Long Term Debt, net current portion	\$ 37,707,628	\$ 37,794,002	\$ 37,667,636
Fund Balances:			
31 Unrestricted	\$ 13,229,305	\$ 12,884,652	\$ 7,325,060
32 Restricted	1,124,812	1,068,395	2,774,525
33 Total Fund Balances	\$ 14,354,117	\$ 13,953,048	\$ 10,099,585
34 Total Liabilities & Fund Balances	\$ 68,213,897	\$ 68,533,489	\$ 61,603,692

**Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended March 2014**

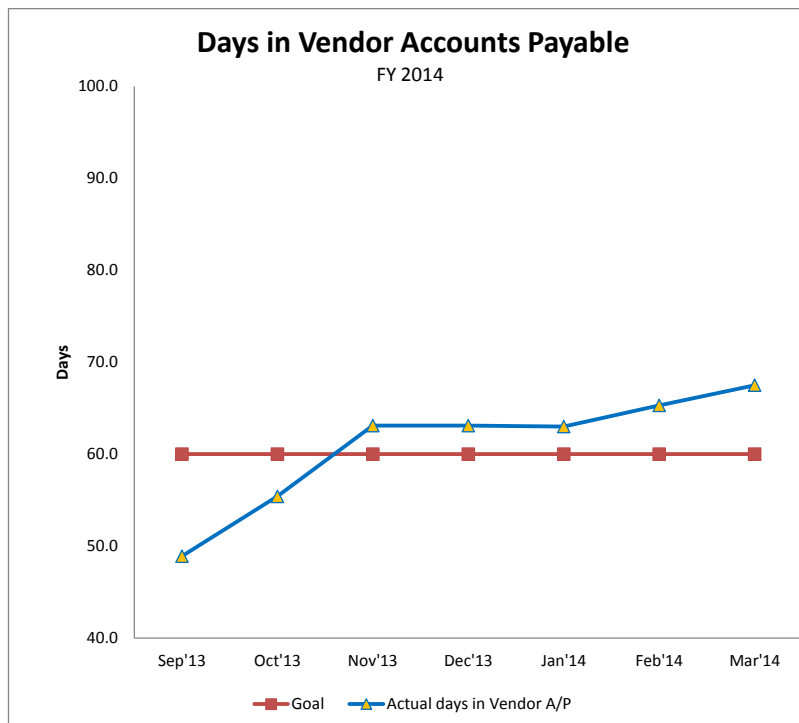
		Month				Year-To-Date				YTD
		This Year		Variance		This Year		Variance		Prior Year
		Actual	Budget	\$	%	Actual	Budget	\$	%	
Volume Information										
1	Acute Discharges	117	142	(25)	-18%	884	1,134	(250)	-22%	1,092
2	SNF Days	750	718	32	4%	5,672	5,852	(180)	-3%	5,927
3	Home Care Visits	1,106	1,250	(144)	-12%	8,056	8,675	(619)	-7%	8,839
4	Gross O/P Revenue (000's)	9,999	9,168	831	9%	\$ 85,126	\$ 81,257	3,869	5%	\$ 76,076
Financial Results										
Gross Patient Revenue										
5	Inpatient	\$ 5,454,039	\$ 5,665,012	(210,973)	-4%	\$ 45,787,838	\$ 50,836,245	(5,048,407)	-10%	\$ 47,982,032
6	Outpatient & Emergency	9,657,526	8,821,823	835,703	9%	82,646,686	78,900,706	3,745,980	5%	73,498,874
7	SNF	2,637,836	2,481,839	155,997	6%	21,711,187	20,186,529	1,524,658	8%	19,236,701
8	Home Care	341,767	346,144	(4,377)	-1%	2,479,153	2,355,898	123,255	5%	2,576,692
9	Total Gross Patient Revenue	\$ 18,091,168	\$ 17,314,818	776,350	4%	\$ 152,624,864	\$ 152,279,378	345,486	0%	\$ 143,294,299
Deductions from Revenue										
10	Contractual Discounts	\$ (14,026,798)	\$ (12,973,234)	(1,053,564)	-8%	\$ (118,223,441)	\$ (113,492,126)	(4,731,315)	-4%	\$ (106,810,788)
11	Bad Debt	(230,000)	(217,105)	(12,895)	-6%	(1,808,255)	(1,909,380)	101,125	5%	(2,060,000)
12	Charity Care Provision	(2,500)	(181,359)	178,859	99%	(195,250)	(1,447,119)	1,251,869	87%	(1,353,951)
13	Prior Period Adjustments	1,300,000	-	1,300,000	0%	2,107,929	-	2,107,929	0%	(300,000)
14	Total Deductions from Revenue	\$ (12,959,298)	\$ (13,371,698)	412,400	-3%	\$ (118,119,017)	\$ (116,848,625)	(1,270,392)	1%	\$ (110,524,739)
15	Net Patient Service Revenue	\$ 5,131,870	\$ 3,943,120	1,188,750	30%	\$ 34,505,847	\$ 35,430,753	(924,906)	-3%	\$ 32,769,560
16	Risk contract revenue	\$ 332,102	\$ 321,917	10,185	3%	\$ 2,615,222	\$ 2,897,253	(282,031)	-10%	\$ 2,910,092
17	Net Hospital Revenue	\$ 5,463,972	\$ 4,265,037	1,198,935	28%	\$ 37,121,068	\$ 38,328,006	(1,206,938)	-3%	\$ 35,679,652
18	Other Op Rev	\$ 83,259	\$ 134,569	(51,310)	38%	\$ 1,148,730	\$ 981,121	167,609	17%	`
19	Total Operating Revenue	\$ 5,547,231	\$ 4,399,606	1,147,625	26%	\$ 38,269,798	\$ 39,309,127	(1,039,329)	-3%	#VALUE!
Operating Expenses										
20	Salary and Wages and Agency Fees	\$ 2,178,672	\$ 2,151,869	(26,803)	-1%	\$ 17,970,406	\$ 18,301,534	331,128	2%	\$ 17,638,355
21	Employee Benefits	760,936	773,377	12,441	2%	6,607,326	6,892,990	285,664	4%	6,624,282
22	Total People Cost	\$ 2,939,608	\$ 2,925,246	(14,362)	0%	\$ 24,577,732	\$ 25,194,524	616,792	2%	\$ 24,262,637
23	Med and Prof Fees (excl Agency)	\$ 420,799	\$ 368,786	(52,013)	-14%	\$ 3,893,893	\$ 3,513,987	(379,906)	-11%	\$ 3,441,636
24	Supplies	563,595	519,941	(43,654)	-8%	4,544,513	4,548,978	4,465	0%	4,636,403
25	Purchased Services	505,698	435,508	(70,190)	-16%	3,682,715	3,915,895	233,180	6%	3,606,196
26	Depreciation	248,464	277,142	28,678	10%	1,531,711	2,005,638	473,927	24%	1,622,791
27	Utilities	89,720	132,354	42,634	32%	719,280	891,186	171,906	19%	680,900
28	Insurance	18,888	18,699	(189)	-1%	169,988	168,290	(1,698)	-1%	176,475
29	Interest	99,041	94,189	(4,852)	-5%	298,619	419,795	121,176	29%	256,755
30	Other	120,147	143,097	22,950	16%	1,514,806	1,207,615	(307,191)	-25%	791,963
31	Operating expenses	\$ 5,005,960	\$ 4,914,962	(90,998)	-2%	\$ 40,933,257	\$ 41,865,908	932,651	2%	\$ 39,475,756
32	Operating Margin	\$ 541,271	\$ (515,356)	1,056,627	205%	\$ (2,663,459)	\$ (2,556,781)	(106,678)	-4%	#VALUE!
Non Operating Rev and Expense										
33	Miscellaneous Revenue	\$ (449,495)	\$ 4,166	(453,661)	-10890%	\$ (157,742)	\$ 37,501	(195,243)	*	\$ 136,030
34	Donations	1,359	-	1,359	0%	444,097	-	444,097	0%	309,877
35	Professional Center/Phys Recruit	-	-	-	0%	-	-	-	0%	-
36	Physician Practice Support-Prima	(56,833)	(65,630)	8,797	-13%	(521,723)	(590,670)	68,947	-12%	(590,670)
37	Parcel Tax Assessment Rev	236,525	237,500	(975)	0%	2,136,135	2,137,500	(1,365)	0%	2,204,576
38	GO Bond Tax Assessment Rev	152,326	153,584	(1,258)	-1%	1,370,931	1,382,256	(11,325)	-1%	1,382,103
39	GO Bond Interest	(80,501)	(80,908)	407	-1%	(375,039)	(401,377)	26,338	-7%	(270,099)
40	Total Non-Operating Rev/Exp	\$ (196,619)	\$ 248,712	(445,331)	*	\$ 2,896,659	\$ 2,565,210	331,449	13%	\$ 3,171,817
41	Net Income / (Loss) prior to Restricted Contributions	\$ 344,652	\$ (266,644)	611,296	-229%	\$ 233,199	\$ 8,429	224,770	2667%	#VALUE!
42	Capital Campaign Contribution	\$ 56,417	\$ 149,505	(93,088)	-62%	\$ 3,260,990	\$ 1,786,319	1,474,671	83%	\$ 524,163
43	Restricted Foundation Contributions	\$ -	\$ -	-	0%	\$ -	\$ -	-	100%	\$ -
44	Net Income / (Loss) w/ Restricted Contributions	\$ 401,069	\$ (117,139)	518,208	-442%	\$ 3,494,189	\$ 1,794,748	1,699,441	95%	#VALUE!
45	Net Income w/o GO Bond Activity	\$ 329,244	\$ (189,815)	519,059	273%	\$ (762,693)	\$ (972,450)	209,757	22%	#VALUE!

Sonoma Valley Hospital
Statement of Cash Flows
For the Period Ended

	<u>Current Month</u>	<u>Year To Date</u>
Operating Activities		
Net Income (Loss)	401,069	3,494,189
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	248,464	1,531,711
Net changes in operating assets and liabilities:		
(Increase)/Decrease Patient accounts receivable - net	(507,982)	378,664
(Increase)/Decrease Other receivables and other assets	(120,041)	3,010,791
(Increase)/Decrease Prepaid expenses	281,624	164,695
(Increase)/Decrease in Inventories	22,549	50,767
(Decrease)/Increase in Deferred revenues	(889,067)	(5,389,523)
(Decrease)/Increase in Accounts payable, accrued expenses	254,090	(174,352)
Net Cash Provided/(Used) by operating activities	<u>(309,293)</u>	<u>3,066,942</u>
Investing Activities		
Net Purchases of property, plant and equipment - Other Fixed Assets	(41,138,357)	(43,326,744)
Net Purchases of property, plant and equipment - GO Bond Purchases	41,058,751	31,801,877
Net Proceeds and Distributions from investments	-	-
Net Book Value of Assets Disposed	-	-
Change in Restricted Funds	-	-
Change in Limited Use Cash	503,157	7,572,398
(Payment)/Refund of Deposits		
Net cash Provided/(Used) by investing activities	<u>423,551</u>	<u>(3,952,469)</u>
Financing Activities		
Proceeds (Repayments) from Borrowings - Banks & Carriers	(85,685)	2,660
Proceeds (Repayments) from Borrowings - Other		
Net Intercompany Borrowings/(Repayments)		
Change in Post Retirement Obligations & Other Net Assets	-	-
Net Equity Transfers to related entities (Cash and Non-Cash)		
Net cash Provided/(Used) by financing activities	<u>(85,685)</u>	<u>2,660</u>
Net increase/(Decrease) in cash and cash equivalents	<u>28,573</u>	<u>(882,867)</u>
Cash and Equivalents at beginning of period	<u>1,226,962</u>	<u>2,138,402</u>
Cash and Equivalents at March 31, 2014	<u><u>1,255,535</u></u>	<u><u>1,255,535</u></u>



Days in A/R	Sep'13	Oct'13	Nov'13	Dec'13	Jan'14	Feb'14	Mar'14
Actual days in A/R	48.9	50.1	50.8	46.3	50.1	45.4	48.8
Goal	50.0	50.0	50.0	50.0	50.0	50.0	50.0



Days in A/P	Sep'13	Oct'13	Nov'13	Dec'13	Jan'14	Feb'14	Mar'14
Actual days in Vendor A/P	48.9	55.4	63.1	63.1	63.0	65.3	67.5
Goal	60.0	60.0	60.0	60.0	60.0	60.0	60.0

Sonoma Valley Hospital

Statistical Analysis

FY 2014

	ACTUAL	BUDGET	ACTUAL							
	Mar-14	Mar-14	Feb-14	Jan-14	Dec-13	Nov-13	Oct-13	Sep-13	Aug-13	Jul-13
Statistics										
Acute										
Acute Patient Days	407	447	300	389	402	318	374	405	385	338
Acute Discharges	117	125	79	91	112	85	91	107	102	100
SNF Days	750	718	641	754	733	531	606	585	615	457
HHA Visits	1,106	1,250	872	1,040	951	903	941	745	736	760
Emergency Room Visits	769	784	655	811	751	665	731	795	789	750
Gross Outpatient Revenue (000's)	\$9,999	\$9,168	\$8,604	\$9,095	\$8,809	\$9,325	\$10,248	\$9,173	\$9,801	\$10,071
Equivalent Patient Days	2,585	2,476	2,136	2,375	2,356	2,145	2,342	2,157	2,256	1,945
Births	19	14	14	6	11	14	12	13	11	15
Surgical Cases - Inpatient	43	38	26	37	31	26	32	33	35	33
Surgical Cases - Outpatient	113	101	95	76	107	109	103	87	95	102
Total Surgical Cases	156	139	121	113	138	135	135	120	130	135
Medicare Case Mix Index	1.63	1.40	1.77	1.94	1.49	1.76	1.52	1.47	1.64	1.54
Productivity										
Productive FTEs	292	286	266	268	277	288	282	279	286	279
Non-Productive FTE's	26	36	34	42	38	25	29	41	30	36
Total FTEs	318	322	301	310	315	313	312	320	315	315
FTEs per Adjusted Occupied Bed	3.81	4.28	4.39	4.39	4.39	4.39	4.12	4.45	4.33	4.25
Balance Sheet										
Days of Expense In General Operating Cash	11		8	7	7	11	7	8	11	8
Net Days of Revenue in AR	49		49	54	50	55	54	52	63	70
Bad Debt Write-Offs as a % of Priv\Othr Rev	44.1%		41.8%	34.1%	36.3%	36.3%	36.4%	33.3%	38.0%	28.1%
Bad Debt Recoveries as a % of Write-Offs	9.2%		10.3%	11.4%	11.5%	13.2%	13.8%	10.9%	9.6%	9.1%

* Budget has been adjusted for actual volume

Reported Exp per Equiv Patient Day - methodology changed 7/2006
to exclude Bad Debt expense from the calculation

5.

CASH FLOW FORECAST

**Sonoma Valley Hospital
Statement of Cash Flows
FY 2014**

	Forecast Mar	Forecast Apr	Forecast May	Forecast Jun	Forecast TOTAL
Operating Activities					
1 Net Income (Loss)	308,653	(258,720)	(175,720)	190,710	(1,274,093)
2 Adjustments to reconcile change in net assets to net cash provided					
3 by operating activities:					
4 Depreciation and amortization	284,464	285,000	285,000	285,000	2,422,711
5 Net changes in operating assets and liabilities:					0
6 (Increase)/Decrease in Patient accounts receivable - net	(504,292)	72,688	78,000	78,000	684,906
7 (Increase)/Decrease in Other accounts/notes receivable	(0)	(0)	-	-	0
8 (Increase)/Decrease in Third party receivables	(1,422,934)	215,000	(445,000)	612,500	(1,272,456)
9 (Increase)/Decrease in Pledges and other receivables	352,417	(6,470)	(49,007)	(84,645)	582,328
10 (Increase)/Decrease in Parcel and GOB tax receivables	850,000	591,458	347,744	-	4,867,564
11 (Increase)/Decrease in Other asset	-	-	-	-	(159,404)
12 (Increase)/Decrease in Inventories	22,549	(6,133)	-	-	44,634
13 (Increase)/Decrease Prepaid expenses	281,624	(90,283)	-	-	74,412
14 (Decrease)/Increase in Deferred revenues	(889,067)	(153,592)	(434,320)	(389,826)	(6,367,261)
15 (Decrease)/Increase in Accounts payable	(405,207)	(221,747)	(125,000)	(125,000)	(3,011,505)
16 (Decrease)/Increase in Accrued compensation	314,308	(392,725)	-	-	315,073
17 (Decrease)/Increase in Interest payable	142,670	142,670	142,670	142,670	(911)
18 (Decrease)/Increase in Accrued expenses	195,319	(130,088)	-	-	174,386
19 (Decrease)/Increase in Other liabilities	-	2,000,000	-	-	3,772,671
20 Net Cash Provided/(Used) by operating activities	(469,496)	2,047,058	(375,633)	709,409	853,054
21					
22 Investing Activities					
23 Net Purchases of property, plant and equipment - Hospital Re	41,058,751	(1,150,667)	(1,150,667)	(1,150,667)	28,349,877
24 Net Purchases of property, plant and equipment - GO Bond Purchases					0
25 Net Purchases of property, plant and equipment - Foundation Funded Purchases					0
26 Net Purchases of property, plant and equipment - Other Fixed	(41,058,751)	-	-	-	(43,247,138)
27 Net Proceeds and Distributions from investments	-	-	-	-	-
28 Net Book Value of Assets Disposed					0
29 (Payment)/Refund of Deposits					0
30 Net cash Provided/(Used) by investing activities	-	(1,150,667)	(1,150,667)	(1,150,667)	(14,897,261)
31					
32 Financing Activities					
33 Proceeds (Repayments) from Borrowings - Banks & Carriers	578,918	883,981	(790,473)	(90,928)	669,843
34 Proceeds (Repayments) from Borrowings - Other					-
35 Change in Restricted Funds (Specific Funds)	503,156	65,239	250,000	250,000	7,454,881
36 Change in Limited Use Cash (Trustee Funds)	-	-	-	-	501,687
37 Change in Board Designated Assets	-	-	-	-	181,069
38 Donations	56,417	50,000	50,000	50,000	4,682,138
39 Change in Unexpended Hospital Revealal Funds	-	-	-	-	-
40 Net Intercompany Borrowings/(Repayments)					-
41 Change in Post Retirement Obligations & Other Net Assets					-
42 Net Equity Transfers to related entities (Cash and Non-Cash)					-
43 Net cash Provided/(Used) by financing activities	1,138,491	999,220	(490,473)	209,072	13,489,618
44					
45 Net increase/(Decrease) in cash and cash equivalents	668,995	1,895,611	(2,016,772)	(232,185)	(554,589)
46					
47 Cash and Equivalents at beginning of period	1,226,962	1,895,957	3,791,569	1,774,797	1,542,611
48					
49 Cash and Equivalents at end of period	1,895,957	3,791,569	1,774,797	1,542,611	

6.

RAC ANALYSIS

**Sonoma Valley Hospital
Current RAC Activity
03/13/2014**

At RAC for Review

of Cases 13 **Note** : These cases are with HDI for decisions
Dollar at Risk \$ 134,006.17

Currently under Appeal

	<u>Cases</u>	<u>Amount</u>
L-1 Appeal (FI)	22	\$187,295.81
L-2 Appeal (QIC)	40	\$284,770.65
L-3 Appeal (ALJ)	29	\$173,991.89
Amount	91	\$646,058.35

**Appealed Denial not taken
back yet**

	<u>Cases</u>	<u>Amount</u>
Waiting Retraction	10	\$ 89,171.13

Appeals Won

of Cases 31
Amount \$ 209,651.09

Denied Cases No Appeals/Appeals Exhausted

	<u># of Cases</u>	<u>Amount</u>
No Appeals	85	\$ 616,710.63
Appeals Exhausted	8	\$ 43,887.86

Note: Additional RAC Take Back since this report total \$10,213.73
Possible Favorable Received \$74,257.12

Sherri # 707-935-5321

7.

FY2015 BUDGET ASSUMPTIONS

FY 2015 MAJOR BUDGET ASSUMPTIONS

- 1) Break even with Parcel Tax
- 2) No volume or growth increases (any increases will be profit)
- 3) Annual salary increase of 3% in January (as usual)
- 4) 5% Benefits increase
- 5) 4.5% Supply cost increase
- 6) Reduce overhead expenses by 10% over prior year
- 7) Prima support payment will stay the same (no MD recruits)

8.

RESOLUTION
No. 321

**SONOMA VALLEY HEALTH CARE DISTRICT
RESOLUTION No. 321**

**RESOLUTION OF THE SONOMA VALLEY
HEALTHCARE DISTRICT (“the District”) AUTHORIZING EXECUTION OF
LINE OF CREDIT AGREEMENT AND RELATED DOCUMENTATION
WITH THE UNION BANK (“the Bank”)**

WHEREAS, the District wishes to secure from the Bank an increase in the Line of Credit from \$5,000,000 to \$7,000,000 to be used for the provision of health care services to the people of the Sonoma Valley Health Care District either for operational or expansion of the Sonoma Valley Hospital.

WHEREAS, the transaction with Union Bank (“the Bank”) by which the Bank will issue the LOC benefiting the District.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Sonoma Valley Healthcare District, as follows:

Section 1. The District shall enter into an arrangement with the Bank hereby approved by the Board of Directors by which the Bank will increase the LOC benefiting the District with all other terms remaining substantially the same.

Section 2. The District’s Chief Executive Officer is authorized and directed to take such action and to execute on behalf of the District any transaction documents necessary or desirable to effectuate securing the LOC from the Bank on terms that are consistent with the terms set forth herein.

Section 3. The Secretary of this District is hereby authorized to execute, acknowledge and deliver a certified copy of this Resolution and the Bank’s authorization to obtain Credit, Grant Security, Guarantee or Subordinate Document to the Bank and any other person or agency which may require copies of this Resolution and that the certification of the Secretary as to the above-named officers will be binding on this District.

PASSED AND ADOPTED on this **1st day of May 2014**, by the following vote:

Ayes: _____

Noes: _____

Absent: _____

Abstain: _____

Sharon Nevins, Chair, Board of Directors

Bill Boerum, Secretary, Board of Directors

9.

RESOLUTION
No. 322

SONOMA VALLEY HEALTH CARE DISTRICT

RESOLUTION No. 322

**RESOLUTION OF THE GOVERNING BOARD OF SONOMA VALLEY HEALTH
CARE DISTRICT OF THE COUNTY OF SONOMA, STATE OF CALIFORNIA,
REQUESTING APPROVAL TO INCREASE THE EQUIPMENT LEASE**

RESOLVED by the Governing Board of the Sonoma Valley Health Care District, a District of the County of Sonoma, State of California, that:

WHEREAS, The District requests approval to increase the Celtic Equipment Lease to \$2,500,000;

NOW, THEREFORE, BE IT RESOLVED by the SVHCD Board of Directors as follows:

1. On March 10, 2014, the SVH Foundation Board of Directors approved to support the District in this need and will provide any and all funds raised for this purpose directly to the District for lease of this equipment.

PASSED AND ADOPTED on this **1st day of May 2014**, by the following vote:

Ayes: _____

Noes: _____

Absent: _____

Abstain: _____

Sharon Nevins, Chair, Board of Directors

Bill Boerum, Secretary, Board of Directors

10.

IMPACT OF
SUSTAINABLE
GROWTH RATE
FORMULA (SGR)



H&HN Daily

SGR Fix Offers Mixed Bag for Hospitals

03.28.14 by Matthew Weinstock Assistant Managing Editor

The SGR legislation in Congress includes more than just a temporary delay to physician reimbursement cuts.

For hospitals and health systems, there's some good, bad and ugly in legislation that is moving swiftly through Congress to change how Medicare pays physicians.

The House of Representatives yesterday passed by voice vote a bill that would postpone a 24 percent cut to physician payments — slated to take effect on Tuesday — until April 1, 2015.

Hoping for a long-term solution to the sustainable growth rate, which seemed to be in the works earlier this year, the AMA opposes the bill and urged House members to vote it down.

The nation's largest doctors group is weary of this Band-Aid approach, which has seen multiple short-term patches to the convoluted payment system.

Looking beyond SGR, the legislation, which is expected to be approved by the Senate early next week, includes several provisions that impact hospitals and health systems.

"There are some good elements and some bad elements," says Tom Nickels, senior vice president for federal relations at the AHA.

First the good: Medicare extenders — the Medicare-dependent hospital program, low-volume adjustment and ambulance add-on payments — were continued until April 1, 2015.

The bill also extends the delay for CMS to enforce the controversial two-midnight rule until March 31, 2015. And, it would prevent RACs from auditing two-midnight inpatient claims for six months.

Nickels says that the AHA was also pleased with what was left out of the bill, namely cuts that had been discussed surrounding graduate medical education, the critical access hospital program and bad debt.

Now some of the bad and ugly: While the bill would delay DSH payment cuts for a year (2017), it tacks another year of cuts on the back-end (2024). Also in 2024, Medicare cuts enacted under the sequester would double to 4 percent, but only for half of the year.

And then this: delaying the transition to ICD-10 until October 2015. If enacted, this would mark the second consecutive year in which ICD-10 was pushed back.

"A delay is not good at this time," says Stephen Stewart, CIO at Henry County Health Center, a critical access hospital in Iowa. "ICD-10 is too far down the implementation path."

Stewart worries about having to essentially double-spend on training for physicians and other staff if a delay goes into effect. And, as the AHA's Nelly Leon-Chisen writes in this month's *H&HN*, hospitals and insurers should be moving into the testing stage.

"Members are doing everything they can to get this done," Nickels adds. "This would bring that work to a grinding halt."

Stewart would rather see lawmakers turn their attention to delaying penalties for Stage 2 of the meaningful use program. That, he says, would provide more appropriate relief for the heavy IT work load providers are carrying.

The AHA, Nickels suggests, will look for policy options to keep ICD-10 on track for this year. With the SGR legislation essentially off the table this year, Nickels says that the AHA will also have to look for alternative vehicles to address key issues impacting hospitals. That includes two rules challenging rural hospitals: one requiring a physician at a CAH to certify at the time of admission that a Medicare beneficiary will be discharged or transferred within 96 hours; and a rule requiring direct supervision by a physician or nonphysician provider, such as a nurse practitioner, for outpatient physical therapy services.

What's Behind the SGR Formula?

John M. Froelich, MD, and Roshan P. Shah, MD, JD

One of the most confusing subjects of any healthcare reform discussion is the Sustainable Growth Rate (SGR) formula. The SGR formula is used by the Centers for Medicare & Medicaid Services to control spending by Medicare on physician services. This article aims to demystify the concept and help readers better understand this aspect of U.S. healthcare policy.

Background

In 1965, the United States government became the single largest healthcare insurance provider with the establishment of the Medicare and Medicaid programs. At first, Medicare reimbursed physicians for services provided based on a 'usual, customary, and reasonable' rate. Over the years, however, the cost of Medicare steadily crept higher.

Under the Omnibus Budget Reconciliation Act of 1992, Congress initially attempted to curb Medicare costs by establishing relative values for all services and applying common conversion factors to determine reimbursement rates. Importantly, this legislation failed to establish any substantial penalties if proposed budgetary goals were not met.

Fast-forward 5 years, and with new leadership in the House of Representatives, the Balanced Budget Act of 1997 (BBA) was passed. A key portion of the BBA was the introduction of the SGR formula to control Medicare costs.

The SGR and physicians

Although many people don't realize it, one key feature of the SGR formula is that it applies only to physician services under Medicare Part B. Specifically, the SGR formula does not affect or apply to hospital reimbursement rates.

The SGR formula attempts to rein in Medicare costs at a constant proportion of the federal budget by tying the Medicare budget to the Gross Domestic Product (GDP). For the first time in U.S. history, healthcare spending was tied directly to the country's economic performance.

The overall SGR calculated each year uses the following four basic estimations to formulate the target Medicare budget for a given year:

- estimated changes in physician fees
- estimated changes in number of Medicare beneficiaries
- 10-year average annual percentage change in GDP per capita
- Medicare budgetary changes based on current legislation

The exact calculation of the Target Medicare budget is more complex than the scope of this article, but the take-home message for every practicing physician can be summed up in this simple formula: *tRVU (total relative value units) × conversion factor = Medicare payment.*

The tRVU is established by the Relative value scale Update Committee (RUC), but the catch is the 'conversion factor.' The conversion factor is composed of two basic elements—the Medicare economic index (MEI) and the update adjustment factor (UAF)—and is determined by the following formula: $[(MEI + 1) \times (UAF + 1)] - 1 = \text{conversion factor}.$

Simply, the MEI is the estimated cost of doing business in a geographic region. It includes several regional expenses such as the cost of medical liability insurance, staffing salaries, and building costs.

The UAF is the driving force of cost control in calculating the SGR. The complex calculations behind the annual target budget are beyond the scope of this article, but it is obvious that the final UAF is a continual balance between achieving the target costs versus actual costs, as shown in [Fig. 1](#).

The reason physicians are now facing progressively larger cuts in reimbursements (requiring legislative patches) is shown in red. Based on this portion of the formula, any deviation from the target expense will be carried over from year to year until it is paid-off or balanced. Therefore, each year's adjustment factor decreases reimbursements until the total compounded difference between actual expenditures and target expenditures is rectified.

Based on current spending trends and legislative patches, the accumulated difference between the target and actual expenditures continues to grow and cannot be "zeroed out" unless large payment cuts are allowed to occur. The lack of flexibility to readjust the growing difference in target and actual expenditures and the across-the-board cut to all providers (no matter specialty or resource utilization) are two reasons the SGR is considered flawed. The compounding effect of the SGR is why temporary legislative patches lead to larger cuts in reimbursement in the future. What is needed is a legislative solution that addresses the basic math at the core of the SGR.

What's next?

Although the SGR was created to keep Medicare from overtaking the federal budget by tying target expenditures to the GDP, its formula includes a fatal flaw. The goal of the SGR was simple: to balance the target and actual expenses of Medicare. The catch, however, is that any

yearly deficit is carried forward and will influence the UAF for the next fiscal year.

This glimpse into the complexity of the SGR may give readers a better understanding of why we, as physicians, face enormous cuts with the expiration of every temporary patch. Over the coming months leading up to the next general election, the AAOS Washington Health Policy Fellows will provide brief informative articles about key issues in health policy.

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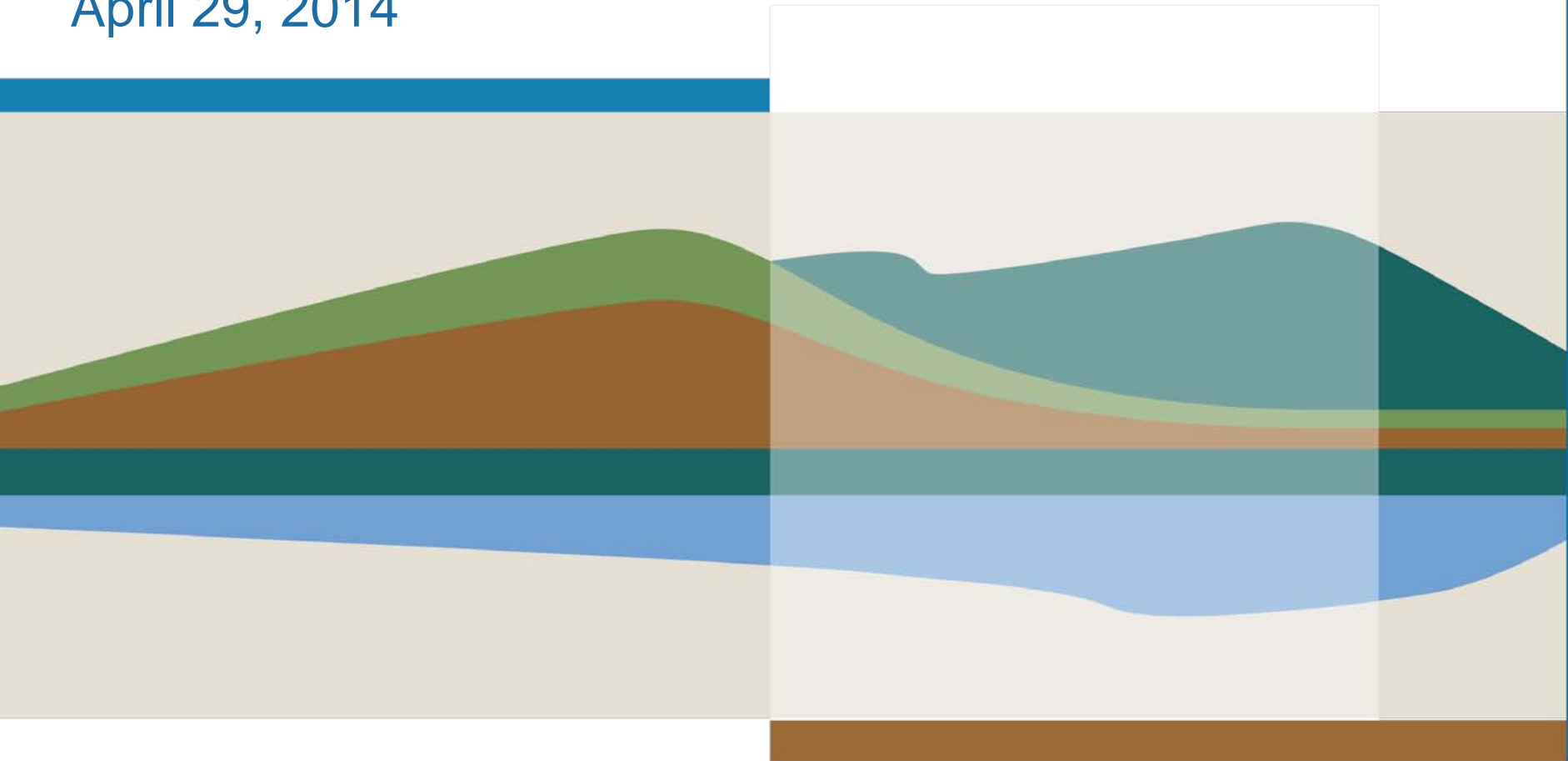
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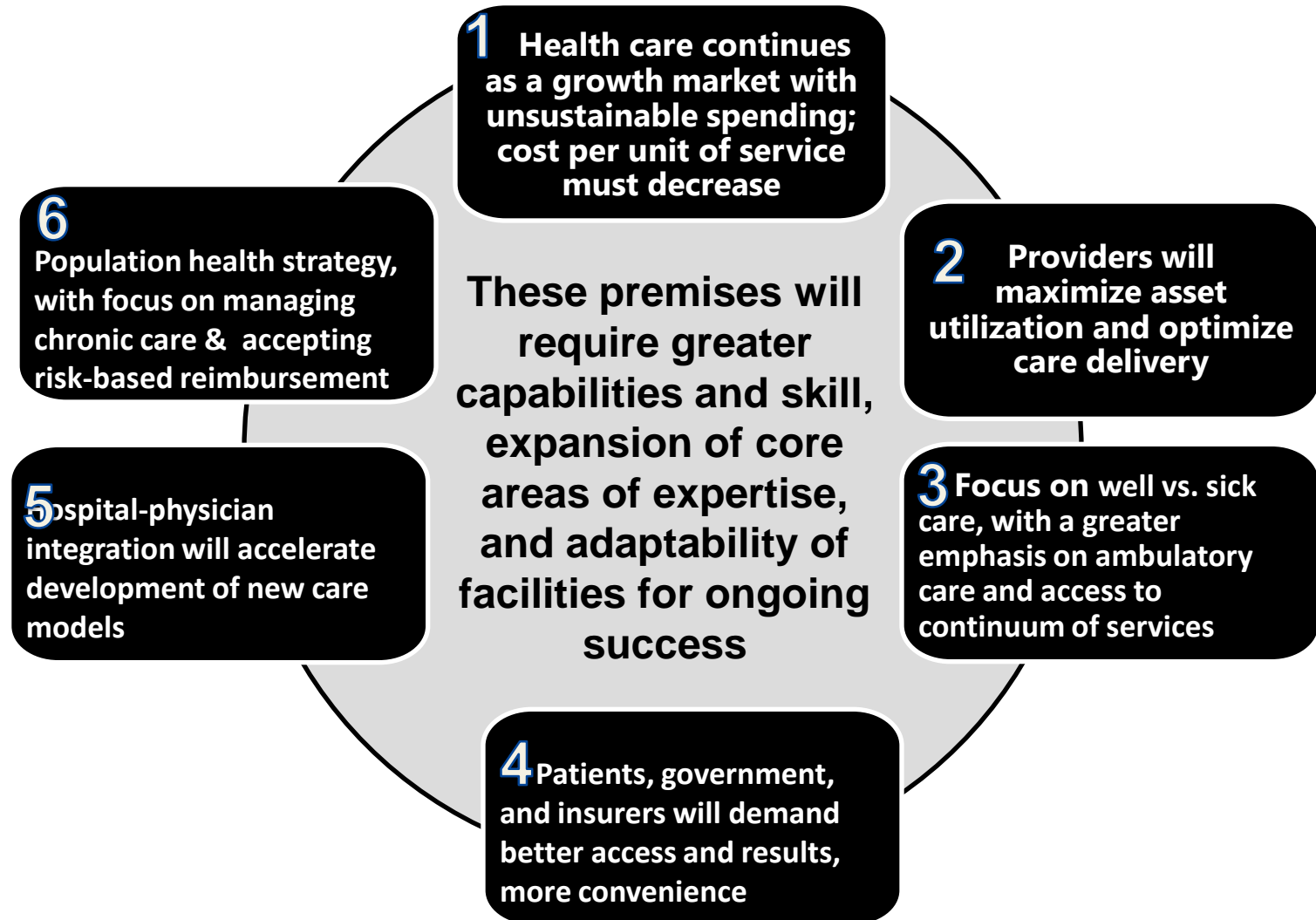
MGH Capitation Strategy

April 29, 2014



Our home. Our health. Our hospital.

Market Changes- Future Healthcare Premises – Community Providers



The Changing Healthcare Economic Model

- Hospital revenues have historically been built on the premise of ever increasing utilization and rate increases, totaling 6% - 8% per year, which was generally sufficient to support increased costs including pay raises, new programs, etc. that totaled 5% - 7% per year.
- However, under our new paradigm, inpatient utilization is decreasing and rate increases, if any, are very modest, which will result in annual revenue increases of 2% - 4% per year, absent new programs or market share growth.
- To survive, we are going to have to reduce cost growth, develop new programs, gain market share, and/or change our economic model to one that works better in the current environment.

California Provider Response to Market Changes

Risk Based Contracting

- Accept risk based approach to managing populations (ACO's, full risk) as a way to ensure future financial viability (maintain or grow revenue stream)
- Developing collaborative relationships with payors
- Developing insurance products which allow providers to contract directly with employers

Hospital/MD integration

- Develop stronger physician partnerships using joint management and/or employment models
- Joint management of patient's along the continuum of care

Cost Reduction

- Implement incentives to offset revenue losses due to reimbursement reductions
- Aggressively manage internal costs like never before

Population Health Management

- Development capability (clinical, operational and financial) to efficiently manage the health of a population (care coordination, analytics, network development)

Incentives of Fee For Service vs. Capitation

- Fee For Service

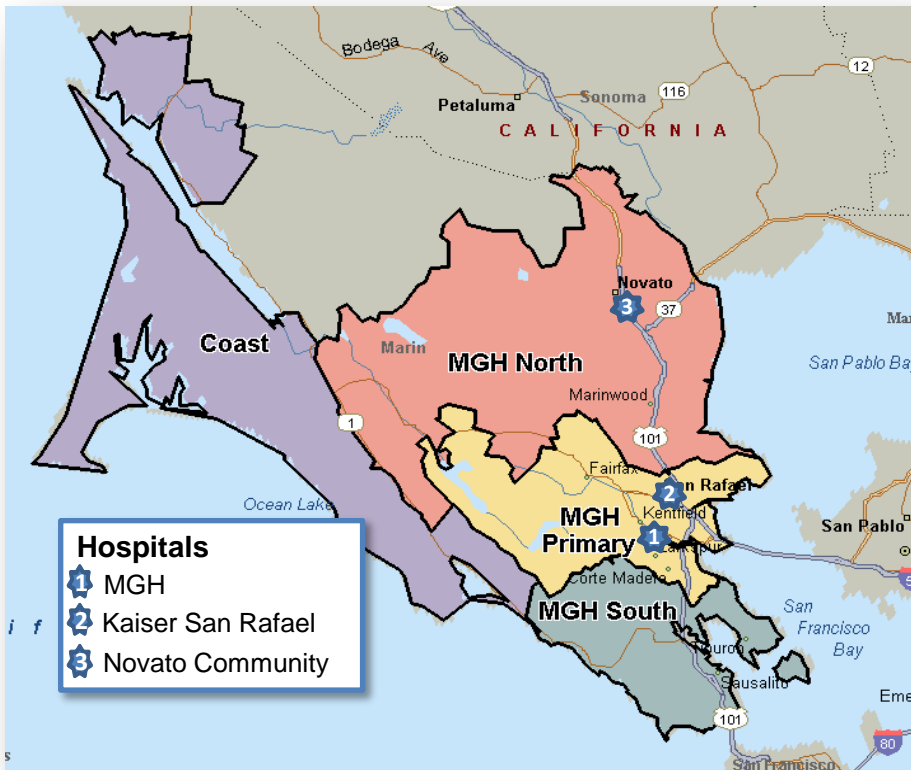
- We get paid only when we do something to somebody.
- We have an economic incentive to do more things and to do the most costly things.
- We have no economic incentive to do things that might be otherwise good, but for which we don't get paid.
- We often have different incentives than our payers; interests are not aligned.
- We don't really have to think about our patients when they are not in our direct care.

- Capitation (Prepaid Healthcare)

- Revenues are fixed based on enrollment.
- We have an incentive to improve efficiency and reduce inappropriate utilization.
- We can change the system in ways that wouldn't make sense before.
- We have an incentive to engage in population management – to keep people well and out of the hospital.

Market Share with MGH's Service Area

- **MGH continues to be the market leader in each of its submarkets**
 - » MGH's market share has slightly increased between 2010-2011, losing share in the North and South, while gaining share in the Primary and Coast regions
 - » Growing in-migration from the North
- **MGH In-Migration of patients has grown**



Submarket	Market Share		MGH Volume Change
	2010	2011	
Primary	51.3%	54.9%	122
North	31.7%	30.0%	(171)
Coast	30.6%	31.5%	(9)
South	44.4%	42.7%	(89)
Total	41.9%	42.2%	(147)

In-migration as % of discharges			
Total	13.4%	14.1%	49

Market Share – Discharges vs. Revenue

- MGH typically defines it's market share as our percent of Inpatient Discharges from the County, about 44%.
- Kaiser defines its market share based on enrolled lives, about 45%.
- However, we estimate that the total market for healthcare services in Marin County is about \$1.7 billion per year.
- Using that metric, MGH has only a 19% market share compared to Kaiser's 38%.

Marin County - Est HC \$ total	Population	PMPM Cost	Ann Net Rev
Medicare	55,000	\$ 1,000	660,000,000
Insured	170,000	\$ 600	1,224,000,000
Other	40,000	\$ 200	96,000,000
Total Healthcare Spending	265,000		\$ 1,980,000,000
MGH Annual Net Revenue			\$ 360,000,000
MGH Actual Market Share (Est)			18%
Estimated Kaiser Net Revenue	Population	PMPM	Ann Net Rev
Medicare	15,000	\$ 1,000	180,000,000
Insured	57,800	\$ 600	416,160,000
Other	-	\$ 200	-
Kaiser Market Revenue (Est)	72,800		\$ 596,160,000
Kaiser Estimated Market Share			30%

MGH Capitated Agreements

Scan

- Medicare Advantage product

- Effective 1-1-14-Marin (expansion to Sonoma in 2015)

- Current enrollment 350

- Meritage physician group

WHA

- Commercial HMO product

- Effective 1-1-14-Marin, Sonoma

- Current enrollment 1,884

- Meritage physician group

PHP

- Managed Medi-Cal product

- Effective 1-1-14-Marin (current discussions re:expansion to Sonoma)

- Current enrollment 8,727

- No physician partner

Current Enrollment – PHP, WHA, and SCAN

	Enrollment/Member Months			
	PHP	WHA	SCAN	Total
Jan	9,059	1,332	332	10,723
Feb	10,388	1,893	345	12,626
Mar	10,828	1,842	351	13,021
Total	30,275	5,067	1,028	36,370
	Premium Revenue			
	PHP	WHA	SCAN	Total
Jan	618,263	211,005	99,179	928,447
Feb	809,364	313,034	65,139	1,122,398
Mar	864,851	290,223	83,350	1,155,074
Total	2,292,478	814,262		3,205,920
	Revenue PMPM			
	PHP	WHA	SCAN	Total
Jan	\$ 68.25	\$ 158.41	\$ 298.73	\$ 86.58
Feb	\$ 77.91	\$ 165.36	\$ 188.81	\$ 88.90
Mar	\$ 79.87	\$ 157.56	\$ 237.46	\$ 88.71
Total	\$ 75.34	\$ 160.44	\$ 241.67	\$ 88.06

MGH Revenue Opportunity

- MGH can realistically target \$180 million of annual prepaid revenue within the next 5 years.
- But, we would have to work with our physicians (Meritage and Prima) to grow enrolled lives, take the premium back from the insurance companies, share risk, and manage utilization.

Commercial	Cost PMPM	Annual Net Revenue - Commercial		
		10K Lives	25K Lives	50K Lives
Inpatient Hospital	\$ 125	\$ 15,000,000	\$ 37,500,000	\$ 75,000,000
Outpatient Hospital	\$ 150	\$ 18,000,000	\$ 45,000,000	\$ 90,000,000
Professional	\$ 175	\$ 21,000,000	\$ 52,500,000	\$ 105,000,000
Drugs and Other	\$ 90	\$ 10,800,000	\$ 27,000,000	\$ 54,000,000
Administration & Profit	\$ 60	\$ 7,200,000	\$ 18,000,000	\$ 36,000,000
Total	\$ 600	\$ 72,000,000	\$ 180,000,000	\$ 360,000,000
Medicare	Cost PMPM	Annual Net Revenue - Medicare		
		10K Lives	15K Lives	20K Lives
Inpatient Hospital	\$ 250	\$ 30,000,000	\$ 45,000,000	\$ 60,000,000
Outpatient Hospital	\$ 250	\$ 30,000,000	\$ 45,000,000	\$ 60,000,000
Professional	\$ 250	\$ 30,000,000	\$ 45,000,000	\$ 60,000,000
Drugs and Other	\$ 175	\$ 21,000,000	\$ 31,500,000	\$ 42,000,000
Administration & Profit	\$ 75	\$ 9,000,000	\$ 13,500,000	\$ 18,000,000
Total	\$ 1,000	\$ 120,000,000	\$ 180,000,000	\$ 240,000,000

So far, MGH Response to market changes has been good

- Case management focus on appropriately reducing length of stay
- Strong Primary care physician base established
- Participation in risk based agreements (WHA, SCAN, PHP Inpatient, MCR ACO)
- Consolidating risk contracting for affiliate hospitals, 1206b and Prima
- Have financial infrastructure to manage full risk (financial reporting, network development, case management) and can expand functionality to utilization management services
- Scope and breadth expansion to leverage economies of scale, lower cost, improve utilization and clinical outcomes
- Integrated system of hospitals and physicians
- Continued investment in technology such as CareinSync, Thrasys
- Push to lower cost structure through initiatives like MedAssets,
- Others...

2014 Payor Capitation/Risk Strategy

1. Preferred Payor Risk Contracting

- Move from parity of rates to “preferred payer” partnerships
- Development of operational and financial capability to support risk based agreements
- Convert HMO to full/partial risk agreements, as indicated
- Convert PPO, POS to shared savings in addition to fixed case rates where possible

2. Hospital/MD Integration

- Develop stronger physician group partnerships with Meritage for HMO
- Align physician compensation to reward performance with Prima and 1206b Clinics for PPO
- Joint physician/hospital management of patient’s along the continuum of care
- Consider physicians as equal partners in risk share arrangements

3. Cost Reductions

- Develop financial model to adjust to emphasis on non-hospital centric care model over time
- Develop outpatient clinical programs to lower total cost of care (palliative care, patient centered medical home, etc)
- Implement incentives so physicians share in the savings
- Creative alternative compensation to other providers (Ancillary, Home Health, Pharmacy, etc)

4. Population Health Management

- Manage the cost and quality of care across the entire continuum (home-outpatient-acute-intensive care)
- Improve access, transparency on cost and quality
- Develop analytic capabilities to identify and manage sickest people

Capitation Infrastructure Development:

Current:

- Medical Management outside hospital is Meritage for HMO contracts
- Claim payment through HealthComp with good reports and oversight
- Knowledgeable but limited staff –mainly in contracting department

Future:

- Build population management expertise-analytics, case management
- Transfer center for hospital services between affiliates, tertiary care and when OOA
- Coordinated care for managed population (HMO) extended to partner plan populations (PPO)
- Network development to maximize capitation contracts performance

2014 Payer Strategy Summary

1. Focus strategic efforts on a few “preferred partners” while continuing to work with all payers
 - Define expectations of payer partners
 - Move to full/shared risk agreements for HMO and PPO products with partners
2. Renegotiate payer contracts with
 - Fixed payment structures
 - Rate differential for “preferred partners” and non-strategic partners
3. Develop plan with affiliated physician groups to more aggressively manage the health of our patient population (Meritage for HMO and Prima/1206b for PPO) and continue infrastructure development to maximize performance.
4. Develop legal structure to negotiate contracts on behalf of affiliates (SVH, PDH, Prima, 1206b Clinics).

Questions???