

CAH Financial Indicators Report
State of Kansas
Report Produced: Summer 2004

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Table of Contents

Report Overview	3
Understanding the Report	5
Profitability Indicators	6
Total Margin	6
Cash Flow Margin	7
Return on Equity	8
Liquidity Indicators	9
Current Ratio	9
Days Cash on Hand	10
Net Days Revenue in Accounts Receivable	11
Capital Structure Indicators	12
Equity Financing	12
Debt Service Coverage	13
Long-Term Debt to Capitalization	14
Revenue Indicators	15
Outpatient Revenues to Total Revenues	15
Patient Deductions	16
Medicare Inpatient Payer Mix	17
Medicare Outpatient Payer Mix	18
Medicare Outpatient Cost to Charge	19
Medicare Revenue per Day	20
Cost Indicators	21
Salaries to Total Expenses	21
Average Age of Plant	22
FTEs per Adjusted Occupied Bed	23
Utilization Indicators	24
Average Daily Census Swing-SNF Beds	24
Average Daily Census Acute Beds	25
Summary Table	26
Technical Appendix	27

Report Overview

What is the purpose of this report?

Throughout the business world, organizations have recognized the need to develop appropriate benchmarking tools. Using Medicare Cost Report data filed by the Critical Access Hospitals (CAHs) in your state, this report has been developed to provide national comparative financial performance data on CAHs.

As the first in a series of reports, you may use these reports to track the median performance of CAHs in your state and in relation to national medians.

Who developed this report?

This report was developed by researchers at the University of North Carolina at Chapel Hill, members of the Flex Monitoring Team, with funding from the federal Office of Rural Health Policy. The team of researchers consisted of George H. Pink PhD, G. Mark Holmes PhD, and Rebecca T. Slifkin PhD, with research assistance from Patrick McGee CPA, Cameron D'Alpe MSPH, and Lindsay Strunk and advice from the Technical Advisory Group (TAG).

Who is on the Technical Advisory Group (TAG)?

The TAG is composed of individuals with extensive experience with rural hospital finance and operations. With backgrounds as consultants and accountants for small rural hospitals, the TAG members include Dave Berk (Rural Health Financial Services, Anacortes, Washington), Brandon Durbin CPA (Durbin & Company, LLP, Lubbock, Texas), Roger Thompson CPA, FHFMA (Seim, Johnson, Sestak & Quist LLP, Omaha, Nebraska), and Gregory Wolf (Stroudwater Associates, Portland, Maine).

How was this report developed?

First, the research team performed a literature review to develop a list of financial ratios that have proven useful for determining hospital financial performance. This list was then discussed with the TAG, and twenty indicators that were deemed appropriate for the assessment of CAH financial performance were chosen. The ratios were calculated using data filed with the Centers for Medicare and Medicaid Services on Medicare's Hospital Cost Report (CMS-2552-96). Items included in the numerators and denominators of the ratios were refined during an iterative process with the TAG.

What data are in this report?

This report compares the median performance of CAHs in your state to national trends. State medians are not reported if less than five hospitals report a valid measure. For this report, no more than one year of the state median is reported. In future reports, we hope to include multiple years. Because the indicators and their definitions are not yet finalized, this year we have only sent hospital-specific information to the hospital administrators. The administrators, of course, are welcome to share this information with you, if they so choose. It is our plan to use feedback about this year's reports to improve the indicators for next year, at which time we will share individual hospital-level data with both the specific hospital administrator and the State Flex Coordinator. Please feel free to distribute copies of this report to any relevant stakeholders.

How should this report be used?

It is likely that your state will have some indicators that look "good" and some that look "bad" relative to the national medians, which may make the overall financial position of the CAHs in your state difficult to determine. For this reason, significant judgment is required when analyzing financial and operating performance. Furthermore, interpretation of the indicators will require knowledge of the operating reality of CAHs. In short, the indicators in this report will help you to identify questions to ask, issues to address, and problems to solve, but they will not necessarily provide you with answers, explanations, or solutions.

What types of financial indicators does this report include?

- **Profitability indicators** measure the ability of the organization to generate the financial return required to replace assets, meet increases in service demands, and compensate investors (in the case of a for-profit organization).
- **Liquidity indicators** measure the ability of an organization to meet its cash obligations in a timely manner.
- **Capital structure indicators** measure the extent to which an organization uses debt and equity financing.
- **Revenue indicators** measure the amount and mix of different sources of revenue.
- **Cost indicators** measure the amount and mix of different types of costs.
- **Utilization indicators** measure the extent to which fixed assets (beds) are fully occupied.

What are some of the findings of this report?

The financial performance of a hospital is determined by many factors, including management decisions, clinical practices, government policies, technological change, and the supply of human resources. For CAHs in particular, the literature and experience suggest that financial performance is strongly influenced by:

- **Patient volume.** More patient activity generates higher revenues and reduces unit costs by spreading fixed costs over more patients.
- **Clinical staff.** An effective mix of medical, nursing, and other staff that can meet local patient demand reduces the number of patients who obtain care at other hospitals.
- **Payer mix.** A substantial proportion of revenue from commercial and private payers reduces the reliance on the fixed margins of Medicare and Medicaid.
- **Cost management.** A system of cost management reduces the likelihood of financial problems due to excessive costs.

In 2003, CAHs without long-term care generally were more profitable, were more liquid, had less debt, and had higher utilization of beds in comparison to CAHs with long-term care. Since 1998, CAHs without long-term care generally have become more profitable, have become less liquid, increased their use of debt, and increased their utilization of beds. Over the same 6 years, CAHs with long-term care generally have become more profitable, have become more liquid, reduced their use of debt, and increased their utilization of beds.

What are the limitations of this report?

- **Use of historical data.** Indicator values reflect the results of past decisions and may not be predictive of future results.
- **Variations in CAH service mix.** Among CAHs there is significant variation in the volume and types of services provided, including physician clinics, home health services, wellness centers, and diagnostic and treatment technology. Indicator values may reflect variation in service mix.
- **No consensus about good performance.** For many of the indicators in this report, there are no ranges of values that are generally accepted to be “good performance” or “bad performance”.
- **Data quality concerns.** Other studies and this report identify various data quality concerns with Medicare Cost Report information. It is our hope that dissemination of indicators that use data from Medicare Cost Reports to CAHs will identify further data quality problems, which could lead to better data in the future. In the meantime, readers should be aware that there are reporting variations and other data quality concerns that could affect the validity of the indicators.

How will this report be evaluated?

As this report is meant to assist you, we welcome any comments or suggestions that you may have. We will attempt to incorporate suggestions in next year’s report. To assist with the evaluation of this report, please fill out the enclosed evaluation form and return it in the enclosed postage paid envelope.

Understanding the Report

This report contains statistics on twenty financial indicators. The indicators are grouped by the financial principle they measure [Profitability, Liquidity, Capital Structure, Revenue, Cost, and Utilization]. Each indicator is featured in a one page fact sheet. The fact sheet (see Figure 1) contains five sections. The first section defines the indicator in terms of financial accounts and Medicare Cost Report lines. The second section contains a paragraph describing the results for the most recent year available. It compares the median indicator for CAHs in your state to the median¹ value for the nation. National medians are reported separately for hospitals with and without long-term care. State medians are not reported if less than five hospitals report a valid measure. For this report, no more than one year of the state median is reported. In future reports, we hope to include multiple years. Note that the state median includes hospitals with and without long-term care. The third section includes trends for national medians. These trends are graphed and presented in tabular format. The final two sections discuss national trends and some details on the calculation of the financial indicator.

Figure 1: Sample Fact Sheet

Definitions: Formulae for the indicator in both conceptual and Medicare Cost Report format.

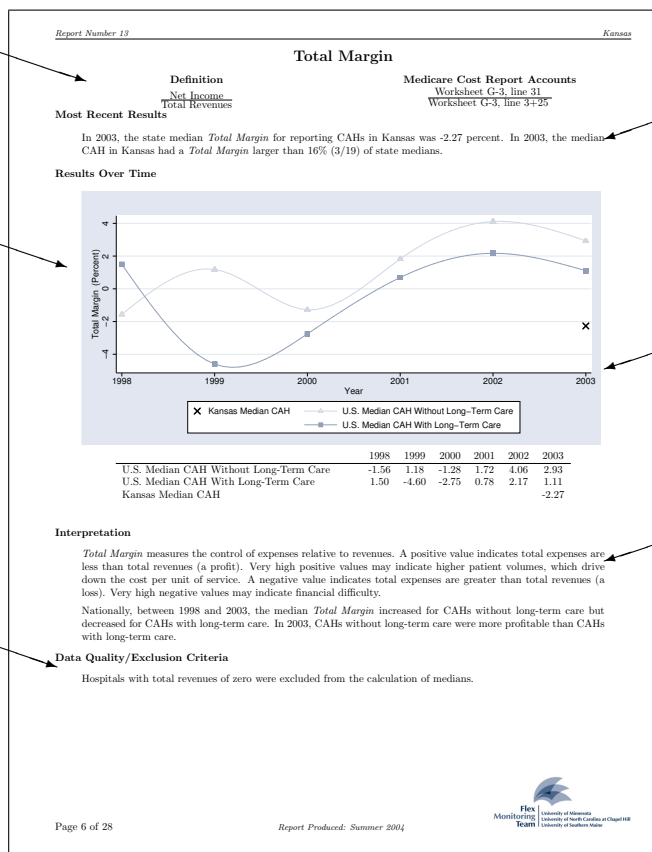
Results Over Time: A graphical and tabular comparison of the state median to national trends over the past few years.

Data Quality/Exclusion Criteria: A description of the rules that were used to define whether a ratio is presented.

Most Recent Results: A snapshot comparing the state median to national data in the most recent year.

National medians for hospitals with long-term care and without long-term care are computed separately. The most recent state median is also presented if five or more values are valid.

Interpretation: A description of the indicator and an overview of national trends.



¹The *median* is the value for which half of the hospitals have a larger value and half of the hospitals have a lower value. It is less sensitive to extreme values than an arithmetic average.

Total Margin

Definition

$$\frac{\text{Net Income}}{\text{Total Revenues}}$$

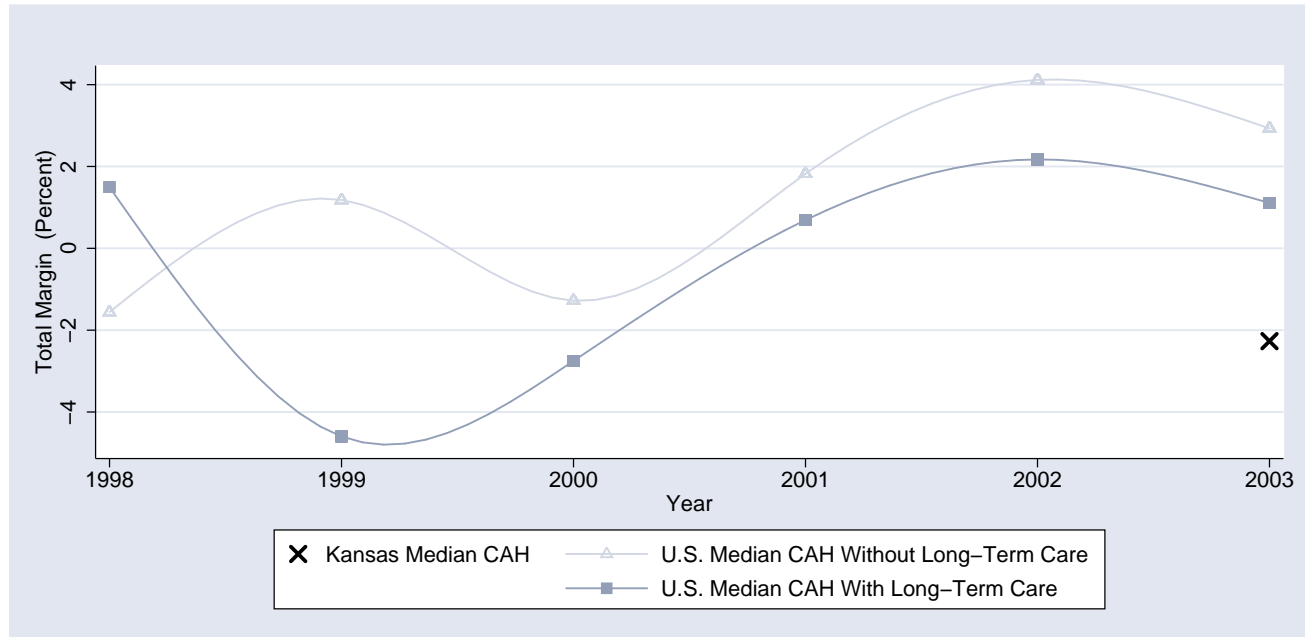
Medicare Cost Report Accounts

Worksheet G-3, line 31
Worksheet G-3, line 3+25

Most Recent Results

In 2003, the state median *Total Margin* for reporting CAHs in Kansas was -2.27 percent. In 2003, the median CAH in Kansas had a *Total Margin* larger than 16% (3/19) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	-1.56	1.18	-1.28	1.72	4.06	2.93
U.S. Median CAH With Long-Term Care	1.50	-4.60	-2.75	0.78	2.17	1.11
Kansas Median CAH						-2.27

Interpretation

Total Margin measures the control of expenses relative to revenues. A positive value indicates total expenses are less than total revenues (a profit). Very high positive values may indicate higher patient volumes, which drive down the cost per unit of service. A negative value indicates total expenses are greater than total revenues (a loss). Very high negative values may indicate financial difficulty.

Nationally, between 1998 and 2003, the median *Total Margin* increased for CAHs without long-term care but decreased for CAHs with long-term care. In 2003, CAHs without long-term care were more profitable than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals with total revenues of zero were excluded from the calculation of medians.

Cash Flow Margin

Definition

(Net Income - (Contrib., Invest. and Approp. + Depreciation Expense + Interest Expense) / Net Patient Revenue + Other Income - Contributions, Investments, and Appropriations

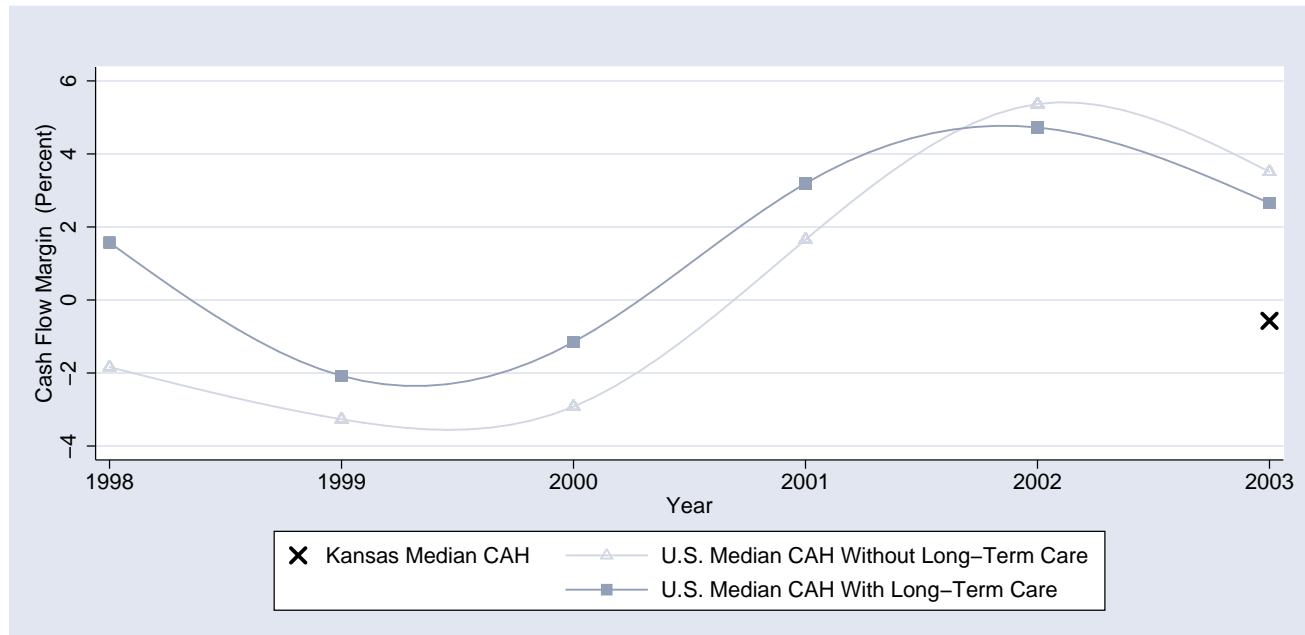
Medicare Cost Report Accounts

Worksheet G-3, line 31 - Worksheet G-3, lines 6, 7, 23 + Worksheet A, col. 3, lines 1-4 + Worksheet A, col. 3, line 88
Worksheet G-3, line 3 + Worksheet G-3, line 25 - Worksheet G-3, lines 6, 7, 23

Most Recent Results

In 2003, the state median *Cash Flow Margin* for reporting CAHs in Kansas was -0.57 percent. In 2003, the median CAH in Kansas had a *Cash Flow Margin* larger than 21% (4/19) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	-1.84	-3.27	-2.92	1.65	5.31	3.51
U.S. Median CAH With Long-Term Care	1.57	-2.08	-1.15	3.22	4.73	2.65
Kansas Median CAH						-0.57

Interpretation

Cash Flow Margin measures the ability to generate cash flow from providing patient care services. A positive value indicates cash outflows are less than cash inflows. A negative value indicates cash outflows are greater than cash inflows.

Nationally, between 1998 and 2003, the median *Cash Flow Margin* increased for both CAHs without long-term care and CAHs with long-term care. In 2003, CAHs without long-term care were more profitable than CAHs with long-term care.

Data Quality/Exclusion Criteria

There may be variations in non-cash items included in net income. Hospitals with net patient revenue, other income, and contributions, investments and appropriations that sum to zero were excluded from the calculation of medians.

Return on Equity

Definition

$$\frac{\text{Net Income}}{\text{Fund Balance}}$$

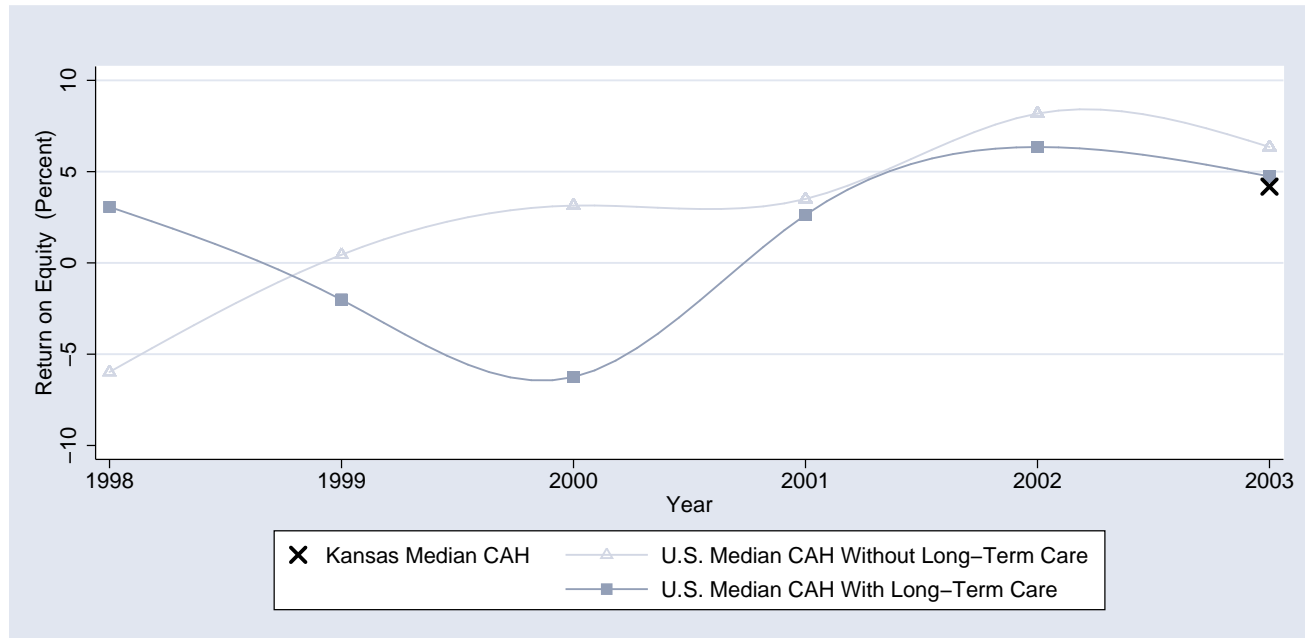
Medicare Cost Report Accounts

Worksheet G-3, line 31
Worksheet G, col. 1-4, line 51

Most Recent Results

In 2003, the state median *Return on Equity* for reporting CAHs in Kansas was 4.18 percent. In 2003, the median CAH in Kansas had a *Return on Equity* larger than 44% (7/16) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	-5.97	0.45	3.14	3.50	8.17	6.35
U.S. Median CAH With Long-Term Care	3.07	-2.02	-6.25	2.88	6.35	4.74
Kansas Median CAH						4.18

Interpretation

Return on Equity measures the net income generated by equity investment (fund balance). In a not-for profit entity, the equity represents the sum of federal, state, and local grants, contributions, and the accumulated earnings of the hospital. A positive value indicates net income was generated by equity investment. Very high positive values may indicate an opportunity for debt financing. A negative value indicates a net loss was generated by equity investment. Very high negative values may indicate financial difficulty.

Nationally, between 1998 and 2003, the median *Return on Equity* decreased for CAHs without long-term care but increased for CAHs with long-term care. In 2003, CAHs without long-term care were more profitable than CAHs with long-term care.

Data Quality/Exclusion Criteria

The real equity of a hospital may not be reflected in its fund balance if it is part of a larger system. Hospitals with a fund balance of \$1 or less were excluded from the calculation of medians.

Current Ratio

Definition

$$\frac{\text{Current Assets}}{\text{Current Liabilities}}$$

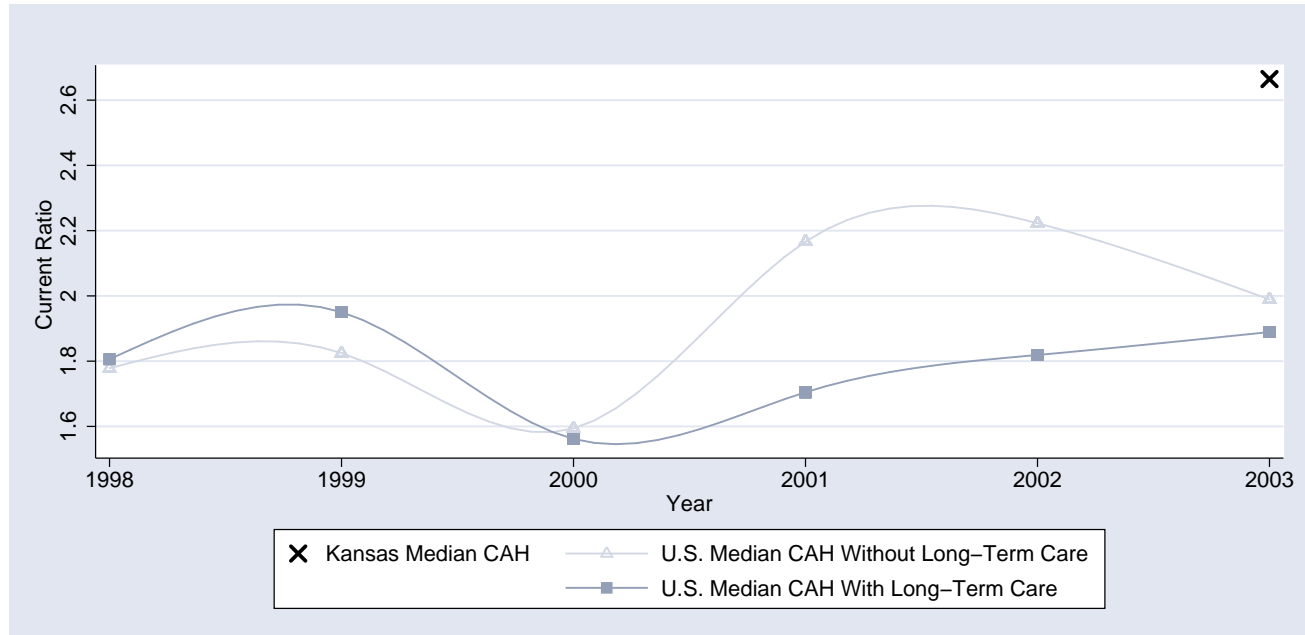
Medicare Cost Report Accounts

Worksheet G, col. 1-4, line 11
Worksheet G, col. 1-4, line 36

Most Recent Results

In 2003, the state median *Current Ratio* for reporting CAHs in Kansas was 2.66. In 2003, the median CAH in Kansas had a *Current Ratio* larger than 82% (14/17) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	1.78	1.82	1.59	2.16	2.22	1.99
U.S. Median CAH With Long-Term Care	1.81	1.95	1.56	1.71	1.82	1.89
Kansas Median CAH						2.66

Interpretation

Current Ratio measures the number of times short-term obligations can be paid using short-term assets. A value greater than 1.0 indicates current assets are greater than current liabilities. Very high values may indicate under-investment in longer-term assets that usually yield higher returns. A value less than 1.0 indicates current assets are less than current liabilities. Very low values may indicate financial difficulty.

Nationally, between 1998 and 2003, the median *Current Ratio* decreased for CAHs without long-term care but increased for CAHs with long-term care. In 2003, CAHs without long-term care were more liquid than CAHs with long-term care.

Data Quality/Exclusion Criteria

There may be variations in the classification of investments as either current or long-term. Hospitals with negative current assets or negative current liabilities were excluded from the calculation of medians.

Days Cash on Hand

Definition

$$\frac{\text{Cash} + \text{Marketable Securities} + \text{Unrestricted Investments}}{(\text{Total Expenses-Depreciation})/\text{Days in Period}}$$

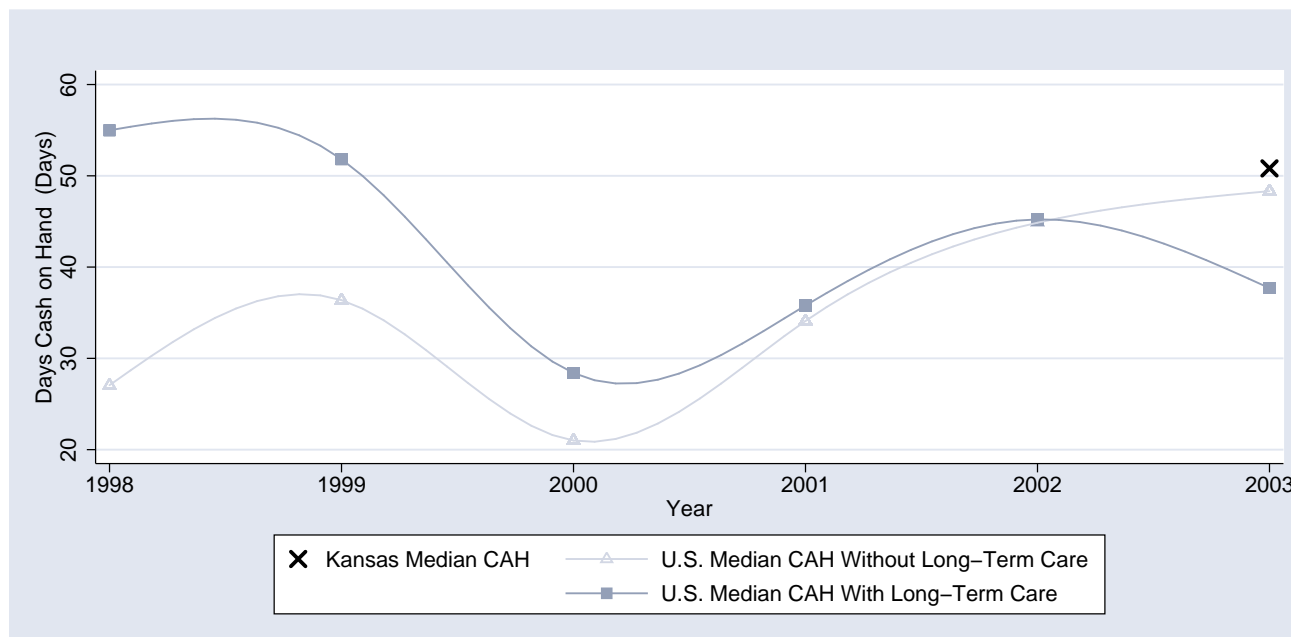
Medicare Cost Report Accounts

$$\frac{\text{Worksheet G, col. 1-4, lines 1, 2, 22}}{(\text{W/S A, col. 3, line 101-W/S A, col. 3, lines 1-4})/\text{Days in Period}}$$

Most Recent Results

In 2003, the state median *Days Cash on Hand* for reporting CAHs in Kansas was 50.81 days. In 2003, the median CAH in Kansas had a *Days Cash on Hand* larger than 58% (11/19) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	27.06	36.38	21.00	34.40	44.86	48.32
U.S. Median CAH With Long-Term Care	54.99	51.82	28.39	34.64	45.23	37.70
Kansas Median CAH						50.81

Interpretation

Days Cash on Hand measures the number of days an organization could operate if no cash was collected or received. A low value indicates only a few days of cash on hand. Very low values may indicate financial difficulty. A high value indicates many days of cash on hand. Very high values may indicate under-investment in longer-term assets that usually yield higher returns. *Days Cash on Hand* is calculated at fiscal year end, which does not reflect uneven cash flows throughout the year.

Nationally, between 1998 and 2003, the median *Days Cash on Hand* increased for CAHs without long-term care but decreased for CAHs with long-term care. In 2003, CAHs without long-term care were more liquid than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals with negative *Days Cash on Hand* were excluded from the calculation of medians, as were those with total expenses of zero. It is possible that worksheet G, columns 1-4, line 22 could include donor restricted, trustee restricted, or board designated investments.

Net Days Revenue in Accounts Receivable

Definition

$$\frac{\text{Net Patient Accounts Receivable}}{(\text{Net Patient Service Revenue})/\text{Days in Period}}$$

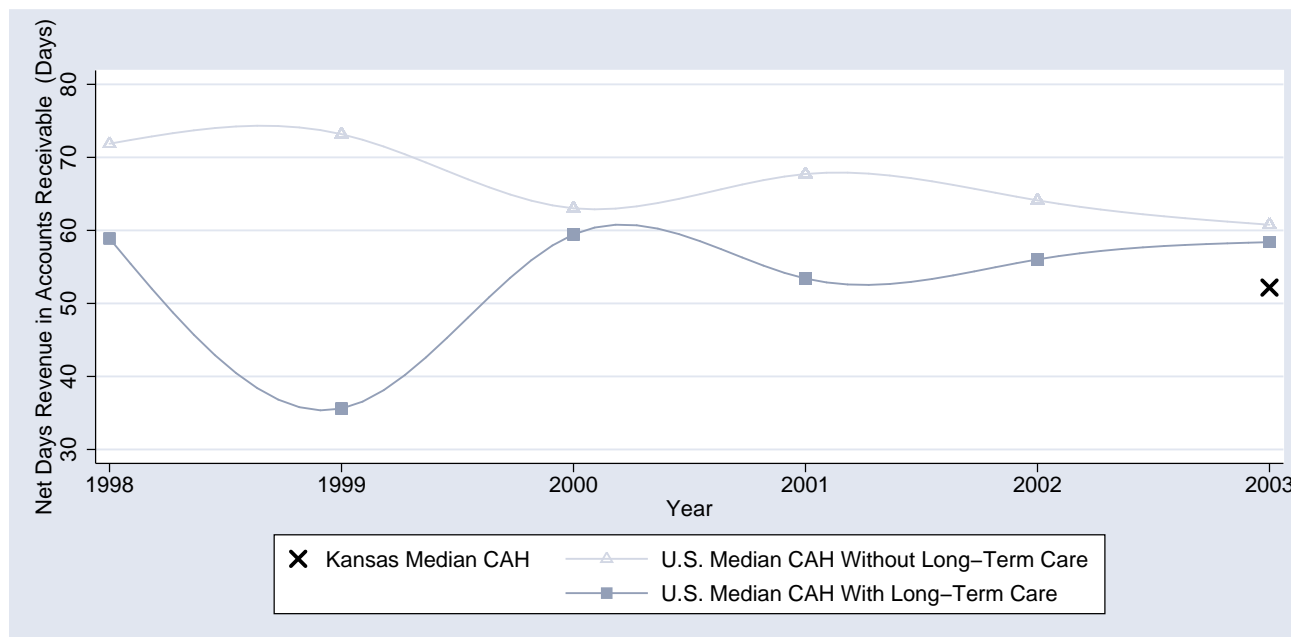
Medicare Cost Report Accounts

$$\frac{\text{Worksheet G, col. 1, line 4 - | Worksheet G, col. 1, line 6|}}{\text{Worksheet G-3, line 3 / Days in Period}}$$

Most Recent Results

In 2003, the state median *Net Days Revenue in Accounts Receivable* for reporting CAHs in Kansas was 52.17 days. In 2003, the median CAH in Kansas had a *Net Days Revenue in Accounts Receivable* larger than 11% (2/19) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	71.87	73.18	63.02	67.05	64.11	60.78
U.S. Median CAH With Long-Term Care	58.90	35.60	59.46	52.85	56.03	58.39
Kansas Median CAH						52.17

Interpretation

Net Days Revenue in Accounts Receivable measures the number of days that it takes an organization, on average, to collect its receivables. A high value indicates many days to collect receivables. Very high values may indicate a need to review collection policies and procedures. A low value indicates only a few days to collect receivables and may indicate a more efficient system for processing accounts receivable, higher Medicare and Medicaid payer mix, offering of long-term care services, or some combination.

Nationally, between 1998 and 2003, the median *Net Days Revenue in Accounts Receivable* decreased for CAHs without long-term care but increased for CAHs with long-term care. In 2003, CAHs without long-term care were less liquid than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals with negative *Net Days Revenue in Accounts Receivable* and those with net patient service revenue of zero were excluded from the calculation of medians.

Equity Financing

Definition

$$\frac{\text{Fund Balance}}{\text{Total Assets}}$$

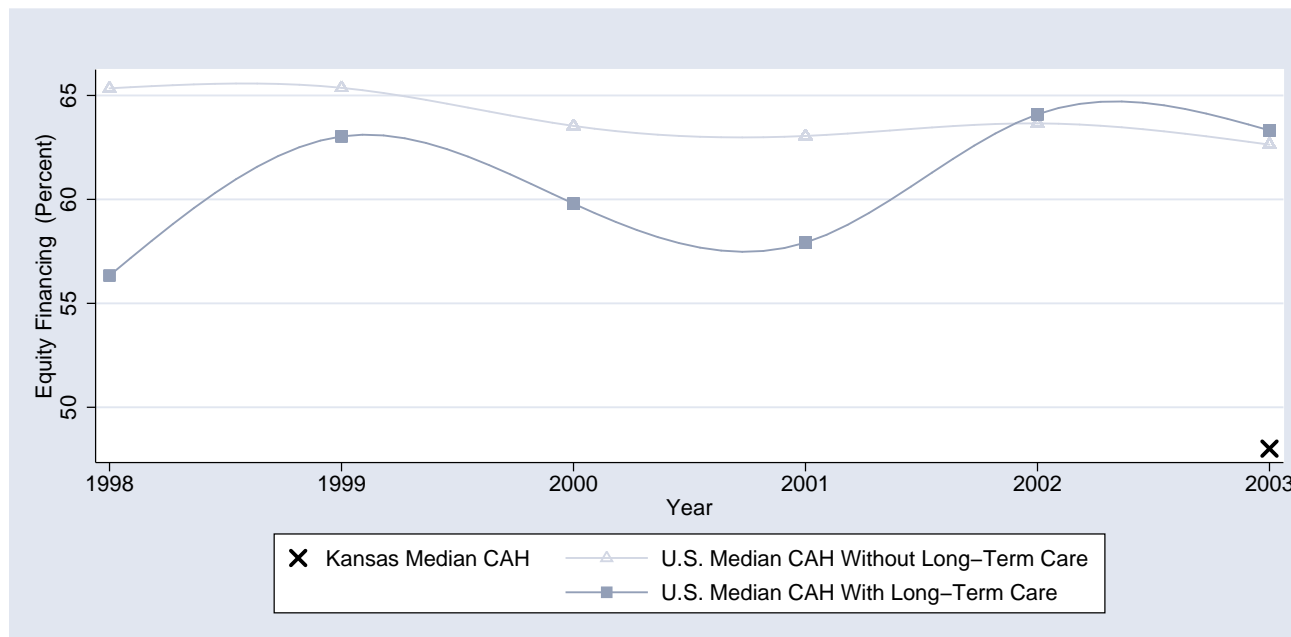
Medicare Cost Report Accounts

Worksheet G, col. 1-4, line 51
Worksheet G, col. 1-4, line 27

Most Recent Results

In 2003, the state median *Equity Financing* for reporting CAHs in Kansas was 48.01 percent. In 2003, the median CAH in Kansas had an *Equity Financing* larger than 25% (4/16) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	65.35	65.37	63.54	63.45	63.66	62.64
U.S. Median CAH With Long-Term Care	56.34	63.03	59.80	57.90	64.10	63.32
Kansas Median CAH						48.01

Interpretation

Equity Financing measures the percentage of total assets financed by equity. In a not-for profit entity, equity represents the sum of federal, state and local grants, contributions, and the accumulated earnings of the hospital. A value greater than 50 percent indicates that more of the assets are financed by equity than by debt. Very high values may indicate opportunities for debt financing. A value less than 50 percent indicates that more of the assets are financed by debt than by equity. Very low values may indicate exposure to financial risk because debt service is a fixed charge.

Nationally, between 1998 and 2003, the median *Equity Financing* decreased for CAHs without long-term care but increased for CAHs with long-term care. In 2003, CAHs without long-term care had lower *Equity Financing* than CAHs with long-term care.

Data Quality/Exclusion Criteria

The real equity of a hospital may not be reflected in its fund balance if it is part of a larger system. Hospitals with a fund balance of \$1 or less were excluded from the calculation of medians.

Debt Service Coverage

Definition

$$\frac{\text{Net Income} + \text{Depreciation} + \text{Interest Expense}}{\text{Current Portion of Long-term Debt} + \text{Interest Expense}}$$

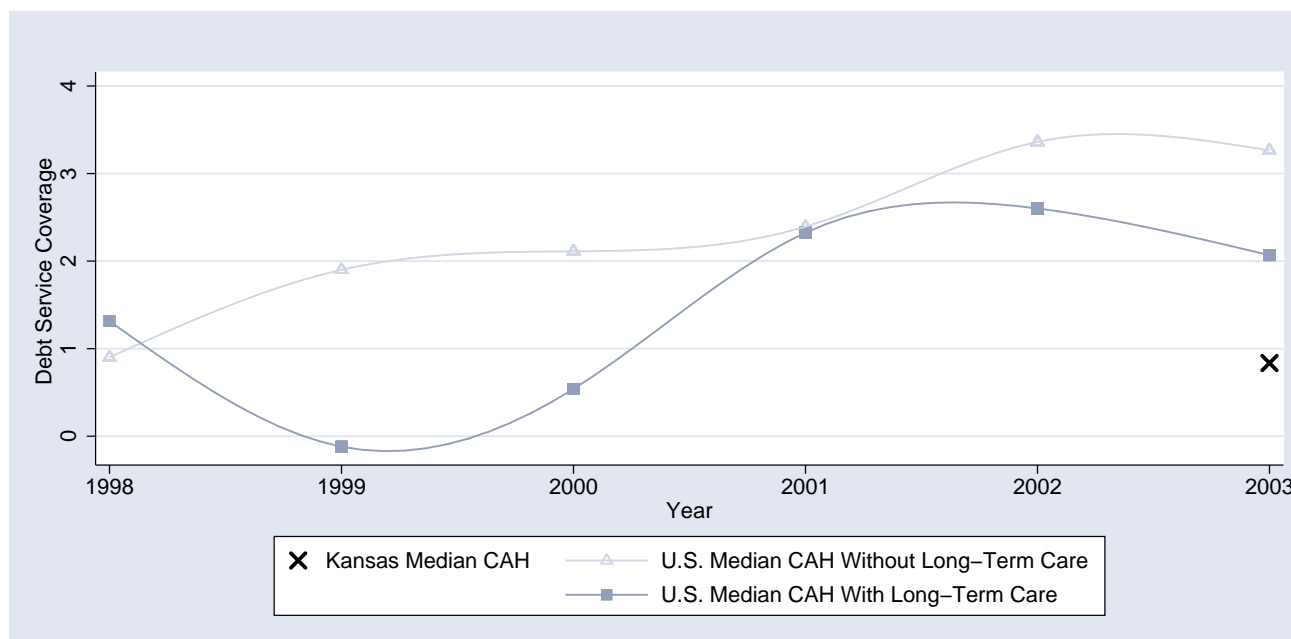
Medicare Cost Report Accounts

Worksheet G-3, line 31 +
Worksheet A, col.3, lines 1-4 + Worksheet A, col. 3, line 88
Worksheet G, col. 1-4, line 31 +
Worksheet A, col. 3, line 88

Most Recent Results

In 2003, the state median *Debt Service Coverage* for reporting CAHs in Kansas was 0.84. In 2003, the median CAH in Kansas had a *Debt Service Coverage* larger than 15% (2/13) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	0.90	1.90	2.11	2.37	3.31	3.26
U.S. Median CAH With Long-Term Care	1.31	-0.12	0.54	2.33	2.60	2.07
Kansas Median CAH						0.84

Interpretation

Debt Service Coverage measures the ability to pay obligations related to long-term debt, principal payments and interest expense. A positive value greater than 1.0 indicates cash flow greater than current fixed charge payments. Very high positive values may indicate an opportunity for debt financing. A positive value less than 1.0 or a negative value indicates cash flow less than current fixed charge payments. Very low values may signal a need to reassess debt policies. Refinancing may be an option if interest rates are lower in the current period than when the original debt financing occurred.

Nationally, between 1998 and 2003, the median *Debt Service Coverage* decreased for CAHs without long-term care but increased for CAHs with long-term care. In 2003, CAHs without long-term care had higher *Debt Service Coverage* than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals with no current portion of long-term debt and no interest expense were excluded from the calculation of medians.

Long-Term Debt to Capitalization

Definition

Long-term Debt
 Long-term Debt + Fund Balance

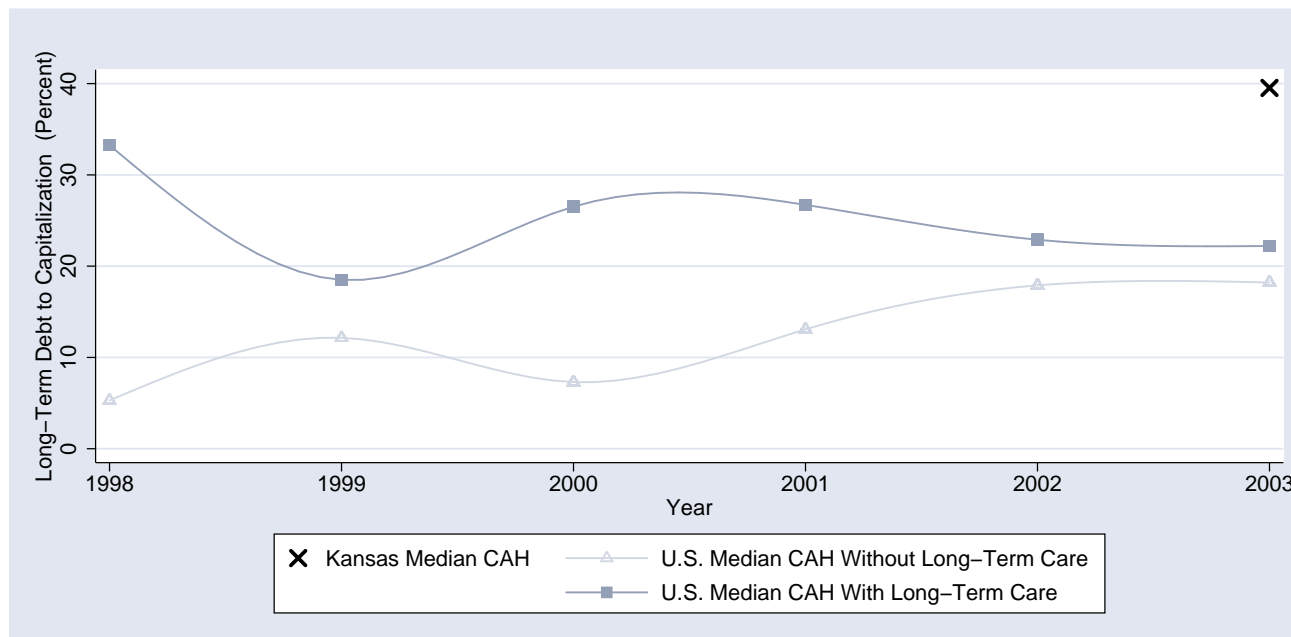
Medicare Cost Report Accounts

Worksheet G, col. 1-4, line 42+31
 Worksheet G, col. 1-4, line 42+31 + Worksheet G, col. 1-4, line 51

Most Recent Results

In 2003, the state median *Long-Term Debt to Capitalization* for reporting CAHs in Kansas was 39.53 percent. In 2003, the median CAH in Kansas had a *Long-Term Debt to Capitalization* larger than 75% (12/16) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	5.29	12.15	7.30	12.81	17.90	18.21
U.S. Median CAH With Long-Term Care	33.26	18.50	26.52	26.78	22.90	22.21
Kansas Median CAH						39.53

Interpretation

Long-Term Debt to Capitalization measures the percentage of total capital that is debt. A value greater than 50 percent indicates that a majority of capital is debt. Very high values may indicate exposure to financial risk because debt service is a fixed charge. A value less than 50 percent indicates that the majority of capital is equity. Very low values may indicate opportunities for debt financing.

Nationally, between 1998 and 2003, the median *Long-Term Debt to Capitalization* increased for CAHs without long-term care but decreased for CAHs with long-term care. In 2003, CAHs without long-term care had lower *Long-Term Debt to Capitalization* than CAHs with long-term care.

Data Quality/Exclusion Criteria

Other long-term liabilities may include some items that do not relate to debt, such as deferred compensation. The real equity of a hospital may not be reflected in its fund balance if it is part of a larger system. Hospitals with a fund balance of \$1 or less or with negative long-term debt were excluded from the calculation of medians.

Outpatient Revenues to Total Revenues

Definition

$$\frac{\text{Total Outpatient Revenue}}{\text{Total Patient Revenue}}$$

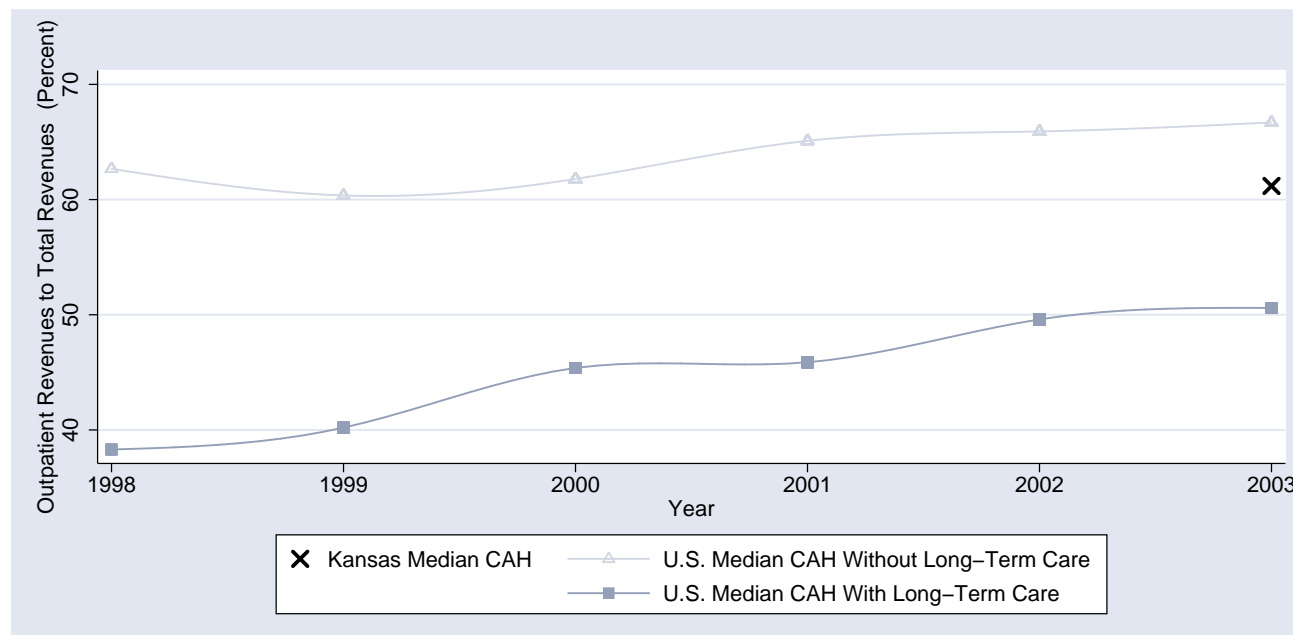
Medicare Cost Report Accounts

Worksheet G-2, col. 2, line 25
Worksheet G-2, col. 3, line 25

Most Recent Results

In 2003, the state median *Outpatient Revenues to Total Revenues* for reporting CAHs in Kansas was 61.18 percent. In 2003, the median CAH in Kansas had an *Outpatient Revenues to Total Revenues* larger than 68% (13/19) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	62.67	60.36	61.80	65.21	66.10	66.70
U.S. Median CAH With Long-Term Care	38.30	40.20	45.38	45.92	49.60	50.59
Kansas Median CAH						61.18

Interpretation

Outpatient Revenues to Total Revenues measures the percentage of total revenues that are for outpatient services (including, for example, Rural Health Clinics, free-standing clinics, and home health clinics). A value greater than 50 percent indicates that the majority of total patient revenues are for outpatient services. A value less than 50 percent indicates that the majority of total patient revenues are for inpatient services.

Nationally, between 1998 and 2003, the median *Outpatient Revenues to Total Revenues* increased for both CAHs without long-term care and CAHs with long-term care. In 2003, CAHs without long-term care had higher *Outpatient Revenues to Total Revenues* than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals with zero total patient charges were excluded from the calculation of medians.

Patient Deductions

Definition

$$\frac{\text{Contractual Allowances} + \text{Discounts}}{\text{Gross Total Patient Revenue}}$$

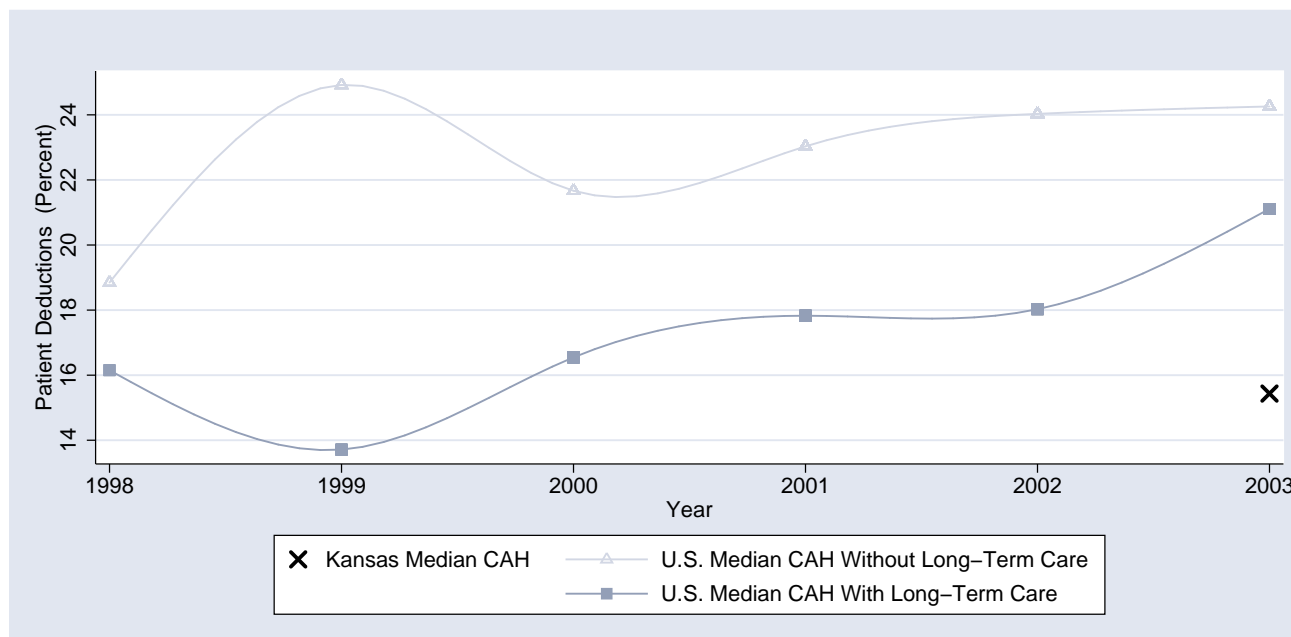
Medicare Cost Report Accounts

Worksheet G-3, line 2
Worksheet G-3, line 1

Most Recent Results

In 2003, the state median *Patient Deductions* for reporting CAHs in Kansas was 15.43 percent. In 2003, the median CAH in Kansas had a *Patient Deductions* larger than 16% (3/19) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	18.85	24.92	21.67	23.22	24.17	24.26
U.S. Median CAH With Long-Term Care	16.15	13.71	16.55	17.86	18.03	21.11
Kansas Median CAH						15.43

Interpretation

Patient Deductions measures the percentage of allowances and discounts per dollar of revenue. A high value indicates high use of discounts and/or allowances. Higher values may result from higher volume of services provided, higher rate structures, or higher penetration of managed care contracts. Lower values may result from lower volume of services provided, lower rate structures, or less penetration of managed care contracts. A low value indicates low use of discounts and/or allowances.

Nationally, between 1998 and 2003, the median *Patient Deductions* increased for both CAHs without long-term care and CAHs with long-term care. In 2003, CAHs without long-term care had higher *Patient Deductions* than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals with zero total patient revenue were excluded from the calculation of medians, as were those with *Patient Deductions* of zero or less.

Medicare Inpatient Payer Mix

Definition

Medicare I/P Days
 (Total I/P Days-Nursery Bed Days-NF Swing Bed Days)

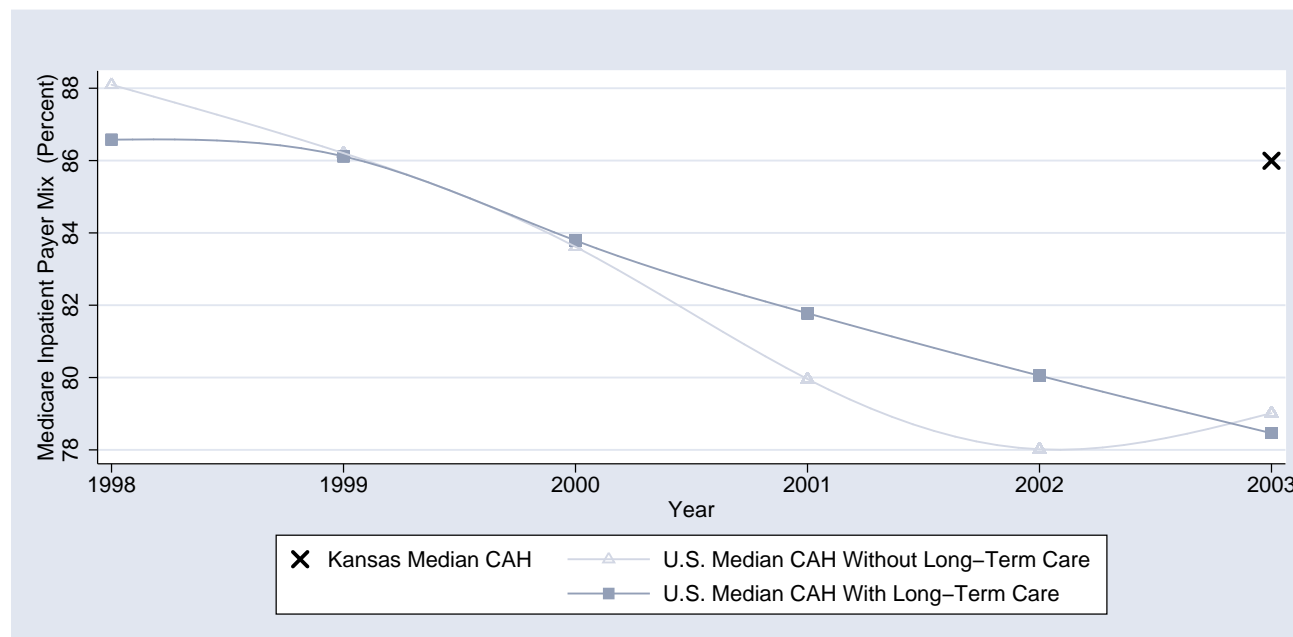
Medicare Cost Report Accounts

Worksheet S-3, col. 4, line 12
 W/S S-3, Part I, col. 6, line 12 - W/S S-3, Part I, col. 6, line 11-
 Worksheet S-3, Part I, col. 6, line 4

Most Recent Results

In 2003, the state median *Medicare Inpatient Payer Mix* for reporting CAHs in Kansas was 85.99 percent. In 2003, the median CAH in Kansas had a *Medicare Inpatient Payer Mix* larger than 89% (16/18) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	88.10	86.21	83.62	80.12	78.08	79.02
U.S. Median CAH With Long-Term Care	86.58	86.12	83.79	81.98	80.05	78.46
Kansas Median CAH						85.99

Interpretation

Medicare Inpatient Payer Mix measures the percentage of total inpatient days that are provided to Medicare patients. A value greater than 50 percent indicates that the majority of inpatient days are for Medicare patients. Very high values may indicate lack of financial diversification due to high dependence on Medicare reimbursement. A value less than 50 percent indicates that the majority of inpatient days are for Medicaid, privately insured, and other patients.

Nationally, between 1998 and 2003, the median *Medicare Inpatient Payer Mix* decreased for both CAHs without long-term care and CAHs with long-term care. In 2003, CAHs without long-term care had a higher *Medicare Inpatient Payer Mix* than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals with zero total inpatient days were excluded from the calculation of medians.

Medicare Outpatient Payer Mix

Definition

$$\frac{\text{Outpatient Medicare Charges}}{\text{Total Outpatient Charges}}$$

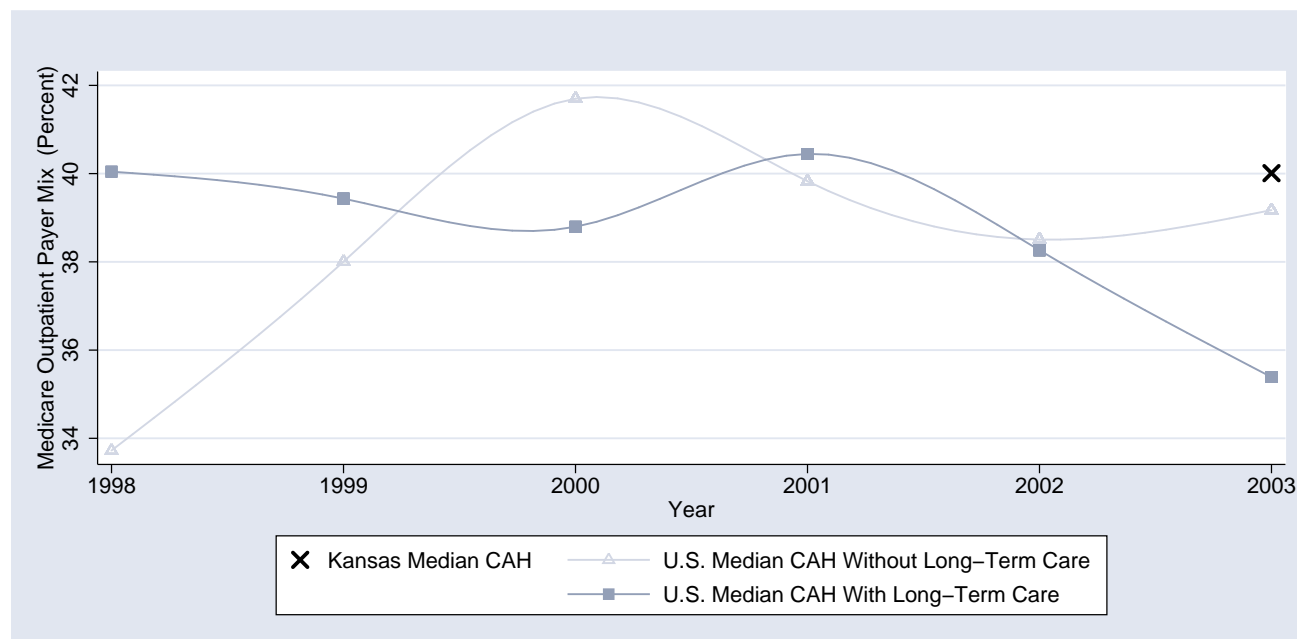
Medicare Cost Report Accounts

Worksheet D, col.2-5, 5.01, 5.02, line 104, Part V, Title XVII, (Hospital)
Worksheet C, col. 7, line 101, part I

Most Recent Results

In 2003, the state median *Medicare Outpatient Payer Mix* for reporting CAHs in Kansas was 40.01 percent. In 2003, the median CAH in Kansas had a *Medicare Outpatient Payer Mix* larger than 58% (11/19) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	33.72	38.00	41.70	39.84	38.63	39.17
U.S. Median CAH With Long-Term Care	40.05	39.43	38.80	40.80	38.26	35.39
Kansas Median CAH						40.01

Interpretation

Medicare Outpatient Payer Mix measures the percentage of total outpatient charges that are for Medicare patients. A value greater than 50 percent indicates that the majority of outpatient charges are for Medicare patients. Very high values may indicate lack of financial diversification due to high dependence on Medicare reimbursement. A value less than 50 percent indicates that the majority of outpatient charges are for Medicaid, privately insured, and other patients.

Nationally, between 1998 and 2003, the median *Medicare Outpatient Payer Mix* increased for CAHs without long-term care but decreased for CAHs with long-term care. In 2003, CAHs without long-term care had a higher *Medicare Outpatient Payer Mix* than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals with zero total outpatient charges were excluded from the calculation of medians. Pre-conversion data have been suppressed because PPS revenue may not be comparable to cost-based revenue as disclosed on the Medicare cost reports.

Medicare Outpatient Cost to Charge

Definition

Outpatient Medicare Costs
 Outpatient Medicare Charges

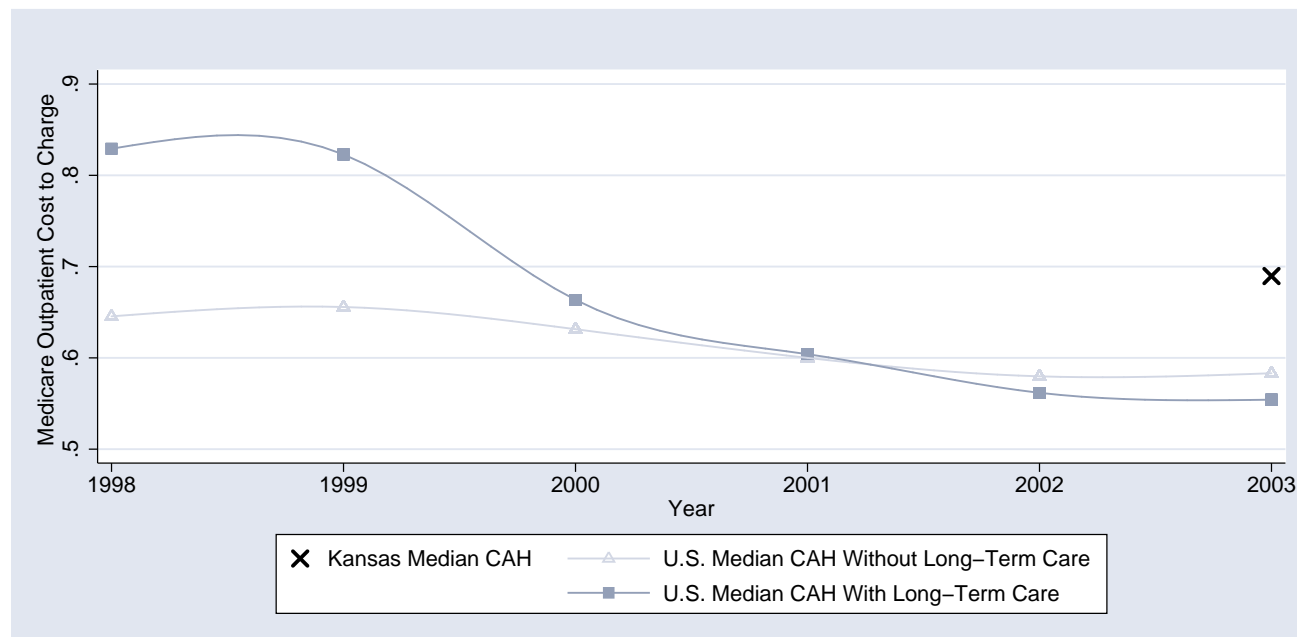
Medicare Cost Report Accounts

Worksheet D, col.6-9, 9.01, 9.02, line 104, part V, title XVII, (Hospital)
 Worksheet D, col.2-5, 5.01, 5.02, line 104, part V, title XVII, (Hospital)

Most Recent Results

In 2003, the state median *Medicare Outpatient Cost to Charge* for reporting CAHs in Kansas was 0.69. In 2003, the median CAH in Kansas had a *Medicare Outpatient Cost to Charge* larger than 79% (15/19) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	0.65	0.66	0.63	0.60	0.58	0.58
U.S. Median CAH With Long-Term Care	0.83	0.82	0.66	0.61	0.56	0.55
Kansas Median CAH						0.69

Interpretation

Medicare Outpatient Cost to Charge measures the percentage of outpatient Medicare costs that are outpatient Medicare charges. A value less than 1.0 indicates that Medicare outpatient costs are less than Medicare outpatient charges. Very low values may indicate patient volume is relatively high, gross charges are relatively high, costs are relatively low, or some combination of these factors. A value greater than 1.0 indicates that Medicare outpatient costs are greater than Medicare outpatient charges. Very high values may indicate low volume, an inadequate rate structure, an opportunity to review operating costs, or some combination.

Nationally, between 1998 and 2003, the median *Medicare Outpatient Cost to Charge* decreased for both CAHs without long-term care and CAHs with long-term care. In 2003, CAHs without long-term care had a higher *Medicare Outpatient Cost to Charge* than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals in states with rate regulation may have higher values than those hospitals in non-rate regulated states. Hospitals with Medicare outpatient charges of zero were excluded from the calculation of medians. Pre-conversion data have been suppressed because PPS revenue may not be comparable to cost-based revenue as disclosed on the Medicare cost reports.

Medicare Revenue per Day

Definition

Medicare Revenue
(Medicare Days-SNF Swing Bed Days)

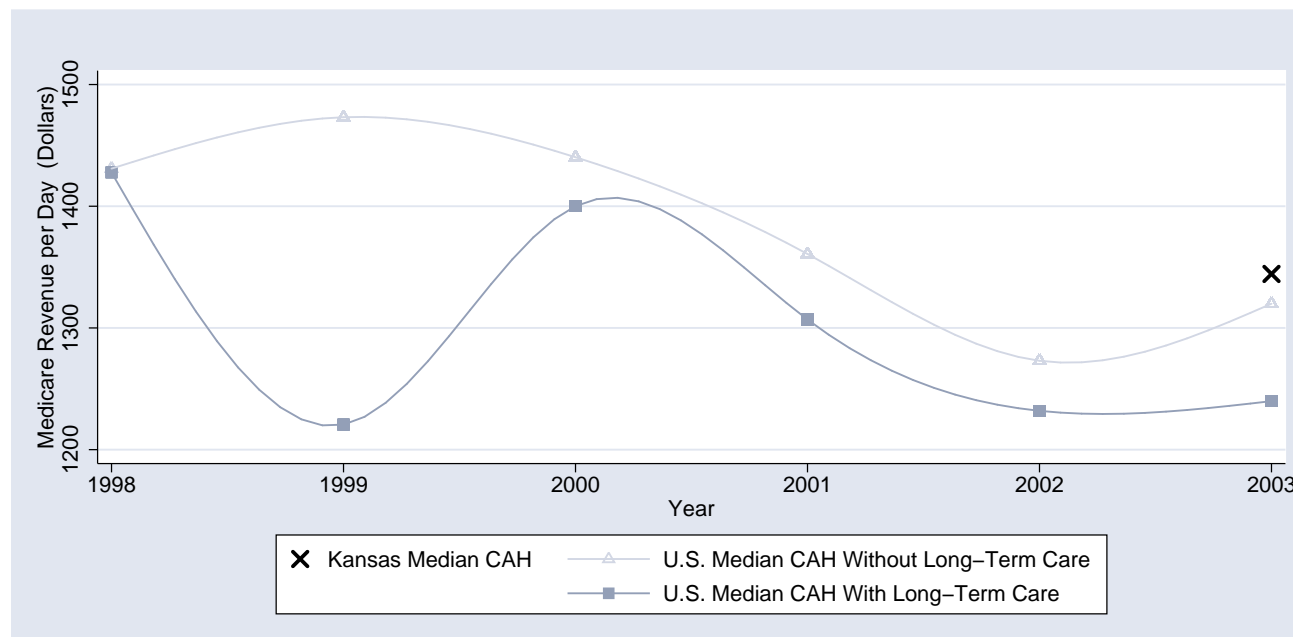
Medicare Cost Report Accounts

Worksheet E-3, line 4, Part II
Worksheet S-3, col.4, line 12 - Worksheet S-3, col.4, line 3 (Part I)

Most Recent Results

In 2003, the state median *Medicare Revenue per Day* for reporting CAHs in Kansas was 1344.37 dollars. In 2003, the median CAH in Kansas had a *Medicare Revenue per Day* larger than 67% (12/18) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	1431	1473	1440	1357	1273	1320
U.S. Median CAH With Long-Term Care	1428	1221	1400	1309	1232	1240
Kansas Median CAH						1344

Interpretation

Medicare Revenue per Day is the amount of Medicare revenue earned per Medicare day. Skilled nursing facility days are excluded. A high value indicates a high amount of Medicare revenue per day. A low value indicates a low amount of Medicare revenue per day. *Medicare Revenue per Day* is influenced by facility occupancy rates, utilization of services, and the ability to manage costs.

Nationally, between 1998 and 2003, the median *Medicare Revenue per Day* decreased for both CAHs without long-term care and CAHs with long-term care. In 2003, CAHs without long-term care had higher *Medicare Revenue per Day* than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals where all Medicare days were SNF swing bed days were excluded from the calculation of medians. Pre-conversion data have been suppressed because PPS revenue may not be comparable to cost-based revenue as disclosed on the Medicare cost reports.

Salaries to Total Expenses

Definition

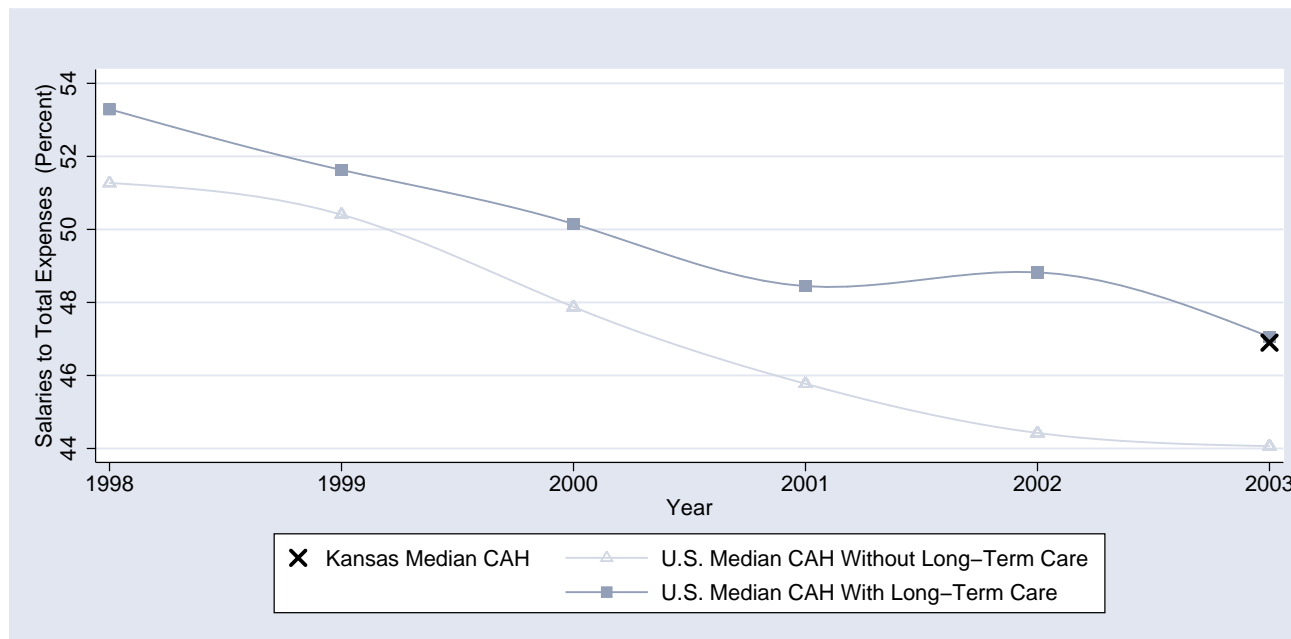
$$\frac{\text{Salary Expense}}{\text{Total Expenses}}$$

Medicare Cost Report Accounts
 Worksheet A, col. 1, line 101
 Worksheet A, col. 3, line 101

Most Recent Results

In 2003, the state median *Salaries to Total Expenses* for reporting CAHs in Kansas was 46.90 percent. In 2003, the median CAH in Kansas had a *Salaries to Total Expenses* larger than 63% (12/19) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	51.27	50.41	47.88	45.78	44.39	44.06
U.S. Median CAH With Long-Term Care	53.29	51.63	50.15	48.44	48.83	47.06
Kansas Median CAH						46.90

Interpretation

Salaries to Total Expenses measures the percentage of total expenses that are labor costs. A value greater than 50 percent indicates that the majority of expenses are for salaries. Very high values may indicate labor intensive organizations, employment of medical staff, or old plant and equipment. A value less than 50 percent indicates that the majority of expenses are for supplies, equipment, and other expenses. Very low values may indicate capital-intensive organizations or new plant and equipment.

Nationally, between 1998 and 2003, the median *Salaries to Total Expenses* decreased for both CAHs without long-term care and CAHs with long-term care. In 2003, CAHs without long-term care had lower *Salaries to Total Expenses* than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals with zero total expenses were excluded from the calculation of medians.

Average Age of Plant

Definition

$$\frac{\text{Accumulated Depreciation}}{\text{Depreciation Expense}}$$

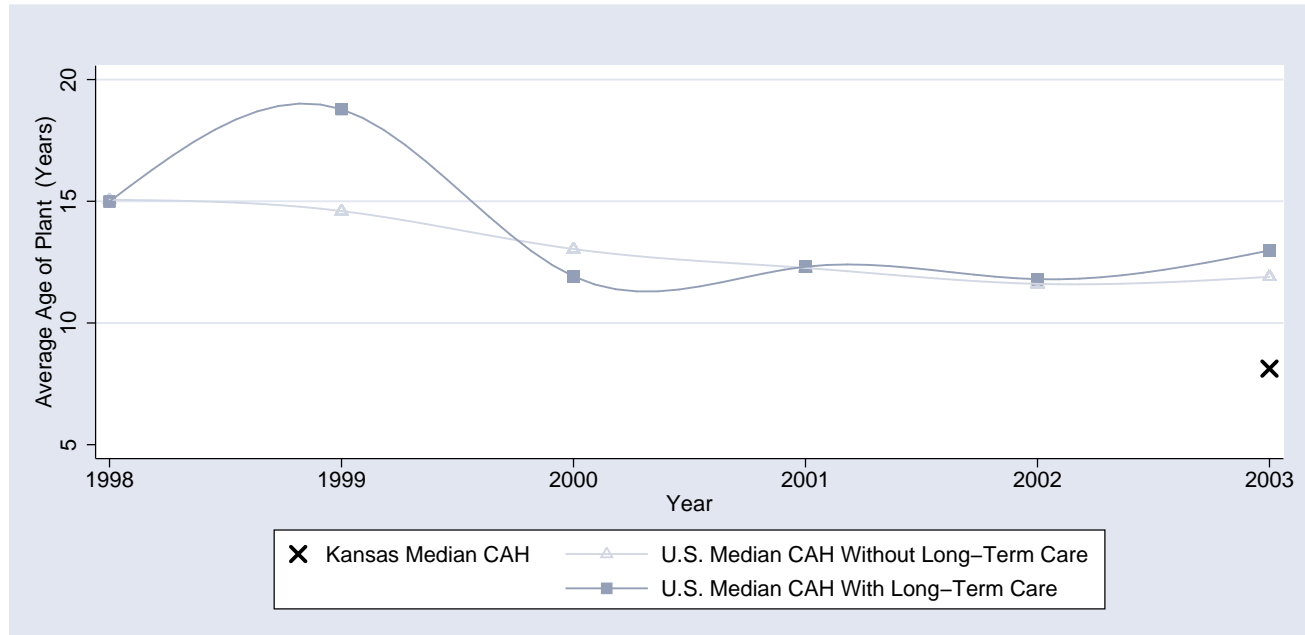
Medicare Cost Report Accounts

Worksheet G, col. 1-4, lines 13.01-19.01
Worksheet A, col. 3, lines 1-4

Most Recent Results

In 2003, the state median *Average Age of Plant* for reporting CAHs in Kansas was 8.13 years. In 2003, the median CAH in Kansas had an *Average Age of Plant* larger than 6% (1/17) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	15.06	14.60	13.04	12.31	11.61	11.90
U.S. Median CAH With Long-Term Care	14.99	18.78	11.91	12.28	11.80	12.98
Kansas Median CAH						8.13

Interpretation

Average Age of Plant measures the average age in years of the fixed assets of an organization. Higher values indicate greater amounts of older assets. Very high values may indicate a need for fixed asset replacement. Lower values indicate greater amounts of newer assets. Very low values may indicate a new building or recent replacement of fixed assets.

Nationally, between 1998 and 2003, the median *Average Age of Plant* decreased for both CAHs without long-term care and CAHs with long-term care. In 2003, CAHs without long-term care had lower *Average Age of Plant* than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals with *Average Age of Plant* of zero or less and those with depreciation expense of zero were excluded from the calculation of medians.

FTEs per Adjusted Occupied Bed

Definition

Number of FTEs

$$\frac{(I/P \text{ Days} - NF \text{ Swing Days} - Nursery \text{ Days})^*}{(\text{Total Patient Revenues} / (\text{Total I/P NF Revenue} - \text{Other LTC Revenue})) / \text{Days in Period}}$$

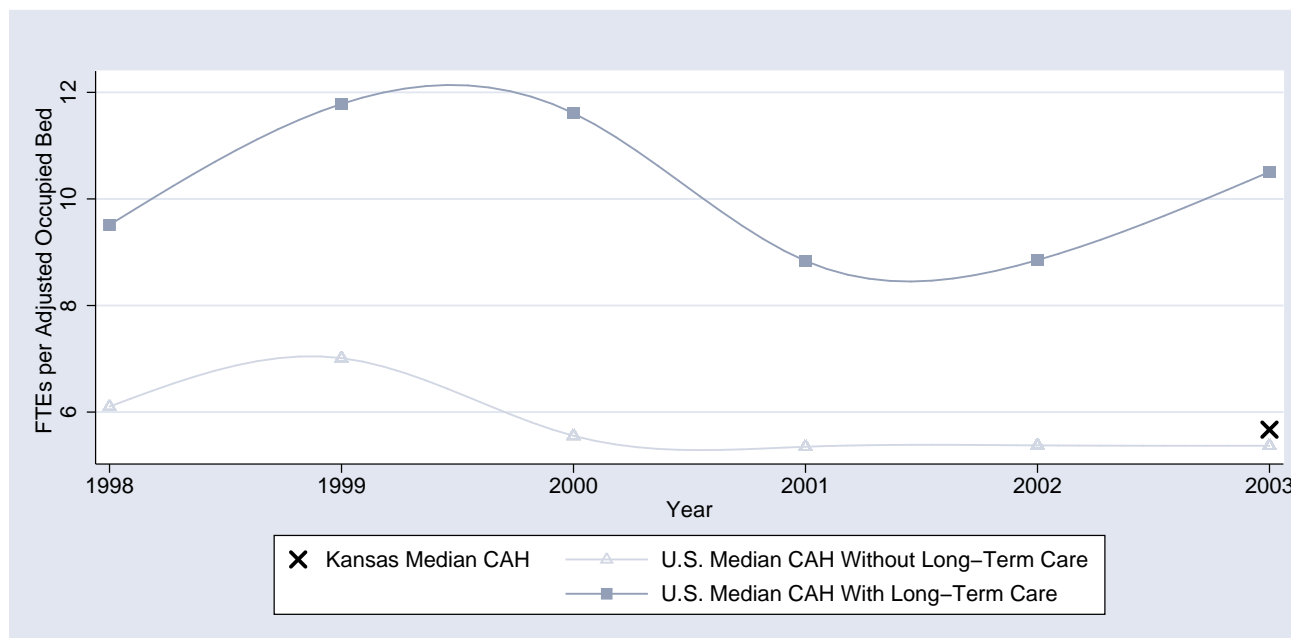
Medicare Cost Report Accounts

Worksheet S-3, Part I, col. 10, line 25
 (S-3, col. 6, line 12 - S-3, col 6, line 4 - S-3, col. 6, line 11)*
 (G-2, revenue-skilled col. 3, line 25/
 (G-2, col. 1, line 25 - G-2, col 1, line 7 - G-2, col 1, line 8))/Days in pd.

Most Recent Results

In 2003, the state median *FTEs per Adjusted Occupied Bed* for reporting CAHs in Kansas was 5.67. In 2003, the median CAH in Kansas had a *FTEs per Adjusted Occupied Bed* larger than 32% (6/19) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	6.10	7.01	5.56	5.34	5.36	5.37
U.S. Median CAH With Long-Term Care	9.51	11.78	11.61	8.84	8.85	10.51
Kansas Median CAH						5.67

Interpretation

FTEs per Adjusted Occupied Bed measures the number of full time employees per each occupied acute bed. A high value indicates many employees per bed. A low value indicates a few employees per bed. Very high values may indicate low volume and a potential opportunity to evaluate staff productivity. Very low values may indicate high volume or a high level of staff productivity.

Nationally, between 1998 and 2003, the median *FTEs per Adjusted Occupied Bed* decreased for CAHs without long-term care but increased for CAHs with long-term care. In 2003, CAHs without long-term care had less *FTEs per Adjusted Occupied Bed* than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals with total inpatient revenues of zero were excluded from the calculation of medians.

Average Daily Census Swing-SNF Beds

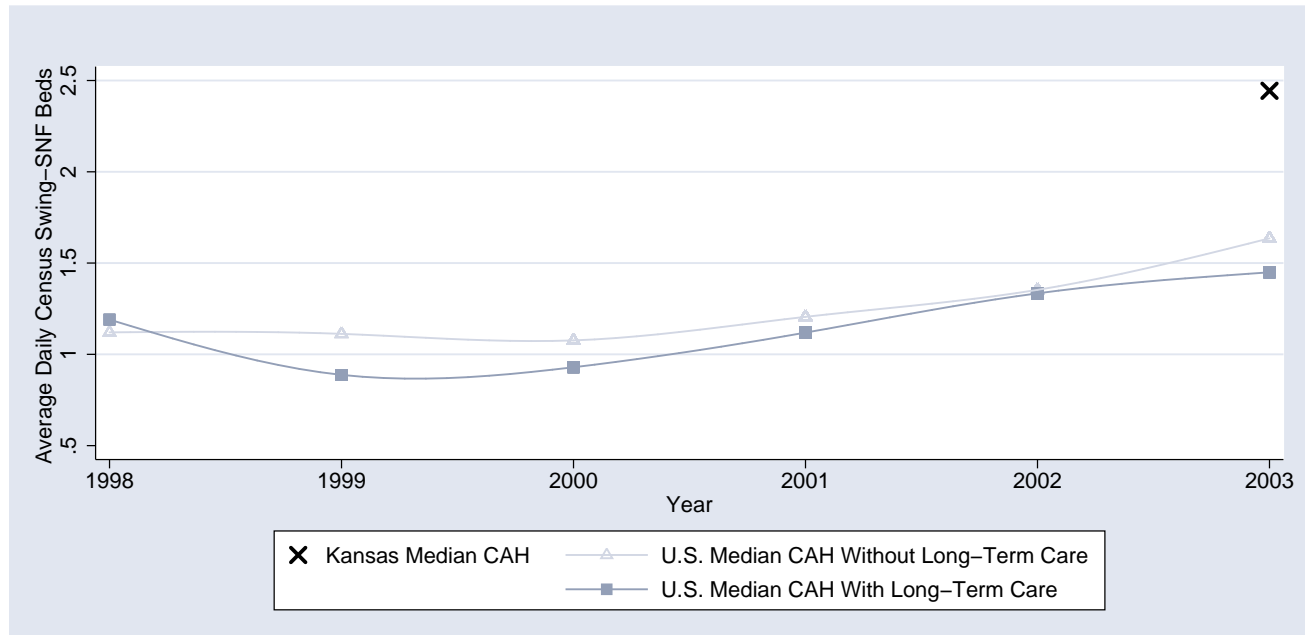
Definition
I/P Swing Bed SNF Days
Days in Period

Medicare Cost Report Accounts
Worksheet S-3, col. 6, line 3, part I
Days in Period

Most Recent Results

In 2003, the state median *Average Daily Census Swing-SNF Beds* for reporting CAHs in Kansas was 2.44 beds per day. In 2003, the median CAH in Kansas had an *Average Daily Census Swing-SNF Beds* larger than 82% (14/17) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	1.12	1.11	1.08	1.20	1.36	1.64
U.S. Median CAH With Long-Term Care	1.19	0.89	0.93	1.14	1.33	1.45
Kansas Median CAH						2.44

Interpretation

Average Daily Census Swing-SNF beds measures the average number of swing beds occupied per day. A high value indicates high use of swing-SNF beds. A low value indicates low use of swing-SNF beds. *Average Daily Census Swing-SNF Beds* is influenced by the number of swing-SNF beds available.

Nationally, between 1998 and 2003, the median *Average Daily Census Swing-SNF Beds* increased for both CAHs without long-term care and CAHs with long-term care. In 2003, CAHs without long-term care had a higher *Average Daily Census Swing-SNF Beds* than CAHs with long-term care.

Data Quality/Exclusion Criteria

Hospitals that were not licensed to maintain swing beds and with no swing beds were excluded from the calculation of medians.

Average Daily Census Acute Beds

Definition

$\frac{\text{I/P Acute Care Bed Days}}{\text{Days in Period}}$

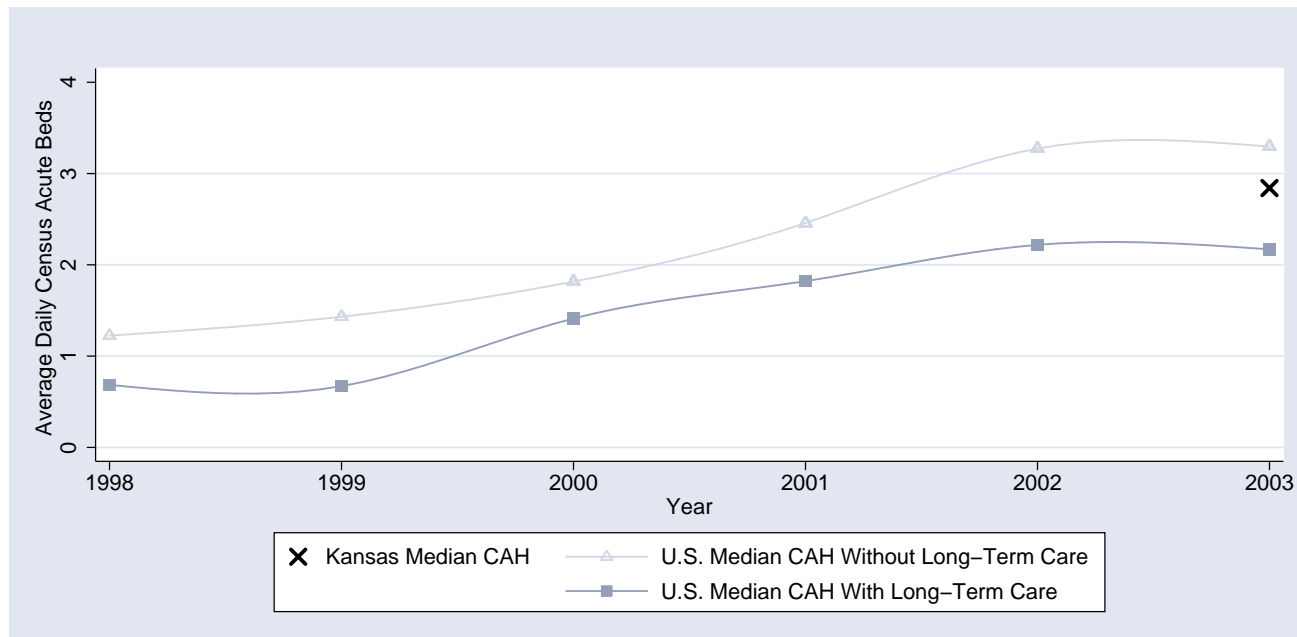
Medicare Cost Report Accounts

$\frac{\text{Worksheet S-3, col. 6, line 12 - (line 3 + line 4 +line 11, part I)}}{\text{Days in Period}}$

Most Recent Results

In 2003, the state median *Average Daily Census Acute Beds* for reporting CAHs in Kansas was 2.84 beds per day. In 2003, the median CAH in Kansas had an *Average Daily Census Acute Beds* larger than 47% (9/19) of state medians.

Results Over Time



	1998	1999	2000	2001	2002	2003
U.S. Median CAH Without Long-Term Care	1.22	1.43	1.82	2.44	3.30	3.30
U.S. Median CAH With Long-Term Care	0.68	0.67	1.41	1.82	2.22	2.17
Kansas Median CAH						2.84

Interpretation

Average Daily Census Acute Beds measures the average number of acute beds occupied per day. A high value indicates high use of acute beds. A low value indicates low use of acute beds. *Average Daily Census Acute Beds* will be influenced by the number of acute beds available.

Nationally, between 1998 and 2003, the median average daily census acute beds increased for both CAHs without long-term care and CAHs with long-term care. In 2003, CAHs without long-term care had a higher *Average Daily Census Acute Beds* than CAHs with long-term care.

Data Quality/Exclusion Criteria

There were no exclusion criteria for this indicator.

Summary Table for Kansas

This table presents in a convenient one page format all values for your state previously reported.

<i>Indicator</i>	Last Valid Year	Last Valid Value
Total Margin	2003	-2.27
Cash Flow Margin	2003	-0.57
Return on Equity	2003	4.18
Current Ratio	2003	2.66
Days Cash on Hand	2003	50.81
Net Days Revenue in Accounts Receivable	2003	52.17
Equity Financing	2003	48.01
Debt Service Coverage	2003	0.84
Long-Term Debt to Capitalization	2003	39.53
Outpatient Revenues to Total Revenues	2003	61.18
Patient Deductions	2003	15.43
Medicare Inpatient Payer Mix	2003	85.99
Medicare Outpatient Payer Mix	2003	40.01
Medicare Outpatient Cost to Charge	2003	0.69
Medicare Revenue per Day	2003	1344.37
Salaries to Total Expenses	2003	46.90
Average Age of Plant	2003	8.13
FTEs per Adjusted Occupied Bed	2003	5.67
Average Daily Census Swing-SNF Beds	2003	2.44
Average Daily Census Acute Beds	2003	2.84

Technical Appendix

Included Values

There are four circumstances under which a hospital’s financial ratio will not be included in a state’s median.

1. *No Cost Report*: Some hospitals have no cost report for a given year. Thus, no indicators can be computed. Note that our cost reports are obtained from the Centers for Medicare and Medicaid Services and there may exist a substantial delay between the time when a hospital files its cost report with an intermediary and the time when CMS releases the cost report data to the public.
2. *Invalid Data*: A financial account entry that is theoretically impossible is denoted “Invalid Data”. An example is negative accumulated depreciation. We classify division by zero problems in this category as well. For example, if total revenues are zero, then total margin is not defined.
3. *Short Fiscal Year*: We only consider cost reports with at least 360 days of reporting.
4. *Outliers*: Calculated ratios that are “very unusual” are not considered. An example is a total margin of over 100 percent.

Number of Reporting Critical Access Hospitals

Figure A-1 presents a map of Critical Access Hospitals. Maps and listings of Critical Access Hospitals are updated quarterly and posted at <http://www.flexmonitoring.org> The following table presents the annual number of reporting Critical Access Hospitals by whether the CAH has long-term care.

Year	1998	1999	2000	2001	2002	2003
Number of U.S. CAHs without LTC	17	24	49	155	292	129
Number of U.S. CAHs with LTC	13	15	27	106	177	97

Included Years

Years are defined based on the closing date of the report. Table A-1 presents the years (for the purpose of this report) and the number of Medicare Cost reports used in this analysis. We eliminated all periods in which the filing period was less than one year. Thus, there may be years for which we present no financial ratios. The reason we adopted this convention is that financial indicators based on short fiscal years may be misleading. In the future, we hope to integrate short fiscal years into the report, but for this version we will not report ratios based on such years. **Note that the number of CAHs filing reports may be greater than the number of valid indicator values if some values are not considered (due to, for example, invalid data).**

Table A-1: Number of Kansas CAHs with available Medicare Cost Reports

Year	Number of CAHs filing reports
1998	14
1999	16
2000	23
2001	37
2002	47
2003	10

Figure A-1: Map of Critical Access Hospitals

