

January 3, 2012

Update: The Future of the Hospital & Long Term Care

Please read this update carefully and completely, it includes important information on the status of the swing bed conversion, the impact on short term cash flow, and the need for a temporary reduction in non-direct care staff hours to sustain the organization until our cash flow position stabilizes.

Swing Bed Transition

Long term care census is currently 27, target occupancy is under 25 to meet the census goals for bed banking; the goal is to reach the 25 bed threshold by the end of January. The district is still awaiting DOH's final approval of the bed banking request. In the meantime we are maximizing the use of available swing-beds. We currently have a waiting list.

Last week we shared with the commissioners that the biggest concern during the transition is that we may not have beds available when a community member needs one. This will be particularly difficult while we are so close to our capacity. Even though these are tough decisions our ultimate goal is to remain open for the community and to remain sustainable, long term.

The bed changes are causing some short term problems for our cash flow but we know from careful analysis by our accounting firm, and from the experience of other rural hospitals, that these changes are necessary to assure our long term sustainability.

Cash Flow is a Big Concern

Last week the management team and finance committee shared concerns with the board about the present cash-flow position of the district. Management team shared that they are working on a plan to manage the short-term cash flow needs of the district but there is no question we will experience a disruption in cash-flow until our new Medicare rates catch up with our current cost structure. It will take up to a year or longer for our Medicare rates to stabilize. The impact of the changes on the short-term cash flow position of the district has hit much sooner and more dramatically than we could have anticipated.

Commissioners Pass a Resolution Calling for a Special Levy

There was further discussion with the board about the need to seek community support for a special levy to bridge the gap until Medicare reimbursement stabilizes. Ultimately the commissioners approved a resolution seeking a 1 year \$750,000 special levy that, if approved by voters, would cost \$2.32 / \$1,000 of assessed property value. If the levy is approved by voters the district could then seek a short term tax anticipation loan based on

the voted tax. Short term financing would be used to stabilize the cash flow position of the district until reimbursement catches us with our current cost structure.

There is a positive impact of the windmills on taxing capacity and how a special levy rate can be at or near historical levels but the revenue produced is greater due to the assessed valuation from the windmills. Net effect is cost to the tax payers is the same or lower but the revenue generated is greater than it would have been historically.

Cost Based Reimbursement is Difficult to Understand

There are complexities of Medicare cost-based reimbursement that make it difficult for consumers to understand the swings in the district's financial position. The situation is not uncommon among rural hospitals. The caution from other critical access hospital leaders is against making drastic cuts to preserve cash flow, only to find that decision was not a good one and could cause irreparable damage to the infrastructure when reimbursement finally catches up with the current cost structure. We do not want this to happen to our organization. So we must be very thoughtful with the cost reductions we make so the changes improve our short term cash flow without harming our reimbursement over the long term.

It Will Take Some Time for Our Cash Flow to Stabilize

Again, although the swing bed migration is necessary and critical to the survival of the hospital, the impact of the changes on the short-term cash flow position of the district has hit much sooner and more dramatically than we could have anticipated. Looking at our cash flow projections we will need to close a cash flow gap of approximately \$70K per month during the transition into our new rates. In the meantime, although we are on budget for both revenue and expenditures, contractual adjustments from Medicare and Medicaid are eating away at our available cash.

In order to manage our current cash flow situation we will have to make a number of changes, none of which are intended to be permanent, but all will be difficult. Again, these issues are not budgetary, everyone in the organization has done an exceptional job meeting our budget goals; the problem is that we are temporarily cash strapped and we must make some adjustments so we can continue to operate and meet the needs of the community.

Difficult but Necessary

We will be implementing a temporary reduction in force in virtually all non-direct care positions until our cash flow stabilizes. All of the reduction steps are difficult but necessary in order to prevent the hospital from running out of cash.

If you recall from the analysis we did prior to the reallocation of beds, we determined that virtually every position was important to the operation of the district and our goal was to avoid any permanent lay-off of staff. While there is no way to guarantee this, it is still

the goal. Although it would have been more desirable to achieve the cash flow gains through voluntary reductions, it became obvious that the level of reduction needed was simply too great to make this practical. I want you to know that I (Andrew) take full responsibility for bringing these reduction strategies forward out of an interest in saving all positions, rather than taking targeted and possibly more permanent reductions to specific positions.

Spreading or sharing the burden of these reductions, as evenly as possible, simply felt like the right way to save jobs, preserve extraordinary talent, sustain high quality of care for our community and still reduce costs. A temporary reduction in non-direct care staff is the best alternative because it tries to preserve every position in the organization, allows us to add back resources as cash flow allows, and avoids long term negative effects to cost based reimbursement.

Priorities - Mission Critical

Our priorities during this season remain the same, our mission has not changed; care and safety is always our top priority. The other two priorities at this moment are revenue generation and targeted cost reduction. The bottom line is; outside of care, anything that effects cash flow is a top priority. Care – Cash Creation – Cost Reduction

Obviously work that usually takes a full time staff to complete will suffer. Any non-care related work that is not Mission Critical should be evaluated and set aside until our cash flow situation stabilizes. Please be honest with your supervisors and each other about what can be put off and what is absolutely necessary for this period of time.

Impact on Workflow

The direct care staff has been adjusting their workloads over the last several months to accommodate the new resident demand.

The biggest impact will be with non-direct care staff and this will be reflected in business office hours and administrative staff availability. At this point the business office will be closed on Friday's however a receptionist will be staffed 5 days a week to admit patients and manage communication only. The clinic will be closed on Friday afternoons. Meeting schedules will be adjusted to accommodate new work schedules and achieve greater efficiency. Other adjustments will be made along the way as we all get used to these changes. Please be patient with each other while we work through this as, it will be stressful on everyone.

How Long Will This Last?

It is hard to say for certain how long this will last. It will take up to a year, possibly as much as 18 months, for our reimbursement to stabilize. In the meantime the commissioners approved a resolution seeking a special levy that would help bridge the gap until cash flow improves. We will evaluate the situation constantly and add back resources as it seems prudent to do so.

This is a Very Important Levy

If the voters do not approve the levy on February 14th, the district may be forced to suspend operations. We are developing contingency plans now so it is very clear to everyone what will occur if this happens.

There are very strict guidelines imposed by the Public Disclosure Commission on the use of hospital district resources during a levy. The district has an obligation to inform the voters of the facts related to the levy proposition. Outside of this; if you approve or disapprove of the levy you may not use hospital district resources to promote your position. The only notable exception to this is the use of facility resources that would not be permitted to any community group under normal circumstances, like use of the learning center for meetings.

In any case, please remember that you are always an ambassador of the hospital to the community. People may ask you questions about the hospital; please stay informed of the issues and respectfully represent and communicate the facts regardless of any opinion on the subject.

Please Stay Plugged-In

The situation is significant and very concerning to everyone. It is absolutely critical that you stay informed and engaged during this transition. We are asking everyone to step up and pull together so we can make this work. With the combined dedication of the entire team and by God's grace we will emerge from this stronger.

If you have any questions please see your supervisor, you may also contact me any time:

- Andrew

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Cost Reduction Strategies

All of these approaches are intended to be temporary means of reducing cost until the cash-flow position of the district stabilizes.

1. **Cross-the-board Reduction in Force (Non-Direct Care Positions)** – Implement a full reduction of all non-direct care staff to 32 hours per week. Maintain reception staff 5 days a week possibly through staggered schedule.
2. **Executive Team Reduction in Force** – Implement full reduction of executive team to .6 FTE. Executive Team will work overlapping 3 day stretches.
3. **Position Reduction** – Implement a further reduction of staff in targeted areas.
 - a. Activities Assistant/Transportation; reduce to .5 FTE
 - b. Restorative; reduce to .5 FTE
 - c. Quality and IC; reduce to .2 FTE (balance of time to nursing direct care)
4. **Provider Contracts** – Negotiate contract extensions and modifications with provider staff.
5. **Wage Freeze** – Implement Cross-the-board wage freeze on all positions.
6. **Revise Quality Team & Ancillary Meeting Structure** – Reduce the burden of meeting schedules while maintaining the integrity of the organization’s mission.
7. **Defer Payment on Invoices** – Stretch out terms on all payments to the maximum allowable.
8. **Freeze Non-Essential Expenditures** – Place all non-essential budgeted expenditures on hold.
9. **Draw on Reserves** – Release encumbered reserves to meet short term obligations.
10. **Prompt Filing of Cost Reports** – Promptly file 2011 cost report and file 2012 interim cost report as soon as practicable.
11. **Special Levy** – Seek support of the community for 1 year supplemental special levy to fund maintenance and operations \$750K