

Statewide Financial Performance of CAHs

Pennsylvania

All hospitals, regardless of size and organizational structure, benefit from comparative data on financial condition and performance. The unique reimbursement and organizational structure of critical access hospitals (CAHs) make it important to have financial indicators that capture their own circumstances for performance assessment. CAHs differ from urban and other rural hospitals that are paid under the Medicare Prospective Payment System (PPS) in important aspects that affect the most appropriate way to measure financial condition. Unlike PPS hospitals, CAHs receive cost-based reimbursement for inpatient and outpatient care, and the incentives, financial management, and utilization practices under these two payment methods differ substantially. There are also organizational differences between CAHs and other hospitals that may affect financial performance; for instance, CAHs have relaxed staffing rules under Medicare, and they have limits on bed-size and average length of stay (and low volume hospitals have been found to face substantially more annual variation in demand for services, making financial planning difficult).

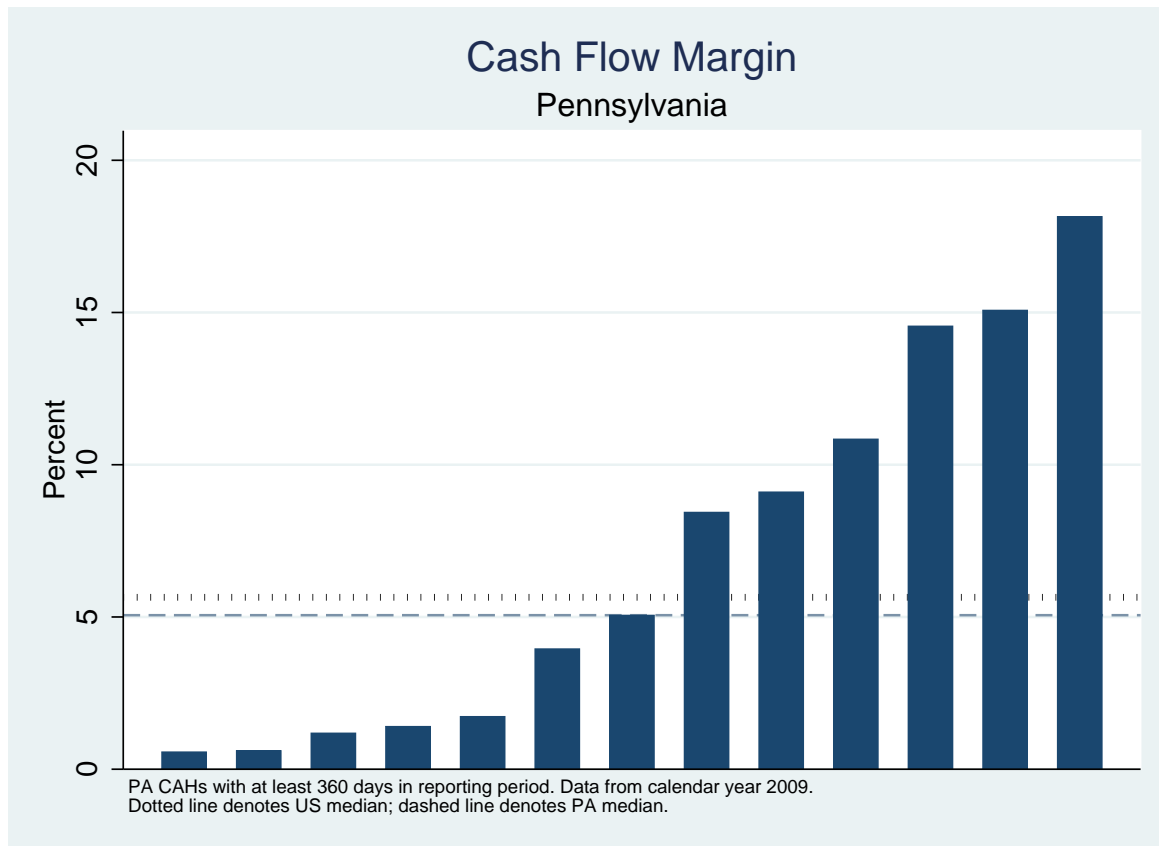
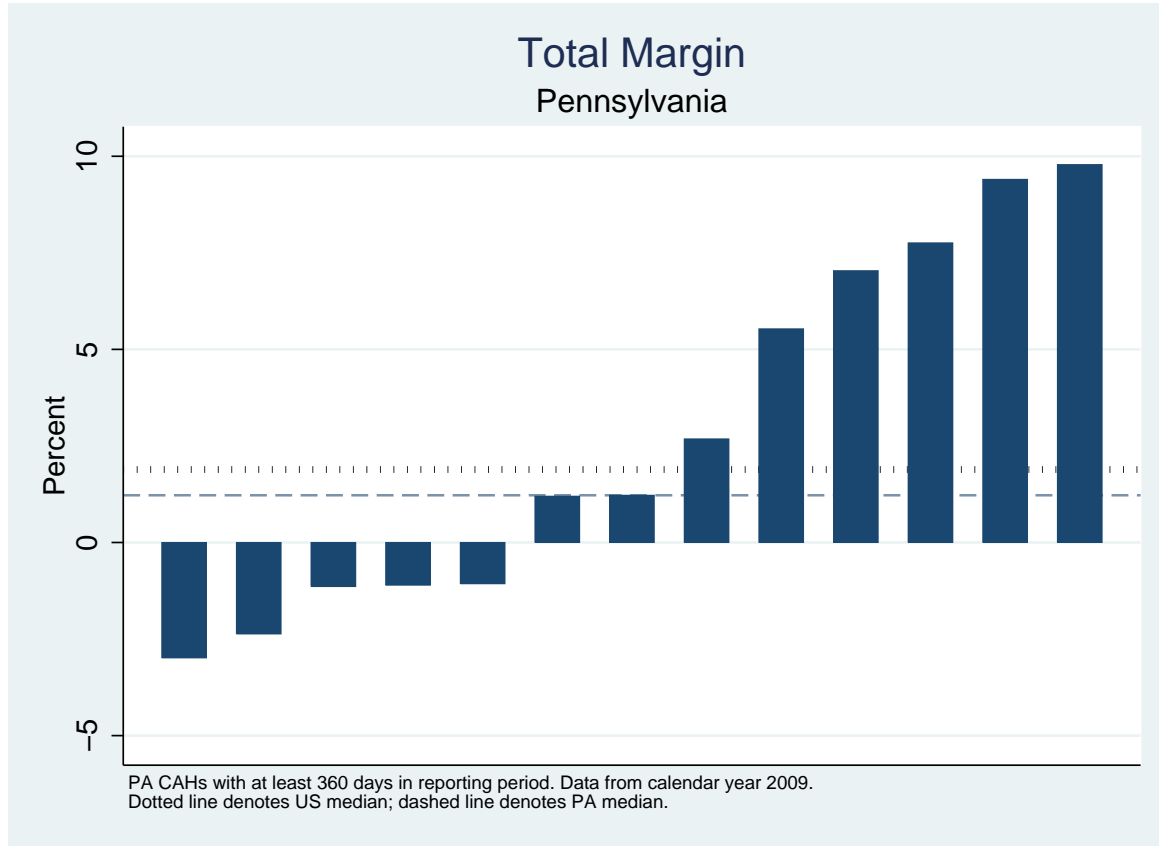
This report graphs individual hospital values for each of the twenty financial indicators. As part of ongoing work of the Flex Monitoring Team, these indicators were specifically designed to capture the financial performance of CAHs. In order to identify the indicators that were most relevant to the financial performance of CAHs, a Technical Advisory Group (TAG) of four individuals knowledgeable in CAH financial and operational issues, data, and reporting practices was selected to provide advice to a research team from the University of North Carolina at Chapel Hill. The TAG evaluated frequently used indicators of hospital financial performance for their applicability to CAHs. Their evaluation relied on three criteria: feasibility (whether the indicator can be accurately calculated from Medicare cost report data), importance (whether the indicator is an important measure of the financial management of CAHs), and usefulness (whether the indicator is useful to CAH administrators). The TAG retained 13 of the most frequently used indicators from the review. In addition, 7 other financial ratios were added that are not commonly used in the financial assessment of larger hospitals, but that group members believed capture important attributes of CAH financial management. Operating margin was added in 2011 to make 21 ratios.

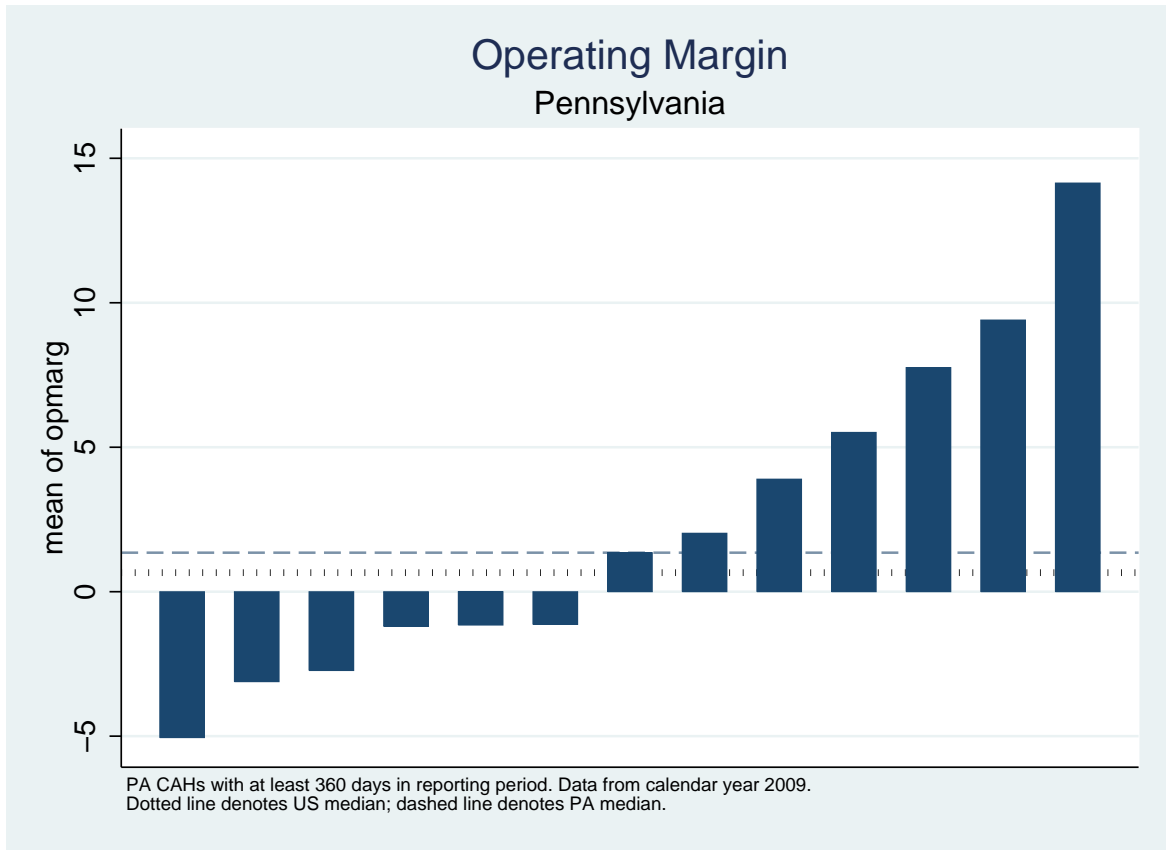
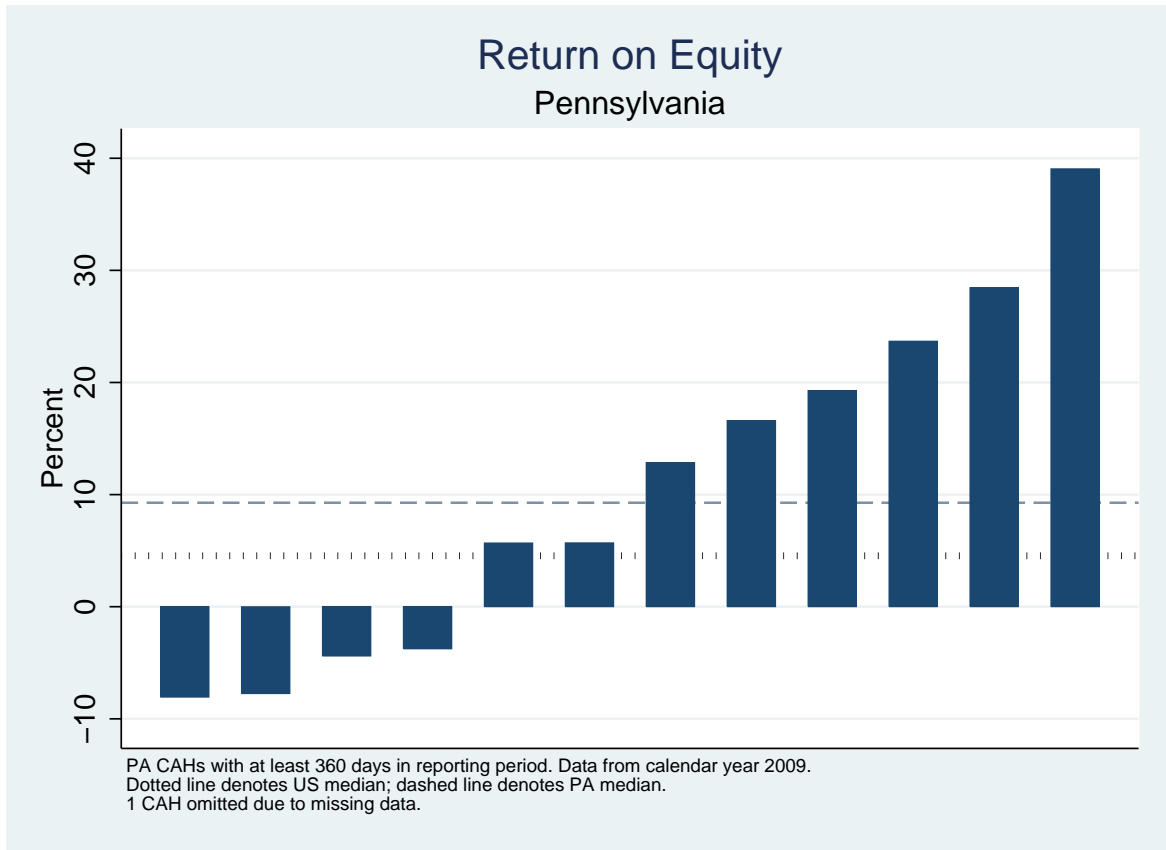
In the pages that follow, we present the 2009 financial indicator values of each CAH. Due to the time lag between the close of a CAH's fiscal year and the release of public use files by the Centers for Medicare and Medicaid Services, 2009 is the most recent year containing financial data for almost all CAHs. Individual hospitals are not identified. Certain values are not reported, such as those for short fiscal years or that look "unusual" (see the CAH Financial Indicator Report for more details). Each of the twenty indicators has its own graph. We also include the national and state median on each graph for comparison.

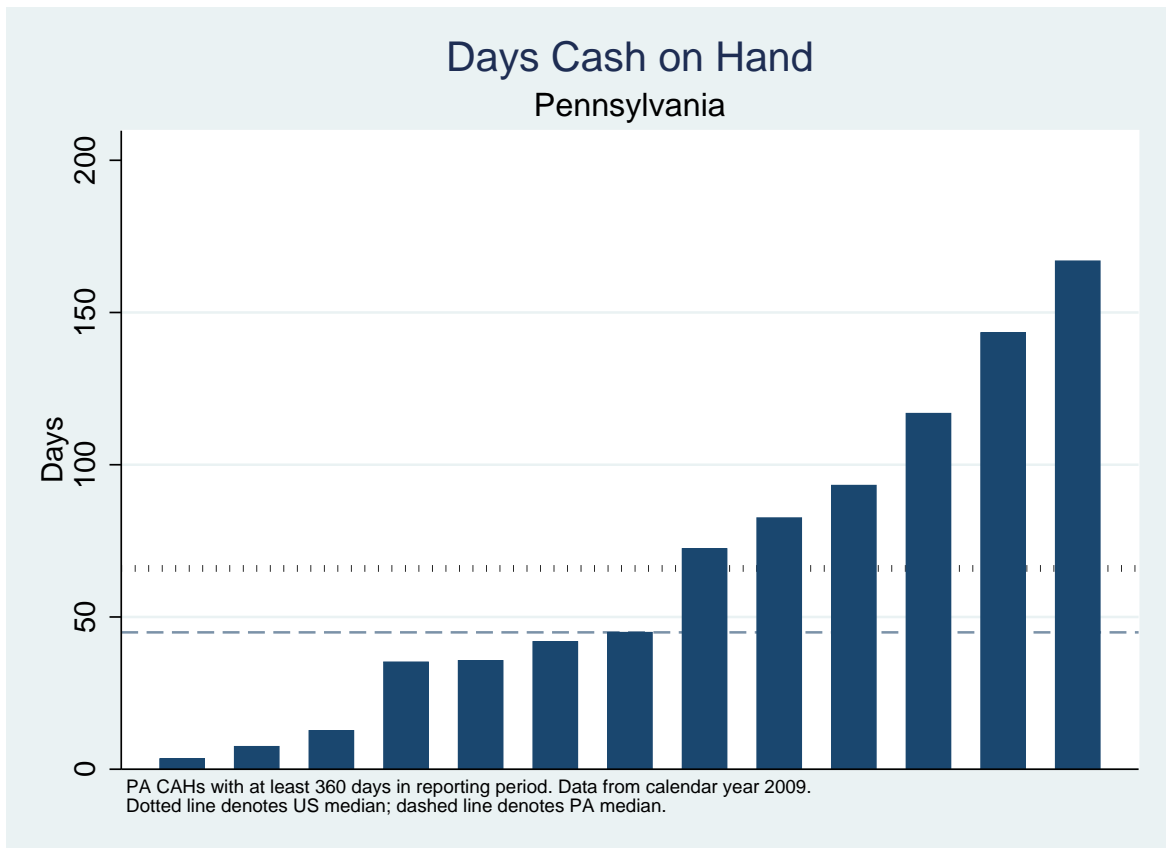
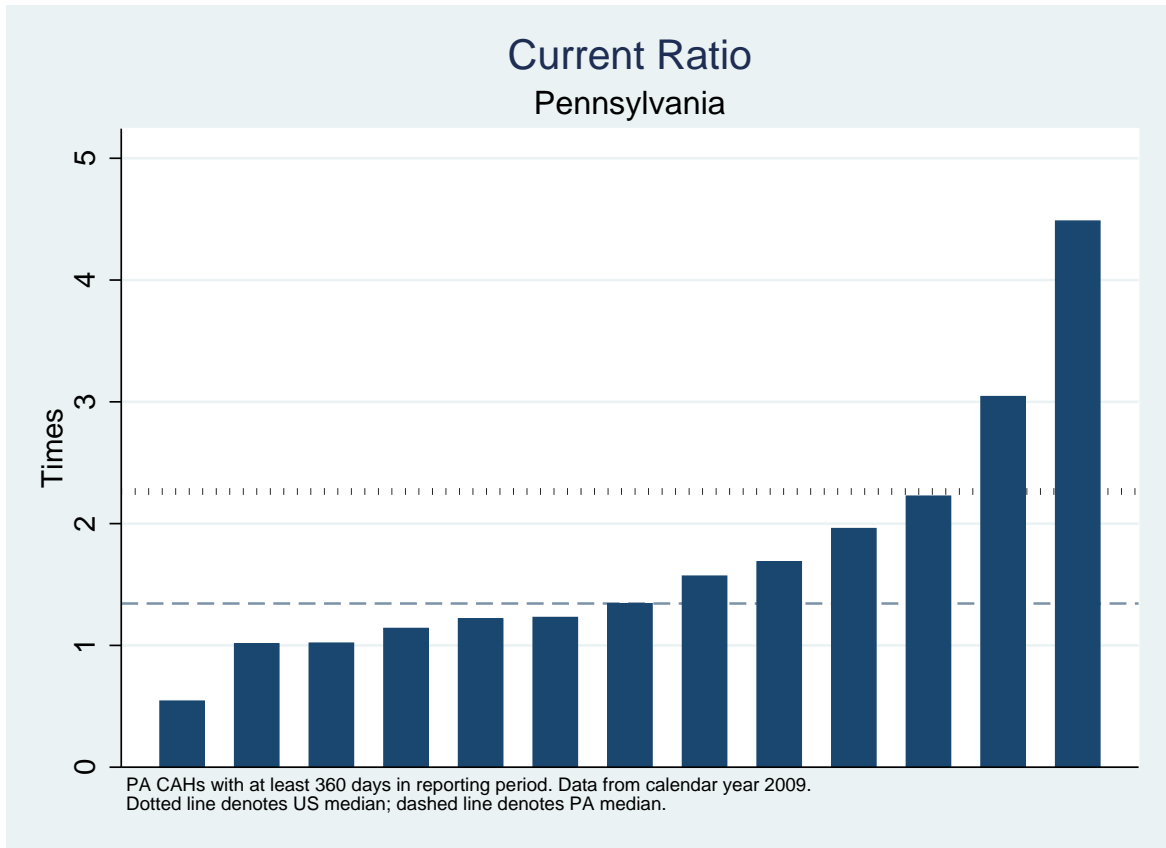
In some states, there are fewer than five Critical Access Hospitals during the reporting year (2009). In these cases, states are grouped to ensure that at least five CAHs report a full year of data. For example, Alabama had fewer than five reporting CAHs in 2009, so Alabama and Mississippi are reported together.

More detailed information about the definition and interpretation of the indicators can be found in the document "Briefing Paper No. 7. Financial Indicators for Critical Access Hospitals May 2005" which can be downloaded from the Flex Monitoring Team website:

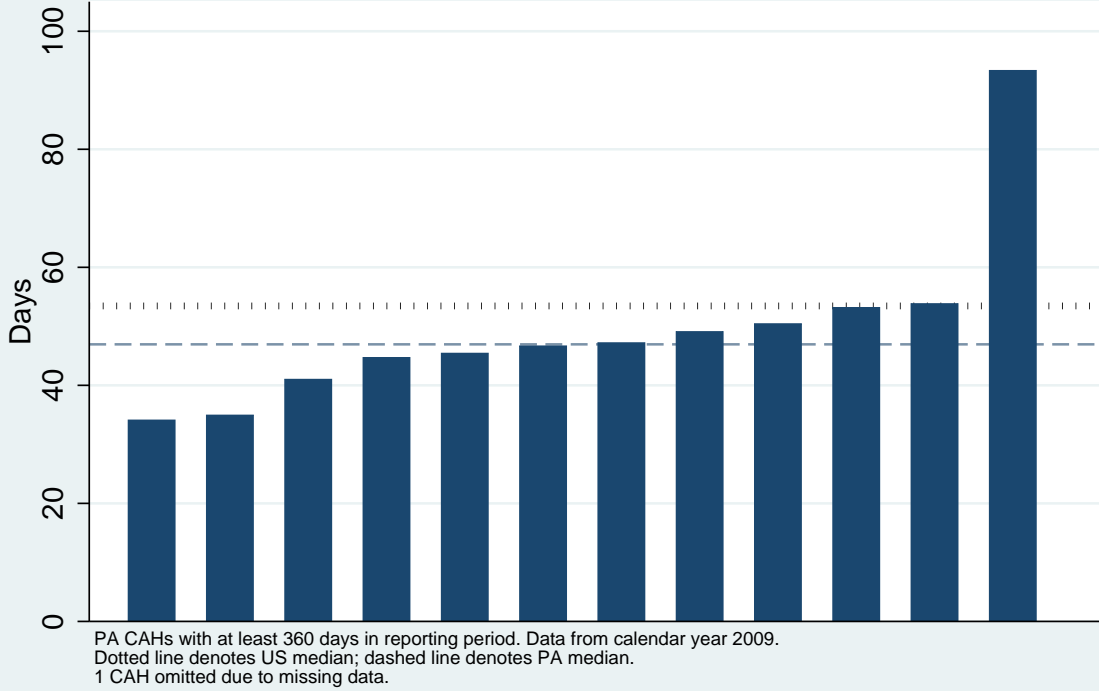
http://www.flexmonitoring.org/documents/BriefingPaper7_FinancialIndicators.pdf







Days Revenue in Accounts Receivable Pennsylvania



Equity Financing Pennsylvania

