GEORGIA DEPARTMENT OF COMMUNITY HEALTH

The Rural Hospital Stabilization Program: A Comprehensive Report

Addendum 1: Rural Hospital Stabilization Grant Program (RHSGP)

Phase Four

Submitted for inclusion on January 31, 2021

Where Are They Now? A Retrospective Evaluation of Outcomes for the Rural Hospital Stabilization Grant Program Phase Four

This document is submitted as an addendum to *The Rural Hospital Stabilization Program: A Comprehensive Report* which was released by the Georgia Department of Community Health, State Office of Rural Health in December 2019.

The methodology for collecting the information reported in this addendum is located on pages 21 and 22 of the original report. To ensure standardization and consistency of information, a modified version (updated to reflect current distribution and deadline dates only) of the original questionnaire (see Appendix D) was used to collect the information from Phase Four sites.

Rural Hospital Stabilization Grant Program Sites: Phase Four

Four Sites Selected • ***Burke Medical Center*** • ***Clinch Memorial Hospital*** • ***Elbert Memorial Hospital*** • ***Evans Memorial Hospital***	***Fiscal Year Funding: 2019*** ***$3,000,000 (annual) award*** ***$750,000 award to each site*** ***Project Period: July 2018 – June 2019***

Phase Four Addendum Executive Summary

The recipients of funding provided through Phase Four of the Rural Hospital Stabilization Grant Program selected fewer and more targeted projects than previous recipients. Phase Four Grantees had access to project outcomes data from the previous three phases of the program, and many previous Project Managers made themselves available to provide guidance and suggestions, as well as offer reliable resources and vendors upon request. This additional information appears to have assisted Phase Four Grantees in selecting beneficial, sustainable projects.

Specific to benefit and sustainability of grant funded projects, Grantees reported that all projects were completed by the end of the project period and every project selected continues

to meet the original objectives. All Grantees reported that on-going projects were self-sustainable after termination of grant funding.

Phase Four Grantees also reported that improvements made through the RHSGP resulted in a better overall relationship with their respective communities and an increased level of confidence and utilization in the services provided.

Regarding the financial analysis, Phase Four Grantees were relatively consistent with the results for hospitals in Phases One through Three. Even with the significant changes they have encountered in the past five years, the hospitals in Phases One through Four reflect overall relatively stable results from 2014 through 2018 and more challenging results in 2019. None of these hospitals have closed during the period under review.

As stated in the original report, and due to many variables beyond the scope of the grant program, it would be difficult to draw the definitive conclusion that the Rural Hospital Stabilization Grant Program prevented additional hospital closures. However, specific to the intent to "stabilize" hospitals and communities with this initiative, it is reasonable to conclude that this program appears to have met its intended goal.

Findings: Project Manager

The RHS Grant allowed Grantee Hospitals to select a Project Manager from within or hire from outside the organization. Grant funds could be used as salary support for a currently existing employee or fund a portion, or all, of a new employee's salary.

Questions specific to the status of the Project Manager

Question	Findings/Results
Was the Project Manager selected from staff already employed with your facility or hired from outside of your organization?	**50%** of Project Managers were already employed by the Grantee Hospital **50%** of Project Managers were hired specifically to manage the grant
Is the Project Manager still an employee of your organization? If so, in what capacity?	**75%** of Project Managers were still employed by the hospital as of October 2020

Specific to the Project Managers' employment status after termination of the grant, the two Project Managers who were employed with the organization prior to receiving the grant continued in their same role after grant termination. The remaining Project Manager hired from outside the organization continues to manage special projects, contracts, and serves as a Physician Liaison.

Findings: Specific Projects Funded

Section Two of the questionnaire required that each respondent complete an "Attachment A" document (see *Appendix D*) for each individual project that had been selected by the Grantee hospital and funded through the RHS Grant. The number of projects selected by each site varied. Specific to those responses, one Grantee hospital selected two projects, two Grantee hospitals selected three projects, and one Grantee hospital selected four projects.

For the purpose of data collection, the following information is specific to the combined number of projects for all participating Phase Four hospitals. Collectively, the projects were grouped based on similarity of design into four separate categories.

A combined total of **12 projects** were funded through the grant during this evaluation period. The categories in which the projects were grouped are listed below:

Grouping of Projects	Number of Projects
Upgrades to Existing Technology/Services	5
Emergency Department Renovations	4
New/Enhanced Service Lines	2
Mental/Behavioral Health	1

The four categories of projects are detailed below:

1. *Upgrades to Existing Technology/Services*
   Most commonly, funding was used for necessary upgrades to equipment, technology, and facilities to improve and enhance existing services lines. Aging facilities/equipment and outdated technology had resulted in a loss of market share/revenue and contributed to the lack of confidence in the hospital expressed by local residents. Burke Medical Center, Elbert Memorial Hospital, and Evans Memorial Hospital each selected one or more projects within this category.
2. *Emergency Department Renovations*
   Each of the Phase 4 Grantee hospitals chose to use a portion of funding to renovate and upgrade the emergency department. Renovation goals included improving patient, visitor, and staff safety; increasing privacy and HIPAA compliance; improving screening, triage, and through-put; improving patient care; improving the general appearance and public perception; improved utilization through patient education and community outreach.
3. *New/Enhanced Service Lines*
   Two Grantees applied funding to add new, and/or enhance current service lines. Clinch Memorial Hospital recruited a primary care provider, renovated and re-opened an

existing (closed) hospital campus facility to provide integrated primary care services. Elbert Memorial Hospital remodeled an existing facility, purchased new equipment, and recruited specialists to provide part time or full-time services not previously available within the community.

4. *Mental/Behavioral Health*
   Evans Memorial Hospital dedicated a portion of funding to create safe outdoor space for behavioral health patients and update the behavioral health unit with ligature resistant patient beds.

The questionnaire also included questions specific to the benefit and sustainability of the projects.

Project Specific Details

Question	Findings/Results
Is this project still on-going?	**100%** of original projects were completed during the funding period and the services provided by the projects are on-going.
Was/Is this project financially sustainable after termination of the grant?	**100%** of original projects were considered financially sustainable post-grant
Would your hospital have selected/funded this project if the RHSGP had not been available?	**50%** of the projects may have been done at some (later) point.
Did this project lead to relationship development with other partners and subsequent additional projects?	**50%** of the projects led to project-specific new relationships

As indicated above, funding from the RHS Grant allowed fifty percent of Grantees an opportunity to implement programs which had been identified for future efforts, as well as allowing fifty percent of Grantees the opportunity to explore new ideas and initiatives.

With hospital Grantees reporting that one hundred percent of the projects were still on-going and financially sustainable post-grant, it is evident that communities have benefited from the effort to design programs to address specific community needs.

Overall Impression and Benefit of the Rural Hospital Stabilization Grant Program

Section three of the questionnaire was designed to collect information specific to the RHS Grant Program as a whole and determine which projects had the most and least impact.

Specific to the overall benefit of the program, the following questions were asked:

Question	Findings/Results
Based on your experience with the RHSGP, do you feel this program met its intended objective to ensure patients receive the "*right care at the right time in the right setting*"?	**100%** (*4/4*) of recipients felt the RHSG Program did meet the objectives.
Did your facility seek other grants/funding sources to expand or sustain any work begun through the RHSGP?	**50%** (*2/4*) of recipients did choose to seek additional funding to continue or strengthen projects begun with RHSGP funds.
Based on your experience with the RHSGP, if given the opportunity to start your project over, would you have made the same decisions, choices, done anything differently, etc.?	**50%** (*2/4*) of recipients would have made different decisions or choices about some aspect of their projects or selected an entirely different project all together. **50%** (*2/4*) of recipients would have made no changes at all to decisions or projects.

Hospital Grantees who indicated they would have made different decisions or choices about projects explained their positions in a commentary format.

Two Grantee hospitals were completely satisfied with the projects selected, although one site felt Grantees would have benefited from additional time to research and plan for their selected projects.

Of the remaining two Grantee hospitals, both sites indicated they would have invested more time in pre-planning to select projects with more impactful outcomes.

Specific to the overall impact of the program, two questions were asked:

Question #1. "Overall, what do you feel was the <u>most</u> beneficial or impactful component of your projects? Please explain."

While there were projects common to all Grantees, each of the four Grantees responded differently to this question. Responses to this question are summarized below:

Grantee	ID Most Impactful	Reason
Burke Medical Center	Emergency Department Renovations	Renovations added privacy and improved flow; increased patient confidence and improved care.
Clinch Memorial	Physician Recruitment and Integrated Primary Care Services	Additional provider, staff, and primary care services improved hospital

		utilization and public perception of hospital.
Elbert Memorial	Public perception resulting from overall improvements and services	Renovations and addition of new services demonstrated the hospital's new commitment to the community.
Evans Memorial	3D Mammography technology upgrades	Resulted in increased market share by allowing access to these services within the community.

Question #2: "Overall, what do you feel was the <u>least</u> beneficial or impactful component of your projects? Please explain."

Responses to this question are summarized below:

Grantee	ID Least Impactful	Reason
Burke Medical Center	Rural Health Clinic upgrades	This project did not include major renovations or equipment upgrades and therefore did not increase utilization as anticipated.
Clinch Memorial	Respondent indicated that all projects were beneficial; did not feel any area was least impactful	N/A
Elbert Memorial	No response provided; did not identify any least impactful project	N/A
Evans Memorial	Outdoor space for Behavioral Health Services	The outdoor space was not utilized as frequently as anticipated due to uncomfortable temperatures during the summer months.

Findings: Other

Respondents were also asked,

"Based on your experience with the RHSGP, what suggestions or advice would you offer to a new RHS Grant recipient?"

Responses to this question are quoted below:

Grantee	Quoted Response
Burke Medical Center	"If we could offer any advice, I would suggest being selective with your projects. Take some time, weigh your options before selecting one. Burke Medical Center changed the project from a new RHC to renovations. The

	renovations were more beneficial and sustaining than a new RHC. If we had selected those projects first, we would have not wasted valuable time and resources."
Clinch Memorial	"Reach out to previous recipients for assistance, take time to plan out your project, connect with other recipients of the project and work together to accomplish your plans. They will be busy to, trying to run their hospitals and you may be able to be of assistance to them."
Elbert Memorial	"Reach out to past recipients about lessons learned and advice. They will be your best support system. Reach out to those in your same phase. Shared ideas and ways to partner are always helpful."
Evans Memorial	"In the competitive bid process, we encountered contractors that were more interested in our "total spend ability" rather than the needs of our organization to improve patient care and outcomes. Our team has to remain vigilant in the process and regardless of grant award amounts, be good stewards of the dollars."

Detailed Analysis

Findings: Financial Analysis

Methodology

Financial, operational, and statistical data was gathered from all of the hospitals in phases one through four. This data was obtained from audited financial statements, cost reports, and other sources provided by the hospitals. The individual hospital data was summarized to calculate and present financial ratios, indicators, and other information.

The most recent six years of available data is presented with reporting to the closest corresponding fiscal year. All hospital data was presented without consideration for the various start dates of the four phases. For reference, start dates and number of hospitals for the various phases are as follows:

- Phase One – July 2015 – four hospitals
- Phase Two – September 2016 – three hospitals
- Phase Three – October 2017 – eleven hospitals
- Phase Four – July 2018 – four hospitals

The most recent fiscal year data was utilized if any of the years were incomplete for an individual hospital. For example, if *Hospital X's* 2019 audited financial statements were not

completed, then *Hospital X's* 2019 internal financial statements would be used for 2019 without any adjustments.

Certain individual hospital data elements were excluded if the data element was not consistently prepared. This reflects the practice where some hospitals are reported as departments and do not prepare individual stand-alone balance sheets separate from the overall multi-hospital system consolidated balance sheets. Certain data elements from two individual hospitals were excluded as a result.

Comparative ratios are presented where applicable and are from the 2020 Almanac of Hospital Financial and Operating Indicators (the Almanac) published by Optum360. The ratios reflected in this report primarily reflect 2018 data from Medicare Cost Report filings as published in the Almanac. Almanac ratios for specific categories include:

- Georgia – average of all Georgia hospitals
- National Rural – average of rural hospitals with revenues less than $90 million

As applicable, each ratio presented will include several key pieces of information:

- Ratio Type
- Desired Trend
- Definition
- Formula

Overall Summary Findings

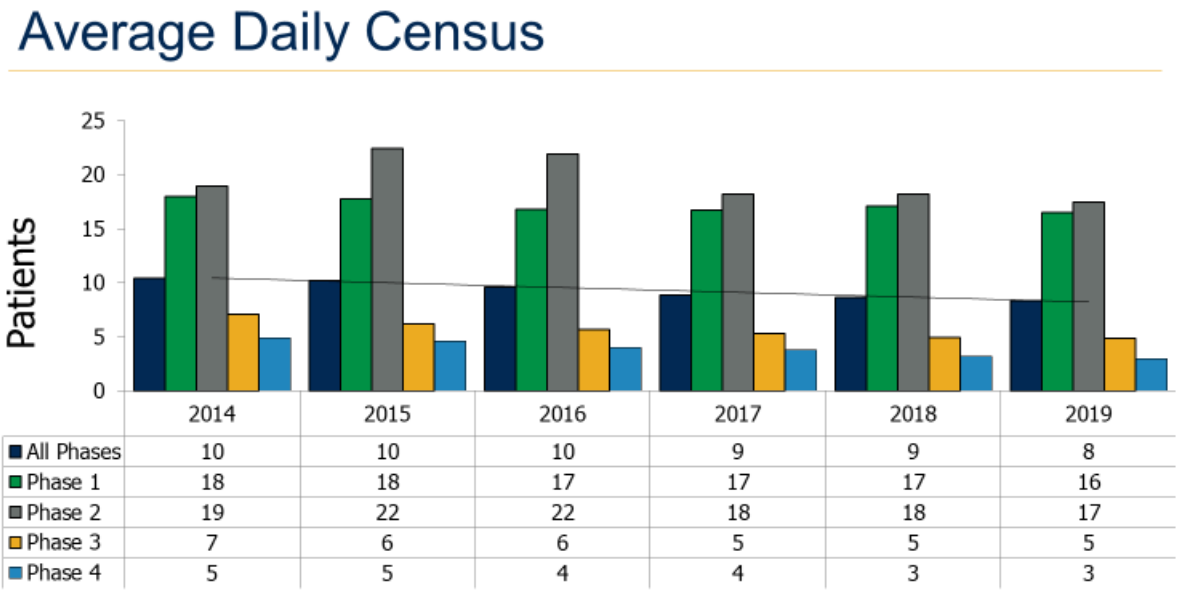
Over the past six years, the hospitals in these first four phases have faced a variety of factors including changing or declining demographics, varying patient preferences, shifts in service patterns from inpatient to outpatient, introduction of new reimbursement mechanisms and models, increasing salary and other costs, and adjusting regulatory or policy impacts. The hospitals are working to address these challenges and adapt to this changing health care environment. Hospitals are compelled to grow revenue to offset increasing expenses, develop new service lines, reduce costs, and implement other operational and financial actions to keep the hospitals' doors open and continue to serve the community.

Overall, when considering the significant changes to the healthcare industry that have occurred in the past six years, the hospitals in Phases One through Four reflect relatively stable results from 2014 through 2018 and more challenging results in 2019. None of these hospitals have closed during the period under review. These hospitals will continue to be evaluated on an annual basis, and future reports will incorporate the results of Phase Five hospitals.

Detailed Analysis

Average Daily Census

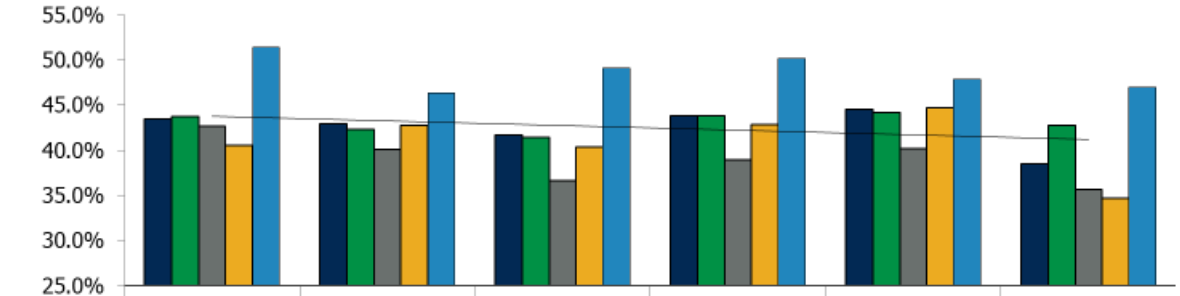
- Ratio Type - Volume
- Desired Trend - Increasing
- Definition – Measures the average number of adult and pediatric inpatient days over a fiscal year. Excludes swing bed and nursery days.
- Formula – Total Adults and Pediatrics Inpatient Days / 365



As reflected in the data, the number of patients reported as inpatient is not a large number for all phases or the individual phases on average for the year. These numbers will fluctuate based on surgical cases, flu season, or other reasons, and the hospital will have to adjust its staffing, medical supplies, and other items to meet the varying demand for services. The trend for these six years reflects an overall decrease in average daily census from 2014 to 2019.

Patient Mix – Inpatient Days – Payer Percentage and Days

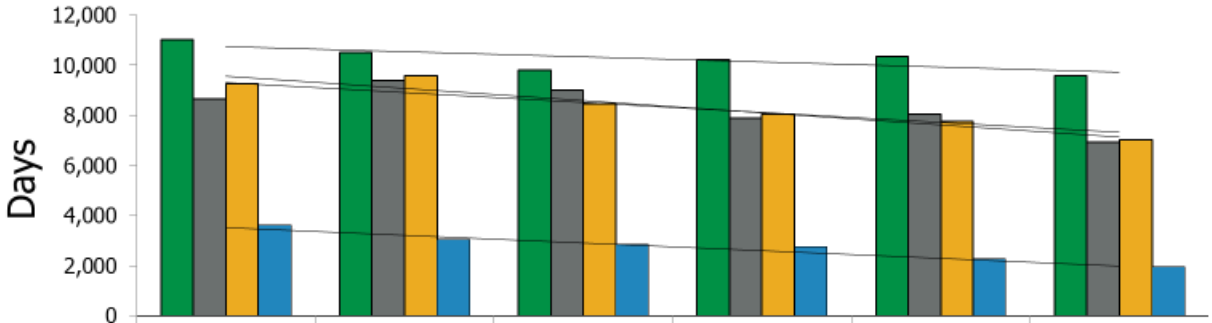
Patient Mix – I/P Days – Medicare %



	2014	2015	2016	2017	2018	2019
All Phases	43.5%	43.0%	41.7%	43.8%	44.6%	38.5%
Phase 1	43.7%	42.4%	41.5%	43.8%	44.2%	42.7%
Phase 2	42.7%	40.1%	36.7%	39.0%	40.2%	35.7%
Phase 3	40.5%	42.8%	40.4%	42.9%	44.7%	34.7%
Phase 4	51.5%	46.4%	49.1%	50.2%	47.9%	47.0%

Draffin Tucker

Patient Mix – I/P Days – Medicare Days

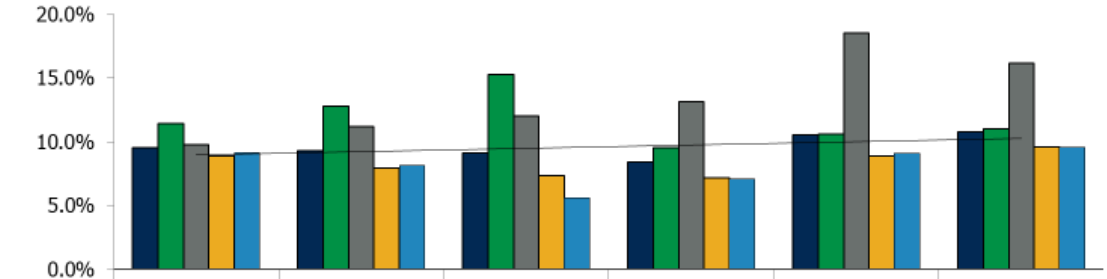


	2014	2015	2016	2017	2018	2019
Phase 1	11,008	10,515	9,809	10,209	10,359	9,590
Phase 2	8,668	9,392	9,006	7,899	8,035	6,929
Phase 3	9,260	9,587	8,471	8,042	7,750	7,028
Phase 4	3,627	3,051	2,851	2,762	2,280	1,959

Draffin Tucker

For Medicare, the inpatient days mix is decreasing from 42% to 39%. The actual patient days declined 13% for Phase One, 20% for Phase Two, 24% for Phase Three, and 46% for Phase Four.

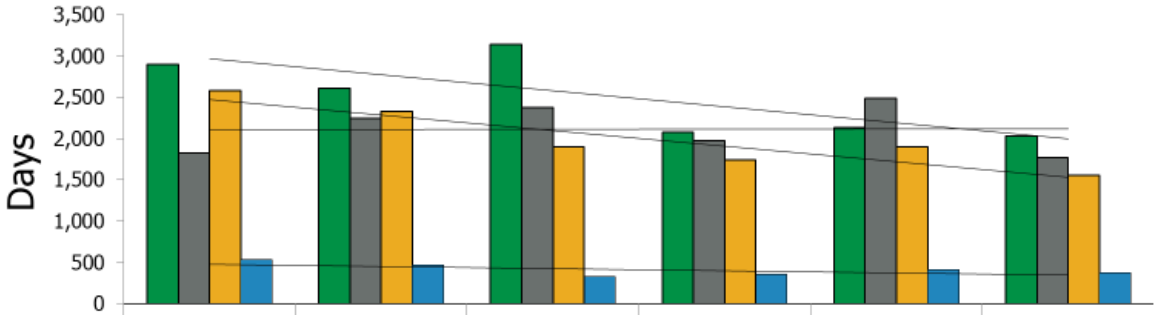
Patient Mix – I/P Days – Medicaid %



	2014	2015	2016	2017	2018	2019
All Phases	9.6%	9.3%	9.1%	8.4%	10.6%	10.8%
Phase 1	11.4%	12.8%	15.3%	9.5%	10.6%	11.0%
Phase 2	9.8%	11.2%	12.0%	13.2%	18.5%	16.2%
Phase 3	8.9%	7.9%	7.3%	7.2%	8.9%	9.6%
Phase 4	9.2%	8.1%	5.6%	7.1%	9.1%	9.6%

Draffin Tucker

Patient Mix – I/P Days – Medicaid Days

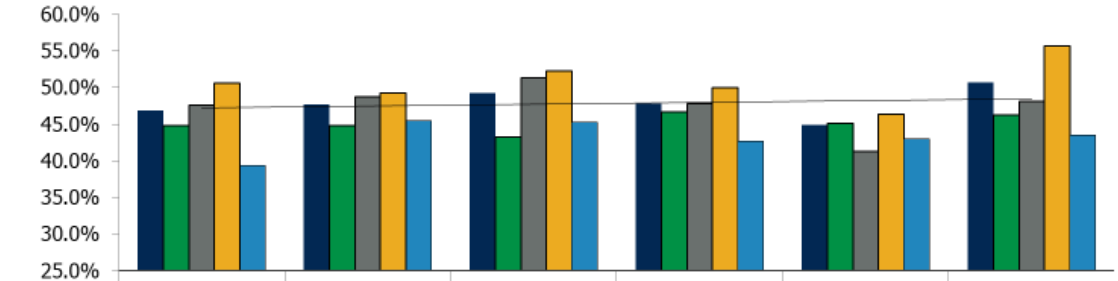


	2014	2015	2016	2017	2018	2019
Phase 1	2,894	2,607	3,138	2,077	2,137	2,033
Phase 2	1,825	2,243	2,376	1,973	2,485	1,771
Phase 3	2,579	2,330	1,904	1,744	1,903	1,557
Phase 4	537	466	327	355	410	376

Draffin Tucker

For Medicaid, the overall inpatient days mix is increasing from 9% to 11%. Inpatient days mix stayed relatively consistent for Phases One and Four. Phase Two inpatient days mix went from 10% to 16%, and Phase Three inpatient days mix went from 9% to almost 10%. Actual Medicaid patient days declined 30% for Phase One, 3% for Phase Two, 40% for Phase Three, and 30% for Phase Four.

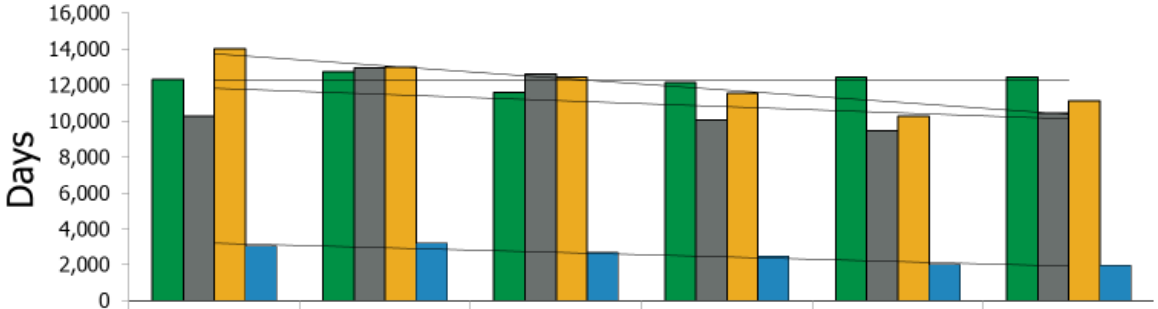
Patient Mix – I/P Days – Other %



	2014	2015	2016	2017	2018	2019
All Phases	46.9%	47.7%	49.2%	47.8%	44.9%	50.7%
Phase 1	44.8%	44.8%	43.3%	46.7%	45.1%	46.2%
Phase 2	47.6%	48.7%	51.3%	47.8%	41.3%	48.1%
Phase 3	50.6%	49.3%	52.3%	50.0%	46.4%	55.7%
Phase 4	39.4%	45.5%	45.2%	42.7%	43.0%	43.5%

Draffin Tucker

Patient Mix – I/P Days – Other Days



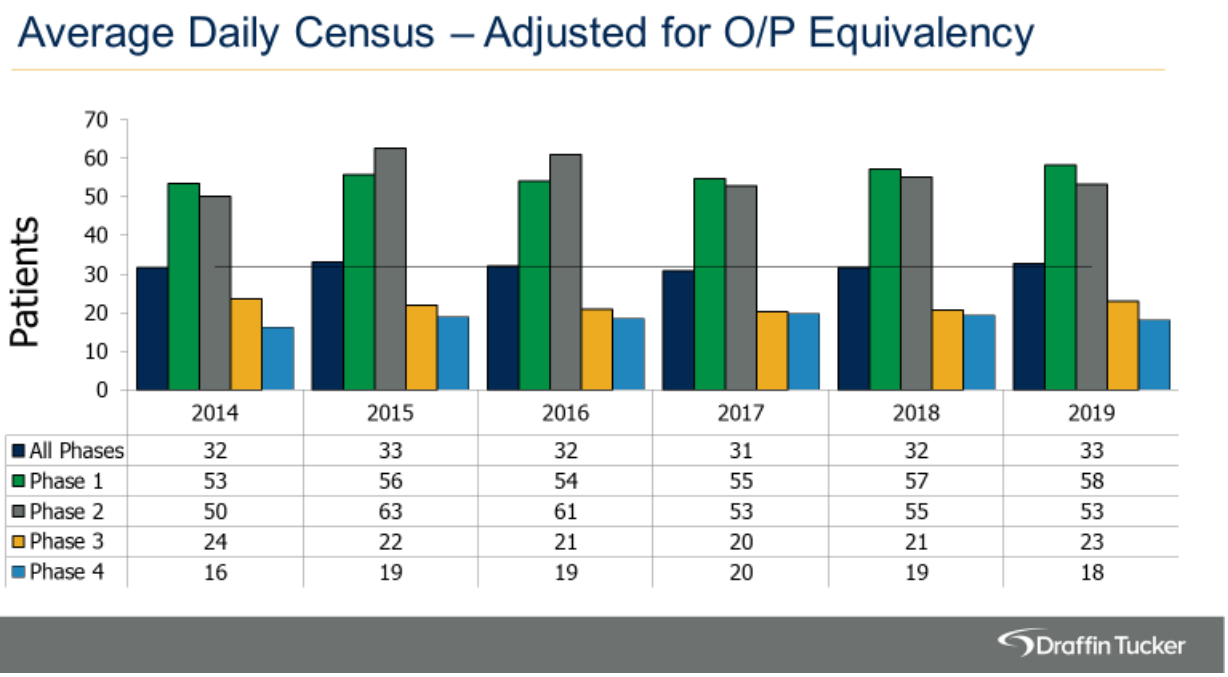
	2014	2015	2016	2017	2018	2019
Phase 1	12,315	12,751	11,602	12,157	12,435	12,448
Phase 2	10,258	12,951	12,626	10,061	9,441	10,455
Phase 3	14,003	12,998	12,442	11,529	10,243	11,097
Phase 4	3,047	3,216	2,705	2,477	2,023	1,972

Draffin Tucker

Inpatient mix for other payers is increasing from almost 47% to almost 51%. Actual patient days for other payers stayed relatively the same for Phase One and Phase Two. Phase Three reflects a 21% decrease, and Phase Four reflects a 35% decrease. Medicare and Medicaid Advantage and Managed Care plans are included in this "Other" category.

Average Daily Census – Adjusted for Outpatient Equivalency

- Ratio Type - Volume
- Desired Trend - Increasing
- Definition – Measures the average number of adjusted patient days over a fiscal year. Numerator consists of inpatient adult and pediatric days plus outpatient equivalent days. Unit measure of volume incorporating outpatient services.
- Formula
    - Outpatient Equivalent Days = Outpatient Revenue / Average Inpatient Revenue per Day
    - Adjusted Patient Days = Inpatient Days + Outpatient Equivalent Days
    - Total Adults and Pediatrics Inpatient Days / 365

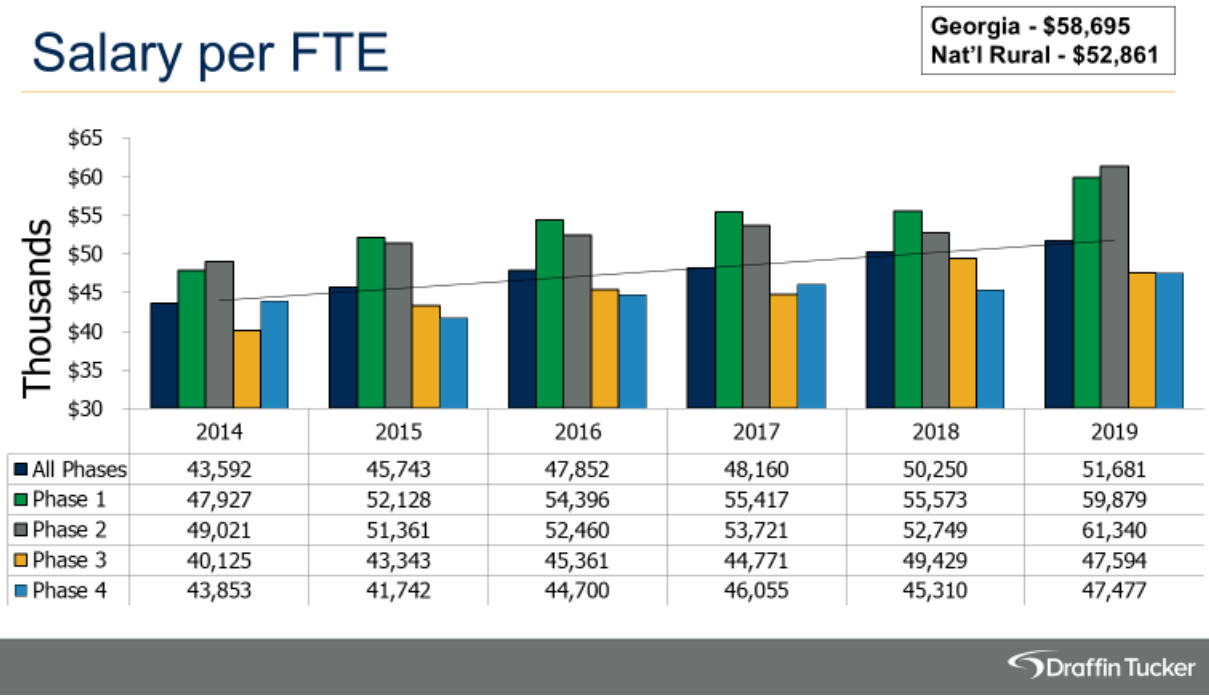


	2014	2015	2016	2017	2018	2019
All Phases	32	33	32	31	32	33
Phase 1	53	56	54	55	57	58
Phase 2	50	63	61	53	55	53
Phase 3	24	22	21	20	21	23
Phase 4	16	19	19	20	19	18

This ratio converts outpatient services to incorporate into an adjusted average daily census. It helps to better reflect the volume, work effort, and activities of the hospital. As noted earlier in the report, average daily census was an overall average of 8 to 10 patients. Including outpatient activity, average daily census is now averaging 32 to 33 patients. Approximately two-thirds of the hospital activity is attributable to outpatient services.

Salary per Full Time Equivalent

- Ratio Type – Unit Cost of Inputs
- Desired Trend - Depends
- Definition – Measures the average salary per full time equivalent (FTE). Full time equivalent determined by dividing total fiscal year paid hours by 2,080 hours (40 hours times 52 weeks). Salaries are typically the largest resource item used in the provision of healthcare services.
- Formula – Total Salary Expense / FTEs

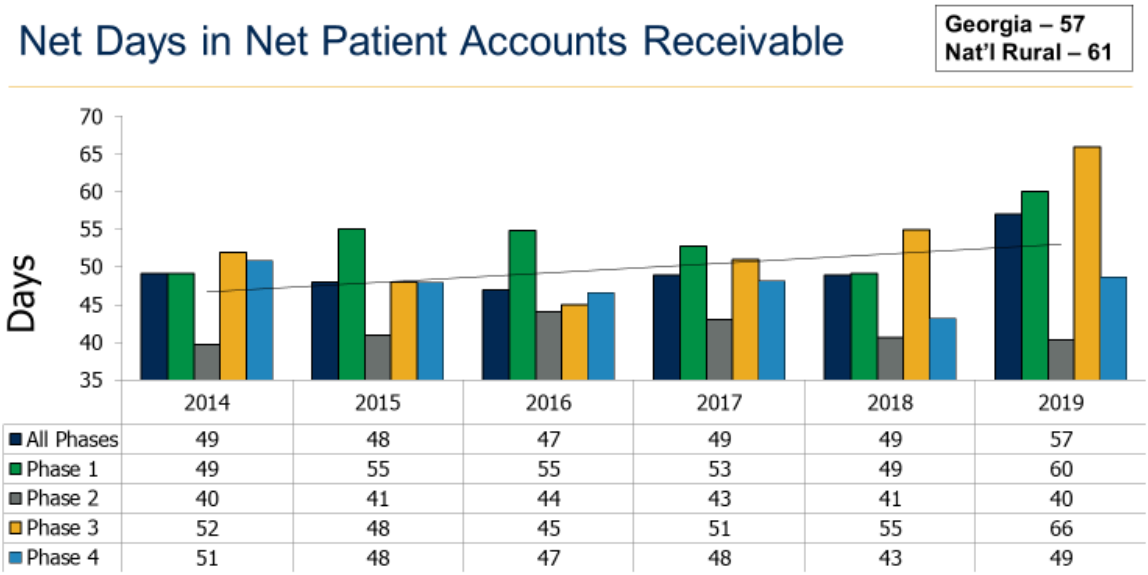


	2014	2015	2016	2017	2018	2019
All Phases	43,592	45,743	47,852	48,160	50,250	51,681
Phase 1	47,927	52,128	54,396	55,417	55,573	59,879
Phase 2	49,021	51,361	52,460	53,721	52,749	61,340
Phase 3	40,125	43,343	45,361	44,771	49,429	47,594
Phase 4	43,853	41,742	44,700	46,055	45,310	47,477

Salary per FTE helps to analyze the cost of the employed labor providing the services at the hospital. This cost does not include benefits, recruitment and retention costs, and external contractors. There is an overall 19% increase since 2014 or an average salary increase of 3% per year.

Net Days in Net Patient Accounts Receivable

- Ratio Type – Liquidity
- Desired Trend - Decreasing
- Definition – Measures the average time that receivables are outstanding, or the average collection period. High values imply longer collection period and thus a need for the hospital to finance its investment in accounts receivable.
- Formula – Net Patient Accounts Receivable / (Net Patient Service Revenue / 365)

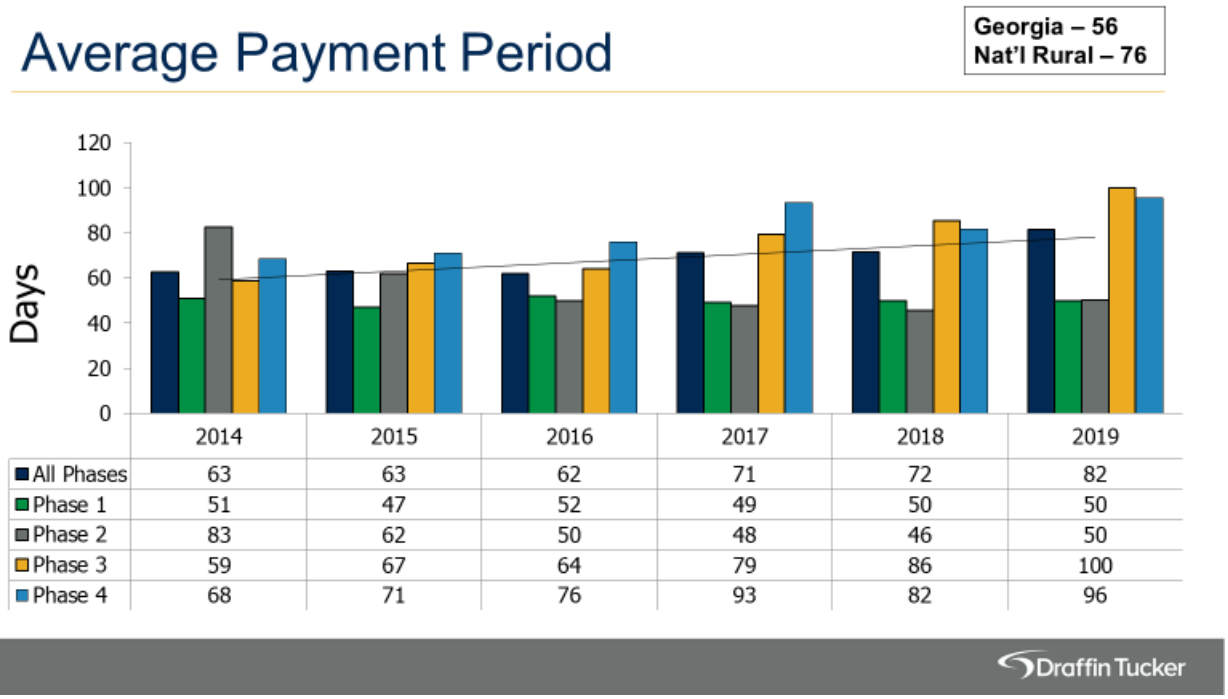


	2014	2015	2016	2017	2018	2019
All Phases	49	48	47	49	49	57
Phase 1	49	55	55	53	49	60
Phase 2	40	41	44	43	41	40
Phase 3	52	48	45	51	55	66
Phase 4	51	48	47	48	43	49

On an overall basis, net days in net patient accounts receivable increased 8 days during the six year period. The data indicates it takes an average of 57 days for hospitals to receive payment for services for the most recent year.

Average Payment Period

- Ratio Type – Liquidity
- Desired Trend - Decreasing
- Definition – Measures the average time that elapses before current liabilities are paid. The denominator is an estimate of the hospital's average daily cash expenses minus depreciation. Creditors regard high values for this ratio as an indication of potential liquidity problems.
- Formula – Current Liabilities / [(Total Expenses – Depreciation) / 365]

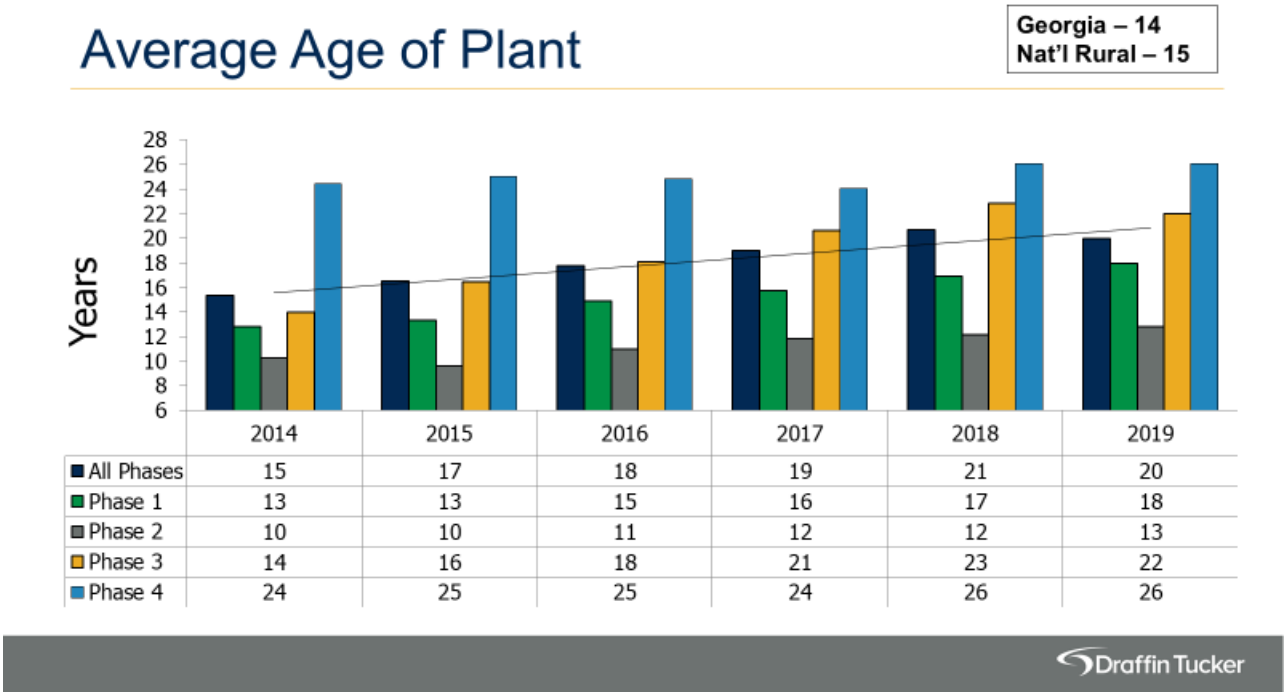


	2014	2015	2016	2017	2018	2019
All Phases	63	63	62	71	72	82
Phase 1	51	47	52	49	50	50
Phase 2	83	62	50	48	46	50
Phase 3	59	67	64	79	86	100
Phase 4	68	71	76	93	82	96

Average payment period is a liquidity measure which shows the average time it takes the hospital to pay its vendors. The trend for this ratio should be decreasing; however, the data reflects the ratio at an average of 82 days in 2019 which is a 30% increase from 2014. In 2019, the individual phases range from a low of 50 days for Phases One and Two to a high of 96 days and 100 days for Phase Four and Phase Three, respectively.

Average Age of Plant

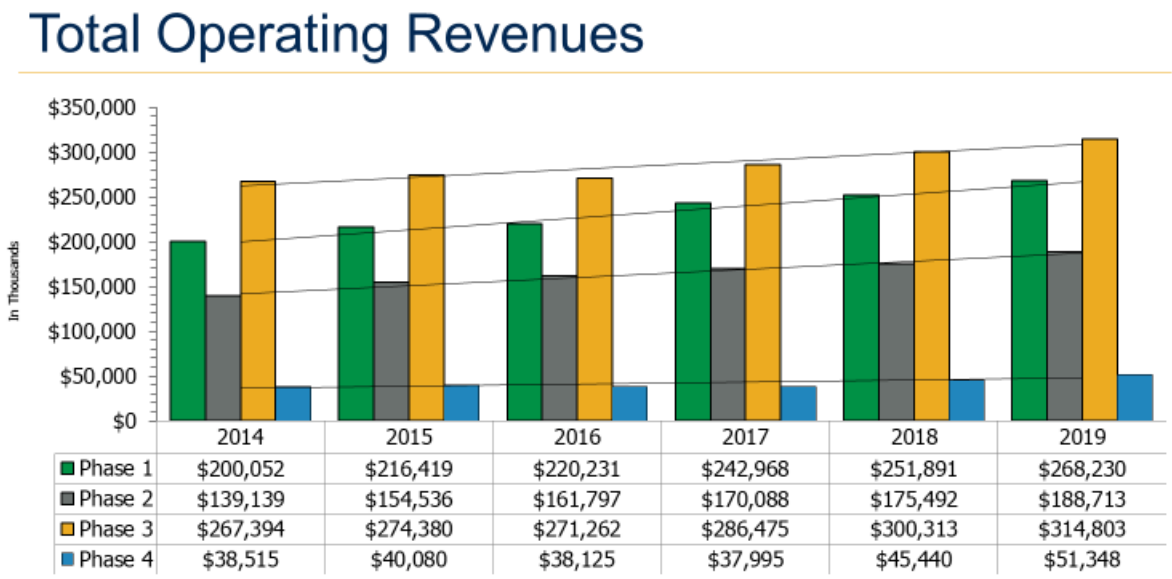
- Ratio Type – Asset Efficiency
- Desired Trend - Decreasing
- Definition – Measures the average age of the hospital's fixed assets in years. Lower values indicate a newer fixed asset base and thus less need for near term replacement.
- Formula – Accumulated Depreciation / Depreciation Expense



	2014	2015	2016	2017	2018	2019
All Phases	15	17	18	19	21	20
Phase 1	13	13	15	16	17	18
Phase 2	10	10	11	12	12	13
Phase 3	14	16	18	21	23	22
Phase 4	24	25	25	24	26	26

Average age of plant is an indicator for how old the equipment, building, and other fixed assets of the hospital are and shows the potential need for replacement or updating. From 2014 to 2019, there was an overall aging of fixed assets from 15 to 20 which is an increase of 5 years or 33% increase in the average age of plant.

Total Operating Revenues



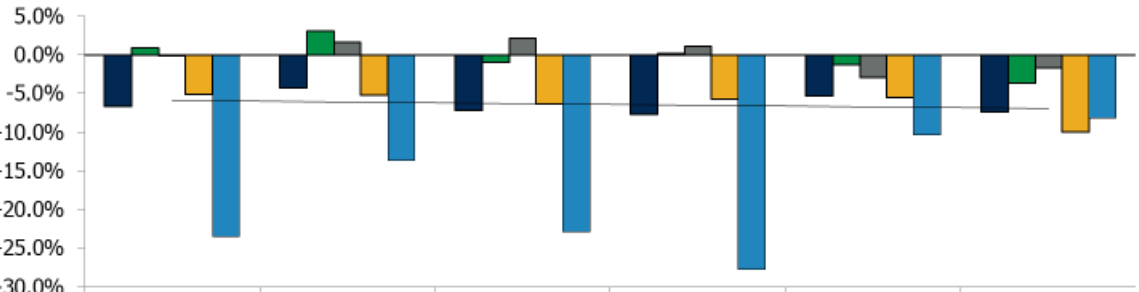
Total operating revenues includes revenue from patient services and reflects the gross charges of the hospital adjusted down to the amounts actually expected to be collected from payers and patients. There is an increase in all phases from 2014 to 2019. Phases One, Two, and Four report a 34%, 36%, and 33% overall increase, respectively, or a 6% year over year increase. Phase Three reports an 18% overall increase or a 3% year over year increase.

Operating Margin

- Ratio Type – Profitability
- Desired Trend - Increasing
- Definition – Reflects the proportion of operating revenue retained as income and is a measure of a hospital's profitability from the provision of patient care services and other hospital operations.
- Formula – (Operating Revenue – Total Expenses) / Operating Revenue

Operating Margin

Georgia – Positive 3.4%
Nat'l Rural – Negative 1.4%



	2014	2015	2016	2017	2018	2019
All Phases	-6.7%	-4.3%	-7.2%	-7.7%	-5.3%	-7.4%
Phase 1	0.9%	3.1%	-1.0%	0.1%	-1.3%	-3.7%
Phase 2	-0.1%	1.6%	2.2%	1.1%	-2.9%	-1.7%
Phase 3	-5.1%	-5.3%	-6.3%	-5.7%	-5.5%	-10.0%
Phase 4	-23.5%	-13.6%	-22.9%	-27.8%	-10.3%	-8.2%

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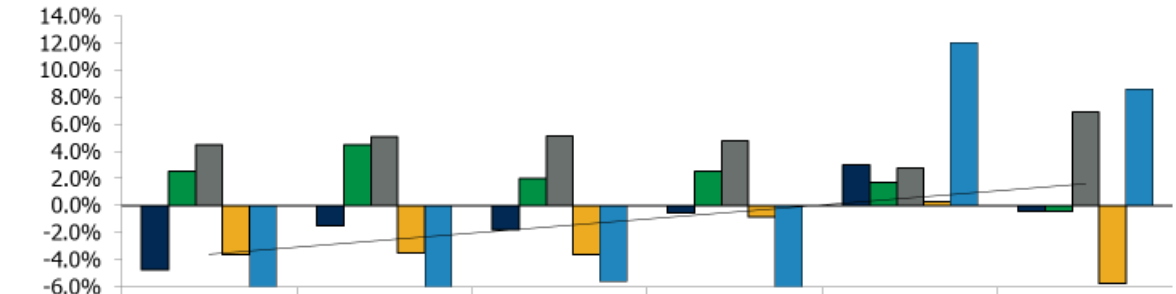
Operating margin is a profitability measure focused on the provided hospital services and generally does not include investment income, donations, nonoperating amounts, or unusual adjustments. Overall operating margin hovered around a loss from 7% with mixed results by individual phases with Phases One, Two, and Three ending up at the same or decreased margins in 2019 as compared to 2014. Phase Four showed an improvement in operating margin of 15% or an increase of 3% year over year.

Total Margin

- Ratio Type – Profitability
- Desired Trend - Increasing
- Definition – Defines the percentage of total revenue that has been realized in the form of net income or excess revenues over expenses. Used by many as a primary measure of hospital profitability.
- Formula – Excess of Revenues (Expenses) / Total Revenue

Total Margin

Georgia – Positive 5.4%
Nat'l Rural – Positive 0.8%



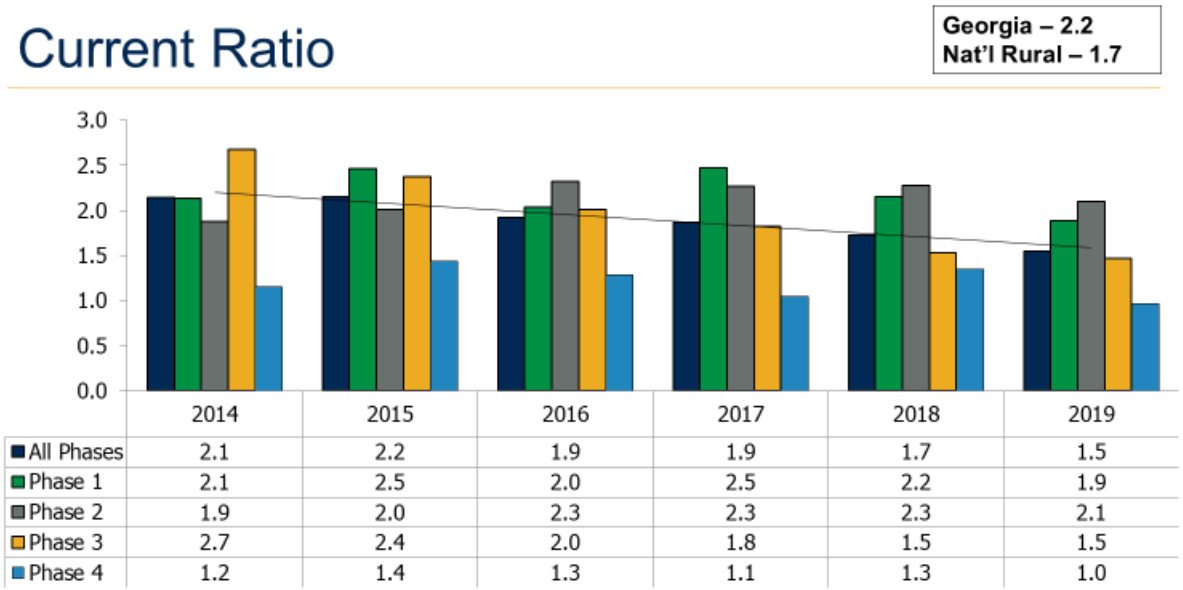
	2014	2015	2016	2017	2018	2019
All Phases	-4.7%	-1.5%	-1.8%	-0.5%	3.0%	-0.5%
Phase 1	2.5%	4.5%	2.0%	2.5%	1.7%	-0.5%
Phase 2	4.5%	5.1%	5.1%	4.8%	2.8%	6.9%
Phase 3	-3.6%	-3.5%	-3.6%	-0.8%	0.3%	-5.8%
Phase 4	-21.9%	-6.9%	-5.6%	-6.7%	12.0%	8.6%

Draffin Tucker

Total margin includes all revenue and expenses, including donations and investment income. Overall results for all phases went from -4.7% (negative margin) in 2014 to -0.5% (negative margin) in 2019. Positive margins are reflected in Phases Two and Four and declining margins in Phases One and Three.

Current Ratio

- Ratio Type – Liquidity
- Desired Trend - Increasing
- Definition – Measures the number of dollars held in current assets per dollar of current liabilities. Most widely used measure of liquidity. High values imply a good ability to pay short term obligations and thus a low probability of technical insolvency.
- Formula – Current Assets / Current Liabilities

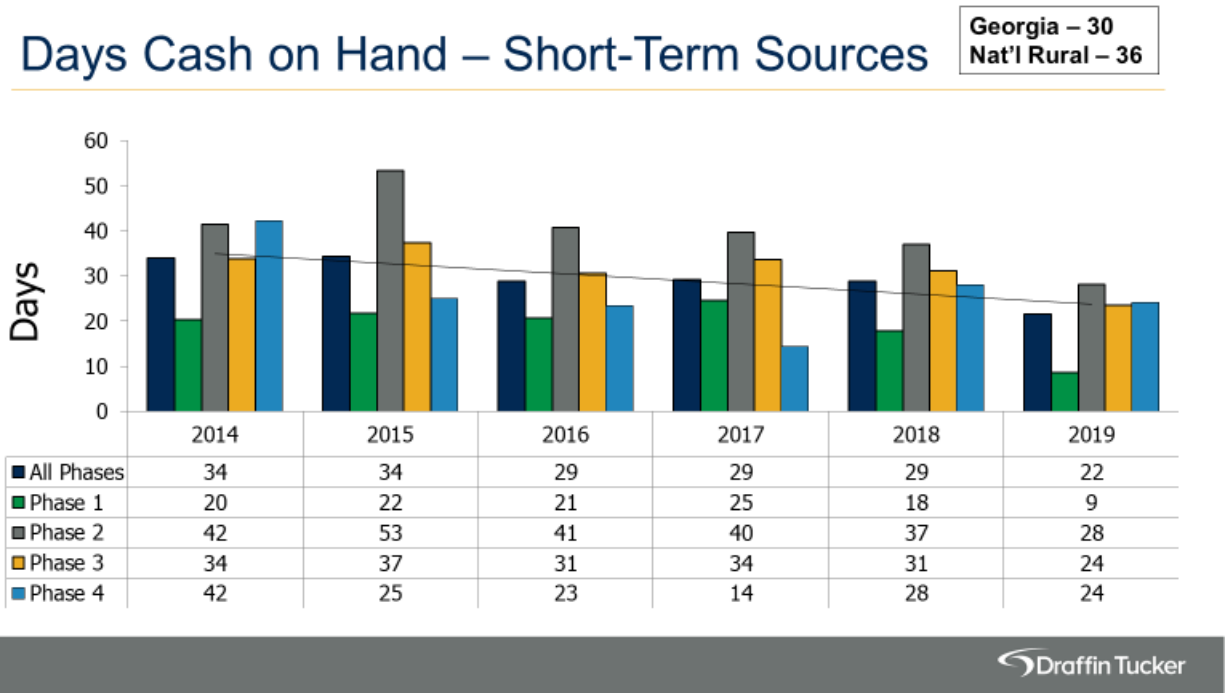


	2014	2015	2016	2017	2018	2019
All Phases	2.1	2.2	1.9	1.9	1.7	1.5
Phase 1	2.1	2.5	2.0	2.5	2.2	1.9
Phase 2	1.9	2.0	2.3	2.3	2.3	2.1
Phase 3	2.7	2.4	2.0	1.8	1.5	1.5
Phase 4	1.2	1.4	1.3	1.1	1.3	1.0

Current ratio reflects liquidity of the hospital with two times current assets over current liabilities. From 2014 to 2019, Phases One and Two hovered around 2, and Phase Four hovered around 1. Phase Three declined from 2.7 to 1.5 over the six years.

Days Cash on Hand – Short-Term Sources

- Ratio Type – Liquidity
- Desired Trend - Increasing
- Definition – Measures the number of days of average cash expenses that the hospital maintains in cash and marketable securities which are classified as current assets. The denominator measures the average daily cash expenses less depreciation. High values usually imply a greater ability to meet short-term obligations and are viewed favorably by creditors.
- Formula – (Cash + Short-Term Investments) / [(Total Expenses – Depreciation) / 365]

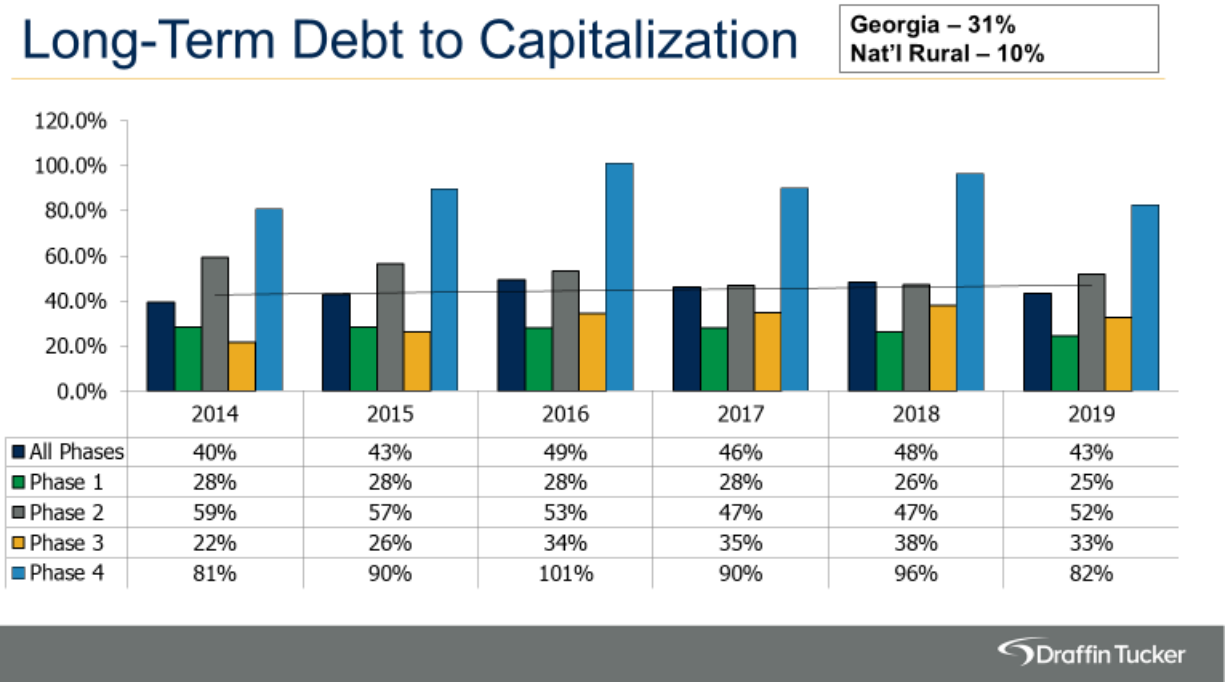


	2014	2015	2016	2017	2018	2019
All Phases	34	34	29	29	29	22
Phase 1	20	22	21	25	18	9
Phase 2	42	53	41	40	37	28
Phase 3	34	37	31	34	31	24
Phase 4	42	25	23	14	28	24

Days cash on hand from short-term sources show declines over the time period with 34 in 2014 to 22 in 2019, a 37% decrease in liquidity. All individual phases showed declines in this ratio with decreases of 58%, 32%, 30%, and 43% in Phase One, Phase Two, Phase Three, and Phase Four, respectively.

Long-Term Debt to Capitalization

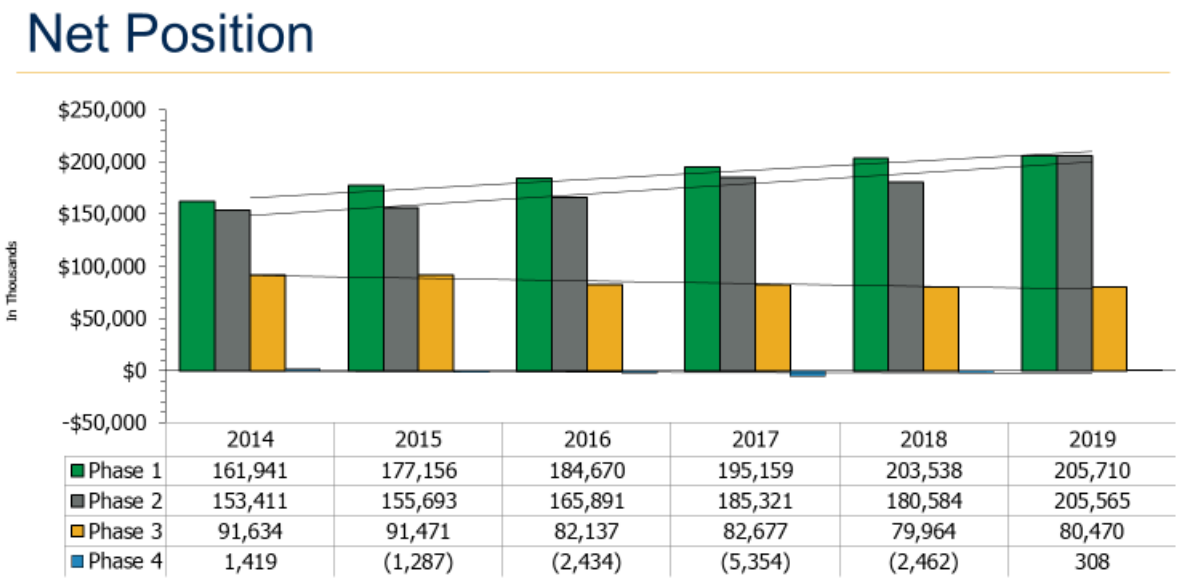
- Ratio Type – Capital Structure
- Desired Trend - Decreasing
- Definition – Measures the relative importance of long-term debt in the hospital's permanent capital structure. Net assets and long-term liabilities are often referred to as permanent capital since they will not be repaid within one year. Hospitals with high values have relied extensively on debt as opposed to equity to finance their assets and are said to be leveraged. Meaning risk may be viewed unfavorably by many creditors.
- Formula – Long-Term Debt / (Long-Term Debt + Net Assets)



	2014	2015	2016	2017	2018	2019
All Phases	40%	43%	49%	46%	48%	43%
Phase 1	28%	28%	28%	28%	26%	25%
Phase 2	59%	57%	53%	47%	47%	52%
Phase 3	22%	26%	34%	35%	38%	33%
Phase 4	81%	90%	101%	90%	96%	82%

Long-term debt to capitalization reflects if the hospital is using debt to finance its operations. The expected trend for this ratio is decreasing; however, for all phases, the ratio increased from 40% in 2014 to 43% in 2019. Both Phases One and Two showed declines from 2014 to 2019, and Phase Four increased slightly from 81% in 2014 to 82% in 2019. Phase Three went from 22% in 2014 to 33% in 2019.

Net Position



Net position is comparative to stockholders' equity and reflects how the hospital's overall net assets are performing. Both Phase One and Phase Two have increased over the time period with 27% and 34% increases, respectively. Phase Three declined 12%, and Phase Four declined 78% over the same time period.