

West Virginia Health Care Authority

2016 Annual Report



YTIPOKITTA

Mission

The West Virginia Health Care Authority works to:



- Protect citizens from unreasonable increases in the cost of healthcare services;
- Promote appropriate distribution of health care services;
- Promote the financial viability of the healthcare delivery system; and,
- Assure the collection, analysis and dissemination of health related information to citizens, providers, policy makers and other customers.

Vision

All West Virginians will have appropriate access to a continuum of affordable, quality, coordinated healthcare services.



West Virginia Health Care Authority FY 2016 Annual Report



Earl Ray Tomblin, Governor

Karen L. Bowling, Cabinet Secretary
West Virginia Department of Health and Human
Resources

Board Members

James L. Pitrolo, Jr., Chairman
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Introduction

The 2016 Annual Report to the Legislature (Annual Report) includes information about both the West Virginia Health Care Authority (Authority) and the state's health care providers. It is required by W. Va. Code §16-29B-9. Information about the Authority's activities are presented within the Agency Highlights section. The provider information focuses primarily on financial data, but also includes some utilization, staffing and quality information. The financial data is based on the provider's 2015 fiscal year and clinical data is presented by calendar year. Quality measurements cover a broader length of time than one 12-month period. The notations of FY and CY are used for fiscal year and calendar year, respectively.

The report includes written narratives, charts, tables and maps. Detailed tables, with information shown by provider, are available on the Authority's website:

<http://www.hca.wv.gov/data/Reports/Pages/default.aspx>.

While the information is published as a report to the Legislature, it is also prepared for use by the industry, other decision makers, researchers, members of the public and anyone who wants to know more about the financial status of the state's health care providers and the services delivered. Comparing data over a span of time is especially useful, so the Authority has on its website all of the Annual Reports since 1997. Additionally, a variety of charts and trend tables that allow the casual reader to gain meaningful information, with a quick review, about the state's health care providers are included within the body of the report.

Provider Information

Health care is delivered by a variety of organizations and professionals. The term "provider" references healthcare entities as opposed to the healthcare professional. Additionally, this report organizes the information by provider type: hospitals, nursing homes, behavioral health centers, primary care centers, home health agencies, hospice agencies, renal dialysis centers and ambulatory surgical centers. The presentation of the information is ordered by the level of revenue reported as a rough means of demonstrating the impact of each provider type. While nursing homes, in aggregate, report total revenue that is greater than the aggregate amount of revenue reported by behavioral health centers, it does not imply that the services provided by nursing homes are more important. However, it may give the reader a clearer perspective on the relative financial impact the various provider types have within the state. The section entitled "Overview of Key Indicators" is useful for comparing aggregate financial information among provider types.

Multiple sources are used for the provider information. Almost all source documents are compiled from submissions made by providers through the financial disclosure program of the Financial Analysis and Clinical Analysis Divisions. Hospital data comes from multiple sources. The Uniform Financial Report contains information on financial operations, staffing, and aggregate utilization data. Uniform Billing data is the source of information regarding clinical utilization.

Information on quality indicators comes from two sources: the Healthcare-Associated Infection Public Reporting Program and the CMS Hospital Compare Quality Reporting Program. Average charges and benchmarking information comes from the Financial Analysis Division. Data for nursing homes, home health agencies, hospice agencies and ambulatory surgical centers are gathered from annual surveys the Authority conducts for each of those provider types. Financial statements submitted as part of the annual financial disclosure requirements are the source of the information for behavioral health centers, primary care centers and ambulatory care centers.

Terminology

To support our goal of providing a valuable document for all interested in learning more about the state's healthcare providers, brief explanations of several terms and concepts found in this report may be beneficial.

Financial terms

Profit, net income and **EROE** (Excess Revenue Over Expenses) are all used interchangeably in this report. The term **EROE** almost defines itself – it is the amount of income or revenue remaining after the expenses of the entity have been incurred. Although providers may be identified as not-for-profit, no organization can continually lose money and still remain a viable entity. Therefore, the financial concept of profit is the key variable in evaluating the financial status of a healthcare provider or category of providers.

The reader should also understand that healthcare entities often incur losses in one year, or even several years, but then return to profitability as circumstances change. As mentioned above, comparing data over a span of time is valuable in gaining a clearer picture of the financial status of a healthcare provider or healthcare sector. Finally, the purpose of this report is not to evaluate and assess the appropriateness of the level of profits or losses, but to provide data that is helpful to others in their analysis or for use in developing more informed questions.

A complementary financial concept to EROE is that of **margins**. While EROE provides a specific dollar amount, it does so without a relationship to any other factor. Margins, while they reflect a level of profit or loss, can only suggest a relationship since they are a percentage that compares profits or losses to another financial variable. Typically, the margins in this report are comparisons of the amount of profit to the amount of net patient revenue and are expressed as a percentage. For example, a profit of \$1.0 million on net patient revenue of \$10.0 million equals a 10.0% margin. In some instances, though, margins are calculated using total revenue instead of net patient revenue. This occurs with certain provider types that either do not have well-defined revenue sources on their financial statements, so that total revenue is used; or, the other revenue is so small that it is not important to present separately. The detailed tables do not include the percentage symbol (%) for readability purposes, but percentage is indicated on the column headings.

Discussions of revenue in this report include **gross patient revenue, net patient revenue, other revenue** and **total revenue**, which equals net patient revenue plus other revenue. **Gross patient revenue** measures the amount charged by the provider at full charge, before any discounts or contractual allowances. **Net patient revenue** is what the provider actually receives in payment for services. It also can be thought of as the cost paid for healthcare services by the consumer and/or payor. The calculation for net patient revenue is gross patient revenue minus contractual allowances, minus bad debts, minus charity.

Other revenue, in this report, refers to other operating and non-operating revenue. These sources of revenue are considered distinct from revenue received from patient services. And, this brings us to the concept of **income (or losses) from patient services**, which are essentially the profits or losses for patient care alone without regard to the receipt of other revenue, the payment of taxes or extraordinary gains or losses, etc. Margins on income from patient services are presented within the hospital narrative in depth.

The last financial term that deserves explanation relates to which measure of central tendency is used in this report and why. In this year's report we have chosen to switch from **average (arithmetic mean)** to **median**. Using the **median** or middle score is not affected by extreme numbers or skewed data and most likely to represent the "typical" experience of the state's health care providers. Therefore, it was determined that going forward the measure of central tendency used in this report will be the **median** value.

Payor categories

The Authority uses five standard categories: Medicare, Medicaid, PEIA (Public Employees Insurance Agency), other governmental and nongovernmental. These categories can include multiple payor entities. For example, the nongovernmental category includes commercial payors, Blue Cross plans, Union plans, self-insurance, etc. In some instances Medicaid and PEIA are discussed together and referred to as "state payors."

Finally, the report has an appendix section that includes a glossary and a list of hospitals along with abbreviated names that are used to improve readability of the report.

Questions about the 2016 Annual Report to the Legislature should be addressed to:

Financial Analysis Division
WV Health Care Authority
100 Dee Drive
Charleston, WV 25311
304.558.7000
888.558.7000

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Agency Review

Agency Highlights

Grant Programs

West Virginia Health Information Network

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Agency Highlights

The mission of the West Virginia Health Care Authority (Authority) encompasses a range of functions in the state's health care sector that relate to: access, cost, information and quality. The agency accomplishes its mission through its Certificate of Need (CON), Health Planning and Rural Health Systems programs; clinical and financial disclosure data collection, analysis and reporting functions; the administration of the West Virginia State Privacy Office (SPO); the West Virginia Health Information Network (WVHIN) and much more. Through these activities, the agency assists hospitals, providers, policymakers and consumers, in the advancement of quality, affordable and coordinated health care in communities across West Virginia.

During the 2016 session of the West Virginia Legislature, two bills were passed which had a significant impact on the Authority. House Bill 4365 became effective June 10, 2016. It streamlined CON law by exempting certain services from review in addition to other changes. Senate Bill 68 became effective July 1, 2016 and removed rate-setting authority.

Access and Quality

The Authority's accomplishments this year for the promotion of access and quality include work on the State Health Plan, quality improvement projects, changes to the CON program, and ongoing funding of services.

The **Clinical Analysis (CAD)** division, through its Health Planning Program, began the process of developing the State Health Plan. This process included the formation of a state agency steering committee, collection of data, determination of health indicators, and interviews with statewide stakeholders to assist in determining community and regional issues. Publication is anticipated in 2017. The framework for the State Health Plan will provide a dashboard approach which can be updated and modified as changes in state health indicators occur.

The **Healthcare-Associated Infection (HAI) Public Reporting Project** was continued as the Authority's primary quality improvement project. The 2017 HAI Annual Report details hospital inpatient healthcare-associated infection rates by hospital and healthcare personnel seasonal influenza vaccination data by hospital as reported to the Centers for Disease Control and Prevention's National Healthcare Safety Network. This report also includes a Clostridium difficile hospital testing improvement project that serves to assist hospitals in appropriate and rapid testing, diagnosis and treatment of infections.

The CON Standard for *In-Home Personal Care Services* was updated in 2016 to better facilitate access to services for underserved populations. A task force comprised of statewide stakeholders and other interested parties met with the Authority and/or provided comments as the updated Standard was developed. The revised In-Home Personal Care Standard was approved by Governor Tomblin on November 28, 2016.

The **Rural Health Systems Program** (Grants) provided funding that promotes access and quality health care services in rural areas throughout the state. Grants awarded during 2016:

- **West Virginia Health Right** for a financial audit to ensure clinical procedures are properly coded to maximize reimbursement in pursuit of financial sustainability as they transition from a charitable clinic to one that may be reimbursed for services.
- **Davis Medical Center** to continue the Healthy Home Program that serves to improve the health of participating seniors and reduce the costs of health and housing services by focusing on prevention, management of chronic health conditions and avoidance of emergency hospitalizations.
- **Wheeling Health Right** to continue and expand the charitable dental program into Hancock, Brooke, Ohio, Marshall and Wetzel counties.
- **Hardy and Grant County Commissions** to sustain emergency medical services.
- **Webster County Hospital** to maintain patient services after flood damage.
- **Wirt County Commission** for an off-road utility vehicle and ancillary equipment to provide emergency transport in remote areas of the county.
- **Change, Inc.** for equipment and supplies for expansion of the existing dental program.
- **West Virginia Health Right** to purchase a generator to maintain pharmacy and patient services in the event of a power outage.
- **Montgomery General Hospital** for hot water tanks to maintain patient services.

The Authority's **Hospital Assistance Program** is another funding source that provided grants to the following projects:

- The **Healthcare Education Foundation of West Virginia**
 - **Professional consulting and other administrative service supports** were funded to support the medical professional health program and for the Critical Access Hospital Network to assist in meeting the challenges of maintaining access to healthcare in rural areas, stabilizing rural hospitals and improving quality of care.
 - **KeySTATS**, a software package that assists West Virginia hospitals in performing individual analysis of Medicare reimbursement changes and the impact to their financial stability, was purchased.

- The **West Virginia Telehealth Alliance (WVTA)** grant was continued. The WVTA is a participant in the Federal Communications Commission’s Rural Health Care Pilot Program, which works to improve broadband connections and capabilities for health care facilities across West Virginia. The grant allows the WVTA to receive additional federal matching funds.

Additional information about the grant funding provided by the Authority can be found in the section on Grant Programs in this report.

Cost Containment

CompareCareWV is an ongoing program that allows consumers to compare charges among hospitals for medical procedures and diagnostic tests. It is an online and interactive service that the consumer uses not only to compare hospitals by cost, but also quality for select services. The program has been utilized more than 100,000 times since 2014 and is available at the following website: <http://www.comparecarewv.gov/>.

Certificate of Need is used to contain healthcare costs by avoiding unnecessary and expensive duplication of services. It is a review process which balances concerns of accessibility, efficiency, quality and stability in the healthcare delivery system. As previously noted, legislation passed in 2016 by the WV Legislature made significant changes to the CON process.

Rate Review ceased on July 1, 2016 as a result of the passage of Senate Bill 68. Some of the last data generated through Rate Review indicated:

- For FY 2015, acute care hospitals requested, on average, a 5.76% increase per inpatient discharge and a 5.78% increase per outpatient visit. Hospitals, on average, were granted a 4.09% increase per inpatient discharge and 4.58% increase per outpatient visit.
- For FY 2016, acute care hospitals requested, on average, a 5.57% increase per inpatient discharge and a 5.57% increase per outpatient visit. Hospitals on average were granted a 4.64% increase per inpatient discharge and a 5.12% increase per outpatient visit.
- *The Almanac of Hospital Financial and Operating Indicators – 2016*, which contains actual data for 2014, indicates that the median Gross Price per Inpatient Discharge in West Virginia is 24.27% lower than the United States median and 27.50% lower than the median Gross Price per Inpatient Discharge in the Southern Region of the United States.

Data and Information Technology

Data, information technology and their importance as an asset necessary for a robust healthcare delivery system continue to grow. The Authority provides a wealth of healthcare data through multiple services and partners with various organizations to use data and new technology to develop such a system.

The **Financial Disclosure** function, which provides clinical, financial, operational and utilization information, is provided by the **Clinical Analysis** and **Financial Analysis** divisions. Information is submitted via Uniform Billing (UB), financial statements, hospital uniform financial reports, Medicare and Medicaid cost reports, charge data, online surveys and many other documents. This information is available either through individual data requests or an online archive called YODA, the acronym for “Your Online Document Archive.”

The **Clinical Analysis (CAD)** division provided access to the UB data from the Hospital Inpatient Discharge System (HIDS) through a variety of dissemination tools, including HealthIQ, HCUP (Health Care Utilization Project) and HCUPnet, standard reports on the HCA website, and custom data requests. In addition to the UB data, the division also works on the collection and reporting of Healthcare Associated Infection (HAI) data via the Center for Disease Control and Prevention’s (CDC’s) National Health Safety Network (NHSN). Additional information regarding the annual HAI reporting and analysis can be found in the Quality Indicators section of this report.

- For the 2015 data collection year, the CAD assisted 60 hospitals with submitting over 270,000 patient claim records through the HIDS system. The data and the submissions are checked for errors or anomalies by the HIDS system and CAD staff to ensure data accuracy.
- In calendar years 2015 and 2016, over 65 custom UB data requests were filled for federal and state agencies, universities, consultants, hospitals, and other health care researchers. Examples of agencies or entities requesting data include the CDC’s Environmental Public Health Tracking System, the WV Bureau for Public Health, West Virginia University researchers and students, numerous hospital and hospital systems, USA Today, the WV Hospital Association, the US Federal Trade Commission, the University of California-Berkeley, and the WV Governor’s Highway Safety Program, to name a few.
- UB data requests are used for a wide variety of research and analysis across the state and around the country, including market research, CON planning, opiate and heroin overdose studies, motor vehicle accident data, accidental injury and poisoning analysis (including children and adults), diabetes trending, and orthopedic procedure claims review. Also, an article was published on Neonatal Abstinence Syndrome using the Authority’s UB data in the peer-reviewed Journal of Rural Health in 2016.
- The CAD provides an annual dataset to HCUP’s State Inpatient Database (SID). From the

data, standardized inpatient hospital discharge data for researchers throughout the country can be requested, which allows for multi-state analyses. Over 50 requests for West Virginia data have been made to HCUP between January 2015 and September 2016, generating revenue for the Authority. Forty-eight states participate in the SID.

Data from approximately 450 health care providers was collected, reviewed and compiled by **Financial Analysis** staff for use in this report, market research, CON methodologies, policy makers and public data requests. Current projects include:

- Responsibility for the production and publication of the Authority's Annual Report, a single-source compilation that includes written analyses, historical trends, financial ratios, graphs and data tables covering the state's major provider types: Hospitals, Nursing Homes, Behavioral Health Centers, Primary Care Centers, Home Health Agencies, Hospice Agencies, Renal Dialysis Centers and Ambulatory Surgical Centers.
- Dataset development of hospital uniform financial report data and survey data for ambulatory surgical centers, home health and hospice agencies and nursing homes for standard or custom reports.
- Participation in an in-depth collaborative review process with other departments formulating and implementing data disclosure security policies.

The Authority's **Information Technology (IT)** division provided essential support to the agency's mission by initiating or completing key projects for external and internal customers and maintaining its many data and technology driven functions. These projects include:

- Improvements in security, speed and efficiency of the Authority's computer systems. These were achieved through ongoing upgrades to servers and desktop computers, and the installation of a Fiber Optic circuit connecting the Agency to the state's high speed physical and electronic network infrastructure, known as the "*Network Backbone*."
- Management of the Authority's frequently used website, www.hca.wv.gov, which receives over 80,000 distinct user visits per year. The website provides a link to YODA, the agency's document archive, which the public uses to view over 70,000 documents. In line with new legislation, a link was added to the site to show all Certificate of Need documents immediately upon receipt.
- Implementation of the Skype business conferencing service, which reduces cost and improves productivity and security.
- Continued support for the state-wide Privacy Impact Assessment (PIA) survey, which has eliminated the costs of using an outside vendor. This survey is utilized throughout state

government and assists agencies in evaluating risk and legal requirements for new projects and technologies.

- Hosting the CompareCareWV site, a user-friendly inter-active website. IT significantly improved the performance of the site.

The **West Virginia Health Information Network (WVHIN)**, has partnered with Chesapeake Regional Information System for our Patients (CRISP), the health information exchange (HIE) serving Maryland and DC. This partnership allows us to:

- Enhance functionality by accessing their proven technology platform,
- Achieve greater economies of scale, and
- Assist patients who move across state borders.

Using our new technology platform we are currently providing real time notifications through the Encounter Notification Service (ENS) to physicians and care managers when their patients have a significant event in a hospital. We are also able to assist hospitals manage readmissions by notifying participating hospitals when a presenting patient has been seen in another participating facility within the last 30 days or when a patient recently discharged presents at another facility.

By the end of March 2017 our goal is to:

- Completely transition all data and functionality over to the new platform,
- Have 40 of the 49 hospitals (acute and critical access) connected, and
- Have connections with other provider types including nursing homes, rehabilitation facilities, physician offices, behavioral health centers, hospice agencies, dialysis facilities, urgent care centers and HIEs in bordering states.

Privacy

The **State Privacy Office (SPO)** leads the Executive Branch's Privacy Program as well as the Privacy Management Team (PMT), which is made up of representation from each department as well as other constitutional officers and higher education. Each year the team focuses on a different privacy dimension or domain, all with the goal of improving our protection of employees' and citizens' personally identifiable information and risk reduction. Generally, the SPO and the PMT's efforts fall into three broad categories: (1) compliance and oversight, (2) education and training, and (3) policies and procedures.

The SPO, accomplished the following new projects in 2016:

- Workforce privacy training objectives were accomplished through an updated online training course. The new course, Think WV Privacy, was completed and rolled out to all employees within the WV Executive Branch in May with 70% completion in six months. The training was also made available to other constitutional offices and higher education.
- Completed a collaborative effort with the Privacy Management Team, the WV Board of Risk and Insurance Management (BRIM) and the WV Office of Technology's Chief Information Security Officer related to the Standards of Participation Program (SOPP). Each year BRIM gathers information using a questionnaire to better understand current efforts to limit and control preventable liability claims. In 2016, Cyber/Information Security and Privacy questions were added. Not only will this information help BRIM, but will also help departments identify specific risk management areas. In the future, Cyber/Information Security and Privacy survey responses will impact premium credits and surcharges.
- Led a workgroup that developed a Data Use Agreement template, which facilitates appropriate and secure data sharing by Executive Branch departments.
- Developed a Desk Audit program regarding review of department Privacy Notice Statements. Privacy Notices are required by a variety of laws and are binding.

Ongoing and/or continued privacy projects include:

- Leading the Authority's interdepartmental team, with staff from the Privacy, Information Technology, Clinical Analysis, and Financial Analysis divisions in completing the update to the Information Security and Privacy policy. Staff training and policy implementation were initiated.
- The administration of the West Virginia Executive Branch Confidentiality Agreement course and electronic signature processes remains an efficient and effective tool for the state's compliance efforts.

More information about additional SPO program accomplishments can be found on the SPO website: www.privacy.wv.gov.

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GRANT PROGRAMS

The West Virginia Health Care Authority (Authority) has administered the Rural Health Systems Program (RHSP) since 1996. The Program, codified in W. Va. Code §16-2D-3, provides the Authority with power to issue grants and loans to financially vulnerable healthcare facilities located in underserved areas. The goal of the program is to avoid the potential crisis or collapse of essential rural healthcare services, while ensuring that healthcare delivery is streamlined and continuous.

The RHSP has two program areas for not-for-profit agencies located in areas that are designated as medically underserved or health professional shortage areas. First, collaborative grants may be sought by a lead agency that is collaborating with other healthcare entities. One-to-one matching funds are required for collaborative grants. Second, crisis grants are available to not-for-profit applicants that are facing closure or severe financial difficulties. In providing grants, the Authority seeks to prevent the loss of essential health services for the people and/or community the applicant serves.

Since its inception, the RHSP has awarded numerous grants. The RHSP program has been successful in ensuring that the entities in crisis are able to continue to function and provide essential healthcare services in their communities.

The Authority also administers the Hospital Assistance Program, whose funds are expended pursuant to W.Va. Code §16-29B-8. The purpose of this funding source is to make grants available to West Virginia hospitals for projects that are of special importance to the hospital or group of hospitals.

WV Health Care Authority Grant Program Awards

State Fiscal Year	Hospital Assistance	Rural Health System		Total Awards
		Collaborative	Crisis	
2010	\$325,000	\$313,805	\$150,000	\$788,805
2011	78,994	98,688	187,000	364,682
2012	339,376	250,000	259,104	848,480
2013	289,710	99,986	261,639	651,335
2014	408,587	210,020	185,000	803,607
2015	333,213	158,330	150,000	641,543
2016	190,567	258,995	111,744	561,306
Total	\$1,965,447	\$1,389,824	\$1,304,487	\$4,659,758

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The only network of its kind in the state, the [West Virginia Health Information Network \(WVHIN\)](#) is the health information exchange (HIE) for the State. The HIE is designed to support West Virginia’s healthcare providers by ensuring all hospitals, healthcare facilities and physicians have access to critical patient-related information in a secure and encrypted digital network. The WVHIN addresses two vital needs in the medical community today: connectivity and improved quality of care. Often patient health information is fragmented and locked in silos that include a variety of provider-specific networks and platforms. This poses a significant barrier to the connectivity needed among providers to establish and maintain a high quality of care for patients – no matter where they go.

Patients today seek medical care and attention that is quick and convenient. Frequently, that means traveling outside their core network of healthcare providers. Thus, to ensure quality of care, it is vital that patients’ medical records are stored in a secure network that can be easily accessed by providers and physicians of any discipline across the state.

The WVHIN has seen great success in recent years. The network has grown to include 20 hospitals and more than 150 hospital-affiliated physician practices. Over 100 organizations utilize the WV e-Directive Registry, 300 plus organizations send messages via WVDirect and more than 40 organizations transmit required public health reporting data through the WVHIN’s network to the Bureau for Public Health. At the last quarterly count the number of patient queries is now averaging over 270,000 and WVDirect, the WVHIN’s clinical messaging system, is averaging over 35,000 messages. These numbers demonstrate that the WVHIN offers a HIE that benefits both patients and providers.

The most significant development in 2016 for the WVHIN is the partnership with the Chesapeake Regional Information Services for our Patients (CRISP), the HIE for the State of Maryland and the District of Columbia. The CRISP partnership provides West Virginia healthcare providers with an expansive regional network of patient-related information, as well as nearly a decade of invaluable expertise and reliable technology infrastructure. CRISP is a sustainable HIE and includes every hospital in its service area and more than 4,000 ambulatory providers.

Initially the partnership will resemble a technology and professional services vendor relationship. During 2017 the WVHIN anticipates transitioning from a state entity to a private nonprofit, which should allow the WVHIN more freedom and the ability to adapt to market needs more quickly. Once the transition is completed, the partnership will evolve to establish a true

regional HIE. West Virginia, DC and Maryland HIEs will exist as independent entities but will be members of a shared technology and professional services enterprise for their respective operations.

In addition, West Virginia providers will now have access to state-of-the-art functionality features, such as a clinical query portal and prescription drug monitoring database. Among the first to be implemented is the Encounter Notification Service (ENS). Registered providers will have access to the ENS, which will allow physicians to receive real-time notifications when patients undergo significant medical events within the expanded regional network, such as emergency room visits, hospital admissions or discharges. This new notification feature will allow providers to deliver timely and appropriate care coordination activities, which benefits providers, payers and patients.

These past achievements have laid a solid foundation to further enable the electronic exchange of patient health information to support patient-centered care along with increasing efficiencies, reducing medical errors, lowering health care costs and assisting with eliminating unnecessary hospital visits. This, at its core, is the mission of the WVHIN – making sure all of West Virginia’s healthcare providers are registered via the health information exchange (HIE) network to advance statewide and regional access, lowering health care costs, and improving the care received by patients across the Mountain State.

Provider Review

Financial Highlights

Overview of Key Indicators

Hospitals

Hospital Quality

Nursing Homes

Behavioral Health Centers

Primary Care Centers

Home Health Agencies

Hospice Agencies

Kidney Dialysis Centers

Ambulatory Surgical Centers

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FINANCIAL HIGHLIGHTS

Hospitals

Overall, the profitability of West Virginia hospitals decreased in FY 2015. Profits of \$278.4 million or 4.7% of net patient revenue (NPR) were reported, down from \$331.2 million (5.8% of NPR) in FY 2014.

The primary focus of the West Virginia Health Care Authority (Authority) emphasizes the *operations* of healthcare providers versus the effects of *financial market fluctuations*. As such, this report excludes the impact of certain market changes related to investments such as derivative agreements and related accounting standards from hospital profits and losses, except where the market effects are specifically addressed or otherwise noted.

A brief discussion of the financial market fluctuations that some West Virginia hospitals experience is provided in the Hospital Narrative section of this report.

Acute Care Hospitals

The profit margin for the 29 general acute care hospitals decreased to 4.6% of NPR in FY 2015, with profits of \$242.6 million, down from \$279.3 million (5.6% of NPR) in the prior year.

Eighteen of the 29 general acute hospitals reported a profit.

Critical Access Hospitals (CAH)

Profitability for the 20 CAHs increased to \$18.3 million (3.9% of NPR) from an aggregate profit of \$15.7 million (3.5% of NPR) in FY 2014.

Thirteen of the 20 CAHs reported a profit.

Long-term Acute Care Hospitals (LTACH)

A total profit of \$3.7 million (8.3% of NPR) was reported for three LTACHs. The total profit in FY 2014 was \$4.9 million (15.4% of NPR) for two hospitals. A new LTACH, Acuity Specialty, provided services in FY 2015.

Psychiatric Hospitals

The psychiatric hospitals had an aggregate loss of \$1.7 million (2.0% of NPR). The two state psychiatric hospitals reported a loss of \$7.6 million (32.4% of NPR); the three private hospitals reported an aggregate profit of \$5.9 million (9.2% of NPR).

Rehabilitation Hospitals

The five rehabilitation hospitals reported an aggregate profit of \$15.6 million (14.2% of NPR). The aggregate profit for the prior year was also \$15.6 million (15.6% of NPR).

Other Facilities

Nursing Homes

Overall profit for the state's 108 nursing homes increased by \$17.6 million in FY 2015 to \$20.5 million (2.2% of NPR); for FY 2014 the EROE was \$2.9 million (0.3% of NPR).

Sixty-eight of 108 facilities were profitable in FY 2015.

Behavioral Health Centers

Behavioral health providers reported a total profit of \$46.4 million (6.1% of total revenue). Profit for the prior year was \$48.5 million, 6.4% of total revenue.

Seventy-five of the 110 facilities were profitable.

Primary Care Centers

Thirty-two primary care centers reported an aggregate profit of \$27.7 million, 9.1% of total revenue. Profit for the prior year was \$2.8 million, 1.0% of total revenue.

Twenty-eight of the 32 centers were profitable.

Home Health

Home health agencies reported a total profit of \$2.2 million, 1.4% on \$156.1 million in total revenue. Aggregate profit for the prior year was \$4.1 million, 2.7% on \$150.0 million in total revenue.

Thirty-seven of the 62 agencies were profitable in FY 2015.

Hospice

Hospice profits for the 20 agencies were \$10.6 million (9.9% of NPR) compared to \$6.9 million (6.7% of NPR) in FY 2014.

Thirteen agencies were profitable in FY 2015.

Renal Dialysis Centers

Thirty-five renal dialysis centers reported an aggregate profit of \$23.7 million, 21.9% of total revenue.

Twenty-four centers were profitable.

Ambulatory Surgical Centers (ASC)

Nine ASCs reported an aggregate profit of \$1.9 million, 10.0% of total revenue.

Five ASCs reported a profit.

OVERVIEW OF KEY INDICATORS

The healthcare industry in West Virginia continues to grow and be a major force in the state. According to the U.S. Department of Commerce’s Bureau of Economic Analysis, the state’s estimated 2015 Gross Domestic Product, in current dollars, was \$73.7 billion down from a revised \$74.4 billion in the prior year. For FY 2015, total revenues of \$8.7 billion were reported to the West Virginia Health Care Authority (Authority) from eight types of healthcare providers, an increase of 4.0% over FY 2014.

The Authority collects and disseminates financial data on healthcare facilities, including hospitals, nursing homes, behavioral health centers, primary care centers, home health agencies, hospice agencies, renal dialysis centers and ambulatory surgical centers. The reporting period is the facility fiscal year which ended during the calendar year. Therefore, the data reflect a span of time that is not the same for each facility. The data are presented here as reported by the facilities.

This report includes information related to 438 healthcare providers operating in West Virginia in FY 2015.

Number of Providers by Service			
Type of Provider	FY 2013	FY 2014	FY 2015
Hospitals	61	61	62
General Acute	31	29	29
Critical Access	19	20	20
Long-term Acute	2	2	3
Psychiatric	4	5	5
Rehabilitation	5	5	5
Nursing Homes	107	107	108
Behavioral Health Centers	105	107	110
Behavioral Health Centers	83	85	88
Comprehensive Centers	13	13	13
Methadone Treatment	9	9	9
Primary Care Centers	32	32	32
Home Health Agencies	62	60	62
Hospice Agencies	20	20	20
Renal Dialysis Centers	34	34	35
Ambulatory Surgery Centers	11	9	9
Total	432	430	438

Total Revenue

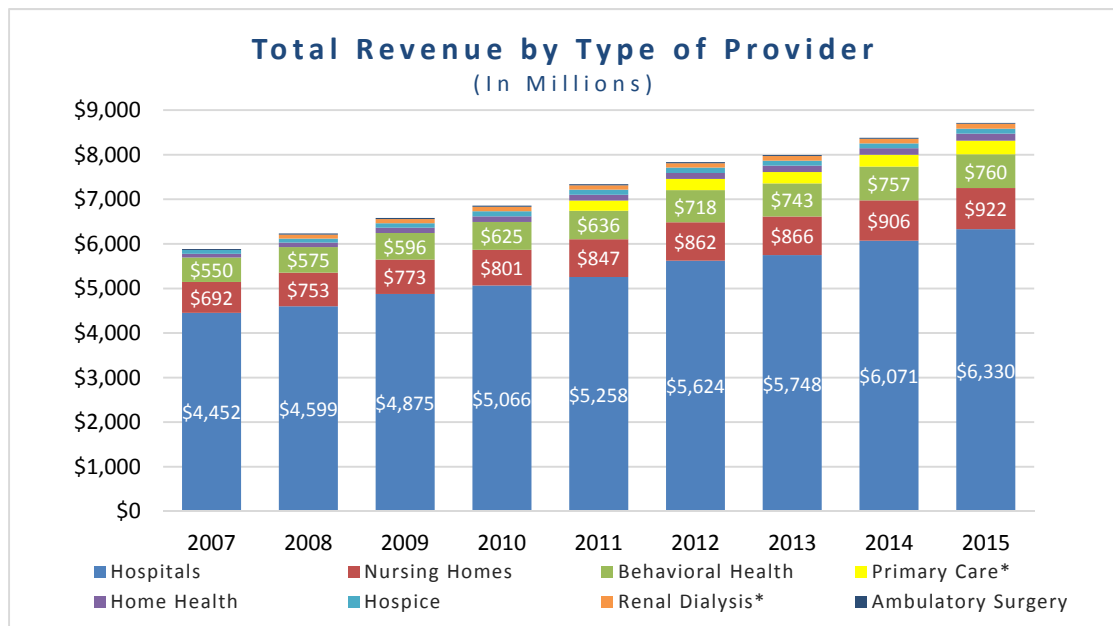
Total revenue of \$8.7 billion was reported by the 438 facilities for FY 2015, an increase of \$334.0 million (4.0%) over FY 2014. Total revenue equals the sum of revenue from patient services plus other operating and non-operating revenue.

General acute care hospitals accounted for \$227.7 million (68.2%) of the growth in revenue. Critical access hospitals provided the second greatest increase in revenue of \$20.3 million (6.1%).

Type of Facility or Agency	Total Revenue (In Thousands)		
	FY 2013	FY 2014	FY 2015
Hospitals	\$5,747,500	\$6,070,659	\$6,329,656
General Acute	5,091,213	5,299,817	5,527,494
Critical Access	405,402	472,879	493,174
Long-term Acute	31,542	32,033	44,367
Psychiatric	115,688	158,426	154,789
Rehabilitation	103,656	107,286	109,833
Nursing Homes	866,207	905,615	922,073
Behavioral Health Centers	743,109	757,282	759,510
Behavioral Health Centers	505,231	515,766	520,621
Comprehensive Centers	213,871	216,110	214,540
Methadone Treatment	24,006	25,407	24,349
Primary Care Centers	255,895	263,646	304,349
Home Health Agencies	140,630	149,952	156,075
Hospices	113,921	107,101	113,920
Renal Dialysis Centers	102,862	104,322	108,009
Ambulatory Surgery Centers	22,779	20,230	19,263
Total	\$7,992,903	\$8,378,808	\$8,712,855
Percentage Change from Prior Year	2.0%	4.8%	4.0%

The percentage of total revenue generated by each provider type in FY 2015 is as follows:

- Hospitals – 72.7%
- Nursing Homes – 10.6%
- Behavioral Health Centers – 8.7%
- Primary Care Centers – 3.5%
- Home Health Agencies – 1.8%
- Hospices – 1.3%
- Renal Dialysis Centers – 1.2%
- Ambulatory Surgery Centers – 0.2%



*Data for Renal Dialysis and Primary Care Centers was added starting in FY 2008 and FY 2011, respectively.

Total revenue grew by 4.0% (\$334.0 million) in FY 2015. The increase in total revenue in FY 2014 was 4.8% (\$385.9 million). Since FY 2007 total revenue has increased approximately 41.0% (\$2.4 billion), not including renal dialysis and primary care revenue. The median annual increase in total revenue for FY 2008 – FY 2015 was 4.3%.¹

The increase in total revenue since FY 2007 is as follows:

- Hospitals – \$1.9 billion (42.2%)
- Nursing Homes – \$230.4 million (33.3%)
- Behavioral Health Centers – \$209.5 million (38.1%)
- Home Health Agencies – \$71.9 million (85.5%)
- Hospices – \$30.1 million (36.0%)

Reviewing total revenue for ambulatory surgery centers since FY 2007 shows a decrease of \$4.7 million (19.7%); however, this decrease has occurred over the last three years. In FY 2013 two ambulatory surgery centers were purchased by a hospital. The revenues previously associated with those services would now be included within the hospital sector.

Total revenue for primary care centers has grown by \$73.7 million (31.9%) since FY 2011. The revenue increase for FY 2015 accounts for over half (55.2%) of total increase.

¹Adjustments were made for renal dialysis and primary care revenue to the calculation of median annual increase in total revenue. Data for these providers were added beginning with FY 2008 and FY 2011, respectively.

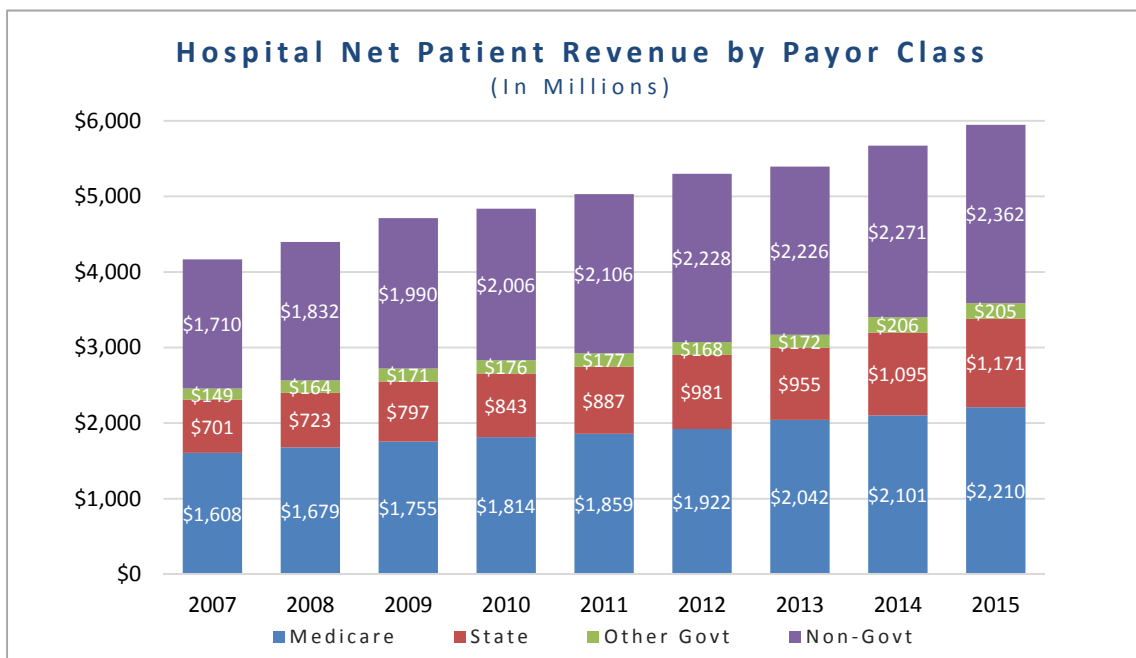
Net Patient Revenue

Net patient revenue (NPR), the amount received in payment for patient services, is also reported by payor categories for hospitals and nursing homes.

Hospitals

Nongovernmental payors (commercial, Blue Cross Blue Shield, Coventry, unions, ERISAs, self-pay) provided the largest amount of hospital revenue with \$2.4 billion (39.7%) in FY 2015. Medicare followed, with revenue of \$2.2 billion (37.2%). State payors (Medicaid, PEIA) and other governmental payors (VA, Worker's Comp, etc.) combined for revenue of \$1.4 billion (23.1%).

Total net patient revenue for all payors equaled \$5.9 billion, an increase of 4.9% over the prior year. Since FY 2007 net patient revenue has grown by \$1.8 billion (42.7%). Nongovernmental revenue increased the most, \$652.6 million (38.2%). The second largest increase was from Medicare, \$602.0 million (37.5%). The state payors category provided the largest percentage increase, 67.1% (\$470.2 million).

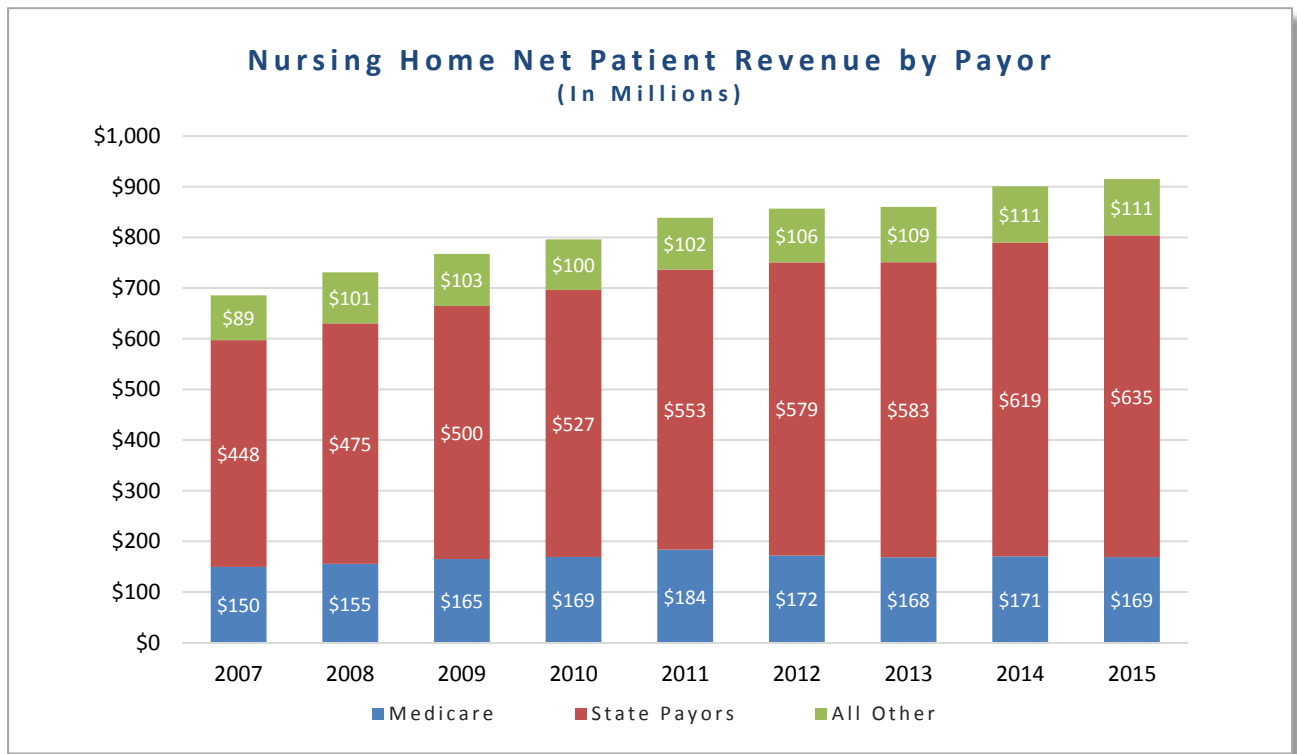


Nursing Homes

For nursing homes, the payor category with the largest amount of revenue is the state payors category; it consists almost entirely of Medicaid revenue, but also includes some PEIA payments. Net patient revenue for the state payors category equaled \$635.1 million in FY 2015. Medicare revenue equaled \$168.8 million. Revenue from all other payors was \$111.4 million.

Total net patient revenue was \$915.3 million in FY 2015, an increase of 1.6% over FY 2014 levels. The prior year's increase was 4.7%. For FY 2015, revenue from the state payors increased by \$15.9 million (2.6%), Medicare revenue decreased by \$1.7 million (1.0%), and the remaining payors increased by \$515,000 (0.5%).

Since FY 2007 net patient revenue has increased by \$230.4 million (33.6%). Revenue from state payors grew by \$188.0 million (42.0%); Medicare revenue increased by \$19.9 million (13.3%), but has decreased by \$14.3 million from the peak of \$183.6 million in FY 2011.



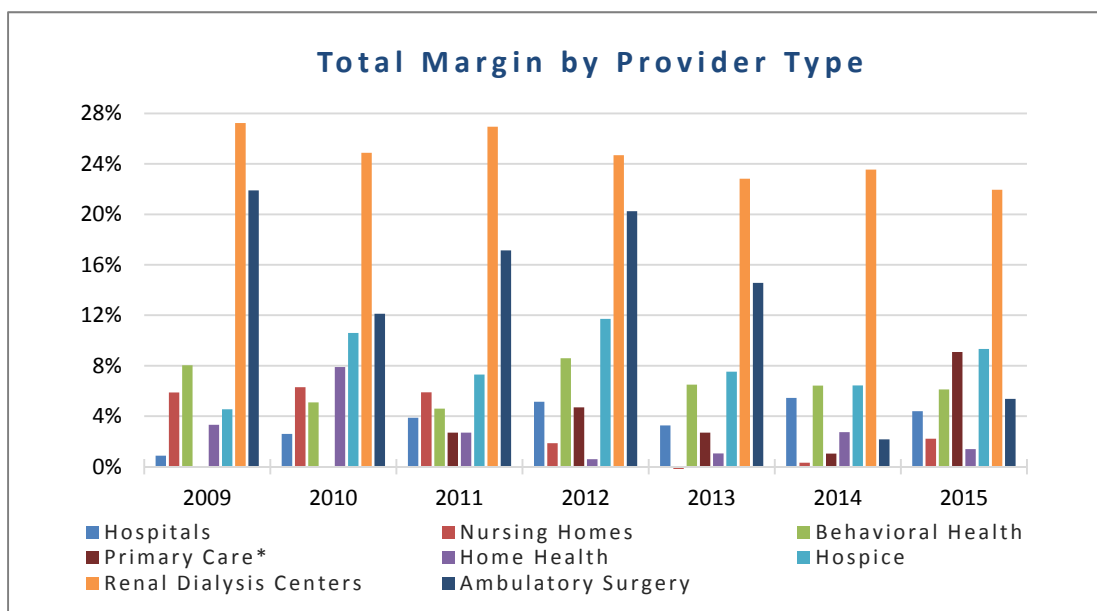
Excess Revenue (Deficit) Over Expenses (EROE)

The aggregate profit for all facilities was \$410.3 million, a decrease of \$14,000 from FY 2014. The term profit (loss) is used here interchangeably with excess (deficit) of revenue before taxes and extraordinary items (EROE), and is applied to all facilities, including not-for-profits.

Type of Provider	EROE (in 000's)			Margin		
	FY 2013	FY 2014	FY 2015	FY 2013	FY 2014	FY 2015
Hospitals*	\$188,104	\$331,150	\$278,135	3.3%	5.5%	4.4%
Nursing Homes	(2,567)	2,890	20,496	(0.3%)	0.3%	2.2%
Behavioral Health	48,452	48,689	46,499	6.5%	6.4%	6.1%
Primary Care	6,813	2,751	27,654	2.7%	1.0%	9.1%
Home Health	1,481	4,097	2,169	1.1%	2.7%	1.4%
Hospice	8,433	6,892	10,633	7.4%	6.4%	9.3%
Renal Dialysis Centers	23,480	24,562	23,700	22.8%	23.5%	21.9%
Ambulatory Surgery	3,318	3,411	1,035	14.6%	16.9%	5.4%
Total	\$277,483	\$424,442	\$410,321	3.5%	5.1%	4.7%

*Profits are adjusted to remove the impact of certain market fluctuations of investments. See Financial Highlights.

Margins (a financial ratio measuring the return on revenue) are calculated comparing EROE to total revenue, as opposed to only operating revenue, and are shown by provider type. Renal dialysis providers have consistently reported the highest margins. Hospital margins have fluctuated between 0.9% and 5.5% over the last seven years. Nursing homes reported the only negative margin during the same period, -0.3%, which occurred in FY 2013. Ambulatory surgery centers reported the greatest decrease in margins going from 21.9% in FY 2009 to 5.4% in FY 2015. Margins for categories of providers and individual providers are included in the narrative and detailed tables of this report.

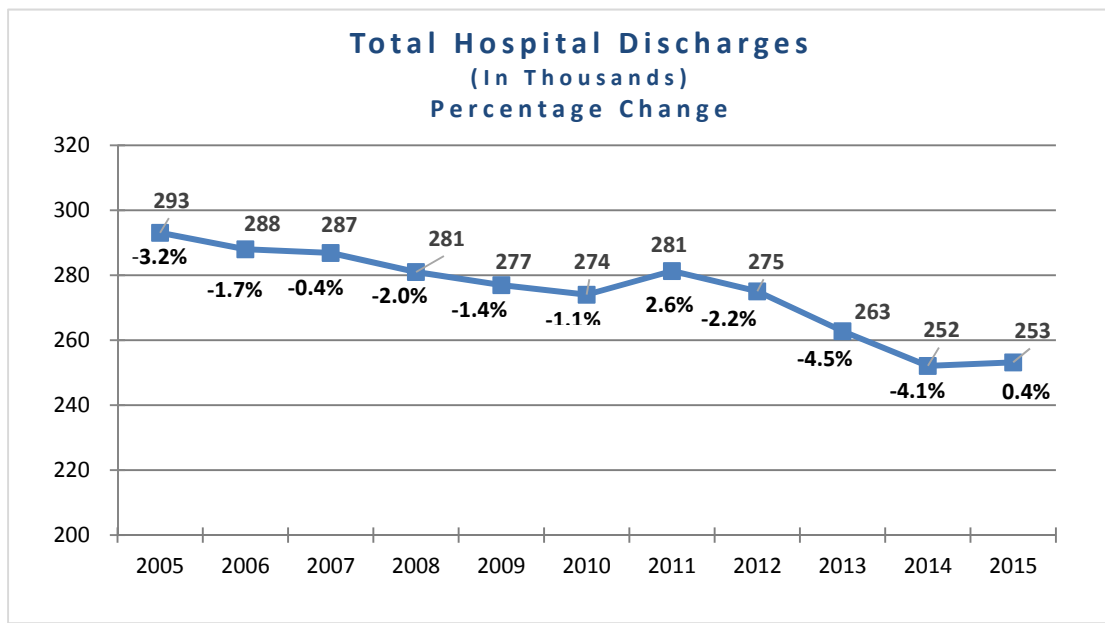


*Primary Care Center margins are presented starting with FY 2011.

Utilization

Hospitals

Hospital inpatient discharges increased by 1,069 (0.4%) in FY 2015 and decreased in FY 2014 by 10,656 (4.1%). This is the first increase in discharges since FY 2011. Between FY 2005 and FY 2015 inpatient utilization decreased by almost 40,000 discharges (13.6%).

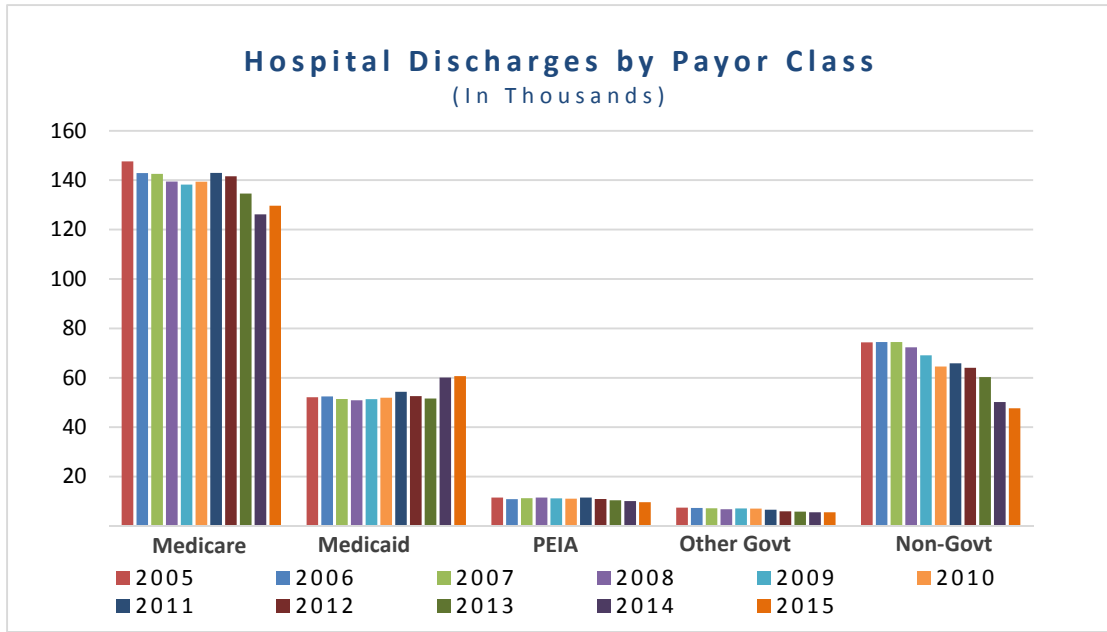


Acuity Specialty, a new Long-Term Acute Care Hospital (LTACH), provided 341 discharges (31.9% of the increase in discharges). Thirty-one (50.8%) out of 61 hospitals reported decreased discharges.² Eighteen general acute hospitals reported a decrease in discharges, as did 12 critical access hospitals and one rehab hospital.

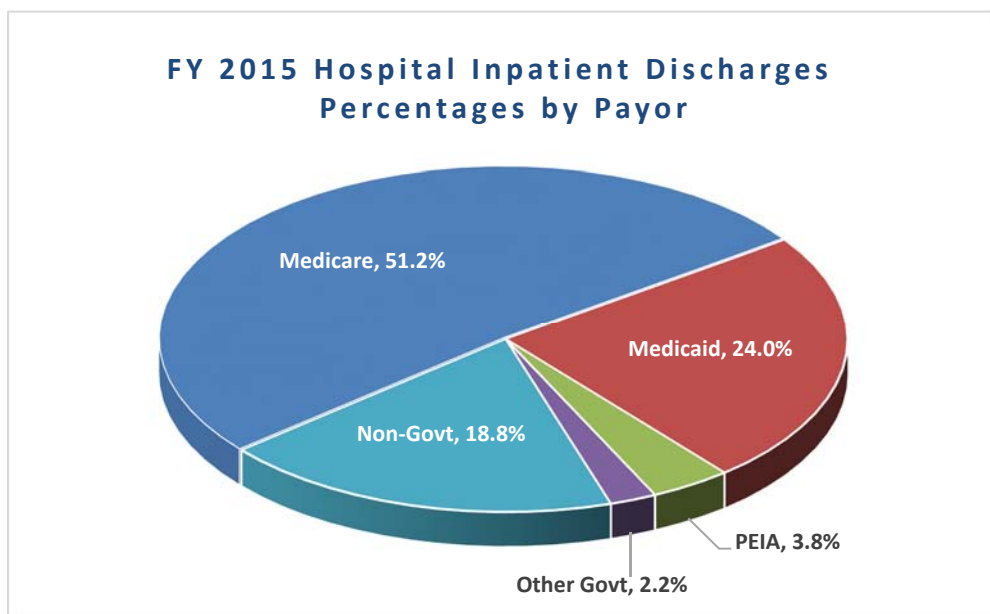
The change in payor mix that occurred in FY 2014 continued in FY 2015 with a slight shift. There was an increase in discharges in both the Medicare and Medicaid categories. Medicare discharges increased by 2.8% (3,477 discharges). Medicaid had an increase in discharges of 1.0% (585) and continued as the second largest payor category for inpatient utilization. Nongovernmental payors had a decrease in discharges of 5.0% (2,519 discharges). PEIA discharges decreased by 4.4% (446) in FY 2015.

Since FY 2005 nongovernmental discharges decreased by 26,729 (35.9%); Medicare discharges decreased by 17,968 (12.2%). Due to the increase that occurred since FY 2013, Medicaid discharges increased by 8,547 (16.4%) over the same time-period, and PEIA discharges decreased by 1,847 (16.1%).

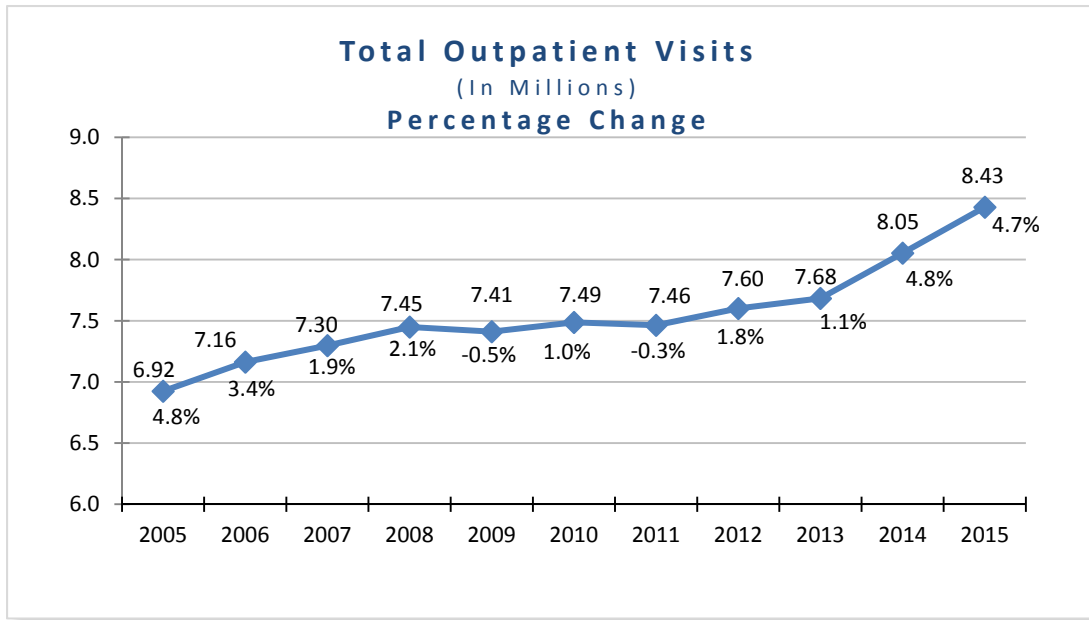
²The total number of hospitals that operated in FY 2015 was 62. Acuity Specialty was not included in this calculation since it did not report utilization in FY 2014.



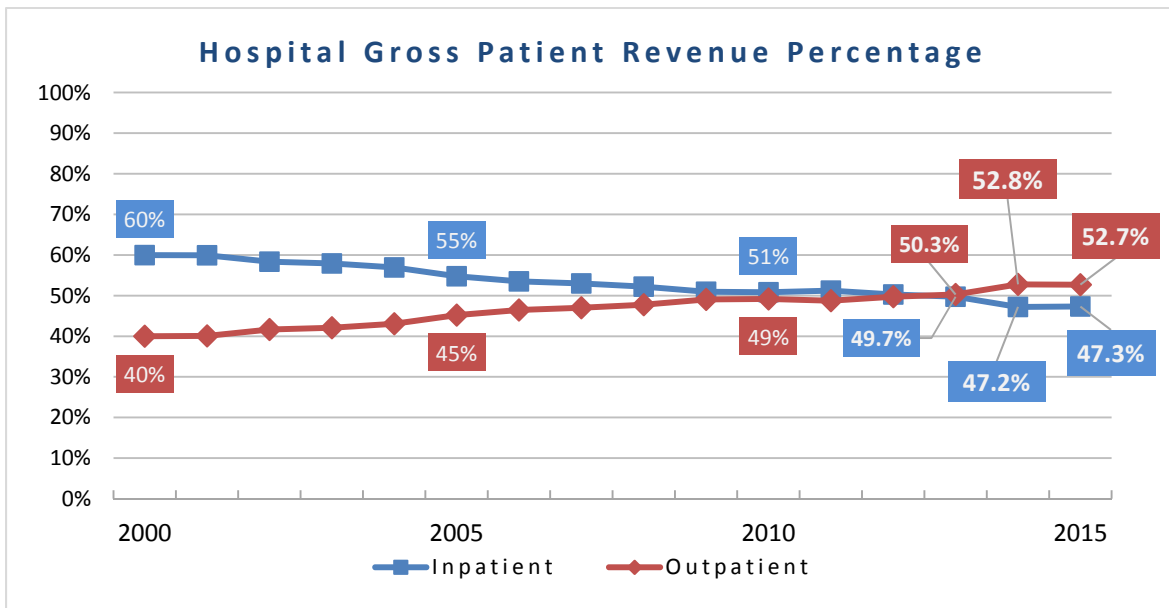
Medicare remains the largest payor category with 51.2% of the total discharges. Medicaid discharges accounted for 24.0%, up from 19.6% of discharges in FY 2013 and 23.8% in FY 2014. The nongovernmental category had 18.8% of discharges, down from 19.9% of discharges in the prior year and 22.9% in FY 2013. The remaining 6.0% of discharges were covered by PEIA and other governmental payors.



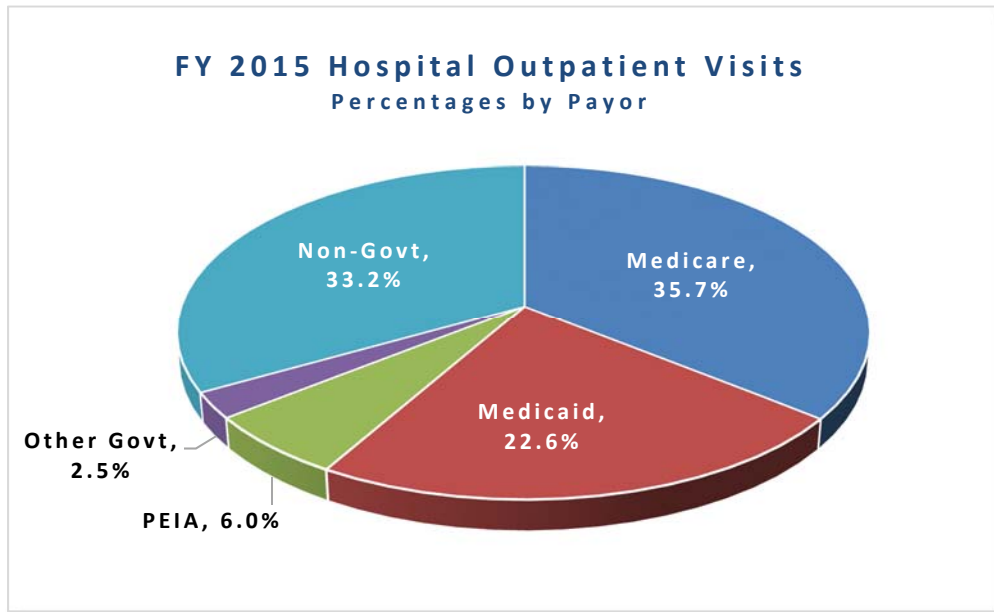
Utilization of hospital outpatient services has increased by 1.5 million visits (21.7%), since FY 2005. In FY 2015 total outpatient visits of 8.4 million were reported, an increase from the prior year of 375,806 (4.7%).



Gross patient revenue is one measure of volume. Outpatient gross patient revenue surpassed inpatient gross patient revenue for the first time in FY 2013 at 50.3% of total charges. In comparison, FY 2000 outpatient revenue was 40.0% of total charges. Outpatient revenue continued in FY 2015 as the larger source of patient revenue over inpatient revenue; however, the margin narrowed slightly (0.2 percentage points) from FY 2014.



Outpatient payor utilization patterns vary from inpatient patterns. However, there was a shift in payor mix for outpatient utilization in FY 2015. Medicare became the largest payor category equaling 35.7% of total visits, with an increase in visits of 208,859 (7.5%) to 3.0 million. Nongovernmental payors decreased by 52,207 visits (1.8%), to the second largest category with 2.8 million visits or 33.2%. Medicaid experienced an increase of 203,046 visits (12.0%) and is the third largest payor category with 22.6% of total visits.

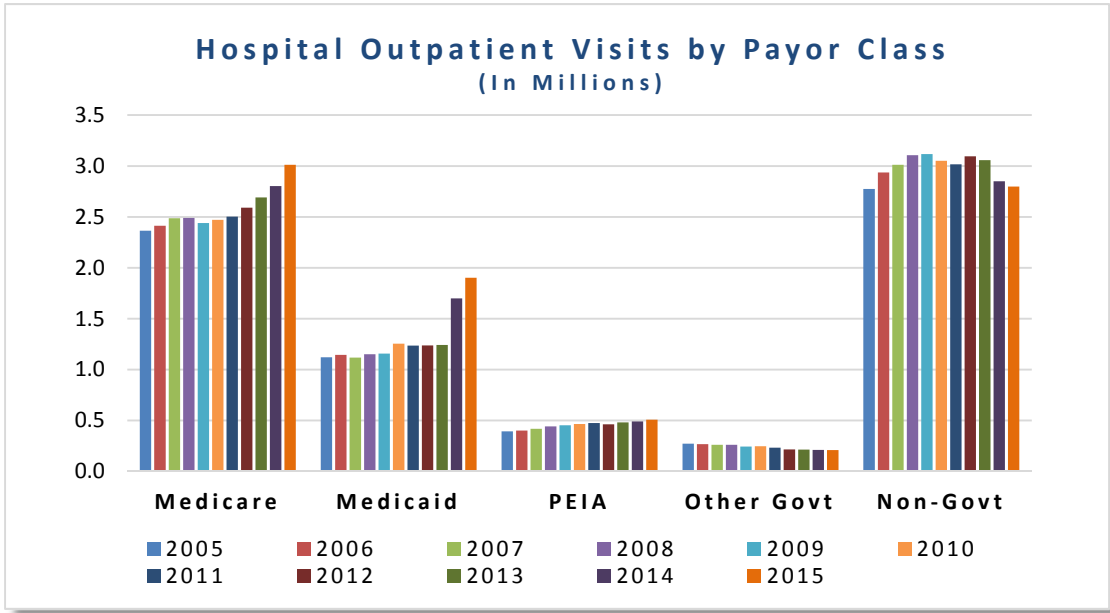


Outpatient utilization since FY 2005 by payor category has changed as follows:

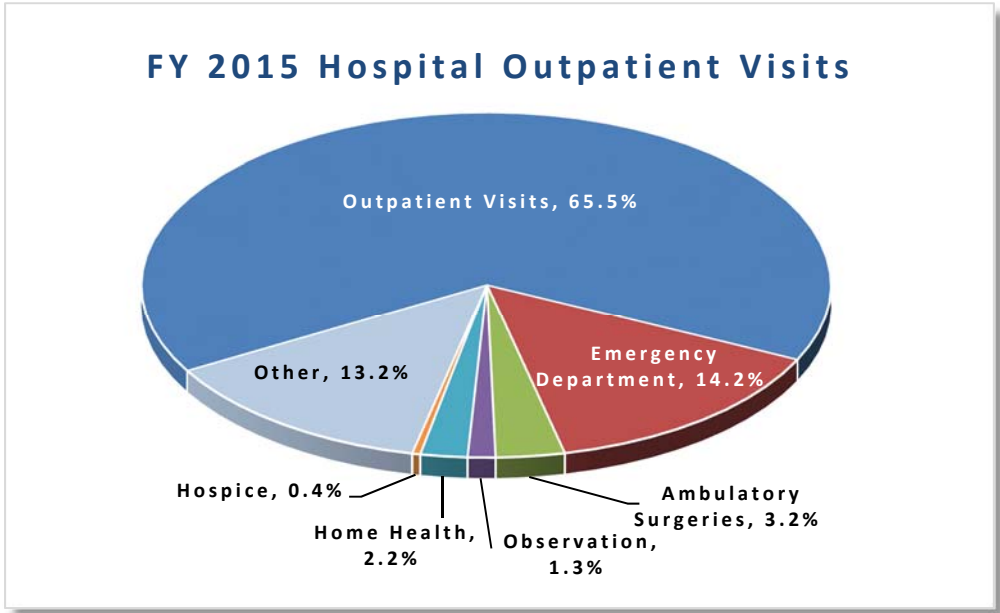
- Medicare – an increase of 27.4% to 3.0 million visits
- Medicaid – an increase of 69.6% to 1.9 million visits
- PEIA – an increase of 29.4% to 508,615 visits
- Other Governmental – a decrease of 23.3% to 208,833 visits
- Non-governmental – an increase of 0.9% to 2.8 million visits

Nongovernmental outpatient visits have decreased in five of the last 10 years and every year since FY 2012. Nongovernmental visits peaked in FY 2009 at 3.1 million.

The increase in Medicaid visits occurred mainly during FY 2014 and FY 2015, adding 660,549 visits and accounting for 84.6% of the 10 year increase in visits.



Outpatient visits cover a wide range of services, including: diagnostic imaging, laboratory tests, physical and mental health therapies, emergency and observation services, same day surgeries, home health and hospice services and a variety of physician specialties.



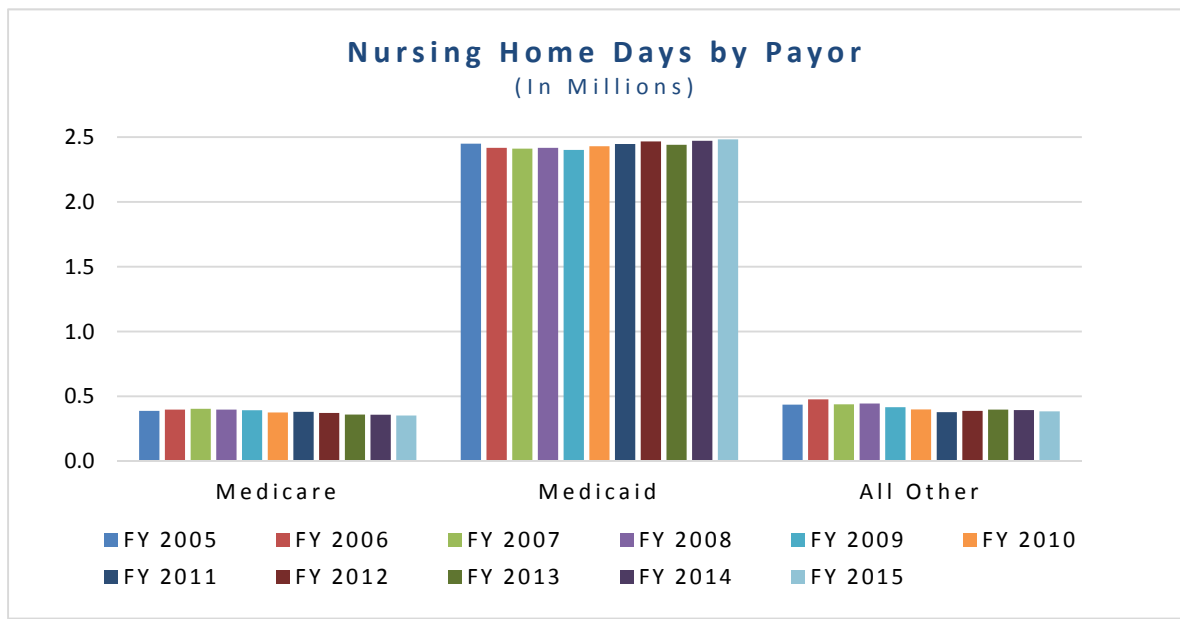
Nursing Home

Nursing home utilization in FY 2015 remained stable at 3.2 million days with 9,908 licensed nursing home beds reported statewide. This equaled an occupancy rate of 89.1%.

The total population served during FY 2015 was approximately 26,160. Population served is estimated by adding total discharges (17,369) to the census count (8,827) at the end of the fiscal year. This calculation may include readmissions in the same year.

Governmental programs pay for the vast majority of nursing home services. Residents covered by Medicare or Medicaid equaled 88.1% of patient days. Medicaid, with 2.5 million inpatient days (77.1%), is by far the largest payor; Medicare days equal 352,883 (11.0%). Medicare coverage requires a more intensive level of care with greater use of skilled nursing and rehabilitation services rather than mainly custodial care.

Some nursing homes offer outpatient services, such as physical, occupational and speech therapies, but the level of utilization has historically been minimal. Five of the 108 nursing homes provided these services in FY 2015.



HOSPITALS

The economic status of West Virginia’s hospitals is reported based on information submitted in the hospitals’ FY 2015 Uniform Financial Report and is presented according to their respective service categories:

- General Acute Care – 29 hospitals
- Critical Access – 20 hospitals
- Long-term Acute Care – 3 hospitals
- Psychiatric – 5 hospitals
- Rehabilitation – 5 hospitals

The services provided by each type of hospital vary considerably, and are presented separately in the 2016 Annual Report. The general acute care hospitals are presented first followed by the other categories in the order listed above.

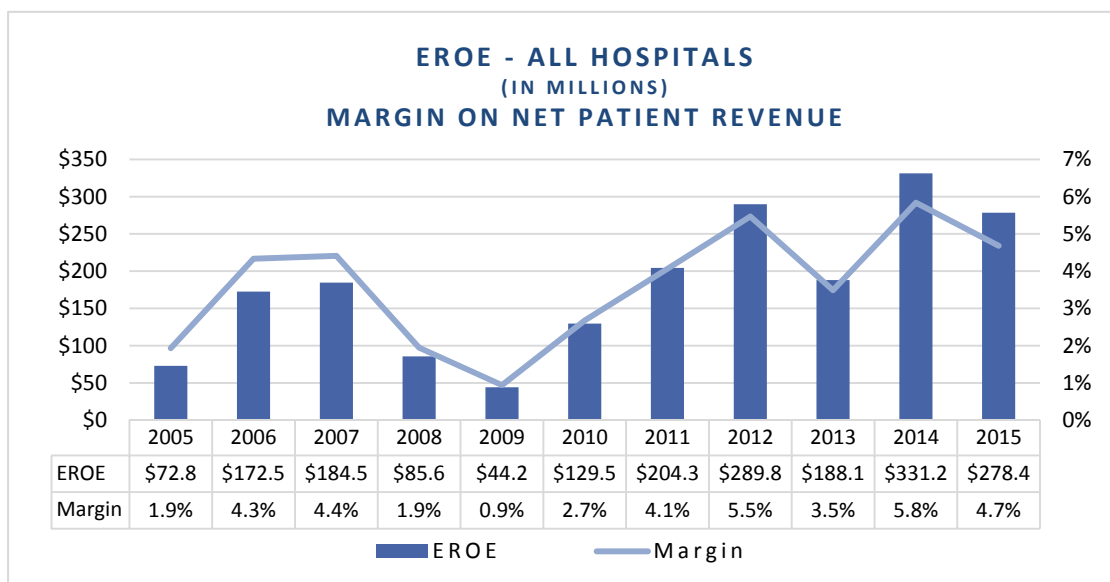
The Annual Report and detailed data tables are available on the website of the West Virginia Health Care Authority (Authority): www.hca.wv.gov. Abbreviations for hospital names are used in this narrative and data tables (see Appendix A for a list of hospital names and abbreviations).

As a group, West Virginia’s 62 hospitals reported a decrease in profitability in FY 2015. Excess (deficit) of revenue over expenses (EROE) is used here to describe profit (loss) prior to

- taxes,
- any extraordinary gains or losses, and
- certain changes in market values of investments.

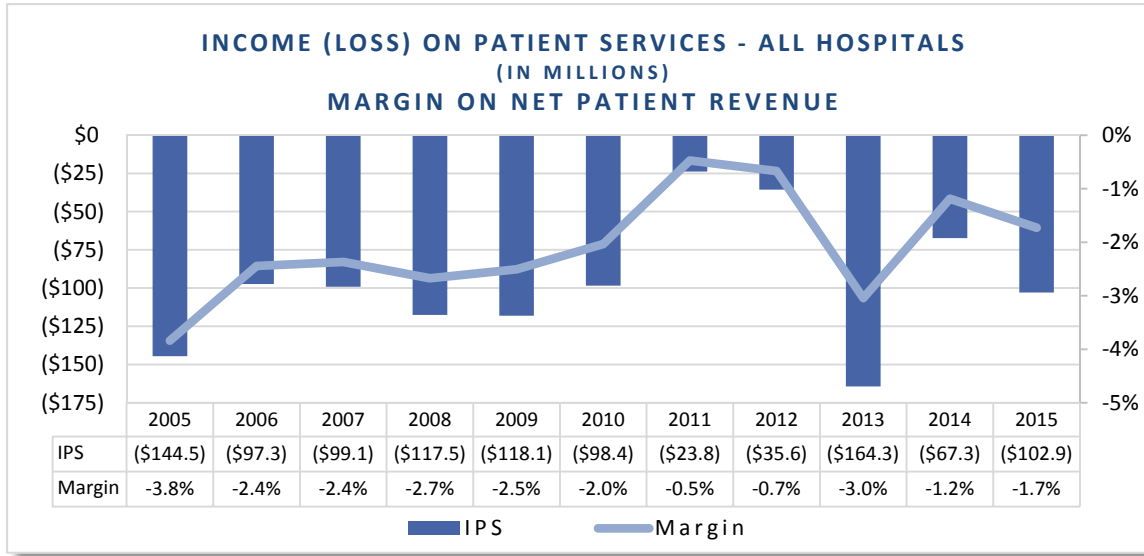
EROE is used for not-for-profit as well as for-profit hospitals.

- Total EROE for FY 2015 was \$278.4 million, 4.7% of net patient revenue (NPR), and a decrease of 15.9% from the prior year.



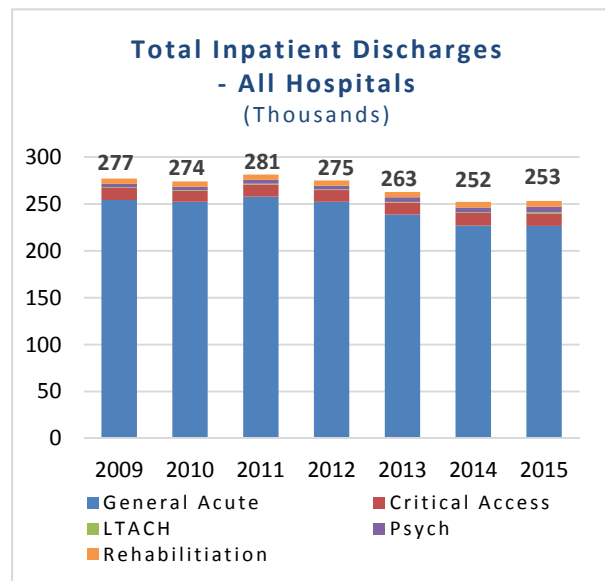
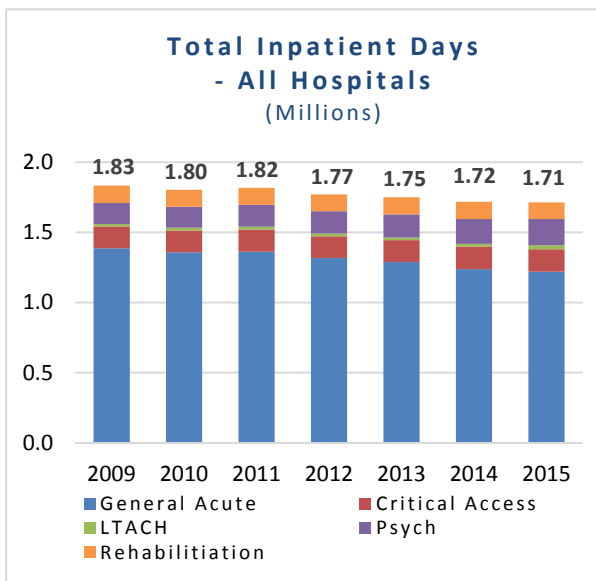
NOTE: EROE for 2009 would be \$69.3 million (a margin of 1.5%), without a \$25 million write-off of Goodwill by one hospital.

- The decrease in the FY 2015 profit is due to an increase in operating expenses that was greater than the increase in net patient revenue, and a decrease in other revenues.
- Losses on patient services (net patient revenue minus expenses) equaled \$102.9 million (1.7% of NPR), an increase of \$35.6 million over the prior year. Net patient revenue increased by \$276.2 million (4.9%) and expenses increased by \$311.7 million (5.4%).

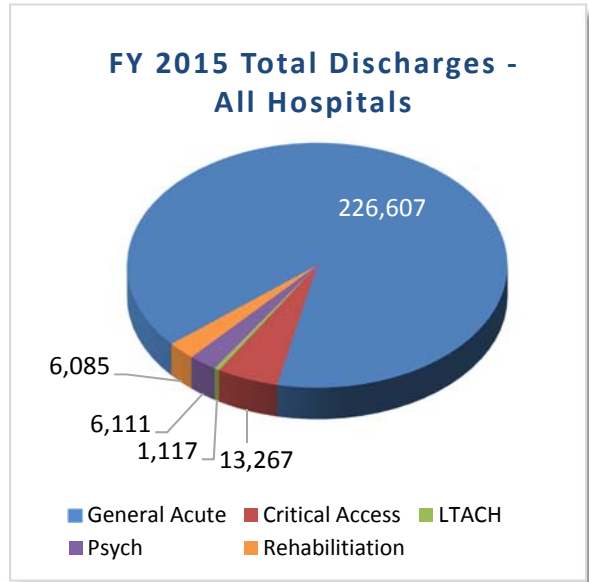
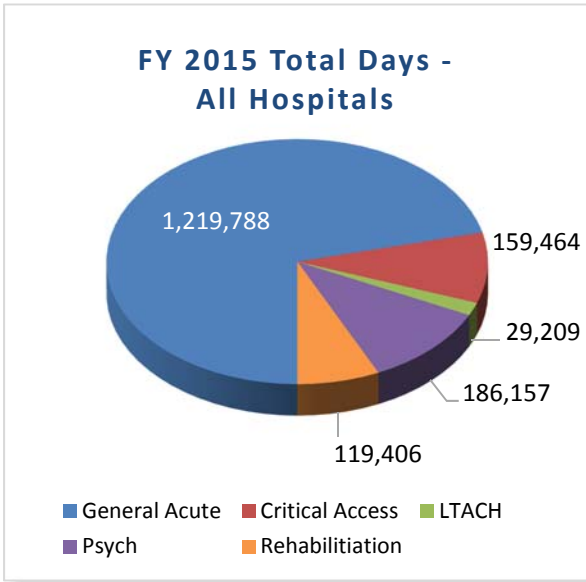


Utilization is one measure of patient care; it is also a key component of economic performance. Each type of hospital provides a significantly different set of services and which results in varying average lengths of stay. The utilization data presented include both acute and distinct part units.

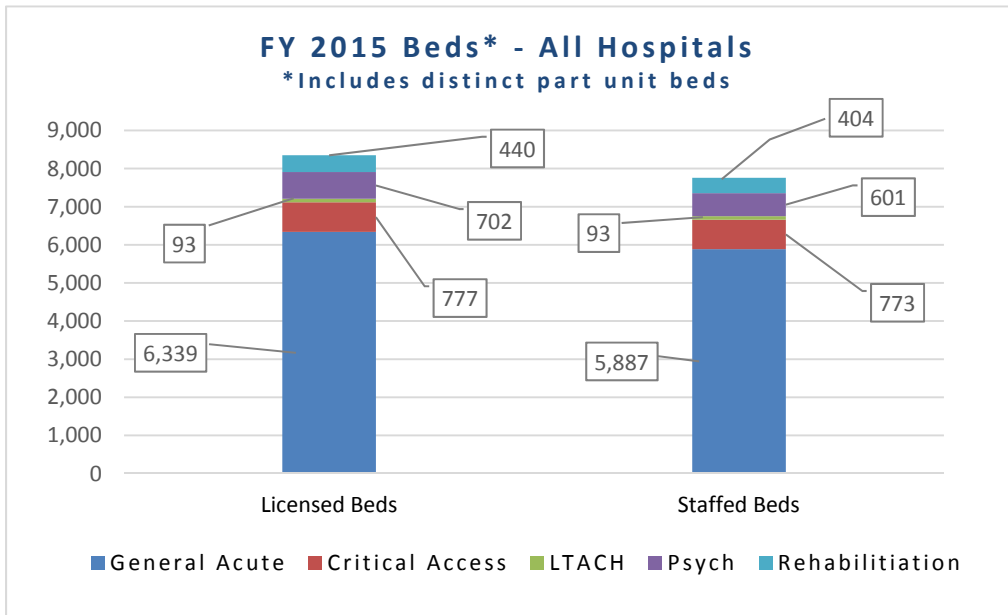
- Total inpatient days of 1.7 million were reported, a decrease of 0.2% from FY 2014. Total inpatient discharges equaled 253,000, an increase of 0.4%.



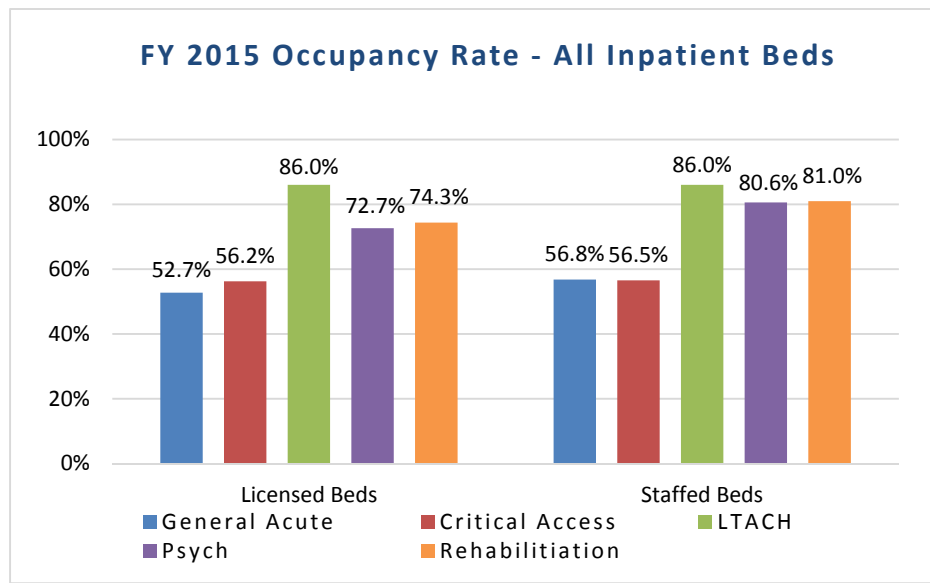
- General acute hospitals provided 71.2% of hospital days and 89.9% of hospital discharges.



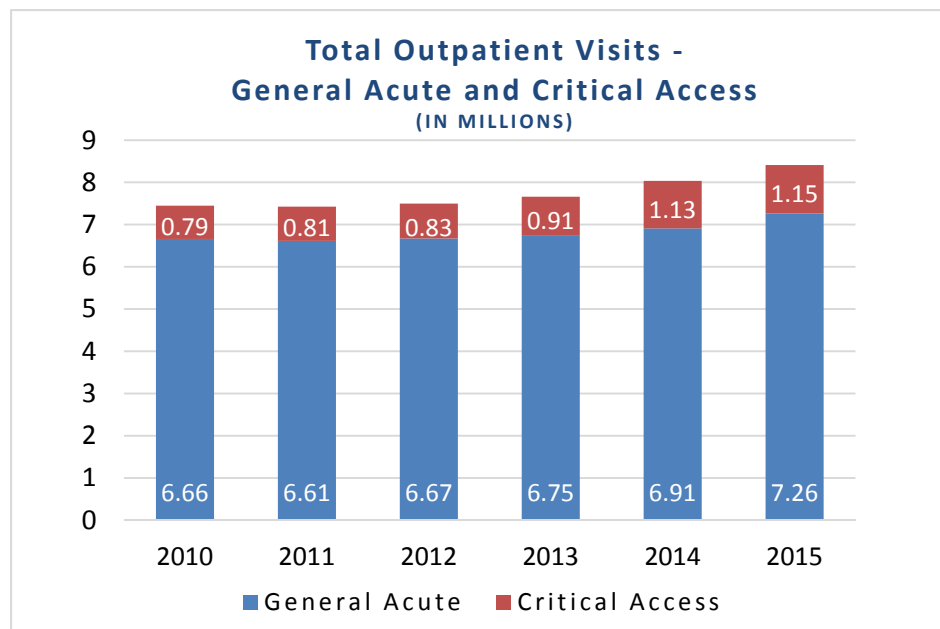
- Total licensed and staffed beds reported for FY 2015 equaled 8,351 and 7,758, respectively. General acute hospitals account for 75.9% of both the total licensed and staffed beds.



- The overall occupancy rate for all licensed beds for FY 2015 was 56.2%, but varies significantly between hospital types.



- General acute and critical access hospitals accounted for 99.8% of total outpatient visits in FY 2015. Total visits of 8.4 million were reported, an increase of 4.7% over FY 2014.



Special Items of Note

- ◆ *The Authority determined that certain market fluctuations, which are included in a hospital's financial statements, should be excluded from the data used for rate setting and reporting functions. Therefore, the profits and losses used in this report, except where noted otherwise, excludes income taxes, extraordinary items, and gains or losses due to changes in the market value of derivatives and other investments impacted by the adoption of related accounting standards. The market changes are included in the profit or loss after tax and after extraordinary items in the Uniform Financial Report (UFR), which is the hospital data source for most of this report.*
- ◆ *Acuity Specialty Hospital was granted CON approval to expand the number of LTACH beds at Weirton Medical Center and Wheeling Hospital by 8 and 16, respectively.*
- ◆ *Cabell Huntington Hospital, Inc. (CHHI) filed a CON application to acquire St. Mary's Medical Center. This CON was approved and is currently on appeal, by an affected party, in Kanawha County Circuit Court. CHHI also filed an application for a Certificate of Approval of a cooperative agreement relating to the acquisition of St. Mary's Medical Center. CHHI was granted a Certificate of Approval for the cooperative agreement. The Certificate of Approval for the cooperative agreement matter was appealed, by an affected party, to the Kanawha County Circuit Court. The appeal was subsequently withdrawn with prejudice.*
- ◆ *Current hospital news of note includes the following 2016 Certificate of Need (CON) activity:*
 - *WVU Medicine acquired Reynolds Memorial Hospital in October 2016. The capital expenditure associated with the acquisition stated as \$15.0 million in the CON, which was issued on May 26, 2016.*
 - *Thomas Memorial Hospital has entered into a joint venture, South Charleston Center, LLC, with Stonerise Healthcare LLC, to build a 90 bed post-acute care facility on the campus of Thomas Memorial Hospital. A CON was granted to South Charleston Center, LLC, for this project on May 31, 2016. The capital expenditure associated with the project is \$16.5 million.*

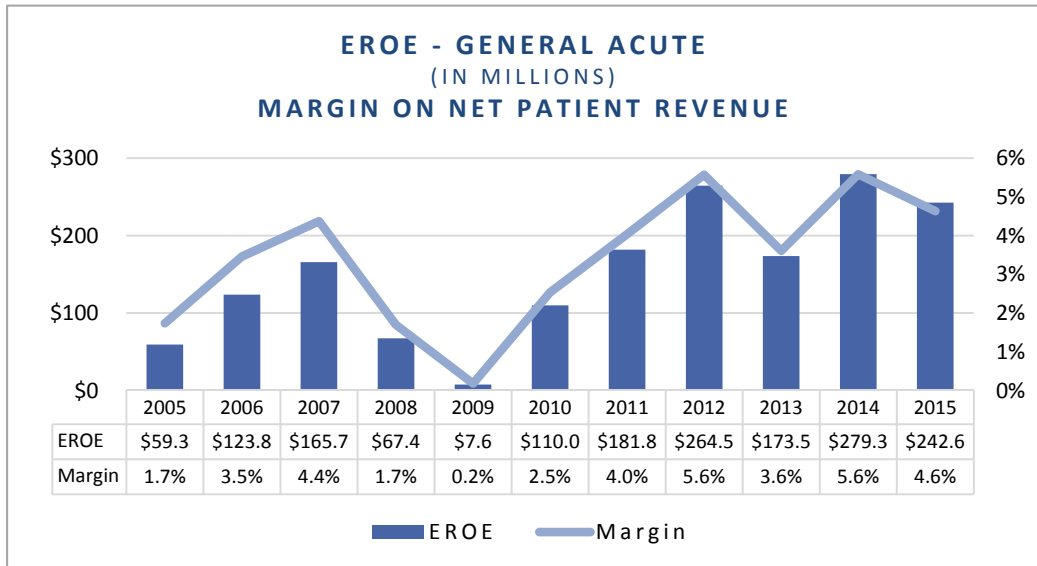
General Acute Care Hospitals

These hospitals primarily provide short-stay, medical-surgical services, although they often include distinct part units providing a wide range of other services, such as physician, psychiatric, skilled nursing and rehabilitation. There were 29 general acute care hospitals providing services during FY 2015.

Financial Indicators

- Profits from acute care hospitals decreased by \$36.7 million (13.1%), from \$279.3 million (5.6% of NPR) in FY 2014 to \$242.6 million in FY 2015 (4.6% of NPR).

- Profitability decreased in FY 2015 due to an increase in operating expenses of \$264.4 million (5.3%) that outpaced an increase in net patient revenue of \$232.8 million (4.7%). Additionally, other revenue decreased by \$5.2 million (1.8%).



NOTE: 2009 EROE would equal \$32.7 million (a margin of 0.8%), without a \$25 million write-off of Goodwill by one hospital.

- Eighteen of the 29 acute care hospitals reported a profit for FY 2015. Positive EROEs ranged from WVUH's \$103.9 million (13.8% of NPR) to St. Mary's \$425,000 (0.1% of NPR).
- The median profit in FY 2015 for the profitable hospitals was \$7.2 million. The median profit in FY 2014 among the profitable hospitals was \$11.3 million.

Hospitals with a Positive EROE – General Acute

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
20	22	27	23	18	17	22	22	18	19	18

- Thirteen hospitals reported an improvement in EROE.
 - Two hospitals that reported losses in FY 2014 reported a profit in FY 2015.
 - Four hospitals reported reduced losses.
 - Seven hospitals reported larger profits in FY 2015 than in FY 2014.
 - The median increase in EROE for these 13 hospitals was \$1.9 million.
- Eleven hospitals reported losses ranging from Welch Community's loss of \$7.4 million (33.6% of NPR) to Wetzel County's \$389,000 loss (2.0% of NPR). The median loss was \$3.6 million.

- Five hospitals reported margins (profits as a percentage of NPR) 10% or greater: Charleston Surgical (30.9%), Greenbrier Valley (22.7%), WVU Hospitals (13.8%), Wheeling (13.1%), and Raleigh General (10.0%).

Hospitals with a Margin of at least 10.0% – General Acute

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
2	3	6	4	3	4	3	4	3	5	5

- Five hospitals had a margin between 5.0% and 9.9%: Monongalia General (8.3%), Logan Regional (7.2%), United Hospital (6.8%), Princeton (6.6%), and Weirton Medical (6.0%).

Hospitals with a Margin of 5.0% - 9.9% – General Acute

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
3	8	7	1	2	5	7	8	7	7	5

- The median EROE for all 29 hospitals was \$2.4 million and the median margin was 2.4%.

Market Fluctuations and Accounting Items

As discussed in the *Special Items of Note* section, certain market fluctuations and related accounting standards are excluded from the results published in this report. Changes in market forces and new investment instruments have significantly impacted global, national and local enterprises over the past decade. Accounting standards adopted in order to recognize unrealized changes in the value of financial investments have compounded the impact on hospitals' statements of operations. These circumstances can result in substantial swings in profitability from year to year and mask factors of operation that are more relevant to the Authority's mission. The Authority determined that these types of market fluctuations would be reported separately; therefore, the impact of market variation is only included in this section of the report.

- In FY 2015 nine hospitals reported a combined net loss of \$75.2 million due to market fluctuations of derivative agreements and accounting changes. Eight hospitals reported losses and one reported a profit from these market changes. Last year, there was a combined loss of \$26.9 million.

***Aggregate Derivative Market and
Certain Accounting Gains/(Losses) – General Acute
(In Millions)**

	2008	2009	2010	2011	2012	2013	2014	2015
Gains / (Losses)	(\$191.5)	\$102.0	\$7.3	(\$59.9)	\$14.5	\$110.5	(\$26.9)	(\$75.2)
Change from Prior Year		\$293.5	(\$94.9)	(\$67.0)	\$74.4	\$96.0	(\$138.9)	(\$48.3)

*These gains and losses are not included in EROE.

- Three hospitals reported losses of over \$5.0 million in FY 2015 from these types of market fluctuations, which include derivatives: WVU Hospitals (\$55.0 million), Wheeling (\$6.8 million), and United Hospital (\$5.9 million).
- CAMC reported a gain of \$904,000 from market fluctuations.
- If these results were included in the FY 2015 data, the aggregate profit of \$242.6 million for general acute care hospitals would decrease to \$167.4 million.

Two other significant items were excluded from the aggregate EROE and reported as extraordinary items. The first was a \$25.5 million asset impairment loss by Camden Clark. The hospital signed a purchase and sale agreement in October 2015 for the property and equipment of St. Joseph’s of Parkersburg for \$500,000. As a result, the carrying value was reduced through the asset impairment loss. In FY 2014 the hospital also reported an impairment loss of \$7.3 million due to the same event. The second significant exclusion of costs was a \$14.4 million charge reported by Cabell Huntington related to the acquisition costs of St. Mary’s Medical Center and the accompanying challenges to that acquisition.

Uncompensated Care

Uncompensated care, which is comprised of bad debt and charity care, decreased 3.7 percentage points from 6.4% to 2.7% of gross patient revenue (GPR) over the past two years. Uncompensated care as a percentage of GPR had remained relatively constant (0.5% fluctuation) from FY 2005 – FY 2013.

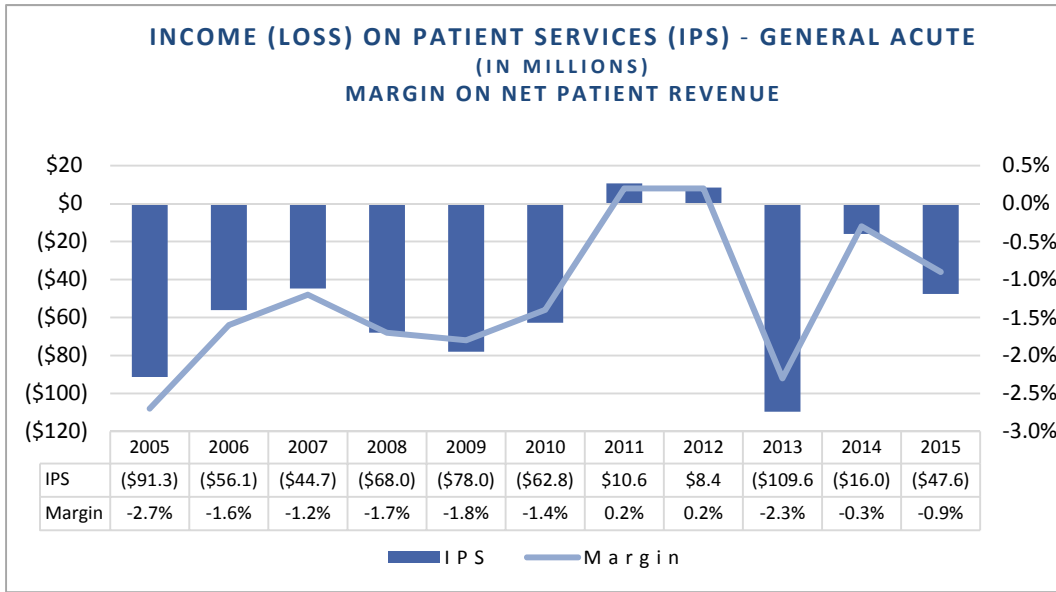
Uncompensated Care as % of Gross Patient Revenue – General Acute

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
5.9%	6.3%	6.4%	6.4%	6.1%	6.4%	6.4%	6.4%	6.4%	3.5%	2.7%

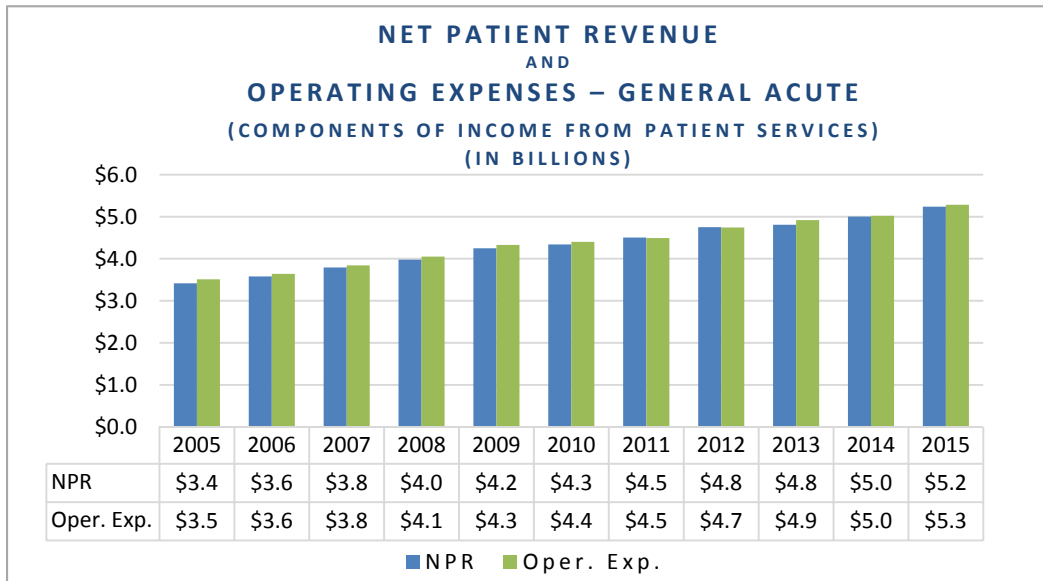
Patient Services

Income from patient services is an important financial and operating indicator. It is derived by subtracting operating expenses from net patient revenue, which is the amount received in payment for patient services.

- General acute hospitals reported an aggregate loss on patient services of \$47.6 million (0.9% of NPR) in FY 2015. The prior year’s loss was \$16.0 million (0.3% of NPR).



- An increase in net patient revenue, of \$232.8 million (4.7%), was outpaced by an increase in operating expenses of \$264.4 million (5.3%).
- Net patient revenue equaled \$5.2 billion in FY 2015, and operating expenses equaled \$5.3 billion.



- Losses on patient services increased by \$31.6 million over the prior year. One hospital (CAMC) reported an increased loss on patient services of \$42.4 million in FY 2015. In FY 2014, CAMC’s loss on patient services was \$2.9 million; in FY 2015 it was \$45.2 million.
- The median change in income from patient services in FY 2015 was a loss of \$204,000.

- Ten hospitals reported positive incomes from patient services ranging from \$22.5 million (7.6% of NPR) at Wheeling to \$449,000 (0.5% of NPR) at St. Francis. The median income from patient services for these 10 hospitals was \$6.3 million. Thirteen hospitals reported positive incomes from patient services in FY 2014.
- Positive margins on income from patient services ranged from 30.0% (\$6.2 million) at Charleston Surgical to 0.5% (\$449,000) at St Francis.
- Two hospitals, both for-profit, reported margins greater than 10%: Charleston Surgical (30.0%) and Greenbrier Valley (20.8%). Three hospitals had margins above 10% in FY 2014.
- Nineteen hospitals reported losses on patient services in FY 2015, ranging from \$45.2 million (5.0% of NPR) at CAMC to \$368,000 (0.4% on NPR) at Davis Medical. The median losses from patient services for these hospitals was \$4.5 million.
- Negative margins on patient services ranged from 50.8% (\$7.7 million) at Williamson to 0.4% (\$368,000) at Davis Medical.
- Since the mid-1990s general acute hospitals have reported aggregate losses on patient services, except for FY 2011 and FY 2012.

Operating Expense

Besides net patient revenue, the other factor in the calculation of income from patient services is operating expense.

- Overall, acute care expenses of \$5.3 billion were reported in FY 2015, an increase of 5.3% over FY 2014. The median rate of increase for FY 2005 through FY 2015 equals 3.8%.

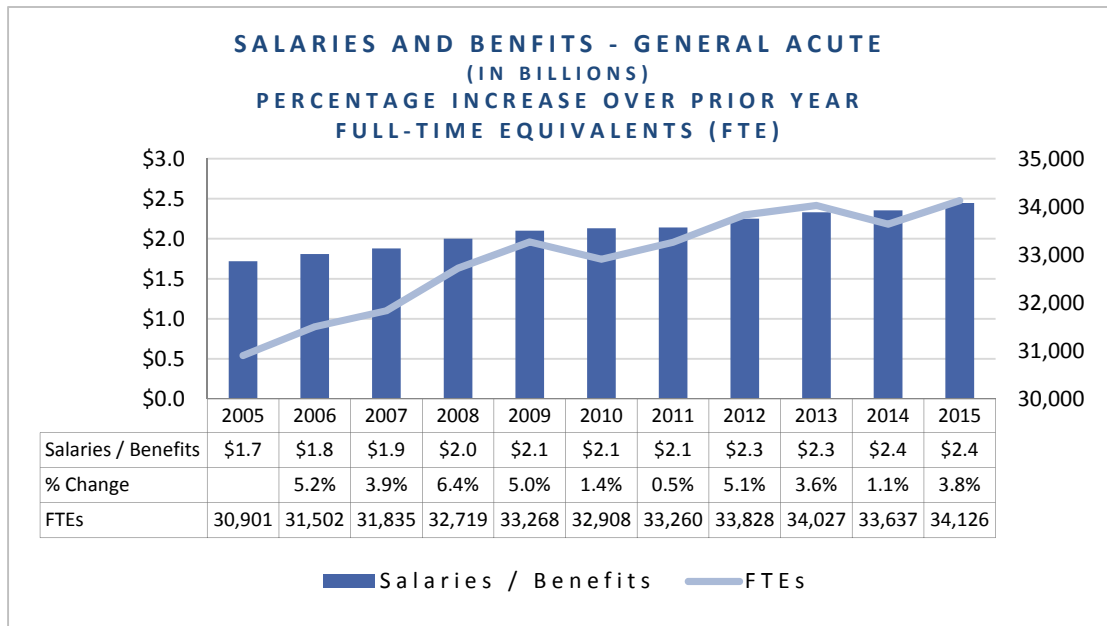
Operating Expenses – General Acute
(In Billions)
Percentage Increases over Prior Year

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
\$3.4	\$3.6	\$3.8	\$4.0	\$4.3	\$4.4	\$4.5	\$4.7	\$4.9	\$5.0	\$5.3
3.8%	3.6%	5.7%	5.4%	6.8%	1.7%	2.1%	5.5%	3.7%	2.1%	5.3%

- Twenty-three hospitals reported an increase in operating expenses. Four hospitals reported an increase of 10.0% or more: Charleston Surgical (25.0%), Ohio Valley (12.2%), Berkeley Medical (11.4%), and Beckley ARH (11.1%).

- Six hospitals reduced operating expenses. Three hospitals reduced expenses by 10.0% or more: Williamson (19.7%), Wetzel County (12.3%), and Fairmont Regional (10.0%).

The largest component of total operating expense is salaries and benefits, which equaled 46.0% of total operating expenses. Total salaries and benefits expense in FY 2015 was \$2.4 billion, an increase of \$90.3 million (3.8%).



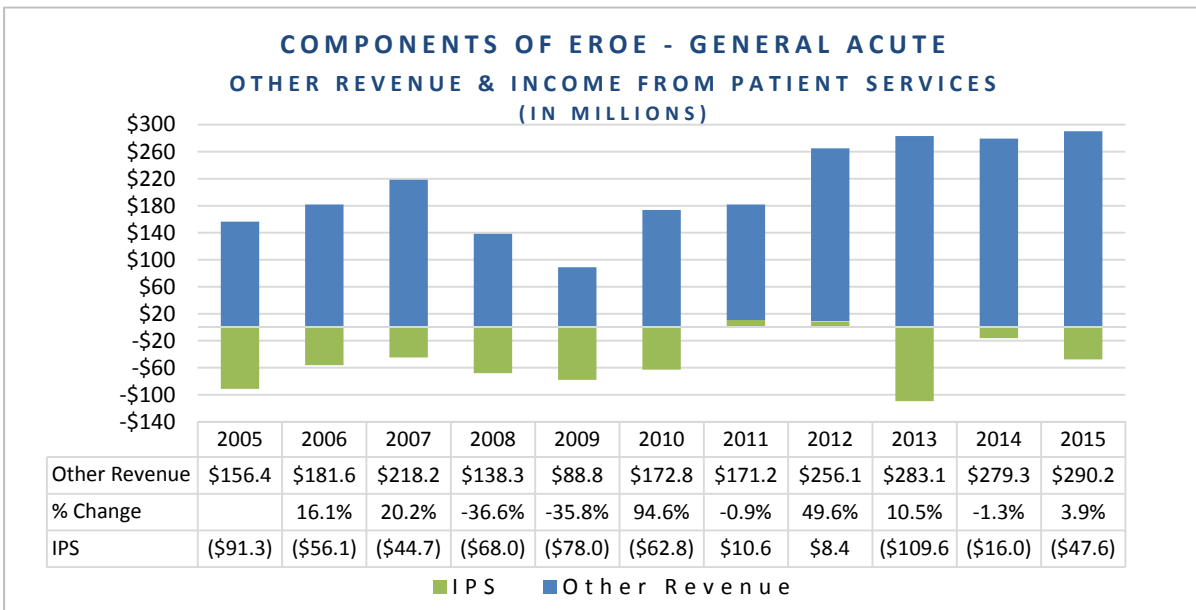
- Eighteen hospitals reported a net increase in salaries and benefits, with a median increase of \$2.9 million (5.3%).
- Eleven hospitals reported a net decrease in salaries and benefits, with a median decrease of \$2.3 million (5.2%).
- Overall, there was a 2.3% increase in average salary and benefits for general acute hospitals from \$70,024 in FY 2014 to \$71,664 in FY 2015.
- Five hospitals reported increases in aggregate salaries and benefits of 10.0% or more: Welch Community (16.5% or \$2.3 million), Monongalia General (14.7% or \$14.3 million), Ohio Valley (11.3% or \$5.3 million), Charleston Surgical (11.1% or \$533,000), and Berkeley Medical (10.5% or \$7.8 million).
- Three hospitals reported an increase in FTEs greater than 5.0%: Greenbrier Valley (9.0%), Monongalia General (8.6%), and Charleston Surgical (8.3%).

- Three hospitals reported a decrease in aggregate salaries and benefits greater than 10.0%: Fairmont Regional (28.3% or \$11.0 million), Williamson (19.7% or \$2.8 million), and Wetzel County (14.0% or \$1.8 million).
- Six hospitals reported a decrease in FTEs greater than 5.0%: Williamson (22.5%), Camden Clark (12.0%), Wetzel County (10.2%), Summersville (6.5%), Bluefield (5.8%), and Weirton Medical (5.2%).

Other Revenue

Other revenue provides a secondary income source compared to patient revenue, but is nevertheless an important component of a hospital’s financial status and is often the only source of a positive margin. Other revenue consists of other non-patient operating revenue and non-operating revenue.

- Other revenue equaled \$290.2 million, a 1.8% decrease from FY 2014.



NOTE: 2009 Other Revenue would equal \$113.9 million, without a \$25 million write-off of Goodwill by one hospital.

- Three hospitals reported other revenue greater than \$20.0 million: WVUH (\$113.6 million), CAMC (\$41.7 million), and Cabell Huntington (\$24.4 million).
- Two hospitals had other revenue between \$10.0 million and \$20.0 million: Wheeling (\$16.4 million), and United Hospital (\$14.2 million).
- The other revenue for the remaining 24 hospitals ranged from \$9.8 million (Thomas) to \$187,000 (Charleston Surgical).
- The median amount of other revenue for all 29 general acute hospitals was \$3.8 million.

- Seven hospitals reported increases in other revenue for FY 2015. Fifteen hospitals reported increases in other revenue in the prior year.
- Eight hospitals reported a profit due solely to other revenue.

Profitable Hospitals Solely Due to Other Revenue – General Acute

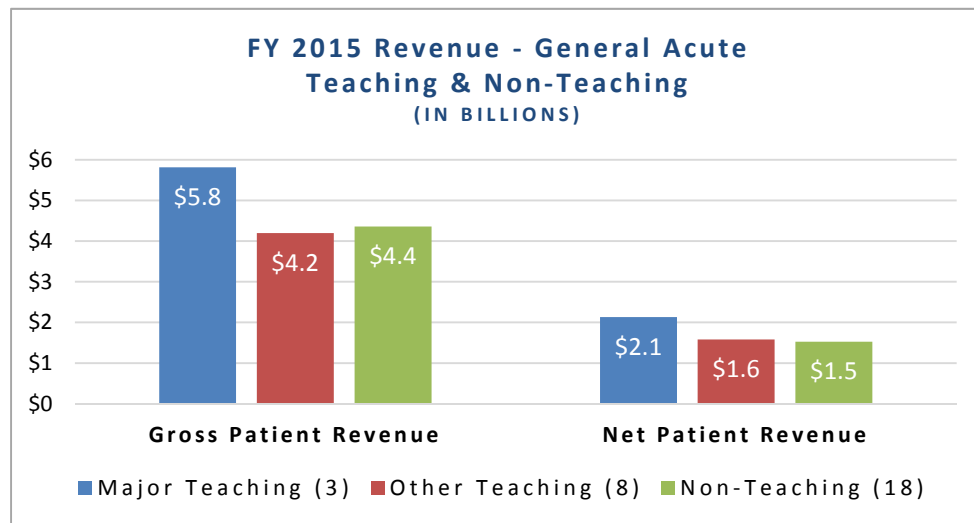
2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
9	9	13	14	7	6	6	10	9	6	8

Teaching Hospitals

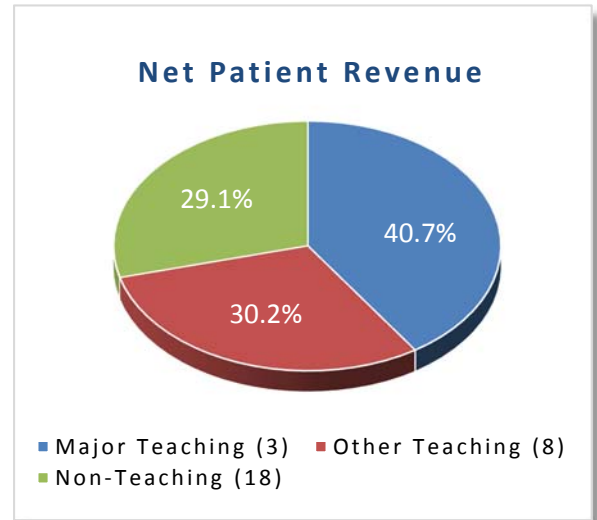
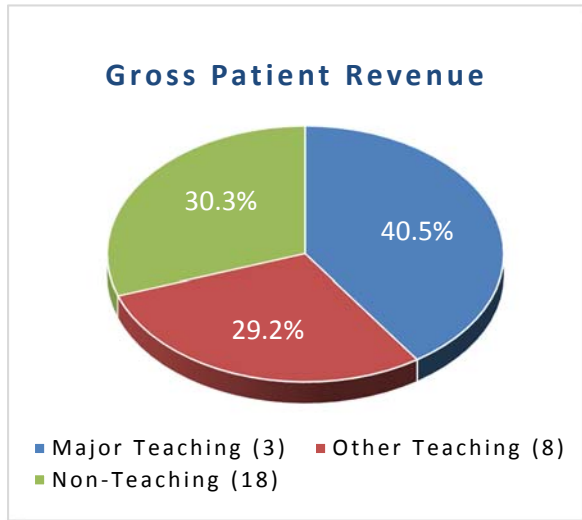
For 2015, the Centers for Medicare and Medicaid identified eleven of the state’s hospitals as teaching hospitals. Three of these hospitals are members of the Council of Teaching Hospitals (COTH), according to the COTH website: Cabell Huntington, CAMC and WVUH. Membership in COTH is often used as an identifier of major teaching hospital status. The other eight teaching hospitals are Berkeley Medical, Bluefield Regional, Camden Clark, Greenbrier Valley, Ohio Valley, St. Mary’s, United and Wheeling.

The services provided by the teaching hospitals in the state are significant. Revenue is one measure of the amount of services provided.

- The three major teaching hospitals reported \$5.8 billion in gross patient revenue (GPR), more than \$1.6 billion greater than the \$4.2 billion aggregate GPR of the other eight teaching hospitals and \$1.5 billion greater than the \$4.4 billion GPR of the 18 non-teaching hospitals.



- Net patient revenue was \$2.1 billion for the three major teaching hospitals, \$1.6 billion for the other teaching hospitals and \$1.5 billion for the non-teaching hospitals.
- The eleven state teaching hospitals reported 69.7% of the gross patient revenue for all acute care hospitals and 69.8% of the net patient revenue.



- Teaching hospitals reported 67.1% of total general acute discharges and 62.6% of outpatient visits.

Utilization by Teaching and Non-Teaching Hospitals – General Acute

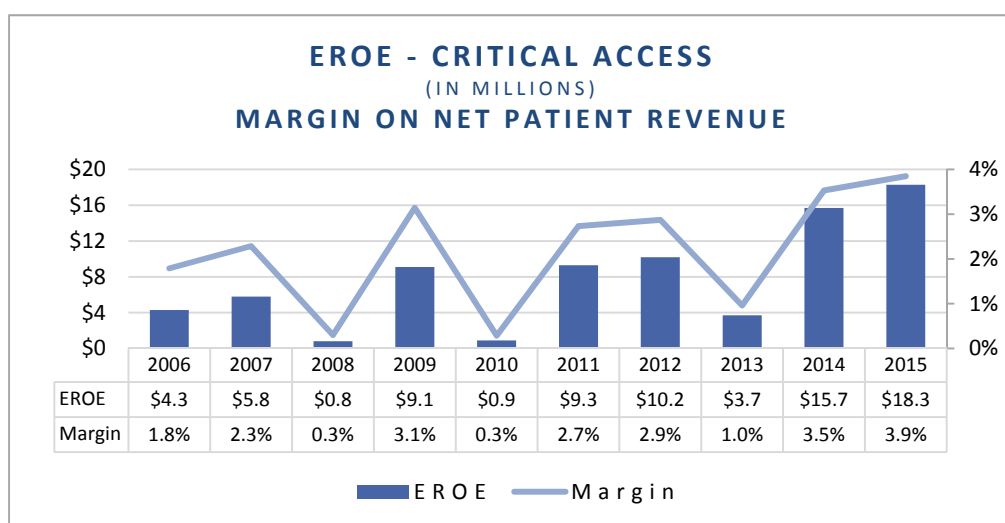
	Total Inpatient Discharges	Inpatient Percentage	Total Outpatient Visits	Outpatient Percentage
Major Teaching Hospitals (3)	80,482	35.5%	2,126,885	29.3%
Other Teaching Hospitals (8)	71,544	31.6%	2,420,193	33.3%
Non-Teaching Hospitals (18)	74,581	32.9%	2,714,721	37.4%
Total General Acute Hospitals (29)	226,607	100.0%	7,261,799	100.0%

Critical Access Hospitals

Critical Access is a federal designation for a small rural hospital where cost-based reimbursement is provided for limited acute care services in combination with swing-bed and skilled nursing care. There are 20 critical access hospitals.

Financial Indicators

- Total profit for FY 2015 was \$18.3 million (3.9% of NPR). The total profit reported for FY 2014 was \$15.7 million (3.5% of NPR).



- The increase in profit of \$2.6 million was due to a decrease in a loss from patient services of \$1.5 million and an increase in other revenue of \$1.1 million.
- Other revenue of \$23.3 million provided the aggregate EROE of \$18.3 million after a loss on patient care of \$5.0 million.
- Thirteen critical access hospitals reported profits in FY 2015.

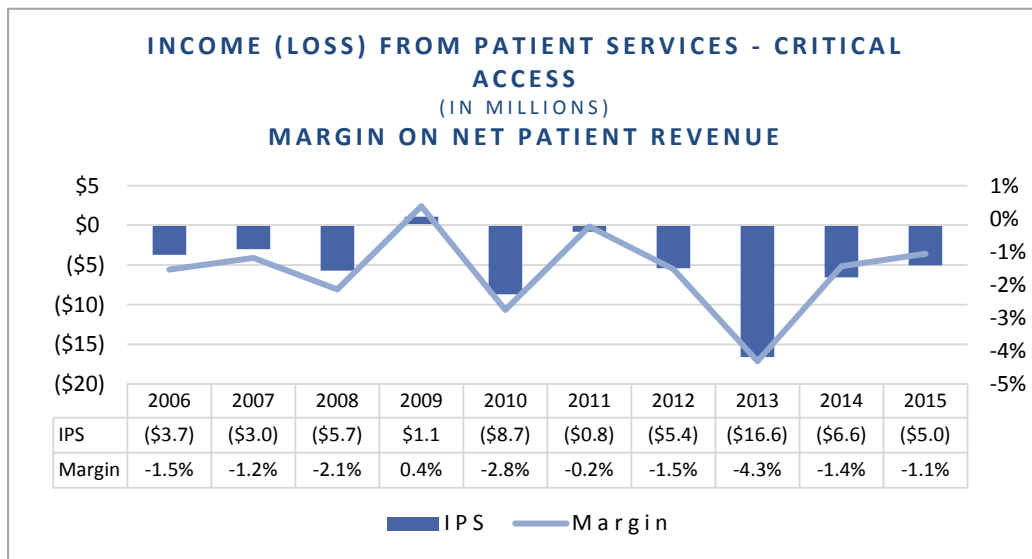
Hospitals with Positive EROE – Critical Access

2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
12	11	9	13	10	11	12	9	14	13

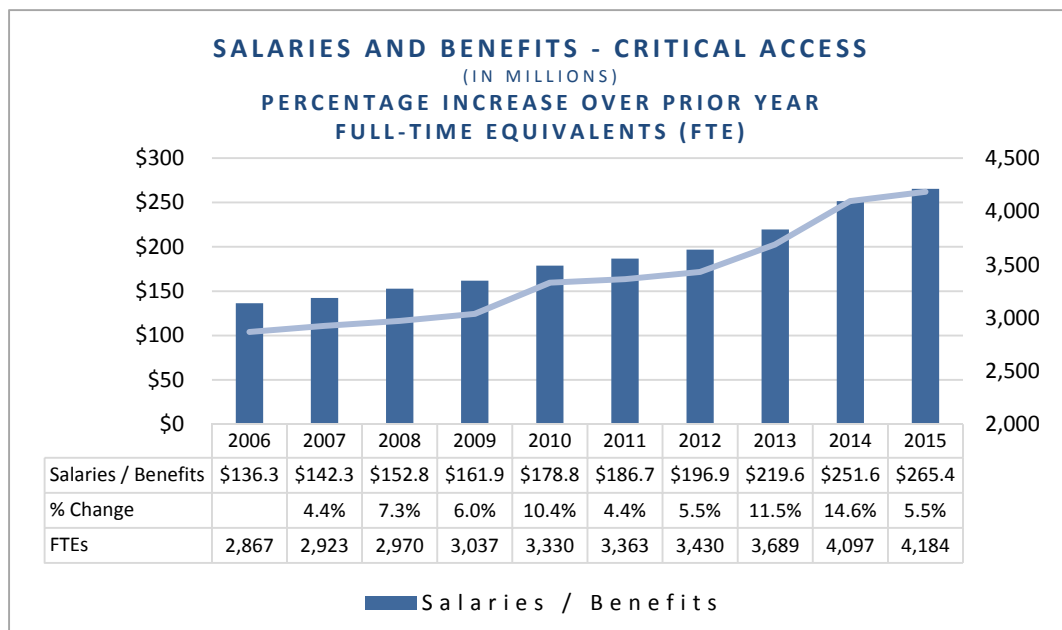
- The median EROE in FY 2015 was \$507,000 and \$395,000 in FY 2014.

Revenue and Expense Items

- The aggregate loss on patient services was \$5.0 million (1.1% of NPR), \$1.5 million less than in FY 2014.
- Net patient revenue of \$470.0 million and operating expenses of \$474.9 million were reported in FY 2015.



- Employee compensation and benefits of \$265.4 million were reported, an increase of 5.5% over the prior year. These expenses equaled 55.9% of total operating expenses.



- Uncompensated care of \$44.8 million (4.5% of gross patient revenue) was reported for the 20 critical access hospitals in FY 2015.

Uncompensated Care – Critical Access
(IN MILLIONS)
Percentage of Gross Patient Revenue
Number of Hospitals

2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
\$35.6	\$38.4	\$43.4	\$50.4	\$57.9	\$62.9	\$69.9	\$76.4	\$56.5	\$44.8
8.3%	8.7%	9.0%	9.4%	9.6%	9.5%	9.9%	9.6%	6.1%	4.5%
19	18	18	17	18	18	18	18	19	20

- Thirteen hospitals reported profits ranging from \$5.5 million (Plateau Medical) to \$181,000 (Montgomery). The median profit for these hospitals was \$1.1 million.
- Four hospitals reported profits greater than \$2.0: Plateau Medical (\$5.5 million, 14.4% of NPR), Jefferson (\$4.9 million, 9.7% of NPR), St. Joseph’s (\$2.7 million, 6.5% of NPR), and Preston Memorial (\$2.5 million, 8.1% of NPR). In FY 2014, two hospitals reported more than \$2.0 million in profits.
- Seven hospitals reported losses ranging from \$1.0 million (Minnie Hamilton) to \$479,000 (Braxton County). The median loss was \$621,000.
- Nine hospitals reported a positive income from patient services ranging from Plateau Medical (\$5.4 million, 14.2% of NPR) to War Memorial (\$12,000, 0.1% of NPR). The median income from patient services for these hospitals was \$700,000.

Hospitals with Positive Income from Patient Services - Critical Access

2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
6	6	5	7	3	5	5	3	6	9

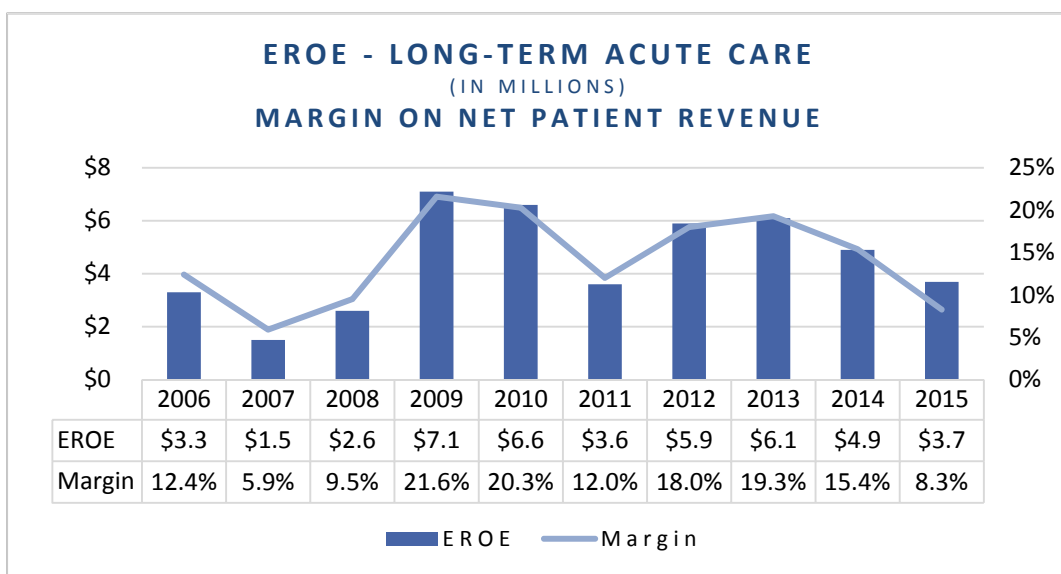
- Eleven hospitals reported losses on patient services ranging from Minnie Hamilton (\$4.0 million, 22.9% on NPR) to Broadus \$389,000 (2.5% on NPR). The median loss was \$1.5 million for the hospitals that reported losses on patient services.
- Total days and discharges reported were 159,464 and 13,267, respectively, for an average length of stay of 12.0 days. This included skilled and long-term care services. The total number of licensed beds equaled 777 with a reported occupancy rate of 56.2%.

Long-Term Acute Care Hospitals

Long-Term Acute Care Hospitals (LTACH) are generally defined as hospitals that provide extended medical and rehabilitative care, generally for stays greater than 25 days, for those with clinically complex issues.

Three LTACHs operated in West Virginia during FY 2015. Acuity Specialty Hospital of Ohio Valley started business on January 28, 2015. It has two campuses in West Virginia, located in Weirton Medical Center and Wheeling Hospital. Cornerstone Hospital of Huntington is located within St. Mary's Medical Center and Select Specialty is located in St. Francis Hospital. All three hospitals are for-profit entities.

- Total profit for FY 2015 was \$3.7 million (8.3% of NPR).



- Acuity Specialty reported a loss of \$610,000 (4.9% of NPR) for its first year of operation.
- Cornerstone reported a profit of \$2.4 million (17.1% of NPR) a decrease of \$762,000 from the prior year's EROE of \$3.1 million (21.4% of NPR).
- Select Specialty reported a profit of \$2.0 million (10.6% of NPR) an increase from \$1.8 million (10.4% of NPR) in FY 2014.
- Uncompensated care of \$313,000, all of which was bad debt, was reported. This equaled 0.2% of gross patient revenue.
- Total days and discharges reported were 29,209 and 1,117, respectively, for an average length of stay of 26.1 days. The occupancy rate for the 93 beds was 86.0%.

Psychiatric Hospitals

Five free-standing psychiatric hospitals operate in West Virginia: three are privately-owned (Highland, Highland-Clarksburg and River Park) and two are state-owned (Mildred Mitchell Bateman and William R. Sharpe, Jr.). Because the state facilities provide substantially more uncompensated care and have a different payor mix, state and private hospitals are reviewed separately. State-run facilities provided \$23.0 million in uncompensated care and the private facilities reported \$915,000 in uncompensated care.

Aggregate EROE for the psychiatric facilities as a sector equaled a loss of \$1.7 million (2.0% of NPR). These facilities provided 702 licensed psychiatric beds to West Virginia. The state hospitals have 310 beds and private hospitals have 392 beds. General acute care hospitals reported an additional 502 psychiatric beds.

Financial Indicators – Private Hospitals

- For FY 2015 the aggregate profit was \$5.9 million (9.2% of NPR).

EROE – Private Psychiatric									
(In Thousands)									
Margin on Net Patient Revenue									
2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
\$1,811	\$1,288	\$1,015	\$3,389	\$3,668	\$962	\$1,234	(\$49)	(\$977)	\$5,855
6.6%	4.9%	3.7%	10.9%	11.4%	2.8%	3.3%	(0.1%)	(1.8%)	9.2%

- Highland-Clarksburg, in its second full year of operation, reported a loss of \$1.8 million (11.9% of NPR). The loss in FY 2014 was \$3.5 million (48.1% of NPR).
- Highland (Charleston) reported a loss of \$283,000 (1.6% of NPR), a decrease from the profit of \$406,000 (2.1% of NPR) in FY 2014.
- River Park reported an EROE of \$7.9 million (26.1% of NPR) in FY 2015. The prior year's profit was \$2.1 million (7.5% of NPR).
- River Park's net patient revenue increased by \$1.9 million and its expenses decreased by \$3.9 million. Not included in FY 2015, was a yearly capital charge of over \$5.0 million that had been included in operating expenses from FY 2011 through FY 2014. The expense began after Universal Health Services, Inc. purchased Psychiatric Solutions, Inc., the prior owner of River Park. Only River Park, a for-profit facility, has consistently reported profits on patient services for the last thirteen fiscal years.
- An aggregate income from patient services of \$5.2 million (8.2% of NPR) was reported by the private psychiatric hospitals in FY 2015. River Park reported income from patient services of \$7.9 million (25.9% of NPR). Highland and Highland-Clarksburg reported a

combined loss on patient services of \$2.7 million (8.0% of NPR). In FY 2014 the loss on patient services for the private hospitals was \$1.7 million (3.1% of NPR).

- The respective occupancy rate and licensed bed count for the three private hospitals were as follows:
 - River Park – 78.7% for 187 beds;
 - Highland – 80.7% for 80 beds; and,
 - Highland-Clarksburg’s – 43.0% for 125 beds.

Financial Indicators – State Hospitals

- The aggregate EROE was a loss of \$7.6 million (32.4% of NPR). The prior year’s EROE was \$16.6 million (72.0% of NPR).

EROE – State Psychiatric									
(In Thousands)									
Margin on Net Patient Revenue									
2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
(\$2,513)	(\$9,584)	(\$4,014)	(\$2,318)	(\$9,934)	(\$13,695)	(\$7,605)	(\$10,855)	\$16,569	(\$7,564)
	NA	NA	NA	(41.8%)	(63.0%)	(32.3%)	(47.4%)	72.0%	(32.4%)

*Margin calculation is not comparable prior to 2010 due to reporting changes of state allocations.

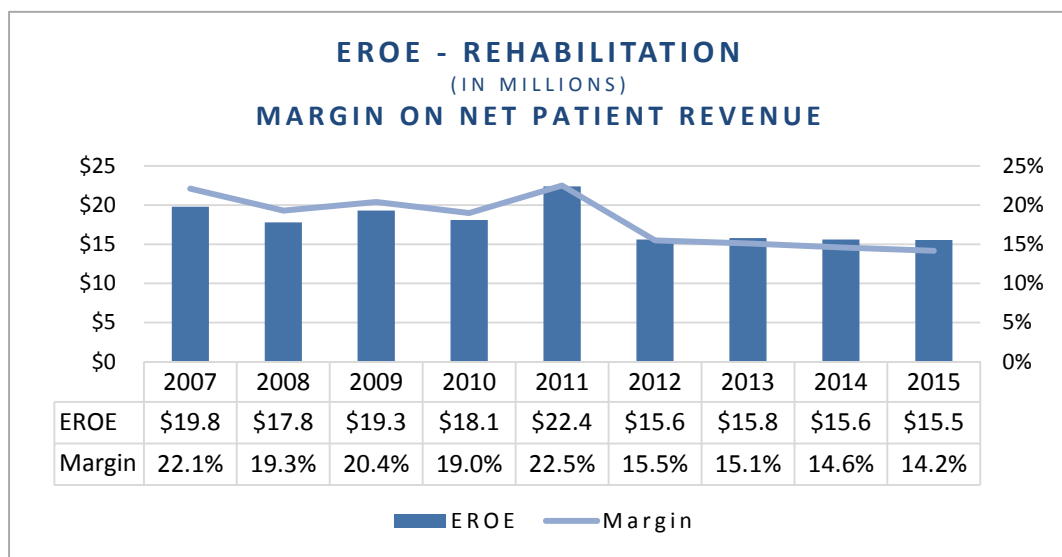
- The financial results for the state hospitals in FY 2015 returned to a more typical status. Included in FY 2014 a one-year capital appropriation, of \$22.8 million, for expansion and renovation projects, which resulted in Sharpe reporting a profit of \$20.7 million.
- The state hospitals reported net patient revenue of \$23.3 million and operating expenses of \$98.2 million for the year, resulting in an aggregate loss on patient services of \$74.9 million (321.2% of NPR). The loss on patient services in FY 2014 was \$63.3 million (275.3% of NPR).
- Net patient revenue for Bateman decreased \$581,000 (5.3%) from the prior year and operating expenses increased by \$5.0 million (13.0%). Sharpe reported an increase in net patient revenue of \$901,000 (7.4%) and an increase in operating expenses of \$6.8 million (14.4%).
- Bateman reported a loss of \$6.9 million (66.6% of NPR) and Sharpe reported a loss of \$702,000 (5.4% of NPR).
- The occupancy rate and licensed bed count for Bateman was 98.0% for 110 beds and 68.4% for 200 beds for Sharpe.

Rehabilitation Hospitals

In FY 2015 five rehabilitation hospitals operated in West Virginia. All five hospitals are for-profit facilities. Four are owned and operated by HealthSouth, Inc; one hospital, Peterson Rehabilitation and Geriatric Center, is owned and operated by Guardian Eldercare. These hospitals have a total of 440 licensed rehabilitation and/or skilled nursing beds in West Virginia.

Financial Indicators

- Aggregate profit for FY 2015 was \$15.5 million (14.2% of NPR). The aggregate profit for FY 2014 was \$15.6 million (14.6% of NPR).



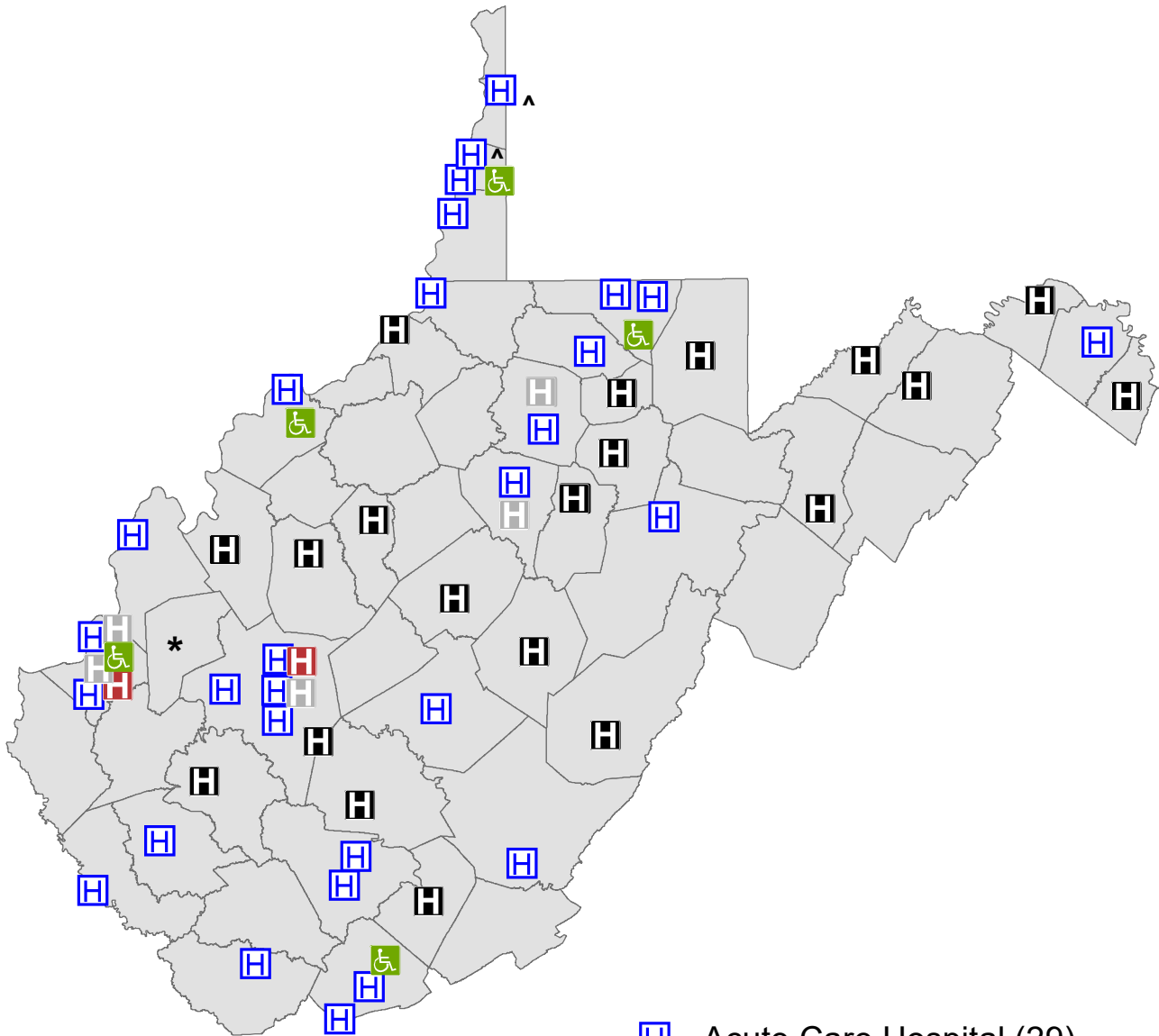
- Net patient revenue increased by \$2.5 million (2.3%) to \$109.7 million, while operating expenses increased by \$2.4 million (2.6%) to \$94.3 million. Income from patient services was \$15.4 million (14.1% on NPR), a \$54,000 increase in over the prior year.
- Income from patient services accounts for 99.1% of the rehabilitation hospitals' profit levels, with only \$133,000 in other revenue reported.
- Discharges increased by 3.5%, from 5,881 in FY 2014 to 6,085. Days decreased by 2.7% to 119,406 from 122,766 in FY 2014. The average length of stay decreased from 20.9 days to 19.6 days in FY 2015. The aggregate occupancy rate for FY 2015 was 74.3%.

Detailed information on hospital rates, income, uncompensated care, staffing, utilization and quality indicators can be reviewed in Tables 1-22 on the Authority's website under the Data and Public Information link, Annual Reports section. The direct link is:

<http://www.hca.wv.gov/data/Reports/Pages/default.aspx>

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West Virginia Hospitals



-  Acute Care Hospital (29)
- * Campus of CAMC located in Putnam County
-  Critical Access Hospital (20)
-  Rehabilitation Hospitals (5)
-  Psychiatric Hospital (5)
-  Long Term Acute Care Hospitals (3)
- ^ Two Campus LTACH

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QUALITY INDICATORS

Healthcare-associated infections (HAIs) are infections that are acquired by patients while seeking treatment in a healthcare setting. In a study conducted in 2011, and the most recent comprehensive study to date, the Centers for Disease Control and Prevention (CDC) estimated that approximately 722,000 HAIs occurred nationally, which equated to 4% of inpatients in U.S. acute care facilities. As many as 75,000 deaths were attributable to HAIs. It is estimated that at any one time in the U.S., one out of every 25 hospitalized patients is affected by an HAI.¹

Not only are HAIs costly in terms of patient morbidity and mortality, they also increase the cost of healthcare substantially. A study of 1.69 million admissions from 77 hospitals in 2006 found that overall net inpatient margins were decreased by \$286 million or \$5,018 per infected patient.² Although the study was conducted 10 years ago, it shows how facility margins are eroded by the high cost of HAIs. Margins will erode even further as reimbursement methodologies change to bundled payments, value-based care models, or some other form of reimbursement other than historical fee-for-service payment if HAIs are not addressed. As a result of the human and financial impact associated with an HAI, healthcare facilities and major public health governments focus on reducing them since they are a preventable cost.

The research found the following associated costs for hospital acquired infections, which probably underestimates the true cost of treating health care-associated infections:

- Central line-associated bloodstream infections average about \$45,000 per case.
- Pneumonia infections that strike patients who are put on ventilators to help them breathe cost about \$40,000 per case.
- Surgical site infections, which occur in about one out of every 50 operations, cost around \$21,000 each to treat.
- *C. difficile* infections, which occur in about four for every 1,000 patients who spend a day in the hospital and the second most common kind of infection, cost about \$11,000 each to treat.
- Urinary tract infections associated with the use of catheters cost about \$900 each.³

A recent report from the U.S. Department of Health and Human Services (DHHS) shows similar outcomes. In a press release published in December 2014, improved patient safety initiatives to reduce hospital-acquired conditions saved an estimated 50,000 patient lives, prevented 1.3 million hospital acquired infections and saved approximately \$12 billion dollars in healthcare

¹ Magill SS, Edwards JR, Bamberg W, et al. Multistate point-prevalence survey of health care-associated infections. *N Engl J Med*. Mar 2014;370:1198-208. Doi: 10.1056/NEJMoa1306801 available at: <http://www.cdc.gov/media/dpk/2014/docs/hai/Multistate-Point-Prevalence.pdf>

² Murphy, Denise, RN, BSN, MPH, CIC, Whiting, Joseph, MBA, FACHE, Hollenbeak, Christopher, PhD, Dispelling the Myths: The True Cost of Healthcare-Associated Infections. *An APIC Briefing*. February, 2007.

costs between 2010 and 2013, which was a 17% reduction in hospital acquired conditions over that time period.³

To reduce the reporting burden on hospitals, the HAI Advisory Panel adopted CMS requirements as West Virginia's reporting requirements. In addition, they also recommended that Critical Access Hospitals (CAHs) report State specific HAI since the Hospital Inpatient Quality Reporting Program is voluntary and not required for CAHs by CMS. Healthcare personnel Influenza vaccination data was also required for all hospitals in West Virginia, except federal programs and state-run psychiatric facilities.

The HCA analyzes the healthcare-associated infections data yearly. For calendar year 2015, the HAI annual report rates, which are based upon the national averages of infections from the National Healthcare Safety Network (NHSN), are the benchmarks used for hospital performance. Key findings for all reporting requirements in 2015 by hospital type are provided. For those years when reporting for multiple years has occurred, comparisons will also be provided.

I. Central Line Associated Blood Stream Infections (CLABSI)

CLABSIs are a serious HAI. The CDC estimates CLABSIs have a mortality rate of 12 to 25 percent, adding more than a billion dollars annually to the costs of the healthcare system.⁴

Although there has been a 46% decrease in CLABSIs in hospitals across the U.S. from 2008-2013, it is estimated that more than 30,000 CLABSIs still occur in intensive care units and wards of U.S. acute care facilities each year.⁵ CLABSIs can also lead to serious complications including an increased number of inpatient stays, increased costs and increased risk of death. The aggregate attributable patient hospital cost of a CLABSI is approximately \$45,000 per case,³ while also causing thousands of deaths per year. CLABSIs can often be prevented by adherence to evidence-based guidelines for the insertion, use, and maintenance of central lines.

Key Findings for CLABSI: General Acute Care Hospitals

- In 2015, 135 CLABSIs were reported in all ICUs, adult/pediatric medical, surgical and medical/surgical wards in West Virginia General Acute Care Hospitals. In 2014, CLABSIs were only reported from ICUs.
- Significantly fewer CLABSIs occurred in West Virginia General Acute Care Hospitals than were expected based on national baselines set by NHSN. The West Virginia Standardized

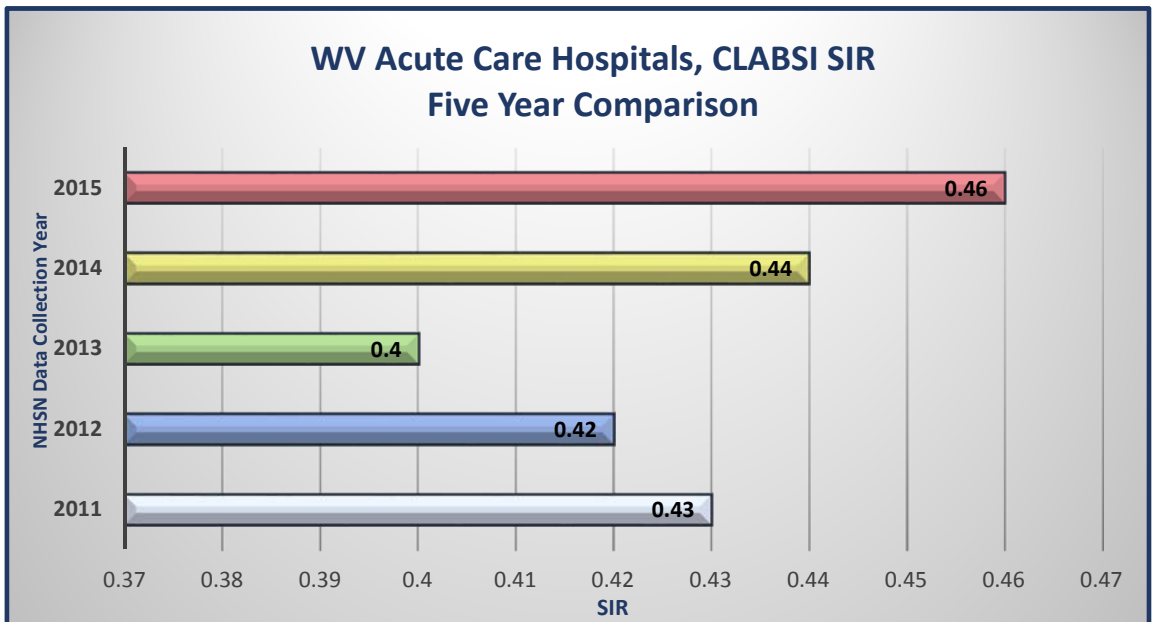
³ US Department of Health and Human Services, *HHS News* (press release). December 2, 2014, available at: <http://www.hhs.gov/news/press/2014pres/12/20141202a.html>.

⁴ The Joint Commission, *New Monograph Aims to Decrease Central Line-Associated Bloodstream Infections (CLABSIs) International Project to Address Preventable Infections*, May 2012, available at: http://www.pwrnewmedia.com/2012/joint_commission/clabsi/.

⁵ CDC National and State Healthcare-Associated Infections Progress Report, published March 2014, available at: <http://www.cdc.gov/HAI/pdfs/progress-report/hai-progress-report.pdf>.

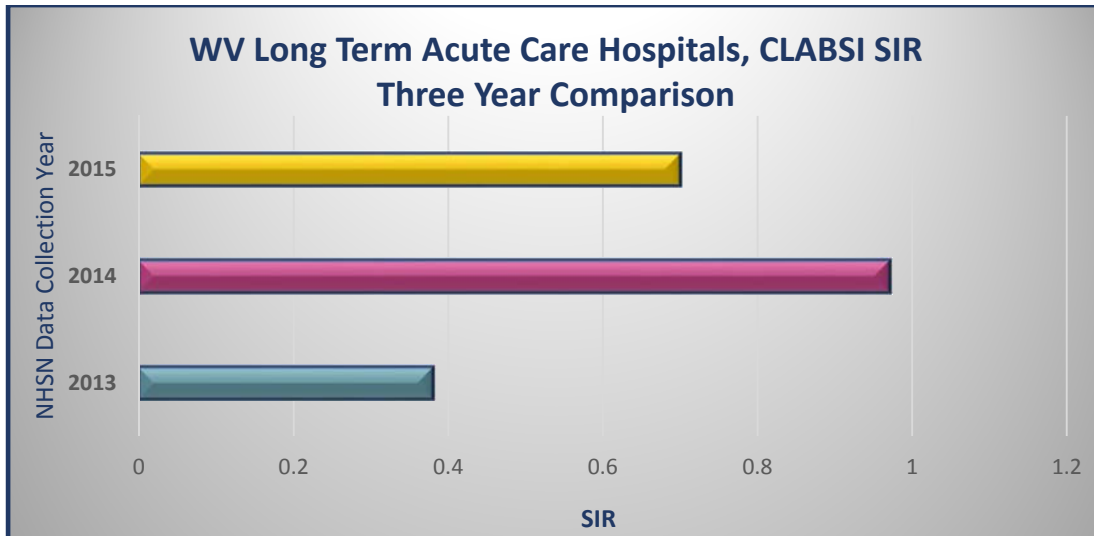
Infection Ratio (SIR) was 0.46, indicating that 54% fewer CLABSI events occurred than the NHSN baseline expected.

- Of 29 General Acute Care Hospitals, 10 (34%) had zero CLABSIs.
- Of those facilities that had a sufficient number of central line days to calculate a reliable SIR, all West Virginia General Acute Care Hospitals met or exceeded national standards of CLABSI events by having as many or fewer events than expected.
- Although fewer CLABSIs occurred than were expected in 2015, CLABSIs were higher in 2015 than in the previous 4 years.



Key Findings for CLABSI: Long Term Acute Care Facilities

- In 2015, one new Long Term Acute Care Health System, that includes 2 hospitals in WV, began reporting.
- In 2015, 13 CLABSIs were reported for Long Term Acute Care Facilities in West Virginia.
- Significantly fewer CLABSIs occurred in Long Term Acute Care Hospitals than were expected based on national baselines set by NHSN. The West Virginia SIR was 0.70, indicating that 30% fewer CLABSI events occurred than the NHSN baseline expected.
- Two West Virginia Long Term Acute Care facilities met CLABSI event national standards by having as many or fewer events than expected; one facility exceeded expectations, while one system had 38% more events than expected. Statewide, the number of infections were similar to the number predicted.



II. Catheter Associated Urinary Tract Infection (CAUTI)

Urinary tract infections are infections of any part of the urinary system, which includes the bladder and the kidneys. Catheter associated urinary tract infections (CAUTI) arise in those hospitalized patients who have had a urinary catheter placed, which is a tube that is inserted into the bladder to drain urine into a connected bag. In the same way that central lines can introduce microorganisms, urinary catheters provide an access point for these infections to spread into the body, in this case the urinary tract.

Per the CDC, CAUTIs are the most common type of healthcare-associated infection. They account for more than 30% of acute care hospital infections, with medical costs of more than \$758 per CAUTI and an aggregate cost of greater than \$340 million in the U.S. each year.⁶

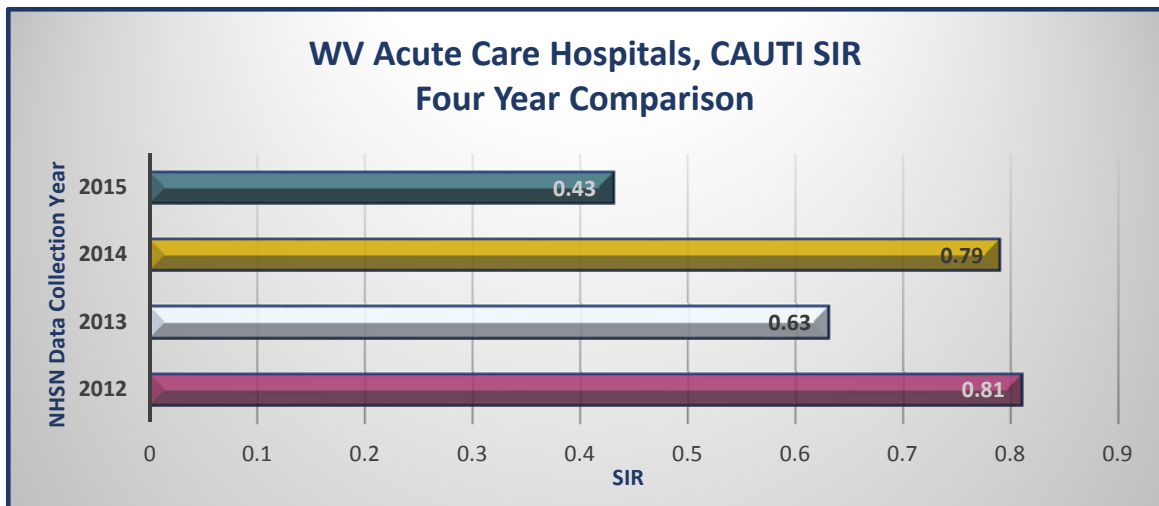
CAUTIs can often be prevented using evidence-based guidelines for insertion, use, and maintenance, just as with all other HAIs, and the costs associated with a CAUTI avoided. Because the incidence and cost of avoidable CAUTIs is substantial, all General Acute Care Hospitals, Critical Access Hospitals, Long Term Acute Care Hospitals and Rehabilitation Hospitals have been required to report CAUTI.

Key Findings for CAUTI: General Acute Care Facilities

- In 2015, there were 156 CAUTIs reported for all West Virginia General Acute Care Hospitals, down from 162 in 2014.
- Significantly fewer CAUTIs occurred in West Virginia General Acute Care Hospitals than were expected based on the national baseline set by NHSN. The West Virginia SIR was 0.43, indicating that 57% fewer CAUTIs occurred than were expected.

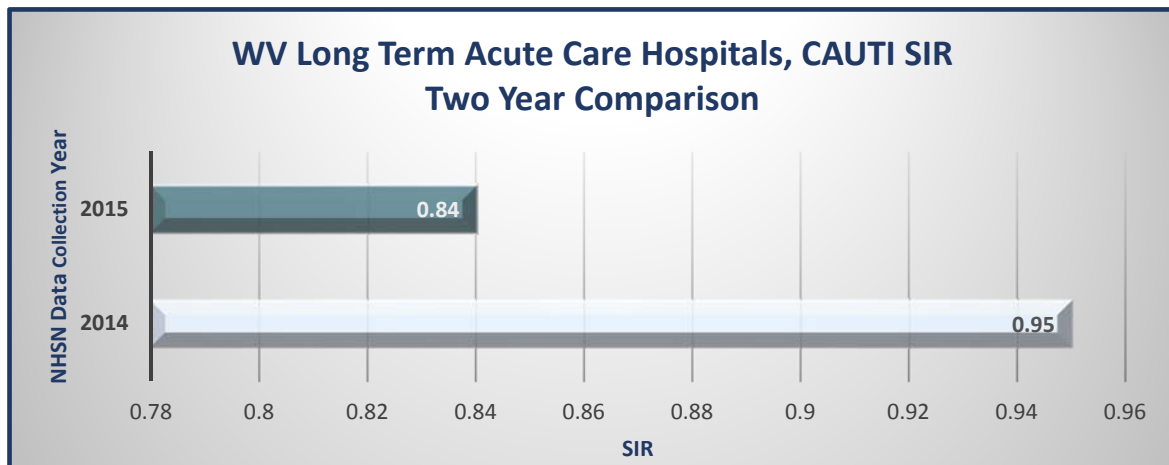
⁶ Centers for Disease Control and Prevention, National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure, available at: <http://www.hospitalsafetyscore.org/media/file/CAUTI.pdf>.

- Of those facilities that had a sufficient number of urinary catheter days to calculate a reliable SIR, national standards were met or exceeded.
- Of 29 General Acute Care Hospitals, 9 (31%) had zero CAUTIs.
- In 2015, General Acute Care Hospitals improved the rate of catheter infections substantially over the previous three years.



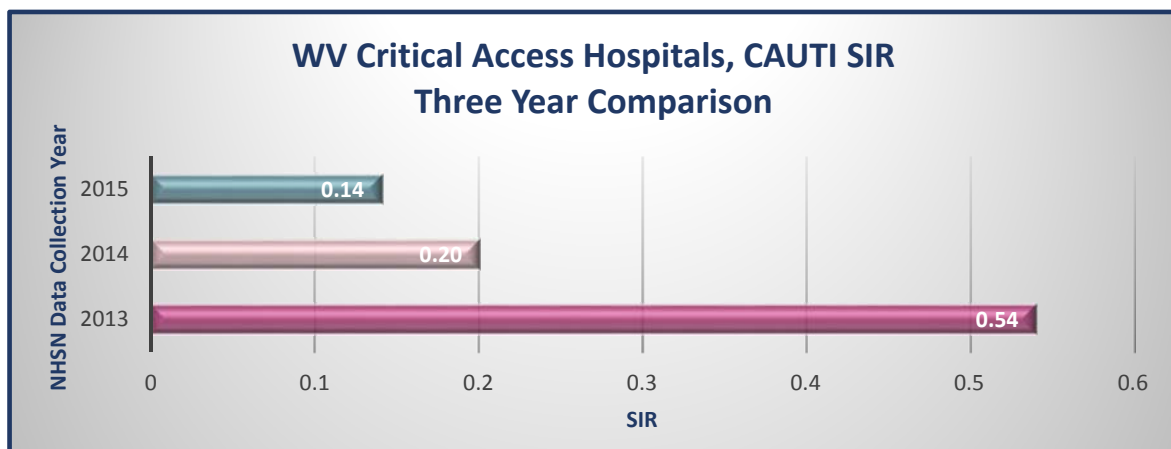
Key Findings for CAUTI: Long Term Acute Care Hospitals

- In 2015, 26 CAUTIs were reported for Long Term Acute Care Facilities in West Virginia.
- The 2015 CAUTI SIR for West Virginia Long Term Acute Care Facilities was not significantly different than the national rate, with 16% fewer CAUTIs than expected.
- One facility exceeded expectations, while all other West Virginia Long Term Acute Care Facilities met national standards for CAUTI events by having a similar number of events compared to what was expected.



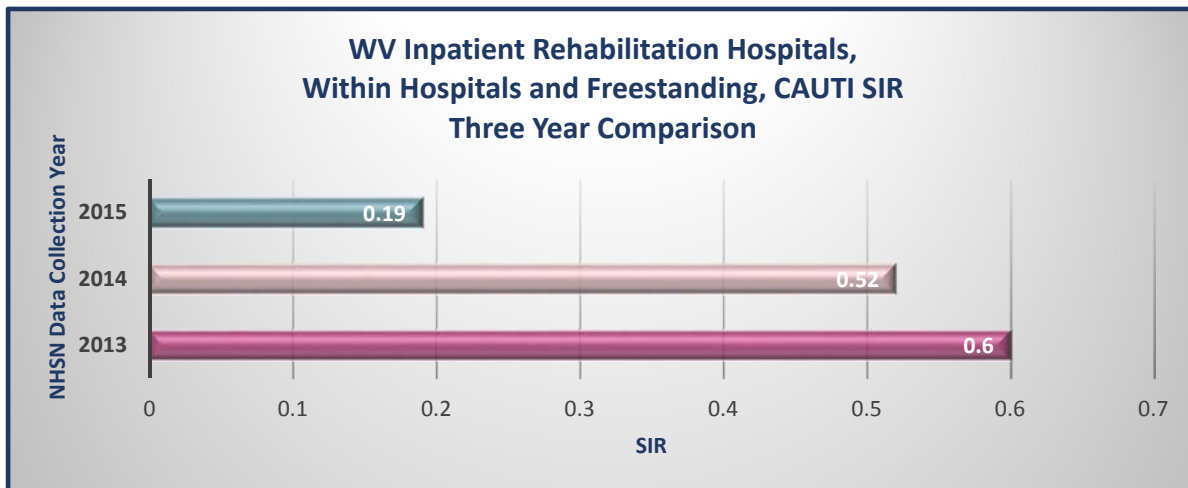
Key Findings for CAUTI: Critical Access Hospitals

- In 2015, there were 2 CAUTIs reported for all West Virginia Critical Access Hospitals.
- The number of CAUTIs that occurred in West Virginia Critical Access Hospitals in 2015 were significantly less than expected based on the national baseline.
- Overall, the West Virginia SIR was 0.14, indicating that 86% fewer CAUTIs occurred than the NHSN baseline expected.
- Of those facilities that had a sufficient number of catheter days to calculate a reliable SIR, all West Virginia Critical Access Hospitals met national standards by having the number of events similar to those expected.
- Of 20 Critical Access Hospitals, 19 (95%) had zero CAUTIs.



Key Findings for CAUTI: Inpatient Rehabilitation Hospitals, Freestanding and Units within a Hospital

- In 2015, a total of 2 CAUTIs were reported for Freestanding Inpatient Rehabilitation Hospitals and Rehabilitation Units within Hospitals in West Virginia, down from 7 in 2014.
- The number of CAUTIs that occurred in West Virginia facilities overall in 2015 were significantly less than expected based on the national baseline.
- Of those facilities that had a sufficient number of catheter days to calculate a reliable SIR, all West Virginia Freestanding and Hospital Inpatient Rehabilitation facilities met national standards by having as many or fewer events than expected.
- Overall, the West Virginia SIR was 0.19, indicating that 81% fewer CAUTIs occurred than the NHSN baseline expected.
- Of the 8 Inpatient Rehabilitation Hospitals and Units in West Virginia, 6 (75%) had zero CAUTIs.



III. Surgical Site Infections (SSI)

Surgical site infections (SSI) are infections that occur at the site where a surgical procedure was performed and may be superficial or involve tissue, organs or implanted material.⁷ In 2010, the CDC estimated 16 million operative procedures were performed in acute care hospitals in the United States.

The CDC HAI prevalence survey found that there were an estimated 157,500 surgical site infections associated with inpatient surgeries in 2011. NHSN data included 16,147 SSIs following 849,659 operative procedures in all groups reported, for an overall SSI rate of 1.9% from 2006-2008. Efforts to improve the rates of SSI have proven successful; SSI related to 10 select procedures have decreased 19% between 2008 and 2013.⁸

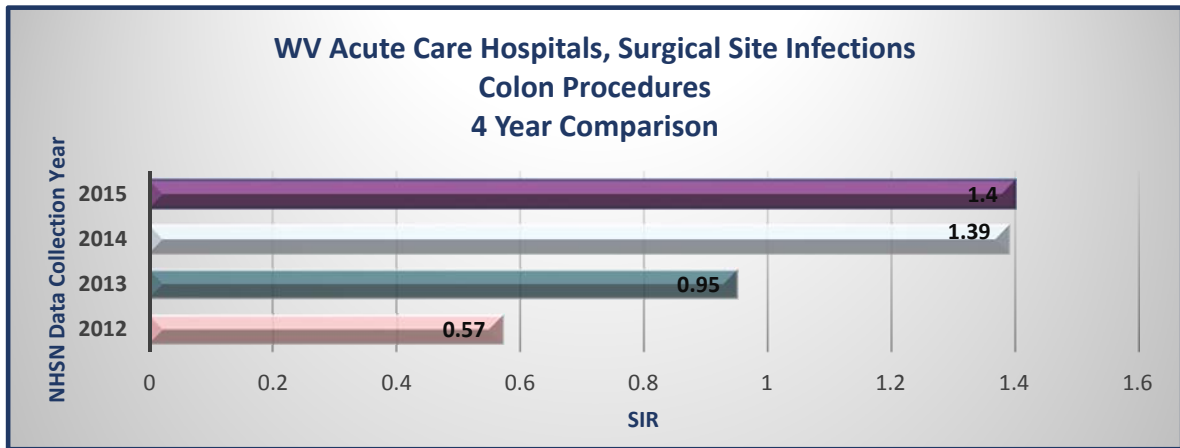
Key Findings for SSI: General Acute Care Hospitals for Colon Procedures

- In 2015, there were 90 SSIs for colon procedures reported for all West Virginia General Acute Care Hospitals, up from 87 in 2014.
- A higher number of SSIs for colon procedures occurred in West Virginia General Acute Care Hospitals in 2015 than were expected based on the national baseline.
- The West Virginia SIR was 1.40, indicating that 40% more SSIs for colon procedures occurred than were expected.
- Of the 29 General Acute Care Hospitals, 11 (38%) had zero SSIs for colon procedures.

⁷ US Department of Health and Human Services, Centers for Disease Control and Prevention, *Surgical Site Infections*, available at: <http://www.cdc.gov/HAI/ssi/ssi.html>.

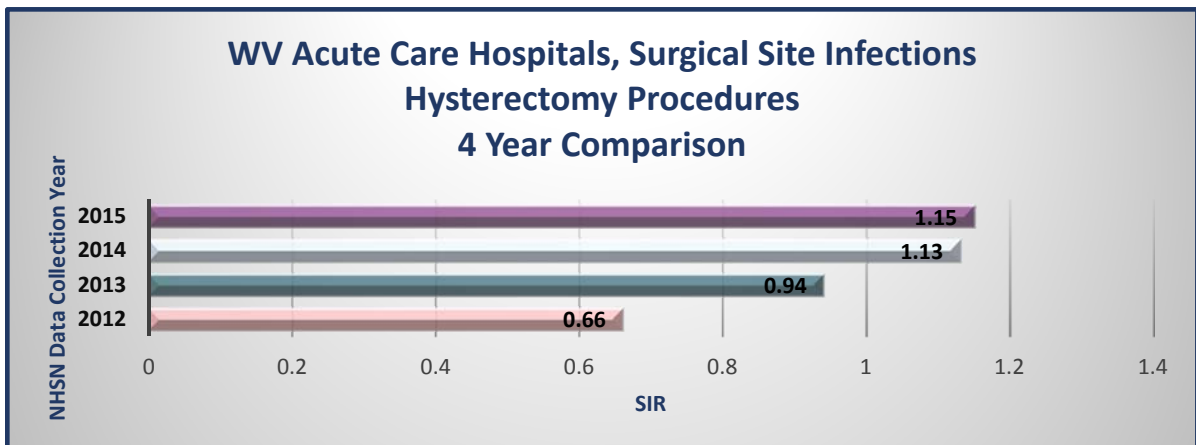
⁸ US Department of Health and Human Services, Centers for Disease Control and Prevention, *Surgical Site Infection (SSI) Event*, January 2016, available at: <http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSICurrent.pdf>.

- SSIs when colon procedures are performed have steadily increased over the past 4 years.



Key Findings for SSI: General Acute Care Hospitals for Abdominal Hysterectomy Procedures

- In 2015, there were 23 SSIs for abdominal hysterectomy procedures reported for all West Virginia General Acute Care Hospitals, up from 22 in 2014.
- A similar number of SSIs for abdominal hysterectomy procedures occurred in West Virginia General Acute Care Hospitals in 2015 as expected based on the national baseline.
- The West Virginia SIR was 1.15, indicating that 15% more SSIs for abdominal hysterectomy procedures occurred than the NHSN baseline expected.
- Of those facilities that had a sufficient number of abdominal hysterectomy procedures to calculate a reliable SIR, all West Virginia General Acute Care Hospitals met national standards.
- Of the 29 General Acute Care Hospitals, 18 (62%) had zero SSIs for abdominal hysterectomy procedures.
- SSIs when hysterectomy procedures are performed have steadily increased over the past 4 years.



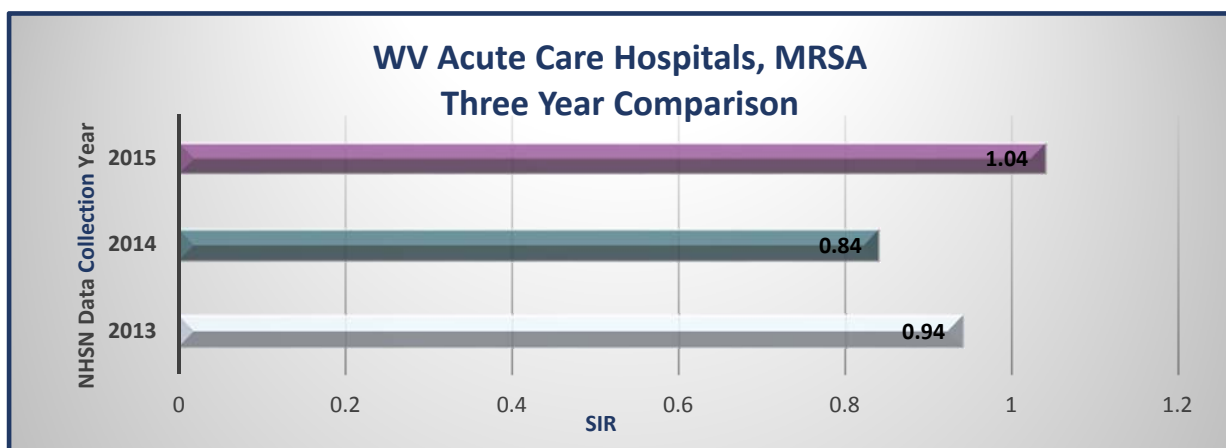
IV. Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia

While *Staphylococcus aureus* is a common bacteria found both in the environment and on humans, it normally does not adversely affect them. MRSA, however, is a variant of the bacteria that is resistant to antibiotics. MRSA is spread via direct contact and can cause serious complications, including wound infections or blood stream infections (bacteremia), which makes hospitals and other healthcare facilities at a high risk of spreading the infection to patients and healthcare workers.⁹

Each year in the United States, at least 2 million people become infected with bacteria that are resistant to antibiotics. It is estimated that at least 23,000 people die each year as a direct result of these infections, while many more die from other conditions complicated by an antibiotic-resistant infection.¹⁰

Key Findings for MRSA Bacteremia LabID Events: General Acute Care Hospitals

- In 2015, there were 84 MRSA Bacteremia LabID events reported for all West Virginia General Acute Care Hospitals, up from 74 in 2014.
- A similar number of MRSA Bacteremia LabID events occurred in West Virginia General Acute Care Hospitals in 2015 as expected based on the national baseline.
- The West Virginia SIR was 1.06 in 2015, indicating that there were 6% more MRSA Bacteremia LabID events occurring than the NHSN baseline expected. In 2014, the SIR was 0.84, indicating that 16% fewer events occurred than expected.
- Of those facilities that had a sufficient number of patient days to calculate a reliable SIR, all but three West Virginia General Acute Care Hospitals met or exceeded national standards; only one facility exceeded expectations.



⁹ US Department of Health and Human Services, Centers for Disease Control and Prevention, *Methicillin-Resistant Staphylococcus aureus (MRSA) Infections*, available at: <http://www.cdc.gov/mrsa/healthcare/index.html>.

¹⁰US Department of Health and Human Services, Centers for Disease Control and Prevention, *Antibiotic Resistance Threats in the United States, 2013*, available at: <http://www.cdc.gov/drugresistance/threat-report-2013>.

Because data collection of MRSA Bacteremia LabID Events began in the 2015 data collection year for Long Term Acute Care Hospitals and Inpatient Rehabilitation facilities, there is no baseline data for comparison purposes, including SIRs. However, data was collected for future national baseline development. Outcomes are available in the tables below for both long term acute care hospitals, freestanding rehabilitation hospitals and rehabilitation units within hospitals.

2015 Methicillin-Resistant Staphylococcus (MRSA) Bacteremia, Long Term Acute Care Hospitals

Facility Name	MRSA Blood Incident LabID Count	Patient Days	MRSA Blood Stream Infection LabID Rate Incidence (per 1,000 patient days)
Select Specialty Hospital, Charleston	1	11195	0.089
*Acuity Specialty Hospital	1	21588	0.046
Cornerstone Hospital of Huntington	1	8372	0.119
WV Totals	3	41155	0.0728

* Acuity Specialty Hospital includes 2 Ohio facilities in 2015

2015 Methicillin-Resistant Staphylococcus (MRSA) Bacteremia, Rehabilitation Facilities, within Hospitals and Freestanding

Facility Name	MRSA Blood Incident LabID Count	Patient Days	MRSA_IRF Blood Incidence LabID Rate (per 1,000 patient days)
HealthSouth Western Hills Regional Rehabilitation Hospital	0	13149	0
HealthSouth Rehabilitation Hospital of Huntington	0	16624	0
HealthSouth Southern Hills Rehabilitation Hospital	0	10869	0
HealthSouth Mountain View Regional Rehabilitation Hospital	0	25524	0
Peterson Rehabilitation Hospital	0	17	0
Weirton Medical Center	0	1580	0
Charleston Area Medical Center	1	5788	0.173
Logan Regional Medical Center	0	1133	0
WV Totals	1	74684	0.134

V. Clostridium difficile Infection (CDI)

Clostridium difficile is a bacteria that can cause diarrhea and large intestine inflammation, usually in those patients with a recent history of antibiotic use. *Clostridium difficile* is spread through direct contact with contaminated surfaces and can live outside the body in a hardy spore form for a long time.¹⁸ Therefore, environmental control in healthcare settings is one of the most critical forms of prevention, along with proper hygiene and adherence to evidence-based practices.¹¹

¹¹ US Department of Health and Human Services, Centers for Disease Control and Prevention, *Healthcare-Associated Infections: Frequently Asked Questions about Clostridium difficile for Healthcare Providers*, available at: http://www.cdc.gov/HAI/organisms/cdiff/Cdiff_faqs_HCP.html.

In a study conducted in 2011, *Clostridium difficile* infection (CDI) is estimated to have caused almost half a million infections in the United States. Of those, an estimated 83,000 of the patients with such infections had at least one recurrence, and approximately 29,000 died within 30 days after the initial diagnosis.

Because continued surveillance for CDI is needed to monitor progress toward prevention, CMS and the WVHCA requires hospitals to report CDI to NHSN. As a result, the WVHCA can track whether or not a facility has higher or lower rates of infection than expected based on a national baseline set by NHSN.

Improvements in CDI at acute care facilities have been made since data collection first began in 2013, but increased slightly since 2014. After reviewing the 2014 data outcomes for CDI among WV hospitals, the HAI Advisory Panel developed the premise that rates of CDI may be lower or higher based upon the testing and laboratory procedures being utilized for diagnosing the infection, since various testing modalities provide differing specificities and sensitivities to *C. diff*.

The Panel requested the WVHCA send a short survey to WV hospitals to obtain data on the lab testing utilized to identify a CDI, symptoms exhibited by the patient that trigger testing, treatment modalities hospitals were providing after CDI confirmation and other treatments provided for those who are infected.

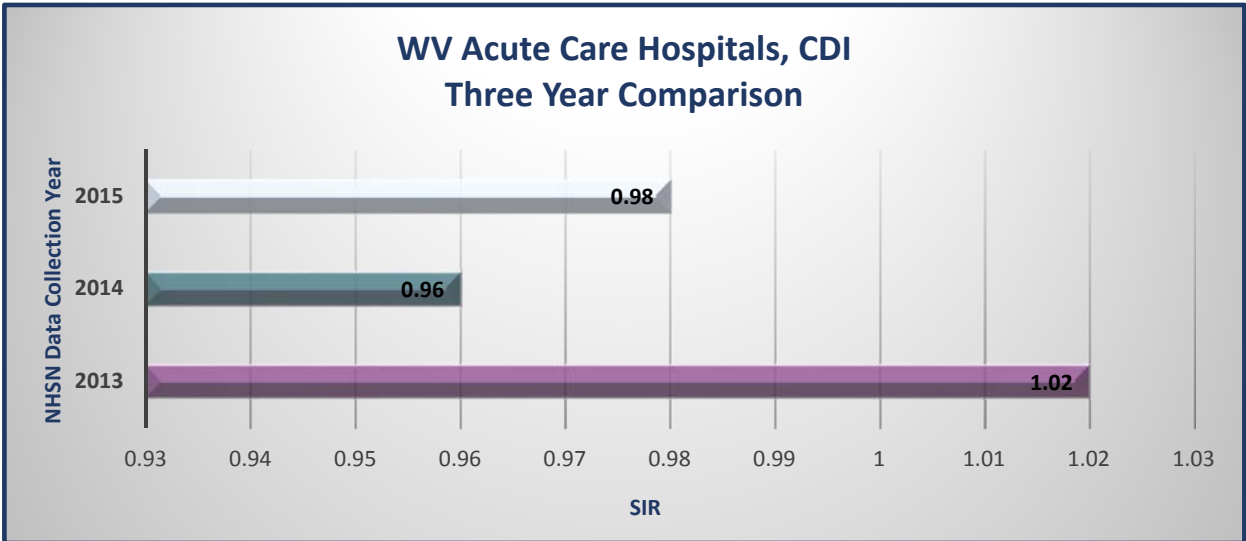
The ultimate goal for performing the survey and quality improvement project was not only to assist hospitals in understanding the testing procedures and the treatments provided by other hospitals across the state, but to also provide information that could lead to improvements in testing and treatment for those hospitals that may be struggling to improve their rates of CDI. At the conclusion of the project at least one hospital, anecdotally, found that lab tests were not appropriately documented in NHSN.

The entire report, “West Virginia Healthcare-Associated Infections *C. difficile* Lab Testing: A Survey of WV Hospital Testing and Treatment Practices,” can be found in the 2017 WVHCA HAI Annual Report at: <http://www.hca.wv.gov/infectioncontrolpanel/annualrp/Pages/default.aspx>.

Key Findings for CDI LabID Events: General Acute Care Hospitals

- In 2015, there were 807 CDI LabID events reported for all West Virginia General Acute Care Hospitals, down 3 from 2014.
- A similar number of CDI LabID events occurred in West Virginia General Acute Care Hospitals in 2015 as expected based on the national baseline.
- The West Virginia SIR was 0.98, indicating that 2% fewer CDI LabID events occurred than the NHSN baseline expected.
- Of those facilities that had a sufficient number of patient days to calculate a reliable SIR, all but 6 West Virginia General Acute Care Hospitals met or exceeded national standards.

- In 2015, 6 facilities had a higher number of infections than expected, up from 2 facilities in 2014.
- Of the 29 General Acute Care Hospitals, 2 (6.9%) had zero CDI LabID Events.



Because data collection of CDI LabID Events began in the 2015 data collection year for Long Term Acute Care Hospitals and Inpatient Rehabilitation facilities, there is no baseline data for comparison purposes, including SIRs. However, data was collected for future national baseline development.

Key Findings for CDI LabID Events: Long Term Acute Care Hospitals

- There were 62 CDI events in 2015.
- The incidence of CDI was 15.064/10,000 patient days.

2015 CDI, WV Long Term Acute Care Hospitals

Facility Name	CDIF Facility Incident Healthcare Facility-Onset LabID Event Count	Patient Days	Facility CDIF Healthcare Facility-Onset Incidence Rate (per 10,000 patient days)
Select Speciality Hospital, Charleston	26	11195	23.225
Acuity Specialty Hospital	26	21588	12.044
Cornerstone Hospital of Huntington	10	8372	11.945
WV Totals	62	41155	15.064

*Acuity Specialty Hospital includes 2 Ohio facilities in 2015

Key Findings for CDI LabID Events: Inpatient Rehabilitation Facilities, within Hospitals and Freestanding

- There were 33 CDI events in 2015.
- The incidence of CDI was 4.42/10,000 patient days.
- There were 2 facilities that had zero events.

2015 CDI, WV Rehabilitation Facilities, within Hospitals and Freestanding

Facility Name	CDIF Facility Incident Healthcare Facility-Onset LabID Event Count	Patient Days	Facility CDIF Healthcare Facility-Onset Incidence Rate (per 10,000 patient days)
HealthSouth Western Hills Regional Rehabilitation Hospital	1	13149	0.761
HealthSouth Rehabilitation Hospital of Huntington	11	16624	6.617
HealthSouth Southern Hills Rehabilitation Hospital	3	10869	2.76
HealthSouth Mountain View Regional Rehabilitation Hospital	16	25524	6.269
Peterson Rehabilitation Hospital	0	26	0
Weirton Medical Center	1	1580	6.329
Charleston Area Medical Center	1	5788	1.728
Logan Regional Medical Center	0	1133	0
WV Totals	33	74693	4.42

VI. Healthcare Personnel Influenza Vaccinations

Influenza vaccinations are important for healthcare personnel as they not only safeguard the individual, they also help protect patients who are vulnerable from becoming infected. The CDC, the Advisory Committee on Immunization Practices (ACIP), and the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommends that all healthcare workers receive a seasonal influenza vaccination.¹²

Hospitals are required to report the number of personnel, including employees and non-employee workers, who received the vaccination during the influenza season (October to March). For the 2015-2016 influenza season, the percent of personnel vaccinated was split into two population categories, hospital employees (paid by the facility) and all healthcare workers (which includes employees, licensed independent practitioners, student volunteers, etc.). Individual facilities can now determine how many non-employee workers in the healthcare facility did not receive a vaccination, potentially putting patients at risk for contracting influenza while receiving

¹² US Department of Health and Human Services, Centers for Disease Control and Prevention, *Influenza Vaccination Information for Health Care Workers*. Website: <http://www.cdc.gov/flu/healthcareworkers.htm>. November 2014.

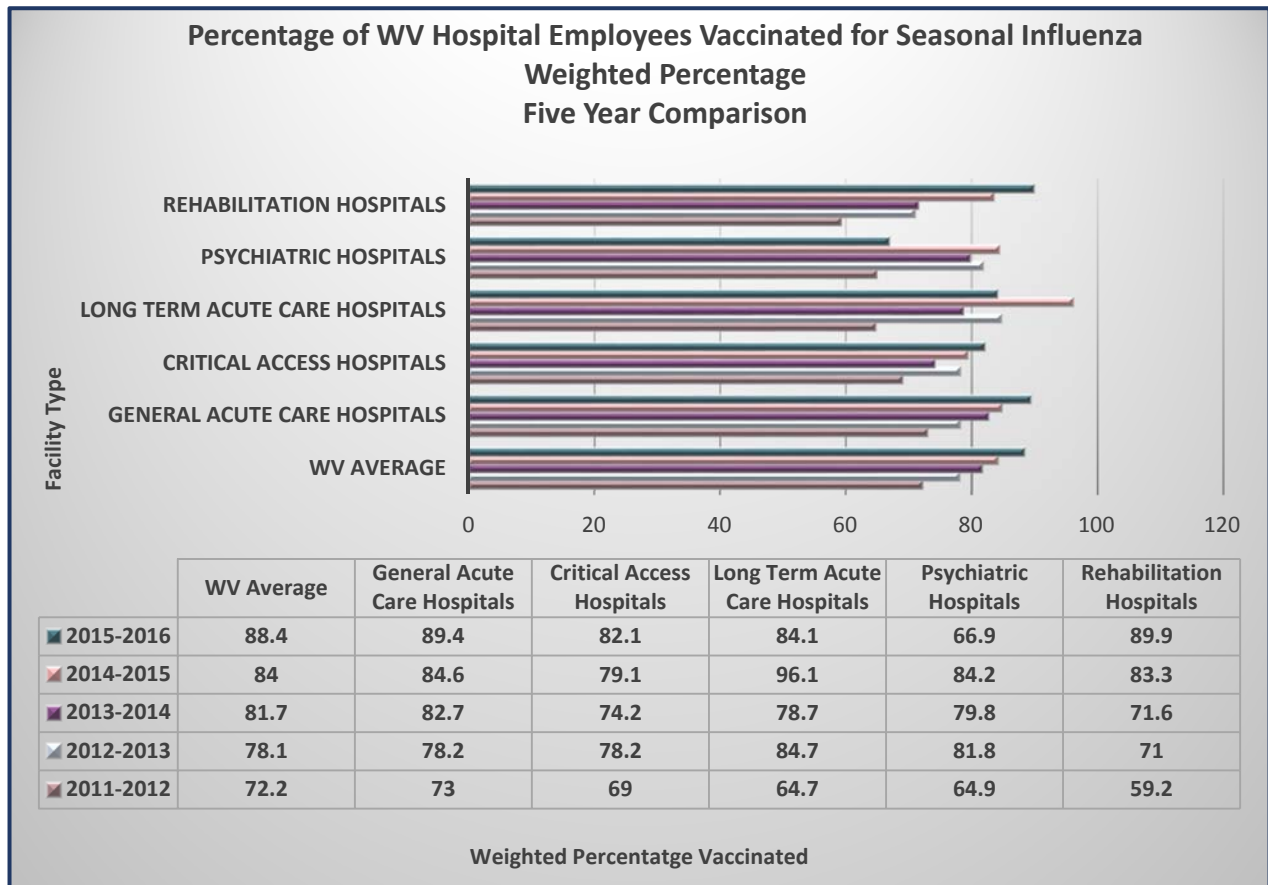
care. By separating employees from non-employees working in the facility, hospitals can easily review their progress in both areas from year to year.

Key Findings for Healthcare Personnel Influenza Vaccinations, by Hospital Type and Healthcare Personnel Population

- On average, 79.52% of all healthcare workers in all West Virginia inpatient facilities received a seasonal influenza vaccination during the 2015-2016 influenza season, up from 78.4% from last year.
- The percentage of healthcare employees in West Virginia that received a seasonal influenza vaccination ranged from a low of 27% for a newly reporting facility to a high of 100% by several facilities, with an average of 82.06% of hospital employees vaccinated.
- In the 2015-2016 season, 31 of 65 (47.7%) reporting facilities exceeded the goal of 90%.
- 27.7% of facilities require the influenza vaccination as a condition of employment.

Additional statistics can be found in the 2017 WVHCA HAI Annual Report.

When the total weighted average of employees vaccinated is delineated by facility type, most of the hospital types have had an ever increasing percentage of employees vaccinated from the beginning of data collection in the 2011-2012 influenza season.



*For more detailed information regarding healthcare-associated infections in West Virginia, see the Healthcare-Associated Infections Annual Report 2017, which is available online at: <http://www.hca.wv.gov/infectioncontrolpanel/annualrp/Pages/default.aspx>

*Additional information on hospital quality indicators can be reviewed in Table 22 on the Authority's website under the Data and Public Information link, Annual Reports section. The direct link is: <http://www.hca.wv.gov/data/Reports/Pages/default.aspx>.

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NURSING HOMES

The FY 2015 Annual Survey of Nursing Homes was submitted by each of the 108 long-term care facilities that provided services in the state, one more than the prior year, Arthur B. Hodges Center. The financial status of West Virginia’s nursing homes is presented according to the respective ownership status.

- Proprietary – 88 nursing homes
- Not-for-profit – 15 nursing homes
- Government – 5 nursing homes

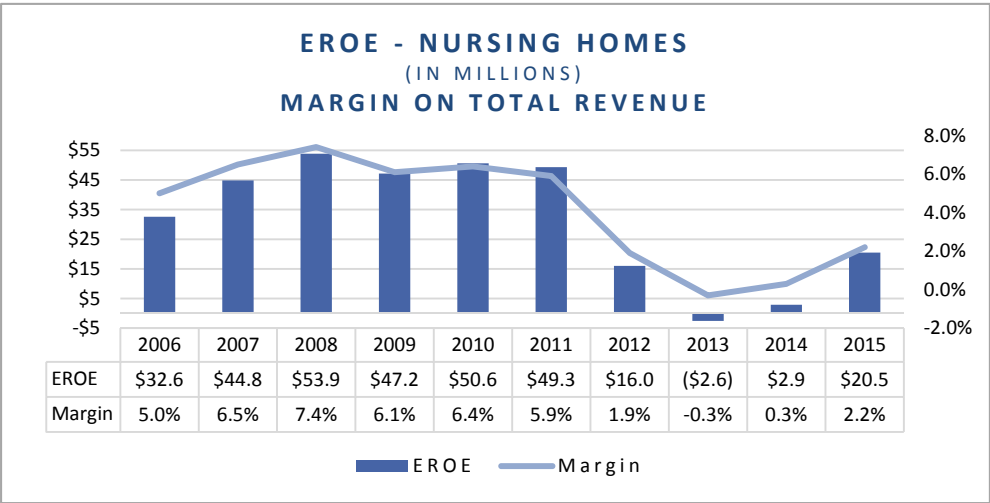
Four proprietary corporate entities owned or operated multiple nursing homes. The number owned or operated, in the state, by each corporate entity is provided in parentheses:

- Genesis HealthCare (34)
- American Medical Facilities Management (16)
- Stonerise Healthcare (15)
- Filmore Capital Partners (3)

West Virginia’s 108 nursing homes reported an aggregate profit in FY 2015. Profit (loss) as reported here is defined as excess (deficit) of revenue over expenses (EROE) after taxes and any extraordinary gains or losses.

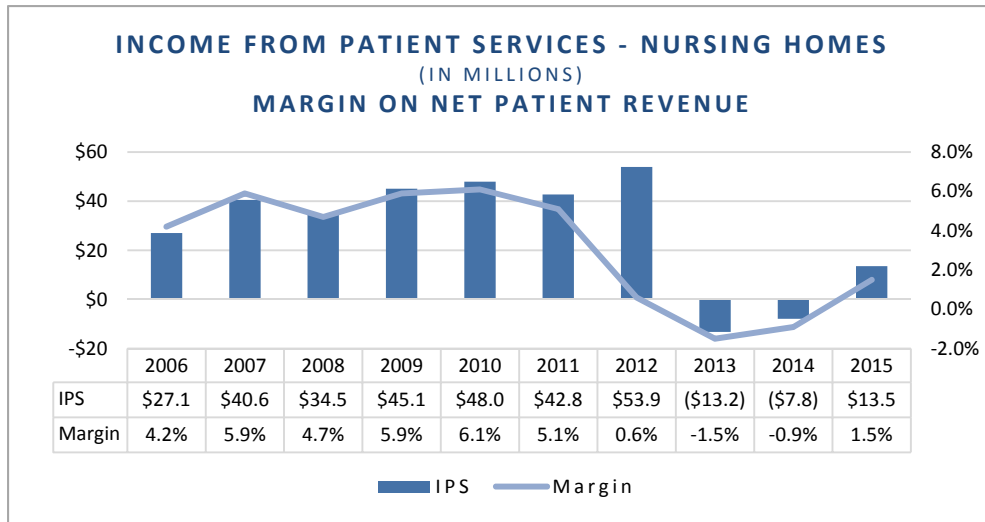
Financial Indicators

- Total profit for FY 2015 was \$20.5 million, 2.2% of net patient revenue (NPR), a \$17.6 million increase from the FY 2014 profit of \$2.9 million (0.3% of NPR).

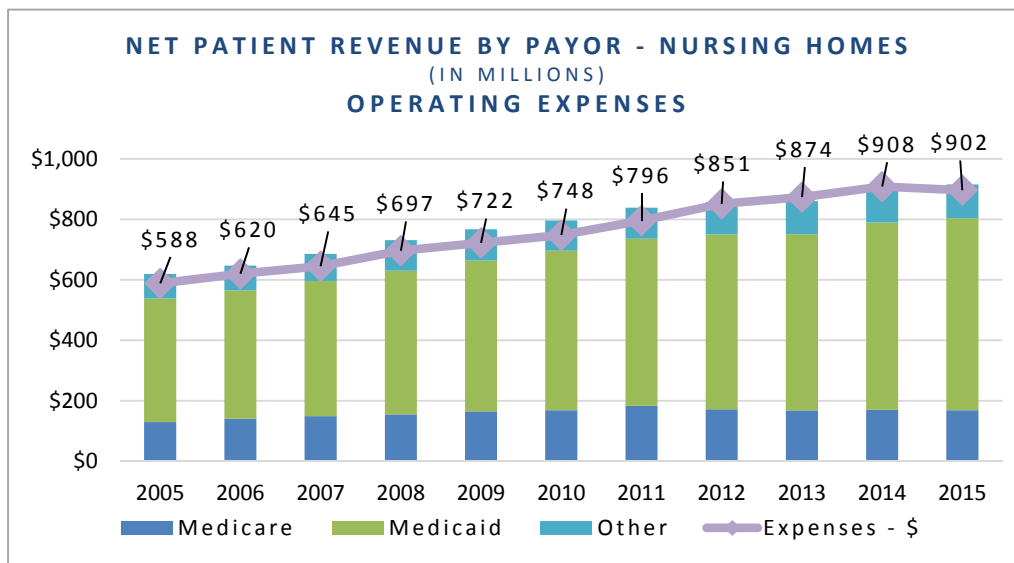


NOTE: FY 2008 included \$14.8 million in total for gains on sale of assets for two facilities.

- Net patient revenue of \$915.3 million, exceeded operating expenses of \$901.8 million in FY 2015 for a positive income from patient services of \$13.5 million (1.5% of NPR). Other revenue of \$6.8 million added to the net profit of \$20.5 million.



- In FY 2015 operating expenses decreased for the first time since FY 2005. The decrease of \$6.7 million (0.7%) in expenses combined with an increase in net patient revenue of \$14.7 million (1.6%) produced an increase of \$21.4 million in income from patient services.
- Medicare and Medicaid operating expenses decreased by \$7.0 million (4.8%) and \$640,000 (0.1%), respectively.



- Aggregate utilization of more than 3.2 million days was reported for FY 2015, a decrease of 4,300 days (0.1%) from FY 2014. Medicare and Medicaid days comprised 10.9% and 77.1% respectively, of total days for FY 2015.

- Medicare days decreased by 7,704 (2.1%) to 351,103 in FY 2015 and decreased by 1,314 (0.4%) in FY 2014. Since FY 2006 Medicare days have decreased by 14.9% and average length of stay has decreased from 60.5 days to 46.6 days.
- Medicaid days increased by 11,654 (0.5%) to 2.5 million. In FY 2014 Medicaid days increased by 30,837 (1.3%). Since FY 1999 the range for Medicaid days has been between 2.4 to 2.5 million.

Total residents served was estimated to be about 26,196. The calculation for residents served equals FY 2015 discharges plus year-end census. It is anticipated that the residents served count would include a certain number of readmissions. Estimated residents served in FY 2014 was 25,090.

Special Items of Note

- ◆ *The following changes in nursing home operations took place in FY 2015.*
 - *AMFM became the operator of Bridgeport Health Care Center.*
 - *Arbors of Fairmont was purchased by Oak Health and Rehabilitation Center, Inc. and affiliates and became a not-for-profit provider.*
 - *Princeton Center, LLC, a for-profit entity, became the operator of Glen Wood Park Retirement Village.*
 - *Stonerise Healthcare affiliate, Clarksburg Center, LLC, acquired the operations of Heartland of Clarksburg.*
 - *Stonerise Healthcare affiliates, Lewisburg Center LLC, Berkeley Springs Center LLC and Wellsburg Center LLC, became the operators of The Brier, Berkeley Springs Rehabilitation and Nursing, and Valley Haven Geriatric Center, respectively.*
 - *Stonerise Healthcare affiliates, Keyser Center LLC, Kingwood Center LLC, Martinsburg Center LLC and Rainelle Center LLC, became the operators of Heartland of Keyser, Heartland of Preston County, Heartland of Martinsburg, and Heartland of Rainelle, respectively. Manor Care, Inc. was the parent company of the Heartland facilities.*
 - ◆ *The following changes in nursing home bed counts took place in FY 2015.*
 - *Nella's Inc. decreased the number of ICF beds from 102 to 100.*
 - *American Medical Facilities Management Holding Company, Inc., reduced the number of beds at Mercer Nursing and Rehabilitation Center from 113 to 83.*
 - *Sundale Nursing Home decreased the number of beds from 115 to 100.*
 - ◆ *Edgewood Summit, Inc., a non-profit retirement community, expanded services to include a 20-bed skilled nursing unit, Arthur B. Hodges Center.*
 - ◆ *American Medical Facilities Management completed construction of a replacement facility for Mercer Nursing and Rehabilitation Center.*
-

Proprietary

There were 88 nursing homes in West Virginia that were proprietary entities. Glenwood Park, a not-for-profit facility, was acquired by Stonerise Healthcare and became for-profit.

Financial Indicators

- A total profit of \$22.6 million (3.0% of NPR) was reported for FY 2015, an increase of \$17.4 million over the prior year's profit of \$5.2 million (0.7% of NPR).
- Income from patient services increased by \$22.2 million. Two providers, Harper Mills and River Oaks, were responsible for \$16.1 million (72.5%) of the total increase in income from patient services. Both providers were purchased by Stonerise Healthcare in the last two years.
- Other revenue increased by \$947,000 (48.2%) to \$2.9 million. The median amount of other revenue for these providers was \$12,000.
- The median EROE was \$262,000. The median profit for the 56 providers with a positive return was \$682,000. For the 32 facilities that reported a negative EROE the median was a loss of \$595,000.
- Income from patient services, which equals net patient revenue minus operating expenses, was \$19.7 million.
- Net patient revenue decreased by \$4.7 million (0.6%) to \$760.2 million and operating expenses decreased by \$27.0 million (3.5%) to a total of \$740.5 million.
- Positive incomes from patient services were reported by 55 nursing homes ranging from \$2.4 million (Golden Living Center Morgantown) to \$40,800 (Willows Center). The median was \$668,000.
- Losses from patient services were reported by 33 nursing homes ranging from \$4.2 million (Bridgeport Health Care Center) to \$342.00 (River Oaks). The median loss was \$598,000.
- Golden Living Center Morgantown reported the largest profit of \$2.4 million (22.2% of NPR); Hampshire Health Care Center reported the second largest profit of \$2.2 million (31.6% of NPR). These facilities also reported the largest EROEs in the prior two years.
- Bridgeport Health Care Center (previously known as Emeritus at the Heritage) reported the largest loss of \$4.2 million. This is the third consecutive loss for this provider. American Medical Facilities Management began operations of the nursing home on November 1, 2015.

- Pocahontas Center reported the second largest loss of \$1.6 million. This provider has reported losses since FY 2005, with the exception of FY 2011 when the provider reported a profit of \$5.8 million due to other revenue gained from a reorganization of property, plant and equipment.

Utilization

- Eighty-five of the facilities provided Medicare and Medicaid services. Three facilities did not provide Medicare services: Bridgeport Health Care Center, Nella's and Nella's Nursing Home.
- The occupancy rate was 89.8% for proprietary facilities and reported 8,067 (81.4%) of the total 9,908 licensed beds. Proprietary staffed beds equaled 7,867 (81.5%).

Not-for-Profit

Fifteen of the 108 nursing homes were not-for-profit providers, one more than the prior year. FY 2015 was the first year for Arthur B. Hodges Center to report data. This provider is a 20 bed skilled nursing unit affiliated with Edgewood Summit. The not-for-profit category included two nursing homes that are affiliated with hospitals, two with church organizations, and eleven independent nursing homes.

Financial Indicators

- Aggregate profit was \$2.4 million (2.0% of NPR), a decrease from the prior year's profit of \$4.4 million (4.3% of NPR). The median EROE was \$347,000.
- Income from patient services decreased by \$2.1 million. Net patient revenue increased by \$17.8 million (17.5%) to \$119.9 million and operating expenses increased by \$19.9 million (20.1%) to a total of \$118.8 million.
- Ten facilities reported a profit ranging from Princeton Health Care Center's \$1.2 million (10.6% of NPR) to St. Barbara's Memorial Nursing Home's \$215,000 (4.7% of NPR) for a median profit of \$472,000. Eleven facilities reported profits in the prior year with a median EROE of \$610,000.
- Good Shepherd Nursing Home reported the largest loss of \$2.2 million (14.2% of NPR) which included a loss on other revenue of \$2.0 million. This loss included a \$3.0 million reduction in revenue due to unrestricted contributions to a related party.

Utilization

- Medicare and Medicaid services were provided by 12 of the 15 providers. Arthur B. Hodges Center did not provide Medicaid services; Main Street Care provided only Medicaid services; and Woodland's Retirement Community was private pay only.

- Facilities in this category reported 1,279 (12.9%) of the total 9,908 licensed beds; the occupancy rate was 92.5%. Staffed and set up beds equaled 1,273 (13.2%) of the total 9,647 beds set up and staffed.

Government

Five nursing homes were owned by government entities: Grant County Nursing Home was county owned; Hopemont Hospital, Jackie Withrow Hospital, John Manchin, Sr. Health Care Center and Lakin Hospital were state owned.

Financial Indicators

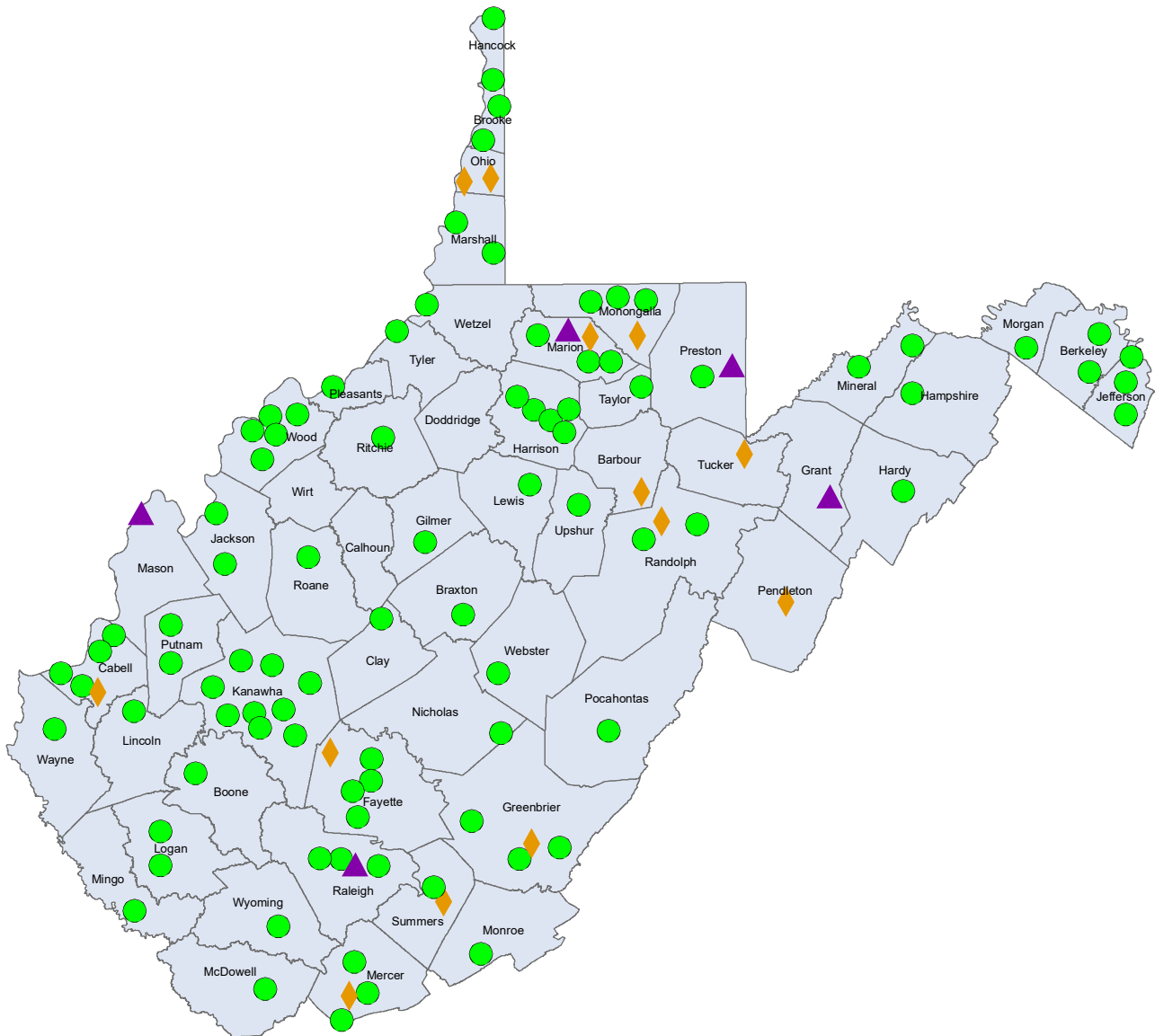
- Aggregate EROE was a loss of \$4.5 million (12.7% of NPR), a decrease of \$2.3 million from the \$6.7 million loss (20.0% of NPR) in FY 2014. The loss was \$4.7 million (13.7% of NPR) in FY 2013.
- Three state owned facilities reported losses: Hopemont (\$2.82 million, 46.0% of NPR) Jackie Withrow (\$2.78 million, 35.0% of NPR), and John Manchin Sr. Health Care (\$54,000, 2.9% of NPR). Jackie Withrow and Hopemont reported losses the last eleven years, with median losses of \$3.3 million and \$2.1 million, respectively. John Manchin Sr. Health Care reported losses five of the last eleven years with a median loss of \$209,000.
- The other state facility, Lakin reported a profit of \$1.0 million (11.0% of NPR). Lakin reported profits eight of the last eleven years with a median profit of \$466,000.
- Grant County Nursing Home, with an occupancy rate of 94.7% and 110 beds reported a profit of \$127,000 (1.3% of NPR), an increase of \$866,000 over the \$739,000 loss (8.8% of NPR) in FY 2014. This provider has reported profits four of the last eleven years for a median profit of \$285,100.

Utilization

- The four state providers reported 452 licensed beds (4.6% of total licensed beds) with an occupancy rate of 65.2%. Beds staffed and set up equaled 397 (4.1% of total staffed and set up beds).
- Medicaid utilization, measured by days of service, equaled 98.5% for the state-owned nursing homes. These providers did not offer Medicare services.

Detailed information on nursing homes can be reviewed in Tables 23-26 on the Authority's website under the Data and Public information link, Annual Reports section. The direct link is: <http://www.hca.wv.gov/data/Reports/Pages/default.aspx>

West Virginia Nursing Homes



- Proprietary (88)
- ▲ Government (5)
- ◆ Not-For-Profit (14)

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BEHAVIORAL HEALTH

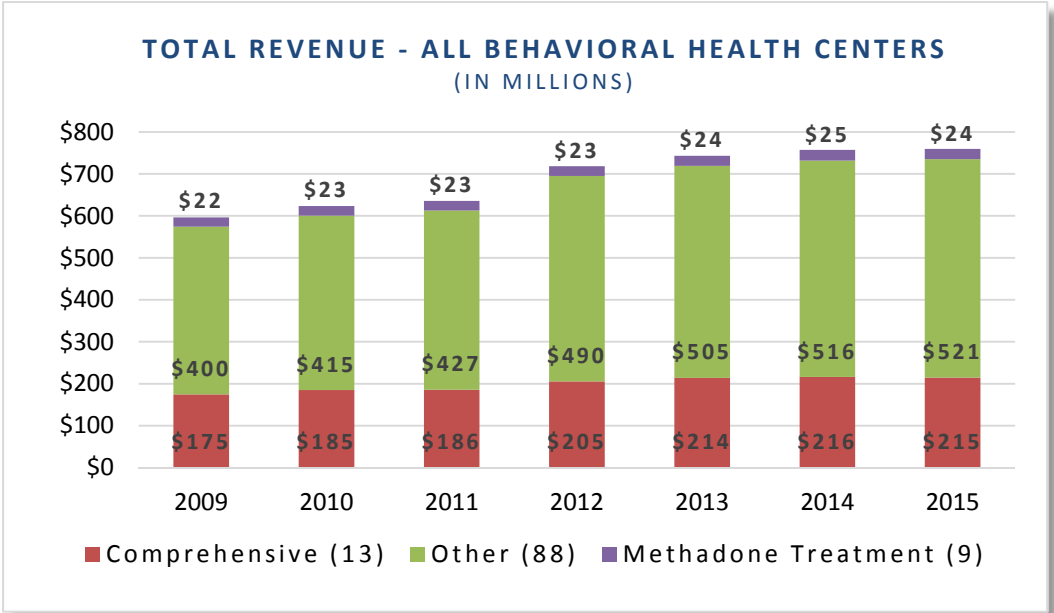
The FY 2015 operations for 110 behavioral health providers, three more than the previous report, are discussed below. The data for these providers are classified in three sections:

- Comprehensive Behavioral Health – 13 centers
- Other Behavioral Health – 88 centers
- Methadone Treatment – 9 centers.

In the aggregate, West Virginia’s behavioral health centers continued to be profitable in FY 2015. Profit (loss) is used here to mean excess (deficit) of revenue over expenses (EROE) or changes in unrestricted net assets and is presented before taxes. Data are compiled from financial statements submitted by the providers, which have various formats.

Financial Indicators

- Total profit for FY 2015 was \$46.4 million (6.1% of total revenue). Total EROE for FY 2014 was \$48.7 million (6.4% of total revenue).
- Total revenue was \$759.5 million, an increase of \$2.2 million (0.3%). Expenses were \$713.1 million, an increase of \$4.5 million (0.6%).
- For FY 2015 total revenue reported was as follows:
 - Comprehensive Centers - \$214.5 million (28.3%)
 - Other Centers - \$520.6 million (68.5%) and
 - Methadone Treatment Centers \$24.3 million (3.2%).



Special Items of Note

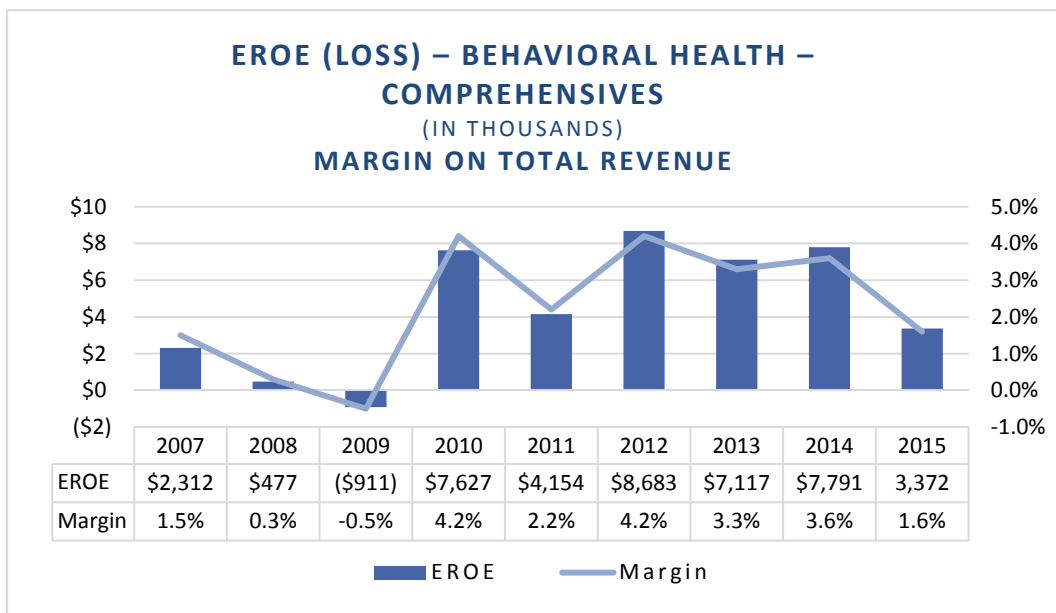
- ◆ Three new behavioral health agencies submitted financial data for FY 2015: Callahan Counseling Services, Lily's Place and Yale Academy. The data for these centers are reported in the category "Other Behavioral Health Providers".
- ◆ CRC Health Group, through subsidiaries, owned seven methadone treatment centers in West Virginia. After merging with Acadia Healthcare Company, Acadia now owns 100% of CRC ownership interests and became the immediate parent of CRC Health Group.

Comprehensive Behavioral Health Centers

Thirteen regional comprehensive behavioral health centers continued to operate in FY 2015. These providers offered a full array of services including crisis services, linkages with inpatient and residential treatment facilities, diagnostic and assessment services, support services and treatment services. Populations served include those with mental health challenges, substance abuse problems and developmental disabilities.

Financial Indicators

- Total profit for FY 2015 was \$3.4 million (1.6% of total revenue), a decrease of \$4.4 million from the prior year.



- The decrease in the FY 2015 profit is due to an increase in operating expenses of \$2.8 million (1.4%) and a decrease in total revenue of \$1.6 million (0.7%).

- Total revenue was \$214.5 million and total expenses were \$211.2 million.
- Labor costs equaled \$160.4 million and 75.9% of total expenses. These expenses consisted of salaries and wages, benefits, professional fees and contract expenses.

Selected Expenses by Type – Behavioral Health – Comprehensives
(In Thousands)

	2008	2009	2010	2011	2012	2013	2014	2015
Salaries/Wages, Benefits	\$91,509	\$107,659	\$109,701	\$115,885	\$127,683	\$132,180	\$132,023	\$138,886
Contract/Pro Fees	21,999	21,649	25,784	22,241	19,332	23,006	19,432	21,469
Utilities/Rents	4,239	5,133	5,488	6,056	6,145	6,896	7,544	7,705
Other	12,119	9,658	4,025	6,161	9,066	8,402	13,791	6,861

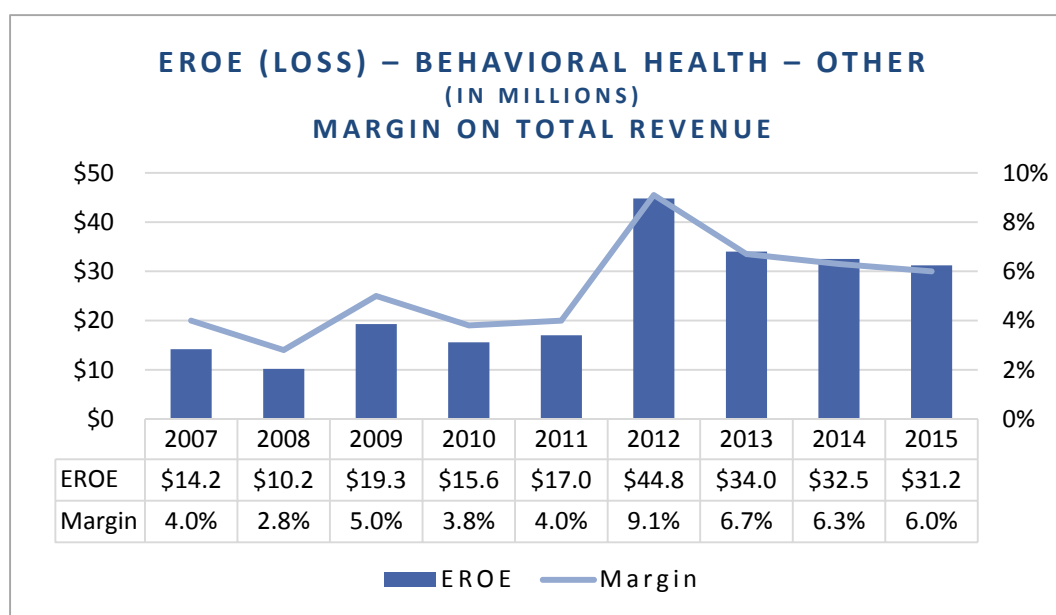
- Potomac Highlands Guild reported the largest increase in total revenue of \$460,000 (4.6%). Healthways reported the largest decrease in total revenue of \$862,000 (7.0%).
- United Summit Center reported the largest increase in expenses of \$1.3 million (5.2%) and Appalachian Community Health Center reported the largest decrease in expenses of \$831,000 (21.5%).
- Eight providers reported profits in FY 2015 ranging from \$1.5 million (Healthways) to \$3,000 (Prester Center), with a median EROE of \$402,000. In FY 2014 the median EROE for 10 profitable centers was \$887,000.
- Northwood had the largest increase in EROE of \$587,000, with a profit of \$364,000, up from a loss of \$223,000 in FY 2014. This provider reported profits in six of the last ten years.
- Five comprehensive centers experienced profits for nine of the last ten years. Three providers reported profits all ten years.
- Five comprehensive centers reported losses ranging from \$485,000 (Logan-Mingo Area Mental Health) to \$51,000 (Southern Highlands Community Mental Health Center). The median loss was \$300,400. In the prior year the median loss for three centers was \$344,000.
- Over the last ten years Logan-Mingo reported seven losses and Southern Highlands Community Mental Health Center reported six losses.

Other Behavioral Health Providers

Eighty-eight behavioral health providers offered specialized services during FY 2015. These services included but were not limited to residential treatment, case management, waiver, counseling or a combination of services.

Financial Indicators

- Total profit for FY 2015 was \$31.2 million (6.0% of total revenue). Total profit for FY 2014 was \$32.5 (6.3% of total revenue).



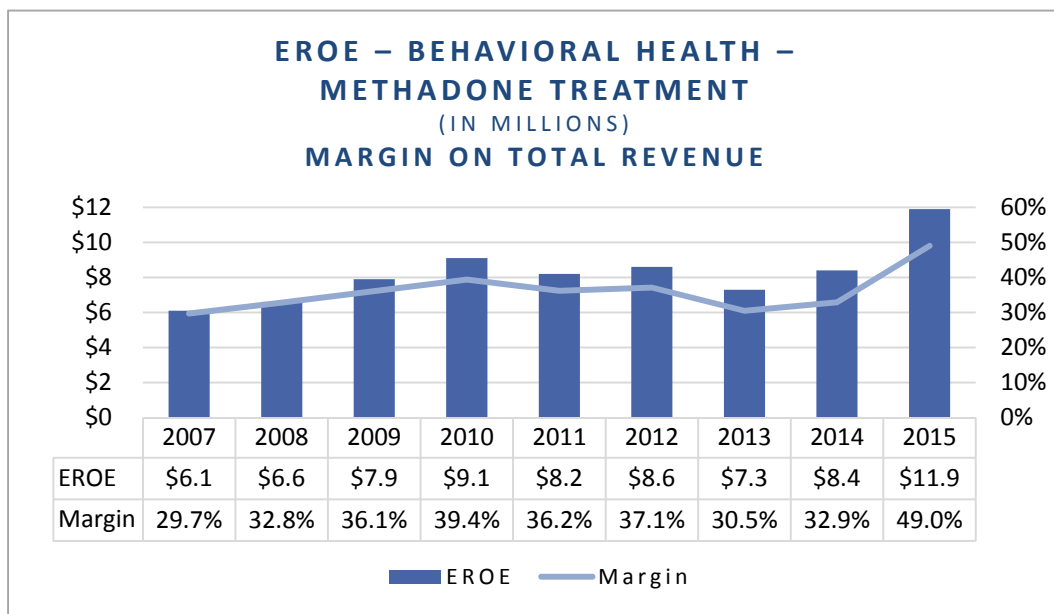
- Revenue increased by \$4.9 million (0.9%) to \$520.6 million and expenses increased by \$6.2 million (1.3%) to \$489.5 million.
- One provider was responsible for 74.6% of the \$4.9 million increase in revenue: Coordinating Council for Independent Living (\$3.6 million, 70.7%).
- Two providers accounted for \$5.4 million (86.8%) of the expense increase: Coordinating Council for Independent Living (\$3.2 million, 51.7%) and Diversified Assessment & Therapy Services (\$2.2 million, 35.0%).
- Profits were reported by 58 centers, ranging from \$12.0 million (VOCA Corporation of WV) to \$1,000 (Youth Advocate Programs). The median EROE for these centers was \$113,500.
- Thirty centers reported losses. The Board of Child Care reported the largest loss of \$2.9 million (77.9% of total revenue). This was the eleventh consecutive loss for this provider. The median loss for these centers was \$62,300.

Methadone Treatment Centers

In FY 2015 nine licensed methadone treatment centers operated in the state. All centers are for-profit. Seven of the treatment centers owned by CRC Health Group experienced a merger with Acadia Health Care which now owns 100% of CRC Health Group ownership interests. Acadia is the immediate parent of CRC.

Financial Indicators

- Total profit was \$11.9 million (49.0% of total revenue) an increase of \$3.6 million. Revenue decreased by \$1.1 million (4.2%) to \$24.3 million, and operating expenses decreased \$4.6 million (27.1%) to \$12.4 million.

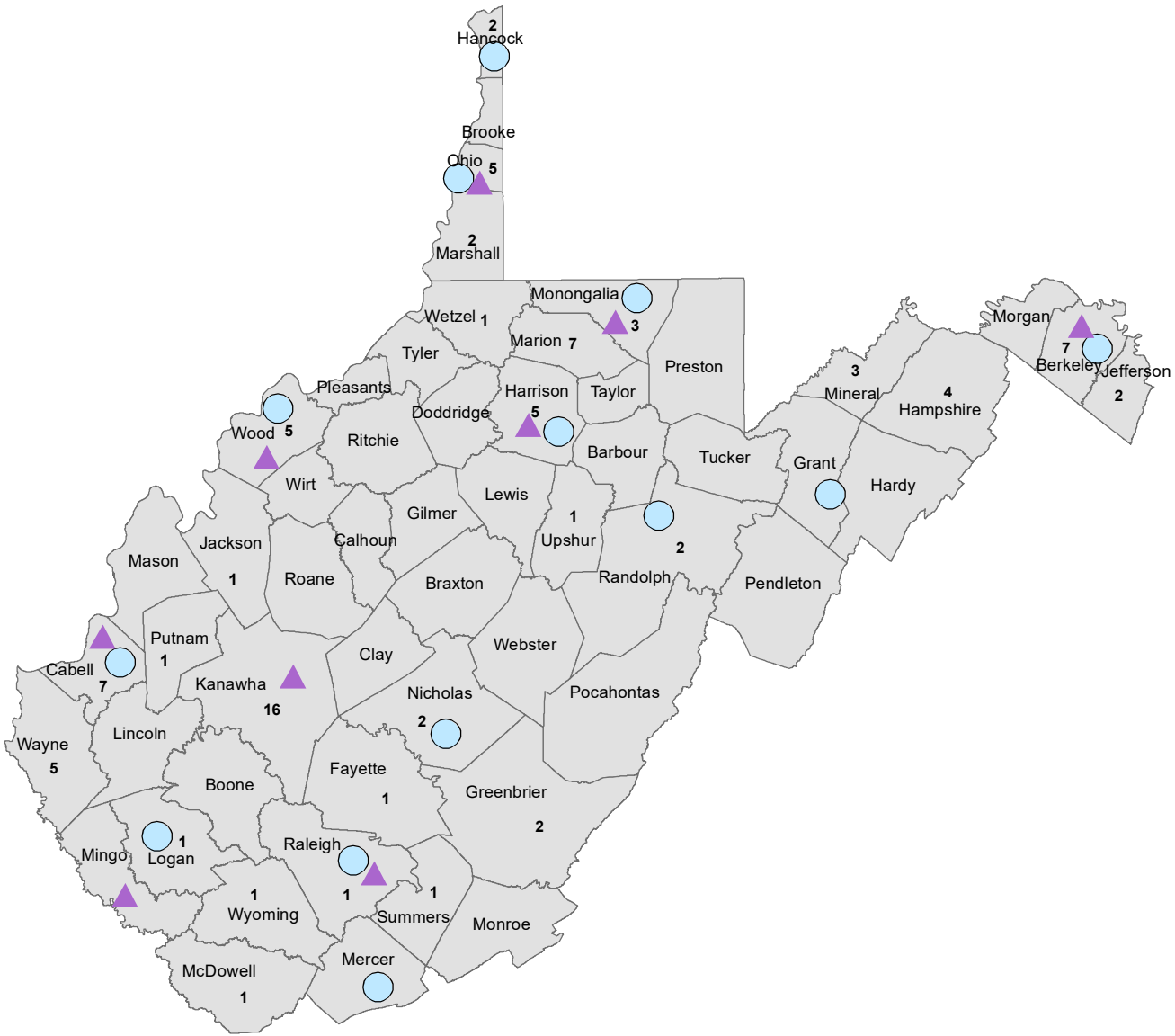


- All treatment centers reported a profit. Two providers reported profits of over \$2.0 million: Huntington (\$3.1 million), and Charleston (\$2.1 million) with margins of 61.0% and 52.4%, respectively. There was one provider that reported profits greater than \$2.0 million in FY 2014.
- Martinsburg Institute reported the smallest profit of \$265,000 (17.9% on total revenue).
- The median profit for FY 2015 was \$1.2 million. The median profits for the prior two years were \$732,000 in FY 2014 and \$647,000 in FY 2013.

Detailed information on behavioral health centers can be reviewed in Table 27 on the Authority's website under the Data and Public Information link, Annual Reports section. The direct link is: <http://www.hca.wv.gov/data/Reports/Pages/default.aspx>.

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West Virginia Behavioral Health Centers



- Comprehensive (13)
- ▲ Methadone (9)
- # Other (88)

Note: This map indicates main office locations only.

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PRIMARY CARE

Primary Care Centers in West Virginia are typically organized as not-for-profit entities for the purpose of providing primary care services to the residents of their respective service areas. Information was compiled from financial statements submitted by 32 centers that operated in 29 West Virginia counties during FY 2015.

The Primary Care Centers operate more than 200 service sites, including approximately 150 school-based health or wellness centers. The financial information provided here and in the Primary Care Center table is for the entire corporate entity.

Financial Indicators

- Total revenue for FY 2015 was \$304.3 million, with expenses of \$276.7 million producing an aggregate profit of \$27.7 million (9.1% on total revenue).

EROE – Primary Care Centers					
<i>(In thousands)</i>					
	2011	2012	2013	2014	2015
EROE	\$6,249	\$11,962	\$6,813	\$2,751	\$27,654
Margin	2.7%	4.7%	2.7%	1.0%	2.7%

- Median profit was \$352,000 in FY 2015 and \$26,000 in FY 2014.
- For FY 2015, twenty-eight centers reported profits ranging from \$8.3 million (Valley Health Systems) to \$17,000 (Women’s Health Center of West Virginia). For FY 2014, seventeen centers reported profits.
- Four centers reported increases in EROE greater than \$2.0 million over the prior year: Lincoln Primary Care (\$4.7 million), Valley Health Systems (\$3.9 million), Community Health Systems (\$2.5 million) and Shenandoah Valley Medical Health Systems (\$2.2 million). According to audit notes within three of the four financial statements, approximately \$9.8 million was received in cost report settlements.
- Four centers reported losses which ranged from \$1.8 million (Gilmer Primary Care Clinic) to \$255,000 (Valley Health Care). Fifteen centers reported losses in FY 2015.

Detailed information on primary care centers can be reviewed in Table 28 on the Authority’s website under the Data and Public Information link, Annual Reports section. The direct link is: <http://www.hca.wv.gov/data/Reports/Pages/default.aspx>.

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HOME HEALTH

The FY 2015 Annual Survey of Home Health Services was completed by 62 home health agencies that serve West Virginia residents, including those agencies based in Kentucky, Maryland, and Ohio. Sixty home health agencies reported in the prior year.

Home health agencies typically experience varied results depending on the type of ownership. Therefore, analysis of the agencies are presented using separate categories. For FY 2015 these categories are:

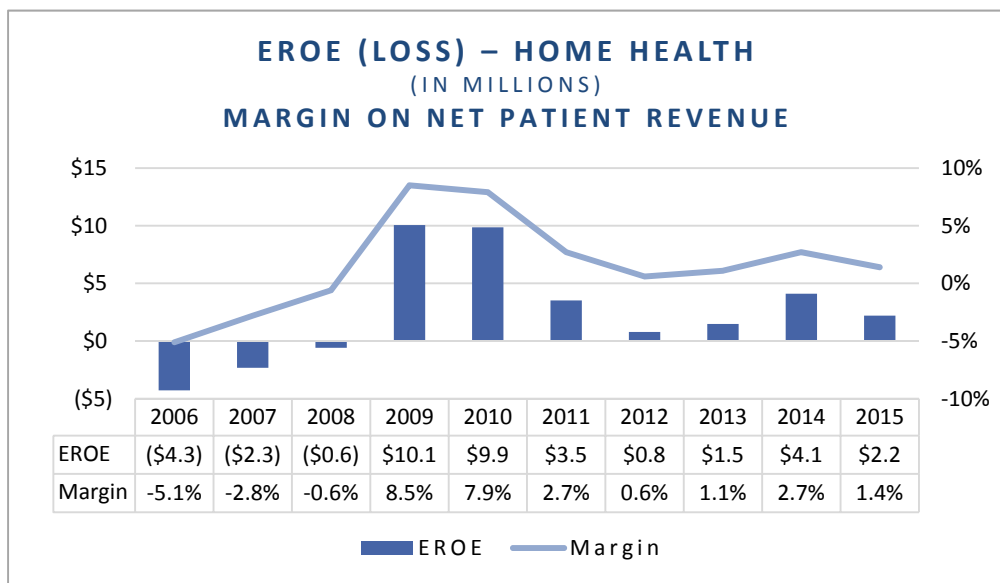
- Proprietary (37 agencies)
- Not-for-profit (9 agencies)
- Hospital-based (16 agencies)

Three publicly-traded companies operated multiple home health agencies in West Virginia. The number operated by each entity is in parentheses:

- LHC Group (13)
- Kindred Healthcare - dba Gentiva (6)
- Amedisys (4)

Financial Indicators

West Virginia's 62 home health agencies reported an aggregate profit in FY 2015 of \$2.2 million, a 1.4% margin on total revenue of \$156.1 million. Total operating expenses equaled \$153.9 million.



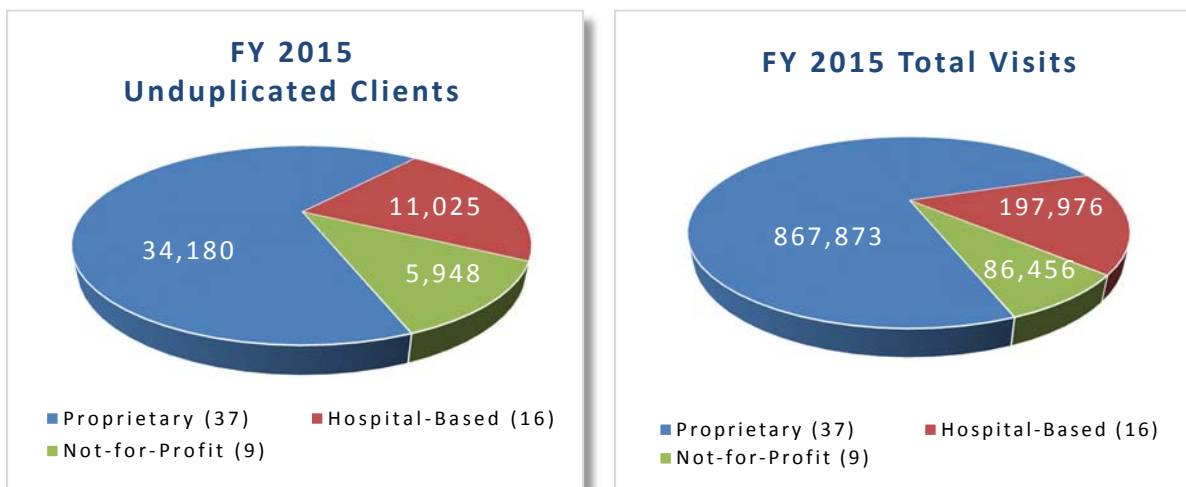
- Thirty-seven of the 62 agencies were profitable.
- FY 2015 is the seventh consecutive year home health agencies reported an aggregate profit. Prior to FY 2009, home health agencies experienced aggregate losses for FY 2004 through FY 2008.

Special Items of Note

- ◆ In FY 2015, two new agencies began providing services, Medi Home Health Agency and Holzer Home Care.
- ◆ An affiliate of Stonerise Healthcare acquired Covenant Home Health on March 1, 2015.
- ◆ Kindred Healthcare, a national company, acquired Gentiva Health Services, which operated six agencies. The capital expenditure for the West Virginia agencies was \$28.9 million.

Utilization

Client counts and numbers of visits are two utilization measures of home health services. For FY 2015, unduplicated clients of 51,100 were reported with total home health visits of 1.2 million. Proprietary home health agencies provided service to a significant share of the population of home health clients (66.8% of total unduplicated clients) during FY 2015. Utilization, as measured by the number of visits, was also indicative of the market share served by the proprietary agencies. This category provided 868,000 visits (75.3%) of 1.2 million total visits.



Overall, home health agencies averaged 22.5 visits per unduplicated client. The average number of visits by category was:

- Proprietary – 25.4
- Hospital-Based – 18.0
- Not-for-Profit – 14.5

Financial Indicators by Category

Proprietary

For FY 2015 there were thirty-seven agencies, one more than the prior year. Medi Home Health agency completed the home health survey for the first year.

- An aggregate profit of \$11.3 million (9.2% of total revenue) was reported for FY 2015, a decrease of \$2.6 million from the prior year.
- Total revenue was \$122.3 million, an increase of \$8.3 million (7.3%) and expenses were \$111.0 million, an increase of \$10.9 million (10.9%).
- Thirty agencies reported profits in FY 2015 ranging from \$2.3 million (Amedisys-Charleston) to \$12,000 (Carriage Inn). The median EROE was \$250,000 for the 30 agencies that reported profits. In FY 2014 the median EROE was \$257,000 for 32 profitable agencies.
- Losses were reported by seven agencies ranging from \$433,000 (Stonerise Home Health) to \$34,000 (Grant Memorial HomeCare) with a median loss of \$206,000. The median loss in FY 2014 was \$115,000 reported by four agencies.

Hospital-Based

Hospital-based agencies are reported in a separate category due to the allocation of administrative expenses, or hospital overhead. Typically, this results in higher cost to charge ratios than stand-alone agencies and hospital-based agencies have historically reported the greatest losses. Fifteen agencies were not-for-profit and one was proprietary.

- The aggregate EROE was a loss of \$9.8 million (45.0% of total revenue) for FY 2015. The prior year aggregate loss was \$10.1 million (46.3% of total revenue).
- Total revenue of \$21.7 million was reported, a decrease of \$168,000 (0.8%) from the prior year. Operating expenses decreased by \$532,000 (1.7%).

- Fourteen providers reported losses ranging from \$2.7 million (Weirton Medical Center) to \$3,000 (Holzer Home Care). The median loss was \$276,000. Twelve of fifteen agencies reported losses in FY 2014 with a median loss of \$911,000.
- Two of the sixteen agencies reported profits: Western Maryland Health System (\$240,000 or 32.1% of total revenue) and Fairmont Regional Medical Center Home Health (\$27,000 or 1.9% of total revenue). Fairmont Regional is the one for-profit home health agency.
- Eleven of the sixteen providers reported losses all three years.

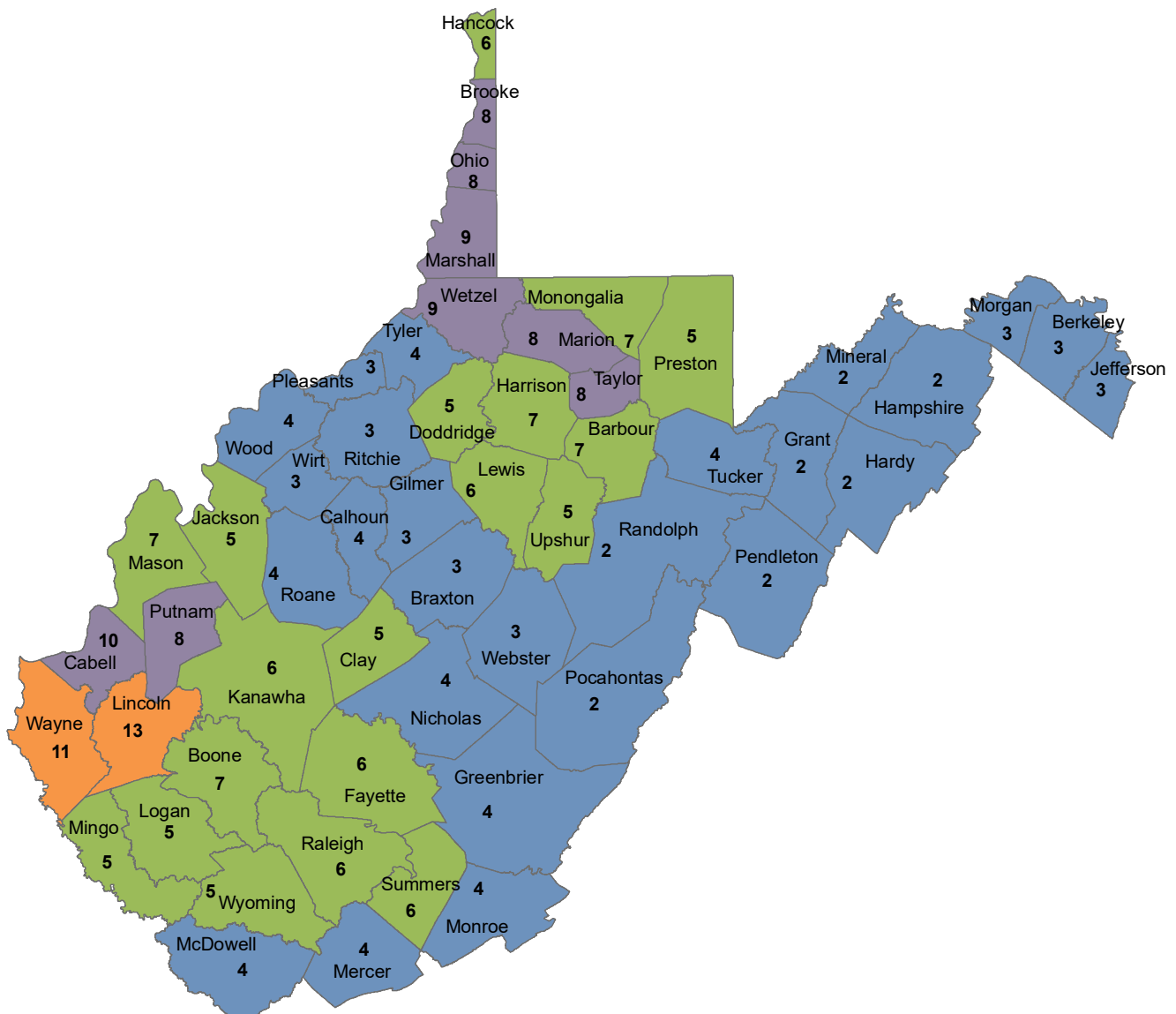
Not-for-Profit

This category includes county agencies. For FY 2015 there were three county facilities and six not-for-profit agencies included within the not-for-profit category.

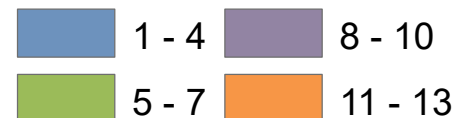
- The aggregate profit in FY 2015 was \$657,000 (5.4% of total revenue). In FY 2014 an aggregate profit of \$354,000 (2.5% of total revenue) was reported.
- Total revenue equaled \$12.1 million, a decrease of \$2.0 million from the prior year. Total expenses of \$11.4 million were reported, a decrease of \$2.4 million (17.1%) from the prior year.
- Five agencies reported profits ranging from \$434,000 (Dignity Home Health) to \$34,000 (Doddridge County Home Health) with a median EROE of \$60,000. In FY 2014 the median EROE for six profitable agencies was \$38,000.
- Four agencies reported losses ranging from \$80,000 (Ohio Valley Home Health Services) to \$12,000 (Panhandle Home Health) with a median loss of \$52,000. Three of the four agencies reported losses all three years.

Detailed information on home health agencies can be reviewed in Tables 29-31 on the Authority's website under the Data and Public Information link, Annual Reports section. The direct link is: <http://www.hca.wv.gov/data/Reports/Pages/default.aspx>.

West Virginia Home Health Agencies by County



Number of Agencies Serving County



Source: 2015 Annual Survey of Home Health Services

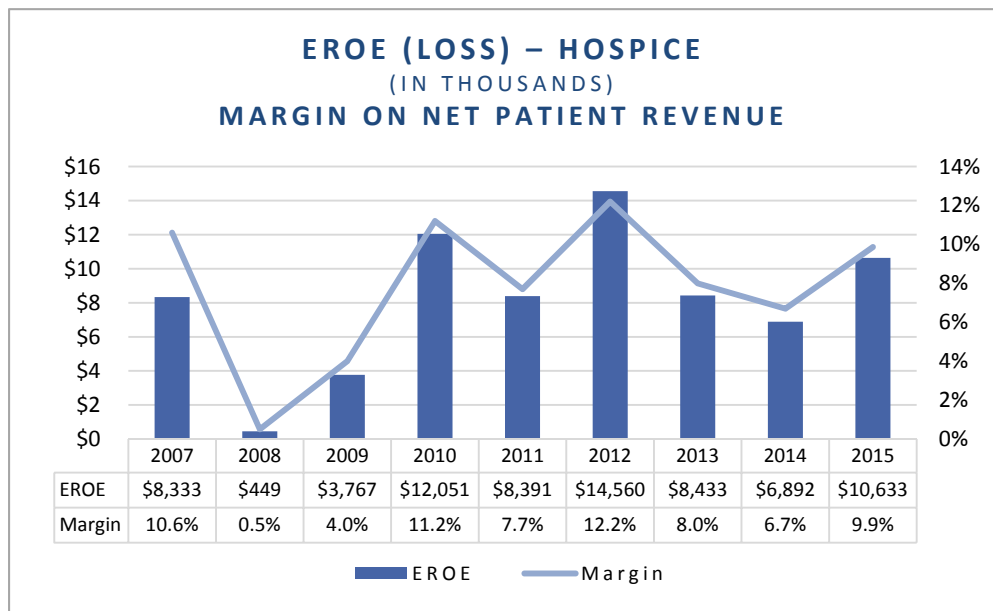
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HOSPICE

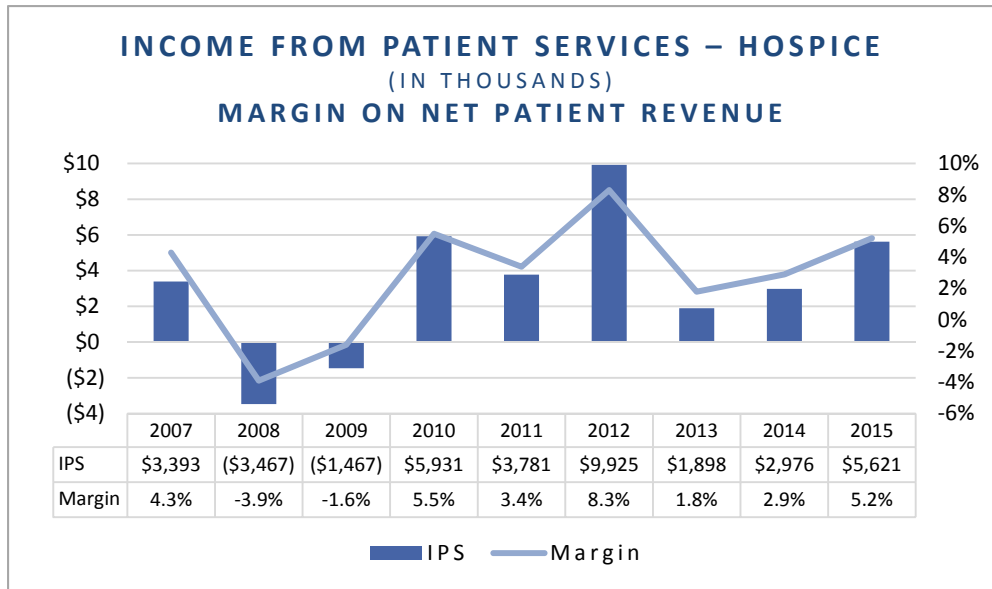
Data was collected from 20 West Virginia hospice organizations using the FY 2015 West Virginia Annual Hospice Survey.

Financial Indicators

- Total hospice profit was \$10.6 million, or 9.9% of net patient revenue (NPR), an increase of \$3.7 million over the prior year's profit of \$6.9 million (6.7% of NPR).



- Thirteen of the 20 hospice agencies reported profits, the same number as in FY 2014 and FY 2013.
- The median profit for all twenty agencies was \$161,000 in FY 2015 and \$148,000 in FY 2014.
- Net patient revenue was \$107.8 million, an increase of \$4.6 million (4.5%) from the previous year.
- Expenses of \$102.2 million were reported, an increase of \$2.0 million (2.0%) from \$100.2 million in FY 2014.
- Income from patient services of \$5.6 million (5.2% on NPR) was reported, an increase of \$2.6 million over FY 2014.



- Eleven agencies reported positive incomes from patient services in FY 2015 and FY 2014.
- Two agencies that experienced a loss from patient services had a positive EROE as a result of other and non-operating revenue.
- Aggregate other and non-operating revenues were \$6.1 million, an increase of \$2.2 million from revenues reported in FY 2014. Non-operating revenues include contributions from fundraising campaigns and other donations. Consequently, non-operating revenue levels may fluctuate widely from year to year.
- Sixteen free-standing agencies reported an aggregate EROE of \$11.0 million (10.6% of NPR), with a median profit of \$283,000.
- Twelve of the 16 free-standing agencies reported profits ranging from \$7.1 million (Amedisys Hospice Care) to \$45,000 (Hospice Compassus).
- Four of the free-standing agencies reported aggregate losses ranging from \$603,000 (Hospice Care Corporation) to \$104,000 (Hospice of Huntington).
- The four hospital-based agencies reported an aggregate loss of \$328,000 (7.6% of NPR). The median EROE was a loss of \$81,000. On average hospital-based agencies serve fewer clients, have hospital overhead costs allocated to the units and have lower amounts of other revenue.
- Three hospital-based agencies reported losses ranging from \$294,000 (People’s Hospice) to \$57,000 (Journey Hospice). One agency (Hospice of Potomac Valley Hospital) reported a profit of \$128,000 (18.8% of NPR).

Utilization

- The number of patients served was 11,200, an increase of 6.8% over FY 2014.
- Total patient days decreased by 2.1%, to 679,600, from 694,200.

Utilization – Hospice Patients Served and Days (Days in Thousands)								
	2008	2009	2010	2011	2012	2013	2014	2015
Patients	8,283	8,929	9,766	10,366	10,982	10,001	10,515	11,233
% Change	3.1%	7.8%	9.3%	6.1%	5.9%	(8.9%)	5.1%	6.8%
Days	577	616	742	729	767	630	694	680
% Change	5.3%	7.7%	20.6%	(1.83%)	5.2%	(17.9%)	10.2%	(2.1%)

Detailed information on hospice agencies can be reviewed in Tables 32-33 on the Authority's website under the Data and Public Information link, Annual Reports section. The direct link is: <http://www.hca.wv.gov/data/Reports/Pages/default.aspx>.

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RENAL DIALYSIS

Renal dialysis centers are distinct entities that provide treatment for patients in kidney failure. Thirty-five renal dialysis centers are located in 27 counties. Information for FY 2015 was compiled from financial statements.

All dialysis centers are for-profit entities. Thirty-one of the 35 centers are associated with two corporations that provide dialysis on both a national and international basis:

- Fresenius Medical Care (23)
- DaVita (8)

Special Items of Note

- ◆ *DaVita opened a 9-station dialysis center in Bridgeport, WV during FY 2015. The financial information provided was for three months of operations.*
- ◆ *As of publication, during calendar year 2016, Fresenius Medical Care has opened a dialysis center in Man and Martinsburg during calendar year 2016.*

Financial Results

- Total revenue reported for FY 2015 was \$108.0 million, with expenses of \$84.3 million resulting in an aggregate profit of \$23.7 million. The profit for FY 2014 was \$24.6 million from total revenue of \$104.3 million.

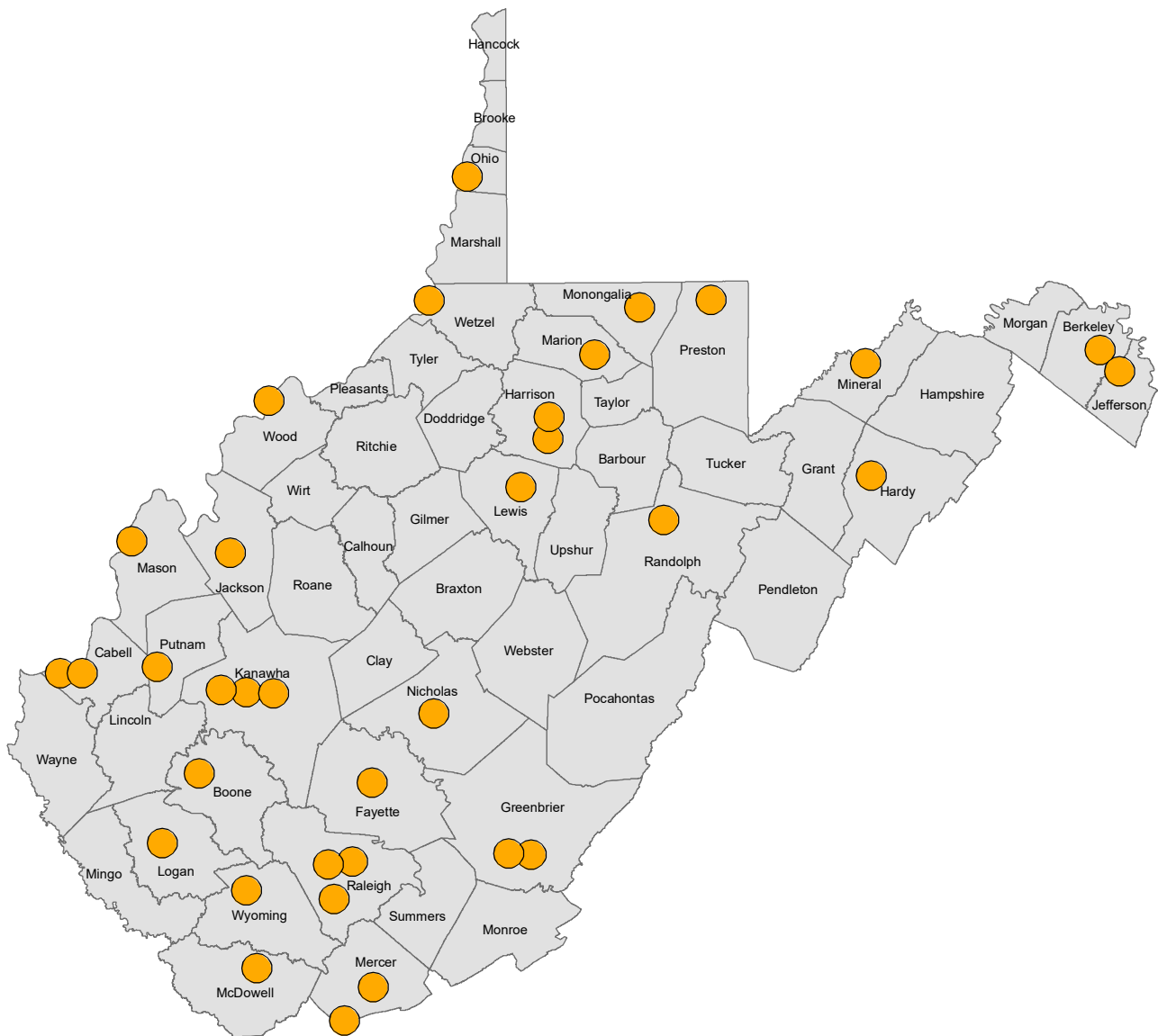
EROE – Renal Dialysis Centers (In thousands)						
	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
EROE	\$25,438	\$26,199	\$23,549	\$23,480	\$24,562	\$23,700
Margin	24.9%	26.9%	24.7%	22.8%	23.5%	21.9%

- Total margin for FY 2015 was 21.9%, a decrease from 23.5% in FY 2014.
- Twenty-four facilities reported profits for FY 2015 ranging from \$3.7 million (Fresenius–Martinsburg) to \$41,000 (Fresenius–Welch). Nine providers earned more than \$1.0 million, the same number as in FY 2014.
- Median profit in FY 2015 was \$335,000.

Detailed information on renal dialysis centers can be reviewed in Table 34 on the Authority's website under the Data and Public Information link, Annual Reports section. The direct link is: <http://www.hca.wv.gov/data/Reports/Pages/default.aspx>.

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West Virginia Renal Dialysis Centers



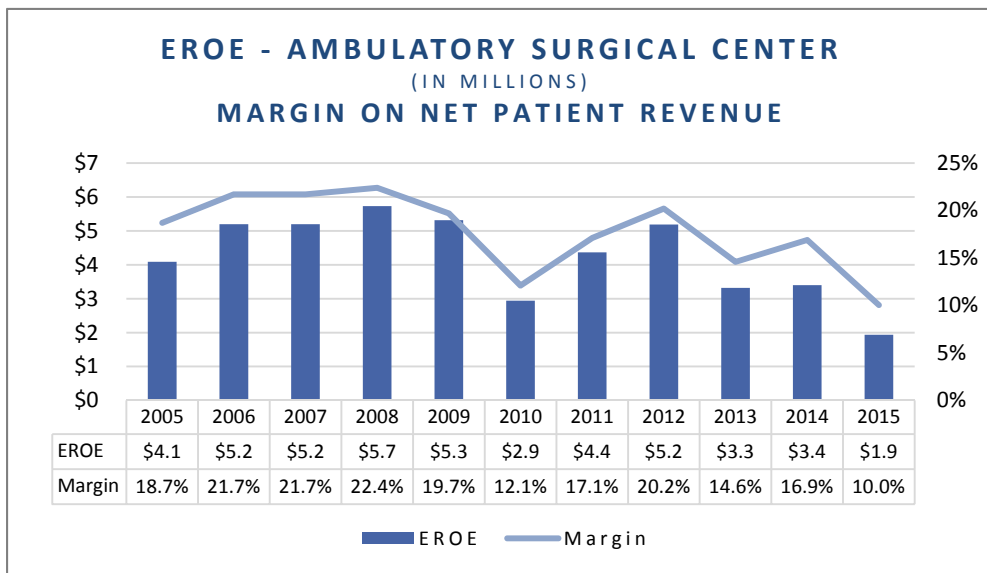
 Renal Dialysis Centers (34)

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AMBULATORY SURGERY

Ambulatory surgical centers (ASCs) are distinct entities that provide surgical services to patients not requiring a hospital admission. Nine certified ASCs operated in West Virginia during the year and submitted information through the FY 2015 Annual Survey for Ambulatory Surgical Centers.

- Total revenue for FY 2015 was \$19.3 million, with expenses of \$16.9 million resulting in an aggregate profit of \$1.9 million, a 0.4% decrease from the FY 2014 profit. The total margin was 10.0%.

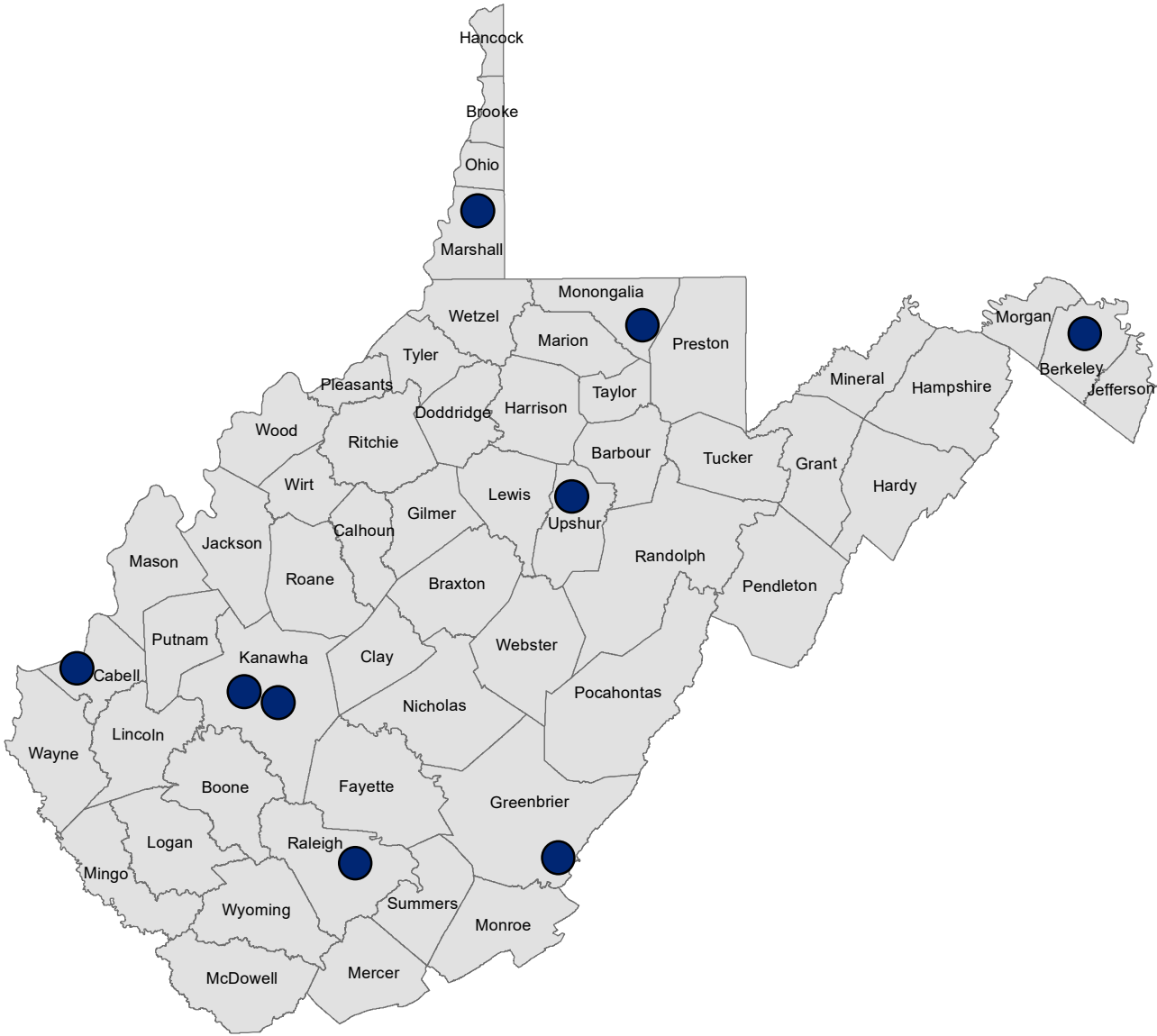


- Total revenue in FY 2015 decreased by \$967,000 (4.8%) and expenses increased by \$82,000 (0.5%).
- The median profit was \$27,000 for FY 2015 and \$162,000 for FY 2014.
- For FY 2015, five centers reported profits ranging from \$1.2 million (Day Surgery Center) to \$27,000 (Greenbrier Clinic). One center reported a zero margin.
- Losses were reported by three centers ranging from \$34,000 (Lee’s Surgicenter) to \$2,000 (Anwar Eye Center).
- All ASCs operated as for-profit entities.
- Aggregate utilization reported for FY 2015 equaled 27,000 cases.

Detailed information on ambulatory surgery centers can be reviewed in Tables 35-36 on the Authority’s website under the Data and Public Information link, Annual Reports section. The direct link is: <http://www.hca.wv.gov/data/Reports/Pages/default.aspx>.

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West Virginia Ambulatory Surgery Centers



● Ambulatory Surgery Centers (9)

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Appendices

List of WV Hospitals and Abbreviations

Glossary

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Appendix A – List of West Virginia Hospitals and Abbreviations (Abbreviated names used in narratives and detailed hospital tables)

General Acute

Hospital Name	Hospital Abbreviation
Beckley Appalachian Regional Hospital	Beckley ARH
Berkeley Medical Center	Berkeley Medical
Bluefield Regional Medical Center	Bluefield Regional
Cabell Huntington Hospital	Cabell Huntington
Camden Clark Medical Center	Camden Clark
Charleston Area Medical Center	CAMC
Charleston Surgical Hospital	Charleston Surgical
Davis Medical Center	Davis Medical
Fairmont Regional Medical Center	Fairmont Regional
Greenbrier Valley Medical Center	Greenbrier Valley
Logan Regional Medical Center	Logan Regional
Monongalia General Hospital	Monongalia General
Ohio Valley Medical Center	Ohio Valley
Pleasant Valley Hospital	Pleasant Valley
Princeton Community Hospital	Princeton
Raleigh General Hospital	Raleigh General
Reynolds Memorial Hospital	Reynolds Memorial
St. Francis Hospital	St Francis
St. Mary's Medical Center	St Mary's
Stonewall Jackson Memorial Hospital	Stonewall Jackson
Summersville Memorial Hospital	Summersville
Thomas Memorial Hospital	Thomas Memorial
United Hospital Center	United Hospital
Weirton Medical Center	Weirton Medical
Welch Community Hospital	Welch Community
West Virginia University Hospitals	WVU Hospitals
Wetzel County Hospital	Wetzel County
Wheeling Hospital	Wheeling
Williamson Memorial Hospital	Williamson

Appendix A – List of West Virginia Hospitals and Abbreviations (cont.)

Critical Access

Hospital Name	Hospital Abbreviation
Boone Memorial Hospital	Boone Memorial
Braxton County Memorial Hospital	Braxton County
Broadus Hospital Association	Broadus
Grafton City Hospital	Grafton City
Grant Memorial Hospital	Grant Memorial
Hampshire Memorial Hospital	Hampshire
Jackson General Hospital	Jackson General
Jefferson Medical Center	Jefferson
Minnie Hamilton Health Care Center	Minnie Hamilton
Montgomery General Hospital	Montgomery
Plateau Medical Center	Plateau Medical
Pocahontas Memorial Hospital	Pocahontas
Potomac Valley Hospital	Potomac Valley
Preston Memorial Hospital	Preston Memorial
Roane General Hospital	Roane General
St. Joseph's Hospital of Buckhannon	St Joseph's
Sistersville General Hospital	Sistersville General
Summers County - ARH	Summers ARH
War Memorial Hospital	War Memorial
Webster County Memorial Hospital	Webster County

Long-Term Acute Care

Acuity Specialty Hospitals of Ohio Valley - (WV)	Acuity Specialty (WV)
Cornerstone Hospital of Huntington	Cornerstone
Select Specialty Hospital	Select Specialty

Psychiatric Hospitals

Mildred Mitchell-Bateman Hospital	Bateman
Highland Hospital	Highland
Highland-Clarksburg Hospital	Highland-Clarksburg
River Park Hospital	River Park
William R. Sharpe, Jr. Hospital	Sharpe

Rehabilitation Hospitals

Huntington Rehabilitation Hospital	Huntington Rehab
MountainView Regional Hospital	Mountainview
Peterson Rehab and Geriatric Center	Peterson Rehab
Southern Hills Regional Hospital	Southern Hills
Western Hills Regional Hospital	Western Hills

APPENDIX B – GLOSSARY OF TERMS

Accounts Payable: Amounts owed to others for goods, services, and supplies purchased and received, but not yet paid for as of the balance sheet date.

Accumulated Depreciation: Amount charged to expense through the annual amortization of the cost of the property, plant, and equipment.

Bad Debt: Amount not recoverable from a patient following exhaustion of all collection efforts.

Capital Lease Obligations: Consists of a portion of the long-term debt obligations incurred for leased items such as equipment and other long-lived assets when leases meet criteria necessary for being capitalized.

Cash: Money in the bank available for immediate expenditure. This may include cash equivalents which are financial instruments that may be readily and quickly converted into cash.

Charity Care: Uncompensated care given by a health care facility to indigent and medically-indigent people as part of a written mission or charity care policy. It does not include accounts written off as “bad debts” or third-party adjustments, including those for Medicare and Medicaid. This represents health care services accounted for on the accrual basis which were provided, but were never expected to result in cash inflows.

Contractual Allowance: Accounting adjustment to reflect uncollectable differences between established charges for services rendered to insured persons and rates payable for those services under contracts with third-party payors. The amount of the discount from total charges negotiated by the health care provider with an insurer for the provision of health care services. Or, the difference between total charges and the reimbursement allowed by a governmental payor.

Critical Access Hospital: Rural acute care hospital with no more than 25 licensed beds consisting of acute care beds and/or swing beds. The average length of stay must not exceed 96 hours. The Critical Access Hospital has emergency services available 24 hours and agreements, contracts or affiliations for transfer and services.

Current Maturities of Long Term Debt: Amounts payable on bonds, mortgage loans, capital lease obligations, and other long-term debts to be paid in the next 12 months.

Derivative Agreement: A financial instrument that is derived from some other asset, index, event, value or condition (known as the underlying asset). Rather than trade or exchange the underlying asset itself, derivative traders enter into an agreement to exchange cash or assets over time based on the underlying asset.

Appendix B – Glossary of Terms (Cont.)

Employment Retirement Income Security Act (ERISA) of 1974: A federal law which established rules for pension and retirement plans, which excluded states from regulating these plans. The majority of health plans in the US are covered by ERISA, and therefore exempted from certain regulations. Only federal courts have jurisdiction for lawsuits against ERISA covered plans.

Excess Revenue (Deficit) Over Expenses (EROE): Bottom line measure of residual income or (loss) that is generated from the aggregate revenues, expenses, gains, and losses of the facility due to the overall activities of the facility.

Fiscal Year: A twelve-month period of time established for an organization’s accounting and reporting purposes without regard to the calendar year.

Fund Balance and/or Equity: Consists of tax-exempt corporation fund balances and proprietary corporation owner’s equity including capital invested and retained earnings.

Goodwill: Additional value above fair value of an entity, creating an intangible asset, which is attributed to an organization for a perceived competitive advantage due to outstanding reputation, employee morale, or potential synergy with a purchasing entity.

Gross Domestic Product (GDP): A measure of the total monetary value of goods produced and services provided within a country or specified region such as a state.

Gross Patient Revenue (GPR): Amount charged by the facility for services provided to patients. It is the standard charge made by the facility before discounts and contractual allowances.

Income (Loss) from Patient Services: Equals net patient revenue less operating expenses. Net patient revenue only includes payments for patient services rendered; it does not include other operating or non-operating revenues.

Inventory: Cost of supply items on hand that will be used in the next period. It may consist of medical supplies, surgical supplies, pharmaceutical supplies, food, and other supplies.

Long Term Acute Care Hospital (LTCH): Acute care hospital that provides care for patients who have been in an intensive care or short-term care setting and who require an extended length of stay (greater than 25 days). LTCHs are often referred to as a “hospital within a hospital”.

Long-term Debt: Consists of notes payable to banks, revenue bonds payable, and, in some cases, capital lease obligations due to be paid at a date more than one year in the future.

Major Diagnosis Category (MDC): Grouping of MSDRGs into a higher category of medically related system classifications.

Margin: The percentage of revenue or net income that has been realized after expenses.

Appendix B – Glossary of Terms (Cont.)

Median: The middle value in a list of numbers arranged in numerical order. It is one measure of central tendency.

Medicare Severity Diagnosis Related Groups (MSDRG): Classification system which groups inpatient discharges by principal and secondary diagnosis. This system became effective as of December 1, 2007, replacing the DRG classification system.

Net Patient Receivables: Amounts owed by patients less contractual adjustments and estimated allowances for bad debt.

Net Patient Revenue (NPR): Amount the facility receives or expects to receive from patients and/or third-party payors for the services provided by the facility less contractual adjustments, and allowances for Charity Care and Bad Debt.

Net Property, Plant, and Equipment: Remaining book value of physical assets such as buildings and equipment after subtracting accumulated depreciation.

Non-operating Revenue: Amounts the facility receives from items that are neither directly nor indirectly the result of treating patients or other operating activity. Examples of revenue in this category are investment income and donations.

Other Assets: Items not expected to be expended in the current period, but with limited use due to restrictions. These consist of items such as funds held for bond indenture requirements, investments for self-insured malpractice, and hospitalization programs.

Other Current Assets: Items expected to be expended during the current period. These consist of items such as short-term investments and current portion of assets.

Other Current Liabilities: Accrued expenses for wages and salaries, benefits, and interest.

Other Liabilities: Consists of items such as liabilities for self-insured malpractice, employee benefit programs (pension and health care), and inter-company payables for affiliated facilities.

Other Operating Revenue: Amount the facility receives from sales of items not directly resulting from treating patients. It includes items such as cafeteria sales and the sale of copies of medical records.

Other Receivables: Receivables from revenue sources other than patients. The receivable may consist of settlement amounts due from Medicare, Medicaid, or from other parties.

Other Revenue: Other operating revenue plus non-operating revenue.

Payor: The person, government body, or public or private organization that is responsible for payment of health care expenses. Payors include insurance companies and self-insured employers.

Appendix B – Glossary of Terms (Cont.)

Pre-tax Income: Revenues minus expenses before income tax, and may also exclude extraordinary items.

Prepaid Expenses: Amounts already paid for the cost of items that will be expended in the current period. The prepaid expenses may consist of items such as prepaid insurance.

Property, Plant, and Equipment: Historical cost of land, buildings, and equipment owned by the facility. It may also include capital leases, which are leases for the approximate life of the asset.

Proprietary: Refers to the concept of ownership; usage in this report indicates a for-profit status for the owned entity as opposed to a not-for-profit, charitable organization.

Provider: An organization that is established for the purpose of providing preventative, therapeutic and rehabilitative medical or healthcare services.

Renal Dialysis: A process that filters the blood, the way kidneys do when functioning normally, using a special machine. The filtration rids the blood of waste products then returns it to the patient through a venous catheter. Also, referred to as End-Stage Renal Dialysis (ESRD).

Swing Bed: Beds certified by Medicare for use in small hospitals as either general medical/surgical or skilled nursing beds with reimbursement based on the specific care provided. Swing beds provide small hospitals with greater flexibility to meet fluctuating demands for inpatient hospital and skilled nursing care.

Total Assets: Total of all assets listed in the balance sheet.

Total Liabilities: Total of all liabilities listed on the balance sheet.

Total Liabilities and Fund Balances and/or Equity: Summation of the total liabilities and fund balance or equity shown on the balance sheet.

Total Operating Expenses: Amount recorded by the facility for items purchased or accrued as normal operating expenses. It includes, but is not limited to, items such as salaries, employee benefits, medical supplies, utilities, depreciation, interest on debt, income and provider taxes (if applicable), and all other necessary supplies.

Uncompensated Care: Amount of patient care provided without compensation or reimbursement, consisting of charity care and bad debt. Contractual allowances are not included.

Unduplicated Client Count: The number of clients served where clients are only counted one time during the year regardless of how many times they received services.