WYOMING LEGISLATIVE SERVICE OFFICE

Memorandum

DATE May 15, 2015

TO Members, Joint Labor, Health and Social Services Interim Committee
Members, Joint Appropriations Committee

FROM Don Richards, Budget and Fiscal Section Manager

SUBJECT Hospital Organization and Data

This memo summarizes background data and information prepared or compiled by LSO staff, with contributions from the Wyoming Department of Health (WDH) to inform interim topic #1 of the Joint Labor, Health and Social Services Interim Committee and interim topic #11 of the Joint Appropriations Committee. The information is categorized as follows:

- Memo and attachments A and B, prepared by LSO Budget/Fiscal Section, provide background on the governance and taxes supporting Wyoming hospitals, as well as information related to multi-payer/all-payer claims databases;
- Attachments C-1 and C-2, prepared by the Wyoming Department of Health (WDH), summarize the most recent available federally-compiled data on uncompensated care. Attachment D provides *estimates* related to health insurance coverage for the Wyoming population and those under 100 percent of the federal poverty level;
- Attachments E-1 and E-2 summarize survey responses of Wyoming hospitals to an on-line survey prepared by LSO staff at the direction of, and with input from, the leadership of the involved committees; and
- Attachment F, prepared by LSO Legal Services, responds to legal questions surrounding the provision of uncompensated care.

1. Summarize the ownership and organizing structure of Wyoming hospitals, e.g. county, special district, private.

In Wyoming at the time this information was prepared, there are 8 county hospitals; 14 special district hospitals, and 7 private, licensed hospitals. (One additional private hospital, Summit Medical Center in Casper, was in the process of opening as this information was being collected.) In addition, there are currently two clinics (one clinic/long-term care center) that are not licensed hospitals under the WDH but are technically organized as special district hospitals for purposes of property taxation. Further, one of the private hospitals is a rehabilitation hospital and another is a psychiatric hospital. Within the private hospitals, there are examples of both for-profit and not-for-profit structures.

Of the eight county hospitals, three are affiliated with an external management entity and 8 of the 14 special district hospitals are affiliated with an external management entity, including management by a private, public, or even a Wyoming county hospital.

Five counties have at least two hospitals and two additional counties have a hospital as well as a clinic, which benefits from the taxing structure of a special district hospital. See Attachment A for a list of all hospitals, locations, and management structures.

2. Summarize the most recent mill levies for hospital operations and bonded indebtedness, including the maximum allowable mill levy and the potential collections from imposing additional mills.

County hospitals' operational costs may benefit from a portion of the countywide maximum 12 mill levy authorized under Article 15, Section 5 of the Wyoming Constitution. The imposition of these mills is further authorized and defined under W.S. 39-13-104(b)(i)(A), which states:

> (b) There shall be annually levied and assessed upon the taxable value of property within each Wyoming county the following county taxes when applicable:
>
> > (i) Not to exceed twelve (12) mills as determined by the board of county commissioners which shall include mill levies, if any, for the following purposes:
> >
> > > (A) The number of mills to *be dedicated to the operation of a county hospital*; (emphasis added)

In 2014, five of the eight counties with a county hospital dedicated a portion of the countywide maximum 12 mill levy for the operation of the county hospital. Laramie County, Natrona County, and Sheridan County did not. Of the five counties that did dedicate a portion of the 12 mill levy for the operation of the county hospital, the levy ranged from 0.329 mills to 1.065 mills and generated tax revenue support ranging from $101,940 to $1,499,496. Attachment A also illustrates the mill levy for each of these hospitals. Additionally, column 14 in Attachment A shows the amount of revenue that would have been generated by the imposition of one mill in each of the eligible counties.

Special district hospitals may benefit from up to six mills for their operations: up to three mills by vote of the board of trustees of the hospital and up to three additional mills by an affirmative vote of a majority of those voting thereon within the hospital district. This maximum levy is included in W.S. 39-13-104(e)(ii) and by reference W.S. 35-2-414(b), (c) and (d):

> W.S. 39-13-104(e) - There shall be annually levied and assessed upon the taxable value of property within the limits of the following special districts the following special district taxes when applicable:
>
> > (ii) Not to exceed six (6) mills by a hospital district as provided by W.S. 35-2-414(b), (c) and (d) plus the number of mills necessary for the payment of the district debt plus interest thereon not to exceed the limitations prescribed by W.S. 35-2-415;

In 2014, five of the 15 hospital districts imposed the maximum six mill levy and nine of the hospitals imposed three mills. Furthermore, the two clinics organized as hospital special districts both benefited from three mills. Attachment A shows the mill levy for each of the hospital special districts, as well as the amount of funds that could have been generated had the nine special district hospitals imposing three mills imposed the maximum six mills.

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Special district hospitals, with the approval and through the county commission, may also impose additional mills for the payment of principal and debt on outstanding bonds pursuant to W.S. and under the limitations of W.S. 32-2-415:

> The board of trustees of a hospital district may upon approval of the board of county commissioners submit to the electors of the district the question whether the board shall be authorized to issue the general obligation coupon bonds of the district in a certain amount, not to exceed five percent (5%) of the assessed value of the taxable property in the district, and bearing a certain rate of interest, payable and redeemable at a certain time, not exceeding twenty-five (25) years for the purchase of real property, for the construction or purchase of improvements and for equipment for hospital purposes.

Similarly, pursuant to W.S. 39-13-104(b)(iii) and within the limitations prescribed by Article 16, Sections 3 and 5 of the Wyoming Constitution, counties may impose the number of mills necessary for payment of the county debt and interest thereon. In 2014, no such a levy was reported.

3. Discuss whether Wyoming hospitals can and do benefit from local optional sales and use tax for operations or capital construction.

W.S. 39-15-202 (for purposes of local sales taxes) and W.S. 39-16-202 (for purposes of local use taxes) preempts the field of imposing tax upon retail sales of tangible personnel property, admissions and services (or storage, use and consumption in the case of use taxes) and no county, city, town or other political subdivision may impose, levy or collect taxes upon retail sales, admissions and services except as provided by statute. Subsections (b) of the relevant statutes authorize a county or resort district (or city or town in the case of sales taxes) to impose additional excise taxes. Put differently, counties (or resort districts or municipalities in some instances) are charged with imposing and collecting sales and use taxes in Wyoming. LSO has identified several instances in which county hospitals or special district hospitals benefit from funds generated by either a one percent general purpose local option sales and use tax or a one percent specific purpose sales and use tax. Table 1, on the next page, summarizes the counties' response to a joint LSO/Wyoming County Commissioners Association inquiry for information.[1]

[1] Five counties did not respond to the inquiry (Campbell, Johnson, Lincoln, Park, and Uinta) and since the Wyoming Department of Revenue does not collect information on the use of local optional sales and use taxes, potential applications in these counties are unknown.

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Table 1. Examples of Wyoming Hospitals Benefiting from Local Optional Sales and Use Taxes.

County	General/ Specific Purpose	Implementation	Amount (s)	Purpose
Carbon	Specific	2009/2010	$8,500,000	Upgrade intensive care unit, operating room, and ambulance purchases
Niobrara	Both	2003, 2009 – 2012	$2,250,000; $724,487	Remodel hospital and nursing home; minor remodel. Additionally, approximately $300,000 from the county share of the general purpose tax passed through to the hospital
Platte	Specific	2013,	$12,000,000	New nursing home and assisted living center
Sheridan[1]	General	Annual	$175,000	General appropriation from county
Teton	Specific	1989; 2001; 2010	$7,750,000; $9,100,000; $11,750,000	Construction; employee housing; and expansion and remodel of cancer, surgery, and OB/GYN facilities
Weston	Specific	*May 5, 2015 ballot (adopted)*	$8,750,000	Planning, design, construction and equipment for Newcastle hospital addition

Note: (1) Sheridan County also provides a transfer to the county hospital in the amount of $120,000/yr from the general fund for Title 25 expenditures.

4. Briefly outline the benefits and challenges of an all-payer claims database for hospital charges.

LSO staff prepared a Research Memo (14RM005) in July 2014 for the Joint Labor, Health and Social Services Committee on all-payer claims databases (APCDs). The findings and considerations remain relevant today, with the addition that the APCD Council reports there are 12 states with existing APCDs in February 2015, as opposed to 14 in July 2014. (See Attachment B for a copy of the Research Memo.)

Prominent goals of APCDs include:

- Opportunities to collect, analyze and distribute health care and fiscal data to promote cost-effective, quality healthcare outcomes;
- Compare costs of treatment delivery and approaches for consumers, policymakers, and healthcare providers;
- Evaluate effectiveness of health care outcomes for consumers, policymakers and healthcare providers; and
- Inform healthcare policy.

Prominent challenges include:

- Assignment of the start-up and administrative costs (for rule development, data management, data analysis, data release policies, and general administration);

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- How are technical parameters and definitions developed in the most efficient, effective manner;
- How comparability and usability of the date insured; and
- How is information accessibility balanced against data protection and proprietary concerns.

The state has a two year contract with a private vendor, HCMS, through November 2015 of up to $276,000 for data analysis services related to the Wyoming Health Information Network (WHIN), to provide participating agencies with analytical and research services and access to an on-line business intelligence tool of health-related data. The involved state agencies include the Departments of Health, Family Services, Workforce Services, Corrections and Enterprise Technology Services (which provides hosting services).

5. **Update of cost of uncompensated care (inclusive of charity care, unreimbursed care and bad debt) delivered by Wyoming hospitals based upon the most recent report available from Centers for Medicare and Medicaid Services (CMS).** *(See Attachments C-1 and C-2, prepared by the Wyoming Department of Health.)*

6. **Census or other federal government estimates of the number of Wyoming residents with employer sponsored health insurance, coverage from Medicare, coverage from Medicaid, and those uninsured who are below the federal poverty level, by county.** (See Attachment D, prepared by the Wyoming Department of Health.)

7. **Summary of results from an April 2015 LSO Survey of Wyoming Hospitals.**

LSO staff, with input from the Chairmen of the Joint Labor, Health and Social Services Interim Committee and Joint Appropriations Committee, administered a survey of Wyoming hospitals. The summary of responses is included in Attachment E-1 and individual responses, except for liability insurance limits, are included as Attachment E-2. LSO staff has modified the submitted responses in four ways: (i) corrected spelling errors, (ii) provided consistent formatting, (iii) rounded to the nearest whole number; and (iv) deleted two duplicate responses.

LSO staff sent the survey to all Wyoming hospitals based upon a listing of hospital licensees from the Wyoming Department of Health as of March 2015, using contact information provided by the Wyoming Hospital Administration (WHA), Department of Health, or individual research. Multiple reminders were sent by LSO to potential respondents, and the WHA was asked to encourage its members to respond. The survey initially closed on April 30, 2015. At the request of at least one hospital, the response period was extended to Friday, May 8, 2015. Fourteen of the 31 Wyoming hospitals (45%) replied to the survey. Of the 14 respondents, some elected to skip several questions or provided partial responses. Select findings include:

- Nine of the 14 responding hospitals (64%) include day-to-day management (at least the chief administrator) hired by the hospital board. Four (29%) contract day-to-day administration to an external private entity and one (7%) has a management agreement with a private non-profit. Of those contracting with an external entity, three contract with a private for-profit company and two contract with a private not-for-profit company.

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- Of the 14 respondents, eight (57%) are comingled with both a clinic and a long-term care center; five (36%) are comingled with a clinic and one (7%) is comingled with just a long-term care center.
- Of the twelve affiliated clinics, 10 (83%) generate less revenue than expenditures; one (8%) breaks even and one clinic generates more revenue than expenditures. Similarly, eight (67%) clinics increase the amount of charity care provided; two (17%) decrease the charity care provided and two (17%) report the clinics have no impact on the amount of charity care provided.
- Of the nine affiliated long-term care centers, 6 (66%) generate less revenue than expenditures; two (22%) break even and one long-term care center (11%) generates more revenue than expenditures. In addition, four (50%) reported that the long-term care center has no impact on the provision of charity care and four (50%) report that the long-term care center increases the provision of charity care.
- Hospitals reported the age of facilities ranging from one to 63 years, with a median of 23 years and an average age of 24 years.
- Of the entities responding to question of the quality of their facilities, roughly two-thirds classified their facilities as being in either "good" or "excellent" condition and one-third classified facilities in the "fair" or "poor" condition. Entities responded that approximately $40 million in estimated deferred maintenance exists and that the old facilities, on occasion, have an adverse impact on patients and that aged facilities and infrastructure require more maintenance.
- Of the ten hospitals responding to the question of capital facilities or major equipment additions in the last five years, the expenditures totaled more than $208 million, ranging from equipment less than $100,000 to facilities in excess of $45 million.
- Revenues, by responding hospital, range from $12.8 million to just over $197 million, while expenses had a similar range: $12.5 million to $190 million. Further, in all cases the gross revenues exceeded the total reported expenditures for the most recent fiscal year.
- The cash balances of the responding hospitals range from $131,268 to over $50 million for the most recent fiscal year, with an average of $17.7 million. For the responding hospitals, the average cash balance reported was just over one-quarter of the annual revenues, or approximately three months of revenues.
- Current assets reported by the hospitals range from just over $3 million to more than $103 million, with an average of approximately $30 million, or roughly one-half of the average annual revenues.
- Current liabilities range from low of $1.1 million to a high of $34.8 million.
- The current ratio of responding hospitals, as calculated by LSO staff by dividing current assets by current liabilities, range from a low of 1.0 to a high of 9.12.
- On average, Medicare payments accounted for 31 percent of the total payments for patient care services; however, this ratio ranged from a low of 14 percent to a high of 45 percent. Despite the broad range, the tendency of most of the responses was in the neighborhood of 30 percent. Further, on average Medicaid payments accounted for 12 percent of the total

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payments for patient care services. Again, the range was wide from a low of 4 percent to a high of 25 percent.

- Of the eleven hospitals responding to the allocation of inpatient days, by type of payment, Medicare patients accounted for an average of 56 percent of the inpatient days, with a range of 29 percent to 85 percent. Similarly, of the eleven hospitals responding to the allocation of inpatient days, by type of payment, Medicaid patients account for an average of 18 percent of the inpatient days, with a range of just 1 percent to 55 percent.
- Of the eleven hospitals responding to the allocation of outpatient visits, by type of payment, Medicare patients accounted for an average of 36 percent of the outpatient visits, with a range of 20 percent to 50 percent. Similarly, of the eleven hospitals responding to the allocation of outpatient visits, by type of payment, Medicaid patients account for an average of 10 percent of the inpatient days, with a range of just 3.5 percent to 15 percent.
- Revenues in the form of grants contributed $17.7 million to the 12 responding hospitals. Revenues from local taxes provided $17.8 million to the eight responding hospitals benefiting from tax revenue. This comprises an average of $2.2 million per hospital, or roughly six percent of their total revenues.
- Across the 11 hospitals responding to the question that quantifies the percent of final payments compared to the initially-billed hospital charges, on average, hospitals responded that Medicare pays 51 percent of initially-billed charges; Medicaid provides an average of 45 percent; and private insurance pays an average of 82 percent of initially-billed charges.
- No hospital reported that Medicaid or Medicare initially-billed charges differed in any way from the charges initially-billed to private insurance.
- In response to a question included to determine how final payments compare to the cost of services provided, the responses are so varied and even internally disparate, that it is not clear the respondents applied the formulas as intended. For example, six of the eight respondents indicated that Medicare payments result in a higher percentage for the cost of services than of the initially-billed charges, for the same hospital. Two hospitals responded in the opposite and did so to a dramatic degree. One could potentially infer that the initial billed amounts are higher in the case of the six respondents than the hospital's cost of services. However, the variability in the responses may also suggest that the respondents did not interpret the question similarly or as intended.
- Figure 1 illustrates the average contribution to uncompensated care at each hospital, by source, as reported by the ten hospital respondents to this question.

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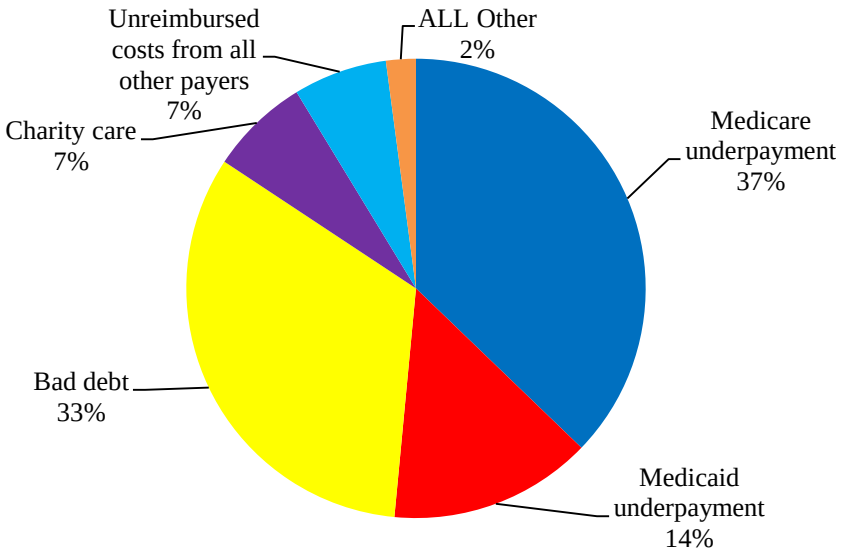
Figure 1. Contribution to uncompensated care.



- Nine respondents (69%) reported being associated with a private foundation, with an average corpus of $4.4 million and a wide range from less than $200,000 to over $13.7 million. One of the larger foundations consistently provides in excess of $1 million annually to the associated hospital, while the small foundations report transfers of a few thousand per year, not necessarily consistently.
- Employed FTE at the thirteen responding hospitals ranged from 67 to 1,058, with an average of 54 percent of the FTE involved in the direct medical care and just four percent of the FTE being physicians. Total payroll for the twelve respondents to this question exceeded $485 million, with an average of $41 million per responding hospital.
- Difficulty recruiting health care personnel, including physicians, nurses and other health care practitioners were regularly cited by respondents, including particular challenges given the rural nature of Wyoming.
- The most common aggregate limits of hospital liability insurance are $1 million per occurrence and $5 million in aggregate. Two of the eleven hospitals responding indicated that the liability insurance did not cover employed physicians; the remaining nine did. Further, of those responding slightly more than half covered contract physicians under the hospital liability insurance.
- The range of state and federal regulatory burdens qualifying as the first, second or third most burdensome varied substantially. Audits, inspection plans, quality reporting, surveys, cost reports and value-based purchasing are all listed as examples.
- In the judgement of respondents, the services provided by community hospitals which cannot be provided through alternative methods regularly cited emergency and trauma care and proximity to family.

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- Primary cost drivers listed by respondents include compensation (salary/wages), insurance burdens, regulations, competition, uninsured patients, expensive equipment, liability for providers, technology, federal programs and reimbursements, and unhealthy behaviors.
- Contributions to the community in terms of economic development included jobs (and associated payroll), attraction of other businesses, and purchases within the community.

8. **Please see Attachment F for responses to the legal research topics posed to LSO staff.**

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ATTACHMENT A

Wyoming Hospital Governance and Tax Collection Summary

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Wyoming Hospitals	**Community**	**County**	**Governance**	**Management Affiliation**	**Acute bed #'s**	**Long-term care (LTC)/Skilled nursing facility (SNF) bed #'s**	**Prospective Payment System (PPS) Acute/Critical Access**	**FY end**	**2014 Total Assessed**	**2014 Levy**	**2014 Amount Generated**	**Did the County impose all 12 mills/OR did the District impose all 6 mills?**	**2014 revenue potential from mills not imposed for special districts and the value of one mill for county hospitals**
Ivinson Memorial Hospital	Laramie	Albany	District	Univ of Colorado Health System	90	9	Acute	June 30	$382,474,421	3.000	$1,147,423	N	$1,147,423
South Big Horn County Hospital	Basin	Big Horn	District		6	37	Critical Access	June 30	$93,450,685	6.000	$560,704	Y	$0
North Big Horn Hospital	Lovell	Big Horn	District	Billings Clinic System	15	85	Critical Access	June 30	$183,634,444	6.000	$1,101,806	Y	$0
Campbell County Memorial Hospital	Gillette	Campbell	District		93	143	Acute	June 30	$5,685,695,158	3.000	$17,057,085	N	$17,057,085
Memorial Hospital of Carbon County	Rawlins	Carbon	County memorial	Quorum Health Resources	25		Critical Access	June 30	$760,910,660	0.329	$250,340	Y	$760,911
Memorial Hospital of Converse County	Douglas	Converse	County memorial		25		Critical Access	June 30	$1,407,977,674	1.065	$1,499,496	Y	$1,407,978
Glenrock Hospital District	Glenrock	Converse	District		NA	NA	Clinic		$136,645,237	3.000	$409,936	N	$409,936
Crook County Medical Services	Sundance	Crook	District	Regional Health Rapid City	16	32	Critical Access	June 30	$238,560,929	3.000	$715,683	N	$715,683
SageWest Health Care - Lander	Lander	Fremont	For-Profit	LifePoint Hospitals, Inc.	89		Acute	Dec 31					
SageWest Health Care - Riverton	Riverton	Fremont	For-Profit	LifePoint Hospitals, Inc.	70		Acute	Dec 31					
Community Hospital	Torrington	Goshen	Non-profit private owned	Banner Health	25	103	Critical Access	Dec 31					
Hot Springs County Memorial Hospital	Thermopolis	Hot Springs	County memorial	HealthTech Mgmt Services	25		Critical Access	June 30	$227,516,949	0.813	$184,971	Y	$227,517
Johnson County Healthcare Center	Buffalo	Johnson	District		25	50	Critical Access	June 30	$857,660,894	3.000	$2,572,983	N	$2,572,983
Cheyenne Regional Medical Center	Cheyenne	Laramie	County memorial		206	16	Acute	June 30	$1,166,877,447	0.000	$0	Y	$1,166,877
Star Valley Medical Center	Afton	Lincoln	District		20	24	Critical Access	Dec 31	$149,625,476	3.000	$448,876	N	$448,876
South Lincoln Medical Center	Kemmerer	Lincoln	District		16	24	Critical Access	June 30	$616,498,917	3.000	$1,849,497	N	$1,849,497
Wyoming Medical Center	Casper	Natrona	Non-profit lease from County		192	15	Acute	June 30	$1,411,882,916	0.000	$0	Y	$1,411,883
Wyoming Behavioral Institute	Casper	Natrona	For-Profit	Universal Health Services	90		Acute - Psychiatric	Dec 31					
Niobrara Health and Life Center	Lusk	Niobrara	District	Wyoming Medical Center	4	20	Critical Access	June 30	$131,501,266	6.000	$789,008	Y	$0
West Park Hospital	Cody	Park	District	Quorum Health Resources	25	97	Critical Access	June 30	$605,467,147	3.000	$1,816,401	N	$1,816,401
Powell Valley Healthcare	Powell	Park	District	HealthTech Mgmt Services	25	100	Critical Access	June 30	$219,326,626	3.000	$657,980	N	$657,980
Platte County Memorial Hospital	Wheatland	Platte	District - leased	Banner Health	25		Critical Access	Dec 31	$171,653,028	6.000	$1,026,918	Y	$0
Sheridan Memorial Hospital	Sheridan	Sheridan	County memorial		88		Acute	June 30	$447,134,821	0.000	$0	Y	$447,135
Memorial Hospital of Sweetwater County	Rock Springs	Sweetwater	County memorial		99		Acute	June 30	$2,829,595,031	0.348	$984,699	Y	$2,829,595
Castle Rock Hospital	Green River	Sweetwater	District	Mission Health Services	NA	59	Clinic/LTC		$811,516,300	3.000	$2,434,549	N	$2,434,549
St. John's Medical Center	Jackson	Teton	District		48	60	Acute	June 30	$1,148,195,544	3.000	$3,444,587	N	$3,444,587
Evanston Regional Hospital	Evanston	Uinta	For-Profit	Community Health Systems, Inc.	42		Acute	April 30					
Washakie Medical Center	Worland	Washakie	County memorial - leased	Banner Health	25		Critical Access	Dec 31	$153,524,497	0.664	$101,940	Y	$153,524
Weston County Health Services	Newcastle	Weston	District	Regional Health Rapid City	21	54	Critical Access	June 30	$162,712,640	6.000	$976,276	Y	$0
Elkhorn Valley Rehabilitation Hospital	Casper	Natrona	Private		NA	NA	Rehab Hospital						
Mountain View Regional Hospital	Casper	Natrona	Private		NA	NA							

Notes:

1) Compiled by The Wyoming Healthcare Facilities Directory (updated 4/6/2015), information provided by the Wyoming Hospitals Association (3/24/15), and the 2014 Department of Revenue Annual Report.

WYOMING LEGISLATIVE SERVICE OFFICE

Research Memo

14 RM 005

Date: July 8, 2014

Author: Michael Swank, Fiscal Analyst

Re: All-Payer Claims Database

QUESTIONS

1. **What is an "all-payer claims database"?**

2. **What are the significant features or considerations to implement an all-payer claims database?**

3. **How have other states implemented their own all-payer claims database?**

ANSWERS

1. **An all-payer claims database (APCD) is a data warehousing unit or repository where the information from a number of major payers compiles healthcare claims data in order to analyze healthcare service pricing and quality. Although several states have used various analogues to APCDs in the past to review health care cost and quality data in limited settings, these more comprehensive systems are a relatively new innovation working to increase the breadth of available data and the depth of possible analysis of healthcare cost and quality.**

   Major payers typically include commercial insurers as well as public programs like Medicaid, Medicare, state children's health insurance programs (S-CHIP), and some large employers which self-insure. Claims elements can range from medical and mental health service claims to pharmaceutical and dental claims; elements typically not included are denied claims, workers' compensation claims, administrative or per-member/per-month fees, and premiums. Much of current data reporting is institution-based (i.e. – hospitals, etc.) even though most healthcare is office-base and not currently covered by most public data disclosures.

   Healthcare price transparency is a prime motivating factor in the development of APCDs as individual consumers (and other purchasers like employers) have generally been required to cover greater out-of-pocket costs for their healthcare. Healthcare pricing is intended to reflect the total payment a provider receives, including:

1) All consumer-associated costs with a service (i.e. – office visits, in/out-patient hospital services, lab and testing charges, therapy, etc.);

2) Consumer out-of-pocket costs like copays and deductibles; and

3) Any other necessary or negotiable costs or discounts.

Significant issues in how pricing information is used and considered encompass how a person is insured or uninsured, where the services are rendered and by which provider (in versus out-of-network providers).

While an APCD may, in the long term, allow for more comprehensive and robust/complex analysis of a state's or national healthcare system, the initial phase of most systems is to gain a simple understanding of what healthcare costs. The key attribute of an APCD is that each claim within the database will contain individual consumers' *service-level* data. Data elements cover use, cost, frequency of service as well as provider and consumer demographics.

A significant goal of using this information is to gain a more complete picture of care in terms of both micro and macro-level system issues; in aggregate, these elements can be analyzed across an entire healthcare system and geographic area (i.e. – local area, state, region, etc.). At the macro or big-picture level, an analysis of the data can indicate the entirety of system costs or perhaps a comparison of the range of pricing/costs for different treatments, drugs, and procedures. At the individual consumer or provider level, the full cost of treating an illness or medical event (i.e. – heart attack, surgery, broken leg, etc.) can be assessed in relation to potential patient outcomes. Yet the availability of individual consumer and population-based cost information is generally the starting point to understand what healthcare spending is currently covering.

2. The development of APCDs include attention to and deliberation of the following:

- **Goals, uses, purposes trying to be achieved with the information;**
- **Mission defined, stakeholder development, implementation and oversight processes; and**
- **Technical specifications and system build process.**

These elements logically follow the sequential ordering noted above – going from planning to implementation to analysis – but there is intended to be a constant feedback loop and revision process to continue to engage participants and stakeholders to maintain a functioning and valuable system over the long-term. Issues present in each step may need to be revisited depending on continuous input; the systems are not meant to become stagnant once the initial build is completed.

Adapted and compiled from several sources, Attachment A provides a tabular summary of issues that may be considered during the development, implementation and revision stages of an APCD over time. The table notes several different goals and uses of a potential system, a

constantly revolving planning and implementation process, and some technical questions about what payers, data, and reporting to include in a potential system.

Due to the iterative nature of APCD development, an expansive and complex system may not be an initial goal. With constant feedback and planning, an initial system may be revised to include greater amounts of data and information over time that is valuable to all stakeholders; keeping stakeholder engagement even as some may not gain immediate value from the system is important. In the long term, the effectiveness and cost efficiency of a system will logically be better understood when costs are matched more closely with patient outcomes and provider performance measures as these features are defined and become more integrated in the system.

The overall value of the system many be gauged on the following example criteria (not intended to be all-inclusive measures/methods to assess value):

- System Comprehensiveness: including number and breadth of payers, providers covered, service pricing, and service quality elements or consumer feedback forums/listings;
- System Function: a user-friendly, primarily web-based, means to compare services, price, quality as well as timeliness of reported data (current or dated information);
- System/Data Accuracy: level of data validation and reliability of information reported;

These issues resonate mostly with price and quality transparency primarily based on the ability of a consumer to access and engage the system information for *timely* healthcare decision-making. Additional issues related to how the APCD dispenses and disperses information among providers and across payers, all within requisite privacy laws and system legal authorizations/rules, may impact system usefulness to more stakeholders.

3. **Much of the push to implement APCDs has occurred mostly at the state government level. Therefore, most APCDs that are currently operational, and most under construction, are mandate/requirement-based systems under the authority of state governments. According to the All-Payer Claims Database Council (coordinated by the New Hampshire Institute for Health Policy and Practice), as of January 2014, there are 11 states operating some form of state-based APCD, while 6 states are implementing an APCD. Maine is noted to be the first state to implement a formal APCD in 2003 with several other early adopter states including New Hampshire (2010), Utah (2009), and Wisconsin (2008)?**

   There are a handful of states where private, voluntary-based systems have begun (i.e. – Washington, Wisconsin, California), but these are generally limited in scope. Table 1, next page, summarizes in a matrix form some, though not all, of the challenges and potential benefits of using a statute/rules-based system versus a private or voluntary system.

Table 1. Possible Attributes and Challenges to Public and Private APCD Development.

APCD Type	Potential Positive and Negative Attributes	
	Pros	**Cons**
Public	• May lead to more uniform and comparable data submissions/standards • Compel data submission, with legal recourse for non-compliance • Contribute more, or more complete, data for state policy-makers and consumers to use • Potential for low/no cost access to general public and researchers • Potential for more open forum for idea vetting and consideration	• Potential for bureaucratic administrative structure • Challenge to fund with public sources (initial start-up and ongoing administrative costs) • Single-state focus may hinder standardization and coordination among governments or providers working in multiple states • Gaining trust over consumer data privacy
Private	• Potential flexibility in governance and operations (particularly with contracting for technical build) • Potential to review information from providers working in multiple states • Voluntary engagement and consensus-building of payers and providers (and other private sector stakeholders) • May be used to pilot ideas to be incorporated into more uniform/statewide project in the future	• Potential for limited/incomplete data submissions • Potential for limited scope of payers covering less of the population • Potential for limited consumer access and reporting (subscriber or member-only access) • May not meet state policy-makers' statewide/population-based information needs • No legal recourse to compel payer participation or set data submission and reporting standards • Challenge to fund with private resources

Source: LSO Research summary of government and private entities' documents.

There may be additional caution to thinking an APCD can replace existing data systems rather than complement and leverage existing systems. For example, there may still be a need for hospital or Medicaid-specific analysis and the scope of data included in an APCD may not be inclusive and robust enough to completely eliminate some existing data systems and reporting in the short-term.

Attachment B provides a tabular summary of selected other states' APCD history and key characteristics, including inception date, governance structure and administrative practices, use of contract vendors, allowance of or use of personal identifying information, and other relevant issues. The states represented include Maine, New Hampshire, Maryland, Colorado, Utah, Washington, and Wisconsin.

In addition to reviewing each state's documents, other resources consulted include the APCD Council (http://apcdcouncil.org/), National Association of Health Data Organizations (https://www.nahdo.org/), Catalyst for Payment Reform (http://www.catalyzepaymentreform.org/), the Robert Wood Johnson Foundation (http://www.rwjf.org/), as well as other organizations.

If you need anything further, please contact LSO Research at 777-7881.

Attachment A: All-Payer Claims Database (APCD) Goals, Implementation and Technical Considerations

Goals/Uses	Implementation Framework: Mission, Planning and Process	Technical Considerations
• **Price Transparency:** Reveal service-level cost variance, help set payment rate benchmarks, etc. • **Systems and Longitudinal Analysis:** Gauge population and public health through prevalence and cost of conditions over time across systems • **Consolidate Disparate Data:** Bring data from multiple sources to cover multiple consumer groups, such as Medicaid (low income, underserved), Medicare (aged and disabled), hospital discharge data (unique service/delivery system, uninsured), etc. • **Provider Payment Reform:** Help establish bundled or global payment strategies, episode-of-care payments, or other pay-for-performance methods, assist with development and measurement of accountable care organizations, etc. • **Quality Assessment of Service Delivery**: Assess value services over volume of services (best care not necessarily the highest cost) • **Total Health Event Cost**: Help establish full service cost from beginning visit (i.e. – office visit, diagnostics) to ending intervention and recovery (i.e. surgery, medications, post-surgery therapy, etc.) • **Healthcare Best Practice Delivery Assessment**: Review prevalence and efficacy of services and intervention to best practice standards to assess quality of services; use of preventive services and disease management, etc. • **Cost of Alternate Treatment Options for Conditions:** Assess differences in cost for "Evidence-based care," "Preference-based care (consumer choice)," "Supply-sensitive (what's available) care" • **Patient Migration:** Possible assessment of movement of patients between healthcare service areas (geography) and service/payment systems (Public and Private plans)	**Mission: To provide detailed information to help design and assess healthcare cost containment and quality improvement efforts** 1. **Engagement of Key Stakeholders:** Examples include policy-makers, payers, health care providers, employers, government agencies (local, state, national – as needed), consumers, health information exchange, health insurance exchange, etc. 2. **Governance/Operations/Oversight:** Legislative authorization (if state/government established), establishment of administrative rules and procedures, continuous monitoring and refinement 3. **Funding (core funding v. special project funding):** Balance high start-up costs with ongoing operations and improvement costs; use of public (general funds, product – cigarette – taxes or assessments) and/or private funding strategies (possibly for voluntary APCD governed by corporate board); use of payer/provider/consumer fees, research product sales, etc. 4. **Technical Build:** Define reporting requirements, timeliness of reporting, threshold for minimum data coverage, etc. 5. **Analysis and Application Development:** (Types of Reporting) Basic Reporting, Risk-Adjustment Reporting, Comparative Reporting, Modeling (Report Access) website reporting, interactive reporting, provider and payer access to data, etc. 6. **Ongoing and Continuous Feedback:** Set reasonable starting point for system and plan for continuous engagement to add data/components to system	**Payers and Data:** 1. Which payers to include at start? 2. How/When to expand payers required to contribute data? 3. Which data elements to include: claims data (services use, frequency, cost, etc.); eligibility data; demographics data; service types (medical, dental, mental health, pharmaceuticals, etc.)? 4. What pre-existing data can be leveraged? **Definitions and Standards:** 5. Data collection standards? 6. Data definitions and submission formats? 7. Timing of data submissions? 8. Minimum covered lives count or monetary Thresholds for which payers should supply data? 9. Review and validation of data submissions (penalties for non-compliance)? 10. Data analysis standards? **Data Access and Reporting:** 11. Data access limitations for payers, consumers, providers, researchers, etc.? 12. What should consumers use/access? 13. To what should payers have access, particularly competitors' provider/consumer data? 14. To what should providers have access? 15. What basic and advanced research should be done, initially and over long-term, and by whom (government, contractor, foundation, etc.)? 16. What should be the timing and breadth of oversight or audit work? 17. Reporting format standards, timing (monthly, quarterly, etc.), and access methods (web-based)? **Technical and Governance Issues:** 18. Process for periodic updating and maintenance planning; timing of technical and reporting changes; management of intake for reporting requests and dissemination of data/reports? 19. Method of contracting or in-house technology build? 20. What security or encryption is used? 21. Governance structure (state agency, commission/board, etc.) with regular and periodic coordination/collaboration with payers (and other stakeholders); use of advisory committees or working groups?

Source: LSO Research summary of government and private entities' documents.

Attachment B: Structure and Use of All-Payer Claims Database (APCD) by Selected Other States

Characteristic	State						
	Maine	**New Hampshire**	**Maryland**	**Colorado** [1]	**Utah**	**Washington**	**Wisconsin**
Begin System (Year)	2003	2010	2000	2012	2009	2008	2008
System Name	Maine Health Care Claims Database	New Hampshire Health Care Information System	Medical Care Database	Colorado All-Payer Claims Database	Utah All-Payer Claims Database	Washington All-Payer Claims Database	Health Analytics Exchange
Method	State	State	State	State/Private	State	Private	Private
Earliest Historical Data	2003	2005	1998	2009	2007	2004	2006
Lead Agency	Main Health Data Organization (MHDO)	Shared between two state agencies (Health and Insurance)	Department of Health and Hygiene, Maryland Health Care Commission	Center for Improving Value in Health Care	Utah Department of Health, Office of Healthcare Statistics	Washington Health Alliance	Wisconsin Health Information Organization
Other Governance/Leadership	MHDO Policy Board	Data Release and Privacy Review Committees	Center for Analysis and Information Systems, Cost and Quality Analysis Division	Advisory Committee with two other data and data release committees	Health Data Committee	Four Separate Stakeholder Committees	Five Committees
Funding	Healthcare provider and payer fee assessment; Data product sales	State general funds; minimal data product sales and non-compliance fines/penalties	State Funds	Private foundation funds, no public funds	State funds	Private/Foundation funds	Private/ Foundation funds
Administration/Database Responsibility	In-house/ contract vendor	Contract Vendor	In-House/Contract Vendor	Contract Vendor	In-House/ Contract Vendor	Contract Vendor	Contract Vendor
Collection of Direct Patient Identifiers	Allowed statutorily, not currently done	Not currently allowed	Statutorily allowed; encrypted	Allowed; encrypted	Statutorily allowed; unencrypted	Unknown	Unknown
Payers Included/Scope of Data submission limitations	Minimum of 200 covered lives per month, per payer; or minimum $500,000 in adjusted premiums or processed claims in CY	Insurers/carriers within small group and individual markets; Third-party payers that write more than $250,000 in annual premiums or cover more than 200 lives	HMOs with over 1000 lives covered; private insurers	21 largest private insurers; Medicaid	All insurers/carriers that cover at least 2,500 lives	Members	Members

Characteristic	State						
	Maine	**New Hampshire**	**Maryland**	**Colorado**	**Utah**	**Washington**	**Wisconsin**
Common Reports	Cost compare of procedures by location	Health cost comparisons for consumers and employers	State health expenditures; Practitioner utilization report	Total cost of care; Service utilization	Hospital discharge statistics	Community Checkup (health care quality and value at medical groups and hospitals)	Unknown
Public Web-Based Reporting (Y/N) - Public Interactive Querying	Yes - Interactive	No/Yes	Yes - Not Interactive	Yes - Interactive	Yes - Interactive	Yes - Not Interactive	No
Public Web Site	https://mhdo.maine.gov/healthcost2014/	https://nhchis.com/NH/ http://www.nhhealthcost.org/default.aspx	http://mhcc.dhmh.maryland.gov/SitePages/Home.aspx	https://www.cohealthdata.org/#/home	http://health.utah.gov/hda/dataproducts.php	http://wahealthalliance.org/	http://www.wisconsinhealthinfo.org/
Example Analyses/Reports	Medicaid/Medicare reimbursement levels and cost shifting to commercial payers (little correlation)	Payment Differences in Reimbursement to Ophthalmologists and Optometrists	Diabetes among Maryland's Privately Insured, Non-elderly Population	Total Imaging Services; High Cost Imaging	Hip and Knee Care; Hearth and Stroke Care	Disparities in Care; Report on Generic Drug Prescribing	Unknown

Source: LSO Research summary of government and private entities' documents.

[1] Colorado's APCD is statutorily required and state government has broad oversight of the program. However, the actual database is operated and coordinated by a private company with the support of private/foundation funds, rather than public funds.

Wyoming Hospital Uncompensated Care Update

Data: Centers for Medicare and Medicaid Systems (CMS) - Hospital Cost Report Information System (HCRIS), downloaded 4/22/2015

* FY 2011 columns with an asterisk were downloaded on April, 2014 and are reported in the Cost Shift Study. Report amendments submitted over the last year likely explain some of the differences between the two FY 2011 columns.
^ FY2013 data for Campbell County Memorial was not available in HCRIS at the time of download.

				Unreimbursed (S-10/19/1)				**Bad Debt** (S-10/29/1)				**Charity** (S-10/23/3)				**Total** (S-10/31/1)			
Hospital	**City**	**CAH**	**Category**	2011 (4/2014)*	2011 (4/2015)	2012	2013	2011 (4/2014)*	2011 (4/2015)	2012	2013	2011 (4/2014)*	2011 (4/2015)	2012	2013	2011 (4/2014)*	2011 (4/2015)	2012	2013
Campbell County Memorial^	Gillette		Small	$0	$0	$1,467,113	N/A	$7,554,290	($11,931)	$9,323,914	N/A	$3,673,192	$3,673,192	$3,315,755	N/A	$11,227,482	$3,661,261	$14,106,782	N/A
Sheridan County Memorial	Sheridan		Small	$676,775	$676,775	$177,034	$113,124	$3,004,780	$3,006,089	$3,715,249	($9,175)	$654,496	$654,496	$1,054,224	$1,124,366	$4,336,051	$4,337,360	$4,946,507	$1,228,315
Riverton Memorial	Riverton		Small	$76,723	$9,242	$1,365,998	$699,440	$2,177,758	$2,140,089	$0	$2,231,730	$91,919	$90,329	$55,773	$44,640	$2,346,400	$2,239,660	$1,421,771	$2,975,810
Lander Regional	Lander		Small	$292,207	$226,164	$483,646	$817,793	$1,448,054	$1,426,641	$1,582,945	$1,722,152	$57,463	$56,613	$61,034	$27,866	$1,797,724	$1,709,418	$2,127,625	$2,567,811
Sweetwater County Memorial	Rock Springs		Small	$224,685	$224,685	$1,217,724	$1,215,481	$3,978,659	$3,978,659	$3,567,936	$4,052,286	$960,205	$960,205	$1,104,172	$1,202,175	$5,163,549	$5,163,549	$5,889,832	$6,469,942
Wyoming Medical Center	Casper		Med - Teaching	$4,685,308	$4,666,839	$5,384,148	$5,031,800	$10,535,433	$10,523,784	$9,700,893	$9,609,774	$9,788,942	$9,772,030	$10,818,813	$9,029,990	$25,009,683	$24,962,653	$25,903,854	$23,671,564
Cheyenne Regional	Cheyenne		Med- Teaching	$1,655,506	$1,655,506	$3,466,280	$2,624,291	$12,539,013	$12,539,013	$12,609,326	$12,427,238	$5,070,478	$5,070,478	$6,151,352	$4,732,427	$19,264,997	$19,264,997	$22,226,958	$19,783,956
St. John's	Jackson		Small	$1,289,334	$1,289,334	$1,124,198	$1,097,114	$2,345,710	$2,345,743	$2,109,395	$1,944,512	$540,647	$540,647	$1,001,505	$1,215,936	$4,175,691	$4,175,724	$4,235,098	$4,257,562
Ivinson Memorial	Laramie		Small	$429,221	$429,221	$876	$530,607	$2,679,402	$2,679,402	$2,120,819	$1,539,223	$482,136	$482,136	$519,409	$432,758	$3,590,759	$3,590,759	$2,641,104	$2,502,588
Evanston Regional	Evanston		Small	$603,676	$557,089	$593,156	$407,789	$793,817	$779,499	$869,841	$641,709	$41,414	$40,660	$47,939	$156,977	$1,438,907	$1,377,248	$1,510,936	$1,206,475
Mountain View Regional	Casper		Very Small	$877,902	$841,354	$680,729	$226,842	$903,157	$888,629	$687,260	$641,497	$0	$0	$17,868	$31,663	$1,781,059	$1,729,983	$1,385,857	$900,002
South Big Horn	Basin	X	Very Small	$203,389	$203,389	$157,639	$168,297	$101,740	$101,740	$158,275	$162,800	$73,790	$73,790	$0	$0	$378,919	$378,919	$315,914	$331,097
Converse County Memorial	Douglas	X	Very Small	$1,265,309	$1,251,180	$1,422,739	$0	$2,200,265	$2,192,365	$3,181,867	$2,997,013	$0	$0	$810,355	$421,636	$3,465,574	$3,443,545	$5,414,961	$3,418,649
Weston County	Newcastle	X	Very Small	$0	$0	$0	$133,883	$392,284	$394,399	$437,415	$543,653	$125,525	$125,525	$39,692	$23,572	$517,809	$519,924	$477,107	$701,108
Hot Springs County Memorial	Thermopolis	X	Very Small	$0	$0	$0	$0	$708,743	$708,743	$697,616	$585,115	$102,676	$102,676	$193,951	$144,378	$811,419	$811,419	$891,567	$729,493
Platte County Memorial	Wheatland	X	Very Small	$179,182	$100,803	$242,190	$238,958	$641,883	$605,048	$746,540	$663,202	$611,517	$576,540	$577,598	$514,989	$1,432,582	$1,282,391	$1,566,328	$1,417,149
Washakie Medical Center	Worland	X	Very Small	$267,253	$256,579	$0	$329,172	$679,600	$676,048	$1,058,596	$604,732	$947,717	$942,764	$873,183	$759,969	$1,894,570	$1,875,391	$1,931,779	$1,693,873
Community Hospital	Torrington	X	Very Small	$804,463	$697,180	$0	$396,461	$466,363	$445,045	($51,389)	$498,875	$773,763	$738,394	$0	$482,372	$2,044,589	$1,880,619	($51,389)	$1,377,708
Johnson County	Buffalo	X	Very Small	$0	$0	$0	$0	$725,045	$725,045	$1,177,344	$1,278,559	$89,051	$89,051	$155,494	$140,163	$814,096	$814,096	$1,332,838	$1,418,722
North Big Horn	Lovell	X	Very Small	$560,522	$560,522	$347,768	$404,939	$368,020	$368,020	$422,639	$472,509	$454,568	$454,568	$1,083,290	$1,130,541	$1,383,110	$1,383,110	$1,853,697	$2,007,989
Powell Valley	Powell	X	Very Small	$836,252	$836,571	$982,440	$1,845,521	$1,587,383	$1,592,748	$3,005,828	$2,726,115	$0	$0	$0	$658,334	$2,423,635	$2,429,319	$3,988,268	$5,229,970
Crook County	Sundance	X	Very Small	$402,656	$402,656	$187,598	$0	$62,729	$62,729	$108,244	$422,234	$0	$0	$101,365	$10,267	$465,385	$465,385	$397,207	$432,501
West Park	Cody	X	Very Small	$574,550	$574,550	$206,397	$511,533	$2,388,346	$2,388,346	$3,139,965	$3,068,015	$495,966	$495,966	$785,347	$2,072,970	$3,458,862	$3,458,862	$4,131,709	$5,652,518
Star Valley	Afton	X	Very Small	$220,953	$220,953	$455,825	$197,352	$862,878	$862,878	$987,679	$626,443	$294,878	$294,878	$318,369	$364,982	$1,378,709	$1,378,709	$1,761,873	$1,188,777
Niobrara Health and Life	Lusk	X	Very Small	$654,752	$654,752	$294,102	$2,290,434	$305,741	$305,741	$253,130	$441,583	$68,919	$68,919	$88,689	$31,423	$1,029,412	$1,029,412	$635,921	$2,763,440
South Lincoln	Kemmerer	X	Very Small	$226,101	$226,101	$243,417	$557,385	$759,197	$759,197	$675,906	$470,701	$295,579	$295,579	$386,053	$326,319	$1,280,877	$1,280,877	$1,305,376	$1,354,405
Carbon County Memorial	Rawlins	X	Very Small	$269,604	$385,411	$0	$640,203	$2,172,433	$2,290,091	$2,775,854	$3,804,569	$773,636	$815,535	$328,451	$258,249	$3,215,673	$3,491,037	$3,655,548	$4,703,021
Total State				$17,276,323	$16,946,856	$20,501,017	$20,478,419	$62,382,723	$54,773,800	$65,063,087	$54,167,064	$26,468,477	$26,414,971	$29,889,681	$25,338,962	$106,127,523	$98,135,627	$116,005,028	$99,984,445
National (medians)																			

Wyoming Hospital Uncompensated Care Update

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^ FY2013 data for Campbell County Memorial was not available in HCRIS at the time of download.

		Total (S-10/31/1)				**Unadjusted Operating Expenses** (A/200/3)				**% of Operating Expenses**			
Hospital	**City**	2011 (4/2014)*	2011 (4/2015)	2012	2013	2011 (4/2014)*	2011 (4/2015)	2012	2013	2011 (4/2014)*	2011 (4/2015)	2012	2013
Campbell County Memorial^	Gillette	$11,227,482	$3,661,261	$14,106,782	N/A	$122,784,402	$122,784,402	$140,695,754	N/A	9.1%	3.0%	10.0%	N/A
Sheridan County Memorial	Sheridan	$4,336,051	$4,337,360	$4,946,507	$1,228,315	$60,094,153	$60,094,153	$69,535,833	$73,198,771	7.2%	7.2%	7.1%	1.7%
Riverton Memorial	Riverton	$2,346,400	$2,239,660	$1,421,771	$2,975,810	$32,882,885	$32,882,885	$33,048,114	$30,566,119	7.1%	6.8%	4.3%	9.7%
Lander Regional	Lander	$1,797,724	$1,709,418	$2,127,625	$2,567,811	$33,915,600	$33,915,600	$35,413,780	$36,826,330	5.3%	5.0%	6.0%	7.0%
Sweetwater County Memorial	Rock Springs	$5,163,549	$5,163,549	$5,889,832	$6,469,942	$53,467,135	$53,467,135	$57,217,244	$67,964,421	9.7%	9.7%	10.3%	9.5%
Wyoming Medical Center	Casper	$25,009,683	$24,962,653	$25,903,854	$23,671,564	$191,217,385	$191,217,385	$182,356,369	$193,132,529	13.1%	13.1%	14.2%	12.3%
Cheyenne Regional	Cheyenne	$19,264,997	$19,264,997	$22,226,958	$19,783,956	$231,341,678	$231,341,678	$245,528,832	$255,855,768	8.3%	8.3%	9.1%	7.7%
St. John's	Jackson	$4,175,691	$4,175,724	$4,235,098	$4,257,562	$72,569,265	$72,569,265	$78,868,991	$83,383,777	5.8%	5.8%	5.4%	5.1%
Ivinson Memorial	Laramie	$3,590,759	$3,590,759	$2,641,104	$2,502,588	$60,259,260	$60,259,260	$60,692,853	$61,751,845	6.0%	6.0%	4.4%	4.1%
Evanston Regional	Evanston	$1,438,907	$1,377,248	$1,510,936	$1,206,475	$21,494,140	$21,494,140	$23,257,673	$22,965,568	6.7%	6.4%	6.5%	5.3%
Mountain View Regional	Casper	$1,781,059	$1,729,983	$1,385,857	$900,002	$34,597,824	$34,597,824	$38,958,700	$43,286,074	5.1%	5.0%	3.6%	2.1%
South Big Horn	Basin	$378,919	$378,919	$315,914	$331,097	$5,955,445	$5,955,445	$6,056,637	$6,734,399	6.4%	6.4%	5.2%	4.9%
Converse County Memorial	Douglas	$3,465,574	$3,443,545	$5,414,961	$3,418,649	$35,426,232	$35,426,232	$41,615,457	$47,354,342	9.8%	9.7%	13.0%	7.2%
Weston County	Newcastle	$517,809	$519,924	$477,107	$701,108	$10,465,482	$10,465,482	$11,010,978	$12,532,293	4.9%	5.0%	4.3%	5.6%
Hot Springs County Memorial	Thermopolis	$811,419	$811,419	$891,567	$729,493	$13,886,815	$13,886,815	$13,978,507	$15,341,248	5.8%	5.8%	6.4%	4.8%
Platte County Memorial	Wheatland	$1,432,582	$1,282,391	$1,566,328	$1,417,149	$13,810,272	$13,810,272	$14,199,213	$13,919,723	10.4%	9.3%	11.0%	10.2%
Washakie Medical Center	Worland	$1,894,570	$1,875,391	$1,931,779	$1,693,873	$16,686,219	$16,686,219	$17,273,039	$17,713,111	11.4%	11.2%	11.2%	9.6%
Community Hospital	Torrington	$2,044,589	$1,880,619	($51,389)	$1,377,708	$17,913,750	$17,913,750	$18,010,990	$17,464,893	11.4%	10.5%	-0.3%	7.9%
Johnson County	Buffalo	$814,096	$814,096	$1,332,838	$1,418,722	$17,996,687	$17,996,687	$18,838,149	$19,849,858	4.5%	4.5%	7.1%	7.1%
North Big Horn	Lovell	$1,383,110	$1,383,110	$1,853,697	$2,007,989	$14,391,772	$14,391,772	$14,456,491	$15,712,087	9.6%	9.6%	12.8%	12.8%
Powell Valley	Powell	$2,423,635	$2,429,319	$3,988,268	$5,229,970	$44,071,898	$44,071,898	$45,773,146	$44,423,787	5.5%	5.5%	8.7%	11.8%
Crook County	Sundance	$465,385	$465,385	$397,207	$432,501	$6,845,809	$6,839,064	$6,727,718	$7,043,040	6.8%	6.8%	5.9%	6.1%
West Park	Cody	$3,458,862	$3,458,862	$4,131,709	$5,652,518	$61,392,105	$61,392,105	$69,303,316	$76,573,280	5.6%	5.6%	6.0%	7.4%
Star Valley	Afton	$1,378,709	$1,378,709	$1,761,873	$1,188,777	$23,168,034	$23,168,034	$37,533,233	$28,899,829	6.0%	6.0%	4.7%	4.1%
Niobrara Health and Life	Lusk	$1,029,412	$1,029,412	$635,921	$2,763,440	$6,044,485	$6,044,485	$6,140,155	$6,548,718	17.0%	17.0%	10.4%	42.2%
South Lincoln	Kemmerer	$1,280,877	$1,280,877	$1,305,376	$1,354,405	$12,839,183	$12,839,183	$12,686,547	$13,190,073	10.0%	10.0%	10.3%	10.3%
Carbon County Memorial	Rawlins	$3,215,673	$3,491,037	$3,655,548	$4,703,021	$21,432,634	$21,532,603	$22,021,193	$21,802,548	15.0%	16.2%	16.6%	21.6%
Total State		$106,127,523	$98,135,627	$116,005,028	$99,984,445	$1,236,950,549	$1,237,043,773	$1,321,198,912	$1,234,034,431	8.6%	7.9%	8.8%	8.1%
National (medians)											6.5%	6.7%	6.7%

ATTACHMENT D

County-level Insurance Estimates (2013)

Wyoming Department of Health

Estimates for insurance coverage by county for all residents are shown in Table 1, below, and depicted graphically in Figure 1, on the next page. Estimates for insurance coverage by county for those residents under 100% of the Federal Poverty Level are shown in Table 2 and Figure 2.

Data sources and methodological notes for each insurance coverage category are explained in subsequent sections.

Table 1: Estimated percent of county population, by type of insurance

County	2013 Population [1]	Insurance Coverage								
		Uninsured [2]	Indian Health Service only [3]	Medicaid/CHIP [4]	Medicaid + Medicare [4]	Medicare [5]	Veterans' Administration [6]	TRICARE [7]	Directly Purchased [8]	Employer Sponsored [8]
Laramie	95,809	12.3%	0.3%	12.3%	0.8%	14.6%	2.5%	14.5%	4.3%	38.4%
Natrona	80,973	13.2%	0.3%	12.6%	1.0%	13.4%	1.5%	0.5%	5.4%	52.1%
Campbell	48,176	11.9%	0.4%	10.2%	0.5%	8.3%	1.2%	0.4%	6.8%	60.4%
Sweetwater	45,237	13.1%	0.3%	10.2%	0.4%	10.5%	1.5%	0.0%	5.6%	58.3%
Fremont	40,998	13.1%	5.0%	19.5%	1.4%	15.9%	1.6%	0.3%	3.8%	39.4%
Albany	37,422	14.8%	0.2%	7.8%	0.6%	10.9%	1.1%	0.3%	6.5%	57.9%
Sheridan	29,824	12.9%	0.3%	10.4%	1.0%	17.9%	2.0%	1.0%	7.5%	47.0%
Park	29,227	14.1%	0.2%	10.4%	1.0%	19.6%	1.7%	0.0%	7.3%	45.8%
Teton	22,268	17.6%	0.2%	6.3%	0.3%	13.3%	1.2%	0.0%	8.4%	52.7%
Uinta	21,066	13.1%	0.3%	13.6%	0.7%	11.7%	1.2%	0.0%	5.2%	54.2%
Lincoln	18,364	13.3%	0.2%	9.7%	0.5%	15.5%	1.1%	0.7%	8.1%	50.8%
Carbon	15,748	15.9%	0.4%	11.4%	0.9%	14.5%	1.9%	0.0%	5.1%	49.9%
Converse	14,313	11.7%	0.3%	10.4%	1.0%	14.3%	1.8%	0.0%	5.7%	55.0%
Goshen	13,612	14.4%	0.2%	12.8%	1.6%	19.5%	1.7%	0.3%	5.0%	44.4%
Big Horn	11,994	16.4%	0.3%	13.4%	1.7%	18.5%	1.7%	0.3%	6.5%	41.1%
Sublette	10,041	13.3%	0.3%	6.0%	0.4%	13.7%	1.3%	0.0%	5.7%	59.3%
Platte	8,765	13.2%	0.2%	11.8%	1.7%	21.5%	2.0%	1.7%	4.9%	43.2%
Johnson	8,628	14.4%	0.4%	8.6%	1.1%	20.5%	2.0%	0.0%	5.4%	47.6%
Washakie	8,463	15.1%	0.4%	12.1%	1.3%	19.3%	1.7%	0.0%	5.1%	45.0%
Crook	7,184	13.3%	0.2%	9.6%	0.6%	18.3%	1.4%	0.0%	5.8%	50.8%
Weston	7,158	12.7%	0.4%	9.9%	1.2%	17.7%	2.0%	0.0%	5.7%	50.4%
Hot Springs	4,847	16.0%	0.4%	14.1%	2.1%	22.1%	2.6%	0.0%	3.7%	38.9%
Niobrara	2,541	15.7%	0.2%	13.3%	2.6%	19.1%	1.4%	1.2%	4.7%	41.7%
Wyoming	582,658	13.4%	0.6%	11.5%	0.9%	14.3%	1.7%	2.6%	5.7%	49.2%

Figure 1: Estimated insurance coverage, percent and number of residents, by county

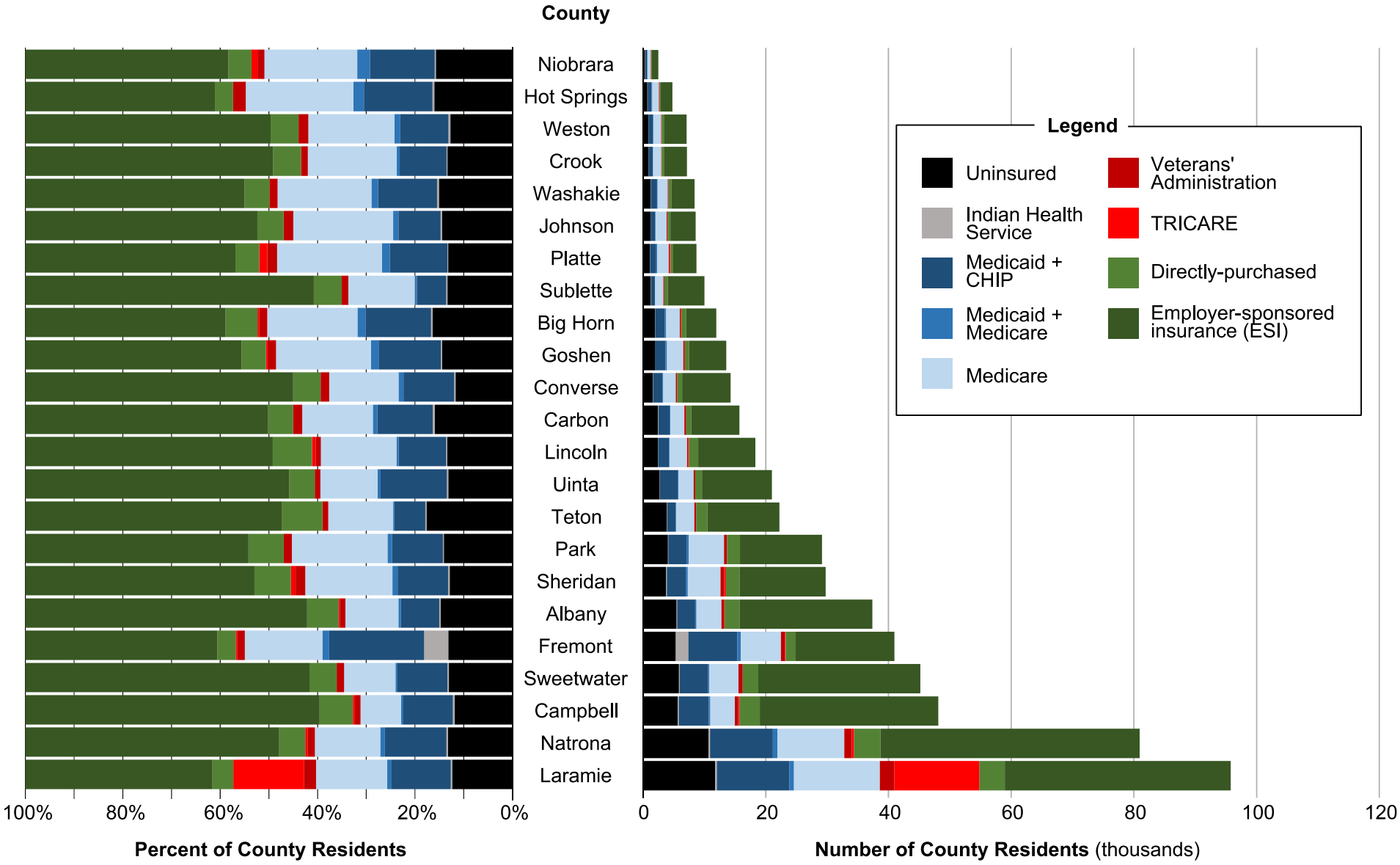
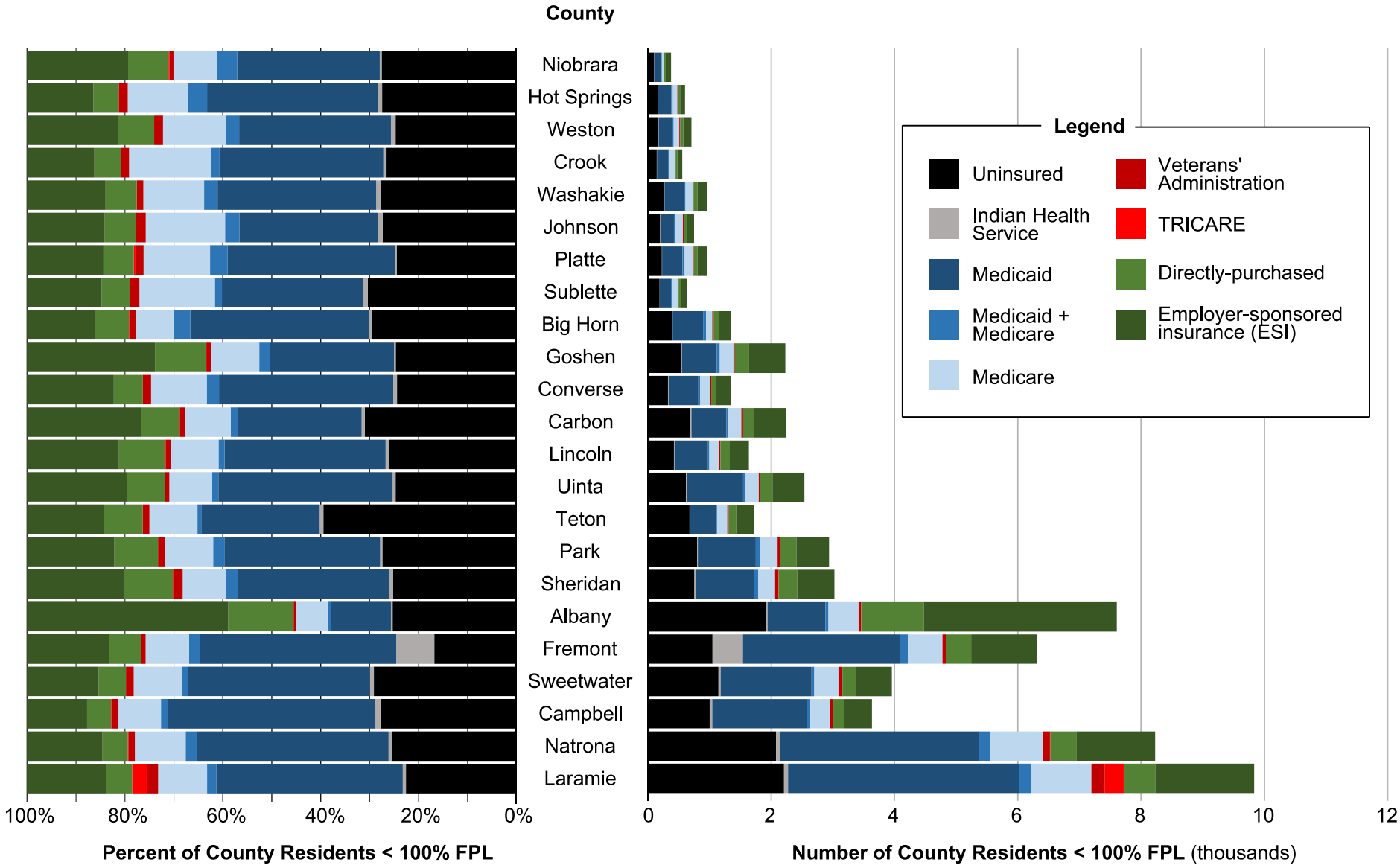


Table 2: Estimated insurance coverage of those county residents under 100% of the Federal Poverty Level (FPL)

County	2013 Estimated population under 100% FPL [9]	Insurance Coverage								
		Uninsured [10]	Indian Health Service only [11]	Medicaid [12]	Medicaid + Medicare [12]	Medicare [13]	Veterans' Administration [14]	TRICARE [14]	Directly Purchased [15]	Employer Sponsored [15]
Laramie	9,773	22.5%	0.7%	38.1%	1.9%	10.0%	2.2%	3.1%	5.3%	16.2%
Natrona	8,178	25.3%	0.8%	39.2%	2.2%	10.4%	1.3%	0.1%	5.2%	15.4%
Campbell	3,613	27.7%	1.2%	42.3%	1.5%	8.7%	1.4%	0.1%	4.9%	12.3%
Sweetwater	3,936	29.1%	0.8%	37.2%	1.1%	10.0%	1.6%	0.0%	5.6%	14.7%
Fremont	6,273	16.7%	7.8%	40.2%	2.2%	8.9%	0.9%	0.0%	6.4%	16.9%
Albany	7,559	25.3%	0.3%	12.3%	0.7%	6.4%	0.5%	0.0%	13.4%	41.1%
Sheridan	3,012	25.1%	0.8%	30.9%	2.4%	8.9%	1.8%	0.2%	9.9%	19.9%
Park	2,923	27.3%	0.5%	31.8%	2.3%	9.8%	1.5%	0.0%	8.9%	17.9%
Teton	1,715	39.4%	0.8%	24.2%	0.8%	9.8%	1.4%	0.0%	7.9%	15.8%
Uinta	2,528	24.6%	0.6%	35.6%	1.3%	8.8%	0.9%	0.0%	7.8%	20.4%
Lincoln	1,634	26.0%	0.7%	32.9%	1.2%	9.7%	1.1%	0.2%	9.4%	18.8%
Carbon	2,236	30.9%	0.7%	25.3%	1.5%	9.3%	1.2%	0.0%	7.8%	23.4%
Converse	1,345	24.4%	0.7%	35.7%	2.5%	11.4%	1.7%	0.0%	5.9%	17.8%
Goshen	2,219	24.6%	0.4%	25.3%	2.3%	9.9%	1.0%	0.0%	10.4%	26.2%
Big Horn	1,343	29.4%	0.7%	36.6%	3.5%	7.7%	1.3%	0.1%	6.9%	13.9%
Sublette	633	30.3%	1.0%	28.8%	1.5%	15.4%	1.9%	0.0%	5.8%	15.3%
Platte	955	24.4%	0.4%	34.3%	3.6%	13.6%	1.6%	0.3%	6.2%	15.6%
Johnson	751	27.3%	1.0%	28.3%	2.9%	16.3%	2.0%	0.0%	6.3%	15.9%
Washakie	956	27.7%	0.8%	32.4%	2.7%	12.5%	1.3%	0.0%	6.4%	16.1%
Crook	560	26.5%	0.7%	33.4%	1.8%	16.7%	1.6%	0.0%	5.5%	13.8%
Weston	709	24.6%	1.0%	31.0%	2.8%	12.7%	1.8%	0.0%	7.4%	18.6%
Hot Springs	606	27.4%	0.8%	35.0%	4.0%	12.2%	1.9%	0.0%	5.2%	13.6%
Niobrara	381	27.5%	0.4%	29.1%	4.1%	9.0%	0.9%	0.2%	8.2%	20.7%
Wyoming	63,838	25.2%	1.4%	32.8%	1.8%	9.6%	1.4%	0.5%	7.4%	19.9%

Figure 2: Estimated insurance coverage of those county residents under 100% of the Federal Poverty Level (FPL)



Data Sources

No one data source has both comprehensive and precise estimates of health insurance coverage at the county level.

The estimates in Tables 1 and 2 were created by combining the best features of five data sources under simplifying assumptions, which are spelled out in the notes section that follows. The five sources used were:

A. US Census 2013 Resident Population Estimates. These tables, which can be found on the website of the State of Wyoming Department of Administration and Information (A&I) Economic Analysis Division website[1] or the American FactFinder website[2] represent the best estimates of various demographic groups (e.g. "males, ages 0-5") originally counted in the 2010 Decennial Census. They do not, however, contain health insurance coverage information.

B. Wyoming Medicaid claims data and CHIP enrollment data used for precise estimates of Medicaid/CHIP and dual-eligible (Medicaid/Medicare) enrollment by county for calendar year (CY) 2013.

C. US Census American Community Survey (ACS). The 2009 - 2013 ACS Public Use Microdata Sample (PUMS)[3] contains the most precise estimates of health insurance coverage for the State Wyoming and its five Public Use Microdata Areas (PUMAs). Each PUMA in Wyoming covers multiple counties, as listed in Table 3, below.

Table 3: Public Use Microdata Areas

PUMA[4]	Counties
100	Sheridan, Park, Teton, Lincoln, Big Horn
200	Campbell, Goshen, Platte, Johnson, Washakie, Weston, Crook, Niobrara
300	Laramie, Albany
400	Natrona, Carbon, Converse
500	Sweetwater, Fremont, Uinta, Sublette, Hot Springs

Note that this ACS sample (28,652 data points) was gathered over five years, so while it allows the most precise and flexible estimates, it will not reflect recent developments in the health insurance market (e.g. the launch of the Federally-Facilitated Marketplace).

[1] http://eadiv.state.wy.us/pop/pop.html
[2] http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml
[3] http://www.census.gov/acs/www/data_documentation/pums_documentation/
[4] http://www.census.gov/geo/maps-data/maps/2010puma/st56_wy.html

The American Community Survey defines various insurance coverages as follows[5]:

- Employer-based health insurance is coverage offered through one's own or a relative's current, or former, employer or union.

- Direct-purchase health coverage is purchased directly from an insurance company by an individual or an individual's relative.

- TRICARE or other military health coverage is offered through health care programs for active-duty military personnel and retired members of the uniformed services, and their families and survivors.

- Medicare is a Federal program which helps pay health care costs for people age 65 older, and for certain people under age 65 with long-term disabilities.

- Medicaid is a government-assistance plan for those with low incomes or a disability.

- The Children's Health Insurance Program (CHIP) is a state-level program providing health care to low-income children whose parents do not qualify for Medicaid.

- VA Health Care is a Department of Veterans Affairs program that provides medical assistance to eligible veterans. Those who have ever used or enrolled in VA Health Care are considered covered to have VA coverage.

- Indian Health Service (IHS) is a health care program through which the Department of Health and Human Services provides medical assistance to eligible American Indians at IHS facilities. In addition, the IHS helps pay the cost of selected health care services provided at non-IHS facilities. *People whose only health coverage is Indian Health Service are uninsured as IHS is not considered comprehensive coverage.*

D. US Census Small Area Health Insurance Estimates (SAHIE). This tool uses the same ACS data to create county-level estimates of the uninsured.[6]

E. US Census Small Area Income and Poverty Estimates (SAIPE). This tool uses ACS data to create county-level estimates of those below the poverty line.[7]

[5] http://www.census.gov/hhes/www/hlthins/methodology/definitions/acs.html
[6] http://www.census.gov/did/www/sahie/index.html
[7] http://www.census.gov/did/www/saipe/data/index.html

Methodology

These notes explain the data sources and assumptions made in constructing estimates for each column in Table 1 and Table 2.

First, however, it is important to illustrate a significant challenge with the health insurance coverage variables reported in the American Community Survey data: namely, duplicate (or more -- up to 7) coverage. Table 4, below, shows how estimates overlap for various insurance types for the non-institutionalized resident population:

Table 4: Insurance coverage overlap in the ACS data, estimated population.

Reported Insurance Coverages (#)	Estimated Number of Individuals
0	79,789
1	387,920
2	73,326
3	17,127
4	4,320
5	679
6	186
7	12
Total	563,359

Note in the table that approximately 17% (95,650 distinct) individuals, highlighted in blue, are estimated to have more than one insurance coverage. This is a problem consistent with national data.[8] Some of the issue can be explained by supplemental insurance - many Medicare recipients also purchase 'Medigap' policies. Some individuals (e.g. Native Americans) may be covered by both HIS and Medicaid, Medicare, or private insurance. In other cases, individuals switch coverage over the year. Still other cases are implausible (e.g the datapoints covered by all 7 forms).

Regardless of the issue, this problem was addressed by assigning individuals to insurance categories hierarchically, by making the assumption that certain types of insurance were more comprehensive or primary than others. The assumed hierarchy was:

Assumption 1: Insurance Coverage Hierarchy
Medicare > Medicaid > VA > TRICARE > ESI > Directly-purchased > IHS only > Uninsured

That is, if an individual was listed as having both directly purchased insurance and Medicare, they were assigned to the Medicare coverage category. If they were covered by ESI, directly-purchased insurance and IHS, they would be assigned the ESI category.

[8] Multiple coverage types are discussed on page 4 of this brief:
https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf

Table 1 Notes

1. County population estimates, by five-year age bands, were obtained from the 2013 county tables (source A).

2. Estimates of the uninsured were calculated by multiplying the estimated percent uninsured under 65 from SAHIE (source D) by the county population estimates under 65 (A). Once IHS-only and Medicare estimates were complete, those covered by IHS were subtracted and estimated uninsured over 65 were added to the total.

3. Indian Health Service (IHS)-only estimates for the State (3,659 total) were obtained from ACS data (C) and distributed by county according to the percentage of Native Americans in each county, as reported in the population tables (A).

> **Assumption 2**: IHS-only individuals are distributed by county similar to Native Americans generally.

As noted in 2, above, the IHS-only totals were subtracted from the uninsured estimates to avoid double-counting; IHS-only are considered uninsured in the ACS/SAHIE estimates.[9]

4. Medicaid estimates were obtained by summing the number of member-months by county for CY 2013 and dividing by 12 to obtain 'member-years,' which best represents the average monthly Medicaid enrollment for the year. One individual enrolled in Medicaid for one month of 2013 would effectively count for 1/12th of a Medicaid member under this methodology.

> **Assumption 3:** "Dual-eligibles" are those Medicaid members age 65 or older.

5. Medicare estimates were obtained by determining the statewide proportion of eligible individuals over 65 on Medicare (97.2%, from source C) and those under 65 on Medicare (i.e. on SSDI, 2.4%) and multiplying this by the number of individuals over 65 and under 65 in each county, respectively (from the tables in source A).

> **Assumption 4**
> Medicare-eligibles in both over-65 and under-65 demographics are distributed evenly throughout the State.

6. Veterans' Administration estimates were calculated similar to IHS-only, by taking the total estimate for the State (9,719 from C) and distributing this by county according to the fraction of veterans reported in each county (A).

> **Assumption 5**: Veterans who rely on the VA for health care are distributed similarly to veterans generally.

[9] "People whose only health coverage is Indian Health Service are uninsured as IHS is not considered comprehensive coverage." http://www.census.gov/hhes/www/hlthins/methodology/definitions/acs.html

7. TRICARE. As with VA and IHS estimates, the number of individuals relying on TRICARE Statewide (15,311 from C) was distributed by county according to the fraction of reported members of the armed forces by county (A).

> **Assumption 6**: TRICARE beneficiaries (to include dependents, retirees, Reserve and National Guard) are distributed by county similar to members of the armed forces.

8. Privately-insured were calculated by subtracting the estimated members above (Uninsured, Medicaid, Medicare, IHS-only, VA, TRICARE) from the total county population. This remainder was multiplied by the estimated fraction of ESI vs. directly-purchased insurance by PUMA, as shown in Table 5, below.

Table 5: Of remaining privately-insured, fraction with ESI vs. directly-purchased, by PUMA.

PUMA	Counties	ESI	Directly-purchased
100	Sheridan, Park, Teton, Lincoln, Big Horn	86.3%	13.7%
200	Campbell, Goshen, Platte, Johnson, Washakie, Weston, Crook, Niobrara	89.8%	10.2%
300	Laramie, Albany	89.9%	10.1%
400	Natrona, Carbon, Converse	90.7%	9.3%
500	Sweetwater, Fremont, Uinta, Sublette, Hot Springs	91.2%	8.8%

Table 2 Notes

9. Individuals under 100% of the Federal Poverty Level were estimated at the county level by multiplying SAIPE county-level percentages (source E) with the 2013 population estimates (source A). This group was divided into over 65 and under 65 groups by using ACS estimates (at the PUMA level) to estimate over-65 poverty rates and subtracting this from the total.

10. Uninsured under 100% for each county was determined by using the statewide estimate (30.4%) and adjusting it across counties using the SAHIE estimates for uninsured < 138% (estimates for < 100% do not exist in this tool).

> **Assumption 7**
> Uninsured rates by county for those under 100% FPL mirror the distribution by county for those under 138% FPL.

11. IHS-only estimates were computed similarly as in Note 3, but using a statewide estimate of IHS-only under 100% FPL as the base (877 instead of 3,659).

12. Medicaid and dual-eligible numbers were calculated by adjusting county-level MMIS counts (B) downward (by factors of 0.34 and 0.23, respectively) such that the total number (20,954 and 1,177) equaled the estimated count of Medicaid recipients under 65 and over 65 in the ACS data (source C).

Assumption 8
The distribution of Medicaid members under the poverty level across counties reflects the distribution of Medicaid members generally.

13. Medicare estimates were arrived at similarly to Note 5, only using the over 65 below poverty level demographic group as a base and an estimate of 91.4% for those on Medicare (C). The under-65 demographic group was multiplied by an 4.5% to arrive at the estimated SSDI-eligible population (C).

Assumption 9
The percent of those under the poverty level who are on Medicare is even across counties for both over-65 and under-65 demographics.

14. VA and TRICARE numbers were estimated similarly to Note 6 and 7, only a base of 873 below 100% was used instead of 9,719 for veterans and 337 below 100% instead of 15,311 for TRICARE-eligibles.

15. ESI and directly-purchased insurance were estimated in the same manner as Note 8. PUMA-level estimates for ESI and directly-purchased insurance were obtained from source C, and can be seen in Table 6, below.

Table 6: Of remaining privately-insured *under the Federal Poverty Level*, fraction with ESI vs. directly-purchased, by PUMA.

PUMA	Counties	ESI	Directly-purchased
100	Sheridan, Park, Teton, Lincoln, Big Horn	66.7%	33.3%
200	Campbell, Goshen, Platte, Johnson, Washakie, Weston, Crook, Niobrara	71.5%	28.5%
300	Laramie, Albany	75.4%	24.6%
400	Natrona, Carbon, Converse	74.9%	25.1%
500	Sweetwater, Fremont, Uinta, Sublette, Hot Springs	72.5%	27.5%

Q1 Demographic information:

Answered: 14 Skipped: 0

Answer Choices	Responses	
Name:	**100.00%**	14
Hospital Name:	**100.00%**	14
Address:	**0.00%**	0
Address 2:	**0.00%**	0
City/Town:	**100.00%**	14
State:	**0.00%**	0
ZIP:	**0.00%**	0
Country:	**0.00%**	0
Email Address:	**100.00%**	14
Phone Number:	**100.00%**	14

#	Name:	Date
1	Robin Roling	5/8/2015 4:28 PM
2	George Winn	4/30/2015 5:18 PM
3	Vickie Diamond	4/30/2015 3:08 PM
4	Chris Smolik	4/30/2015 1:05 PM
5	Curtis R. Dugger, CHFP	4/30/2015 12:49 PM
6	Irene Richardson	4/30/2015 8:43 AM
7	Bryan Chalmers	4/29/2015 2:36 PM
8	Jessica Romo	4/29/2015 12:03 PM
9	Rick Schroeder	4/27/2015 11:46 AM
10	Charlie Button	4/27/2015 8:58 AM
11	Mike Long	4/23/2015 10:39 AM
12	Maureen Cadwell	4/21/2015 4:44 PM
13	Jackie Claudson	4/20/2015 12:15 PM
14	Kent Ward	4/1/2015 10:53 AM

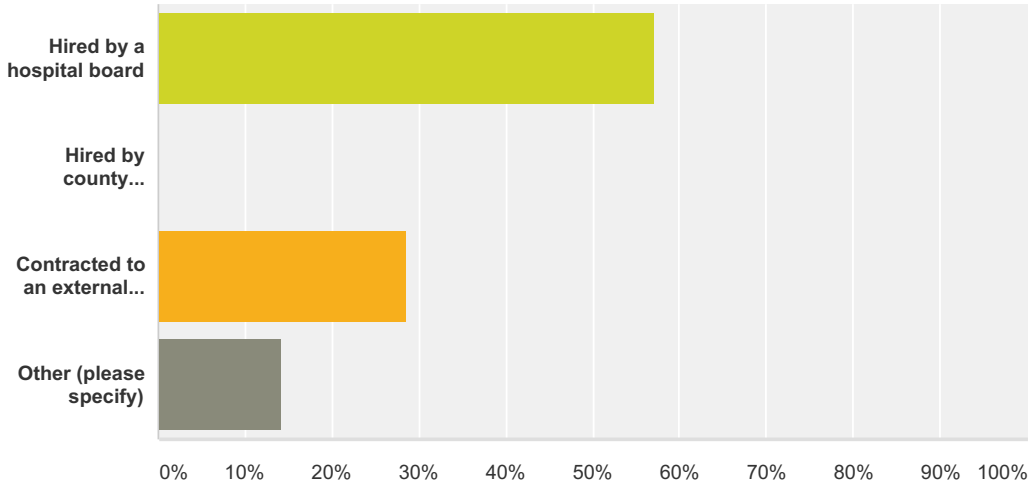
#	Hospital Name:	Date
1	Hot Springs County Memorial Hospital	5/8/2015 4:28 PM
2	Evanston Regional Hospital	4/30/2015 5:18 PM
3	Wyoming Medical Center	4/30/2015 3:08 PM
4	Niobrara Health and Life Center	4/30/2015 1:05 PM
5	Memorial Hospital of Converse County	4/30/2015 12:49 PM

6	Memorial Hospital of Sweetwater County	4/30/2015 8:43 AM
7	Ivinson Memorial Hospital	4/29/2015 2:36 PM
8	Teton County Hospital District dba St. John's Medical Center	4/29/2015 12:03 PM
9	North Big Horn Hospital District	4/27/2015 11:46 AM
10	Star Valley Medical Center	4/27/2015 8:58 AM
11	Powell Valley Healthcare	4/23/2015 10:39 AM
12	Weston County Health Services	4/21/2015 4:44 PM
13	South Big Horn Critical Access Hospital	4/20/2015 12:15 PM
14	Johnson County Healthcare Center	4/1/2015 10:53 AM
#	**Address:**	**Date**
	There are no responses.	
#	**Address 2:**	**Date**
	There are no responses.	
#	**City/Town:**	**Date**
1	Thermopolis	5/8/2015 4:28 PM
2	Evanston	4/30/2015 5:18 PM
3	Casper	4/30/2015 3:08 PM
4	Lusk	4/30/2015 1:05 PM
5	Douglas	4/30/2015 12:49 PM
6	Rock Springs	4/30/2015 8:43 AM
7	Laramie	4/29/2015 2:36 PM
8	Jackson	4/29/2015 12:03 PM
9	Lovell	4/27/2015 11:46 AM
10	Afton	4/27/2015 8:58 AM
11	Powell	4/23/2015 10:39 AM
12	Newcastle	4/21/2015 4:44 PM
13	Basin	4/20/2015 12:15 PM
14	Buffalo, Wyoming	4/1/2015 10:53 AM
#	**State:**	**Date**
	There are no responses.	
#	**ZIP:**	**Date**
	There are no responses.	
#	**Country:**	**Date**
	There are no responses.	
#	**Email Address:**	**Date**
1	robin.roling@mail.hscmh.org	5/8/2015 4:28 PM
2	george_winn@chs.net	4/30/2015 5:18 PM
3	vdiamond@wyomingmedicalcenter.org	4/30/2015 3:08 PM
4	jcsmolik@niobrarahospital.org	4/30/2015 1:05 PM

5	cdugger@mhccwyo.org	4/30/2015 12:49 PM
6	307-352-8413	4/30/2015 8:43 AM
7	bchalmers@ivinsonhospital.org	4/29/2015 2:36 PM
8	jkopina@tetonhospital.org	4/29/2015 12:03 PM
9	307-548-5200	4/27/2015 11:46 AM
10	cbutton@svmcwy.org	4/27/2015 8:58 AM
11	mlong@PVHC.org	4/23/2015 10:39 AM
12	mcadwell@wchs-wy.org	4/21/2015 4:44 PM
13	jclaudson@midwayclinic.com	4/20/2015 12:15 PM
14	kentw@jchealthcare.com	4/1/2015 10:53 AM
#	**Phone Number:**	**Date**
1	3078643121	5/8/2015 4:28 PM
2	307-783-8260	4/30/2015 5:18 PM
3	307-577-2211	4/30/2015 3:08 PM
4	307-334-4000	4/30/2015 1:05 PM
5	307-358-2122	4/30/2015 12:49 PM
6	irichardson@sweetwatermemorial.com	4/30/2015 8:43 AM
7	307-755-4603	4/29/2015 2:36 PM
8	307-739-7655	4/29/2015 12:03 PM
9	rschroeder@nbhh.com	4/27/2015 11:46 AM
10	307-885-5855	4/27/2015 8:58 AM
11	307-754-1125	4/23/2015 10:39 AM
12	3077463733	4/21/2015 4:44 PM
13	307-568-3311	4/20/2015 12:15 PM
14	307-684-6188	4/1/2015 10:53 AM

Q2 Is the day-to-day administration of the hospital:

Answered: 14 Skipped: 0

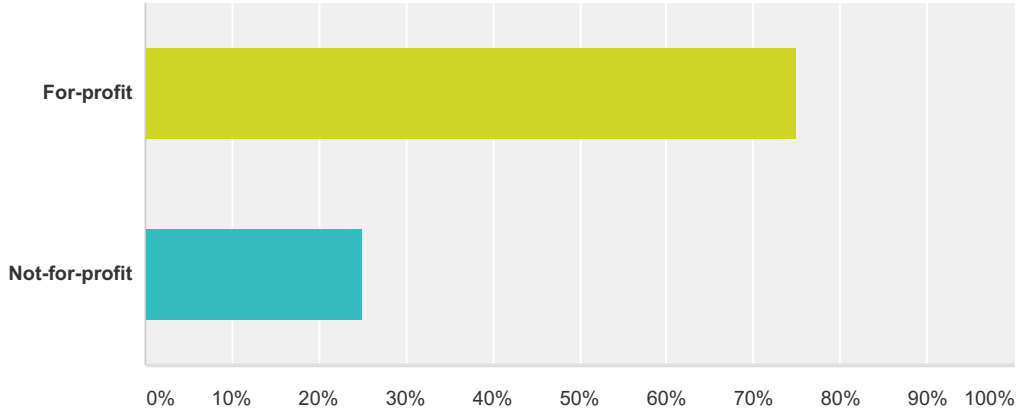


Answer Choices	Responses	
Hired by a hospital board	**57.14%**	8
Hired by county commissioners	**0.00%**	0
Contracted to an external private company	**28.57%**	4
Other (please specify)	**14.29%**	2
Total		**14**

#	Other (please specify)	Date
1	The CEO is hired by the hospital board, all other administration employees are hired by Human Resources.	4/29/2015 12:04 PM
2	Management Agreement with Private Non-Profit	4/21/2015 4:45 PM

Q3 If the hospital administration is contracted to a private company, is the management company:

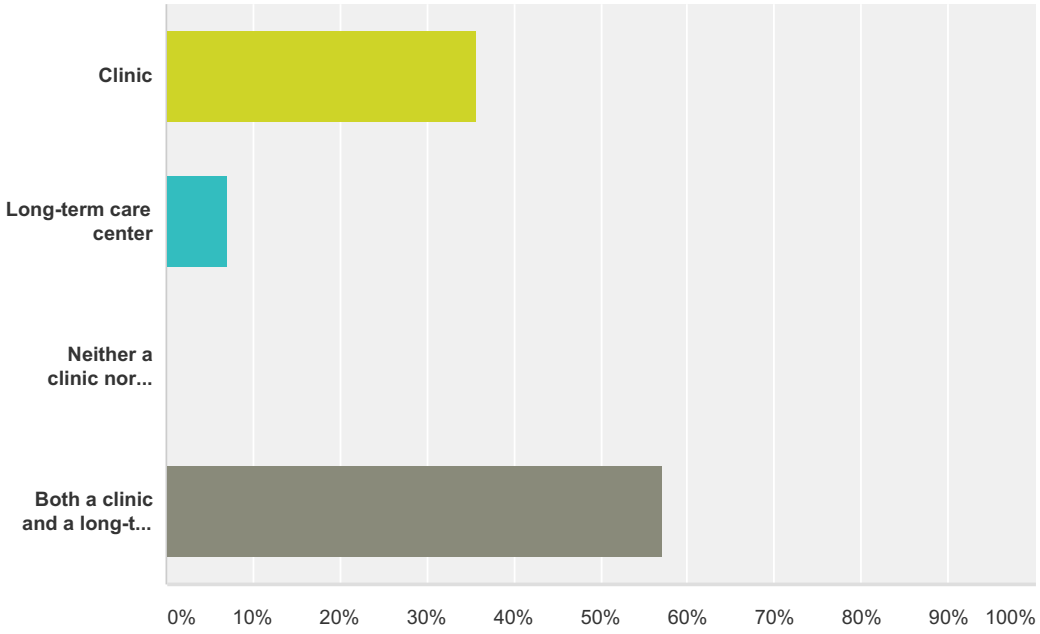
Answered: 4 Skipped: 10



Answer Choices	Responses	
For-profit	**75.00%**	3
Not-for-profit	**25.00%**	1
Total		**4**

Q4 Is the hospital financially comingled with a long-term care center or clinic?

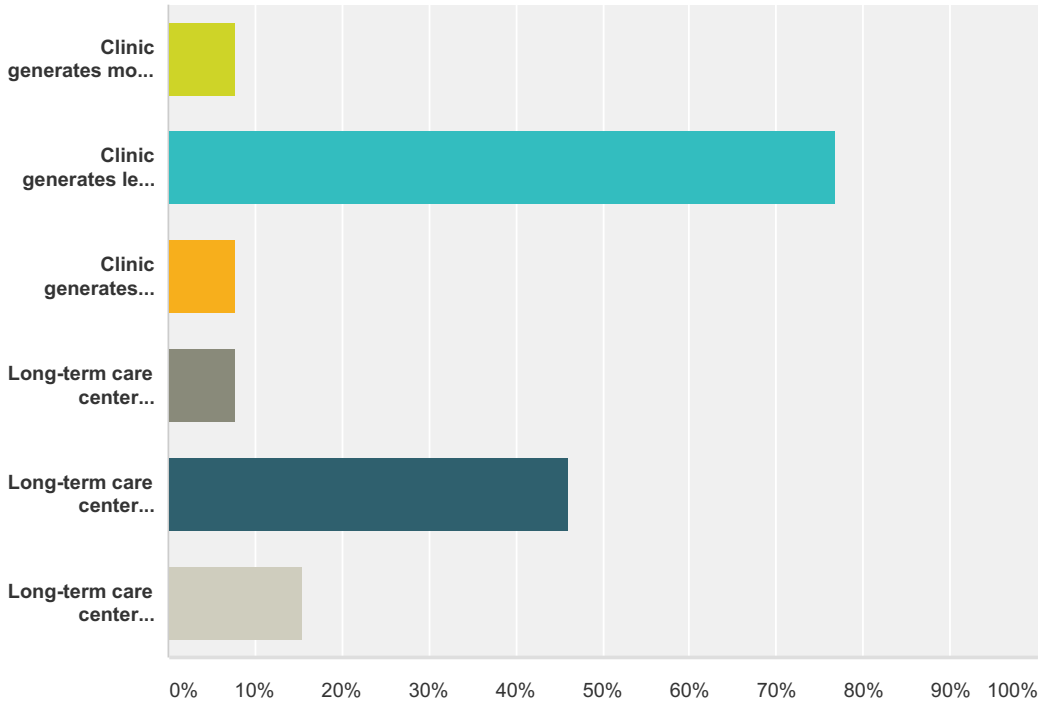
Answered: 14 Skipped: 0



Answer Choices	Responses	
Clinic	**35.71%**	5
Long-term care center	**7.14%**	1
Neither a clinic nor long-term care center	**0.00%**	0
Both a clinic and a long-term care center	**57.14%**	8
Total		**14**

Q5 If comingled with a long-term care facility or clinic, does the long-term care center or clinic generate:

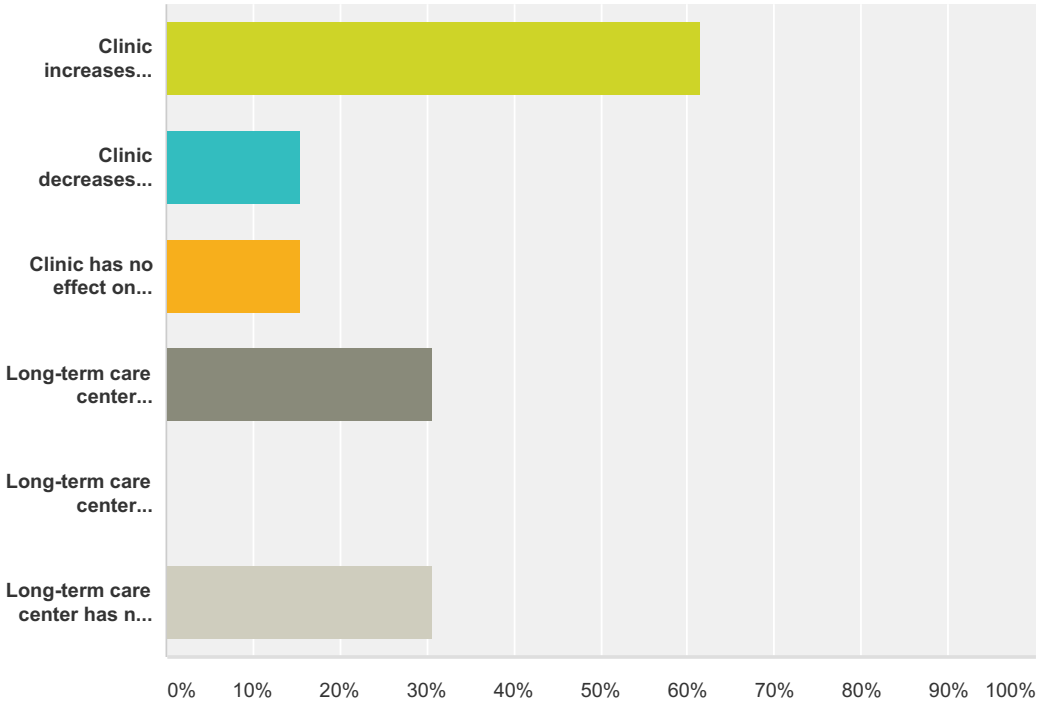
Answered: 13 Skipped: 1



Answer Choices	Responses	
Clinic generates more revenue than expenditures	**7.69%**	1
Clinic generates less revenue than expenditures	**76.92%**	10
Clinic generates exactly the same revenue as expenditures	**7.69%**	1
Long-term care center generates more revenue than expenditures	**7.69%**	1
Long-term care center generates less revenue than expenditures	**46.15%**	6
Long-term care center generates exactly the same revenue as expenditures	**15.38%**	2
Total Respondents: 13		

Q6 If comingled with a long-term care facility or clinic, does the long-term care center or clinic increase or decrease the amount of charity care provided:

Answered: 13 Skipped: 1



Answer Choices	Responses	
Clinic increases amount of charity care	**61.54%**	8
Clinic decreases amount of charity care	**15.38%**	2
Clinic has no effect on amount of charity care	**15.38%**	2
Long-term care center increases amount of charity care	**30.77%**	4
Long-term care center decreases amount of charity care	**0.00%**	0
Long-term care center has no effect on amount of charity care	**30.77%**	4
Total Respondents: 13		

Q7 For all primary facilities in which medical care is delivered, please identify the facility name; age (in years); condition (poor, fair, good, excellent); and estimated accumulated deferred maintenance ($). Example: Facility #1 - "Main hospital; 22 years; fair; $1,200,000"

Answered: 14 Skipped: 0

Answer Choices	Responses	
Facility #1	**100.00%**	14
Facility #2	**57.14%**	8
Facility #3	**35.71%**	5
Facility #4	**21.43%**	3
Facility #5	**14.29%**	2
Facility #6	**7.14%**	1
Facility #7	**7.14%**	1
Facility #8	**0.00%**	0
Facility #9	**0.00%**	0
Facility #10	**0.00%**	0

#	Facility #1	Date
1	Hot Springs Cty Memorial; 60 years; Fair	5/8/2015 4:29 PM
2	Evanston Regional Hospital; 30 years; fair	4/30/2015 5:36 PM
3	Main Hospital; Good; $2.8M/annual maintenance	4/30/2015 3:09 PM
4	Main Hospital; 32 years; good	4/30/2015 2:35 PM
5	Niobrara Health & Life Center; condition good; ecdm $500,000	4/30/2015 1:36 PM
6	Main hospital;14 years; good;1,500,000	4/30/2015 12:54 PM
7	MHSC; 37 years; excellent; $1,200,000	4/30/2015 8:56 AM
8	Ivinson Memorial Hospital, Average Age of Plant is 10 years, The palnt is fair to excellent, estimated deferred maintenance cost is 10m.	4/29/2015 3:13 PM
9	Main Hospital; 24 years; Excellent; N/A	4/29/2015 12:14 PM
10	NBHHD; 31 years; good; $180,000	4/27/2015 11:48 AM
11	Hospital 29 year; Fair- Good; $1,000,000	4/23/2015 10:43 AM
12	CAH Hospital; 28 years; fair; $0	4/21/2015 4:55 PM
13	Hospital/Clinic/LTC 1 main bldg; 59 years; 3,603,549	4/20/2015 12:16 PM
14	Original hospital; 63 years; poor; NA	4/1/2015 12:54 PM

#	Facility #2	Date
1	Uinta Medical Plaza; 15 years; fair	4/30/2015 5:36 PM
2	Addition to Main Hospital; 13 years; excellent	4/30/2015 2:35 PM
3	Thayne Clinic; 10 years; good; 300,000	4/30/2015 12:54 PM
4	Medical office building; 1 year; excellent; $200,000	4/30/2015 8:56 AM
5	Long Term Care Facility; 23 years; Good; N/A	4/29/2015 12:14 PM
6	Care Center 18 years; Good; $750,000	4/23/2015 10:43 AM
7	Nursing Home; 56 years; fair; $0	4/21/2015 4:55 PM
8	1980 hospial addition; 35 years; fair; NA	4/1/2015 12:54 PM
#	**Facility #3**	**Date**
1	Bridger Valley Family Practice; 5 years; good	4/30/2015 5:36 PM
2	Medical Office Building; 1 year; excellent	4/30/2015 2:35 PM
3	Alpine Clinic; 20 years; excellent; 0	4/30/2015 12:54 PM
4	Clinics 10-40 years; Fair - Excellent; $4,000,000	4/23/2015 10:43 AM
5	1995 OR addition; 20 years; good; $200,000	4/1/2015 12:54 PM
#	**Facility #4**	**Date**
1	Mountain View Clinic; 30 years; fair	4/30/2015 5:36 PM
2	Physical Therapy; 5 years; excellent; 0	4/30/2015 12:54 PM
3	2005 hospital addition; 10 years; excellent; none	4/1/2015 12:54 PM
#	**Facility #5**	**Date**
1	Orthopedics; 28 years; excellent; 0	4/30/2015 12:54 PM
2	2012 hospital addition; 3 years; excellent; none	4/1/2015 12:54 PM
#	**Facility #6**	**Date**
1	nursing home; 52 years; poor; $14,000,000 - bldg new facility	4/1/2015 12:54 PM
#	**Facility #7**	**Date**
1	clinic: 10 years; good; $250,000	4/1/2015 12:54 PM
#	**Facility #8**	**Date**
	There are no responses.	
#	**Facility #9**	**Date**
	There are no responses.	
#	**Facility #10**	**Date**
	There are no responses.	

Q8 Explain how age, condition or deferred maintenance impact the quality of the health care services provided at the hospital?

Answered: 12 Skipped: 2

#	Responses	Date
1	Old, worn out things take a lot of money to maintain. And it's rarely easy to get the capital necessary to replace old stuff. So you spend a ton of money keeping old stuff operational, which compromises your ability to buy new stuff. The new stuff may in fact improve the quality of care, but if you can't afford to buy it then you may not be maintaining high quality standards.	4/30/2015 5:36 PM
2	We have the latest technology and upgrade to hospital creates a great enviornment to provide healthcare.	4/30/2015 2:35 PM
3	Effects efficiency at times & creates potential harms at times to all constituencies using facility.	4/30/2015 1:36 PM
4	Mostly cosmetic and mechanical. Little impact of quality of health care.	4/30/2015 12:54 PM
5	Maintenance of an older facility is expensive but does not interfere with the quality of healthcare services provided. Maintenance of the facility is a budgeted cost of doing business. Maintenance of the facility, age of plant and condition are all very important in ensuring that the highest quality of care can be provided to patients with the most up-to-date equipment.	4/30/2015 8:56 AM
6	The deferred maintenance requires a larger allocation of capital and maintenance dollars that would be used to invest in technology and new equipment.	4/29/2015 3:13 PM
7	The age and condition of the facility, specifically the Living Center, directly relate to the ability to control infection. With older facilities, it can be much harder to keep patient areas clean/sterile. The more modern the facility, the more likely the ability to have higher end treatments available, such as the newer Outpatient Surgeries. Older facilities are also less efficient, whereas, new facilities really enhance work flows.	4/29/2015 12:14 PM
8	Drafty windows in LTC resident room; Carpeting that needs to be replaced to reduce trip hazards	4/27/2015 11:48 AM
9	Structural Viability of the main facility - HVAC in Care Center - Functionality of the Clinic - 2 floors are not completed and not in use	4/23/2015 10:43 AM
10	Small rooms, small bathrooms, shared rooms, shared bathrooms, make it difficult to care for more needy patients	4/21/2015 4:55 PM
11	Small spaces to perform all tasks, one ADA toilet in the facility, large dollars spent on heating and cooling, infrastructure repairs not easily accomplished and often create need for more repairs, difficulty competing with more modern facilities.	4/20/2015 12:16 PM
12	The biggest impact is in our nursing home. It is a very old facility, small rooms, shared bathrooms. It is felt that it has an adverse impact on residents. The older part of the hospital is not air conditioned, has old rooms and shared bathrooms. It is not a very attractive facility.	4/1/2015 12:54 PM

Q9 For the last five calendar years (2010, 2011, 2012, 2013, 2014), please list the construction or acquisition of any addition, major renovation, major maintenance or property purchase, including major equipment, in excess of $250,000? For each year, include the square feet added; name of major equipment; estimated total project cost; and source of funding (cash reserves, bond, loan, other). Example: "2010 - 5,000 square feet; CT scan; $750,000; cash reserves and loan"

Answered: 12 Skipped: 2

Answer Choices	Responses	
2010	**58.33%**	7
2011	**66.67%**	8
2012	**66.67%**	8
2013	**66.67%**	8
2014	**91.67%**	11

#	2010	Date
1	1565000 MRI machine and building addition for MRI	4/30/2015 5:36 PM
2	Spect/CT; $347,000; cash reserves	4/30/2015 2:35 PM
3	N/A	4/30/2015 1:36 PM
4	cysto table 410,152 cash, nuclear med camera 380,373 cash, MRI 1.57m cash	4/29/2015 3:13 PM
5	2010 - CT Scanner - $2,554,214 - Cash Reserves; 2010 - Property - $933,375 - Cash Reserves	4/29/2015 12:14 PM
6	Lab & Radiology addition; 5244 sq ft; $2,993,000; SLIB grant	4/20/2015 12:16 PM
7	Spent $414,208 on CE - $75,000 on EHR; operating funds and taxes	4/1/2015 12:54 PM
#	**2011**	**Date**
1	506986 PACS	4/30/2015 5:36 PM
2	ER Expansion; $8.5M; Operating Cash & Contributions	4/30/2015 3:09 PM
3	2 ultrasound machines; cash reserves	4/30/2015 2:35 PM
4	N/A	4/30/2015 1:36 PM
5	Digital Mammo; $385,992; private grant	4/30/2015 8:56 AM
6	2011 - House - $265,000; 2011 - Diagnostic Xray - $288,433 - Cash Reserves	4/29/2015 12:14 PM
7	CT Scan; $500,000; facility savings	4/20/2015 12:16 PM
8	Spent $725,912 on CE - $345, 655 on digital mammo; grant, operating funds & taxes	4/1/2015 12:54 PM
#	**2012**	**Date**

1	X-ray Equip; $258,360; cash reserves	5/8/2015 4:29 PM
2	697035 IT infrastructure	4/30/2015 5:36 PM
3	Cerner; $10.4M; Operating Cash	4/30/2015 3:09 PM
4	House; $534,000; cash reserves	4/30/2015 2:35 PM
5	N/A	4/30/2015 1:36 PM
6	radiology machine 391,910 cash, Linear Accelerator 2.13m loan	4/29/2015 3:13 PM
7	N/A	4/29/2015 12:14 PM
8	Spent $932, 815 on CE; $262,624 on new flour room, $130,000 on IT expenses, completed 20,000 + square foot addition at a cost of $11,348,797, paid for by operating funds and taxes	4/1/2015 12:54 PM
#	**2013**	**Date**
1	Pharmacy Disp Equip; $336,170; grants funds	5/8/2015 4:29 PM
2	358681 Nuclear camera; 297287 HVAC upgrade	4/30/2015 5:36 PM
3	VOIP Phone System; $258,000; cash reserves, Portable x-rays; $450,000; cash reserves. Devinci Surgical System; $1,980,000; cash reserves. MRI; $1,350,000; bank loan	4/30/2015 2:35 PM
4	N/A	4/30/2015 1:36 PM
5	30,000 square feet; Therapy and Primary Clinic Space; $1,500,000; 8,000 square Feet; Remodel of Clinic Space for Othopedics; 450,000; 2,500 Square Feet; Remodel of Alpine Clinic Space; $180,000	4/30/2015 12:54 PM
6	nurse call system 375,081 cash	4/29/2015 3:13 PM
7	2013 - MRI - $2,399,809 - Cash Reserves	4/29/2015 12:14 PM
8	Spent $586,524 on CE, $124,624 on C-Arm, $75,378 on ICU monitors & $66,000 on bus; used grant, operating funds & taxes	4/1/2015 12:54 PM
#	**2014**	**Date**
1	638465 CT scanner	4/30/2015 5:36 PM
2	West Tower/MRI; $45.2M; Operating Cash & Bond Funds	4/30/2015 3:09 PM
3	Medical Office Building: $8,500,000; 38,000 sq. ft.; secured loan with hospital CDs	4/30/2015 2:35 PM
4	N/A	4/30/2015 1:36 PM
5	600 Square Feet; MRI; 1,100,000	4/30/2015 12:54 PM
6	Linear Accelerator; $2,340,961; private grant; Medical Office Building; $24,000,000; special purpose tax, cash reserves	4/30/2015 8:56 AM
7	building renovation and addition 38,721 additional sq ft 35m cash	4/29/2015 3:13 PM
8	2014 - Central Energy Plant - 4700 sq ft - $6,644,837 - Specific Purpose Excise Tax & Cash Reserves; 2014 - Expansion & Remodel - 54,590 sq ft - $9,045,627 - Specific Purpose Excise Tax & Cash Reserves	4/29/2015 12:14 PM
9	MRI & R & F Rooms; 2,372,641 Vendor financed	4/23/2015 10:43 AM
10	Construction in Progress; hospital/ER 18,446 sq ft; $7,000,000; SLIB grant - $2,000,000; USDA loan - $4,000,000; facility savings, $1,000,000	4/20/2015 12:16 PM
11	Spent $840,321 on CE; Spent $105,057 on EHR expenses	4/1/2015 12:54 PM

Q10 On what date did your most recent fiscal year end?

Answered: 13 Skipped: 1

#	Responses	Date
1	June 30, 2014	5/8/2015 4:33 PM
2	December 31, 2014	4/30/2015 5:39 PM
3	June 30, 2014	4/30/2015 3:10 PM
4	6/30/14	4/30/2015 2:47 PM
5	June 30, 2014	4/30/2015 1:07 PM
6	June 30, 2014	4/30/2015 9:05 AM
7	June 30, 2014	4/29/2015 3:13 PM
8	6/30/2014	4/29/2015 12:26 PM
9	June 30, 2014	4/27/2015 12:04 PM
10	6-30-14	4/23/2015 10:59 AM
11	06/30/2014	4/21/2015 5:04 PM
12	6./30/2014	4/20/2015 12:17 PM
13	June 30, 2014	4/1/2015 1:11 PM

Q11 For the hospital's most recent fiscal year, what were the hospital's total revenues?

Answered: 12 Skipped: 2

#	Responses	Date
1	15562690	5/8/2015 4:33 PM
2	35564296	4/30/2015 5:39 PM
3	197.4M	4/30/2015 3:10 PM
4	59,247,000	4/30/2015 2:47 PM
5	29,353,306	4/30/2015 1:07 PM
6	$107,057,524	4/30/2015 9:05 AM
7	81,072,765	4/29/2015 3:13 PM
8	$96,292,957	4/29/2015 12:26 PM
9	15815247	4/27/2015 12:04 PM
10	42,707,511 Net - (Gross = 64,172,653	4/23/2015 10:59 AM
11	$12,749,434	4/21/2015 5:04 PM
12	20335861	4/1/2015 1:11 PM

Q12 For the hospital's most recent fiscal year, what were the hospital's total expenditures?

Answered: 12 Skipped: 2

#	Responses	Date
1	15325849	5/8/2015 4:33 PM
2	28075691	4/30/2015 5:39 PM
3	190.9M	4/30/2015 3:10 PM
4	51,084,000	4/30/2015 2:47 PM
5	28,749,224	4/30/2015 1:07 PM
6	$66,717,327	4/30/2015 9:05 AM
7	62,620,132	4/29/2015 3:13 PM
8	$83,145,066 (Total Expenses)	4/29/2015 12:26 PM
9	15202873	4/27/2015 12:04 PM
10	44,053,251	4/23/2015 10:59 AM
11	$12,526,439	4/21/2015 5:04 PM
12	18511556	4/1/2015 1:11 PM

Q13 As of December 31, 2014, what were the hospital's cash reserves?

Answered: 12 Skipped: 2

#	Responses	Date
1	2301056	5/8/2015 4:33 PM
2	131268	4/30/2015 5:39 PM
3	48.1M	4/30/2015 3:10 PM
4	13,163,000	4/30/2015 2:47 PM
5	3,709,076	4/30/2015 1:07 PM
6	$29,388,905	4/30/2015 9:05 AM
7	50,070,628	4/29/2015 3:13 PM
8	$47,188,786 (Unrestricted Cash Reserves)	4/29/2015 12:26 PM
9	3395486	4/27/2015 12:04 PM
10	2,985,667	4/23/2015 10:59 AM
11	$4,328,768	4/21/2015 5:04 PM
12	8280152	4/1/2015 1:11 PM

Q14 As of December 31, 2014, what were the hospital's current assets?

Answered: 12 Skipped: 2

#	Responses	Date
1	6684543	5/8/2015 4:33 PM
2	6614827	4/30/2015 5:39 PM
3	103.9M	4/30/2015 3:10 PM
4	27,147,000	4/30/2015 2:47 PM
5	34,790,220	4/30/2015 1:07 PM
6	$27,656,897	4/30/2015 9:05 AM
7	48,512,991	4/29/2015 3:13 PM
8	$64,399,293	4/29/2015 12:26 PM
9	3068084	4/27/2015 12:04 PM
10	12,443,251	4/23/2015 10:59 AM
11	$7,784,763	4/21/2015 5:04 PM
12	12290687	4/1/2015 1:11 PM

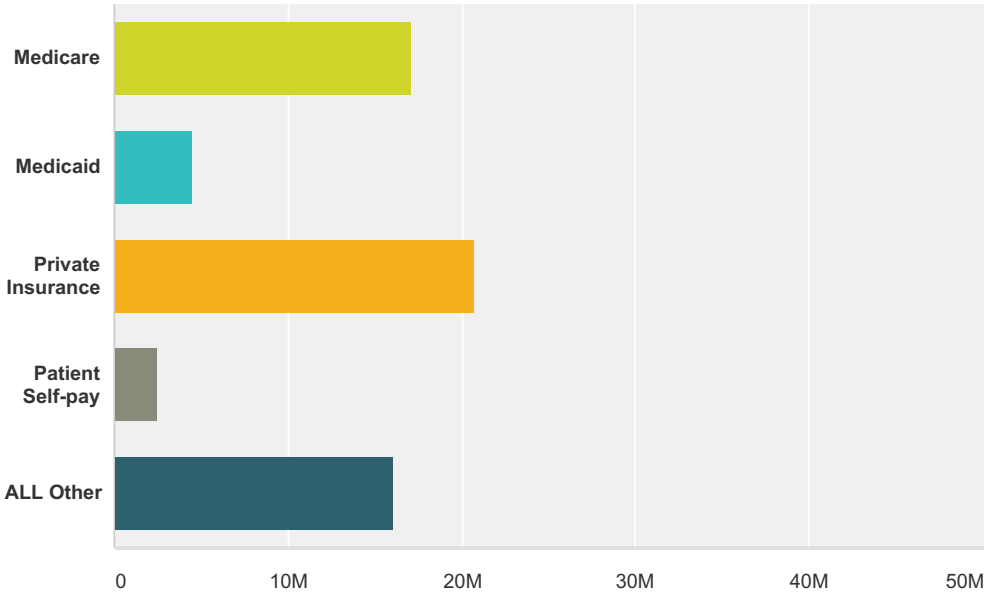
Q15 As of December 31, 2014, what were the hospital's current liabilities?

Answered: 12 Skipped: 2

#	Responses	Date
1	3088104	5/8/2015 4:33 PM
2	1765708	4/30/2015 5:39 PM
3	23.9M	4/30/2015 3:10 PM
4	4,623,000	4/30/2015 2:47 PM
5	34,790,220	4/30/2015 1:07 PM
6	$22,367,392	4/30/2015 9:05 AM
7	7,561,922	4/29/2015 3:13 PM
8	$10,947,320	4/29/2015 12:26 PM
9	1110168	4/27/2015 12:04 PM
10	3,750,312	4/23/2015 10:59 AM
11	$1,480,625	4/21/2015 5:04 PM
12	1347685	4/1/2015 1:11 PM

Q16 For the hospital's most recent fiscal year, what were the dollar amounts of patient care services paid by the following sources?

Answered: 12 Skipped: 2



Answer Choices	Average Number	Total Number	Responses
Medicare	17,112,033	188,232,364	11
Medicaid	4,456,553	49,022,079	11
Private Insurance	20,814,686	208,146,864	10
Patient Self-pay	2,496,114	12,480,570	5
ALL Other	16,038,355	176,421,903	11
Total Respondents: 12			

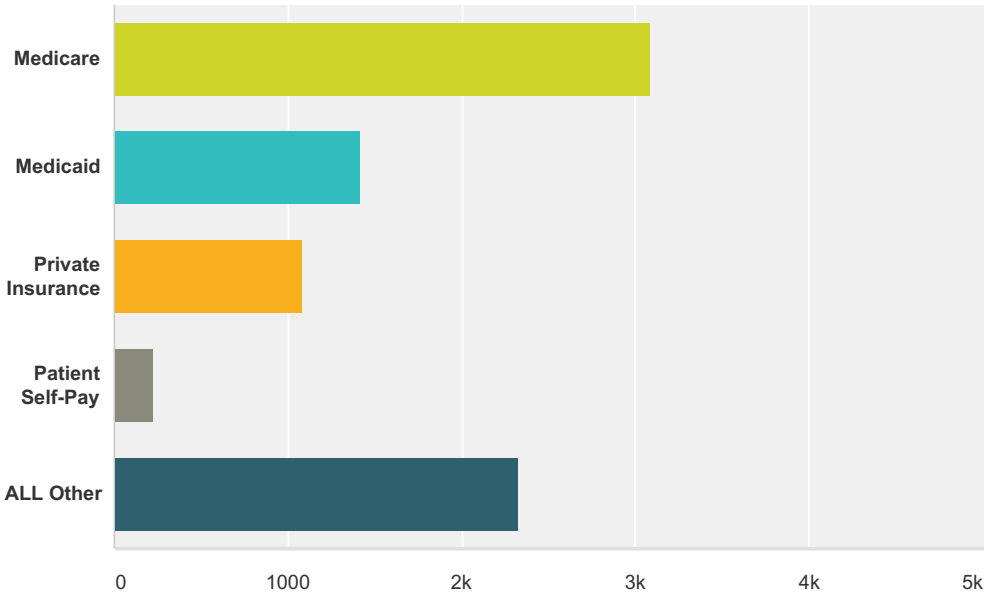
#	Medicare	Date
1	4681733	4/30/2015 5:39 PM
2	54100000	4/30/2015 3:10 PM
3	19024000	4/30/2015 2:47 PM
4	8862801	4/30/2015 1:07 PM
5	18533205	4/30/2015 9:05 AM
6	29486399	4/29/2015 3:13 PM
7	20042098	4/29/2015 12:26 PM
8	3139690	4/27/2015 12:04 PM
9	20127309	4/23/2015 10:59 AM

10	3950549	4/21/2015 5:04 PM
11	6284580	4/1/2015 1:11 PM
#	**Medicaid**	**Date**
1	1621614	4/30/2015 5:39 PM
2	7400000	4/30/2015 3:10 PM
3	5820000	4/30/2015 2:47 PM
4	3251297	4/30/2015 1:07 PM
5	6053684	4/30/2015 9:05 AM
6	6135118	4/29/2015 3:13 PM
7	3543322	4/29/2015 12:26 PM
8	3331068	4/27/2015 12:04 PM
9	6944518	4/23/2015 10:59 AM
10	2305417	4/21/2015 5:04 PM
11	2616041	4/1/2015 1:11 PM
#	**Private Insurance**	**Date**
1	26822426	4/30/2015 5:39 PM
2	27862000	4/30/2015 2:47 PM
3	13663200	4/30/2015 1:07 PM
4	27613732	4/30/2015 9:05 AM
5	31467330	4/29/2015 3:13 PM
6	54804616	4/29/2015 12:26 PM
7	2366315	4/27/2015 12:04 PM
8	14978453	4/23/2015 10:59 AM
9	2969792	4/21/2015 5:04 PM
10	5599000	4/1/2015 1:11 PM
#	**Patient Self-pay**	**Date**
1	4020000	4/30/2015 2:47 PM
2	242338	4/30/2015 1:07 PM
3	4674027	4/29/2015 3:13 PM
4	2084643	4/23/2015 10:59 AM
5	1459562	4/1/2015 1:11 PM
#	**ALL Other**	**Date**
1	14787349	5/8/2015 4:33 PM
2	1402890	4/30/2015 5:39 PM
3	127800000	4/30/2015 3:10 PM
4	2520000	4/30/2015 2:47 PM
5	1412678	4/30/2015 1:07 PM
6	9824832	4/30/2015 9:05 AM

7	3746498	4/29/2015 3:13 PM
8	7720590	4/29/2015 12:26 PM
9	4448305	4/27/2015 12:04 PM
10	993302	4/23/2015 10:59 AM
11	1765459	4/21/2015 5:04 PM

Q17 For the hospital's most recent fiscal year, how many inpatient days were paid for by the following sources:

Answered: 11 Skipped: 3



Answer Choices	Average Number	Total Number	Responses
Medicare	3,092	34,007	11
Medicaid	1,420	15,623	11
Private Insurance	1,091	10,908	10
Patient Self-Pay	229	916	4
ALL Other	2,325	23,246	10
Total Respondents: 11			

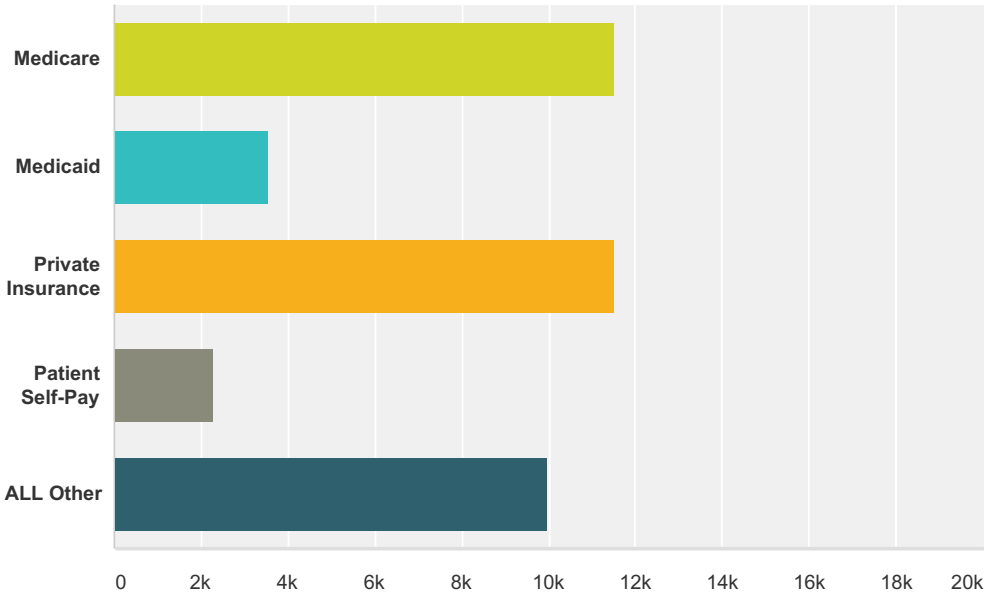
#	Medicare	Date
1	848	5/8/2015 4:33 PM
2	860	4/30/2015 5:39 PM
3	16701	4/30/2015 3:10 PM
4	1040	4/30/2015 2:47 PM
5	1974	4/30/2015 9:05 AM
6	4692	4/29/2015 3:13 PM
7	4402	4/29/2015 12:26 PM
8	116	4/27/2015 12:04 PM
9	656	4/23/2015 10:59 AM
10	1008	4/21/2015 5:04 PM

11	1710	4/1/2015 1:11 PM
#	**Medicaid**	**Date**
1	128	5/8/2015 4:33 PM
2	234	4/30/2015 5:39 PM
3	2965	4/30/2015 3:10 PM
4	338	4/30/2015 2:47 PM
5	645	4/30/2015 9:05 AM
6	1468	4/29/2015 3:13 PM
7	8508	4/29/2015 12:26 PM
8	9	4/27/2015 12:04 PM
9	187	4/23/2015 10:59 AM
10	1121	4/21/2015 5:04 PM
11	20	4/1/2015 1:11 PM
#	**Private Insurance**	**Date**
1	196	5/8/2015 4:33 PM
2	644	4/30/2015 5:39 PM
3	850	4/30/2015 2:47 PM
4	2940	4/30/2015 9:05 AM
5	2927	4/29/2015 3:13 PM
6	2504	4/29/2015 12:26 PM
7	20	4/27/2015 12:04 PM
8	376	4/23/2015 10:59 AM
9	350	4/21/2015 5:04 PM
10	101	4/1/2015 1:11 PM
#	**Patient Self-Pay**	**Date**
1	145	4/30/2015 2:47 PM
2	396	4/29/2015 3:13 PM
3	75	4/23/2015 10:59 AM
4	300	4/1/2015 1:11 PM
#	**ALL Other**	**Date**
1	166	5/8/2015 4:33 PM
2	109	4/30/2015 5:39 PM
3	13367	4/30/2015 3:10 PM
4	59	4/30/2015 2:47 PM
5	1047	4/30/2015 9:05 AM
6	317	4/29/2015 3:13 PM
7	7997	4/29/2015 12:26 PM
8	12	4/27/2015 12:04 PM

9	62	4/23/2015 10:59 AM
10	110	4/21/2015 5:04 PM

Q18 For the hospital's most recent fiscal year, what were the number of outpatient visits paid for by the following sources?

Answered: 11 Skipped: 3



Answer Choices	Average Number	Total Number	Responses
Medicare	11,526	126,784	11
Medicaid	3,560	39,160	11
Private Insurance	11,535	115,348	10
Patient Self-Pay	2,312	9,246	4
ALL Other	9,971	99,706	10
Total Respondents: 11			

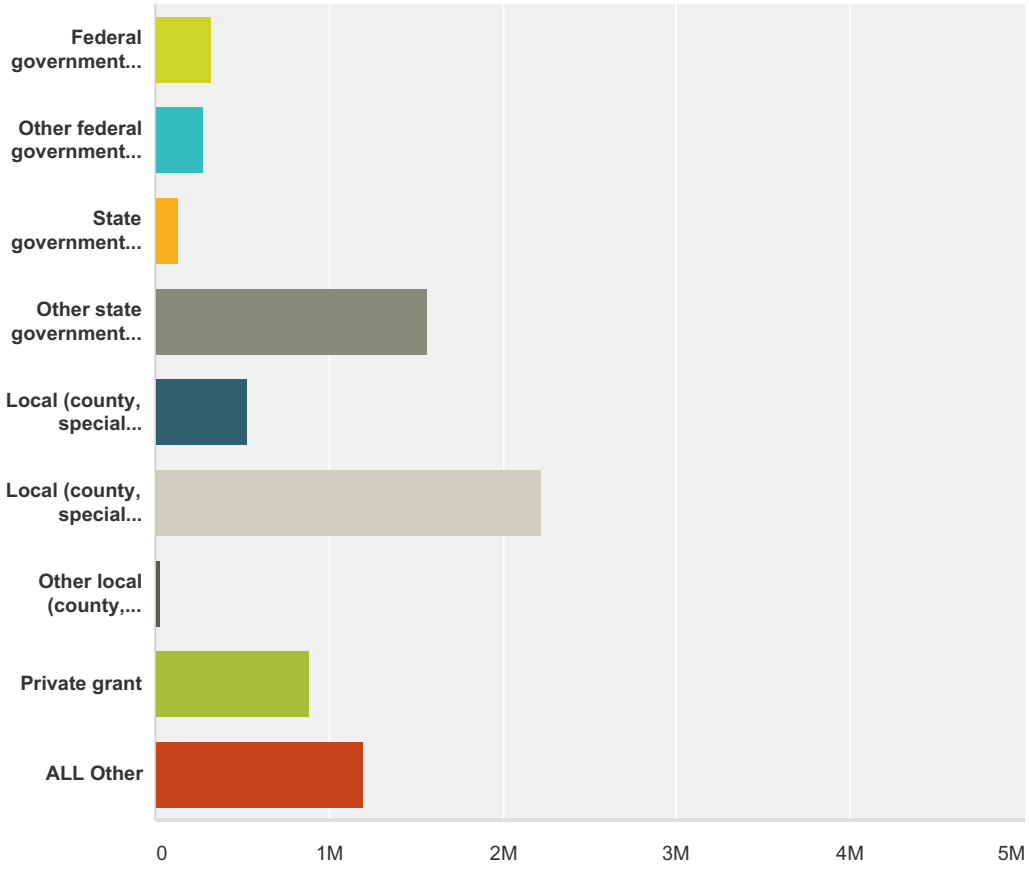
#	Medicare	Date
1	6787	5/8/2015 4:33 PM
2	6159	4/30/2015 5:39 PM
3	25349	4/30/2015 3:10 PM
4	9313	4/30/2015 2:47 PM
5	19840	4/30/2015 9:05 AM
6	14183	4/29/2015 3:13 PM
7	8950	4/29/2015 12:26 PM
8	9760	4/27/2015 12:04 PM
9	15166	4/23/2015 10:59 AM
10	2680	4/21/2015 5:04 PM

11	8597	4/1/2015 1:11 PM
#	**Medicaid**	**Date**
1	1367	5/8/2015 4:33 PM
2	2777	4/30/2015 5:39 PM
3	10963	4/30/2015 3:10 PM
4	3104	4/30/2015 2:47 PM
5	6480	4/30/2015 9:05 AM
6	4438	4/29/2015 3:13 PM
7	1325	4/29/2015 12:26 PM
8	2886	4/27/2015 12:04 PM
9	4155	4/23/2015 10:59 AM
10	461	4/21/2015 5:04 PM
11	1204	4/1/2015 1:11 PM
#	**Private Insurance**	**Date**
1	4391	5/8/2015 4:33 PM
2	12293	4/30/2015 5:39 PM
3	12417	4/30/2015 2:47 PM
4	29561	4/30/2015 9:05 AM
5	8846	4/29/2015 3:13 PM
6	18176	4/29/2015 12:26 PM
7	13369	4/27/2015 12:04 PM
8	7980	4/23/2015 10:59 AM
9	2985	4/21/2015 5:04 PM
10	5330	4/1/2015 1:11 PM
#	**Patient Self-Pay**	**Date**
1	2483	4/30/2015 2:47 PM
2	1196	4/29/2015 3:13 PM
3	3505	4/23/2015 10:59 AM
4	2062	4/1/2015 1:11 PM
#	**ALL Other**	**Date**
1	1334	5/8/2015 4:33 PM
2	4013	4/30/2015 5:39 PM
3	45027	4/30/2015 3:10 PM
4	3727	4/30/2015 2:47 PM
5	10519	4/30/2015 9:05 AM
6	959	4/29/2015 3:13 PM
7	9748	4/29/2015 12:26 PM
8	23021	4/27/2015 12:04 PM

9	211	4/23/2015 10:59 AM
10	1147	4/21/2015 5:04 PM

Q19 Other than for patient care, report all dollar amounts, by revenue source, received by the hospital in the most recent fiscal year?

Answered: 12 Skipped: 2



Answer Choices	Average Number	Total Number	Responses
Federal government grant	326,680	1,306,719	4
Other federal government payments	284,521	569,042	2
State government grant	135,260	676,302	5
Other state government payment	1,564,078	4,692,233	3
Local (county, special district, municipal) grant	537,429	537,429	1
Local (county, special district, municipal) tax collections	2,226,066	17,808,527	8
Other local (county, special district, municipal) payment	26,187	26,187	1
Private grant	891,640	2,674,920	3
ALL Other	1,196,964	7,181,784	6

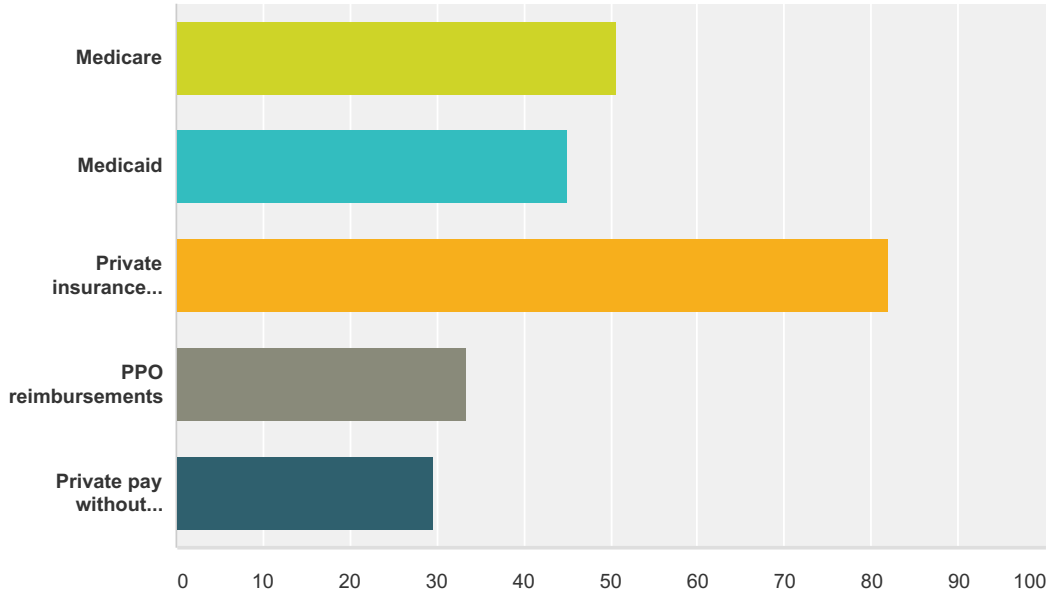
Total Respondents: 12			

#	Federal government grant	Date
1	9000	4/30/2015 5:39 PM
2	341657	4/30/2015 3:10 PM
3	716680	4/29/2015 12:26 PM
4	239382	4/1/2015 1:11 PM
#	Other federal government payments	Date
1	173876	4/30/2015 3:10 PM
2	395166	4/21/2015 5:04 PM
#	State government grant	Date
1	65522	5/8/2015 4:33 PM
2	255326	4/29/2015 3:13 PM
3	239811	4/27/2015 12:04 PM
4	17066	4/23/2015 10:59 AM
5	98577	4/21/2015 5:04 PM
#	Other state government payment	Date
1	3900960	4/29/2015 12:26 PM
2	769546	4/27/2015 12:04 PM
3	21727	4/21/2015 5:04 PM
#	Local (county, special district, municipal) grant	Date
1	537429	4/30/2015 1:07 PM
#	Local (county, special district, municipal) tax collections	Date
1	208927	5/8/2015 4:33 PM
2	1365000	4/30/2015 2:47 PM
3	6236427	4/30/2015 9:05 AM
4	1351427	4/29/2015 3:13 PM
5	3666725	4/29/2015 12:26 PM
6	1244092	4/27/2015 12:04 PM
7	1093007	4/21/2015 5:04 PM
8	2642922	4/1/2015 1:11 PM
#	Other local (county, special district, municipal) payment	Date
1	26187	4/21/2015 5:04 PM
#	Private grant	Date
1	329434	5/8/2015 4:33 PM
2	2340961	4/30/2015 9:05 AM
3	4525	4/21/2015 5:04 PM
#	ALL Other	Date
1	171458	5/8/2015 4:33 PM

2	3956640	4/29/2015 3:13 PM
3	1897967	4/29/2015 12:26 PM
4	276920	4/27/2015 12:04 PM
5	119028	4/21/2015 5:04 PM
6	759771	4/1/2015 1:11 PM

Q20 As a percent, how do the final payments from the following payor types compare to the initially billed hospital charges? (numerator = final payment; denominator = initial charge)

Answered: 11 Skipped: 3



Answer Choices	Average Number	Total Number	Responses
Medicare	51	559	11
Medicaid	45	495	11
Private insurance (aggregate simple average)	82	821	10
PPO reimbursements	33	167	5
Private pay without insurance	30	325	11
Total Respondents: 11			

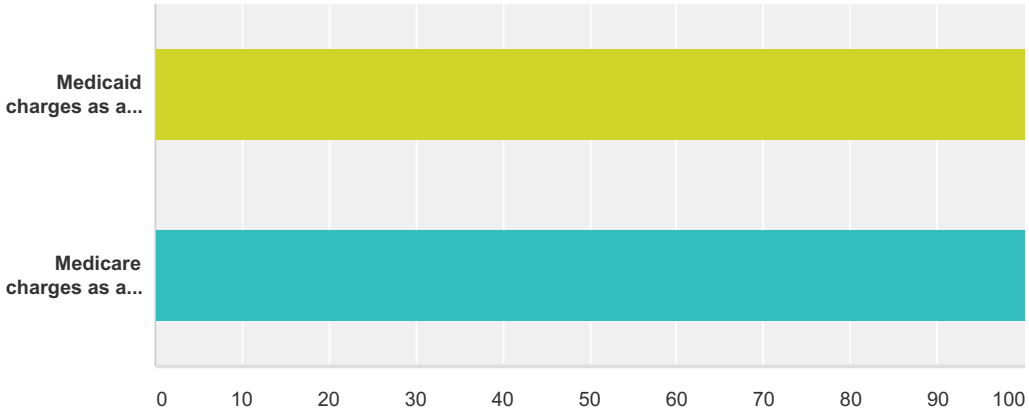
#	Medicare	Date
1	57	5/8/2015 4:33 PM
2	23	4/30/2015 5:39 PM
3	26	4/30/2015 3:10 PM
4	70	4/30/2015 2:47 PM
5	42	4/30/2015 9:05 AM
6	26	4/29/2015 3:13 PM
7	39	4/29/2015 12:26 PM
8	89	4/27/2015 12:04 PM

9	50	4/23/2015 10:59 AM
10	67	4/21/2015 5:04 PM
11	70	4/1/2015 1:11 PM
#	**Medicaid**	**Date**
1	42	5/8/2015 4:33 PM
2	14	4/30/2015 5:39 PM
3	28	4/30/2015 3:10 PM
4	70	4/30/2015 2:47 PM
5	31	4/30/2015 9:05 AM
6	26	4/29/2015 3:13 PM
7	44	4/29/2015 12:26 PM
8	44	4/27/2015 12:04 PM
9	64	4/23/2015 10:59 AM
10	77	4/21/2015 5:04 PM
11	55	4/1/2015 1:11 PM
#	**Private insurance (aggregate simple average)**	**Date**
1	86	5/8/2015 4:33 PM
2	75	4/30/2015 5:39 PM
3	90	4/30/2015 2:47 PM
4	93	4/30/2015 9:05 AM
5	65	4/29/2015 3:13 PM
6	80	4/29/2015 12:26 PM
7	76	4/27/2015 12:04 PM
8	83	4/23/2015 10:59 AM
9	78	4/21/2015 5:04 PM
10	95	4/1/2015 1:11 PM
#	**PPO reimbursements**	**Date**
1	72	4/30/2015 5:39 PM
2	0	4/29/2015 12:26 PM
3	0	4/27/2015 12:04 PM
4	0	4/23/2015 10:59 AM
5	95	4/1/2015 1:11 PM
#	**Private pay without insurance**	**Date**
1	14	5/8/2015 4:33 PM
2	56	4/30/2015 5:39 PM
3	2	4/30/2015 3:10 PM
4	27	4/30/2015 2:47 PM
5	32	4/30/2015 9:05 AM

6	36	4/29/2015 3:13 PM
7	31	4/29/2015 12:26 PM
8	23	4/27/2015 12:04 PM
9	9	4/23/2015 10:59 AM
10	60	4/21/2015 5:04 PM
11	35	4/1/2015 1:11 PM

Q21 If the hospital's initially billed charges differ for Medicaid, Medicare and private insurance, what percentage of the private insurance initially billed hospital charges are charged to Medicaid and Medicare? (If all payors are initially charged the same amount for a procedure, skip this question.)

Answered: 1 Skipped: 13



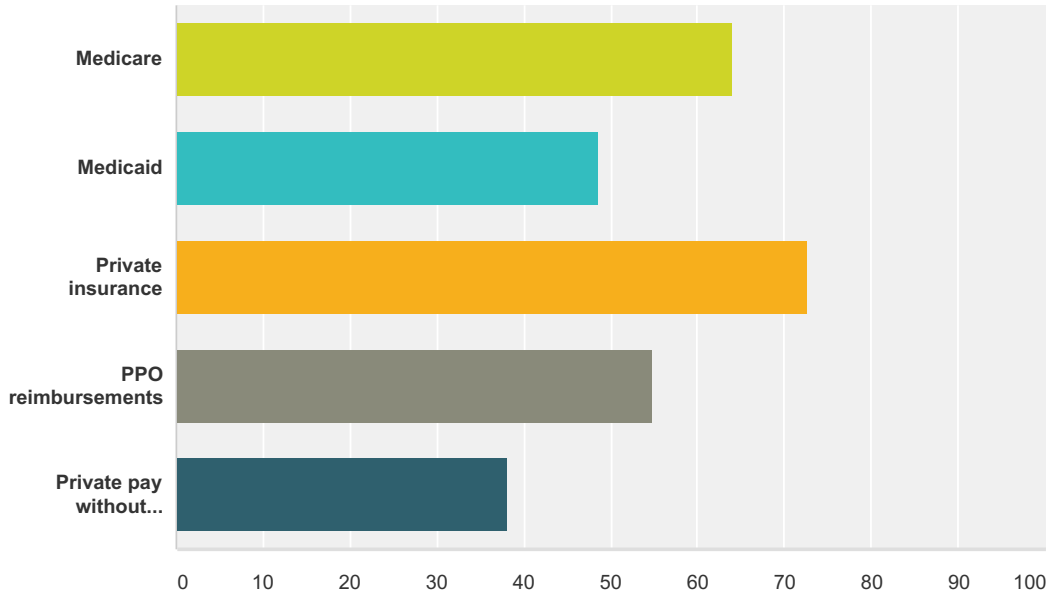
Answer Choices	Average Number	Total Number	Responses
Medicaid charges as a percent of private insurance billed charges?	100	100	1
Medicare charges as a percent of private insurance billed charges?	100	100	1
Total Respondents: 1			

#	Medicaid charges as a percent of private insurance billed charges?	Date
1	100	4/1/2015 1:11 PM

#	Medicare charges as a percent of private insurance billed charges?	Date
1	100	4/1/2015 1:11 PM

Q22 As a percent, how do the final payments from the following payor types compare to the cost of services provided, as determined by the hospital? (Please use the hospital's own determination of the cost of services, which may include components not included by CMS in the Medicare reports.) (numerator = final payment; denominator = hospital-determined cost of services)

Answered: 8 Skipped: 6



Answer Choices	Average Number	Total Number	Responses
Medicare	64	512	8
Medicaid	49	340	7
Private insurance	73	436	6
PPO reimbursements	55	220	4
Private pay without insurance	38	267	7
Total Respondents: 8			

#	Medicare	Date
1	71	5/8/2015 4:33 PM
2	78	4/30/2015 5:39 PM
3	72	4/30/2015 3:10 PM

4	27	4/30/2015 9:05 AM
5	56	4/29/2015 12:26 PM
6	24	4/27/2015 12:04 PM
7	101	4/23/2015 10:59 AM
8	83	4/1/2015 1:11 PM
#	**Medicaid**	**Date**
1	40	4/30/2015 5:39 PM
2	60	4/30/2015 3:10 PM
3	9	4/30/2015 9:05 AM
4	63	4/29/2015 12:26 PM
5	25	4/27/2015 12:04 PM
6	93	4/23/2015 10:59 AM
7	50	4/1/2015 1:11 PM
#	**Private insurance**	**Date**
1	97	4/30/2015 5:39 PM
2	41	4/30/2015 9:05 AM
3	101	4/29/2015 12:26 PM
4	18	4/27/2015 12:04 PM
5	96	4/23/2015 10:59 AM
6	83	4/1/2015 1:11 PM
#	**PPO reimbursements**	**Date**
1	142	4/30/2015 5:39 PM
2	0	4/29/2015 12:26 PM
3	0	4/23/2015 10:59 AM
4	78	4/1/2015 1:11 PM
#	**Private pay without insurance**	**Date**
1	64	4/30/2015 5:39 PM
2	5	4/30/2015 3:10 PM
3	15	4/30/2015 9:05 AM
4	47	4/29/2015 12:26 PM
5	33	4/27/2015 12:04 PM
6	53	4/23/2015 10:59 AM
7	50	4/1/2015 1:11 PM

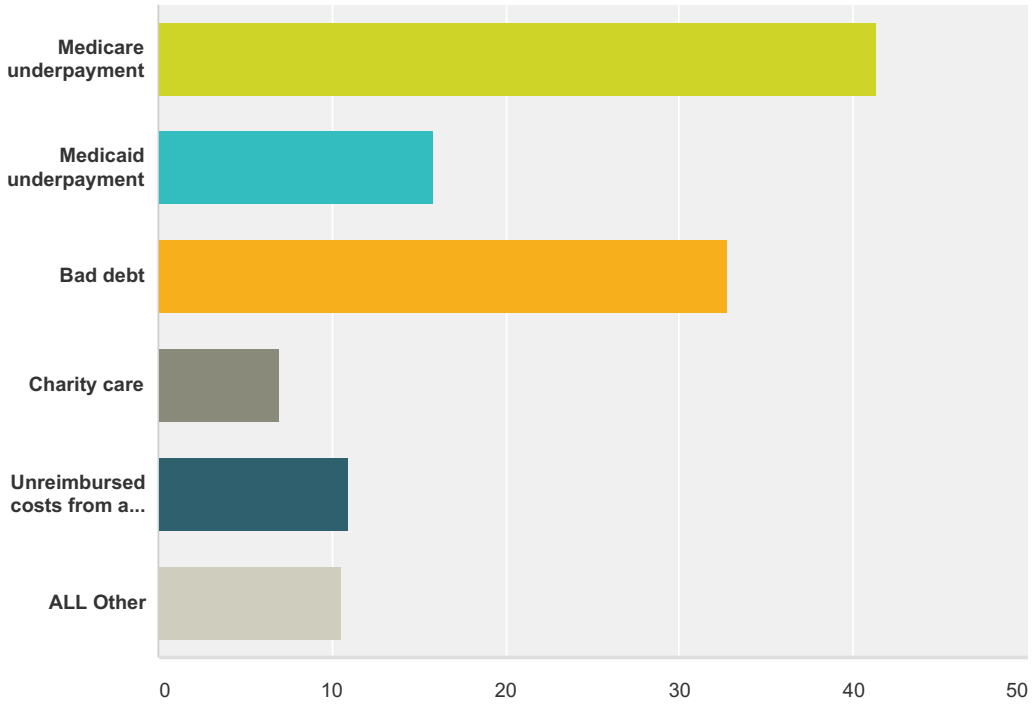
Q23 In your opinion, what components, if any, are not included in the CMS (Medicare) standardized calculation of costs of hospital services that should be?

Answered: 5 Skipped: 9

#	Responses	Date
1	Contracted and employed physicians. Trauma call.	4/30/2015 3:10 PM
2	All cost related to the delivery of care and functions to support and deliver the care should be an allowable cost.	4/29/2015 3:13 PM
3	Marketing, Physician Services expenses, Televisions in patient rooms, Homecare & Hospice expenses, Advertising, and payment for services of CRNA's.	4/29/2015 12:26 PM
4	Increase the cap limit on Therapy (Physical & Occupational) - Allow physician recruitment expense - Allow advertising expense	4/23/2015 10:59 AM
5	The cost of physician services	4/1/2015 1:11 PM

Q24 Estimate the contributions of each of the following to uncompensated care at your hospital? (Total should add to 100%)

Answered: 10 Skipped: 4



Answer Choices	Average Number	Total Number	Responses
Medicare underpayment	41	372	9
Medicaid underpayment	16	143	9
Bad debt	33	328	10
Charity care	7	70	10
Unreimbursed costs from all other payors	11	66	6
ALL Other	11	21	2
Total Respondents: 10			

#	Medicare underpayment	Date
1	17	4/30/2015 5:39 PM
2	55	4/30/2015 3:10 PM
3	10	4/30/2015 2:47 PM
4	54	4/30/2015 9:05 AM
5	52	4/29/2015 12:26 PM
6	62	4/27/2015 12:04 PM

7	47	4/23/2015 10:59 AM
8	25	4/21/2015 5:04 PM
9	50	4/1/2015 1:11 PM
#	**Medicaid underpayment**	**Date**
1	32	4/30/2015 5:39 PM
2	11	4/30/2015 3:10 PM
3	10	4/30/2015 2:47 PM
4	18	4/30/2015 9:05 AM
5	6	4/29/2015 12:26 PM
6	17	4/27/2015 12:04 PM
7	17	4/23/2015 10:59 AM
8	25	4/21/2015 5:04 PM
9	7	4/1/2015 1:11 PM
#	**Bad debt**	**Date**
1	50	4/30/2015 5:39 PM
2	10	4/30/2015 3:10 PM
3	70	4/30/2015 2:47 PM
4	14	4/30/2015 9:05 AM
5	86	4/29/2015 3:13 PM
6	8	4/29/2015 12:26 PM
7	14	4/27/2015 12:04 PM
8	18	4/23/2015 10:59 AM
9	40	4/21/2015 5:04 PM
10	18	4/1/2015 1:11 PM
#	**Charity care**	**Date**
1	1	4/30/2015 5:39 PM
2	10	4/30/2015 3:10 PM
3	8	4/30/2015 2:47 PM
4	4	4/30/2015 9:05 AM
5	14	4/29/2015 3:13 PM
6	8	4/29/2015 12:26 PM
7	7	4/27/2015 12:04 PM
8	4	4/23/2015 10:59 AM
9	10	4/21/2015 5:04 PM
10	4	4/1/2015 1:11 PM
#	**Unreimbursed costs from all other payors**	**Date**
1	2	4/30/2015 2:47 PM
2	10	4/30/2015 9:05 AM

3	19	4/29/2015 12:26 PM
4	14	4/23/2015 10:59 AM
5	0	4/21/2015 5:04 PM
6	21	4/1/2015 1:11 PM

#	ALL Other	Date
1	14	4/30/2015 3:10 PM
2	7	4/29/2015 12:26 PM

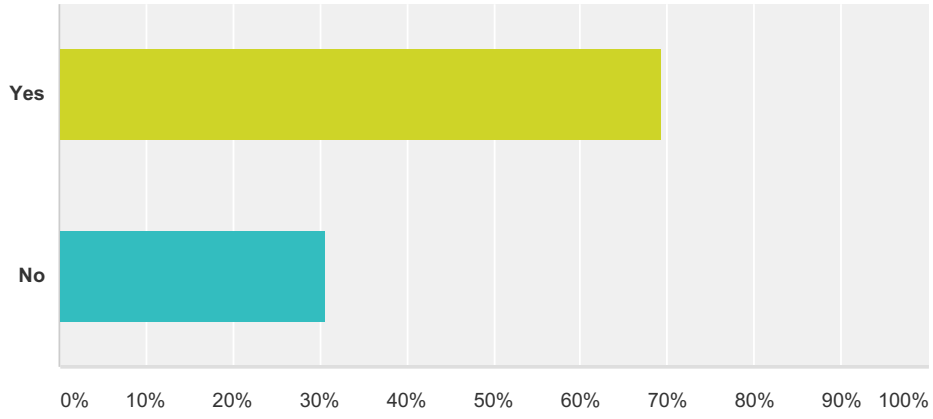
Q25 Describe the effect of cost-shifting within the hospital and to private payors?

Answered: 8 Skipped: 6

#	Responses	Date
1	The effect is that everyone hates hospitals because they charge so much- except Medicare patients, Medicaid patients, charity patients and self-pay patients.	4/30/2015 5:39 PM
2	We as a facility do not engage in cost shifting to private payors, meaning we do not charge private payors more in response to shortfalls in public payments. This phenomenon is detrimental to the cost of healthcare because the shift in costs to private payors ultimately increases health insurance premiums and leads to healthcare plans that offer less benefits and higher deductibles. When this happens, the hospital eventually has to assume that cost, sometimes as bad debt.	4/30/2015 9:05 AM
3	Wyoming Department of Health has a paper from September 1, 2014 that has information on cost shifting written by Thomas O. Forslund Director, Wyoming Department of Health	4/29/2015 3:13 PM
4	The biggest impact is that Businesses and Self-Insured individuals are having to pay more for their health care than what they truly should have to due to the need to cover Medicare/Medicaid/Charity patients that aren't covering the cost to provide healthcare services. Cost-shifting also heavily skews pricing. Because the hospital is required to take all payors, the overall pricing is much higher than it would need to be if everyone was paying the price associated with treatment.	4/29/2015 12:26 PM
5	Increases costs to private payors	4/27/2015 12:04 PM
6	Due to the reimbursement by Medicare & Medicaid rate increases are needed in order to cover expenses, therefore impacting private payors	4/23/2015 10:59 AM
7	Private payors are charged the full rates for services. If they provide financial information they may qualify for Charity Care but otherwise owe the full amount charged. In comparison, discounts are applied to full charges for Medicare, Medicaid and Commercial Insurance coverage and the patient is responsible for the co-pays, deductibles or non-covered charges.	4/21/2015 5:04 PM
8	We could reduce prices by 30% if all payors paid us what we bill	4/1/2015 1:11 PM

Q26 Is the hospital associated with a private foundation?

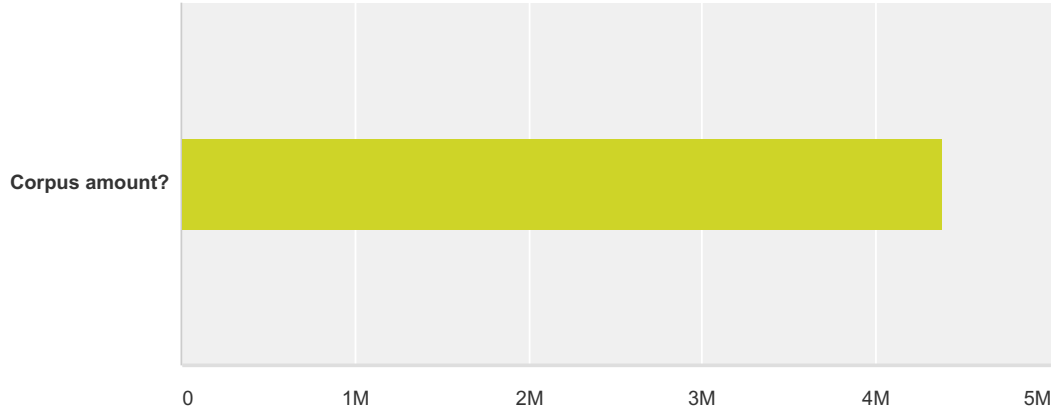
Answered: 13 Skipped: 1



Answer Choices	Responses	
Yes	69.23%	9
No	30.77%	4
Total		13

Q27 As of December 31, 2014, what was the balance of the foundation's corpus dedicated to support of the hospital?

Answered: 9 Skipped: 5



Answer Choices	Average Number	Total Number	Responses
Corpus amount?	4,383,277	39,449,495	9
Total Respondents: 9			

#	Corpus amount?	Date
1	500000	5/8/2015 4:33 PM
2	6500000	4/30/2015 3:10 PM
3	817000	4/30/2015 9:45 AM
4	13738421	4/29/2015 3:14 PM
5	8782000	4/29/2015 12:28 PM
6	174777	4/27/2015 12:04 PM
7	998657	4/23/2015 11:01 AM
8	212000	4/21/2015 5:05 PM
9	7726640	4/1/2015 1:13 PM

Q28 What amount of financial support and for what purposes did the private foundation provide funds in each of the following years? (Amount; Purposes) Example: "$100,000 for equipment, salaries, and renovation")

Answered: 9 Skipped: 5

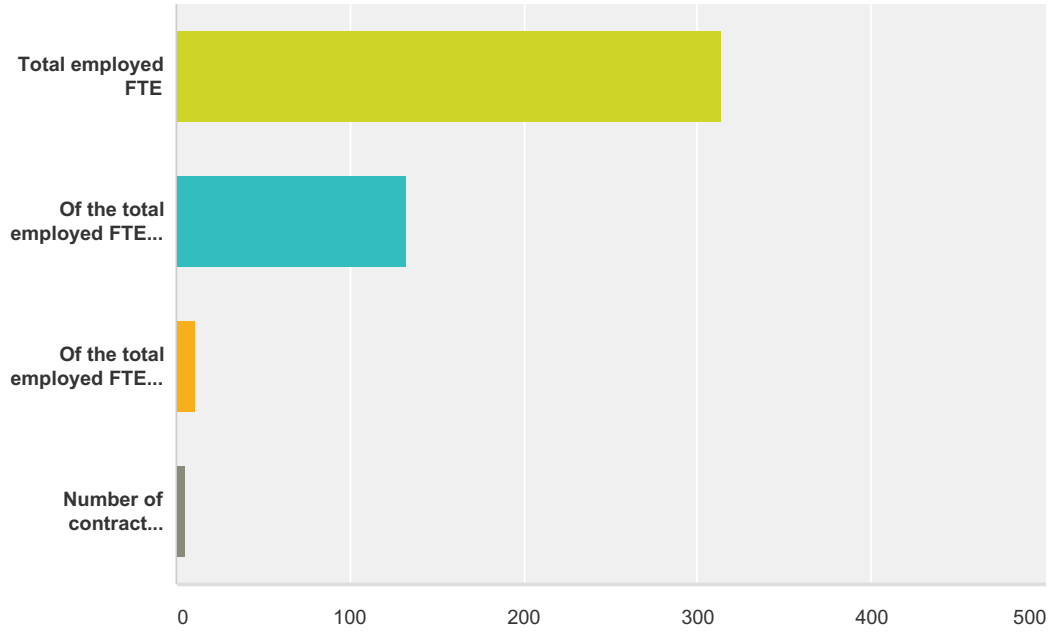
Answer Choices	Responses	
2012	88.89%	8
2013	100.00%	9
2014	100.00%	9

#	2012	Date
1	$6,050; equipment	5/8/2015 4:33 PM
2	$2,314; Pediatric cart	4/30/2015 9:45 AM
3	503,407 equipment	4/29/2015 3:14 PM
4	$1,020,086 for Hospital Operations, Capital Equipment, Cognitive Wellness, Education, Chemotherapy, Hospice, Development	4/29/2015 12:28 PM
5	8320 for lifts and ambulance	4/27/2015 12:04 PM
6	$63,235 Care Center & IP room Remodel	4/23/2015 11:01 AM
7	44450	4/21/2015 5:05 PM
8	$196,000 for support of operations and to fund the educational assistance program	4/1/2015 1:13 PM
#	2013	Date
1	$8,061; equipment	5/8/2015 4:33 PM
2	$1,009,629; Building Projects	4/30/2015 3:10 PM
3	$7,955; chemoinfusion pumps	4/30/2015 9:45 AM
4	387,849 equipmant	4/29/2015 3:14 PM
5	$1,138,647 for Hospital Operations, Capital Equipment, Cognitive Wellness, Education, Chemotherapy, Hospice, Development	4/29/2015 12:28 PM
6	8054 for direct resident care	4/27/2015 12:04 PM
7	$29,869 Care Center Projects	4/23/2015 11:01 AM
8	36401	4/21/2015 5:05 PM
9	$196,000 to fund operations and to fund the educational assistance program	4/1/2015 1:13 PM
#	2014	Date
1	$8,836; equipment	5/8/2015 4:33 PM
2	$558,038; Building Projects	4/30/2015 3:10 PM
3	$3,715; tailgate cooker	4/30/2015 9:45 AM
4	1,229,060 guest house	4/29/2015 3:14 PM

5	$1,663,455 for Hospital Operations, Capital Equipment, Cognitive Wellness, Education, Chemotherapy, Hospice, Development	4/29/2015 12:28 PM
6	15395 for artwork and direct resident care	4/27/2015 12:04 PM
7	$170,492 OB Project -Lab Equipment	4/23/2015 11:01 AM
8	15595	4/21/2015 5:05 PM
9	$196,000 to help fund operations and to fund the educational assistance program	4/1/2015 1:13 PM

Q29 What were the total, full-time equivalent (FTE) personnel in the hospital at the end of the most recent fiscal year for each of the following categories?

Answered: 13 Skipped: 1



Answer Choices	Average Number	Total Number	Responses
Total employed FTE	314	4,087	13
Of the total employed FTE, number of licensed health care professionals who provide direct medical care, such as nurses, physician assistants, physicians, etc.	132	1,586	12
Of the total employed FTE, number of physicians	11	137	12
Number of contract physicians	5	57	12
Total Respondents: 13			

#	Total employed FTE	Date
1	94	5/11/2015 10:41 AM
2	172	4/30/2015 5:41 PM
3	1058	4/30/2015 3:11 PM
4	325	4/30/2015 2:49 PM
5	230	4/30/2015 1:08 PM
6	400	4/30/2015 9:45 AM
7	380	4/29/2015 3:43 PM
8	495	4/29/2015 12:33 PM

9	181	4/27/2015 12:04 PM
10	376	4/23/2015 11:03 AM
11	128	4/21/2015 5:06 PM
12	67	4/20/2015 12:19 PM
13	181	4/1/2015 1:17 PM
#	**Of the total employed FTE, number of licensed health care professionals who provide direct medical care, such as nurses, physician assistants, physicians, etc.**	**Date**
1	58	5/11/2015 10:41 AM
2	102	4/30/2015 5:41 PM
3	142	4/30/2015 2:49 PM
4	155	4/30/2015 1:08 PM
5	184	4/30/2015 9:45 AM
6	266	4/29/2015 3:43 PM
7	190	4/29/2015 12:33 PM
8	98	4/27/2015 12:04 PM
9	177	4/23/2015 11:03 AM
10	74	4/21/2015 5:06 PM
11	22	4/20/2015 12:19 PM
12	118	4/1/2015 1:17 PM
#	**Of the total employed FTE, number of physicians**	**Date**
1	8	4/30/2015 5:41 PM
2	15	4/30/2015 3:11 PM
3	18	4/30/2015 2:49 PM
4	14	4/30/2015 1:08 PM
5	30	4/30/2015 9:45 AM
6	9	4/29/2015 3:43 PM
7	13	4/29/2015 12:33 PM
8	3	4/27/2015 12:04 PM
9	18	4/23/2015 11:03 AM
10	0	4/21/2015 5:06 PM
11	2	4/20/2015 12:19 PM
12	7	4/1/2015 1:17 PM
#	**Number of contract physicians**	**Date**
1	5	5/11/2015 10:41 AM
2	9	4/30/2015 5:41 PM
3	0	4/30/2015 2:49 PM
4	0	4/30/2015 1:08 PM
5	2	4/30/2015 9:45 AM
6	6	4/29/2015 3:43 PM

7	31	4/29/2015 12:33 PM
8	0	4/27/2015 12:04 PM
9	3	4/23/2015 11:03 AM
10	0	4/21/2015 5:06 PM
11	0	4/20/2015 12:19 PM
12	1	4/1/2015 1:17 PM

Q30 Describe any difficulties attracting and retaining medical, IT, or other staff:

Answered: 9 Skipped: 5

#	Responses	Date
1	It is very difficult to attract new physicians, new physical therapists, and new OR scrub techs. The Legislature would do a great service for the state by providing more funding for loan repayment for doctors who come to Wyoming. The average physician is now graduating with debt above $300,000.	4/30/2015 5:41 PM
2	Nursing shortage has been challenging	4/30/2015 3:11 PM
3	Sweetwater County is a rural community that has a boom and bust economy. The population of Sweetwater County is about 44,000 people. Due to the rural nature of the area, it is difficult to recruit professional staff because many amenities that are available in larger communities are not available here. We are forced to hire staff at a premium in order for them to justify relocating to a rural community. it is also difficult to retain staff, due to the volatility of the economy. A lot of the staff we hire are secondary wage earners in the family, and when the economy is experiencing a downturn, they leave if the primary wage earner in the family is transferred out of the area.	4/30/2015 9:45 AM
4	Rural setting with high cost of living and low wages.	4/29/2015 3:43 PM
5	The hospital is located in a very remote area that has a very high cost of living. It is hard to attract and retain staff that can afford housing and other day-to-day expenses, as well as individuals (and their family's) that appreciate being far away from material and social conveniences. Also, because of the rural location, it is hard for a physician to support the appropriate rate of pay based upon the volume that they will see without hospital supplementation. There is also a high demand for these positions all over the country, so there is a lot of competition involved in the recruiting process. Also, with all of the consolidation of positions, more compliance requirements, etc., a lot of these qualified individuals are leaving the industry in pursuit of other industries.	4/29/2015 12:33 PM
6	Lack of applicants for nursing, CNA, lab, x-ray, dietary Lack of experience	4/27/2015 12:04 PM
7	Due to our rural location, approx. 100 miles from closest Metro area, it is difficult to recruit physicians and providers as well as expertise in IT due to the high complexities of health care organizations.	4/23/2015 11:03 AM
8	Limited local pool of candidates and talent. Most positions do not justify relocating candidate to the area. Also, when we do have outside applicants, we must "vet" them carefully so they understand what living in Wyoming truly means.	4/21/2015 5:06 PM
9	None	4/1/2015 1:17 PM

Q31 Describe the three primary federal or state statutory or regulator burdens in terms of time and complexity:

Answered: 9 Skipped: 5

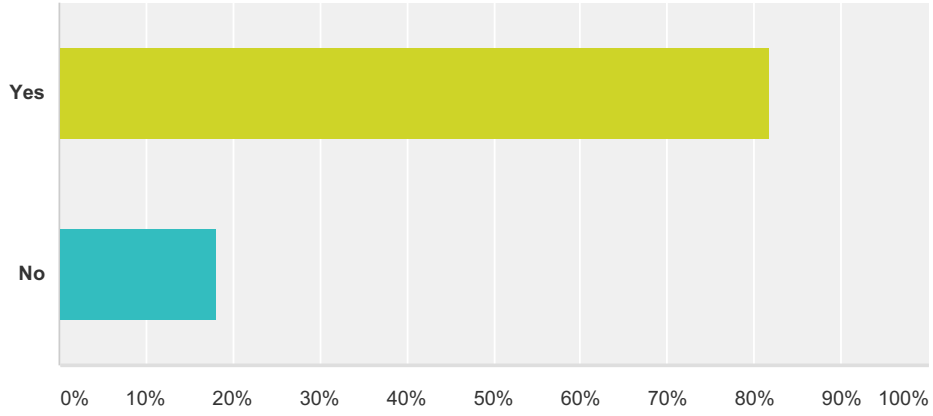
Answer Choices	Responses	
Most burden	100.00%	9
Second most burdensome	88.89%	8
Third most burdensome	88.89%	8

#	Most burden	Date
1	RAC and similar audits	4/30/2015 5:43 PM
2	Medicare	4/30/2015 2:50 PM
3	Nursing Home surveys	4/30/2015 1:09 PM
4	The Joint Commission - focused on ensuring that healthcare organizations provide quality care. We have dedicated a large amount of time and resources to ensuring that we comply with the Joint Commission standards and receive accreditation. We have many dedicated staff members who meet weekly to ensure that standards are being met and we are compliant.	4/30/2015 9:45 AM
5	ICD-10	4/29/2015 3:43 PM
6	Value Based Purchasing Program thru CMS. The core measures are highly complex and time consuming. Likewise, the Joint Commission Standards are complex, and new standards are continuously being added.	4/29/2015 12:37 PM
7	Bureaucratic Burden	4/23/2015 11:03 AM
8	Building upgrade process - Submission of plans to approval takes significant time and slows down projects.	4/21/2015 5:11 PM
9	DOH surveys	4/1/2015 1:19 PM
#	**Second most burdensome**	**Date**
1	Stark regulations	4/30/2015 5:43 PM
2	Medicaid	4/30/2015 2:50 PM
3	The Centers for Medicare and Medicaid (CMS) - oveersees most of the regulations related directly to the healthcare system. CMS is also responsible for ensuring compliance to the Health Insurance Portability and Accountability Act (HIPAA) and the Agency for Healthcare Research and Quality (AHRQ). We are diligent about adhering to regulations enforced by CMS by hiring staf to ensure compliance and constant continuing education in order to remain current with changing regulations.	4/30/2015 9:45 AM
4	Meaningful Use	4/29/2015 3:43 PM
5	Meaningful Use has impacted the IT Department and the Hospital as it is both a time and cost burden. Not only is new software needed in order to adhere to all new requirements, but additional IT staff is needed to implement and oversee the project and upkeep. Other departments are also having to spend more time at their computers completing paperwork vs. spending time with patients.	4/29/2015 12:37 PM
6	Lack of Torte Reform	4/23/2015 11:03 AM
7	Quality Reporting to several places takes a lot of time and is inconsistent	4/21/2015 5:11 PM
8	Conditions of Participation standards	4/1/2015 1:19 PM
#	**Third most burdensome**	**Date**
1	Medicare Conditions of Participation	4/30/2015 5:43 PM

2	Federal Government	4/30/2015 2:50 PM
3	Wyoming Department of Health - oversees regulations related to the health delivery system related to Wyoming residents. Similar to CMS, we ensure that we are compliant with the regulations and devote many staff hours in order to achieve this.	4/30/2015 9:45 AM
4	Value Based Purchasing	4/29/2015 3:43 PM
5	Wyoming Federal Medicaid DSH Examination - this survey is very time consuming due to reporting limitations with the hospital's software.	4/29/2015 12:37 PM
6	Surveys	4/23/2015 11:03 AM
7	Health Inspection Plan of Correction submissions - the document is not easy to complete and takes time as the form is not computer driven.	4/21/2015 5:11 PM
8	Cost reports	4/1/2015 1:19 PM

Q33 Are hospital-employed physicians covered under the hospital's liability insurance?

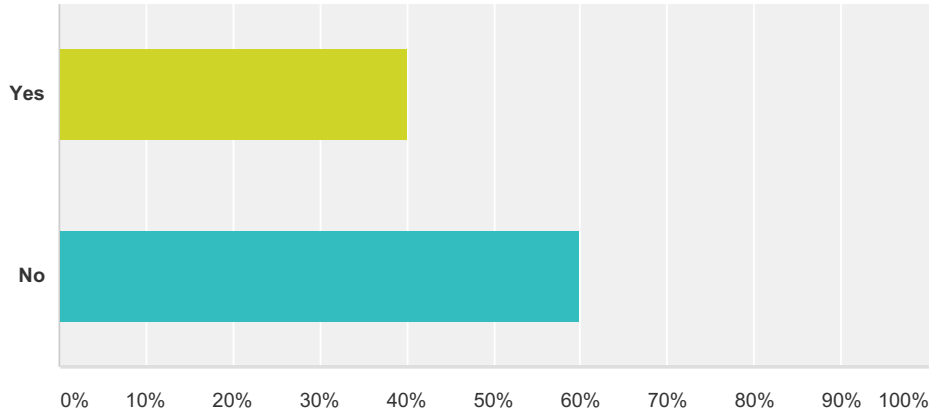
Answered: 11 Skipped: 3



Answer Choices	Responses	
Yes	**81.82%**	9
No	**18.18%**	2
Total		**11**

Q34 Are hospital-contracted physicians covered under hospital liability insurance?

Answered: 10 Skipped: 4



Answer Choices	Responses	
Yes	**40.00%**	4
No	**60.00%**	6
Total		**10**

Q35 From a medical standpoint, what are the services community hospitals provide which cannot be provided through alternative methods of health care delivery? (For example, do local hospitals have specialized expertise and equipment for the timely, accurate diagnosis and treatment of stroke and hearth attack patients allowing the best practices for best outcomes thereby reducing death and disability?)

Answered: 12 Skipped: 2

#	Responses	Date
1	We save the lives of many sick and injured people because we have specialized expertise and equipment.	4/30/2015 5:48 PM
2	WMC provides multiple specialties to our community and to the state of Wyoming. These include, but are not limited to medical & critical care services, pediatrics and obstetrics, trauma care, stroke care, heart and vascular services, neurosurgery, and orthopedic care.	4/30/2015 3:11 PM
3	The hospital is the only place to receive surgeries, trama care and ob services	4/30/2015 2:52 PM
4	Emergency and Trauma Care	4/30/2015 1:11 PM
5	It is difficult for many community hospitals to keep up with specialized expertise and state of the art equipment in order to allow for best practices for best outcomes. Community hospitals must juggle high dollars of uncompensated care, the high cost of providing care and fixed reimbursement, which results in very narrow margins. Additional legislation that would assist rural hospitals in being reimbursed for uncompensated care would help broaden bottom lines and allow for more services around the state; resulting in best practices.	4/30/2015 9:45 AM
6	Local hospitals have specialized expertise and equipment for the timely and accurate diagnosis for patients in need allowing the best practices for best outcomes thereby reducing death and disability	4/29/2015 3:43 PM
7	Because of the location of the hospital, most of the care provided cannot be provided through other methods of health care delivery. Specifically, all emergency treatment, timely diagnostics, emergency surgery, most labor and delivery, urgent care, community focused wellness, inpatient services, long term care in a community that the patient is familiar with, and patient convenient medical oncology. Unless the patient is physically able to travel several hours, these services need to be provided at the local hospital.	4/29/2015 12:38 PM
8	Stabilizing trauma patients, reduced time to ER; studies show patients heal better closer to home	4/27/2015 12:07 PM
9	With reduced reimbursement in Medicare & Medicaid payor mix will suffer - Small communities hospitals can no longer be everything to everyone within the community - they will have to make choices to reduce costly services	4/23/2015 11:08 AM
10	Community hospitals provide care that is close to the patient's families. Improvement in accessibility for specialists would expand the capabilities of community hospitals.	4/21/2015 5:16 PM
11	Emergency Care Family Support Care	4/20/2015 12:22 PM
12	Emergency services Services that are not financially attractive	4/1/2015 1:22 PM

Q36 Some research indicates that patient outcomes are better when treatment is closer to home, near family and community supports. What is the trade off between this effect and the advantages of treatment in more distant centers with broader or more specialized capabilities?

Answered: 10 Skipped: 4

#	Responses	Date
1	We save the lives of many sick and injured people because we have specialized expertise and equipment.	4/30/2015 5:48 PM
2	some treatments can't wait to drive 50 miles	4/30/2015 2:52 PM
3	Cannot see a trade off. Services can be provided locally cost effectively.	4/30/2015 1:11 PM
4	As the focus of healthcare moves from inpatient to outpatient services, home health, population health, post-acute care and penalizing hospitals for readmissions, I think that now more than ever it is important to try to keep treatment close to home and focus on the importance of that. With technology, more specialized treatment is available through tele-health. We are able to bring many aspects of specialized care to the rural setting, allowing patients to stay close to home.	4/30/2015 9:45 AM
5	Treatment in more distant centers may reduce the need for duplicate services for a low volume area. Reducing duplicate services may decrease costs, and have a positive/negative impact on outcomes.	4/29/2015 3:43 PM
6	There are many tradeoffs if the patient utilizes treatment in a distant center. If the patient has to travel any sort of distance, they are faced with many different stressors, including: time off from work for both the patient and family members, travel expenses, inability to fulfill family obligations, and being away from their main support system. All of these factors can lead to a poor outcome for the patient. Adversely, if the patient is treated in the local hospital, the patient benefits from being close to the physicians that are familiar with the details of their case in instances of complications. Follow-up visits are also much more convenient, both in time and cost. The patient outcome is typically better if they are not having to continuously travel and be away from home, as well as being able to stay on top of daily responsibilities. The hospital also benefits in that it is able to spread its overhead and staffing over more patients, gain more experience with patient care, and offer more personalized care.	4/29/2015 12:38 PM
7	I see none. We only send patients when needed for specialized care and they come right back to us. What is the purpose of this question?	4/27/2015 12:07 PM
8	Hospitals not only provide services, they also provide jobs, support of local business. A small town with no hospital will have a difficult time recruiting for other industry.	4/23/2015 11:08 AM
9	Patients need to be at the facility that provides the most appropriate level of care. However, there are opportunities to expand the reach of specialists through tele-medicine that the state of Wyoming needs to improve and that would help keep patients closer to home.	4/21/2015 5:16 PM
10	In small communities, the focus should be on primary care services. Patients should be sent out of the community for more specialized services. It should be a well run continuum of care.	4/1/2015 1:22 PM

Q37 What do you identify as the three primary drivers of the cost of hospital care?

Answered: 12 Skipped: 2

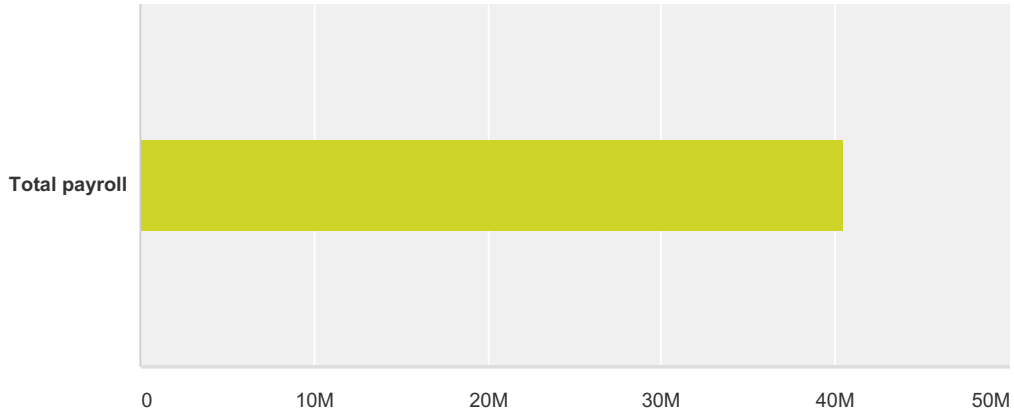
Answer Choices	Responses	
(i)	**100.00%**	12
(ii)	**100.00%**	12
(iii)	**100.00%**	12

#	(i)	Date
1	Patients' perceptions that they need it all, now	4/30/2015 5:48 PM
2	Labor costs	4/30/2015 3:11 PM
3	Medicare and Medicaid	4/30/2015 2:52 PM
4	Salary requirements	4/30/2015 1:11 PM
5	Physician, equipment and drug costs. It is difficult to recruit physicians to rural areas; therefore, we must incentivize them more than our urban counterparts. Facility costs are high as the cost of equipment keeps increasing while hospital margins keep decreasing. Drug costs are tremendously high and we are bound to paying the high costs while reimbursement is negligible in comparison.	4/30/2015 9:45 AM
6	cost of capital and equipment	4/29/2015 3:43 PM
7	Salaries	4/29/2015 12:38 PM
8	Expensive equipment	4/27/2015 12:07 PM
9	Salaries	4/23/2015 11:08 AM
10	Liability for Providers	4/21/2015 5:16 PM
11	Wages	4/20/2015 12:22 PM
12	Employee wages & fringe benefits	4/1/2015 1:22 PM
#	(ii)	Date
1	Bureaucracy - government, insurance, industry watchdogs	4/30/2015 5:48 PM
2	Equipment and supply costs	4/30/2015 3:11 PM
3	uninsured	4/30/2015 2:52 PM
4	State and Federal regulations	4/30/2015 1:11 PM
5	Expensive technology. As electronic health records become more mainstream, and meaningful use becomes a requirement, the cost of keeping up with technology is becoming more burdensome to hospitals. The systems are expensive, as is the maintenance of them, and the productivity of the providers is lessened by the sheer magnitude of information required to achieve meaningful use. In the future, reimbursement will be impacted as penalites will be imposed if hospitals do not achieve meaningful use with their electronic health record.	4/30/2015 9:45 AM
6	salaries and benefits	4/29/2015 3:43 PM
7	Low volume and/or irregularity of patient visits	4/29/2015 12:38 PM
8	People with no insurance	4/27/2015 12:07 PM
9	Implementation of an E.H.R	4/23/2015 11:08 AM
10	Keeping up with the technology/equipment for services	4/21/2015 5:16 PM
11	Insurance reductions	4/20/2015 12:22 PM

12	Physician services	4/1/2015 1:22 PM
#	**(iii)**	**Date**
1	Unfair competition, such as surgical centers and imaging centers	4/30/2015 5:48 PM
2	Regulations	4/30/2015 3:11 PM
3	wages	4/30/2015 2:52 PM
4	Insurance burdens	4/30/2015 1:11 PM
5	Unhealthy behaviors. As the population ages, more and more patients are presenting with multiple co-morbidities that are difficult to treat. Chronic illness - like heart disease, cancer and diabetes - causes about 70% of all deaths in the United States, and they are the most expensive to treat. A majority of chronic illnesses stem from unhealthy behaviors. These illnesses drive up the cost of healthcare, with little reimbursement for hospitals.	4/30/2015 9:45 AM
6	patient volumes	4/29/2015 3:43 PM
7	Other overhead costs (Government compliance, medical malpractice insurance, billing & denial claims, etc.)	4/29/2015 12:38 PM
8	people who don't pay copays or deductibles	4/27/2015 12:07 PM
9	Medicare & Medicaid Reimbursement	4/23/2015 11:08 AM
10	Keeping qualified staff salaries to keep workforce	4/21/2015 5:16 PM
11	IT requirements	4/20/2015 12:22 PM
12	Supplies and equipment	4/1/2015 1:22 PM

Q38 What is the hospital's total annual payroll?

Answered: 12 Skipped: 2



Answer Choices	Average Number	Total Number	Responses
Total payroll	40,488,100	485,857,201	12
Total Respondents: 12			

#	Total payroll	Date
1	14263320	4/30/2015 5:51 PM
2	92900000	4/30/2015 3:11 PM
3	23500000	4/30/2015 2:53 PM
4	13346630	4/30/2015 1:14 PM
5	32583165	4/30/2015 9:49 AM
6	22633119	4/29/2015 3:43 PM
7	43767370	4/29/2015 12:41 PM
8	8920695	4/27/2015 12:08 PM
9	214193560	4/23/2015 11:08 AM
10	6000000	4/21/2015 5:21 PM
11	3500000	4/20/2015 12:38 PM
12	10249342	4/1/2015 1:24 PM

Q39 What are the two most direct economic consequences of local hospitals and the economic development impacts of not having a local hospital?

Answered: 12 Skipped: 2

Answer Choices	Responses	
(i)	**100.00%**	12
(ii)	**91.67%**	11

#	(i)	Date
1	Job loss of the community's best paid employees	4/30/2015 5:51 PM
2	Loss of jobs	4/30/2015 3:11 PM
3	The town would dry up	4/30/2015 2:53 PM
4	Hospitals are economic drivers	4/30/2015 1:14 PM
5	First of all, the impact would be to decrease the economic well-being of the community. Most hospitals are one of the top ten employers in small communities. A hospital employs many highly educated staff, including physicians, nurses, executives, etc. Evidence shows that in the long run, with a hospital closure, the estimate is that per capita income may decline; thereby negatively impacting the local economy.	4/30/2015 9:49 AM
6	Loss of community members.	4/29/2015 3:43 PM
7	The hospitals existence enhances the ability for people to live in the area. Most people would not be willing or able to live hours from a facility that provides the emergent and chronic care that a hospital does.	4/29/2015 12:41 PM
8	Largest employer in county. Imagine if 240 empolyees and families leave a community of 2400.	4/27/2015 12:08 PM
9	Jobs, Jobs, Jobs	4/23/2015 11:08 AM
10	Healthcare Facility is a major employer in our area. Lack of the jobs would greatly diminish the economy of the area.	4/21/2015 5:21 PM
11	People expect healthcare in their community without it they live elsewhere.	4/20/2015 12:38 PM
12	Loss of a significant employer.	4/1/2015 1:24 PM
#	(ii)	Date
1	Inability of communities to bring in new businesses, because there are no hospital or doctors	4/30/2015 5:51 PM
2	Loss of the ability to attract new business to the community	4/30/2015 3:11 PM
3	people would not move here	4/30/2015 2:53 PM
4	outside firms would not relocate	4/30/2015 1:14 PM
5	Secondly, the challenge for small, local hosptials is to be able to increase economic efficiency, which is very difficult to achieve because of low volumes and fixed reimburesement systems, such as Medicare and Medicaid. If these pressures become too great and a hospital must close, there is a negative effect on the health and health care access in rural communities. the impacts of a closure create barriers to receipt of critical emergency services, create increased travel time to inpatient care and create a decrease in physician supply if there is not a hospital.	4/30/2015 9:49 AM
6	Loss of a business that uses other local businesses and services.	4/29/2015 3:43 PM
7	The hospital directly supports the local economy in many ways. The hospital is the largest year-around employer in the county, which promotes a stable middle class. The hospital also supports local businesses with the purchase of supplies and contract labor.	4/29/2015 12:41 PM

8	Economic Growth ceases to exist	4/23/2015 11:08 AM
9	If the facility was gone, many would travel out of state for services.	4/21/2015 5:21 PM
10	Millions in lost revenue throughout the community.	4/20/2015 12:38 PM
11	Loss of a significant purchaser of services.	4/1/2015 1:24 PM

Q40 Thank you for your participation; please include or attach any additional comments as you deem appropriate regarding this survey or the delivery of health care in Wyoming:

Answered: 2 Skipped: 12

#	Responses	Date
1	If the legislature is determined to make hospitals compete, then they need to realize that hospitals will always lose. That because hospitals are inherently more costly than surgery centers, freestanding imaging centers, urgent care clinics, etc. In such a competitive environment, hospitals will close. If the legislature wants to keep them, then hospitals will need to be subsidized by the state, and regulated as public utilities.	4/30/2015 5:55 PM
2	Along with the many issue discussed above, rural hospitals in Wyoming also face the challenge of efficiently providing care, while trying to maintain profitability. This challenge is exacerbated by the fact that many hospitals must write off large amounts of uncompensated care. Bad debt and charity care consist of 10% of our gross revenue at a cost of $11,500,000, annually. We are seeing health insurance plans with high deductibles; which sometimes eventually translate into bad debt because patients do not get to realize any benefit from their insurance plan and do not want to pay the out of pocket, high cost deductible. We have seen a rise in our bad debt because of this phenomenon. Another issue affecting the delivery of healthcare in Wyoming is the introduction of private specialty hospitals that are allowed to compete with local hospitals. According to the Affordable Care Act, physician owned, for-profit hospitals cannot accept Medicare and Medicaid patients. Also, many times, these hospitals do not have an emergency room and the patients must go to the local hospital for this type of care. The result is that the competition is not level and the local hospital suffers. The privately owned, for profit hospitals will eventually skim off the patients with private insurance and leave the fixed reimbursement and self-pay patients for the local hospital. this will ultimately negatively affect the bottom line and services will be jeopardized. The for-profit hospital is not a full service hospital and if the presence of such causes the local hospital to close, then all patients will suffer in the community. Legislation must be passed that will allow local hospitals to compete on a more level playing field, or impose stricter rules and regulations for physician owned, for profit hospital to enter a rural community.	4/30/2015 9:57 AM

Wyoming Hospitals Survey Responses: Raw Data

Hospital Name:	City/Town:	Is the day-to-day administration of the hospital:	If the hospital administration is contracted to a private company, is the management company:	Is the hospital financially comingled with a long-term care center or clinic?	If comingled with a long-term care facility or clinic, does the long-term care center or clinic generate:	If comingled with a long-term care facility or clinic, does the long-term care center or clinic increase or decrease the amount of charity care provided:	For all primary facilities in which medical care is delivered, please identify the facility name; age (in years); condition (poor, fair, good, excellent); and estimated accumulated deferred maintenance ($). Example: Facility #1 - "Main hospital; 22 years; fair; $1,200,000"	Explain how age, condition or deferred maintenance impact the quality of the health care services provided at the hospital?
Star Valley Medical Center	Afton	Hired by a hospital board		Both a clinic and a long-term care center	Clinic generates more revenue than expenditures; Long-term care center generates less revenue than expenditures	Clinic decreases amount of charity care; Long-term care center has no effect on amount of charity care	Main hospital;14 years; good;1,500,000 / Thayne Clinic 10 years; good; 300,000 / Alpine Clinic; 20 years; excellent; 0 / Physical Therapy; 5 years; excellent; 0 Orthopedics; 28 years; excellent; 0	Mostly cosmetic and mechanical. Little impact of quality of health care.
South Big Horn Critical Access Hospital	Basin	Hired by a hospital board		Both a clinic and a long-term care center	Clinic generates less revenue than expenditures; Long-term care center generates exactly the same revenue as expenditures	Clinic has no effect on amount of charity care; Long-term care center has no effect on amount of charity care	Hospital/Clinic/LTC 1 main bldg; 59 years; 3,603,549	Small spaces to perform all tasks, one ADA toilet in the facility, large dollars spent on heating and cooling infrastructure repairs not easily accomplished and often create need for more repairs, difficulty competing with more modern facilities.
Johnson County Healthcare Center	Buffalo, Wyoming	Hired by a hospital board		Both a clinic and a long-term care center	Clinic generates exactly the same revenue as expenditures; Long-term care center generates less revenue than expenditures	Clinic increases amount of charity care; Long-term care center increases amount of charity care	Original hospital; 63 years; poor; NA / 1980 hospital addition; 35 years; fair; NA / 1995 OR addition; 20 years; good; $200,000 / 2005 hospital addition; 10 years; excellent; none / 2012 hospital addition; 3 years; excellent; none / nursing home; 52 years; poor; $14,000,000 - bldg new facility / clinic: 10 years; good; $250,000	The biggest impact is in our nursing home. It is a very old facility, small rooms, shared bathrooms. It is felt that it has an adverse impact on residents. The older part of the hospital is not air conditioned, has old rooms and shared bathrooms. It is not a very attractive facility.
Wyoming Medical Center	Casper	Hired by a hospital board		Clinic	Clinic generates less revenue than expenditures	Clinic increases amount of charity care	Main Hospital; Good; $2.8M/annual maintenance	
Memorial Hospital of Converse County	Douglas	Hired by a hospital board		Clinic	Clinic generates less revenue than expenditures	Clinic increases amount of charity care	Main Hospital; 32 years; good / Addition to Main Hospital; 13 years; excellent / Medical Office Building; year; excellent	We have the latest technology and upgrade to hospital creates a great environment to provide healthcare.
Evanston Regional Hospital	Evanston	Contracted to an external private company	For-profit	Clinic	Clinic generates less revenue than expenditures	Clinic increases amount of charity care	Evanston Regional Hospital; 30 years; fair / Uinta Medical Plaza; 15 years; fair / Bridger Valley Family Practice; 5 years; good / Mountain View Clinic; 30 years; fair	Old, worn out things take a lot of money to maintain. And it's rarely easy to get the capital necessary to replace old stuff. So you spend a ton of money keeping old stuff operational, which compromises your ability to buy new stuff. The new stuff may in fact improve the quality of care, but if you can't afford to buy it then you may not be maintaining high quality standards.

Wyoming Hospitals Survey Responses: Raw Data

	City/Town:	Is the day-to-day administration of the hospital:	If the hospital administration is contracted to a private company, is the management company:	Is the hospital financially comingled with a long-term care center or clinic?	If comingled with a long-term care facility or clinic, does the long-term care center or clinic generate:	If comingled with a long-term care facility or clinic, does the long-term care center or clinic increase or decrease the amount of charity care provided:	For all primary facilities in which medical care is delivered, please identify the facility name; age (in years); condition (poor, fair, good, excellent); and estimated accumulated deferred maintenance ($). Example: Facility #1 - "Main hospital; 22 years; fair; $1,200,000"	Explain how age, condition or deferred maintenance impact the quality of the health care services provided at the hospital?
Teton County Hospital District dba St. John's Medical Center	Jackson	The CEO is hired by the hospital board, all other administration employees are hired by Human Resources.		Both a clinic and a long-term care center	Clinic generates less revenue than expenditures; Long-term care center generates less revenue than expenditures	Clinic increases amount of charity care; Long-term care center increases amount of charity care	Main Hospital; 24 years; Excellent; N/A / Long Term Care Facility; 23 years; Good; N/A	The age and condition of the facility, specifically the Living Center, directly relate to the ability to control infection. With older facilities, it can be much harder to keep patient areas clean/sterile. The more modern the facility, the more likely the ability to have higher end treatments available, such as the newer Outpatient Surgeries. Older facilities are also less efficient, whereas new facilities really enhance work flows.
Ivinson Memorial Hospital	Laramie	Hired by a hospital board		Both a clinic and a long-term care center	Clinic generates less revenue than expenditures; Long-term care center generates less revenue than expenditures	Clinic has no effect on amount of charity care; Long-term care center has no effect on amount of charity care	Ivinson Memorial Hospital, Average Age of Plant is 10 years, The plant is fair to excellent, estimated deferred maintenance cost is 10m.	The deferred maintenance requires a larger allocation of capital and maintenance dollars that would be used to invest in technology and new equipment.
North Big Horn Hospital District	Lovell	Contracted to an external private company	Not-for-profit	Both a clinic and a long-term care center	Clinic generates less revenue than expenditures; Long-term care center generates exactly the same revenue as expenditures	Clinic increases amount of charity care; Long-term care center has no effect on amount of charity care	NBHHD; 31 years; good; $180,000	Drafty windows in LTC resident room; Carpeting that needs to be replaced to reduce trip hazards
Niobrara Health and Life Center	Lusk	Hired by a hospital board		Both a clinic and a long-term care center	Clinic generates less revenue than expenditures; Long-term care center generates more revenue than expenditures	Clinic decreases amount of charity care; Long-term care center has no effect on amount of charity care	Niobrara Health & Life Center; condition good; ecdm $500,000	Effects efficiency at times & creates potential harms at times to all constituencies using facility.
Weston County Health Services	Newcastle	Management Agreement with Private Non-Profit		Long-term care center	Long-term care center generates less revenue than expenditures	Long-term care center increases amount of charity care	CAH Hospital; 28 years; fair; $0 / Nursing Home; 56 years; fair; $0	Small rooms, small bathrooms, shared rooms, shared bathrooms, make it difficult to care for more needy patients

Wyoming Hospitals Survey Responses: Raw Data

	City/Town:	Is the day-to-day administration of the hospital:	If the hospital administration is contracted to a private company, is the management company:	Is the hospital financially comingled with a long-term care center or clinic?	If comingled with a long-term care facility or clinic, does the long-term care center or clinic generate:	If comingled with a long-term care facility or clinic, does the long-term care center or clinic increase or decrease the amount of charity care provided:	For all primary facilities in which medical care is delivered, please identify the facility name; age (in years); condition (poor, fair, good, excellent); and estimated accumulated deferred maintenance ($). Example: Facility #1 - "Main hospital; 22 years; fair; $1,200,000"	Explain how age, condition or deferred maintenance impact the quality of the health care services provided at the hospital?
Powell Valley Healthcare	Powell	Contracted to an external private company	For-profit	Both a clinic and a long-term care center	Clinic generates less revenue than expenditures; Long-term care center generates less revenue than expenditures	Clinic increases amount of charity care	Hospital 29 year; Fair- Good; $1,000,000 / Care Center 18 years; Good; $750,000 / Clinics 10-40 years; Fair - Excellent; $4,000,000	Structural Viability of the main facility - HVAC in Care Center - Functionality of the Clinic - 2 floors are not completed and not in use
Memorial Hospital of Sweetwater County	Rock Springs	Hired by a hospital board		Clinic	Clinic generates less revenue than expenditures	Clinic increases amount of charity care	MHSC; 37 years; excellent; $1,200,000 / Medical office building; 1 year; excellent; $200,000	Maintenance of an older facility is expensive but does no interfere with the quality of healthcare services provided Maintenance of the facility is a budgeted cost of doing business. Maintenance of the facility, age of plant and condition are all very important in ensuring that the highest quality of care can be provided to patients with the most up-to-date equipment.
Hot Springs County Memorial Hospital	Thermopolis	Contracted to an external private company	For-profit	Clinic			Hot Springs Cty Memorial; 60 years; Fair	

Wyoming Hospitals Survey Responses: Raw Data

	List the construction or acquisition of any addition, major renovation, major maintenance or property purchase, including equipment in excess of $250,000					On what date did your most recent fiscal year end?	For the hospital's most recent fiscal year, what were the hospital's total revenues?	For the hospital's most recent fiscal year, what were the hospital's total expenditures?	As of December 31, 2014, what were the hospital's cash reserves?	As of December 31, 2014, what were the hospital's current assets?	As of December 31, 2014, what were the hospital's current liabilities?
Hospital Name:	2010	2011	2012	2013	2014						
Star Valley Medical Center				30,000 square feet; Therapy and Primary Clinic Space; $1,500,000; 8,000 square Feet; Remodel of Clinic Space for Orthopedics; 450,000; 2,500 Square Feet; Remodel of Alpine Clinic Space; $180,000	600 Square Feet; MRI; 1,100,000	06/30/2014	$29,353,306	$28,749,224	$3,709,076	$34,790,220	$34,790,220
South Big Horn Critical Access Hospital	Lab & Radiology addition; 5244 sq ft; $2,993,000; SLIB grant	CT Scan; $500,000; facility savings			Construction in Progress; hospital/ER 18,446 sq ft; $7,000,000; SLIB grant - $2,000,000; USDA loan - $4,000,000; facility savings, $1,000,000	6./30/2014					
Johnson County Healthcare Center	Spent $414,208 on CE - $75,000 on EHR; operating funds and taxes	Spent $725,912 on CE - $345, 655 on digital mammo; grant, operating funds & taxes	Spent $932, 815 on CE; $262,624 on new flour room, $130,000 on IT expenses, completed 20,000 + square foot addition at a cost of $11,348,797, paid for by operating funds and taxes	Spent $586,524 on CE, $124,624 on C-Arm, $75,378 on ICU monitors & $66,000 on bus; used grant, operating funds & taxes	Spent $840,321 on CE; Spent $105,057 on EHR expenses	06/30/2014	$20,335,861	$18,511,556	$8,280,152	$12,290,687	$1,347,685
Wyoming Medical Center		ER Expansion; $8.5M; Operating Cash & Contributions	Cerner; $10.4M; Operating Cash		West Tower/MRI; $45.2M; Operating Cash & Bond Funds	06/30/2014	197.4M	190.9M	48.1M	103.9M	23.9M
Memorial Hospital of Converse County	Spect/CT; $347,000; cash reserves	2 ultrasound machines; cash reserves	House; $534,000; cash reserves	VOIP Phone System; $258,000; cash reserves, Portable x-rays; $450,000; cash reserves. Devinci Surgical System; $1,980,000; cash reserves. MRI; $1,350,000; bank loan	Medical Office Building $8,500,000; 38,000 sq. ft.; secured loan with hospital CDs	06/30/2014	$59,247,000	$51,084,000	$13,163,000	$27,147,000	$4,623,000
Evanston Regional Hospital	1565000 MRI machine and building addition for MRI	506986 PACS	697035 IT infrastructure	358681 Nuclear camera; 297287 HVAC upgrade	638465 CT scanner	12/31/2014	$35,564,296	$28,075,691	$131,268	$6,614,827	$1,765,708

Wyoming Hospitals Survey Responses: Raw Data

	List the construction or acquisition of any addition, major renovation, major maintenance or property purchase, including equipment in excess of $250,000					On what date did your most recent fiscal year end?	For the hospital's most recent fiscal year, what were the hospital's total revenues?	For the hospital's most recent fiscal year, what were the hospital's total expenditures?	As of December 31, 2014, what were the hospital's cash reserves?	As of December 31, 2014, what were the hospital's current assets?	As of December 31, 2014, what were the hospital's current liabilities?
Teton County Hospital District dba St. John's Medical Center	2010 - CT Scanner - $2,554,214 - Cash Reserves; 2010 - Property - $933,375 - Cash Reserves	2011 - House - $265,000; 2011 - Diagnostic Xray - $288,433 - Cash Reserves	N/A	2013 - MRI - $2,399,809 - Cash Reserves	2014 - Central Energy Plant - 4700 sq ft - $6,644,837 - Specific Purpose Excise Tax & Cash Reserves; 2014 - Expansion & Remodel - 54,590 sq ft - $9,045,627 - Specific Purpose Excise Tax & Cash Reserves	06/30/2014	$96,292,957	$83,145,066 (Total Expenses)	$47,188,786 (Unrestricted Cash Reserves)	$64,399,293	$10,947,320
Ivinson Memorial Hospital	cysto table 410,152 cash, nuclear med camera 380,373 cash, MRI 1.57m cash		radiology machine 391,910 cash, Linear Accelerator 2.13m loan	nurse call system 375,081 cash	building renovation and addition 38,721 additional sq ft 35m cash	06/30/2014	$81,072,765	$62,620,132	$50,070,628	$48,512,991	$7,561,922
North Big Horn Hospital District						06/30/2014	$15,815,247	$15,202,873	$3,395,486	$3,068,084	$1,110,168
Niobrara Health and Life Center											
Weston County Health Services						06/30/2014	$12,749,434	$12,526,439	$4,328,768	$7,784,763	$1,480,625

Wyoming Hospitals Survey Responses: Raw Data

	List the construction or acquisition of any addition, major renovation, major maintenance or property purchase, including equipment in excess of $250,000				On what date did your most recent fiscal year end?	For the hospital's most recent fiscal year, what were the hospital's total revenues?	For the hospital's most recent fiscal year, what were the hospital's total expenditures?	As of December 31, 2014, what were the hospital's cash reserves?	As of December 31, 2014, what were the hospital's current assets?	As of December 31, 2014, what were the hospital's current liabilities?
Powell Valley Healthcare				MRI & R & F Rooms; 2,372,641 Vendor financed	06/30/2014	42,707,511 Net - (Gross = 64,172,653	$44,053,251	$2,985,667	$12,443,251	$3,750,312
Memorial Hospital of Sweetwater County	Digital Mammo; $385,992; private grant			Linear Accelerator; $2,340,961; private grant; Medical Office Building $24,000,000; special purpose tax, cash reserves	06/30/2014	$107,057,524	$66,717,327	$29,388,905	$27,656,897	$22,367,392
Hot Springs County Memorial Hospital		X-ray Equip; $258,360; cash reserves	Pharmacy Disp Equip; $336,170; grants funds		06/30/2014	$15,562,690	$15,325,849	$2,301,056	$6,684,543	$3,088,104

Wyoming Hospitals Survey Responses: Raw Data

	For the hospital's most recent fiscal year, what were the dollar amounts of patient care services paid by the following sources?					For the hospital's most recent fiscal year, how many inpatient days were paid for by the following sources:					For the hospital's most recent fiscal year, what were the number of outpatient visits paid for by the following sources?				
Hospital Name:	Medicare	Medicaid	Private Insurance	Patient Self-pay	ALL Other	Medicare	Medicaid	Private Insurance	Patient Self-Pay	ALL Other	Medicare	Medicaid	Private Insurance	Patient Self-Pay	ALL Other
Star Valley Medical Center	$8,862,801	$3,251,297	$13,663,200	$242,338	$1,412,678										
South Big Horn Critical Access Hospital															
Johnson County Healthcare Center	$6,284,580	$2,616,041	$5,599,000	$1,459,562		1,710	20	101	300		8,597	1,204	5,330	2,062	
Wyoming Medical Center	$54,100,000	$7,400,000			$127,800,000	16,701	2,965			13,367	25,349	10,963			45,027
Memorial Hospital of Converse County	$19,024,000	$5,820,000	$27,862,000	$4,020,000	$2,520,000	1,040	338	850	145	59	9,313	3,104	12,417	2,483	3,727
Evanston Regional Hospital	$4,681,733	$1,621,614	$26,822,426		$1,402,890	860	234	644		109	6,159	2,777	12,293		4,013

Wyoming Hospitals Survey Responses: Raw Data

	For the hospital's most recent fiscal year, what were the dollar amounts of patient care services paid by the following sources?					For the hospital's most recent fiscal year, how many inpatient days were paid for by the following sources:					For the hospital's most recent fiscal year, what were the number of outpatient visits paid for by the following sources?				
Teton County Hospital District dba St. John's Medical Center	$20,042,098	$3,543,322	$54,804,616		$7,720,590	4,402	8,508	2,504		7,997	8,950	1,325	18,176		9,748
Ivinson Memorial Hospital	$29,486,399	$6,135,118	$31,467,330	$4,674,027	$3,746,498	4,692	1,468	2,927	396	317	14,183	4,438	8,846	1,196	959
North Big Horn Hospital District	$3,139,690	$3,331,068	$2,366,315		$4,448,305	116	9	20		12	9,760	2,886	13,369		23,021
Niobrara Health and Life Center															
Weston County Health Services	$3,950,549	$2,305,417	$2,969,792		$1,765,459	1,008	1,121	350		110	2,680	461	2,985		1,147

Wyoming Hospitals Survey Responses: Raw Data

	For the hospital's most recent fiscal year, what were the dollar amounts of patient care services paid by the following sources?					For the hospital's most recent fiscal year, how many inpatient days were paid for by the following sources:					For the hospital's most recent fiscal year, what were the number of outpatient visits paid for by the following sources?				
Powell Valley Healthcare	$20,127,309	$6,944,518	$14,978,453	$2,084,643	$993,302	656	187	376	75	62	15,166	4,155	7,980	3,505	211
Memorial Hospital of Sweetwater County	$18,533,205	$6,053,684	$27,613,732		$9,824,832	1,974	645	2,940		1,047	19,840	6,480	29,561		10,519
Hot Springs County Memorial Hospital					$14,787,349	848	128	196		166	6,787	1,367	4,391		1,334

Wyoming Hospitals Survey Responses: Raw Data

	Other than for patient care, report all dollar amounts, by revenue source, received by the hospital in the most recent fiscal year?									As a percent, how do the final payments from the following payer types compare to the initially billed hospital charges? (numerator = final payment; denominator = initial charge)					If the hospital's initially billed charges differ for Medicaid, Medicare and private insurance, what percentage of the private insurance initially billed hospital charges are charged to Medicaid and Medicare? (If all payers are initially charged the same amount for a procedure, skip this question.)	
Hospital Name:	Federal government grant	Other federal government payments	State government grant	Other state government payment	(county, special district, municipal)	(county, special district, municipal)	local (county, special district,	Private grant	ALL Other	Medicare	Medicaid	Private insurance (aggregate simple average)	PPO reimburse ments	Private pay without insurance	Medicaid charges as a percent of private insurance billed charges?	Medicare charges as a percent of private insurance billed charges?
Star Valley Medical Center					$537,429											
South Big Horn Critical Access Hospital																
Johnson County Healthcare Center	$239,382					$2,642,922			$759,771	70	55	95	95	35	100	100
Wyoming Medical Center	$341,657	$173,876								26	28			2		
Memorial Hospital of Converse County						$1,365,000				70	70	90		27		
Evanston Regional Hospital	$9,000									23	14	75	72	56		

Wyoming Hospitals Survey Responses: Raw Data

	Other than for patient care, report all dollar amounts, by revenue source, received by the hospital in the most recent fiscal year?						As a percent, how do the final payments from the following payer types compare to the initially billed hospital charges? (numerator = final payment; denominator = initial charge)				If the hospital's initially billed charges differ for Medicaid, Medicare and private insurance, what percentage of the private insurance initially billed hospital charges are charged to Medicaid and Medicare? (If all payers are initially charged the same amount for a procedure, skip this question.)
Teton County Hospital District dba St. John's Medical Center	$716,680		$3,900,960	$3,666,725			$1,897,967	39	44	80	0	31
Ivinson Memorial Hospital		$255,326		$1,351,427			$3,956,640	26	26	65		36
North Big Horn Hospital District		$239,811	$769,546	$1,244,092			$276,920	89	44	76	0	23
Niobrara Health and Life Center												
Weston County Health Services	$395,166	$98,577	$21,727	$1,093,007	$26,187	$4,525	$119,028	67	77	78		60

Wyoming Hospitals Survey Responses: Raw Data

	Other than for patient care, report all dollar amounts, by revenue source, received by the hospital in the most recent fiscal year?				As a percent, how do the final payments from the following payer types compare to the initially billed hospital charges? (numerator = final payment; denominator = initial charge)				If the hospital's initially billed charges differ for Medicaid, Medicare and private insurance, what percentage of the private insurance initially billed hospital charges are charged to Medicaid and Medicare? (If all payers are initially charged the same amount for a procedure, skip this question.)
Powell Valley Healthcare	$17,066				50	64	83	0	9
Memorial Hospital of Sweetwater County		$6,236,427	$2,340,961		42	31	93		32
Hot Springs County Memorial Hospital	$65,522	$208,927	$329,434	$171,458	57	42	86		14

Wyoming Hospitals Survey Responses: Raw Data

	As a percent, how do the final payments from the following payer types compare to the cost of services provided, as determined by the hospital? (Please use the hospital's own determination of the cost of services, which may include components not included by CMS in the Medicare reports.) (numerator = final payment; denominator = hospital-determined cost of services)					In your opinion, what components, if any, are not included in the CMS (Medicare) standardized calculation of costs of hospital services that should be?	Estimate the contributions of each of the following to uncompensated care at your hospital? (Total should add to 100%)					
Hospital Name:	Medicare	Medicaid	Private insurance	PPO reimbursements	Private pay without insurance	Open-Ended Response	Medicare underpayment	Medicaid underpayment	Bad debt	Charity care	Unreimbursed costs from all other payers	ALL Other
Star Valley Medical Center												
South Big Horn Critical Access Hospital												
Johnson County Healthcare Center	83	50	83	78	50	The cost of physician services	50	7	18	4	21	
Wyoming Medical Center	72	60			5	Contracted and employed physicians. Trauma call.	55	11	10	10		14
Memorial Hospital of Converse County							10	10	70	8	2	
Evanston Regional Hospital	78	40	97	142	64		17	32	50	1		

Wyoming Hospitals Survey Responses: Raw Data

	As a percent, how do the final payments from the following payer types compare to the cost of services provided, as determined by the hospital? (Please use the hospital's own determination of the cost of services, which may include components not included by CMS in the Medicare reports.) (numerator = final payment; denominator = hospital-determined cost of services)					In your opinion, what components, if any, are not included in the CMS (Medicare) standardized calculation of costs of hospital services that should be?	Estimate the contributions of each of the following to uncompensated care at your hospital? (Total should add to 100%)					
Teton County Hospital District dba St. John's Medical Center	56	63	101	0	47	Marketing, Physician Services expenses, Televisions in patient rooms, Homecare & Hospice expenses, Advertising, and payment for services of CRNA's.	52	6	8	8	19	7
Ivinson Memorial Hospital						All cost related to the delivery of care and functions to support and deliver the care should be an allowable cost.			86	14		
North Big Horn Hospital District	24	25	18		33		62	17	14	7		
Niobrara Health and Life Center												
Weston County Health Services							25	25	40	10	0	

Wyoming Hospitals Survey Responses: Raw Data

	As a percent, how do the final payments from the following payer types compare to the cost of services provided, as determined by the hospital? (Please use the hospital's own determination of the cost of services, which may include components not included by CMS in the Medicare reports.) (numerator = final payment; denominator = hospital-determined cost of services)					In your opinion, what components, if any, are not included in the CMS (Medicare) standardized calculation of costs of hospital services that should be?	Estimate the contributions of each of the following to uncompensated care at your hospital? (Total should add to 100%)				
Powell Valley Healthcare	101	93	96	0	53	Increase the cap limit on Therapy (Physical & Occupational) - Allow physician recruitmen expense - Allow advertising expense	47	17	18	4	14
Memorial Hospital of Sweetwater County	27	9	41		15		54	18	14	4	10
Hot Springs County Memorial Hospital	71										

Wyoming Hospitals Survey Responses: Raw Data

Hospital Name:	Describe the effect of cost-shifting within the hospital and to private payers?	Is the hospital associated with a private foundation? Yes	As of December 31, 2014, what was the balance of the foundation's corpus dedicated to support of the hospital? Corpus amount?	What amount of financial support and for what purposes did the private foundation provide funds in each of the following years? (Amount; Purposes) Example: "$100,000 for equipment, salaries, and renovation") 2012	2013	2014
Star Valley Medical Center		No				
South Big Horn Critical Access Hospital		No				
Johnson County Healthcare Center	We could reduce prices by 30% if all payers paid us what we bill	Yes	$7,726,640	$196,000 for support of operations and to fund the educational assistance program	$196,000 to fund operations and to fund the educational assistance program	$196,000 to help fund operations and to fund the educational assistance program
Wyoming Medical Center		Yes	$6,500,000		$1,009,629; Building Projects	$558,038; Building Projects
Memorial Hospital of Converse County		No				
Evanston Regional Hospital	The effect is that everyone hates hospitals because they charge so much- except Medicare patients, Medicaid patients, charity patients and self-pay patients.	No				

Wyoming Hospitals Survey Responses: Raw Data

	Describe the effect of cost-shifting within the hospital and to private payers?	Is the hospital associated with a private foundation?	As of December 31, 2014, what was the balance of the foundation's corpus dedicated to support of the hospital?	What amount of financial support and for what purposes did the private foundation provide funds in each of the following years? (Amount; Purposes) Example: "$100,000 for equipment, salaries, and renovation")		
Teton County Hospital District dba St. John's Medical Center	The biggest impact is that Businesses and Self Insured individuals are having to pay more for their health care than what they truly should have to due to the need to cover Medicare/Medicaid/Charity patients that aren't covering the cost to provide healthcare services. Cost-shifting also heavily skews pricing. Because the hospital is required to take all payers, the overall pricing is much higher than it would need to be if everyone was paying the price associated with treatment.	Yes	$8,782,000	$1,020,086 for Hospital Operations, Capital Equipment, Cognitive Wellness, Education, Chemotherapy, Hospice, Development	$1,138,647 for Hospital Operations, Capital Equipment, Cognitive Wellness, Education, Chemotherapy, Hospice, Development	$1,663,455 for Hospital Operations, Capital Equipment, Cognitive Wellness, Education, Chemotherapy, Hospice, Development
Ivinson Memorial Hospital	Wyoming Department of Health has a paper from September 1, 2014 that has information on cost shifting written by Thomas O. Forslund Director, Wyoming Department of Health	Yes	$13,738,421	503,407 equipment	387,849 equipment	1,229,060 guest house
North Big Horn Hospital District	Increases costs to private payers	Yes	$174,777	8320 for lifts and ambulance	8054 for direct resident care	15395 for artwork and direct resident care
Niobrara Health and Life Center						
Weston County Health Services	Private payers are charged the full rates for services. If they provide financial information they may qualify for Charity Care but otherwise owe the full amount charged. In comparison, discounts are applied to full charges for Medicare, Medicaid and Commercial Insurance coverage and the patient is responsible for the co-pays, deductibles or non-covered charges.	Yes	$212,000	44450	36401	15595

Wyoming Hospitals Survey Responses: Raw Data

	Describe the effect of cost-shifting within the hospital and to private payers?	Is the hospital associated with a private foundation?	As of December 31, 2014, what was the balance of the foundation's corpus dedicated to support of the hospital?	What amount of financial support and for what purposes did the private foundation provide funds in each of the following years? (Amount; Purposes) Example: "$100,000 for equipment, salaries, and renovation")		
Powell Valley Healthcare	Due to the reimbursement by Medicare & Medicaid rate increases are needed in order to cover expenses, therefore impacting private payers	Yes	$998,657	$63,235 Care Center & IP room Remodel	$29,869 Care Center Projects	$170,492 OB Project -Lab Equipment
Memorial Hospital of Sweetwater County	We as a facility do not engage in cost shifting to private payers, meaning we do not charge private payers more in response to shortfalls in public payments. This phenomenon is detrimental to the cost of healthcare because the shift in costs to private payers ultimately increases health insurance premiums and leads to healthcare plans that offer less benefits and higher deductibles. When this happens, the hospital eventually has to assume that cost, sometimes as bad debt.	Yes	$817,000	$2,314; Pediatric cart	$7,955; chemoinfusion pumps	$3,715; tailgate cooker
Hot Springs County Memorial Hospital		Yes	$500,000	$6,050; equipment	$8,061; equipment	$8,836; equipment

Wyoming Hospitals Survey Responses: Raw Data

	What were the total, full-time equivalent (FTE) personnel in the hospital at the end of the most recent fiscal year for each of the following categories?				Describe any difficulties attracting and retaining medical, IT, or other staff:	Describe the three primary federal or state statutory or regulator burdens in terms of time and complexity:		
Hospital Name:	Total employed FTE	Of the total employed FTE, number of licensed health care professionals who provide direct medical care, such as nurses, physician assistants, physicians, etc.	Of the total employed FTE, number of physicians	Number of contract physicians		Most burden	Second most burdensome	Third most burdensome
Star Valley Medical Center	230	155	14	0		Nursing Home surveys		
South Big Horn Critical Access Hospital	67	22	2	0				
Johnson County Healthcare Center	181	118	7	1	None	DOH surveys	Conditions of Participation standards	Cost reports
Wyoming Medical Center	1058		15		Nursing shortage has been challenging			
Memorial Hospital of Converse County	325	142	18	0		Medicare	Medicaid	Federal Government
Evanston Regional Hospital	172	102	8	9	It is very difficult to attract new physicians, new physica therapists, and new OR scrub techs. The Legislature would do a great service for the state by providing more funding for loan repayment for doctors who come to Wyoming. The average physician is now graduating with debt above $300,000.	RAC and similar audits	Stark regulations	Medicare Conditions of Participation

Wyoming Hospitals Survey Responses: Raw Data

	What were the total, full-time equivalent (FTE) personnel in the hospital at the end of the most recent fiscal year for each of the following categories?				Describe any difficulties attracting and retaining medical, IT, or other staff:	Describe the three primary federal or state statutory or regulator burdens in terms of time and complexity:		
Teton County Hospital District dba St. John's Medical Center	495	190	13	31	The hospital is located in a very remote area that has a very high cost of living. It is hard to attract and retain staff that can afford housing and other day-to-day expenses, as well as individuals (and their family's) tha appreciate being far away from material and social conveniences. Also, because of the rural location, it is hard for a physician to support the appropriate rate of pay based upon the volume that they will see without hospital supplementation. There is also a high demand for these positions all over the country, so there is a lot of competition involved in the recruiting process. Also, with all of the consolidation of positions, more compliance requirements, etc., a lot of these qualified individuals are leaving the industry in pursuit of othe industries.	Value Based Purchasing Program thru CMS. The core measures are highly complex and time consuming. Likewise, the Joint Commission Standards are complex, and new standards are continuously being added.	Meaningful Use has impacted the IT Department and the Hospital as it is both a time and cost burden. Not only is new software needed in order to adhere to all new requirements, but additional IT staff is needed to implement and oversee the project and upkeep. Other departments are also having to spend more time at their computers completing paperwork vs. spending time with patients.	Wyoming Federal Medicaid DSH Examination - this survey is very time consuming due to reporting limitations with the hospital's software.
Ivinson Memorial Hospital	380	266	9	6	Rural setting with high cost of living and low wages.	ICD-10	Meaningful Use	Value Based Purchasing
North Big Horn Hospital District	181	98	3	0	Lack of applicants for nursing, CNA, lab, x-ray, dietary Lack of experience			
Niobrara Health and Life Center								
Weston County Health Services	128	74	0	0	Limited local pool of candidates and talent. Most positions do not justify relocating candidate to the area. Also, when we do have outside applicants, we must "vet" them carefully so they understand what living ir Wyoming truly means.	Building upgrade process - Submission of plans to approval takes significant time and slows down projects.	Quality Reporting to several places takes a lot of time and is inconsistent	Health Inspection Plan of Correction submissions - the document is not easy to complete and takes time as the form is not computer driven.

Wyoming Hospitals Survey Responses: Raw Data

	What were the total, full-time equivalent (FTE) personnel in the hospital at the end of the most recent fiscal year for each of the following categories?				Describe any difficulties attracting and retaining medical, IT, or other staff:	Describe the three primary federal or state statutory or regulator burdens in terms of time and complexity:		
Powell Valley Healthcare	376	177	18	3	Due to our rural location, approx. 100 miles from closest Metro area, it is difficult to recruit physicians and providers as well as expertise in IT due to the high complexities of health care organizations.	Bureaucratic Burden	Lack of Torte Reform	Surveys
Memorial Hospital of Sweetwater County	400	184	30	2	Sweetwater County is a rural community that has a boom and bust economy. The population of Sweetwater County is about 44,000 people. Due to the rural nature of the area, it is difficult to recruit professional staff because many amenities that are available in large communities are not available here. We are forced to hire staff at a premium in order for them to justify relocating to a rural community. it is also difficult to retain staff, due to the volatility of the economy. A lot of the staff we hire are secondary wage earners in the family, and when the economy is experiencing a downturn, they leave if the primary wage earner in the family is transferred out of the area.	The Joint Commission - focused on ensuring that healthcare organizations provide quality care. We have dedicated a large amount of time and resources to ensuring that we comply with the Joint Commission standards and receive accreditation. We have many dedicated staff members who meet weekly to ensure that standards are being met and we are compliant.	The Centers for Medicare and Medicaid (CMS) - oversees most of the regulations related directly to the healthcare system. CMS is also responsible for ensuring compliance to the Health Insurance Portability and Accountability Act (HIPAA) and the Agency for Healthcare Research and Quality (AHRQ). We are diligent about adhering to regulations enforced by CMS by hiring staff to ensure compliance and constant continuing education in order to remain current with changing regulations.	Wyoming Department of Health - oversees regulations related to the health delivery system related to Wyoming residents. Similar to CMS, we ensure that we are compliant with the regulations and devote many staff hours in order to achieve this.
Hot Springs County Memorial Hospital	94	58		5				

Wyoming Hospitals Survey Responses: Raw Data

Hospital Name:	From a medical standpoint, what are the services community hospitals provide which cannot be provided through alternative methods of health care delivery? (For example, do local hospitals have specialized expertise and equipment for the timely, accurate diagnosis and treatment of stroke and hearth attack patients allowing the best practices for best outcomes thereby reducing death and disability?)	Some research indicates that patient outcomes are better when treatment is closer to home, near family and community supports. What is the trade off between this effect and the advantages of treatment in more distant centers with broader or more specialized capabilities?	What do you identify as the three primary drivers of the cost of hospital care? (i)	(ii)	(iii)
Star Valley Medical Center	Emergency and Trauma Care	Cannot see a trade off. Services can be provided locally cost effectively.	Salary requirements	State and Federal regulations	Insurance burdens
South Big Horn Critical Access Hospital	Emergency Care Family Support Care		Wages	Insurance reductions	IT requirements
Johnson County Healthcare Center	Emergency services Services that are not financially attractive	In small communities, the focus should be on primary care services Patients should be sent out of the community for more specialized services. It should be a well run continuum of care.	Employee wages & fringe benefits	Physician services	Supplies and equipment
Wyoming Medical Center	WMC provides multiple specialties to our community and to the state of Wyoming. These include, but are not limited to medical & critical care services, pediatrics and obstetrics, trauma care, stroke care, heart and vascular services, neurosurgery, and orthopedic care.		Labor costs	Equipment and supply costs	Regulations
Memorial Hospital of Converse County	The hospital is the only place to receive surgeries, trauma care and ob services	some treatments can't wait to drive 50 miles	Medicare and Medicaid	uninsured	wages
Evanston Regional Hospital	We save the lives of many sick and injured people because we have specialized expertise and equipment.	We save the lives of many sick and injured people because we have specialized expertise and equipment.	Patients' perceptions that they need it all, now	Bureaucracy - government, insurance, industry watchdogs	Unfair competition, such as surgical centers and imaging centers

Wyoming Hospitals Survey Responses: Raw Data

	From a medical standpoint, what are the services community hospitals provide which cannot be provided through alternative methods of health care delivery? (For example, do local hospitals have specialized expertise and equipment for the timely, accurate diagnosis and treatment of stroke and hearth attack patients allowing the best practices for best outcomes thereby reducing death and disability?)	Some research indicates that patient outcomes are better when treatment is closer to home, near family and community supports. What is the trade off between this effect and the advantages of treatment in more distant centers with broader or more specialized capabilities?	What do you identify as the three primary drivers of the cost of hospital care?		
Teton County Hospital District dba St. John's Medical Center	Because of the location of the hospital, most of the care provided cannot be provided through other methods of health care delivery. Specifically, all emergency treatment, timely diagnostics, emergency surgery, most labor and delivery, urgent care, community focused wellness, inpatient services, long term care in a community that the patient is familiar with and patient convenient medical oncology. Unless the patient is physically able to trave several hours, these services need to be provided at the local hospital.	There are many tradeoffs if the patient utilizes treatment in a distan center. If the patient has to travel any sort of distance, they are faced with many different stressors, including: time off from work for both the patient and family members, travel expenses, inability to fulfi family obligations, and being away from their main support system All of these factors can lead to a poor outcome for the patient. Adversely, if the patient is treated in the local hospital, the patien benefits from being close to the physicians that are familiar with th details of their case in instances of complications. Follow-up visit are also much more convenient, both in time and cost. The patient outcome is typically better if they are not having to continuously travel and be away from home, as well as being able to stay on top of daily responsibilities. The hospital also benefits in that it is able t spread its overhead and staffing over more patients, gain more experience with patient care, and offer more personalized care.	Salaries	Low volume and/or irregularity of patient visits	Other overhead costs (Government compliance, medical malpractice insurance billing & denial claims, etc.)
Ivinson Memorial Hospital	Local hospitals have specialized expertise and equipment for the timely and accurate diagnosis for patients in need allowing the best practices for best outcomes thereby reducing death and disability	Treatment in more distant centers may reduce the need for duplicate services for a low volume area. Reducing duplicate services may decrease costs, and have a positive/negative impact on outcomes.	cost of capital and equipment	salaries and benefits	patient volumes
North Big Horn Hospital District	Stabilizing trauma patients, reduced time to ER; studies show patients heal better closer to home	I see none. We only send patients when needed for specialized care and they come right back to us. What is the purpose of this question?	Expensive equipment	People with no insurance	people who don't pay copays or deductibles
Niobrara Health and Life Center					
Weston County Health Services	Community hospitals provide care that is close to the patient's families. Improvement in accessibility for specialists would expand the capabilities of community hospitals.	Patients need to be at the facility that provides the most appropriate level of care. However, there are opportunities to expand the reach of specialists through tele-medicine that the state of Wyoming needs to improve and that would help keep patients closer to home.	Liability for Providers	Keeping up with the technology/equipment for services	Keeping qualified staff salaries to keep workforce

Wyoming Hospitals Survey Responses: Raw Data

	From a medical standpoint, what are the services community hospitals provide which cannot be provided through alternative methods of health care delivery? (For example, do local hospitals have specialized expertise and equipment for the timely, accurate diagnosis and treatment of stroke and hearth attack patients allowing the best practices for best outcomes thereby reducing death and disability?)	Some research indicates that patient outcomes are better when treatment is closer to home, near family and community supports. What is the trade off between this effect and the advantages of treatment in more distant centers with broader or more specialized capabilities?	What do you identify as the three primary drivers of the cost of hospital care?		
Powell Valley Healthcare	With reduced reimbursement in Medicare & Medicaid payer mix will suffer - Smal communities hospitals can no longer be everything to everyone within the community they will have to make choices to reduce costly services	Hospitals not only provide services, they also provide jobs, support of local business. A small town with no hospital will have a difficu time recruiting for other industry.	Salaries	Implementation of an E.H.R	Medicare & Medicaid Reimbursement
Memorial Hospital of Sweetwater County	It is difficult for many community hospitals to keep up with specialized expertise and state of the art equipment in order to allow for best practices for best outcomes. Community hospitals must juggle high dollars of uncompensated care, the high cost of providing care and fixed reimbursement, which results in very narrow margins. Additional legislation that would assist rural hospitals in being reimbursed for uncompensated care would help broaden bottom lines and allow for more services around the state; resulting in best practices.	As the focus of healthcare moves from inpatient to outpatient services, home health, population health, post-acute care and penalizing hospitals for readmissions, I think that now more than ever it is important to try to keep treatment close to home and focus on the importance of that. With technology, more specialized treatment is available through tele-health. We are able to bring many aspects of specialized care to the rural setting, allowing patients to stay close to home.	Physician, equipment and drug costs. It is difficult to recruit physicians to rural areas; therefore, we must incentivize them more than our urban counterparts. Facility costs are high as the cost of equipment keeps increasing while hospital margins keep decreasing. Drug costs are tremendously high and we are bound to paying the high costs while reimbursement is negligible in comparison.	Expensive technology. As electronic health records become more mainstream, and meaningful use becomes a requirement, the cost of keeping up with technology is becoming more burdensome to hospitals. The systems are expensive, as is the maintenance of them, and the productivity of the providers is lessened by the sheer magnitude of information required to achieve meaningful use. In the future, reimbursement will be impacted as penalties will be imposed if hospitals do not achieve meaningful use with their electronic health record.	Unhealthy behaviors. As the population ages, more and more patients are presenting with multiple co-morbidities that are difficult to treat. Chronic illness - like heart disease, cancer and diabetes - causes about 70% of all deaths in the United States, and they are the most expensive to treat. A majority of chronic illnesses stem from unhealthy behaviors. These illnesses drive up the cost of healthcare, with little reimbursement for hospitals.
Hot Springs County Memorial Hospital					

Wyoming Hospitals Survey Responses: Raw Data

	What is the hospital's total annual payroll?	What are the two most direct economic consequences of local hospitals and the economic development impacts of not having a local hospital?		Thank you for your participation; please include or attach any additional comments as you deem appropriate regarding this survey or the delivery of health care in Wyoming:
Hospital Name:	Total payroll	(i)	(ii)	
Star Valley Medical Center	$13,346,630	Hospitals are economic drivers	outside firms would not relocate	
South Big Horn Critical Access Hospital	$3,500,000	People expect healthcare in their community without it they live elsewhere.	Millions in lost revenue throughout the community.	
Johnson County Healthcare Center	$10,249,342	Loss of a significant employer.	Loss of a significant purchaser of services.	
Wyoming Medical Center	$92,900,000	Loss of jobs	Loss of the ability to attract new business to the community	
Memorial Hospital of Converse County	$23,500,000	The town would dry up	people would not move here	
Evanston Regional Hospital	$14,263,320	Job loss of the community's best paid employees	Inability of communities to bring in new businesses, because there are no hospital or doctors	If the legislature is determined to make hospitals compete, then they need to realize that hospitals will always lose. That because hospitals are inherently more costly than surgery centers, freestanding imaging centers, urgent care clinics, etc. In such a competitive environment, hospitals will close. If the legislature wants to keep them, then hospitals will need to be subsidized by the state, and regulated as public utilities.

Wyoming Hospitals Survey Responses: Raw Data

	What is the hospital's total annual payroll?	What are the two most direct economic consequences of local hospitals and the economic development impacts of not having a local hospital?		Thank you for your participation; please include or attach any additional comments as you deem appropriate regarding this survey or the delivery of health care in Wyoming:
Teton County Hospital District dba St. John's Medical Center	$43,767,370	The hospitals existence enhances the ability for people to live in the area. Most people would not be willing or able to live hours from a facility that provides the emergent and chronic care that a hospital does.	The hospital directly supports the local economy in many ways. The hospital is the largest year-around employer in the county, which promotes a stable middle class. The hospital also supports local businesses with the purchase of supplies and contract labor.	
Ivinson Memorial Hospital	$22,633,119	Loss of community members.	Loss of a business that uses other local businesses and services.	
North Big Horn Hospital District	$8,920,695	Largest employer in county. Imagine if 240 employees and families leave a community o 2400.		
Niobrara Health and Life Center				
Weston County Health Services	$6,000,000	Healthcare Facility is a major employer in our area. Lack of the jobs would greatly diminish the economy of the area.	If the facility was gone, many would travel out of state for services.	

Wyoming Hospitals Survey Responses: Raw Data

	What is the hospital's total annual payroll?	What are the two most direct economic consequences of local hospitals and the economic development impacts of not having a local hospital?		Thank you for your participation; please include or attach any additional comments as you deem appropriate regarding this survey or the delivery of health care in Wyoming:
Powell Valley Healthcare	$214,193,560	Jobs, Jobs, Jobs	Economic Growth ceases to exist	
Memorial Hospital of Sweetwater County	$32,583,165	First of all, the impact would be to decrease the economic well-being of the community Most hospitals are one of the top ten employers in small communities. A hospita employs many highly educated staff, includin physicians, nurses, executives, etc. Evidence shows that in the long run, with a hospital closure, the estimate is that per capita income may decline; thereby negatively impacting th local economy.	Secondly, the challenge for small, local hospitals is to be able to increase economic efficiency, which is very difficult to achiev because of low volumes and fixed reimbursement systems, such as Medicare and Medicaid. If these pressures become too great and a hospital must close, there is a negative effect on the health and health care access in rural communities. the impacts of a closure create barriers to receipt of critical emergency services, create increased travel time to inpatient care and create a decrease in physician supply if there is not a hospital.	Along with the many issue discussed above, rural hospitals in Wyoming also face th challenge of efficiently providing care, while trying to maintain profitability. This challen is exacerbated by the fact that many hospitals must write off large amounts o uncompensated care. Bad debt and charity care consist of 10% of our gross revenue at a cost of $11,500,000, annually. We are seeing health insurance plans with high deductibles which sometimes eventually translate into bad debt because patients do not get to realize any benefit from their insurance plan and do not want to pay the out of pocket, high cost deductible. We have seen a rise in our bad debt because of this phenomenon. Another issue affecting the delivery of healthcare in Wyoming is the introduction of private specialt hospitals that are allowed to compete with local hospitals. According to the Affordable Care Act, physician owned, for-profit hospitals cannot accept Medicare and Medicaid patients. Also, many times, these hospitals do not have an emergency room and the patients must go to the local hospital for this type of care. The result is that the competition is not level and the local hospital suffers. The privately owned, for profit hospitals will eventuall skim off the patients with private insurance and leave the fixed reimbursement and self-pa patients for the local hospital. this will ultimately negatively affect the bottom line an services will be jeopardized. The for-profit hospital is not a full service hospital and if th presence of such causes the local hospital to close, then all patients will suffer in the community. Legislation must be passed that will allow local hospitals to compete on a more level playing field, or impose stricter rules and regulations for physician owned, for profi hospital to enter a rural community.
Hot Springs County Memorial Hospital				

WYOMING LEGISLATIVE SERVICE OFFICE

Memorandum

DATE May 15, 2015

TO Joint Appropriations Interim Committee
Joint Labor, Health and Social Services Interim Committee

FROM Ian D. Shaw, LSO

SUBJECT Hospital Organization and Funding - Charity Care Obligations

Both the Joint Appropriations Interim Committee and the Joint Labor, Health and Social Services Interim Committee are considering issues related to hospital organization and funding this interim. Pursuant to a memorandum dated March 25, 2015 from Don Richards, Budget and Fiscal Section Manager, LSO's Legal Section has researched the following issues related to hospitals' obligations to provide free or reduced-cost medical care (i.e. charity care):

1. Federal and state statutory and regulatory obligations to provide charity care by county hospitals, special district hospitals, and private hospitals in Wyoming, including review of the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) and the Hospital Survey and Construction Act (Hill-Burton);
2. Legal responsibilities of Wyoming municipalities for charity care;
3. Statutory assigned responsibility for charity care for citizens residing in counties where there is no health care facility; and
4. Legal summaries of:
    a. New requirements of charitable 501(c)(3) hospitals;
    b. Excise taxes for failure to meet the community health needs assessment;
    c. Any tax exemptions that hospitals receive for providing charity care; and
    d. Requirements related to financial assistance and emergency medical care.

1. State and Federal Statutory and Regulatory Obligations to Provide Charity Care; Wyoming Statutes; Hill-Burton; EMTALA; IRS Code 501(c)(3):

The Wyoming Constitution does not explicitly require county memorial hospitals, hospital special districts or private hospitals to provide no cost or reduced-cost charity health care in Wyoming. The Constitution does contemplate support of the poor through extension of the state's credit, the creation of charitable institutions, and the right of access to health care. [See Wyo. Constitution Art. 1 § 38; Art. 7 §18; Art. 16 §6.] No case law or other binding authority,

however, directly applies these mandates so as to require charity care at county, special district or private hospitals.

The Wyoming Legislature has chosen to require charity care at county memorial hospitals. W.S. 18-8-106 provides:

> **18-8-106. To be maintained as public hospitals; charges for services; when free services to be given; payment for resident indigent hospitalization**.
>
> Every county memorial hospital established and maintained as provided by law is a public county hospital. It may charge persons able to pay the same a reasonable price for use of the hospital and its facilities during the time required for proper treatment, and **shall furnish free to residents of the county having no means to pay for the same all necessary facilities and maintenance during the time such persons are required to remain there for proper treatment.** As long as a county department of public assistance and social services functions in the county as provided by law, the funds in control of the board for hospitalization purposes shall be deemed "means" for payment of resident indigent hospitalization. (emphasis added)

There does not appear to be any case law or other guidance on the application of W.S. 18-8-106 to charity care. In the only case considering the statute, the Wyoming Supreme Court held that W.S. 18-8-106 cannot be read to automatically declare all county hospitals to be charitable organizations for purpose of determining their immunity from civil liability as a body administering a public charity. See Bondurant v. Board of Trustees, 354 P.2d 219 (Wyo. 1960).

While charity care is required in Wyoming's county memorial hospitals, there is no state law requiring hospital special districts or private hospitals to provide charity care. However, as explained below, any hospital accepting Medicare or seeking tax-exempt status as a 501(c)(3) charitable organization is required by federal law to provide charity care.

Three federal laws form the basic framework for hospitals' obligations to provide charity care: 1) The Hill-Burton Act of 1964; 2) the Emergency Medical Treatment and Active Labor Act ("EMTALA"); and 3) non-profit charitable organization status under IRS Code 501(c)(3). Each of these laws is discussed below.

A. Hill-Burton Act of 1964:

The Hill-Burton Act of 1964 was enacted to promote hospital modernization and construction. It provided federal grants to non-profit hospitals in exchange for a commitment to provide free or discounted care for patients who could not afford care at regular rates. The program stopped providing funding in 1997. However, approximately 170 health care facilities nationwide remain obligated to provide free or reduced-cost care under Hill-Burton. None of the facilities are located in Wyoming.

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B. Emergency Medical Treatment and Active Labor Act ("EMTALA"):

The Emergency Medical Treatment and Active Labor Act ("EMTALA") was enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act. [See 42 U.S.C. 1395dd.] EMTALA applies to all "participating hospitals," defined to include all hospitals that accept Medicare payments. Congress passed EMTALA after receiving testimony regarding the practice of patient dumping and the failure of hospitals to abide by Hill-Burton's charity care requirements. Under EMTALA, hospitals are required to provide emergency health care treatment to anyone needing emergency care, regardless of citizenship, legal status or ability to pay. EMTALA requires hospitals to:

- Provide a medical screening for all patients to determine if an emergency medical condition exists. A hospital can inquire about payment ability and billing only after determining that the inquiry will not interfere with or compromise patient care;
- Treat a patient with an emergency medical condition until the condition is resolved or stabilized and the patient is able to provide self-care or provide for needed continued care;
- If the hospital is not capable of treating the emergency medical condition, the hospital must make an appropriate transfer to another facility for stabilization. A transferee hospital may not discharge the patient before stabilization of the emergency medical condition.

EMTALA is enforced through civil penalties and civil causes of action. A participating hospital or physician who violates the emergency treatment requirements of EMTALA is subject to a civil penalty up to $50,000 to be assessed by the Secretary of Health and Human Services. In addition, any individual or other medical facility may bring a civil action for damages suffered as a result of a participating hospital's EMTALA violation.

Absent a direct conflict, EMTALA does not preempt state or local laws.

C. Internal Revenue Code, 26 U.S.C. §501(r):

As charitable organizations, non-profit hospitals have traditionally qualified for tax exempt status under IRS Code §501(c)(3). Prior to 2010, through rule making, the IRS generally required non-profit 501(c)(3) hospitals to maintain their tax-exempt status by operating an emergency department and by providing care to patients without insurance and without other means to pay for care. Before 2010, neither the IRS' rules, Hill-Burton or EMTALA prohibited a hospital providing emergency care from billing for that care and attempting to collect on the debt. Further, while most non-profit hospitals provided uncompensated care outside of the emergency department, there was generally no requirement that they do so.

In 2010, the Patient Protection and Affordable Care Act of 2010 ("ACA") added Section 501(r) to the IRS Code, 26. U.S.C. §501. Section 501(r) codifies new requirements for how 501(c)(3) hospitals deal with uninsured/indigent clients and uncompensated care (i.e. charity care). The

new subsection applies broadly to all "hospital facilities," defined to include all health care facilities which must be licensed as hospitals under state law. The definition includes governmental hospitals which are required to be licensed under state law and which enjoy 501(c)(3) non-profit, tax-exempt status. Section 501(r) applies to hospital-owned physician practices and other entities providing care in a hospital facility, depending on how the entity is classified for federal tax purposes.

Section 501(r) adopts four new requirements which must be met in order for a non-profit hospital to maintain its 501(c)(3) tax exempt status. The hospital must:

i. Develop a written community health needs assessment (CHNA) based on an analysis performed every three years;
ii. Create a financial assistance policy;
iii. Follow specified limitations on charges which may be assessed; and
iv. Follow specified billing and collection practices.

Final rules implementing new Section 501(r) were adopted by the IRS on December 31, 2014.

i. Community Health Needs Assessments

In order to enjoy tax-free 501(c)(3) status, a non-profit hospital must now create a written community health needs assessment ("CHNA") based on an analysis performed every three years. The document must define the community the hospital serves and include a prioritized description of the community's health needs. A hospital may not define the community it serves so as to exclude medically underserved, low-income or minority populations. Each CHNA must contain a description of existing local healthcare options, must identify the methodologies used in its analysis, and must include broad-based community input, including input from low-income patient populations, minority patient populations, and governmental public health departments. Each CHNA must be made widely available to the public. After developing its CHNA, a hospital must adopt a written implementation strategy designed to meet the needs identified in the CHNA or explain why the hospital cannot meet a specified need. On its annual tax form, a hospital must describe the steps it is taking to address the health needs identified in its CHNA.

ii. Financial Assistance Policy

New 501(r) also requires entities enjoying a tax-free 501(c)(3) status to create and widely publicize a written financial assistance policy. The financial assistance policy must establish criteria for patients to receive financial assistance in the form of free or reduced-cost care. The financial assistance policy must describe, among other things: (a) eligibility criteria and whether the assistance includes free or discounted care; (b) the basis for calculating amounts charged to patients and the permitted methods used to determine amounts generally billed; (c) the method for applying for financial assistance and the documentation required to determine qualification; (d) the actions the hospital might take in the event of nonpayment; and (e) the measures that will be taken to widely publicize the financial assistance policy within the community. Importantly,

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financial assistance policies apply to all emergency and other medically necessary care, not just care provided in the emergency department. Many hospitals apply their financial assistance policies broadly to cover care that is not medically necessary.

Neither the law nor IRS rules mandate specific eligibility requirements for financial assistance policies nor do they require that a financial assistance policy be linked to the findings of the hospital's community health needs assessment. Further, neither the law nor the rules define what is "medically necessary care." Instead, a hospital is allowed to use a definition applicable under the laws of the state in which it is licensed, a definition that refers to generally accepted standards of medicine in the community or to an examining physician's determination.

Under new 501(r), a non-profit 501(c)(3) hospital also must establish a written policy that requires the hospital to provide, without discrimination, care for emergency medical conditions regardless of whether an individual is eligible under the hospital's financial assistance policy. This written policy cannot discourage individuals from seeking emergency care by using such tactics as demanding payment prior to receiving treatment. Further, the policy must require treatment for emergency medical conditions consistent with EMTALA, discussed above.

iii. Limitations on Charges

Section 501(r) requires tax-exempt hospitals to limit charges for emergency or medically necessary care to the amounts "generally billed" to patients with insurance. Importantly, this limitation applies to all medically necessary care, not only care delivered in the emergency department. The IRS' new rules provide specific methods for determining the generally billed rates. Also, all medical care provided to individuals qualifying under a hospital's financial assistance policy, whether emergency / medically necessary care or not, must be charged at less than the full "chargemaster" or "gross" rate (i.e. the highest, undiscounted rate charged by the hospital). Thus, only patients who are not eligible for financial assistance under the written financial assistance policy can be charged the hospital's highest rates.

iv. Billing and Collection Practices

Under new Section 501(r), hospitals may not take extraordinary collection actions without first making reasonable efforts to determine whether an individual qualifies for financial assistance under the hospital's financial assistance policy. Extraordinary collection actions are defined to include selling a patient's debt to another party (subject to certain exceptions), reporting adverse information to a credit bureau, deferring, denying or conditioning future medically necessary care on the payment of uncollected debt, or taking other actions requiring legal or judicial process. A written waiver of an individual's right to financial assistance is not effective and does not relieve a hospital of its obligation to determine a patient's qualification for financial assistance.

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v. Failure to Comply

A hospital which fails to meet the requirements of new Section 501(r) and its related regulations may have its tax-exempt status revoked and, thereby, be subject to taxation. Revocation of a hospital's 501(c)(3) status is effective as of the first day of the taxable year in which the failure occurs. The IRS' new regulations establish various factors that must be considered when determining whether to revoke a hospital's 501(c)(3) status. These factors include the size, scope and nature of the hospital's failures, previous failures, the nature of the facilities which have failed to meet the standards, the reasons for the failures, the existence of policies and the adoption of procedures designed to promote compliance, and whether the failures were promptly corrected.

A $50,000 excise tax is imposed on hospitals who fail to comply with the community health needs assessment (CHNA) standards discussed above. Specifically, a $50,000 excise tax is imposed in the third year of the three-year period in which the CHNA, and its implementation plan, are required to be satisfied. An additional $50,000 excise tax will be imposed in the following year if the hospital fails to correct its error.

2. Legal Responsibilities of Wyoming Municipalities to Provide Charity Care:

There do not appear to be specific requirements for a Wyoming municipality to provide charity care in Wyoming. If a municipality were to operate a hospital which accepted Medicare and/or sought 501(c)(3) tax exempt status, the hospital would have to provide charity care as described above, but not specifically because of its connection to any municipality.

3. Statutorily Assigned Duty for Charity Care in Counties Without Health Care Facilities:

There do not appear to be specific requirements for a Wyoming county to provide charity care outside of those responsibilities imposed on county hospitals by W.S. 18-8-106 and the federal laws discussed in Section 1. of this memorandum. Consequently, in counties where no health care facilities exist, the county does not appear to have any obligations to provide charitable care. Some funding and other requirements are imposed on counties related to Title 25 involuntary commitments, but such circumstances are beyond the scope of this memorandum.

4. Legal Summaries:

a. New requirements of charitable 501(c)(3) hospitals. These new requirements are discussed in Section 1.C. of this memorandum.

b. Excise tax for failure to meet the community health needs assessment. This excise tax is discussed at Section 1.C.v of this memorandum.

c. Any tax exemptions that hospitals receive for providing charity care. The primary tax benefit that non-profit hospitals receive for providing charity care are those given to 501(c)(3)

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tax exempt charitable organizations, as described in Section 1.C. of this memorandum. LSO has queried the Wyoming Hospital Association for additional information about possible tax exemptions and no other exemptions have been disclosed or otherwise revealed through research.

d. Requirements related to financial assistance and emergency medical care. As indicated above, other than the requirements discussed in Section 1.C of this memorandum, there appear to be no other requirements related to financial assistance for providing emergency medical care.

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