Windom Area Health

2021 Audit Results and Report to the Board of Directors

WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING

Table of Contents

Executive Summary

Results of Professional Services

Results of Professional Services

Significant Transactions

- Receipt and recognition of COVID funding (Provider Relief)
- Payroll Protection Program (PPP) Loan

Audit Adjustments

- No auditor proposed audit adjustments
- No passed audit adjustments

Subsequent Events

- No Subsequent Events

Internal Control Results

- Material Weaknesses
  - Control Over Financial Reporting Process

Understanding Your Industry

HHS Provider Relief Funds Reporting Timeline

- **Key Dates & Events:**
  - July 1, 2021: Reporting portal opened

	Payment Received Period (Payments Exceeding $10,000 in Aggregate Received)	Reporting Time Period
Period 1	April 10, 2020 to June 30, 2020	July 1, 2021 to September 30, 2021
Period 2	July 1, 2020 to December 31, 2020	January 1, 2022 to March 31, 2022
Period 3	January 1, 2021 to June 30, 2021	July 1, 2022 to September 30, 2022
Period 4	July 1, 2021 to December 31, 2021	January 1, 2023 to March 31, 2023

5 Required Data Elements for Reporting

1. **Basic organization information (TIN, FYE, etc.)**
2. **Health care expenses attributable to COVID, *over and above what has been reimbursed by other sources,* w/varying levels of detail required:**
   - $10,000 < $500,000: aggregated into two categories: (1) G&A expenses and (2) other health care related expenses.
   - $500,000+ will be required to provide greater detail of expenses included under G&A and other health care expenses (covered later)
3. **Lost revenues from patient care attributable to COVID, by payor**
4. **Other assistance *"received"* (i.e., PPP, FEMA, CARES Act Testing, local/state assistance, business insurance, etc.). Other assistance will not factor into PRF calculation (update as of 7/1/21).**
5. **Additional information (facility, patient metrics, staffing, CHOWs…)**

Funding Subject to Single Audit Requirements

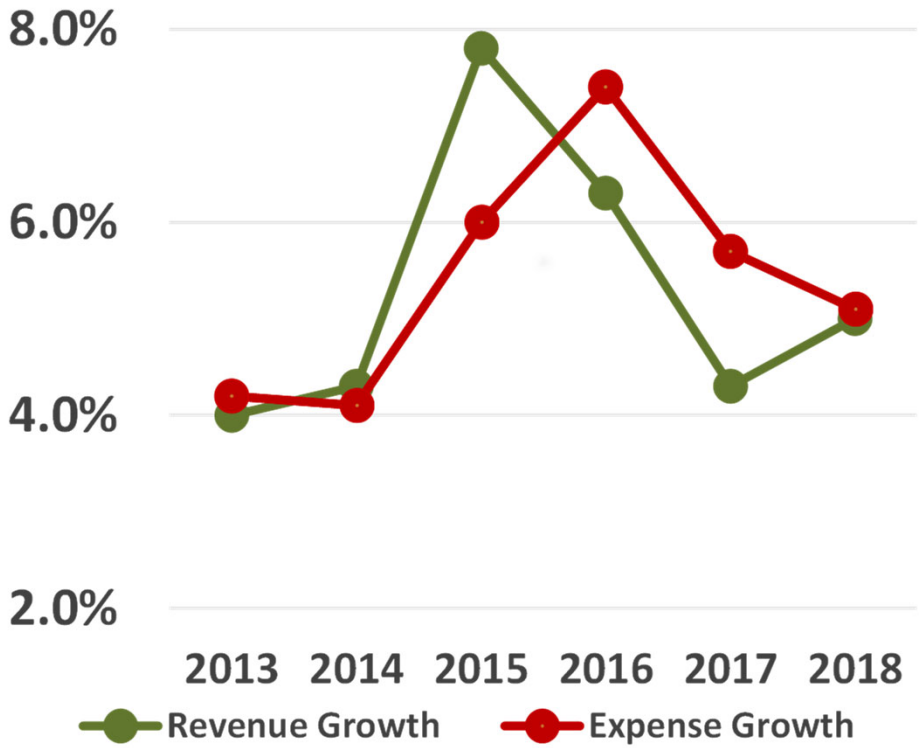
- **Specific programs impacting health care (not comprehensive)**
  - Provider Relief Fund (HHS) - CFDA 93.498.
  - Disaster assistance loans (Economic Injury Disaster Loans, SBA) CFDA 59.008.
  - Uninsured COVID Testing and Treatment (HHS) – CFDA 93.461.
  - Grants for new and expanded services under the Health Center Program (HHA) – CFDA 93.527.
  - Emergency Grants to address mental and substance use disorders during COVID-19 (HHS) CFDSA 93.665.
  - Rural Health Clinic Testing (HHS) – CFDA 93.697.

- **Organizations with $750,000 or more in federal expenditures during a single fiscal year will be required to have a single audit.**

COVID-19 Compounds Financial Challenges

Prior to COVID-19, Hospitals faced increasing financial pressures.

Median revenue and expense growth rate for nonprofit hospitals.



COVID-19 Pandemic Increased Those Pressures

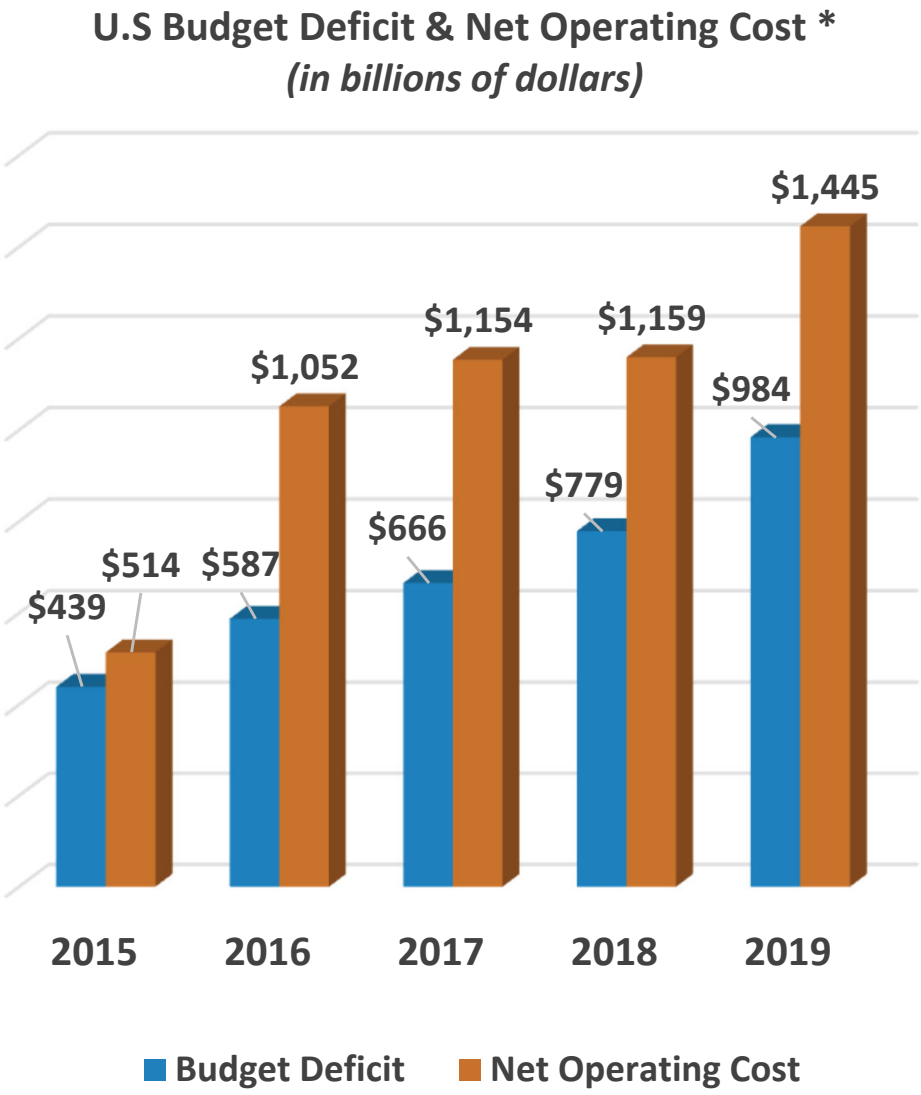
- **> 50% observed decline in hospital operating revenue during shutdown.**
- **~90% volume levels today when compared to pre-COVID baseline; final gap to 100% expected to close slowly, if ever.**
- **50% of hospitals projected to end 2020 with negative operating margins.**

Source: The Advisory Board "State of the Union 2020: The Resilient Health Care System"

Federal Government Economic Relief

A tale of two stories…….

- The federal government has distributed trillions to help organizations and people get through the pandemic.
- However, deficit spending has resulted in total debt of $27T which has been labeled as *"unsustainable"* by the GAO.
- As additional funding is considered, additional deficit spending and could very well trigger statutory cuts known as "PAYGO."*
- The CBO has estimated, absent Congressional intervention, more funding could trigger PAYGO reductions amounting to $381B/year, beginning in 2022.
- If enacted, it could result in a maximum 4% reduction in health care payments to providers, which is in addition to 2% sequestration, which has been suspended through March.
- The CBO believes Congress will have to intervene due to there are not enough resources available to cut that will fully offset the $381B per year of increased deficits.
- However, it's important to note "intervention" doesn't necessarily mean health care will fully escape the 4% reduction.



* Source: *"Financial Report of the United States Government"* for FFYE 2019, issued by GAO, Dept. of Treas. & OMB; Letter from CBO to Honorable Kevin McCarthy, Republican Leader U. S. House of Representatives dated February 25, 2021.

Purchasers Feeling Pressures Too!

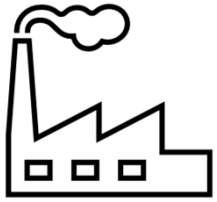
What levers will purchasers pull to manage costs?

Medicare

Continued efforts to shift care to lower cost setting, and shift risk to providers willing to accept it. Hospital Insurance Trust Fund is running low, so "price" cuts and strategies designed to reduce total health care spend are all in play.

Medicaid

State Medicaid budgets were challenged before COVID-19, and loss of tax revenues during the pandemic will compound this; expect near term cuts and accelerated movements towards managed care.



Employers

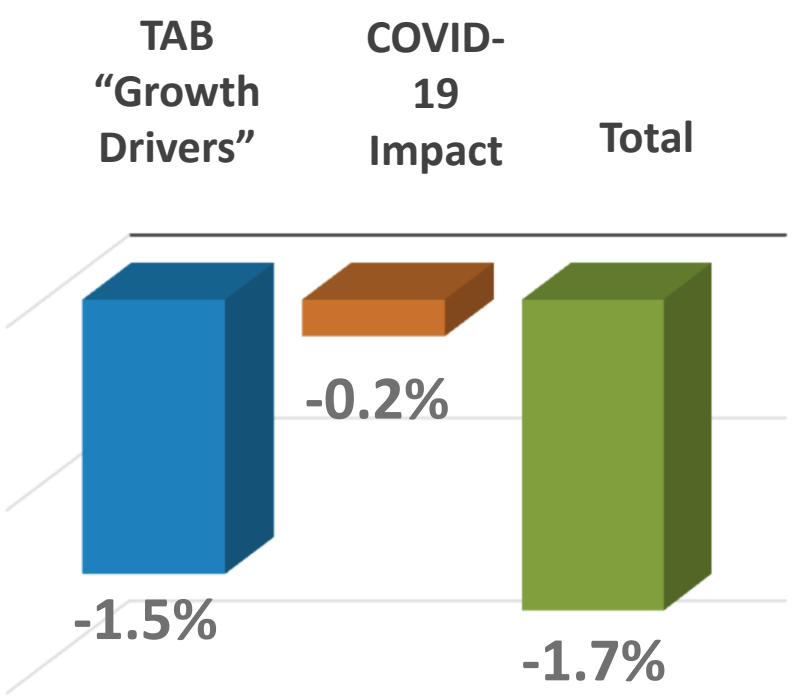
Struggling to manage and/or reduce costs due to lost revenues and employer sponsored insurance will continue to be a focus. Look for aggressive movements towards plans that manage steerage of patients and show promise of cost management. Enhanced public options by the new Administration may become attractive options for some.

Source: The Advisory Board "State of the Union 2020: The Resilient Health Care System"

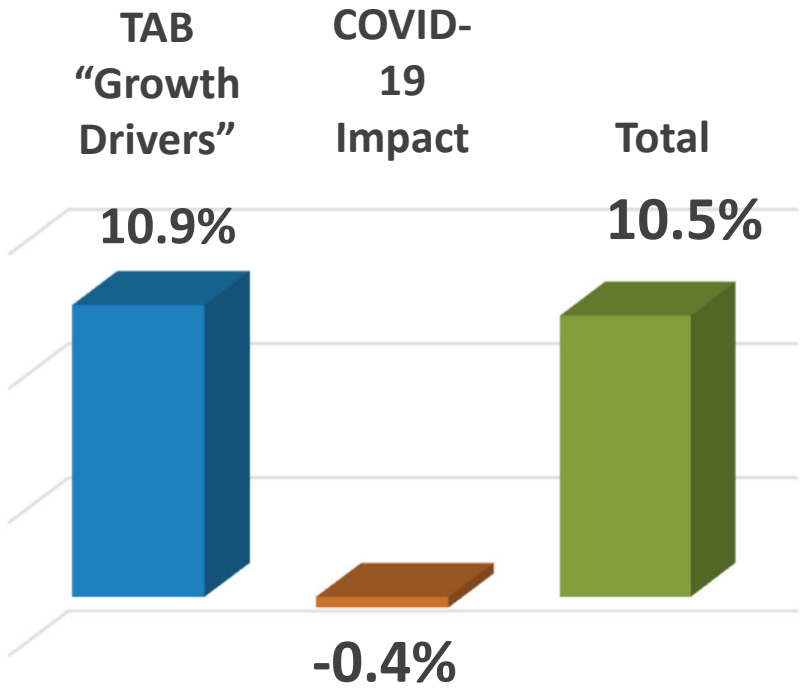
Despite COVID Site of Service Shift Continues

*Advisory Board National Forecast 2019 – 2024**

5 Year Inpatient Growth Projection



5 Year Outpatient Growth Projection



The market forces driving site-of-care shifts, including payer incentives, physician and consumer preferences, technological progress, and regulatory change, remain in effect and will continue to cause migration of services to lower cost settings into the future.

Source: The Advisory Board (TAB) "State of the Union 2020: The Resilient Health Care System"

Shifting Care to Home Gaining Traction

The impact of COVID-19 has opened new doors to delivering care differently. The long-term impacts will evolve over time, but there is definite increased awareness and acceptance of these models. Reimbursement formulas will play a vital role in growth.

	Pre-Acute	Acute				Post-Acute	
	Virtual Care	Hospital at Home	Home Infusion	Home Dialysis	Home Birth	Home Health	SNF at Home
Shift During Pandemic							
Post Pandemic Outlook							
Explanation	Volumes will decline from COVID peak.	Pandemic growth likely sustained.	COVID accelerated this trend.	COVID accelerated this trend.	Regulatory restrictions limit growth.	Fears of infection will limit growth.	Practical constraints limit growth.

 Slight shift

 Moderate shift

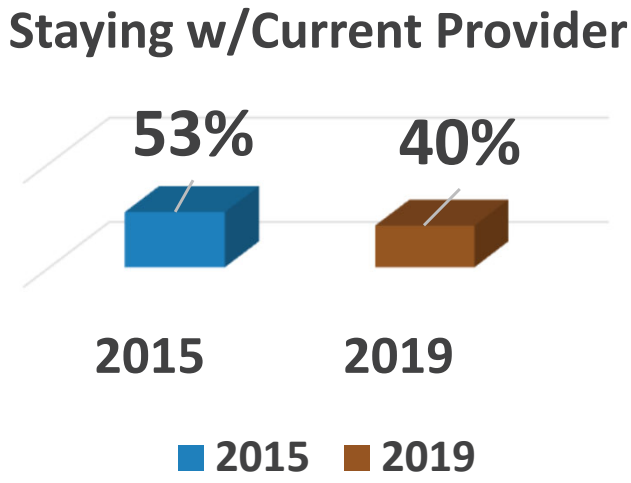
 Significant shift

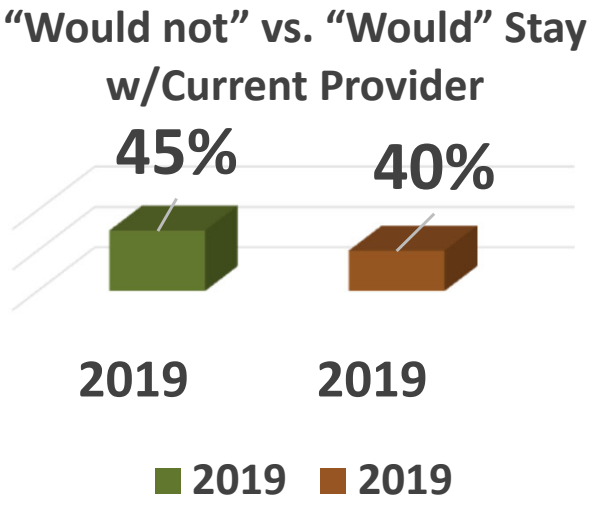
Source: The Advisory Board "State of the Union 2020: The Resilient Health Care System"

Rising Tide of Consumer Expectations

Erosion of patient loyalty

- Consumer loyalty to primary care providers has declined from 2015 to 2019.
- Two measurements of note:
  - The percentage who planned to stay with current PCP declined from 53% in 2015 to 40% in 2019.
  - In the 2019 survey, more respondents, 45% indicated they WOULD NOT stay with current PCP vs. 40% who indicated they WOULD stay.
- Understanding the attributes that drive consumer loyalty and designing systems to meet expectations is critical as options for PCP access evolve.





** Source: The Advisory Board Company survey of thousands of consumers across the United States; www.adivisory.com/mplc/pcsurvey*

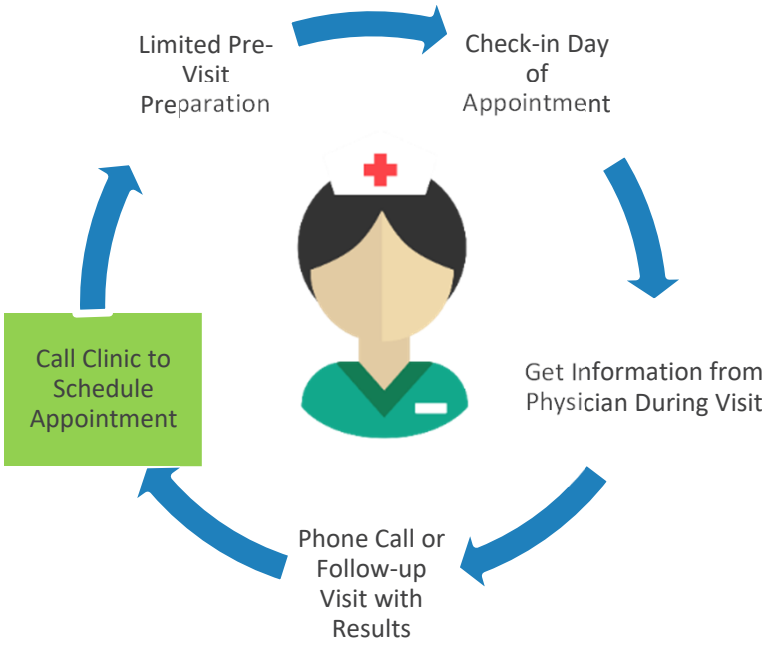
What Do Consumers Really Want?

Meeting expectations will increase loyalty

	ON-DEMAND PRIMARY CARE	PRIMARY CARE PHYSICIAN (PCP) LOYALTY	SPECIALTY CARE	SURGICAL CARE	VIRTUAL VISITS	THE BOTTOM LINE
 18–29	**Cost-Conscious** A **free visit ranked #1** out of 56 clinic attributes. *Access Preference* 54% prefer **after-hours** access over weekend access	**Option Seekers** Likelihood to Switch PCPs in Next Year *Scale: 0 (not at all likely) to 10 (extremely likely)* 1.43 · 1.81 · 2.69 · **3.78** This group is the **least loyal**—they were the most likely to switch PCPs and the most likely to be enticed to leave for a new competitor's offering.	**Referral Rebels + Online Shoppers** Likelihood to Break a Referral 33.9% *Not Likely* — *Very Likely* 33.9% of self-referrers in this group said they broke a referral to see a specialist of their choosing. They were also the **most likely to find a provider online**.	**Most Likely to Travel for Quality** **15.9%** of decision determined by travel time *Important* — *Not Important* This age group is the **least concerned** about traveling for surgery. Perceived surgeon quality, hospital affiliation, and a referral determine more of their surgical decisions than other groups'.	**Ready for Virtual** 67% would consider a virtual visit if in-person care is unavailable that day 20% would consider a virtual visit if it was less expensive than in-person care *Ranking of Virtual Channels* 1 · 2 · 3	This digitally fluent group is the **most socially connected generation**—they're the most likely to read reviews and compare prices to find providers offering maximum convenience at the lowest cost. They're also the most likely to shop for providers and write reviews online.
 30–49	**Cost-Conscious** A **free visit topped** this group's list of priorities. *Access Preference* 51% prefer **after-hours** access over weekend access	**Price Beats Quality** This group was **more likely to leave** their PCP **because of a $250/year care cost increase** than experiencing a medical error.	**Willing to Break a Referral** Likelihood to Break a Referral 17.9% *Not Likely* — *Very Likely* 17.9% of self-referrers in this age group received a specialist referral but **shopped for care** instead of following it.	**Local Over Top Quality** **17.3%** of decision determined by travel time *Important* — *Not Important* **Travel is not make-or-break** for this group—it factored less in their decisions than costs, but was still nearly 3x more important than perceived surgeon quality.	**Prime Virtual Visit Targets** 73% would consider a virtual visit if in-person care is unavailable that day 47% would consider a virtual visit if it was less expensive than in-person care *Ranking of Virtual Channels* 1 · 2 · 3	These are the **health care decision influencers**—they often direct not only their own care, but also that of their partners, children, and aging parents. They want care to fit into their busy lives—during nontraditional hours and through virtual options.
 50–64	**Access Seekers** This group **might pay more for access and convenience**: time to first available appointment and ancillaries on site outranked a free visit. *Access Preference* 57% prefer **weekend** access over after-hours access	**Quality Over Price** **Experiencing a medical error was more likely to make this group leave** their PCP than a $250/year care cost increase.	**Unlikely Referral Breakers** Likelihood to Break a Referral 7.5% *Not Likely* — *Very Likely* 7.5% of self-referrers in this age group did not follow their doctor's referral for a specialist but instead **shopped for a specialist** of their choice.	**Cost Sensitive** **18.9%** of decision determined by travel time *Important* — *Not Important* This group is **disinterested** in traveling for care and was the most cost-sensitive of the age cohorts when it comes to surgical care.	**Receptive to Virtual Visits** 62% would consider a virtual visit if in-person care is unavailable that day 32% would consider a virtual visit if it was less expensive than in-person care *Ranking of Virtual Channels* 1 · 2 · 3	Increasingly delaying retirement, this group is **staying active** and **engaged in personal wellness** longer than before. Often managing multiple chronic care conditions, these consumers expect timely access to in-person care.
 65+	**Physician-Centric** Provider **continuity and credentials** were more important than a free visit. *Access Preference* 61% prefer **weekend** access over after-hours access	**Most Loyal** Likelihood to Switch PCPs in Next Year *Scale: 0 (not at all likely) to 10 (extremely likely)* **1.43** · 1.81 · 2.69 · 3.78 The 65+ cohort is the **most loyal**—they were the least likely to leave their PCPs and also the most likely to recommend their providers.	**Affiliation Influences Choice** Likelihood to Break a Referral 7.0% *Not Likely* — *Very Likely* Only 7% of these self-referrers reported breaking a referral to see a provider of their choosing. **Hospital affiliation was most important** in this cohort's specialist selection.	**Travel Avoiders** **20.3%** of decision determined by travel time *Important* — *Not Important* This age group **doesn't want to travel** for care—travel time was more than twice as important as following a referral or hospital affiliation to this group.	**Most Resistant to Virtual** 58% would consider a virtual visit if in-person care is unavailable that day 20% would consider a virtual visit if it was less expensive than in-person care *Ranking of Virtual Channels* 1 · 2 · 3	These are **health care's traditionalists**: they are the most loyal age group, least likely to break a referral, and disinterested in traveling for care. However, as the Baby Boomers age into Medicare, they will alter the profile of the 65+ consumer group.

** Source: The Advisory Board Company survey of thousands of consumers across the United States; www.adivisory.com/mic/consumerstrategy*

Do Systems Align With Consumer Expectations?

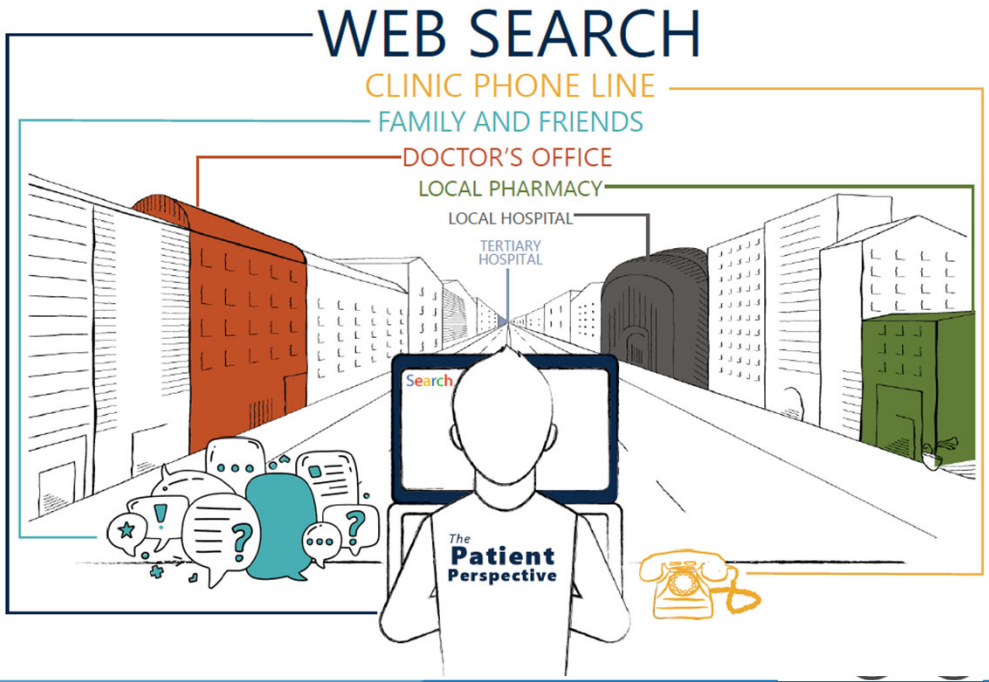


The "Good Ol' Days"

- Care access based largely on geography
- Organized around provider availability
- Mon. – Fri. "banker's hours"
- Primary Care trusted source for patient information
- Little price or quality transparency

The "New Era"

- Access no longer limited by geography
- Flexible hours
- Treasure trove of information available
- Accessible pricing & quality indicators
- Options puts loyalty at risk



What Next? Strategies to Consider

CLA Belief: COVID-19 accelerated transitions (and made permanent) already in progress!

Assess Governance & Leadership Effectiveness

Pandemic highlighted importance of efficient decision making, and hazards of structures that create barriers.

Address Operational Efficiencies

Financial pressures are causing organizations to reassess operational efficiency, and "rebasing" cost structures to more align with transitioning reimbursement models.

Service Evaluation

Underperforming services are being evaluated to determine if they should continue or be terminated.

Consider Consumer Preferences

Are systems aligned to meet consumer preference, or are they outdated and leading to loyalty erosion?

Embrace Shifting Sites of Service

Readdress readiness to embrace the shift and new models – COVID has accelerated it – the time is now!

Go Virtual!

COVID demonstrated the value of virtual care – where does it fit into your strategic direction?

** Source: The Advisory Board Company survey of thousands of consumers across the United States; www.adivisory.com/mic/consumerstrategy*

Do any of these changes concern you? Excite you? Grab your attention? They should! These topics and many others are what CLA's newest blog, HI2, will be focusing on → the ongoing disruption and innovations in health care.

Subscribe to Blog

blogs.claconnect.com

Your Business

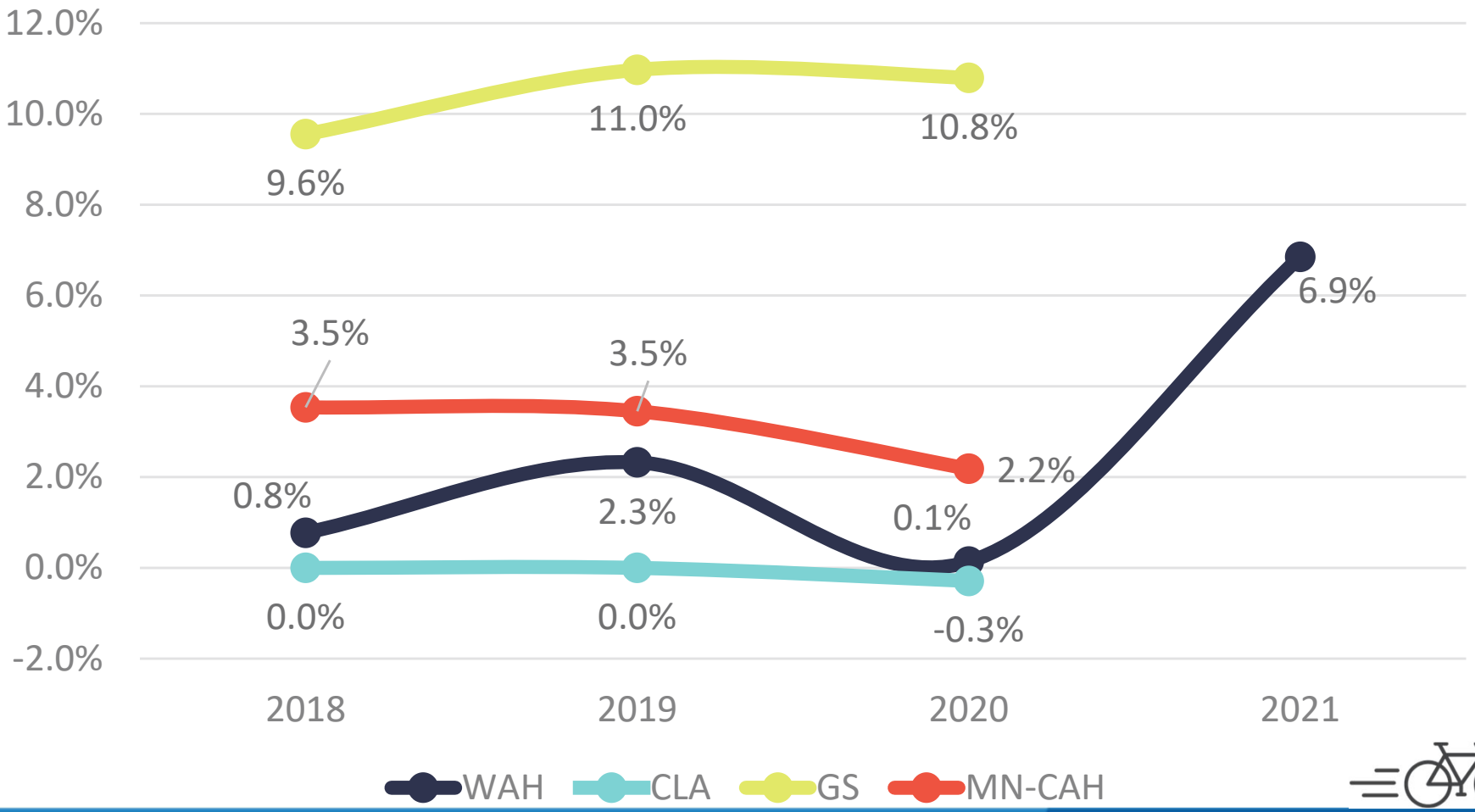
Financial Ratios – Comparative Data Used

- **Windom Area Health (WAH)**
  - $21.5 Million Net Patient Service Revenue
  - 2018-2021 Data, Based on Audited Financial Statements
- **CLA CAH Clients (CLA)**
  - Critical Access Hospitals with Net Patient Service Revenue less than $25 Million
- **CLA MN Clients (MN-CAH)**
  - All MN CAH facilities from the Gold Standard Report
- **CLA Gold Standard (GS)**
  - Over 1,000 fiscal year reports analyzed in preparation of ratios and benchmarks
  - 35 Gold Standard Facilities

Operating Margin

Definition:

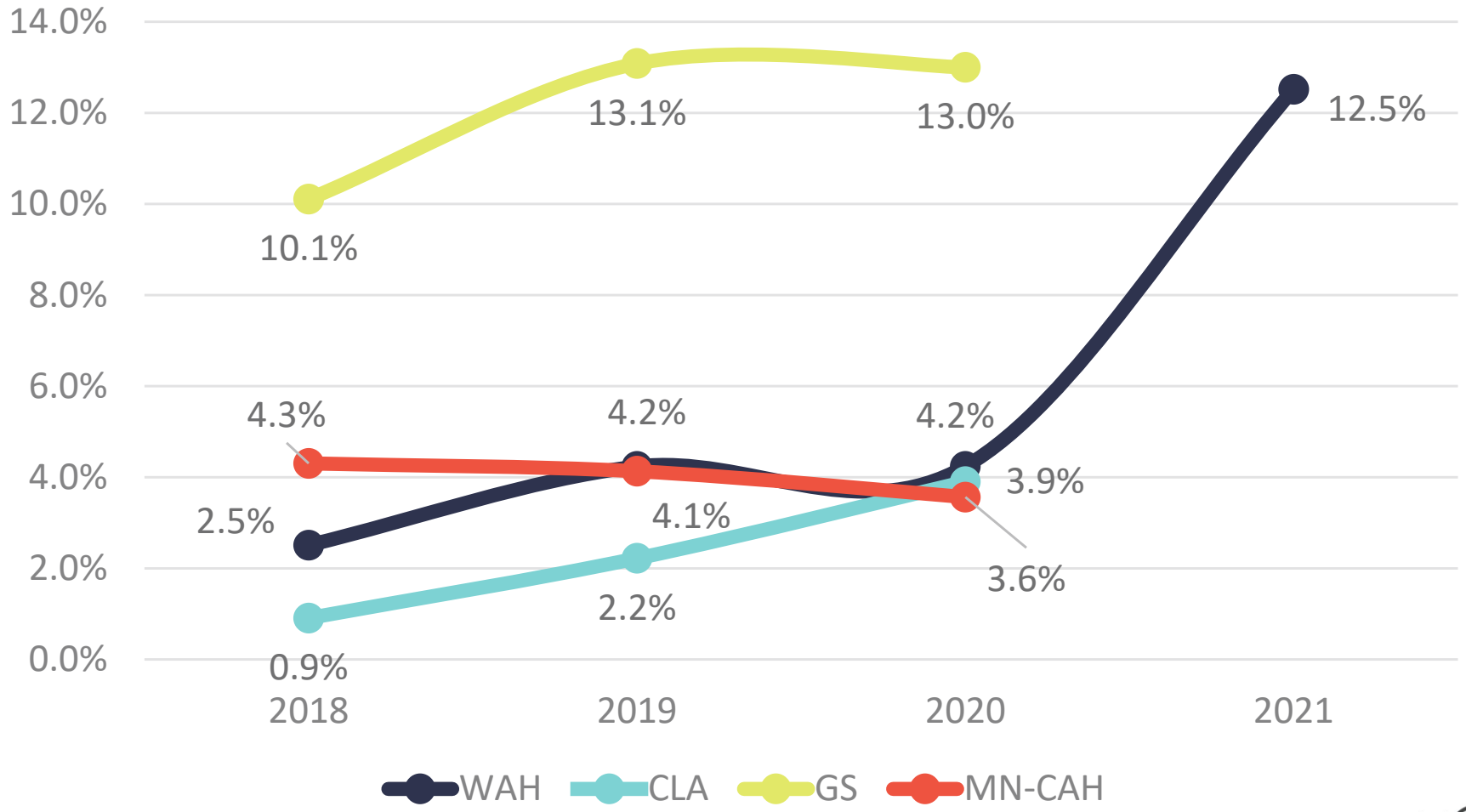
This ratio is operating income as a percentage of net patient service revenue plus other operating revenues. It is used to report the facility's return on revenues which relate to the main purpose of operations.



Total Margin

Definition:

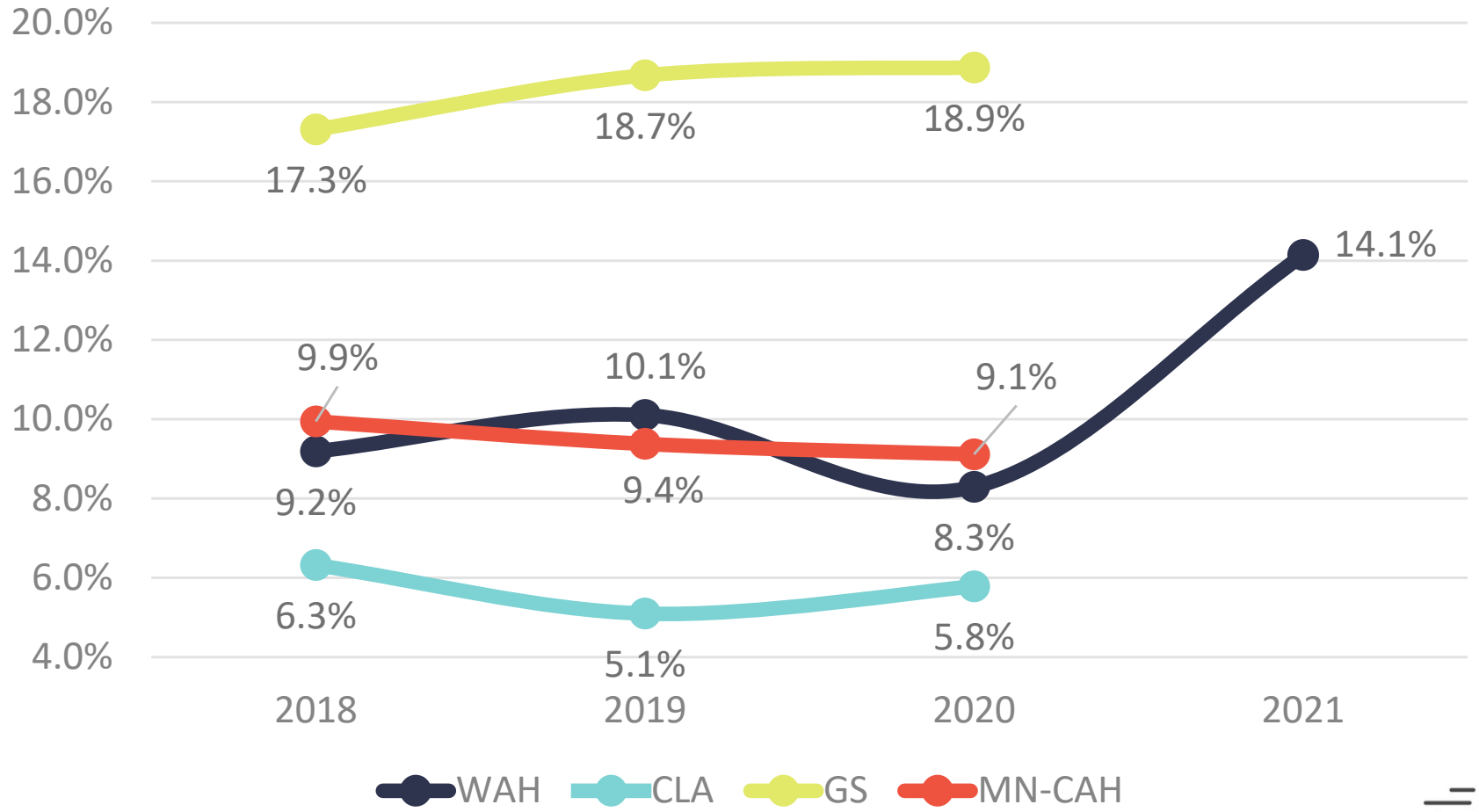
Total margin reflects excess of revenue over expenses as a percentage of total revenues, including nonoperating revenues.



Operating EBIDA

Definition:

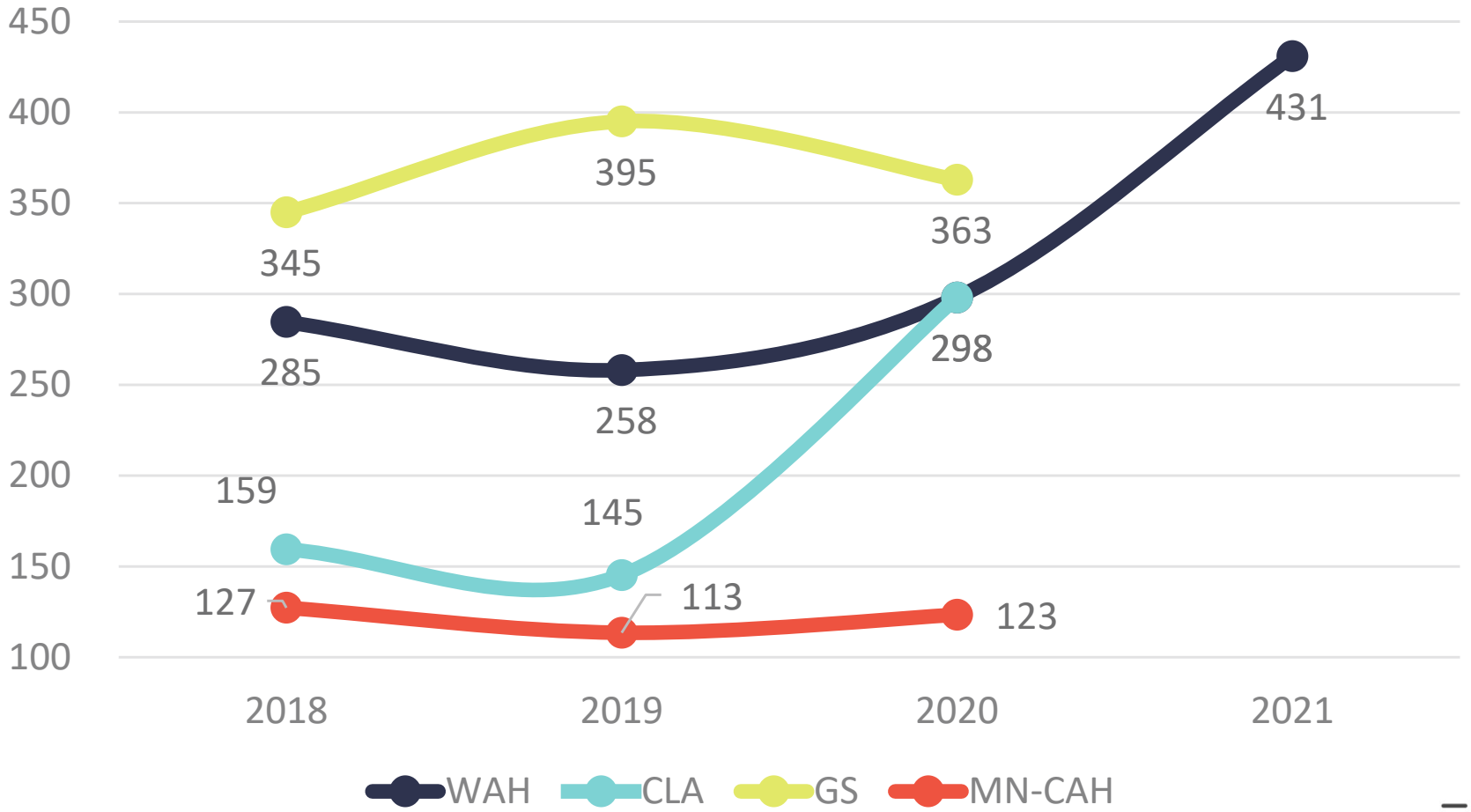
Operating EBIDA represents Earnings (operating income) Before Interest, Depreciation and Amortization divided by total operating revenues. It is used as a rough measure of operating cash flow in a facility. This ratio is often used when evaluating debt capacity.



Days Cash on Hand (All Sources)

Definition:

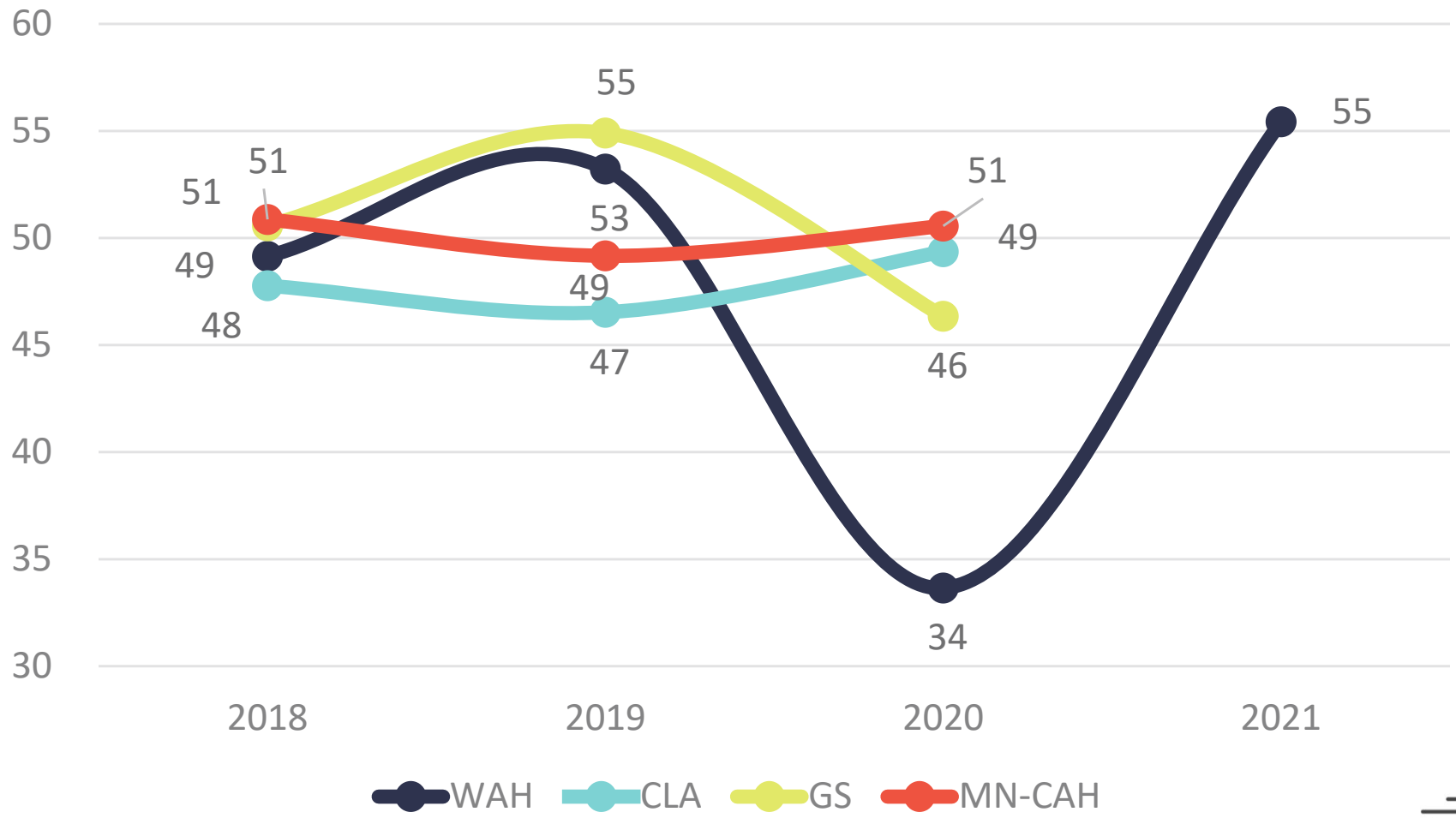
Days Cash on Hand measures the number of days of average cash expenses that the facility maintains in cash and amounts reserved for capital improvements. High values usually imply a greater ability to meet both short-term obligations and long-term capital replacement needs.



Net Days in Accounts Receivable

Definition:

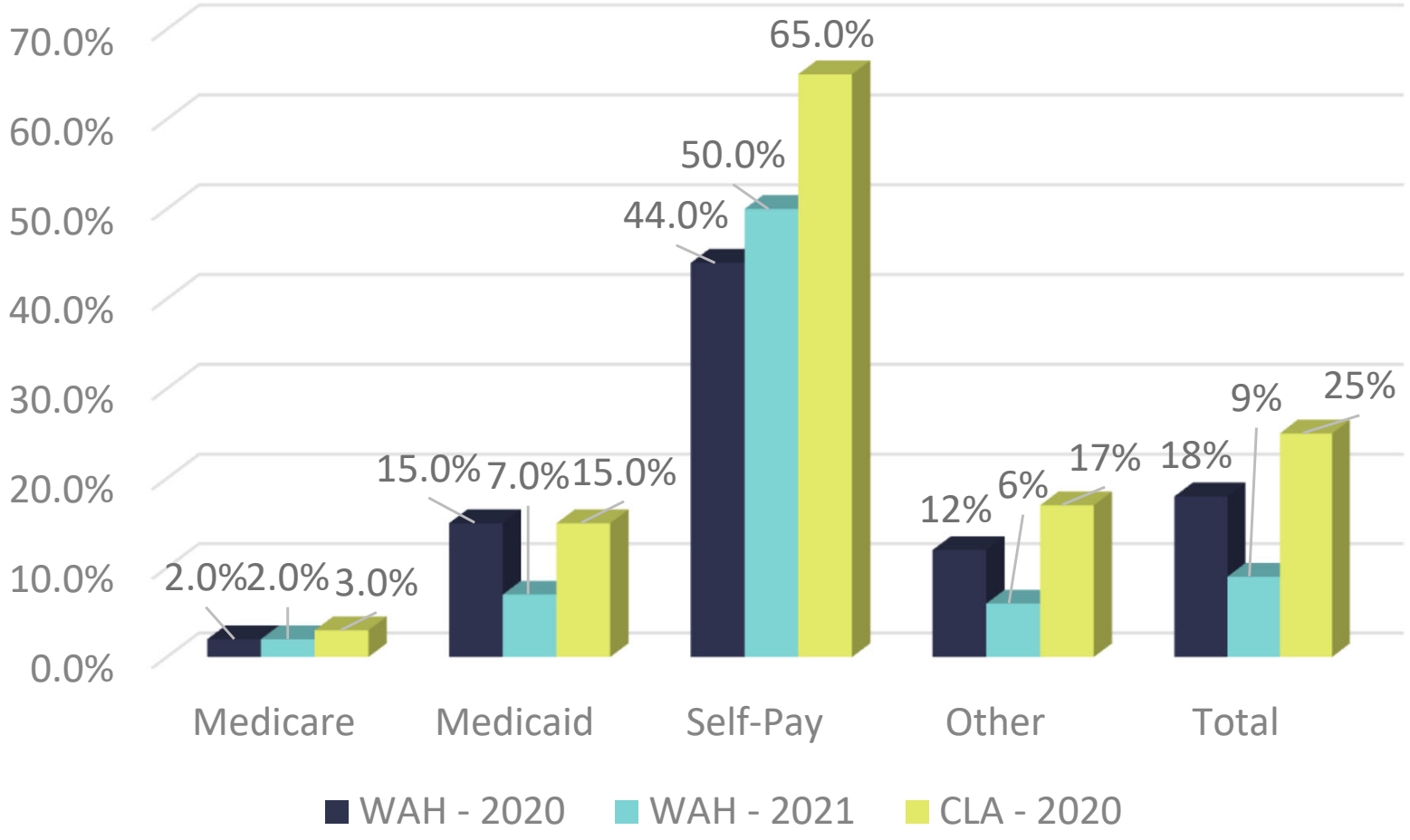
Days in patient accounts receivable is defined as the average time that receivables are outstanding, or the average collection period.



Percentage of A/R over 90 days old

Definition:

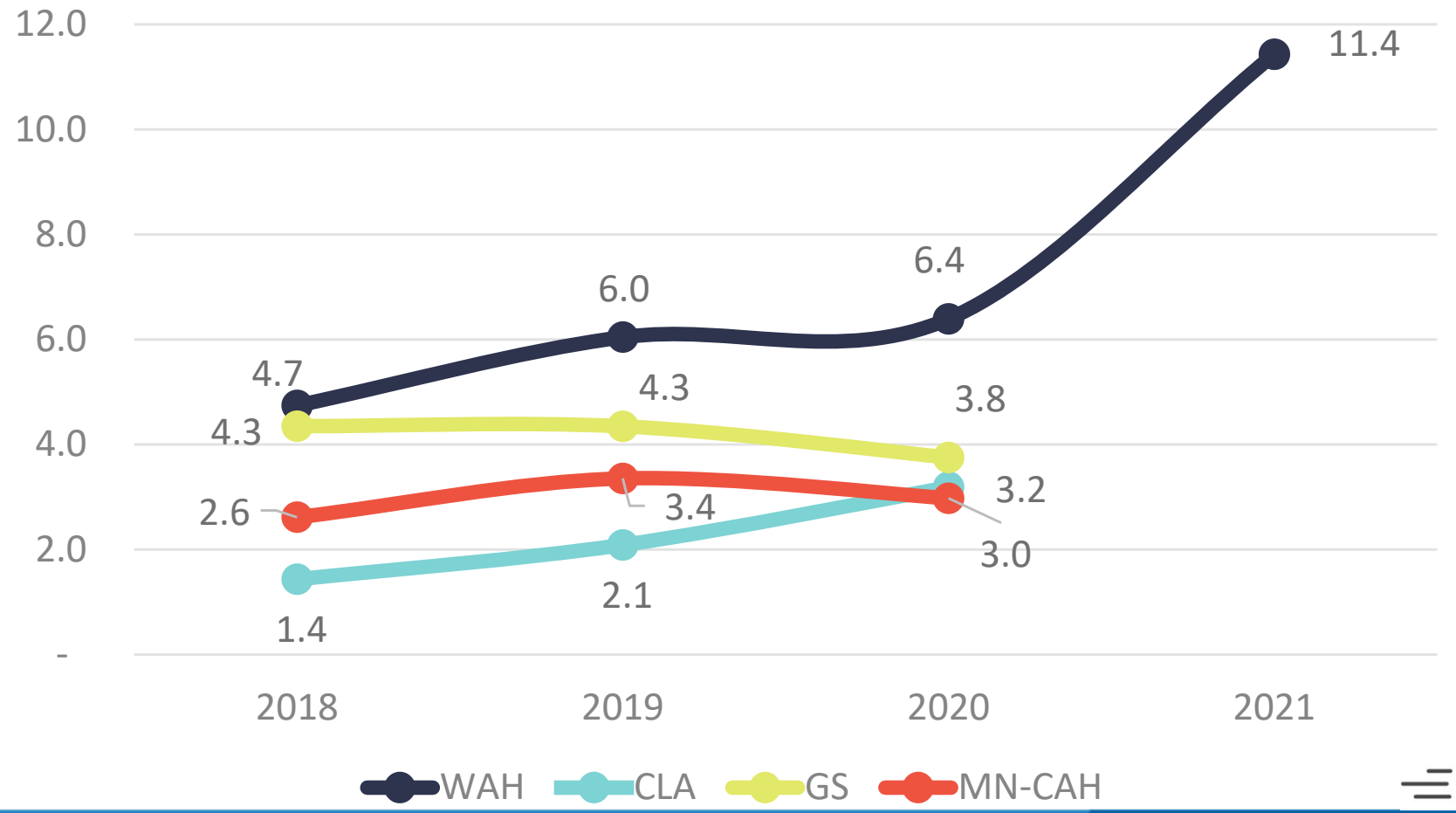
This is measured by dividing the amount of patient accounts receivable over 90 days by the total receivables in that payer category. Generally, the lower this percentage is the shorter turn around time the facility has for collecting receivables.



Debt Service Coverage

Definition:

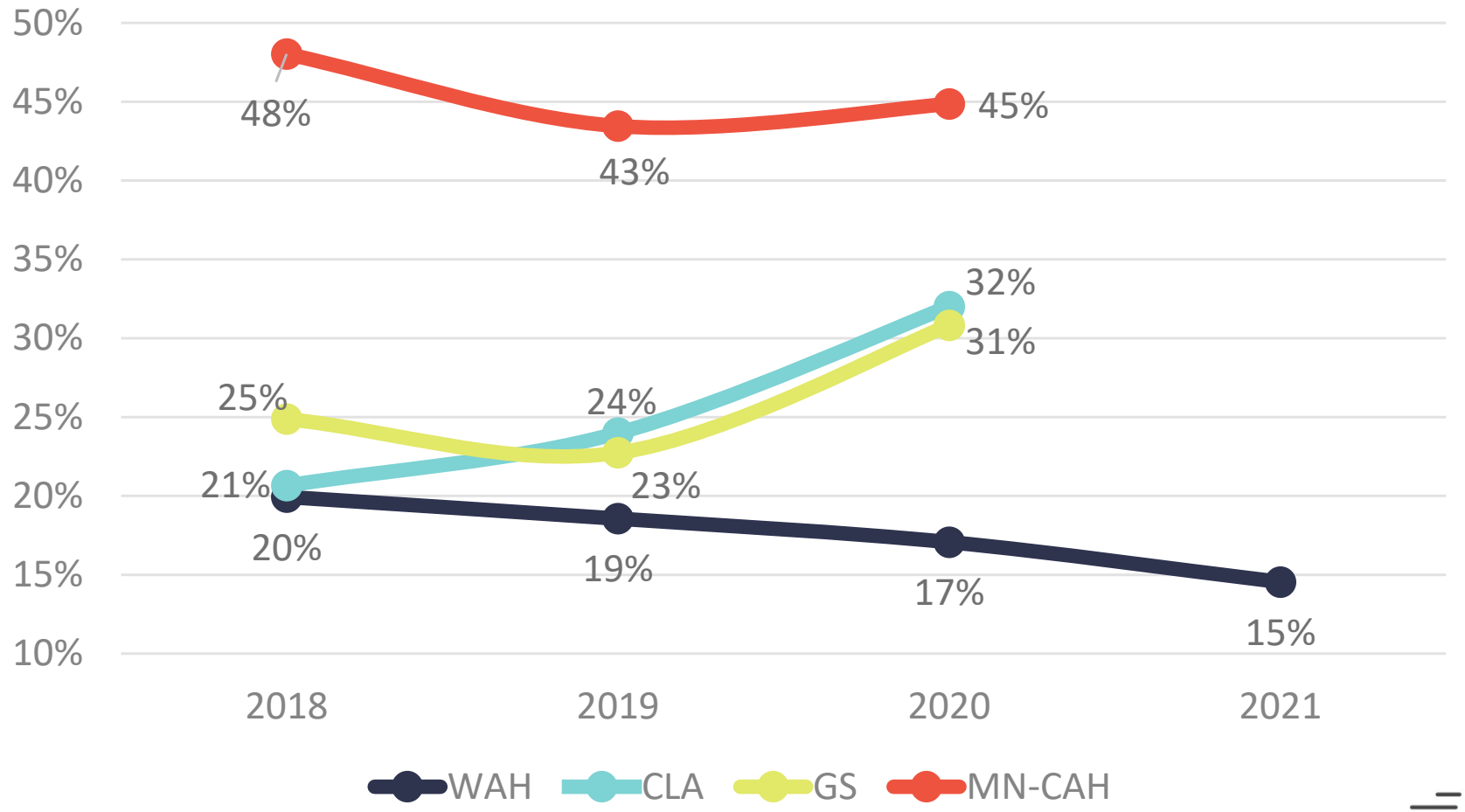
Debt service coverage is calculated as income available for debt service (net income + depreciation and amortization + interest expense) divided by the annual debt service requirements (principal payments made + interest expense).



Debt to Capitalization

Definition:

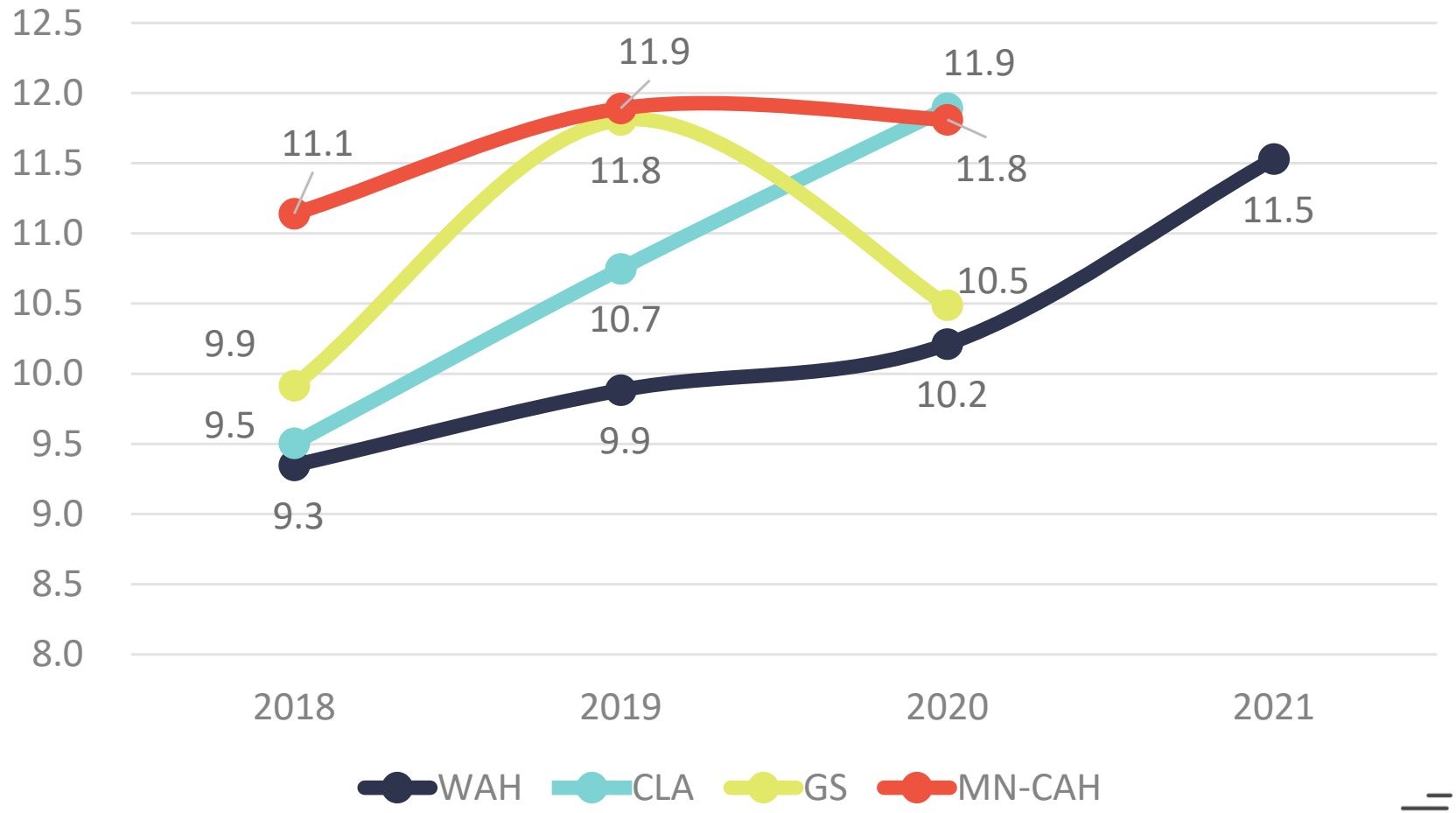
This ratio is defined as the proportion of long-term debt divided by long-term debt plus total net assets. Higher values for this ratio imply a greater reliance on debt financing and may imply reduced ability to carry additional debt.



Average Age of Plant

Definition:

Average age of plant attempts to approximate the average age of an organization's fixed assets. A low value is considered to be desirable as it indicates a newer facility.



Appendix

New Accounting Standards

Topic	Communication
Leases – GASB 87	1. Addresses accounting and financial reporting for leases by state and local governments. 2. The Statement establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset 3. Requires the recognition of certain right to use lease assets and related liabilities for leases that were previously classified as operating leases 4. Effective for years **beginning after** June 15, 2021, with earlier application permitted

Required Communications

Topic	Communication
Our responsibility under Generally Accepted Auditing Standards	• Express an opinion on the fair presentation of the financial statements in conformity with GAAP • Plan and perform the audit to obtain reasonable, nonabsolute assurance that the combined financial statements are free of material misstatement • Evaluate internal control over financial reporting • Utilize a risk-based audit approach • Communicate significant matters to appropriate parties
Planned Scope and Timing of the Audit	• Performed the audit according to the planned scope and timing previously discussed
Other Information in Documents Containing the Audited Financial Statements	• Financial statements may only be used in their entirety • Our approval is required to use our audit report in a client prepared document • We have no responsibility to perform procedures beyond those related to the financial statements

Required Communications

Topic	Communication
Significant Accounting Policies	• Management is responsible for the accounting policies of the organization • Accounting policies are outlined in Note 1 to the financial statements • No significant changes to the accounting policies in the current year • Accounting policies deemed appropriate • No unusual transactions occurred
Significant Accounting Estimates	• An area of focus under a risk-based audit approach • Significant estimates include: **contractual allowances, allowance for bad debts, third-party payor settlement estimates, and Provider Relief funds recognition** • Estimates determined by management based on their knowledge and experience • No management bias indicated • Estimates were deemed reasonable • Estimate uncertainty is disclosed in the financial statements
Significant Financial Statement Disclosures	Net Patient Service Revenue – Note 2 Deposits and Investment Income – Note 4 Long-Term Debt – Note 6 Defined Benefit Pension Plan – Note 7 Other Postemployment Benefits – Note 8

Required Communications

Topic	Communication
Required Supplemental Information	• Schedule of Employer's Share of Net Pension Liability, Schedule of Employer's Contributions, and Other Postemployment Benefit Plan • Engaged to report in relation to the financial statements as a whole • Method of preparing has not changed from the prior year • Supplemental information is appropriate and complete in relation to our audit
Management Representation Letter	• Management provided a signed representation letter prior to finalization of audit reports
Other	• No difficulties encountered in performing the audit • No issues discussed prior to retention as independent auditors • No disagreements with management regarding accounting, reporting, or other matters • No Consultations with other independent auditors • No other findings or issues were discussed with, or communicated to, management

Internal Control Matters

Topic	Communication
Purpose	• Express an opinion on the financial statements, not on the effectiveness of internal controls. • Our consideration of internal controls was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore material weaknesses or significant deficiencies may exist that were not identified. In addition, because of inherent limitations in internal control, including the possibility of management override of controls, misstatements due to fraud or error may occur and not be detected by such controls.
Material Weakness	• Reasonable possibility that a material misstatement would not be prevented, or detected and corrected on a timely basis.
Significant Deficiencies	• Less significant than a material weakness, yet important enough to merit the attention of governance.
Restricted Use	• This communication is intended solely for the information and use of management, the audit committee, and others within the Organization, and is not intended to be, and should not be, used by anyone other than these specified parties.
Results	• Material Weaknesses – financial statement preparation

Deliverables

Report on the Financial Statements

Report on Minnesota Legal Compliance

Board Packet including Required Communications, Internal Control Communications and Financial Ratios

Report on Debt Compliance

Ryan Strusz, CPA
Principal
Health Care
ryan.strusz@CLAconnect.com
612-376-4680

CLAconnect.com

WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING