

*New Hampshire Insurance Department*

*Understanding Hospital Costs  
In  
New Hampshire*

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## Executive Summary

*There are two primary objectives in producing this report. The first objective is an inventory NH's 26 hospital systems by examining the size and scope of the services provided by the corporate entity. This inventory is Part III of this report and was developed with the input of Chief Financial Officers (CFO) of the hospitals. The second objective is the identification of the cost pressures faced by hospitals and their health systems to understand better why the amount spent by employers and the government on health care services continues to rise. This report examines the costs for the hospital portion of the health care system as a whole, and does not discuss individual hospitals or hospital systems. For analysis purposes, hospitals have been aggregated into size cohorts based on their revenue.*

*The report methodology used interviews with all hospital CFOs in the state (except Exeter Hospital), experts on hospitals as well as analysis the following documents:*

- *Medicare Cost Reports for the most current year*
- *2010 and 2009 Audited Financial Statement as aggregated by New Hampshire Hospital Association (NHHA)*
- *Community Benefits Reports*
- *IRS 990s*
- *Hospital websites*

*The report recognizes why hospitals cannot be studied using standard economic theory. Hospitals generally do not respond to price competition because the patient is separated from choice by his/her doctor and insulated from health care prices by insurer or government payer. Unlike most other industries, hospitals do not have any input into what they are paid as there are a significant numbers of patients covered by Medicare and Medicaid whose payment rates are set with no input from hospitals. Half of NH's hospitals are paid through the Prospective Payment System (PPS) with payments based upon anticipated resource consumption. The other half, those with 25 beds or fewer, are Critical Access Hospitals (CAH) and are reimbursed based upon cost. For commercial insurance each individual hospital must negotiate its payment rates with virtually no knowledge of rates being paid to other hospitals.*

*The following are the key findings of this study:*

- *Hospital costs are established through a budgeting process that projects volume by department and the resources necessary to meet this patient demand.*
- *Charges are set by hospitals but only rarely do patients pay charges, although some insurance contracts are based on a percentage of charges.*
- *Charges represent approximately a 70% markup for PPS hospitals and 50% for CAH.*
- *2010 Medicare payments to PPS hospitals are approximately 73% of costs, not including patient copays and deductibles. This means PPS hospitals must find other revenue sources to cover \$330 million in costs. CAH hospitals are paid*

about 85% of cost leaving the hospitals with a need to cover a shortfall of \$38 million, some of which is covered by patient co-payments.

- *In 2010, Medicaid paid approximately 58% of the cost of treating eligible patients. For PPS hospital, NH does not provide any subsidies for uncompensated care while the hospitals have to pay the Medicaid Enhancement Tax (MET), that was originally established to provide greater Medicaid reimbursement and some subsidies. Between the shortfall in costs and the MET, PPS must obtain approximately \$290 million from other sources.*
- *Commercial insurance and payments from patients are relied upon to offset the losses associated with Medicare and Medicaid.*
- *Charity care in 2010 for all hospitals was \$117 million or 2.5% of costs.*
- *In 2010 there was \$130 million (2.8% of costs) recorded as bad debt. CFOs are concerned that bad debt will increase with the popularity of high deductible health insurance plans. Between 2009 and 2010 bad debt increased by 6.6%*
- *Competition exists among hospitals, primarily to attract well insured patients. Major competitive methods include:*
  - *Advertising, but this primarily among larger hospitals.*
  - *The deployment of PCPs to outlying communities where they may compete with other PCP practices set up by other hospitals.*
  - *Arms-race for high technology*
  - *Building hospitals to appeal to well insured patients.*
- *Hospitals now competing with niche providers that provide routine surgery, radiology and laboratory services to commercially insured patients. These niche providers can provide these services for a lower price because they do not treat all patients nor do they offer the unprofitable services hospitals provide.*
- *A new insurance benefit design, referred to as "Site of Service", offers financial incentives to patients to use lower priced providers for high volume routine services. This decreases the volume and revenue from profitable services that is available offset losses from government patients and free care.*
- *Personnel costs, including employed physicians, accounts for 57% of all costs at hospitals*
- *Hospitals have initiated several programs designed to reduce personnel costs including the use of part-time employees and staffing to meet the daily volume.*
- *NH Hospitals have \$1.9 billion in capital assets and \$1.5 billion in long term debt. Annual debt service is approximately \$100 million for all hospitals.*
- *The state has a mechanism to hold down capital costs through the Certificate of Need CON program; however the current structure this regulatory structure is not highly effective.*
- *Hospitals own many primary care and specialty practices and MDs practices, which account for 12.8% of all hospital system costs. Ownership of practices is essential as private ownership of physician practices is not financially viable. Often physicians will not locate in a community unless they are employed by the hospital.*
- *Ownership of physician practices is not profitable for hospitals and has resulted in reduced hospital margins.*

- *Regulatory and administrative requirements are increasingly imposed on hospitals and are unfunded. An example is an initiative referred to as Meaningful Use, which encourages system-wide integration of health care information.*
- *Overall 45% of hospital costs are indirect. Of these 15% are administrative and general. Indirect costs offer the best opportunity for reducing costs without affecting patient care.*

## *Introduction*

*New Hampshire is home to twenty-six hospitals, distributed fairly well throughout the state. Most of NH's hospitals began as charitable institutions or, in the case of Wentworth-Douglass Hospital, a municipal hospital. These early facilities provided care with some payment from patient but most funding came from endowments and churches.*

*This report examines the costs at NH's Hospitals. The purpose is to understand better why the insurance premiums and personal out-of-pocket health care expenditures rise each year. Hospitals are the single largest component of the health care system and the cost of operating these institutions is a substantial driver of overall health insurance premiums. The report explores the world in which hospitals operate as hospitals function in environment with unique economic forces. Understanding hospital's economic realities requires consideration of the various payment mechanisms. The health care environment also radically impacts the way hospitals compete, collaborate and interact with the system as a whole. The report focuses on major cost centers for hospitals, including personnel costs, the cost of operating and managing physician practices and the cost of capital expenditures. External forces are explored in order to gain insight into the cost pressures that result from the requirements from accreditation, licensing and state and federal reporting. Finally, the issue of direct and indirect costs is explored as a means of determining where the opportunities for cost cutting exist.*

*New Hampshire has a very well organized network of hospitals. Without any centralized planning entity, every city in the state and major population center in southern NH has a hospital. Among the small towns, hospitals are distributed with services readily available in all the population centers smaller counties of Coos, Carroll, Grafton and Sullivan. Over the past century there has been almost no change in the location of hospitals. One small facility in Newport closed and an attempt to get approval for a hospital in Salem in 1989 was denied a Certificate of Need. The possible exception to the appropriate geographic distribution of NH's hospital is the state's*

*teaching hospital, which if health planning principles were applied, would likely be in a more densely populated part of the state instead of Lebanon.*

*The bed compliment at each hospital has been more flexible, but this has been determined by the individual hospitals based on the fluctuations in occupancy. Hospitals may not operate more than the number of beds for which they are licensed, but many do not have their full licensed capacity set up and staffed. This means there is considerable flexibility in the number of beds that can be made available. This flexibility may become critical as the state's population continues to age and residents use more hospital bed days.*

*The twenty-six NH hospitals fall into two categories based on the way they are paid by the Center for Medicare/Medicaid Services (CMS) for the Medicare program. The 13 larger hospitals are Prospective Payment System (PPS) hospitals. These hospitals are paid by Medicare for admitted patients using the Diagnostic Related Groups (DRG) system, which calculates payment based on the patients diagnoses and anticipated length of stay and resources needed. Payment for outpatient services is based on the Outpatient Prospective Payment System (OPPS) and other mechanisms. The remaining 13 hospitals are designated Critical Access Hospitals (CAH). To maintain this designation by CMS they must have no more than 25 inpatients on any given day and patients should be discharged home or to a swing or skilled care bed within four days of admission. These hospitals receive reimbursement for their Medicare patients based on the allowable costs of the institution. For inpatients the hospital receives 101% of the allowable costs incurred. For outpatients, CAH receives the 101% of allowable costs, less the 20% copay that is the Medicare recipient's responsibility (this may be covered by a commercial Medicare supplemental insurance plan), resulting in 101% of the 80% covered by Medicare.*

*The PPS and CAH Hospitals in New Hampshire are:*

### **Prospective Payment System Hospitals**

*Catholic Medical Center – Manchester  
Cheshire Medical Center – Keene  
Concord Hospital - Concord  
Elliot Hospital – Manchester  
Exeter Hospital – Exeter*

*Frisbie Memorial Hospital – Rochester  
Lakes Region General Hospital – Laconia  
Mary Hitchcock Memorial Hospital/Dartmouth Hitchcock Medical Center – Lebanon  
Parkland Medical Center – Derry  
Portsmouth Regional Hospital – Portsmouth  
St. Joseph Hospital – Nashua  
Southern NH Medical Center – Nashua  
Wentworth-Douglass Hospital - Dover*

### **Critical Access Hospitals**

*Alice Peck Day Memorial Hospital – Lebanon  
Androscoggin Valley hospital – Berlin  
Cottage Hospital – Woodsville  
Franklin Regional Hospital – Franklin  
Huggins Hospital – Wolfeboro  
Littleton Regional Hospital – Littleton  
Memorial Hospital – North Conway  
Monadnock Community Hospital – Peterborough  
New London Hospital – New London  
Speare Memorial Hospital - Plymouth  
Upper Connecticut Valley Hospital – Colebrook  
Valley Regional Hospital – Claremont  
Weeks Medical Center - Lancaster*

*There are both not-for-profit and for-profit hospitals in NH. Of the 26 hospitals only two, Parkland Medical Center and Portsmouth Regional Hospital, are for profit, both owned by Hospital Corporation of America (HCA). Benefits of being a part of large hospital system include sharing back office functions, group contracting with large national insurers and support in the development of policies and procedures. It should be noted that despite out-of-state ownership both Portsmouth and Parkland have local boards that provide input into the operation of these hospitals.*

*Not-for-profit hospitals operate under the direction of a community based boards of trustees. The basis of a not-for-profit organization is ownership is by the community and the profits are not distributed to owners or shareholders. A non-profit relies on some excess of revenue over expenses for investment in the hospital to keep it viable.*

*Some of NH's hospitals, including both CAH and smaller PPS, are stand-alone corporations that own the physical plant, all the hospital's operations and physician*

*practices. Other hospitals are part of a system with a parent corporation and one or more subsidiaries or sister corporations. Some systems separate the hospital and physician practices. Others incorporate physician practices but separate real estate. For some hospitals the system is quite large and includes assisted living facilities, physician/hospital joint ventures and/or related agencies. As Henry Lipman, Executive Vice President and CFO of LRGHealthcare stated during an interview, “If you’ve seen one hospital system, you’ve seen one hospital system”. In the Inventory in Part III is a description of the organizational structure of each hospital/system in the state.*

*The consensus by those interviewed for this report is that system wide costs are the most accurate way to present costs because all cost associated with the hospitals, real estate, physician practices and other programs are included in the system costs. In a few instances the system also includes some non-related costs. Alice Peck Day’s system costs include its retirement communities. The small distortion of the data caused by including a few non-hospital services is much less problematic than not including a large portion of hospital based costs.*

*In 2010, according to the hospital’s audited financial statements made available by the New Hampshire Hospital Association (NHHA), the 26 hospital systems spent a total of \$4.663 billion<sup>1</sup> in the operation the facilities and hospital owned physician practices. The following facts summarize this spending:*

- \$3,543.33 in spending for every person living in New Hampshire<sup>2</sup>.*
- 26% of the total was spent by Mary Hitchcock Memorial Hospital/Dartmouth Hitchcock Clinic, the state’s only academic medical center. This spending includes all activities in Lebanon as well as Dartmouth Hitchcock Clinics in Concord, Keene, Manchester and Nashua.*
- 61% of the spending was by the remaining 12 PPS hospitals. The proportion of spending ranged from a high of 6% to a low of 2%.*
- The 13 CAH hospitals spent 14% of the total.*
- Each CAH hospital spent less than 1.5% of the total*

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<sup>1</sup> 2010 Hospitals Audited Financial Statements as provided by NHHA.

<sup>2</sup> Based on the US Census population for 2010 of 1,316,256

- *The hospitals employed a total of 37,000 workers<sup>3</sup>*
- *There were approximately 111,000 inpatient admissions, excluding newborns. These admissions resulted in 505,000<sup>4</sup> patient days.*
- *The hospitals collectively preformed 229,000<sup>5</sup> outpatient and emergency procedures.*

*Hospitals charged the government, commercial insurance companies and individuals approximately \$9.6 billion<sup>6</sup> for the services provided. In return hospitals received only about half of these billings, \$4.8 billion<sup>7</sup> in payments from Medicare, Medicaid, private insurance and other payor sources. The explanation for the difference between the billed and received amount will be covered in the next chapter.*

*Each year insurers report they have to increase premiums. It is generally reported by insurers that these increases are the result of increases in hospital costs. To understand health care costs several source documents were researched. These included:*

- *Medicare Cost Reports (MCR),*
- *IRS 990 forms for the 24 non-profit hospitals,*
- *Audited financial statements for both 2009 and 2010, both as provided by the NH Hospital Association and as provided by the individual hospitals, and*
- *Community Benefit Reports.*
- *Hospital web sites*

*Interviews were held with 23 of the hospital CFOs. Two hospitals are owned by the same parent and share a single CFO. Two other CAH hospitals in Coos County have recently begun sharing a CFO as a cost saving measure. The CFO of Exeter Hospital refused to participate. The interviews were between 60 and 90 minutes. There were*

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<sup>3</sup> Extrapolated from the 2010 audited financial statements provided by the NHHA, data on employees for Portsmouth Regional Hospital and Upper Connecticut Valley Hospital were not provided. Employees for Androscoggin Valley Hospital and Speare Memorial Hospital for 2009 were used.

<sup>4</sup> NHHA Uniform Hospital Discharge Data Set, 2009

<sup>5</sup> NHHA Ambulatory data set, 2009

<sup>6</sup> The total amount billed was aggregated from the 2010 audited financial statements as provided by the NHHA, The gross patient revenue (the amount billed) does not include 4 small CAH hospitals.

<sup>7</sup> The total amount received is the net patient service revenue aggregated from the 2010 audited financial statements from NHHA. This figure includes all but one very small hospital.

consistent questions asked of all CFOs, however, time was given to explore issues raised. The service areas of each hospital are different and thus the environments in which they operate are unique. As a result, there were a variety of opinions on the cost pressures faced.

For the most part, individual hospitals will not be named. Statistics refer to clusters of similar hospitals based on the total costs as reported in the Medicare Cost Report.

PPS Large

MHMH/DHMC  
Concord  
Elliot  
CMC

PPS Mid-size

Wentworth-Douglass  
Cheshire  
Exeter  
Southern NH Medical Center

PPS Small

St. Joseph  
Portsmouth  
LRG – Laconia  
Frisbie  
Parkland

CAH Large

Monadnock Community Hospital  
Littleton  
New London  
Memorial  
Androscoggin Valley  
Huggins

CAH Small

Speare Memorial  
Alice Peck Day  
Valley Regional  
Weeks Memorial  
Franklin Regional  
Cottage  
Upper Connecticut Valley  
Hospital

Part I

External Factors

## *Charges, Costs and Payment*

*The role of the consumer, the person or entity that makes decisions to purchase health care services, is at best is vague. It could be expected that the patient is the consumer because he determines if he will seek health care services. But once he does he is directed by his physician as to which services are obtained. The patient cannot secure treatment in a hospital without a referral from a physician. Once he receives treatment payment for any services he receives is usually the responsibility of his insurer, insulating him from price.*

*If the physician determines what services are purchased, then perhaps she is the consumer? But the physician has no economic relationship to these decisions and as such does not behave as a consumer.*

*The insurance company, acting for the employers who purchase this service, pays for care, but except in a few cases when there is a pre-approval process for tests or surgery, the insurer does not have a role in the choice to obtain hospital services.*

*The lack of a clear consumer is why standard economic theory does not apply to most of health care markets, and particularly not to hospitals. The patient is separated from choice by the physician who must make a referral for a test or treatment or an inpatient hospital stay and he is usually unaware of the price of the services he receives because payment is covered by his insurer.*

*The inability to respond to standard economic principles goes even further, because, as an industry, hospitals do not have a typical playing field. While hospitals have to determine charges, they rarely have control what they will be paid for a service. There is virtually no payer who pays what a hospital charges. In fact, RSA 151:12 sets out what hospitals must accept as payment in full from the uninsured as follows:*

**Hospital Rates for Self-Pay Patients.** – *When billing self-pay patients for a service rendered, a hospital, as defined in RSA 151-C:2, shall accept as payment in full an amount no greater than the amount generally billed and received by the hospital for that service for patients covered by health insurance. A hospital shall determine the amount generally billed to health carriers in a manner consistent with Section 9007 of the Patient Protection and Affordable Care Act of 2009. A hospital shall provide written notice to a self-pay patient in advance of providing a*

*service and at the time the service is billed regarding the requirements under this section.*

## **Charges**

*It is often said that charges are unimportant when attempting to understand hospital financials. If so, why do hospitals have charges? To what degree do charges relate to the reimbursement and costs?*

*Charges exist because hospitals are required to have charges, by Medicare and oftentimes commercial insurers. Medicare reimbursement cannot exceed the hospitals charges.*

*Charges also exist because there are a significant number of contracts between hospitals and insurance companies that are based on charges. Insurers will write the contract so that the hospital is paid a percentage of the hospital's charges. Often there is a cap on the percentage hospitals can increase their charges under these contracts but this is not always the case. This type of contract is most common in mid-size to small PPS Hospitals and CAH. CFOs all report this type of contract is the most financially advantageous.*

## Cost to Charge Ratios<sup>8</sup>

Generally the charges are set at a level that, if paid, would make hospitals very profitable. Medicare requires that each hospital submit the ratio of cost to the charges they have set for many services. These ratios demonstrate the markup hospitals have for services.

Department	Large PPS		Mid-size PPS		Small PPS	
	Costs (000)	Ratio	Costs (000)	Ratio	Costs (000)	Ratio
Operating Room	\$ 12,668	0.177	9,294	0.293	\$ 9,410	0.220
Recovery Room	\$ 1,796	0.397	3,689	0.483	\$ 1,739	0.363
Delivery and labor	\$ 832	0.504	999	0.617	\$ 858	0.640
Anesthesiology	\$ 691	0.049	567	0.061	\$ 377	0.060
DX Radiology	\$ 12,904	0.120	10,822	0.137	\$ 17,666	0.208
Laboratory	\$ 2,277	0.208	14,196	0.209	\$ 12,421	0.211
Respiratory Therapy	\$ 1,036	0.266	2,937	0.287	\$ 1,334	0.125
Physical Therapy	\$ 1,569	0.435	909	0.662	\$ 7,116	0.504
Occupational Therapy	\$ 1,181	0.366	524	0.695	\$ 1,192	0.343
ECG	\$ 5,926	0.269	2,832	0.208	\$ 1,203	0.126
Supplies charged Pt.	\$ 26,255	0.560	5,549	0.464	\$ 6,728	0.325
Drugs charged to Pt.	\$ 19,851	0.273	4,858	0.337	\$ 17,538	0.381
Department	Large CAH		Small CAH			
	Costs (000)	Ratio	Costs (000)	Ratio		
Operating Room	\$ 3,881	0.281	2,954	0.787		
Recovery Room	\$ 842	0.625	-			
Delivery and labor	\$ 82	0.488	497	1.656		
Anesthesiology	\$ 316	0.173	35	0.055		
DX Radiology	\$ 5,300	0.273	3,478	0.266		
Laboratory	\$ 4,263	0.318	2,838	0.248		
Respiratory Therapy	\$ 968	0.828	867	0.277		
Physical Therapy	\$ 1,466	0.483	809	0.728		
Occupational Therapy	\$ 214	0.293	463	0.599		
ECG	\$ 64	0.111	-			
Supplies charged Pt.	\$ 2,977	0.459	2,048	0.686		
Drugs charged to Pt.	\$ 4,113	1.106	3,121	0.361		

<sup>8</sup> Data are aggregated from Medicare Cost Reports for the most recent fiscal years, which is 2010 or 2011 depending on the filing date for the individual hospital. These reports are as reported and have not been reconciled.

## **Costs**

*The term “health care costs” is often misused as it tends to be used to refer to how much individuals, businesses and insurers pay for health care insurance or services. However, health care costs simply mean the expenses incurred by health care providers. “Reducing health care costs” can only occur if a provider does not make an expenditure it would normally make.*

*Part II of this report focuses on the costs at hospitals, including personnel, indirect, capital, physician practices and other costs. Anticipated hospitals expenditures are established through a fairly complex budgeting process. This process uses historic utilization data, information from physician practices and data on demographic and social-economic shifts in the population to project the utilization by department anticipated for the next year. The resources, staff, supplies and equipment needed to meet this level of use by each department is determined.*

## **Reimbursement or Payments**

*Hospitals are paid a different amount for the services they provide depending upon who is responsible for the patient’s bill. Patients fall into four reimbursement categories. There are two major government programs<sup>9</sup>; Medicare for those over age 65 and acute services for persons with disabilities, and Medicaid for low-income individuals and seniors and people with disabilities who require long-term care. There are patients covered by commercial insurance. The majority of NH residents are covered by a few commercial insurance companies; Anthem, Cigna, MVP and Harvard Pilgrim Health Care. Also included in this group are employees covered by self-insured employers, which is when the employer holds the risk for employees and hires a third party administrator (TPA) to contract with providers and pay claims. The last group is the uninsured or self-paying patients. Despite the rare individual who can afford to live without health insurance, the overwhelming majority of these patients have minimal income or assets and covering a hospital bill is a major challenge.*

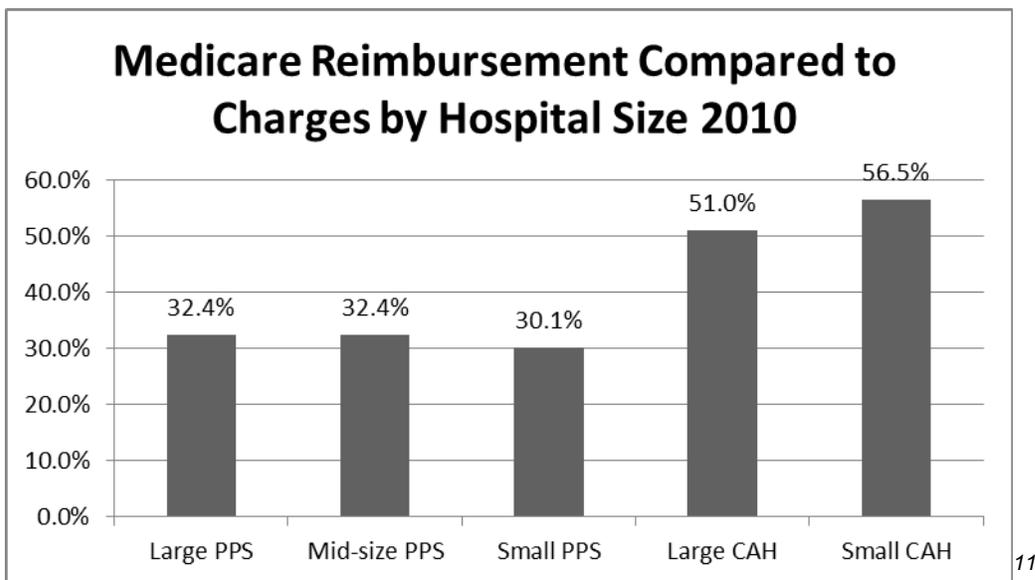
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<sup>9</sup> There are other government payers including CHAMPUS and VA, however these are relatively small.

## **Medicare**

The largest payer is Medicare program with approximately 221,000 beneficiaries<sup>10</sup> in NH. CMS calculates payments to larger hospitals through an algorithm based the patient's diagnosis and comorbidities determining the anticipated length of stay and the resources needed to treat the patient. For services provided on an outpatient basis, payments are procedure driven through the Outpatient Prospective Payment System or a fee schedule. Although the payment structure is fairly uniform across hospitals there are differences in the payments depending on designations such as "rural referral center", "Medicare dependent hospital" or "sole community provider".

For CAHs CMS pays 101% of the allowable costs for an inpatient stay and for outpatient services 101% of the allowable costs minus the 20% copay that is the patient's responsibility. Allowable costs exclude marketing costs, philanthropy and costs associated with the gift shop, cafeteria and other amenities. The following graph shows the percentage received by each hospital in 2010 from Medicare in relationship to the amount billed this includes both inpatient and outpatient payments.

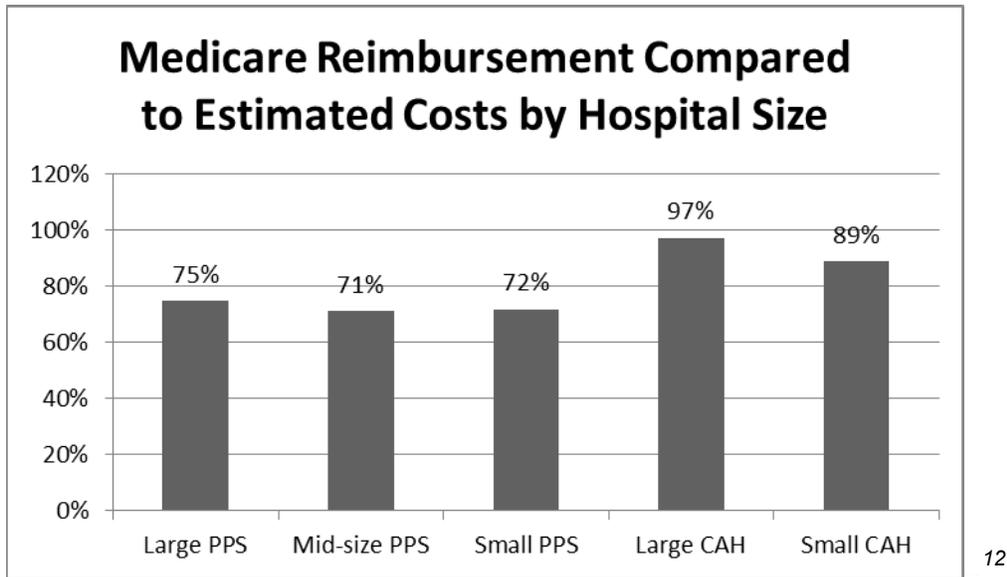


This chart compares what is received from what was billed. Since hospital charges are set by the hospital and there are very few restrictions on how these are set, it would be more accurate to compare the reimbursement to costs. The following chart

<sup>10</sup> Kaiser Family Foundation

<sup>11</sup> Hospital Audited Financial Statements as provided by NHHA

compares what was received from Medicare from what it cost to provide services. Medicare costs were estimated by multiplying the total operating costs by percentage of total charges billed to Medicare.



The graph indicates that PPS hospitals are paid by Medicare less than three-quarters of the cost to provide care to these patients. The effect of this is that in 2010 the 13 PPS hospitals experienced a \$330 million shortfall in costs that were not paid by Medicare.

For the CAHs Medicare pays 101% of inpatient allowable costs and 101% of 80% of inpatient costs. Even with this favorable reimbursement structure there is \$38 million in costs that are not covered by Medicare.

It should be noted that all hospitals do recover some of the 80% co-pay for outpatient services from Medicare gap private insurance or the patient directly.

## **Medicaid**

Medicaid is a state/federal partnership to provide health coverage for the low-income children and pregnant women and long-term care for the elderly and persons

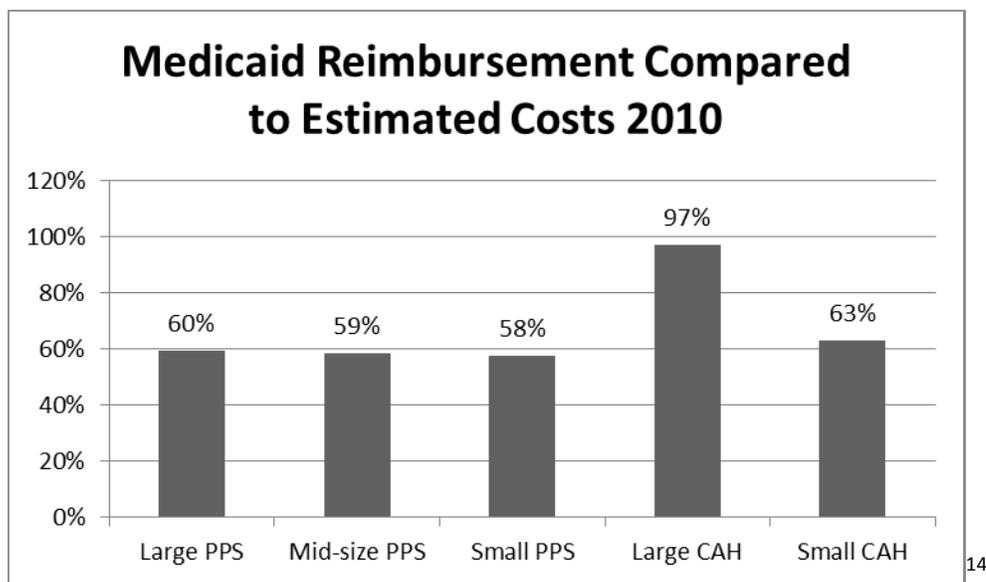
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<sup>12</sup> ibid

with disabilities. There are approximately 130,000 Medicaid recipients in NH.<sup>13</sup> The largest expenditure in NH's Medicaid program is for long-term care services.

Medicaid reimbursement from the state to hospitals differs for PPS and CAH hospitals. For CAHs inpatient care is paid on a DRG basis. For outpatient services NH Medicaid reimbursement is 91% of outpatient costs, higher than the national average of 85%.

For PPS hospitals, Medicaid reimbursement is much lower. The following chart examines the amount reimbursed as a percentage of the cost of treating these patients. Costs were estimated by multiplying the total costs by the proportion of gross revenue billed to Medicaid.



The large CAH cluster contains two hospitals with nursing facilities that receive more Medicaid revenues for services for Intermediate Care Facility (ICF) residents.

The 13 PPS hospitals must cover \$120 million in costs associated with Medicaid patients that are not covered by the Medicaid reimbursement.

### **Medicaid Enhancement Tax and Disproportionate Share Hospitals**

Between 1991 and 2009 NH secured matching federal funds from CMS through the Disproportionate Share Hospital (DSH) program that was intended to benefit

<sup>13</sup> NH DHHS

<sup>14</sup> 2010 Audited financial statements as provided by NHHA

*hospitals providing services to Medicaid and uninsured patients. A part of this methodology was the Medicaid Enhancement Tax (MET) which was paid by the hospitals but returned through the subsidies. The state used excess funds collected from CMS to contribute to the general fund.*

*In 2010 the state changed the methodology used resulting in nine hospitals receiving less in DSH payments than they paid in through the MET. MET is equal to 5.5% of revenue for qualified inpatient and outpatient services. The SFY 2012-2013 state budget further reduced Medicaid reimbursement but retained the MET. At the time this report was written 10 NH PPS hospitals have filed a lawsuit against the state over Medicaid reimbursement,*

*The lack of DSH payments coupled with the requirement that the hospitals pay the MET has significant cost implications for the hospitals.<sup>15</sup> PPS hospitals collectively underwrote \$120 million in costs for Medicaid patients for which they were not reimbursed. If this is added to the estimated \$150 to \$200 million<sup>16</sup> in MET payments it means PPS hospitals are underwriting between \$170 million and \$220 million in costs. This means that between 11% and 14% of hospitals' costs are not reimbursed, leaving a significant hole in hospital budgets.*

### **Commercial Insurance**

*The payments to hospitals by third party insurers is varied and complex. Each hospital enters into negotiations with an insurance company covering patients that use the hospital. These negotiations result in a myriad of various payment structures.*

*Inpatient payment arrangement include (the list is not exhaustive):*

- DRG based payments*
- Per diem payments*
- Case rates*
- Percentage of hospital charges*

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<sup>15</sup> During interviews with CFOs each discussed this issue but always tended to speak of it from the perspective of what the hospital charged Medicaid. This overstates the impact of the problem caused by the MET and lack of DSH payments so costs are used in this analysis.

<sup>16</sup> The amount of MET tax hospitals will pay is the subject of ongoing discussions with the Department of Revenue Administration (DRA) The amount collected by DRA is less than what was budgeted due to a dispute over the definition of the net patient service revenue for MET purposes.

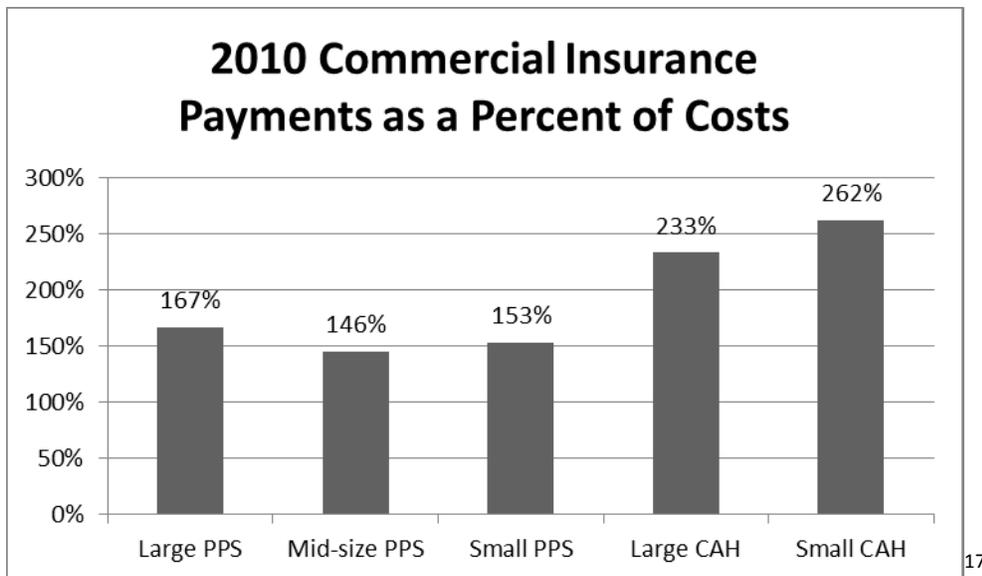
*For outpatients, payment models include but are not limited to:*

- *Fee Schedules*
- *Percentage of charges*
- *Case rate*

*Hospital CFOs all stated that they negotiate with no idea what other hospitals are paid or how contracts between insurers and other hospitals are structured. During interviews with large hospital CFOs, several told the author there were no large insurers who have contracts based on a percentage of the hospital's charges with NH PPS hospitals. However several CFOs of mid-size and small PPS hospitals reported they had such contracts with Anthem and Harvard Pilgrim.*

*The requirement imposed on hospitals by insurance companies of complete confidentiality as to the terms negotiated is another indication of how hospitals operate outside a traditional market. In virtually every industry each business knows the prices its competitors are able to get for goods and services similar to those they offer. Hospitals do not have this information and therefore cannot adjust prices in a competitive manner.*

*Payments from commercial insurers allow hospitals to receive revenue in excess of expenses. The importance of payments from private insurers can be seen in the following chart, which was created using the same methodology as the charts in Medicare and Medicaid.*



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### **Uncompensated Care**

*Hospitals have an obligation to provide services to persons who are not capable of paying. All hospitals in NH, including the two for-profit facilities, must maintain a Charitable Care Policy as a mandate the Emergency Medical Treatment and Active Labor Act of 1986, which requires all hospitals to provide emergency medical care regardless of citizenship, legal status or ability to pay<sup>18</sup>. In addition, in order to obtaining a Certificate of Need a hospital must demonstrate a commitment to providing charity care by providing a copy of the charity care policy with the limits for fee and reduced care as well as the number of patients served under charity care and the amount of this care in the last 12 months.<sup>19</sup> Generally charity care policies grants free to care to patients whose income is less than 250% of the federal poverty limit. For patients above this limit, hospitals usually offer a sliding fee scale.*

*Charitable care is a part of each hospital's mission and it is an obligation of the not-for-profit hospitals in part because these facilities do not pay federal or state business taxes. In most communities, hospitals are exempt from property taxes, although some may make a payment in lieu of taxes to cover the cost of city and town services. All NH hospitals are obligated to file a Community Benefits Plan with the Office*

<sup>17</sup> Ibid

<sup>18</sup> EMTALA.Com a service of Garan, Lucow and Miller

<sup>19</sup> Cynthia Carrier Managing Analyst, Health Services Planning and Review

*of the Attorney General detailing the amount of free care, bad debt and shortfalls from Medicare and Medicaid as well as the amount spent on charitable activities in the community. Hospitals must file form 990 with Internal Revenue Service which also requires information about its charitable care.*

*In 2010 NH PPS hospitals reported on their audited financial statements that they provided over \$241 million<sup>20</sup> in charitable care exclusive of bad debt and Medicaid shortfalls measured by gross charges. This represents 2.4% of the total amount billed and 5% of the revenue received. The accounting for charitable care in charges overstates the level of services offered by hospitals because hospitals do not expect payment of charges for these. A better measure of charity care is the costs incurred by these patients. This is consistent with many definitions of charity care and is consistent with guidance provided by the Hospital Financial Management Association discusses the accounting for charity care as follows:*

*Although charges are the basis for charity care recordkeeping purposes, costs, not charges, should be the primary reporting unit for valuing charity care. The P&P Board agrees with the AICPA Expert Panel that reporting based on costs is more reliably measured and will provide more consistency when comparing amounts of charity care from different providers. By contrast, there is great variance among providers' charges, and consequently very little comparability. Also, measures on charges provide little and potentially misleading information about the resources consumed in providing charity care.<sup>21</sup>*

*Using the 38% factor which is the ratio of cost to charges, it is estimated hospitals spent \$117 million or 2.6% of net patient service revenue.*

*Not included in the charity care figure is bad debt. The difference between charity care and bad debt is that patients are approved for charity care before the patient is treated or at the time of treatment. Bad debt is charges billed but not paid. In 2010 PPS hospitals wrote off \$267.1 million in bad debt<sup>22</sup>. Again reporting bad debt as charges overstates the amount of loss to the hospitals. Bad debt is reported on the financial statement as a cost. Based on the charge to cost ratio the PPS Hospital bad*

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<sup>20</sup> 2010 NHHA Audited Financial Statements

<sup>21</sup> HFMA, Model Charity Care Policy for Non-Profits

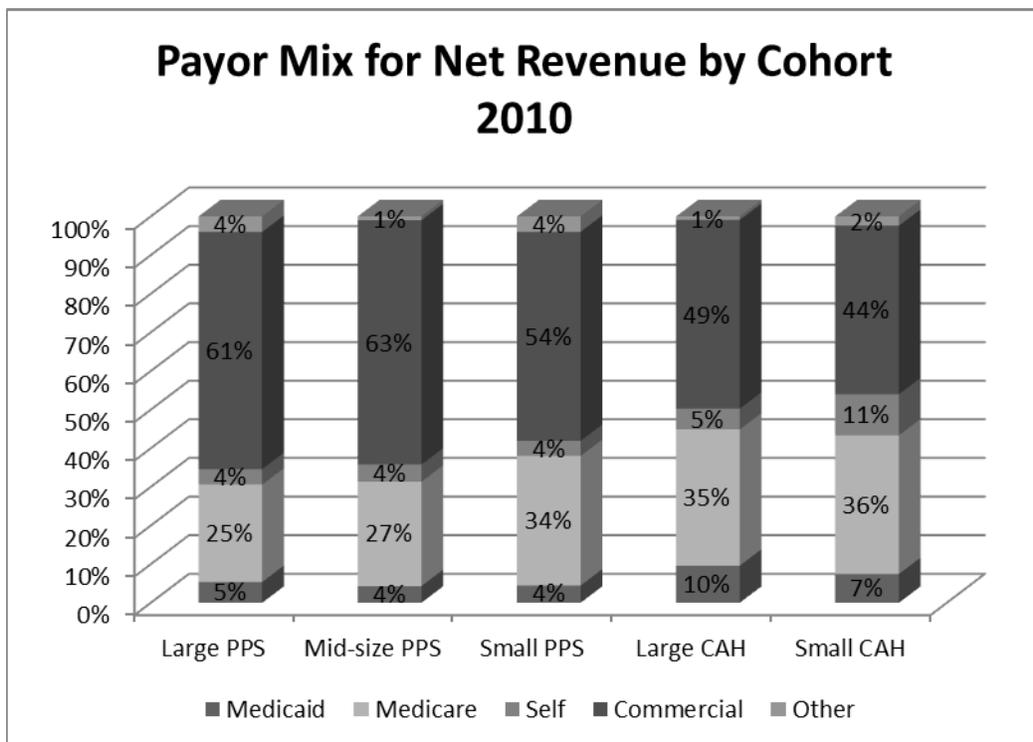
<sup>22</sup> 2010 Audited Financial Statements

debt is \$129.6 million which was 2.8% of net patient service revenue and 2.7% of total operating costs.

A growing problem facing hospitals is that more and more patients have high deductible insurance plans. Although the patient has insurance, he will have a large balance due because his/her insurance covers a smaller portion of the bill. Each CFO interviewed cited this as a growing problem. The evidence of this is shown between 2009 and 2010 when bad debt costs increased 6.6%

### **Payer Mix**

To understand how hospitals cover costs it is important to look at payer mix or the percent of each payer class that makes up the total revenue received. The following chart shows the payor mix for each hospital cohort. The data show the larger the hospital the greater the amount from commercial insurance, while the smaller the hospital the greater reliance on government payments.



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<sup>23</sup> Audited financial statement as aggregated by NHA 2010

## Competition and Collaboration

*There has are varying degrees of competition in the health care field and with hospitals in particular. Because of the unique nature of the hospital industry, hospitals have not traditionally competed based on price. Instead hospitals engage in activities designed to attract the most patients covered by good insurance. These are usually relatively young families who are covered by good insurance plans. Because of these circumstances, hospitals do not realize cost reduction that would typically result from price based competition. Since competition is non-price based and is geared to attracting patients, the effect is that competitive actions may actually increase hospital costs.*

### **Inter-Hospital Competition**

*Hospitals in the same service area have competed against each other for many years. Each facility attempts to increase its volume in its service area and broaden its geographic draw by improving its physical plant, providing more amenities and offering the services that will attract patients with good insurance.*

*The competitive environment each hospital faces can be defined by three categories, identified as follows.<sup>24</sup>*

- *In a bubble: Some NH hospitals are very fortunate because, as a result of the location, history with their community and/or the strength and relationship with its medical staff, it faces very little competition. These hospitals include many CAHs but also a number of PPS facilities. The hallmark of a “bubble” hospital is the large market share of the primary service area.*
- *On the field: Some hospitals face a competitive environment where there are similar sized hospitals competing for patients that can travel to any of the facilities. An example of “the field” is the Seacoast area where there are four hospitals geographically distributed throughout the region, but the region is compact enough to enable patients to select any of the hospitals. The field can*

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<sup>24</sup> These were developed as a result of interviews with CFO and their descriptions of the level of competition they face.

also be found in hospitals where there is competition for some towns that are equally distant from two or more hospitals.

- At the Vortex: There is one area of the state that can be defined as the vortex of competition; the Manchester area. There are two hospitals in this area that are fiercely competitive. The CFOs of these two hospitals report each hospital has or is affiliated with a medical staff that rarely admits to the other hospitals. These systems constantly compete for patients.

Hospital competition takes a number of forms and all have the potential of adding to hospital costs. Probably the most obvious of these is advertising. The two Manchester hospitals tend to use media outlets other than print to advertise their services. The number of TV and radio commercials residents experience makes hospital advertising seem ubiquitous. A review of Medicare Cost Reports Worksheet A was undertaken and costs associated with advertising and marketing are not considered allowable costs, but they should be listed on the worksheet under non-reimbursable costs.<sup>25</sup> One of the two Manchester hospitals showed expenses for marketing over \$3 million which is less than 1% of their total operating costs. The other Manchester Hospital reports marketing as a part of administrative and general expense. The author was told the cost of marketing at this hospital is \$1.5 million; also well under 1% of total costs.

Beyond advertising, hospitals employ a wide variety of techniques for expanding their patient base. One common method is the deployment of primary care providers in a community that borders a hospital's service area. The purpose is to attract patients and secure the referrals for laboratory, radiology, surgery, obstetrics and other hospital based services. If two hospitals are attempting to secure the referrals from the same community, they may both set up primary care offices in the town. The population of a town may not be able to support two or more primary care providers and the result is increased costs to both hospitals as they underwrite the practice in the outlying community.

An example of deploying physicians as a competitive move is the development of a large multi-specialty clinic in a downtown area and another facility in nearby affluent

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<sup>25</sup> Non-reimbursable costs are critically important to CAH because these expenses are excluded from the cost based reimbursement. For PPS hospitals this designation is less meaningful.

community. Although many of the physicians now housed in these facilities were originally on or near the hospital's campus the hospital recruited new specialist to replace physicians that change their admitting patterns to another hospital. This action does have the potential to create an oversupply of specialty physicians and thereby increasing costs in the service area.

Another impact of competition among hospitals is an "arms race" for technology. This was seen with CT scanning in the 1980s, MRI in the 1990s and robotic surgery in the 2000s. There have been a number of studies over the past 20 years demonstrating an over utilization of diagnostic medical equipment when it is readily available.<sup>26</sup> This is due to patients demanding to go to the hospital with the latest technology. There are cost implication of an oversupply of medical equipment, as the over use of high tech diagnostic equipment results in unnecessary payments for the service. Also equipment operating at less than optimum capacity can lead to under-utilized personnel because the equipment is not routinely in service,

Many health economists argue that competition has resulted in overbuilding of facilities.<sup>27</sup> Between 2007 and 2011 NH's hospitals spent \$672 million in building projects. The hospitals argued this construction was necessary for improved patient care, updated surgical suites and enhanced clinical space. A part of this construction was undertaken to make the hospital more appealing. Considerable expense is directed at luxurious lobbies, amenities and non-patient care areas that are designed to attract patients. The implications of these capital expenditures will be covered in greater detail in the section on Capital Costs and CON.

The idea of increased, but possibly unnecessary, amenity driven hospital construction to attract high paying consumers has been substantiated by Professor Robert Woodward of UNH. According to Woodward the cost curve of health care is a

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<sup>26</sup> The following are three articles on the overuse of MRI

<http://www.nytimes.com/2011/10/29/health/mris-often-overused-often-mislead-doctors-warn.html?pagewanted=all> or his specialty this market

<http://www.kevinmd.com/blog/2010/06/mri-abuse-dangerous-expensive-patients.html>,

<http://careandcost.com/2011/02/05/over-testing-over-utilization-unintended-consequences-and-associated-costs/>

<sup>27</sup> During the interview with Robert Woodward, Professor of Health Economics, UNH he stressed that NH hospitals have been building with increased emphasis on non-patient care amenities.

remarkably straight upward line. Woodward hypothesizes that it is the introduction of new technology, the increase in non-medical amenities and an increase in “hope” through medicine that drives cost up. About the amenities in health care he states:

*We define consumption components to include both obvious and far-from-obvious aspects of health care. First, as one compares health care in the USA in the 1950s with health care in the 21st century, some changes are obviously amenities. These are exemplified by the switch from wards to elaborate ‘five-star’ facilities that hospitals increasingly offer to attract well-insured patients. Second and less obvious, are the diagnostic procedures that provide information that may increase utility because of reduced uncertainty but are nevertheless unrelated to health outcomes. Sonograms, for example, are greatly appreciated by most families despite the fact that Ewigman and the RADIUS Study group (1993) argued that they have no measurable impact on either the mother’s or the baby’s health when the pregnancy is routine.<sup>28</sup>*

## **Collaboration**

*Hospitals engage in collaboration as a way to reduce costs. Over the past several decades there have been a number of collaborative efforts that were aimed at reducing overall costs. These initiatives have ranged from sharing equipment to full mergers. Some have been successful and others not.*

*Examples of some of successful collaborations are:*

- *The Nashua Regional Cancer Center is a not for profit corporation established to deliver health care and other services, including radiation oncology. The program is a consortium of three acute care hospitals, SNHMC, St. Joseph and MHMH.*
- *Physicians from CMC’s New England Heart Institute operate practices at Huggins Hospital and Parkland Medical Center.*
- *The radiation therapy program at Concord Hospital operated by The Elliot Hospital, thereby eliminating the need for duplication many costs,*
- *The sharing of administrative functions among the three hospitals in Coos County,*

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<sup>28</sup> Robert S. Woodward and Le Wang, “The Oh-So Straight and Narrow Path: Can the Health Care Expenditure Curve be Bent” [Health Economics](#), 2011 DOI:10/1002/hec.

- *The group purchasing affiliation that was established by the former Dartmouth Hitchcock Alliance*
- *Sharing of specialist between PPS hospitals and CAH hospitals. For example some specialists from Cheshire Hospital have office hours and admit to Monadnock Community Hospital,*
- *The use of mobile technologies for MRI, PET scanning and lithotripsy allow the technology to be available at all hospitals but spreads the fixed costs of these services,*
- *The newly established Granite Health Network, an affiliation of five PPS hospitals that is currently managing the self-insurance health plans for the hospitals' employees, but has the potential of further collaborations.*

### **Competition with Non Hospital Providers**

*A growing trend in NH is that hospitals compete against non-hospital providers, often referred to as “niche” providers. These entities offer a limited array of services to a narrow slice of the population. Privately owned ambulatory surgery centers, diagnostic radiology centers and laboratories offer services to persons with insurance. These facilities generally do not treat Medicare or Medicaid or uninsured patients. A hallmark of these facilities is that they are set up to provide routine services that are profitable.*

*During the interviews with the hospital CFOs the author was told repeatedly that there are essentially three services; ambulatory surgery, radiology and laboratory that are profitable because they are routine and bring patients covered by commercial insurance. These services, while used by all patients, are frequently used by younger patients covered by commercial insurance. The favorable payer mix for ambulatory surgery, laboratory and diagnostic radiology enable the hospital to offset losses from other services and other payers.*

*Private entrepreneurs, with a few exceptions, restrict their presence in the health care arena to these three highly profitable services. With the exception of a few birthing centers that offer alternative models, there are no large scale birth centers because they*

are not profitable. Another example is that niche providers do not offer cardiac treatment because the patient base is older and not covered by commercial insurance.

Competition between hospitals and niche providers takes place on a non-level playing field. Niche providers can provide selective services at a price much lower than hospitals. This is partly due to the greater efficiencies than hospitals but is also because hospitals are required to treat all patients regardless of insurance coverage and the scope and complexity of the services needed.

Hospitals face higher expenses because, they are open 24 hours a day, seven days a week and must be able to carry out many functions beyond routine surgery, radiological testing and basic lab tests. Hospitals must care for inpatients, including some of whom are critically ill and require the level of care only available in an ICU. Hospitals must be able to respond to immediate needs of our communities from one person's cardiac arrest to a school bus roll-over. Hospitals must have highly trained staff available to operate specialized technical equipment around the clock. These facilities cannot staff and equip the facility for only the relatively routine surgery performed at most ASCs.

Niche providers often "cherry pick" the best patients. Prices are lower when patients are well insured and relatively healthy and the facility can be staffed to provide a limited number of services eight hours a day.

Another observation about the niche providers is that they appear in areas where the population is relatively affluent and young. ASC and diagnostic facilities dot southern NH but are not available north of Concord.

Some hospitals have reduced the impact of external competition by forming joint ventures with the owners of these facilities. This enables the hospital to secure some of the revenue from the facility rather than losing all of it.

### **Competition Driven by Insurers**

A new insurance benefit referred to as "Site of Service", is forcing competition between hospitals and niche providers. This insurance benefit design applies to all of Anthem's small group products and encourages members to use the lowest cost provider of a service by varying the individual's co-pay if a low-cost provider is used for

*ambulatory surgery and laboratory. From the member's perspective this type of plan offers a "carrot" to participate in the program making it very appealing.*

*The CFOs voiced a number of concerns about the Site of Service benefit design. They clarified that due to the requirements and expectations on hospitals; they cannot compete against niche providers that only provide profitable services to well-insured patients.*

*The concerns of the CFOs go beyond just the obvious loss of patients with this type of insurance. At least four CFO explained that they have no control over where the physicians located at their hospitals perform surgery, even when they employ these physicians. If a patient requests surgery at an ASC, because his co-pay will be less, the physician can comply. However, the surgeon is unlikely to want to travel back to the hospital for other surgeries that day. To accommodate his schedule the surgeon will treat all the privately insured patients at the ASC on the same day for his convenience. This means the less profitable and often more complex surgeries on Medicare and Medicaid patients will be done at the hospitals.*

*Laboratory is another area where members can reduce their copay if they use a lower cost alternative. Private laboratories use draw stations, which send the samples to their headquarters out of state for processing. The turn-around time can be similar to the hospital. However, these labs cannot fulfill STAT orders, nor can they do tests on tissue removed during surgery. For these reasons hospitals must keep their laboratories open with lower overall volume to spread across fixed costs. The need still exist to get the lab results to providers quickly, increasing the demand for implementing secure data sharing systems with these external organizations, increasing the cost to the hospital.*

*The Site of Service benefit design affects all hospitals including the rural CAHs. Some North Country patients may choose ASCs in Southern NH. Large national laboratory facilities may be opening blood draw stations in small communities to collect specimens and send these to the headquarters for processing. Once again removing standard lab work from the hospitals could have a significant impact on the bottom line.*

## *PART II*

### *Internal Factors*

## Personnel Costs

Hospitals are very labor intensive and personnel costs make up 47% of the total costs in NH’s hospitals systems, exclusive of physician salaries. In 2010, \$2.128 billion was paid in salaries and benefits to NH hospital employees. The following chart<sup>29</sup> shows the personnel costs, exclusive of physician salaries.

Cluster	Wages & Benefits	Full Time Employees	Part Time Employees	Average Salary & Benefits FT&PT
Large PPS (4)	\$1,103,507,523	13,454	4,724	\$60,705.66
Mid-Size PPS (4)	\$463,344,457	4,292	3,861	\$56,831.16
Small PPS (4)	\$283,057,200	2,835	1,803	\$61,030.01
Large CAH (6)	\$161,054,994	2,134	1,282	\$47,147.25
Small CAH (7)	\$116,698,057	1,477	1,077	\$45,692.27
Total	\$2,127,662,231	24,192	12,747	\$57,599.35

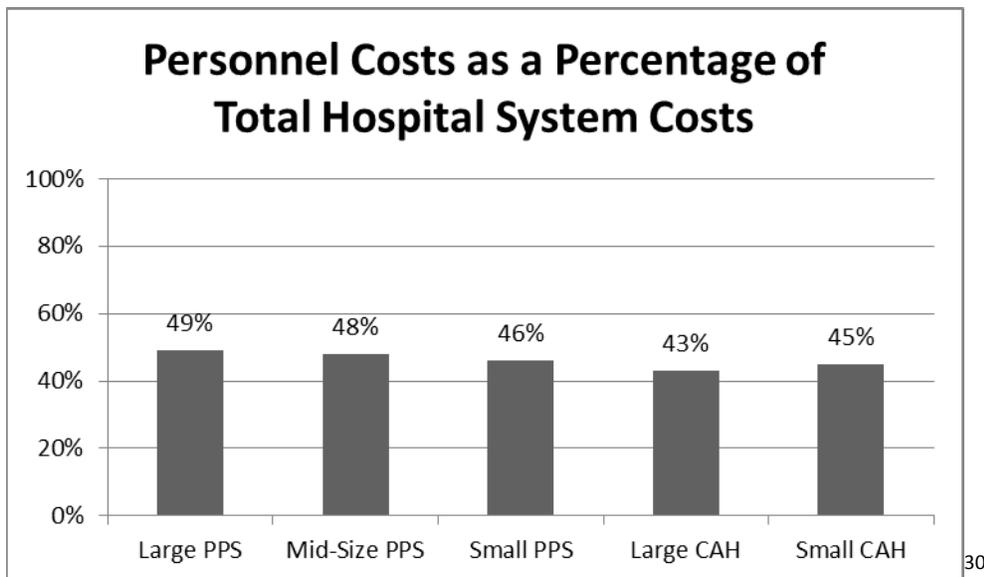
Hospitals employees range from unskilled workers, such as housekeepers, to technical professional personnel such as radiation physicists and pharmacists. However the majority of the hospital personnel are well-educated and skilled. This is reflected in the relatively high salaries, especially given that fully one third of all hospital employees are part time and the salaries and benefits represent both full-time and part-time employees.

Registered nurses are the largest class of employees at hospitals. The following chart shows the mean hourly salary for nurses by labor area from the NH Department of Employment Security.

<sup>29</sup> Data are from the 2010 Audited Financial Statements as provided by NHA

	2008	2009	2010	2011
Lebanon/Hanover	\$32.39	\$32.70	\$33.01	\$34.22
Manchester	\$31.16	\$31.70	\$31.88	\$32.64
Nashua/Derry	\$29.83	\$29.72	\$29.97	\$31.96
State	\$29.26	\$29.36	\$30.21	\$30.99
Exeter/Seabrook	\$27.04	\$28.15	\$31.87	\$30.84
Concord	\$28.42	\$28.78	\$29.71	\$30.75
Portsmouth	\$30.14	\$30.32	\$29.91	\$30.64
Laconia	\$26.66	\$27.16	\$28.66	\$30.49
Keene	\$26.24	\$27.61	\$28.17	\$30.02
Plymouth	\$31.85	\$29.94	\$29.42	\$29.14
Peterborough	\$26.89	\$27.48	\$27.65	\$28.41
North Country	\$25.93	\$25.20	\$25.92	\$27.14
Claremont	\$26.10	\$29.40	\$30.02	\$27.00
Rochester/Dover	\$27.00	\$27.01	\$26.90	\$26.01
Conway	\$26.99	\$27.21	\$28.01	\$25.82

*There are virtually no economies of scale for personnel in hospitals. The following graph shows personnel costs as a percent of overall hospital costs. What is interesting is that this is very consistent across all the clusters. The percentage of personnel costs actually increases by a percentage point or two as the size of the hospital increases.*



<sup>30</sup> Audited financial statements as provided by NHHA

*In addition to the nature of the employees and the competitive environment for scarce skilled labor, there are other factors that cause personnel costs to be high. Many CFOs discussed the costs of maintaining “on-call” teams for technology and surgery that may or may not be used on any given night or weekend. As Peter Walcek of Wentworth-Douglass stated, “You don’t want the ‘B team’ on call. If we need to respond to an emergency with technology, we want our best on call.” To ensure competent and skilled staff are available around the clock, hospitals must pay on-call fees so personnel are always available and ready to work if the need arises.*

*Another issue raised by CFOs is the costs of staffing for demand. Most hospitals use flexible staffing programs so that the number of nurses and other patient care personnel working on any given day matches the number of patients they have to care for. The effect of this is that on some days personnel are paid a portion of their salary not to come to work while on busy days part-time or per diem personnel are called in to work.*

*Hospitals do utilize a number of techniques to restrain personnel costs such as the use of part-time personnel. Part-time employees make up 35% of all hospital workers. At some mid-size PPS hospitals this is much higher, for example 65% of the employees at Exeter Hospital and 50% at Wentworth-Douglass Hospital are part-time.<sup>31</sup> The use of part-time personnel may result in both cost savings and flexible staffing.*

*John Marzinik, CFO of Frisbie Memorial Hospital (FMH) explained that the hospital was able to save considerable money by using an employee leasing company. Frisbie leases its housekeeping, plant operations, transportation and switchboard. The benefit of this arrangement is that the costs of health care insurance and worker’s compensation insurance are under the contract. FMH has been able to reduce benefits costs by using a large national firm. The result is that personnel costs at Frisbie are only 37% of their total costs compared to the statewide average of 51%. Contract costs are higher at Frisbie but there is a net savings.*

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<sup>31</sup> 2010 Audited financial statements as provided by NHHHA

## *Capital Expense<sup>32</sup> and Certificate of Need*

*Infrastructure, new equipment and improved physical plants all make up hospital's capital expense. Capital expenditures can be made either through borrowing, the use of hospital funds, or philanthropic gifts, but what distinguishes these expenses from operating expenses is that the amount spent is depreciated over the "useful life" of the asset. It is critical that hospitals upgrade their physical plants, buy new and replacement equipment, and ensure there is sufficient clinical and other space for patients, staff and visitors. It is also true that capital expenditures are expensive and are a major factor in the increased costs at hospitals. Each year hospitals must pay back large sums to pay down the principal and pay the interest due on borrowing undertaken for capital expenditures.*

*Based on the 2010 audited financial statements the capital assets of NH's hospital, including property, plant and equipment minus accumulated depreciation totaled over \$2 billion. These assets were supported by over \$1.5 billion in debt exclusive of the amount spent during that year.<sup>33</sup>*

*The following chart shows the aggregated property, plant and equipment (PPE) minus accumulated depreciation.<sup>34</sup> There are several hospitals excluded from this analysis and the reasons for these exclusions are included footnotes.*

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<sup>32</sup> The examination of capital will focus on the hospital systems because it is much more representative of what is spent for capital, as some system have separate corporations that just hold the real estate assets.

<sup>33</sup> Hospital balance sheets as aggregated by NHA.

<sup>34</sup> Ibid

	PPE – Accumulated Depreciation	Long Term Debt - Current Portion
Large PPS (4)	\$ 892,023,000	\$ 787,881,000
Mid-size PPS (3) <sup>35</sup>	\$ 285,373,000	\$ 181,725,000
Small PPS (3) <sup>36</sup>	\$ 333,398,000	\$ 288,093,000
Large CAH (6)	\$ 223,240,000	\$ 144,236,000
Small CAH (6) <sup>37 38</sup>	\$ 145,418,000	\$ 93,639,000
TOTAL	\$ 1,879,452,000	\$ 1,495,574,000

To understanding better what this capital means to the overall health care system, the data on the long-term debt has been analyzed using two ratios. The first is the “debt to equity” ratio which measures how much debt each hospital has for each dollar of equity (total assets minus total liabilities). This ratio is an indication of whether the hospital can support the level of debt it is carrying, the higher the value of the equity the better the ratio. The second ratio is the “debt service coverage” ratio. This ratio looks at the ability of the hospital to repay the current portion of its long term debt through its income and is a measure of how many times greater the income is than the debt. The ratio divides the principal and interest payment into the total of the hospitals net operating revenue, interest, depreciation and amortization. Once again the higher value indicates a stronger value. The following shows these two ratios.

	Debt to Equity			Debt-Service Coverage		
	Low	High	Average	Low	High	Average
Large PPS (4)	2.17	3.84	2.70	3.14	6.72	4.62
Mid-size PPS (3)	1.20	2.97	2.01	6.15	4.56	5.29
Small PPS (3)	2.38	8.86	4.90	1.83	4.01	2.83
Large CAH (6)	2.01	5.30	3.35	0.68	40.10	8.57
Small CAH (6)	1.13	6.55	4.00	0.42	18.25	5.42

<sup>35</sup> Wentworth Douglass Hospital was excluded because it refinanced its debt at the beginning of the FY 11 and the repayment of full outstanding debt and the lack of debt at the end of the fiscal year distorted the data. This hospital added \$87 million in total debt with an offset of \$144 million in PPE minus accumulated depreciation.

<sup>36</sup> Parkland Medical Center and Portsmouth Regional Hospital, the state’s two for-profit hospitals are excluded from this analysis because all borrowing is through the parent corporation and the cost of capital is not reflected on the individual hospitals balance sheet.

<sup>37</sup> The borrowing for Franklin Regional Hospital is with Lakes Region General Hospital.

Alice Peck Day had a high LTD, but this was used to build a retirement community. This has been included because the proceeds from the lease of these apartments will be leveraged to pay for a renovation of the hospitals physical plant.

Overall NH's hospitals can handle the debt they have incurred. There are a few hospitals with ratios below 2 but these institutions were able to borrow funds despite these less than optimum ratios

In terms of hospital costs, it is important to look at what these capital expenses translate into for annual debt service as that is the amount the hospital must pay each year. The following chart shows the annual debt service in terms of current portion of long-term debt and annual interest.<sup>39</sup>

	Current Portion of LTD	Annual Interest
Large PPS (4)	\$ 20,364,463	\$ 25,758,000
Mid-size PPS (3)	\$ 3,653,996	\$ 7,160,000
Small PPS (3)	\$ 5,702,408	\$ 9,635,000
Large CAH (6)	\$ 7,684,016	\$ 4,631,000
Small CAH (6)	\$ 13,095,470	\$ 3,175,000
TOTAL	\$ 50,500,353	\$ 50,359,000

This chart indicates that among the 22 hospitals analyzed over \$100 million is paid annually for capital.

A large amount of capital has been used to upgrade aging physical plants including replacing antiquated heating, ventilation and air conditioning (HVAC) systems. New space has been built to make hospitals more consistent with the way care is provided, including reorienting physical plants to improve accessibility to outpatient space. Hospitals have invested capital to upgrade the inpatient facilities, in some cases converting to private rooms to reduce infections and be more compliant with the Health Insurance Portability and Accountability ACT (HIPAA).

Although much of the space built by hospitals is warranted, there have been a parts of many capital projects which cannot be justified for patient care reasons. A tour of NH hospitals reveals that many have built elaborate lobbies with hotel grade amenities. Other facilities have invested in large outpatient/medical office buildings that are designed to attract new patients and often from other facilities.

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<sup>39</sup> 2010 Financial Statements as aggregated by NHHA

*Capital expense also covers the purchase of equipment. Technology is constantly changing and hospitals are under pressure from physicians and patients to upgrade equipment. Much of the radiology equipment is now digital and clinicians argue that the hospital must upgrade machines to meet the standards of quality. Robotic surgery has become a major innovation in medical care and hospital managers are increasingly under pressure to acquire this equipment.*

*Hospitals need strong medical staffs to serve patients. Attracting physicians is often the function of an “arms race” with the technology. Several CFOs said their physicians want the level of technology they trained with and often will demand this as a condition of practicing at a given hospital. A surgeon who has trained using robotics will require a hospital to obtain robotic surgery equipment, even if use is infrequent and few other surgeons know how to use this equipment.*

*The cost of physical assets and the projected future expenses can be assessed through the “Average Age of Plant” ratio. By comparing accumulated depreciation to annual depreciation expense, the age of plant can be ascertained. This shows how modern the plant and equipment are and helps to determine if more investment in hospitals’ plant and equipment will be necessary. In NH the physical plants are all relatively new. The average age of plant among large PPS, mid-size PPS, and all CAH hospitals is around 8 years. For small PPS the average age is 10 years.*

*Several joint ventures have been undertaken as a means of reducing capital costs. Chief among these has been the use of mobile technology. Trucks with MRI units travel throughout the state, parking at hospitals for a day or more, offer the service. While most large hospitals have their own MRI units today, most small hospitals still utilize the mobile system and a few larger facilities use mobile units to supplement their fixed units. The use of mobile technology is also used for PET scanning, a technology used in cancer staging, and lithotripsy, a therapeutic tool used to breakdown kidney stones. The mobile process allows access throughout the state to those patients who need a very refined technology that normally would only exist in university based medical centers. This system of delivery allows access to all residents of the state without the increased capital expenditures.*

## **Certificate of Need**

*The capital expenditures for construction projects and equipment have been approved by the state through the Certificate of Need Program (CON). CON is a regulatory process for approving all new hospital or nursing home beds, capital expenditures over a threshold<sup>40</sup> and diagnostic or therapeutic equipment costing over \$400,000. This program has existed in NH since 1979. A state CON process was originally mandated by the federal government as a means of regulating the cost of capital to the Medicare program. At that time Medicare paid hospitals a rate based on overall costs including depreciation and interest.*

*In the early 1980s the federal government eliminated the mandate that states have a CON program. This coincided with the introduction of DRG based payment structure which eliminated the capital payment pass-through by Medicare. The option to maintain a CON program fell to the states and NH, like many other states, chose to continue this program as a means of controlling the cost of capital expenditures.*

*NH's CON program was transformed in 1985<sup>41</sup>, and the model remains the same. The program in NH is unique among CON programs because the responsibility for growing the health care delivery system lies with Health Services Planning and Review Board (the Board). The Board has the authority to study the need for new services and, only if a need is determined, can CON applications be submitted. For all services under the prevue of CON, the HSPRB establishes subcommittees which study the service and write rules that identify the utilization thresholds that determine when there is need for additional services. This has led to some significant savings for the state, much of which cannot be measured, because it is what was not spent, built or added to the health care system. For example, since 1996 NH has only four open-heart surgery programs when the Board determined there was no need for additional programs. Savings have also occurred in the area of radiation therapy as the state can determine when there is need for new services. Trends suggest that without the CON*

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<sup>40</sup> The current threshold for acute care constructions projects is \$2.780 million. This is adjusted annually based on an inflation factor.

<sup>41</sup> The author of this report was the Assistant Director of Public Health for Health Services Planning and Review and responsible for the CON program when the 1985 law was passed. Since leaving state service she has been involved in the CON program, served on a variety of subcommittees and has written and carried through to conclusion many CON applications. The factual information provided here is based on her expertise.

*program there would be at least two to three more cardiac surgery programs and several unneeded radiation therapy services.*

*A “request for applications” (RFA) is issued when the Board determines there is a need for additional services and a competitive bidding process follows. An example of this is radiation therapy on the Seacoast. In 2002, the Board determined a need existed for a radiation therapy program in the Seacoast. Two entities filed applications to fill this need and the Board determined that one applicant best met the need. The underpinning of this system is that once a need is identified and an RFA issued, a CON is expected to be granted to fill this need.*

*This system works very well when dealing with a specific program for which the need can be easily quantified. For example “there should be 12 physical rehabilitation beds for every 100,000 residents of a region” or “a hospital should be doing 1,000 scans on a mobile MRI before applying for a new unit”. However the system breaks down when there can be no quantifiable measure of need. Such is the case with acute care hospital capital expenditures.*

*The HSPR Board does not have a mechanism for measuring the need for a hospital capital project. Once a year the Board issues an RFA permitting any acute care hospital that wishes to submit an application. It was originally thought that this method would allow HSPRB to collectively consider the expense of any project the impact to the overall system. A mechanism exists, to sever acute care application so that they do not have to be reviewed at together. Hospitals generally argue that their projects are upgrades to their physical plant and do not have any impact on other hospitals in the state. The HSPB has virtually always granted requests for severance, eliminating the review of the over systemic impact of many expensive projects.*

*The CON process has two major problems when it comes to evaluating the need for hospital capital expenditures. First, each project is reviewed independently with no perspective into the impact on the system. Most hospital projects start with a need, such as upgrading the HVAC system or creating space for more modern surgical suite. Unnecessary additions may be included with the application. As a result hospitals can always demonstrate the importance of the project based on need. Each applicant can stand before the Board and demonstrate why this project is necessary to making the*

*hospital operate more efficiently and effectively. Since there is rarely any opposition to any of these projects the Board has little recourse but to accept the hospital's position.*

*The legislation was written to allow for the approval of any application that meets a need determined by the Board through the issuance of an RFA making denying any application difficult. There are criteria the Board must adhere to in making its decision however these criteria are skewed toward the applicant. For example, all acute care hospitals must run a series of financial ratios for the past three years, the period of construction and three years into the future. Since most hospitals in NH are in a strong financial position so they can demonstrate financial feasibility of the proposed project through these ratios. If this is accomplished the Board has no alternative but to approve the application.*

*The HSPRB has established a number of precedents that further pave the way for approval projects that may not be in the best interest of the state as a whole. For example, Board has determined that equipment projects involving a lease are not subject to CON. This was done despite wording in the law that states,*

*The board shall develop standards for new institutional health services. These include the following:...the purchase, lease, donation or other comparable arrangement by or on behalf of a health care provider of diagnostic or therapeutic equipment for which the cost, or in the case of donation, value is in excess of \$400,000. <sup>42</sup>*

*Another example is that the Board has ruled that robotic surgery is merely an extension of basic surgery, clearing the way for hospitals to acquire this technology without review and oversight.*

*The CON program is an artifact of the old fee-for-service health care system and is antiquated in the way it operates today. In 2010 a legislative committee was established to examine the CON process and a report with a modified CON plan was developed. This plan was disregarded when the legislature majority shifted in 2011.*

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<sup>42</sup> RSA 151-C:5 II(d)

## *Hospital Ownership of Physician Practices*

*One of the recent changes in the organization of hospitals is the migration of physicians from private entrepreneurs to employees of hospitals. Thirty years ago hospitals only employed what was called “hospital based physicians”, primarily, radiologists, pathologists and anesthesiologists. These specialists moved away from hospital employment into private practices, billing separately for the reading of the radiology exams, laboratory tests and providing anesthesiology.*

*While some specialties traditionally employed by hospitals were setting up private practices, primary care physicians, who had traditionally owned their own practices, became employees of hospitals. In NH all hospitals, except Cheshire Medical Center, employ primary care physicians. Cheshire has a unique affiliation with Dartmouth Hitchcock-Keene (DHK) that obviates the need for the hospital to own and operate the physician practices. Among CAHs, all operate primary care practices but at Cottage Hospital in Woodsville most of the PCPs are employed by a Federally Qualified Health Center (FQHC) and Rural Health Clinic, eliminating the need for the hospital to employ the physicians directly. The number and types of physicians employed by NH hospitals is detailed in the Inventory in Part III.*

*In virtually every interview with CFOs, the topic of the employment of physicians was paramount. CFOs are aware that the ownership of physician practices has benefits for both the hospitals and the providers, but this trend has significant financial implications for the hospitals.*

*From the primary care providers’ point of view, becoming employed is the only way to practice economically. Running a private practice is expensive as it includes the employment of nurses, office personnel, coders, and insurance liaisons. The income the physicians are able to make from their service is not sufficient to cover these personnel costs in addition to rent, malpractice insurance and other operating costs. In some cases to make their practices economically viable, physicians needed to create new revenue streams by having in-office labs and diagnostic equipment which put them in competitive with the hospitals. Operating these services was expensive and physicians*

*had to be constantly aware of the regulations relating to self-referral to entities owned by physicians.*

*When employed by a hospital, physicians do not have to worry about the salaries of office staff, the cost of equipment or malpractice insurance. Some primary care physicians are even able to get assistance with paying student loans as a part of their employment agreement. The CFOs explained that joining the hospital gives the physicians the opportunity to set their work hours, as doctors employed by hospitals have limited on-call schedules and generally work an eight hour day. Hospitals also provide hospitalists and intensivists that follow all inpatients, freeing PCPs from this responsibility.*

*From the hospitals' perspective the employment of physicians has its economic benefit as well as its costs. The CFOs were clear that not employing primary care physicians is not an option. Michael Rose, CFO of Southern NH Medical Center told the author that if his Nashua hospital did not employ primary care providers there would be no primary care in his city. He claims primary care doctors simply will not locate in any community where they do not receive the financial incentives and fixed work week that comes with hospital employment. With a growing shortage of primary care providers, physicians are able to demand more and more incentives from hospitals.*

*Employing physicians guarantees a dedicated and loyal base for referrals of hospital services and to the specialists affiliated with the hospitals. Although Medicare self-referral laws prohibit hospitals from requiring physicians to refer to hospital owned entities, the proximity of the physicians to the hospital and the formal relationship does encourage referrals. Employing physicians reduces the number of laboratory and diagnostic services offered in physicians' offices, and return this business to the hospital.*

*As other physicians see the benefits accrue to primary care providers, specialists are seeking similar arrangements. In the Inventory in Part III it is evident there are a wide variety of specialty physicians employed by all hospitals. For specialty physicians the reasons for the employment arrangements are similar to PCPs. Comparing across hospitals in the Inventory, there is no consistency as to which specialists are employed*

and which maintain private practice. For example, in some communities orthopedists are employed, yet in others they operate large independent group practices.

Although it is difficult to determine with specificity the amount that hospitals recouped as a result of employing these physicians, it is estimated that the downstream benefit from each physician at the hospital is approximately \$1 million to \$2 million per year.<sup>43</sup>

Physician practices do lose the hospitals money. The following chart shows the revenue, expense and loss by hospital cohort<sup>44</sup>. The total number of providers in the chart includes all physicians, surgeons and mid-level providers employed by hospitals.

	Prov.	Revenue	Expense	Loss	Margin
Large PPS (3)	513	\$ 127,987,824	\$ 154,099,044	\$ (26,111,220)	-20.4%
Mid-size PPS (3)	409	\$ 157,442,454	\$ 201,703,486	\$ (44,261,032)	-28.1%
Small PPS (5)	334	\$ 92,136,170	\$ 139,327,735	\$ (47,191,565)	-51.2%
Large CAH (6)	180	\$ 49,835,260	\$ 67,320,320	\$ (17,485,060)	-35.1%
Small CAH (4)	115	\$ 31,562,865	\$ 32,077,116	\$ (514,251)	-1.6%
Total	1,551	\$ 458,964,573	\$ 594,527,701	\$ (135,563,128)	-29.5%

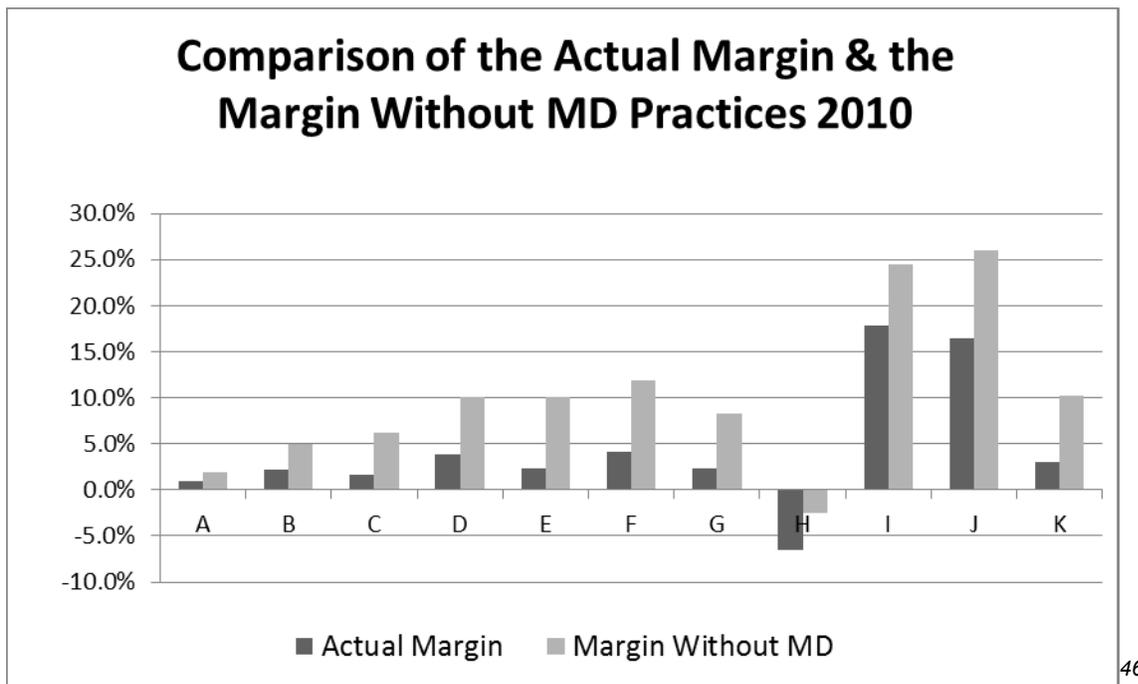
NH hospitals are losing \$136 million annually on the practices they own. The CFOs report this is largely the result of insurance payments for office visits that are below the cost of maintaining physician practices. Another cause cited by CFOs is that physicians who are employed do so because they do not wish to work the long hours that physicians traditionally worked when they were in private practice. Some hospitals are beginning to implement productivity based contracts with employed physicians as a means of ameliorating this problem.

The degree to which hospitals subsidize practices is seen in the following chart. This graph shows the eleven NH PPS hospitals that employ physicians. The current

<sup>43</sup> Mark D. Halley, The Economics of Physician-Hospital Relationships, HFMA, November 2011

<sup>44</sup> Excluded from this analysis is Mary Hitchcock Memorial Hospital because of its unique relationship with Dartmouth Hitchcock which is a sister corporation in Dartmouth Hitchcock Medical Center and Cheshire Medical Center which has an affiliation with DHK. Also excluded is Upper Connecticut Valley Hospital and Weeks Memorial Hospital which show no physician practices on the audited financial statements provided by the NHHA.

hospital margin is shown next to the margin that would have occurred if the revenue and expense were constant but the hospital did not own and operate physician practices. This was estimated by looking at the margin without the costs and revenue resulting from the practices.<sup>45</sup>



### In Locum Tenens

When a hospital loses a vital specialist or primary care provider it must find a way to recruit one to serve the community. As there are generally very few providers in rural communities, CAHs find that the loss of a physician can mean the community does not have access to a vital physician such as a radiologist, surgeon or obstetrician. The time it takes to recruit these doctors can be very long and hospitals must find a way to provide the services in the interim. To do this hospitals hire temporary physicians (locum tenens) to fill-in during the recruitment process. This can be very expensive. Clare Bowen, the Chief Executive Officer (CEO) and CFO of Valley Regional Hospital told the author that during 2011 they spent over \$600,000 on in locum tenens

<sup>45</sup> Audited financial statements as provided by NHHA

<sup>46</sup> Hospital audited financial statement as provided by NHHA, the margins are for the hospital systems

physicians. According to the CFO's the use of in locum tenants is most common in emergency room doctors and obstetrics and gynecology.

### **Hospitalists and Intensivists**

Another growing trend among hospitals is the employment of a relatively new specialty, hospitalists. Hospitalists specialize in the care and treatment of inpatients. Primary care providers, who admit a patient to the hospital, sign their patients over to the hospitalist to manage the patients care during their inpatient stay. Similarly, in most hospitals there are intensivists who cover the care in the intensive care unit. According to the CFOs, these intensivists are generally pulmonologists, often serving both as the community's pulmonology physicians and as the hospital's intensivists.

In most PPS hospitals and some of the busier CAH hospitals, hospitalists, and often intensivists, are in the hospital 24 hours a day seven days a week. In order to maintain this coverage seven days a week each hospital must have a minimum of 5 hospitalists to cover all the shifts. According to CFOs a hospitalist commands salary and benefits of approximately \$250,000 annually, thus having a 24-hour hospitalist coverage costs hospitals \$1,250,000 year. Medicare and most insurers only allow payment for one inpatient bedside visit per day limiting the amount the hospital can recoup to cover the costs of hospitalists.

Like most innovations there are both supporters and detractors. The author heard both these sides of the hospitalist/intensivist argument during the interviews. A key driver of the hospitalist model is that primary care providers are not as comfortable with inpatient care as they are with office care. Most claim that their patients receive better care when they are covered by a physician who is specially trained to treat acute illness and manage inpatient care. Some feel that physicians employed by hospitals opt for that arrangement because they like the hours that come with employment. The hospitalist model means primary care providers do not have to make rounds and cover their inpatients. The availability of hospitalists is often one of the requirements of primary care physicians looking for employment in a hospital.

Quality is another argument in favor of the hospitalist model. Prior to this initiation of hospitalist care, the overnight hours the hospital was almost exclusively covered by nurses. The only physician in the hospital was the emergency room

*physician who was often very busy. With the hospitalist concept the hospital's inpatients are covered 24 hours a day by qualified physicians in the facility.*

*Another view is consistent with the movement spearheaded by NCQA for patients to have a "medical home", a practice where all their records reside and where the physicians and other providers know the patient. This leads to the argument that, during a critical medical episode, patients should be covered by the physician who knows them best and understands their medical history. This issue is somewhat ameliorated with the advent of the electronic medical record and Meaningful Use because all the medical information is available to the hospital through the integrated medical record.*

*Regardless it would appear the hospitalist/intensivist model is a permanent part of health care, as is the \$1 million to \$2 million annual cost is a part of hospital costs.*

## Meaningful Use

*It would be impossible to list all the regulatory programs and accreditation processes that hospitals must comply with as a condition of licensing and government reimbursement. Some of these are reporting or record-keeping requirements while others require impose regulations on the way facilities, such as radiology equipment and backup generators are maintained and tested. In addition to government programs there are a number of “voluntary” programs established by accrediting bodies that certify department such as laboratory or rehabilitation units. The voluntary accreditation bodies set up standards that hospitals must comply with in order to be granted the accreditation. As potential patients we want hospitals to have to comply with quality standards to ensure a high standard of care.*

*This report will focus on one new program that was raised by virtually every CFO, Meaningful Use.<sup>47</sup> Meaningful Use was a part of the American Recovery and Reinvestment Act of 2009. CMS wants hospitals to establish a certified Electronic Health Record (EHR) throughout the organization. There are three stages to the implementation, each with definitive criteria which must be met. In the fall of 2011, only two hospitals, Elliot and Cottage, had met the criteria for Stage One. Stage One criteria require e-prescribing, the transfer of medical information across the system and the reporting of quality and quantity measurements.*

*Other facilities indicated they were close to meeting the criteria and may have attained Stage One since then. Achieving Stage One eligibility is important because there are no upfront payments to help hospitals meet these criteria. Only when CMS certifies criteria are met will a hospital receive an incentive payment. For CAHs this payment is an increase to their capital costs, for PPS hospitals the incentive payment is added on to overall reimbursement.*

*The existence of system-wide Health Record Management will benefit all patients. Physicians and other health personnel will be able to transfer information*

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<sup>47</sup> Information on Meaningful Use comes from CMS.Gov at the following site [https://www.cms.gov/EHRIncentivePrograms/30\\_Meaningful\\_Use.asp](https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp)

*about patients to each other immediately and all information about the patient and his/her interaction with the delivery system will be consolidated. Prescriptions can be sent directly to the pharmacy. Despite the benefits this “voluntary” program, it is an expensive program to implement and is an example of the cost pressures on hospitals.*

## *Indirect Costs*<sup>48</sup>

*Hospitals direct costs are those expenditures that directly go to the care of patients. Indirect costs are the expenses that go to running the hospital but do not have a direct impact on patient care. Direct costs include clinical personnel salaries, the cost of supplies and pharmaceuticals and the expenses associated with inpatient units, surgery and diagnostic testing. Indirect costs are less obvious but no less important to running a hospitals. Costs designated as indirect in the Medicare Cost Report include:*

- *Employee benefits*
- *Administrative and General Costs*
  - *Financial services*
  - *Information services*
  - *Administrative services*
- *Operation of plant*
- *Linen and laundry services*
- *Housekeeping*
- *Dietary*
- *Cafeteria*
- *Nursing administration*
- *Central sterile supply*
- *Medical records*
- *Social services*

*These services are vital to the operation of the hospital but none of them bring any revenue into the facility. In order to allocate the costs associated with these non-revenue producing departments, hospitals use a 'step down' methodology that proportionally assigns these costs to the revenue producing departments. For example housekeeping and plant operations are allocated based on the square footage of a department while dietary are allocated by meals served per unit. The result is the cost*

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<sup>48</sup> Information on direct/indirect costs is from the Medicare Cost Reports.

of operating each department is expanded to include the indirect costs associated with each department.

In 2010, NH hospitals spent \$1.452 billion on indirect costs. This represents 46% of all NH hospitals cost. This equates to \$.86 in indirect spending for every \$1 spent in direct patient care.

Chief among indirect costs are administrative and general costs (A&G). This is a catchall category that includes administrative costs, including administrative overhead, the cost of operating the financial department and the cost of information systems. A&G spending totaled for all NH hospitals totaled \$466.8 million which accounted for 14.7% of the overall costs in NH hospitals.

The following chart looks at the ratio of direct to indirect costs at all NH hospital by size cluster based on data aggregated from the most recently filed Medicaid Cost Reports:

	Direct:Indirect	Percent A&G	Percent Total Indirect
Large PPS (4)			
Low	0.67	11.8%	40.1%
High	0.85	18.1%	46.0%
Average	0.75	14.5%	42.8%
Mid-size PPS (4)			
Low	0.77	12.4%	43.6%
High	1.24	16.8%	55.3%
Average	0.93	14.0%	48.2%
Small PPS (5)			
Low	0.76	11.4%	43.3%
High	1.29	24.0%	56.4%
Average	1.00	16.1%	49.9%
Large CAH (6)			
Low	0.89	10.6%	51.6%
High	1.23	18.5%	42.8%
Average	0.99	13.0%	48.3%
Small CAH (7)			
Low	0.70	13.4%	41.1%
High	1.33	25.2%	56.6%
Average	1.00	19.3%	49.7%

*These data suggest there are economies of scale at large hospitals. Large hospitals have a lower ratio of direct costs to indirect costs, meaning they spread indirect costs over a larger base. As a result, the largest hospitals in the state have the smallest proportion of A&G costs and overall indirect costs and the lowest ratio of indirect to direct costs. It should be noted that there has been considerable discussion statewide about administrator salaries, especially at the largest hospitals. These salaries are included in A&G costs.*

*There is a wide distribution in indirect costs and A&G expenses. Among PPS hospitals the percentage of costs that are indirect range from a low of 40% to a high of 56%. A&G costs track closely with all indirect costs and range from 11% to 24% of total costs. Wide variations exist in the ratio of direct to indirect costs. The lowest ratio is \$.67 of indirect costs for every \$1 of direct cost while the highest is \$1.29 for every \$1 of direct costs. There are four PPS hospitals that spend more on indirect costs than direct costs. Small PPS hospitals often have high indirect costs because they have many of the same functions as larger hospitals but do not have the patient volume over which to spread A&G costs*

*Because of smaller economies of scale, CAH hospitals tend not to be as efficient as the larger facilities. A&G costs at CAH range from 10.6% to 25.2%. Despite this, two CAH hospitals, Speare and New London, had lower administrative costs than any PPS hospitals. Nine of the thirteen CAH hospitals spent more on indirect costs than direct costs.*

*A review of all costs indicates that indirect costs, specifically A&G costs, offer the best opportunity for large scale cost savings in hospitals. One of the reasons the HCA for-profit hospitals are able to have a sizeable margin is that the back office functions: billing, coding, accounting, information services and other activities are done in Richmond, Virginia. David McClung, CFO at Portsmouth Regional Hospital told the author that he is able to run the entire finance department at the hospital with only ten employees.*

*This suggests that if the not-for-profit hospitals can find a way to share these back office functions savings could be realized. The major barrier to accomplishing these savings is that each hospital has its own computer system and, unless these*

*systems can “talk” to each other, merging these functions would be difficult. There has been some progress on this front. The three hospitals in Coos County have recently begun sharing many of these functions. As a gateway to this, Celeste Pitts, the CFO at Weeks Memorial Hospital is now serving as the CFO at Upper Connecticut Valley Hospital and the two CEOs at the Weeks and Androscoggin Valley Hospital are covering the third hospital.*

*Michelle McEwen, CEO of Spear Memorial Hospital, said she contacted the CEOs at the other CAHs using the same computer system to consider sharing of services.*

*No other CFOs expressed any major plans to reduce administrative and general costs. The author met with Rachel Rowe, President of Granite Health Networks, a corporation made up of five PPS hospitals. When asked if there were any plans to share back office functions Rowe explained that all five hospitals had different computer systems and therefore could not integrate these systems. It would be a major step in lowering costs if these five PPS hospitals could determine the best computer system and move to a single program that could result in shared back office functions.*

## Conclusions

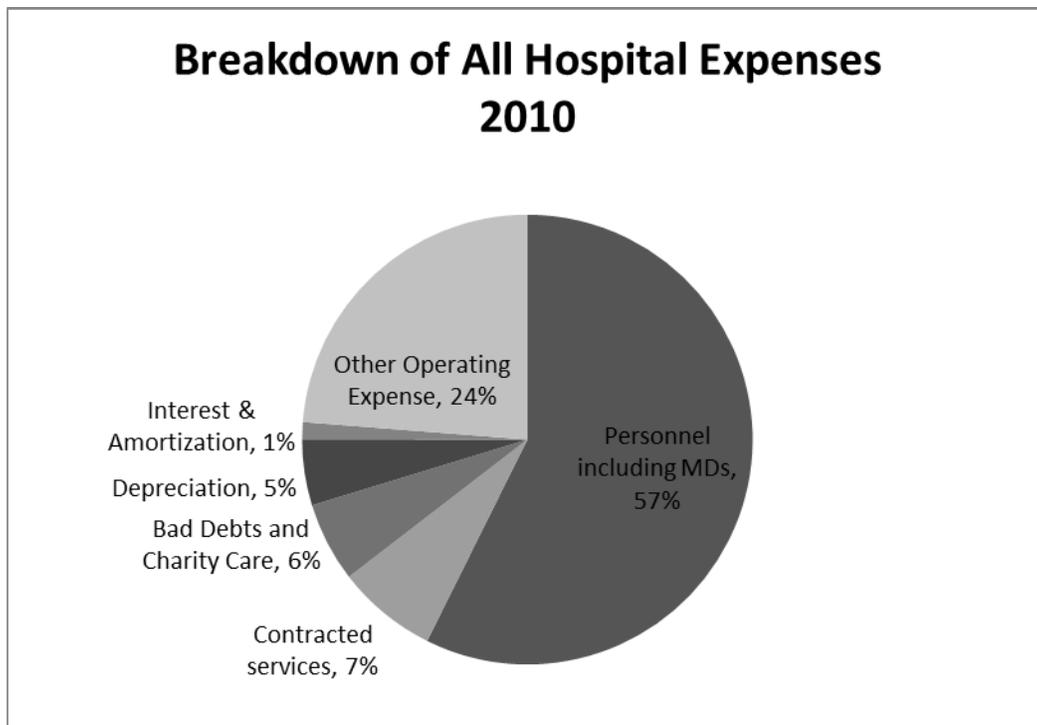
*Hospitals in NH face a number of cost pressures that are not faced by entities in other industries. This is due in part to the fact that hospitals do not have a typical economic relationship with its customers or patients. A hospital cannot tailor costs and prices in a manner that responds to the demands of its patients. It must keep larger inventories of services available because many hospital services only available at hospitals are not always “demanded” by consumers but “needed” by patients. A victim of a car accident will not consider price or weigh the decision to purchase hospital services. The hospital must stand ready to provide these emergent/urgent services to all persons regardless of the patient’s ability to pay for the service.*

*Despite this relationship between hospitals and those they serve, most of what hospitals provide is not a matter of “life and death”. Hospitals provide complex and routine surgery, conduct diagnostic tests, assist women giving birth and many other functions that improve our health and quality of life. Many of these non-life-and-death functions can be performed by small specialized providers at a lower price precisely because they do not have to be prepared for an emergency or take patients who have no ability to pay.*

*Payers must acknowledge the changes in the way many health care services are provided and not merely embrace the lower costs on some routine surgeries and diagnostic testing. If payers want to direct patients to lower cost services for routine services they must be prepared to increase reimbursement for those services their subscribers require that can only be offered in hospitals.*

*A major cost pressure is the volume of patients for whom hospitals do not receive payment that cover expenses. During 2010 NH hospitals underwrote \$368 million in costs for Medicare patients that were not reimbursed. Hospitals absorbed \$120 million in costs above what was paid by Medicaid as well as payments between \$150 and \$200 million for the MET. In addition the hospitals underwrote \$117 million in costs for charity care and \$126 million in bad debt. This totals \$906 million in uncovered costs or 19.4% of total costs.*

Hospitals are expensive and they should continue to review costs and make adjustments in order to hold down what is spent on health care in the state. The following chart shows the breakdown of hospital expenses.



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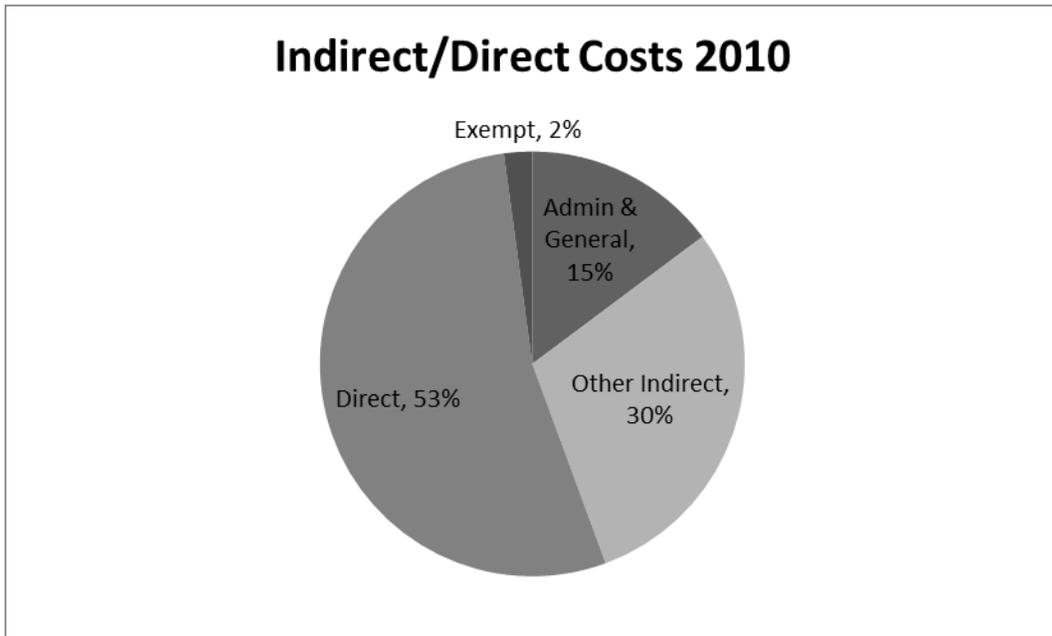
The cost of personnel including physicians, salaries and benefits make up over half of all costs in hospitals. Hospitals have initiated a number of cost saving measures, particularly in the area of personnel management and group purchasing. Given the growing pressures on hospitals, the current cost structure is not sustainable and hospitals must continue to find cost savings. Hospitals should continue to seek out these methods and share them with their colleagues.

Other operating expenses make up about a quarter of all expenses. An example, Meaningful Use was provided as an example of external factors that increase costs. It is important that, payers and policy makers be mindful that hospitals face a number of licensing, accreditation and reporting requirements that increase costs.

The cost of direct patient care and the indirect costs are a major contributor to hospital costs. The following graph shows breakdown of direct and indirect costs:

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<sup>49</sup> Audited financial statements as provided by NHHA



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*The split between direct and indirect patient care costs and is 53% direct to 47% indirect. The greatest opportunity for cost savings without effecting patient care is through reductions in indirect costs. Securing these savings may involve major changes, such as implementing new computer based systems so hospitals can reduce the costs of back office functions.*

*State government should acknowledge the importance of hospitals to our communities and design policies that preserve the basic financial viability. Insurers must recognize that hospitals offer a wide range of services and rather than focusing on savings for a limited number of routine activities must focus on the total book of health care business and design payment structures that acknowledge this. Finally hospitals have to assume an active role in reducing costs. Cost saving decisions must focus on the overall system and not merely be designed to protect their own facility.*

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<sup>50</sup> Aggregated from the Medicare Cost Reports

*Part III*

*Inventory*

Hospital: Alice Peck Day Memorial Hospital (APD)

Location: Lebanon

Bed Capacity: 25 Total, Acute care, Swing and Obstetrics

Fixed Assets as of 9/30/2010: Hospital: \$15,551,210 System: \$35,097,515

Hospital type: Not-for-Profit, Critical Access

Organizational Structure: APD is a subsidiary of Alice Peck Day Health System Corp. The only other active subsidiary of this corporation is Alice Peck Day Lifecare Center, Inc, which owns and operates an assisted living facility, Harvest Hill, and an independent living facility, The Woodlands. There are two inactive corporations that are also subsidiaries of Alice Peck Day Health Systems Corp., Alice Peck Day Reality Corp and Alice Peck Day Health Management Corp, but neither of these have any assets.

Hospital Owned Physician Practices: APD owns and operates eight physician practices all of which are departments of the hospital and the finances of these practices are incorporated in the hospital's financial statements. These hospital owned practices, include:

- Community Care - 15 Internal Medicine, Family Practice and Pediatric providers (13 physicians and 2 mid-levels)
- Women's Care Center - 3 OB/GYN and 1 GYN physicians
- Midwifery practice – 3 Nurse Midwife providers
- Orthopedic clinic – 1 physician and 1 mid-level provider
- General Surgery Clinic - 2 physicians
- Occupational Health – 1 physician
- Pain Management Clinic – 1 mid-level provider
- Hand and Upper Extremity Clinic – 1 physician
- Neurosurgery Services at APD – 2 physician and 1 mid-level provider

Other Physicians: There are a number of private practices that use APD as their primary hospital, but the finances of these practices are all separate from the hospitals. Of particular note with private practices are:

- A private radiology group which is shared with New London Hospital, Valley Regional Hospital and Mt Ascutney Hospital in Vermont.
- Primary care practitioners

Other Information: Until mid-2010 APD operated a 50 bed extended care unit. This facility was phased out during 2009 and 2010 with final closure in August 2010. The hospital license allows the hospital to operate all beds as either acute or swing beds. The inpatient swing beds allow the hospital to care for sub-acute patients, especially those discharged from Mary Hitchcock Memorial Hospital, who no longer require the intensity of care offered at the teaching hospital.

Hospital: Androscoggin Valley Hospital (AVH)

Location: Berlin

Bed Capacity: 25 Total, Acute Care and Obstetrics

Assets: \$53,338,145

Hospital type: Not-for-Profit, Critical Access

Organizational Structure: Androscoggin Valley Hospital (AVH) is a critical access hospital located in Berlin. The hospital is a 501(c)(3) non-profit corporation controlled by NorthCare, a non-profit entity organized as a holding company. NorthCare is the sole member of AVH. Related parties, Mountain Health Services, Inc. and AVH Foundation, are also controlled by NorthCare. The three Coos County hospitals, AVH, Weeks, and UCVH, have been collaborating in many different ways. Pending Federal approval, the three hospitals plan to form a new corporation, The Northern NH Healthcare Collaborative, NNHHC, LLC. The new entity will be owned by the hospitals in equal shares and will have an operating Board of 9 members, 3 from each hospital.

Hospital Owned Physician Practices: In 2004 AVH transferred the employment of their primary care providers to the Federally Qualified Health Center and AVH provides substantial financial support to the FQHC. AVH does however operate AVH Surgical Associates which employs a majority of the specialists in the community. Among the specialties, AVH employs 21 physicians and 5 mid-level providers. Some of these are shared with the other Coos County hospitals, Weeks in Lancaster and Upper Connecticut Valley in Colebrook.

Employed/contracted providers include:

- 2 Urology
- 3 Orthopedics (however the hospital has had to employ a locum tenant to ensure the availability of this service)
- 1 Neurologist
- 3 OB/GYN
- 3 General surgeons
- 3 Hospitalists
- 2 Radiologists
- 1 ENT
- 1 Audiologist
- 1 Anesthesiologist
- 1 Sleep Medicine Physician
- 2 CRNAs
- 2 Physician Assistants
- 1 Nurse Practitioner

*AVH is currently recruiting a pulmonologist and ophthalmologist*

*Other Physicians:* *There are a number of private practices that use AVH as their primary hospital, but the finances of these practices are all separate from the hospitals.*

Hospital: Catholic Medical Center (CMC)

Location: Manchester

Bed Capacity: 330 Total, Acute care, ICU, OB and Rehabilitation

Assets: Hospital: \$258,565,498, System: \$293,511,410

Hospital type: Not-for-Profit, Prospective Payment

Organizational Structure: CMC, which includes the New England Heart Institute and CMC Associates, is a subsidiary of CMC Health Care System. The hospital holds 88% of the total system's assets and contributes 97% of the net revenue. Other components of the system and their purpose are:

- Alliance Enterprises – real estate
- Alliance Resources – real estate
- Doctors Medical Association – real estate
- Alliance Health Services – physician practices
- Physician Practice Associates – provider owned physician practices
- St. Peter's Home – Children's Day Care
- Alliance Ambulatory Services (Bedford Ambulatory Surgery Center) - 50% ownership
- In addition to all the hospital services and the New England Heart Institute CMC also has a 23 bed distinct part physical rehabilitation unit.

Within CMC is the New England Heart Institute that provides cardiology and cardiac surgery services. The hospital employs the cardiologists that are a part of the Institute but the cardiac surgeons are an independent group practice.

Hospital Owned Physician Practices: Physician Practice Associates employs approximately 23 physicians and 14 mid-level providers. All of these physicians are primary care providers. The hospital does employ most of the cardiologists that work at the New England Heart Institute, but the cardiac surgeons are all self-employed. CMC also has a contract with Dartmouth Hitchcock for hospitalists covering inpatients, as well as a separate contract with Dartmouth Hitchcock pulmonologists who serve as intensivists and cover the ICU.

Other Physicians: CMC also employs one other private practitioner in the psych med clinic. Physicians in Manchester are all aligned with one of the two hospitals. There is very little cross referrals with the exception of referrals from Elliot for open heart surgery at CMC and referrals from CMC for radiation therapy at Elliot Hospital.

CMC maintains an affiliation with Dartmouth Hitchcock Manchester which provides primary and specialty services to patients at the hospital. A plan to

*merge with DHMC has been dropped and it appears the relationship will not be legally formalized.*

Hospital: Cheshire Medical Center (Cheshire)

Location: Keene

Bed Capacity: 169 Total, Acute care, ICU, OB, Adult and Adolescent Psychiatry and Rehabilitation

Assets: Hospital: \$124,631,712, System: \$152,851,342

Hospital type: Not-for-Profit, Prospective Payment, Medicare Dependent Hospital

Special Designation: Cheshire has the special designation as a Medicare Dependent Hospital because over 60% of its total patient days are used by Medicare recipients. This designation provides enhanced reimbursement from Medicare.

Organizational Structure: Cheshire Medical Center is a subsidiary of Cheshire Health Foundation which holds the system's investment funds and also coordinates a variety of community health initiatives. Cheshire has a unique partnership arrangement with Dartmouth Hitchcock Clinic Keene (DHK). Cheshire has a joint operating agreement with DHK, which means they function as a single integrated campus. DHK provides the majority of hospital based physician services including the emergency room, hospitalists and medical director positions and the physician ambulatory operations are provider-based for Medicare. Cheshire supports the professional practice operations of DHK and this support is reflected as "other expenses relating to the joint provision of medical services" below the hospital's operating margin line.

In addition to the acute care beds Cheshire has two distinct units; a physical rehabilitation and a psychiatric unit.

Hospital Owned Physician Practices: 97% of physician services offered in the Keene service area are provided by DHK. Some of the services provided by DHK are shared with Monadnock Community Hospital and two small Vermont hospitals. These services include; oncology, gastroenterology, some surgical specialties and rheumatology.

Other Physicians: There are a few community based physician. The independent physicians include:

- Psychiatry which staff the inpatient psychiatric unit
- Radiology
- Anesthesiology
- 3-4 independent primary care physicians.

Hospital: Concord Hospital (Concord)

Location: Concord

Bed Capacity: 295 beds; Acute Care, Intensive and Cardiac Care, Obstetrics, Psych

Assets: Hospital: \$410,280,000, System: \$418,025,000

Hospital type: Not-for-Profit, Prospective Payment

Organizational Structure: Concord Hospital is a subsidiary of Capital Region Health Care Corporation (CRHC). The sister companies are Concord Regional Visiting Nurses Association and Riverbend Community Mental Health Center. Physician practices owned and/or managed by Concord are treated as a department of the hospital and the revenue and expense associated with these practices are included in the hospital's financial statements. The hospital has a number of joint ventures with private physicians on its staff and financials associated with these joint ventures are included in the hospital's financial statements.

Concord has, within the past two years, joined the Granite HealthCare Network, a collaboration between Concord, Elliot, LRGH, SNHMC and WDH. This affiliation has a number of future plans, but at the current time the only entity is Granite Shield Insurance Exchange, a captive insurance company providing professional and general liability coverage for several of the member organizations.

Hospital Owned Physician Practices: Concord employs or manages approximately 225 physicians and mid-level providers. All but a few primary care physicians are employed by the hospital and deployed to offices throughout the service area. The hospital also owns or manages many specialty groups, including general surgery, urologists, hospitalists and cardiology.

Concord Hospital owns the Family Health Center, located on the grounds of the hospital. This primary care practice houses the NH-Dartmouth Family Medicine Residency Program. The program trains primary care doctors and uses the Family Health Center as its training site.

Concord has a lease relationship with the Dartmouth Hitchcock Clinic – Concord (DHC). The physicians associated with this practice are technically employed by DHMC, but Concord Hospital leases all the physicians and staff from DHMC. Concord pays a lease payment to the group, and bills for the services provided through the site.. The expense and revenue associated with this practice is included in hospital's financial statements.

Other Physicians: Many of the specialists associated with Concord Hospital are in independent practices. Concord has established a number of joint ventures with

*these practices including ambulatory surgical centers (ASC) with Concord Orthopedics, Capital Orthopedics and Concord Gastroenterology as well as imaging centers with the radiology group. Concord has expanded imaging centers and opened joint ventures throughout the service area.*

*Among other private physicians there are a broad number of specialists in the community who refer to Concord for surgical services and inpatient care.*

Hospital: Cottage Hospital (Cottage)

Location: Woodsville/Haverhill

Bed Capacity: 25 beds; Acute Care, Obstetrics,

Assets: \$22,566,307

Hospital type: Not-for-Profit, Critical Access

Organizational Structure: Cottage Hospital is a stand-alone corporation, it has no subsidiaries, sister corporation or parent.

Hospital Owned Physician Practices: Cottage owns and operates a Rural Health Clinic with 2 internal medicine physicians and an ARNP. There is also an ARNP in Monroe as well as a very part-time gynecologist. The specialists Cottage employs include emergency room physicians and gastroenterology. In many cases these physicians are retired or part-time. The hospital also employs 1 hospitalist who provides coverage for inpatients during the days.

Other Physicians: The majority of physicians who practice at Cottage Hospital are employed by one of two Federally Qualified Community Health Centers; Amonoosic Community Health Center in Haverhill and Little River Healthcare in Bradford, Vermont.

Hospital: Elliot Hospital (Elliot)

Location: Manchester

Bed Capacity: 296 beds; Acute Care, Obstetrics, ICU, Cardiac Care Unit, Neonatal Care Unit, Psychiatry Hospital type: Not-for-Profit, Prospective Payment

Assets: Hospital - \$354,022,963, System: \$420,458,951

Organizational Structure: Elliot Hospital is owned by Elliot Health System, which is also the parent to several other not-for-profit and for-profit corporations. In addition to the hospital the system owns or is the sole corporate member of:

- Elliot Health Physician Network, a network of primary care physicians (In 2010 the ownership passed from Elliot Health System to Elliot Hospital),
- Elliot Professional Services, a network of specialty physicians (In 2010 the ownership passed from Elliot Health System to Elliot Hospital),
- Visiting Nurse Association of Manchester and Southern New Hampshire, Inc.
- Mary and John Elliot Charitable Foundation, and
- Elliot Health Systems Holdings, Inc. a for-profit corporation that owns interests in health care related partnerships and provides real estate and business management services.

Elliot Hospital has expanded its services in recent years opening an ambulatory care facility, including urgent care in Londonderry and another in downtown Manchester, Elliot at River's Edge.

Elliot has, within the past two years, joined the Granite Health Network, a collaboration between Concord, Elliot, LRGH/FRH, SNHMC and WDH. This affiliation has a number of future plans, but at the current time the only entity is Granite Shield Insurance Exchange that is a captive insurance company providing general and professional liability insurance.

Hospital Owned Physician Practices: Elliot Hospital employs a majority of the physicians who practice at the hospital. The hospital has responded to changes in the physician marketplace by recruiting and hiring specialists

Other Physicians: Elliot does not employ radiologists, pathologists, anesthesiology, urology, otolaryngology and ophthalmology.

Hospital: Exeter Hospital (Exeter) Exeter refused to participate in this study.

Location: Exeter

Bed Capacity: 100 acute care, ICU, obstetrics, Separate nursing facility

Hospital type: Not-for-Profit, Prospective Payment

Assets: Hospital \$ 281,810,222 System \$301,441,792

Organizational Structure: Exeter Hospital is owned by Exeter Health Resources. This parent Corporation also owns Exeter Health Care, a nursing facility; CORE Physicians and Rockingham VNA. There are two other corporations, Exeter Med Real, Convergent Health and VX Health Service.

Hospital Owned Physician Practices: Exeter employs 99 physicians and 28 mid-level providers. No information is available on the specialties of these physicians.

Other Physicians: No information is available

Hospital: Franklin Regional Hospital (FRH)

Location: Franklin

Bed Capacity: 25 acute care and swing

Hospital type: Not-for-Profit, Critical Access, Operates two Rural Health Clinics

Assets: \$31,514,465

Organizational Structure: FRH is owned and operated by LRGHealthcare. See Lakes Regional General Hospital for details

Hospital Owned Physician Practices: There are about 15 physicians currently employed by LRGHealthcare dedicated to FRH. For further discussion see LRGH

Other Physicians: See LRGH

Hospital: *Frisbie Memorial Hospital (FMH)*

Location: *Rochester*

Bed Capacity: *112, Acute care, Obstetrics, Gero-Psychiatry, operates the ambulance*

Hospital type: *Not-for-Profit, Prospective Payment*

Assets: *Hospital - \$130,821,436, System - \$156,417,365*

Organizational Structure: *FMH is both the hospital and the system. The hospital owns three subsidiary corporations, only 2 of which are currently active. One of these, Seacoast Business and Health, is a walk-in service with an occupational health focus and primarily serves local businesses. Frisbie Foundation is the subsidiary that holds the hospitals investment and real estate.*

*The physician practices owned by FMH are treated as departments of the hospital and the financials are mingled with the hospitals.*

Hospital Owned Physician Practices: *FMH employs 62 physicians in a variety of specialties. These include primary care including both family practice and internal medicine. FMH employs its emergency room physicians and the physicians that staff the gero-psychiatric unit, as well as the hospitalists and 3 intensivists. Other specialists employed by the hospital include cardiology, obstetrics and pulmonology, infectious disease, endocrinology and pediatrics. Some of the relationships with physicians are less direct than owned employment. For example FMH has an income guarantee with 3 general surgeons. FMH also maintains an affiliation with DHMC that allows the lease of two hematology and oncology physicians.*

Other Physicians: *FMH shares physicians with other hospitals, especially Wentworth-Douglass Hospital in Dover, but also with other hospitals in the eastern part of the state including Huggins. Private physician specialties include ENT, neurology, orthopedics, vascular surgery and nephrology.*

Hospital: Huggins Hospital (Huggins)

Location: Wolfeboro

Bed Capacity: 25 acute care and swing

Hospital type: Not-for-Profit, Critical Access

Assets: \$105,206,394

Organizational Structure: Huggins Hospital is a stand-alone hospital which has no other corporations affiliated.

Hospital Owned Physician Practices: Huggins hospital employs 28 providers, 18 physicians and 10 mid-level providers. These include primary care providers and the following specialties:

- Pediatrics
- General Surgery
- Orthopedics
- Gynecologist (non-obstetric)
- Hospitalist

Other Physicians: There are several private physicians in the Wolfeboro area.

Hospital: Littleton Regional Hospital (Littleton)

Location: Littleton

Bed Capacity: 25 acute care, Obstetrics and swing

Hospital type: Not-for-Profit, Critical Access

Assets: \$79,806,884

Organizational Structure: Littleton is a stand-alone hospital which has no other corporations affiliated. The hospital has a management contract with Quorum Health Care, however, the decision was made three years ago to no longer have the CEO and the CFO employed by Quorum. Now Quorum is primarily involved in purchasing, vendor contracting and meets three times a year with the executive team to provide management assistance.

Physician Owned Practices: Littleton employs 17 physicians and two mid-level practitioners. Most of these are primary care providers; however there are also two general surgeons, two OB/GYN and two orthopedists.

Other Physicians: There are several private physician practices in the Littleton area. Within the last couple of years an orthopedic group practice, the Alpine Clinic, opened in Franconia. This clinic is in talks with Littleton about the possibility of changing the relation and becoming a part of the hospital. Littleton also has established a relationship with the Norris Cotton Cancer Center in St. Johnsbury, Vermont for both medical and radiation oncology.

*Hospital: Lakes Region General Hospital (LRGH)*

*Location:* *Laconia*

*Bed Capacity:* *137 beds - acute care, ICU, obstetrics, geriatric psychiatric unit and swing*

*Hospital type:* *Not-for-Profit, Prospective Payment, Sole Community Hospital, Rural Referral Center*

*Assets:* *Hospital \$181,414,577, System \$212,929,042*

*Organizational Structure:* *LRGH is owned by LRGHealthcare which also owns Franklin Regional Hospital. The two hospitals operate as a single entity for IRS purposes but for Medicare the two organizations have separate provider numbers and are considered two separate hospitals filing separate Medicare cost reports. In addition to the two hospitals, LRGHealthcare owns three ambulatory surgery centers. One facility is located in Gifford at Hillside Medical Park, a large medical office building partially owned by LRGHealthcare. LRGHealthcare also owns the single specialty ASC at Laconia Urology in a medical office building connected to the hospital. Finally, LRGH owns the ASC in Laconia Clinic proximal to the hospital campus in a medical office building leased by the system.*

*LRGH also operates the ambulance service for the City of Laconia.*

*Hospital Owned Physician Practices:* *LRGHealthcare currently employs approximately 50 physicians, with about 15 of which are dedicated to Franklin campus. The majority of these employed physicians are primary care; however, there are also hospitalists and surgical related specialists. In addition the system maintains lease relationships with several physician groups. The largest of these is the Laconia Clinic, which is housed in the building leased by the system and located less than a half a mile to the Laconia hospital campus. The Laconia Clinic professional corporation and the facilities leased by LRGH are owned by its member physicians, and are leased by LRGHealthcare exclusively and are operated as a department of the hospital. In July, 2011 LRGH established a similar lease arrangement with orthopedic practice and in September with an ENT practice and are also operated as a department of the hospital. A professional services lease arrangement also exists between the system and a general surgery group.*

*IN 2011 LRGH and FRH joined the Granite Health Network, collaboration between Concord, Elliot, LRGH/FRH, SNHMC and WDH. This joint venture affiliation has a number of future plans, but at the current time the main operating entity is Granite Shield Insurance Exchange that provides the support for the hospitals' self-insurance as well as programs for both general and private liability.*

Other Physicians: There are two independent family practices, two independent internal medicine practices two independent pediatric practices, two locations of Federally Qualified Health Center based in Franklin and Laconia and a number of private single specialty physician practice, such as cardiology, nephrology, ophthalmology and oral surgery in the both the Laconia and Franklin area.

Hospital: Memorial Hospital (Memorial)

Location: North Conway

Bed Capacity: 25 acute care, obstetrics and ICF

Hospital type: Not-for-Profit, Critical Access

Assets: Hospital \$ 66,074,571, System \$ 66,146,478

Organizational Structure: Memorial Hospital is a stand-alone corporation with a single subsidiary, MWV Healthcare Associates, Inc. This for-profit subsidiary owned a pharmacy, located at the hospital, however, this has been closed and the corporation is now a shell. Physician practices are treated as departments of the hospital.

In addition to the acute care hospital Memorial Hospital owns Merriman House, an intermediate care nursing facility.

Hospital Owned Physician Practices: Memorial employs 17 physicians and nine mid-level practitioners. Most of these are primary care providers; however there are also three general surgeons, three OB/GYN and two orthopedists, and they are in the process of recruiting a third. The hospital is also in the process of recruiting hospitalists.

Other Physicians: There are a few private physician practices in the North Conway area.

**Hospital:** *Mary Hitchcock Memorial Hospital*

**Location:** *Lebanon, NH and St. Johnsbury, VT*

**Bed Capacity:** *396 Beds acute care, ICU, CCU, Obstetrics/NICU Obstetrics, Psychiatry, Norris Cotton Cancer Center, and the Children's Hospital at Dartmouth*

**Hospital Type:** *Not-For Profit, Prospective Payment, Sole Community Provider and Rural Referral Center.*

**Assets FY10:** *MHMH \$1,129,681,214, D-H combined AFS \$1,353,952,341 (see below)*

**Organizational Structure:** *Mary Hitchcock Memorial Hospital (MHMH) is fully integrated with the Dartmouth-Hitchcock Clinic (DHC) and operates as one, commonly referred to as Dartmouth-Hitchcock, through an enhanced affiliation agreement between the two entities. MHMH has two main locations while DHC maintains multiple clinics throughout NH. MHMH and DHC's parent company structure changed from a partnership agreement effective 8/31/10, when a 501(C)(3) exempt organization known as Dartmouth-Hitchcock Health (D-HH) became the sole corporate member of both the Clinic and Hospital. D-H files consolidated financial statements that include MHMH, DHC, and The Hitchcock Foundation, an exempt org of which DHC is the sole corporate member.*

*Underneath MHMH is the New England Alliance for Health (NEAH), an entity which replaced the Dartmouth-Hitchcock Alliance in 2009 and assists its members to improve the health of the communities they serve. The New England Alliance for Health promotes collaboration, coordination of care and population-based resource planning among its members and regional partners. NEAH also manages the New England Pharmacy Collaborative, a partnership among New England Organizations for group pharmaceutical purchasing.*

**Hospital-Owned Physician Practices:** *Because of the integrated nature of MHMH and DHC, DHC provides MHMH with physicians under the affiliation agreement and costs are split based on an allocation between the two organizations. Both MHMH and DHC provide other local exempt health care entities access to staff and physicians as needed through contractual arrangements, however MHMH itself does not own any other Physician Practices.*

**Other Physicians:** *Only D-HC employed physicians with Dartmouth School of Medicine faculty appointments are granted appointment and clinical privileges. Other clinicians*

Hospital: Monadnock Community Hospital (MCH)

Location: Peterborough

Bed Capacity: 25 acute care including skilled nursing and obstetrics

Hospital type: Not-for-Profit, Critical Access

Assets: Hospital \$ 88,337,402

Organizational Structure: Monadnock Community Hospital is a stand-alone corporation with no subsidiaries. A department of the hospital is a large medically based health and wellness center.

Hospital Owned Physician Practices: MCH employs or contracts with 31 physicians and 11 mid-level practitioners. All primary care providers in the area are employees of the hospital. The hospital also owns Monadnock Orthopedic Associates, a three physician group practice, a neurologist, and a general surgery practice. Other specialty care is provided by other hospital owned physician groups who have offices in or travel to Peterborough; these include New England Heart Institute of CMC, Monadnock Anesthesia Associates, and Monadnock Emergency Room Associates. Oncology services are provided by the DHK-Cheshire oncology group as well as urology, gastroenterology, and ENT services. Hospitalist coverage is provided by Catholic Medical Center. Pathology services are provided through The Elliot Hospital.

Other Physicians: There are specialists, including Monadnock OB/GYN, Monadnock Ophthalmology, Concord ENT and podiatry.

Hospital: *New London Hospital (NLH)*

Location: *New London*

Bed Capacity: *25 acute care, Obstetrics and nursing facility*

Hospital type: *Not-for-Profit, Critical Access*

Assets: *Hospital \$56,339,585 System \$56,515,245*

Organizational Structure: *New London Hospital is a non-profit hospital with a number of subsidiaries. The largest of these is the Clough Center, a 58 bed nursing facility offering both intermediate and skilled care. Kearsarge Community Services holds the real estate for the corporation and New London Medical Center East is the Condo Association for the medical office building. Physician practices owned by the hospital are treated as departments of the hospital. The hospital owns and operates the ambulance service for six communities.*

*Between 1997 and 2010 NLH had an affiliation with Concord Hospital. In 2010 this affiliation was dissolved and MLH switched its affiliation to DHMC.*

Physician Owned Practices: *New London Hospital employs 34 physicians and seven mid-level providers. These include primary care providers in both new London and Newport. In addition NLH employs the following specialties:*

- *Gynecology*
- *Pediatrics*
- *Neurology*
- *General Surgery*
- *Rheumatology (shared with Valley Regional Hospital)*

*The hospital also employs emergency room and hospitalists and is recruiting for both these specialties.*

Other Physicians: *NLH relies upon specialty groups from both DHMC and Concord. In Addition, there are a few private physician practices.*

Hospital: Parkland Medical Center (PMC)

Location: Derry

Bed Capacity: 86 acute care, ICU, obstetrics

Hospital type: For-Profit owned by HCA, Prospective payment

Assets: Hospital \$31,490,429, System \$33,105,933

Organizational Structure: PMC is wholly owned by HCA. This arrangement offers many benefits to the hospital, as the corporation provides many services for their hospitals. For example many back office functions; billing, coding, and accounting are done at HCA headquarters, saving on personnel services. PMC also owns a Medical Office Building.

There is an ASC associated with PMC, however, this facility is actually owned by another HCA corporation. Physicians employed by the hospital are actually employed by HCA.

Hospital Owned Physician Practices: PMC employs 14 physicians and 8 mid-level providers. Seven physicians are PCPs and there are physician owned practices offering general surgery, endocrinology and nephrology. PMC maintains a contract relationship with an urology group and gastroenterology. Hospitalists and ER physicians are under contract.

Other Physicians: PMC is located in very competitive market and as a result there are a 2 large multispecialty groups that are in the service area. One, the Derry Medical Center is a multi-specialty group practice with 28 providers that does refer to Parkland Medical Center. The other, Elliot in Londonderry, is also a large multi-specialty group practice that refers exclusively to Elliot Hospital in Manchester. .

Hospital: Portsmouth Regional Hospital (PRH)

Location: Portsmouth

Bed Capacity: 144, acute care, ICU, CCU, obstetrics, psychiatry

Hospital type: For-Profit owned by HCA, Prospective payment

Assets: Hospital \$147,180,775, System \$155,184,497

Organizational Structure: PRH, like PMC is wholly owned by HCA and the benefits of this arrangement can be seen in PMC.

PRH owns a Medical Office Building, this is maintained the hospital's system financials as are the hospital owned physician practices.

Hospital Owned Physician Practices: PRH employs 78 physicians and 20 mid-level providers. In addition to primary care providers the hospital employs or manages the practices for the following specialties:

OB/GYN

Orthopedics

General Surgery

Ophthalmology

Urology

Nephrology

Gastroenterology

PRH maintains contracts with hospitalists who also provide coverage for the Northeast Rehabilitation Hospital at Pease.

Other Physicians: There are very few private physicians in the Portsmouth area. The hospital based physicians; radiology, pathology, anesthesiology and emergency medicine all have private practices.

Hospital: Southern NH Medical Center

Location: Nashua

Bed Capacity: 188 beds, acute care, ICU, Obstetrics, SNHMC hosts physical rehabilitation beds owned by Northeast Rehabilitation Hospital

Hospital type: Not-for-Profit Prospective payment

Assets: Hospital \$ 269,274,791 System \$ 289,267,076

Organizational Structure: There are two components to SNHMC, the hospital and the Foundation for Medical Partners that is the home of the physician practices. The hospital owns a separate facility, which was once a psychiatric hospital, that housed its psychiatric unit and the physical rehabilitation unit owned and operated by Northeast Rehabilitation Hospital.

SNHMC has, within the past two years, joined the Granite Network, a collaboration between Concord, Elliot, LRGH, SNHMC and WDH. This affiliation has a number of future plans, but at the current time the only entity is Granite Shield Insurance Exchange that provides the support for the hospitals' self-insurance health plans.

Physician Owned Practices: The Foundation for Medical Partners includes 149 physicians and 49 mid-level providers. In addition to primary care providers these the hospital employed physicians include a wide variety of specialists, including:

OB/GYN

Gastroenterology

ENT

Pulmonary medicine (these physicians also serve as intensivists)

General surgery

Endocrinology

Hospitalists

Other Physicians: As note in the SJH inventory the 95 providers affiliated with Dartmouth Hitchcock Nashua use both hospitals. In fact, even among primary care providers, patients are allowed to select which Nashua hospital they would prefer to use.

There are approximately 20-25 primary care providers in private practice in Nashua. There are also some private specialists including orthopedists, ENT, ophthalmologist and gastroenterologists. Several of these specialists are entering a joint venture with Bedford Ambulatory Surgery and SJH to open an ASC.

Hospital: *Speare Memorial Hospital (SMH)*

Location: *Plymouth, NH; in southern Grafton county serving 16 surrounding towns*

Bed Capacity: *25 inpatients-acute care; which includes acute care adult and pediatric, intensive care, obstetrics/newborn, observation care, and sub acute care.*

Hospital type: *Not-for-Profit, Critical Access-Rural; community based*

*Provides inpatient, outpatient, and physician practice services.*

*Services includes: emergency care 24/7, surgery, full service imaging including MRI, oncology, rehabilitation including medical fitness, school health and dental programs, occupational health services, prescription drug assistance services, emergency preparedness, clinic-offsite, community education programs, etc.*

Assets: *Hospital and System \$62,396,320 (FY 2010) and \$65,442,181 (FY 2011)*

Organizational Structure: *Speare Memorial Hospital is a non-profit hospital with a number of subsidiaries. These include:*

*Speare Health Venture a wholly-owned subsidiary, which holds a 50% equity interest in a joint venture< Plymouth Regional Rehabilitation Services, LLC*

*Speare Health Network, SMH owns 50% of this Physician/Hospital Organization.*

*Speare Memorial At Boulder Point, This wholly owned subsidiary owns real estate; a medical office building that leases space to SMH in Plymouth, NH.*

Hospital Physician Owned Practices: *SMH employs approx. 24 physicians and 10 mid-level providers. Three of these are primary care providers. In addition SMH employs the following specialties:*

- *OB/GYN*
- *Orthopedics*
- *Ophthalmology*
- *General Surgery*
- *Emergency*
- *Anesthesia*
- *Hospitalist (these physicians also read EKGs)*

Other Physician Services: *SMH contracts with DHMC for radiology, pathology and oncology physician coverage. SMH also contracts for family practice services.*

Other Medical Staff Physicians/Providers: *there are about the same number of private physicians/providers practicing in the community on a part time or full time basis. Also, Genesis Care provides psychiatry services in the community.*

Hospital: St. Joseph Hospital (SJH)

Location: Nashua

Bed Capacity: 208 acute care, ICU, obstetrics, Gero-psych and physical rehabilitation

Hospital type: Not-for-Profit Prospective payment

Assets: Hospital \$217,297,000 System \$230,518,000

Organizational Structure: St. Joseph Hospital is independently owned, sponsored by Covenant Health Services, a large not-for-profit health system located in Tewksbury, Massachusetts. Between 2009 and 2011 the hospital divested itself of several sub corporations including; an ambulance service, a durable medical equipment company and an ASC. SJH still owns a home health agency, physician groups and corporate services which is billing and financial services. SJH maintains, as a department of the hospital, an emergency room and ancillary center in Milford.

Physician Owned Practices: SJH employs 79 physicians and 21 mid-level providers. In addition to primary care the hospital employs the following specialties:

OB/GYN

Pediatrics

Pulmonology – These physicians also serve as the intensivists

Oncology

General Surgery

SJH contracts with a national company for hospitalists.

Other Physicians: Unlike Manchester, the other two hospital community, the specialty physicians in Nashua tend to use both hospitals. This is especially true of Dartmouth Hitchcock Nashua, a large multi-specialty group with 95 providers that practices at both hospitals.

There are also a few primary care private practices in the area as well as private specialists including orthopedists, ENT, ophthalmologist and gastroenterologists.

Hospital: Upper Connecticut Valley Hospital (UCVH)

Location: Colebrook

Bed Capacity: 16 acute care

Hospital type: Not-for-Profit, Critical Access

Assets: Hospital and System \$ 14,933,689 (FY2009) - \$15,323,454 for FY2010

Organizational Structure: UCVH is the smallest hospital in the state. It has traditionally been very reliant upon DHMC. An affiliation is currently being developed between UCVH and the other two Coos County Hospitals, Androscoggin Valley Hospital (AVH) and Weeks Medical Center. This affiliation will result in the sharing of various services, including the CAO and CFO through the development of a shared service organization. Pending Federal approval, The Northern NH Healthcare Collaborative (NNHHC) LLC will be formed. This new entity will be owned by the hospitals in equal shares and will have an operating Board of 9 members, 3 from each hospital.

Physician Owned Practices: UCVH has traditionally been reliant upon Dartmouth Hitchcock physicians. Another benefit of the affiliation with AVH & Weeks is the sharing of physicians from AVH. In addition, an independent FQHC next door offers primary care services for the area and works closely with UCVH.

Hospital: Valley Regional Hospital (VRH)

Location: Claremont

Bed Capacity: 25 acute care, Obstetrics

Hospital type: Not-for-Profit, Critical Access

Assets: Hospital \$56,224,360 – System \$58,277,676

Organizational Structure: VRH is owned by Valley Regional Health Care, Inc (VRHC).

The physician owned practices are cost centers of VRH with the physicians being employees of the hospital. In addition VRHC owns a home health care organization.

Physician Owned Practices: VRHC employs 24 physicians and 7 mid-level providers. In addition to primary care these physicians are in the following specialties:

- Pediatrics
- Obstetrics including a midwife
- Orthopedics
- Urology
- General surgery
- Emergency
- ENT shared with Springfield Hospital

The hospital has been dependent upon locum tenants as it has a difficult to recruit physicians. In 2010 the hospital spent over \$600,000 on temporary physicians.

Other Physicians: There are other primary care providers within the community that are privately owned.

Hospital: Weeks Medical Center (WMC)

Location: Lancaster

Bed Capacity: 25 acute care

Hospital type: Not-for-Profit, Critical Access

Assets: Hospital \$40,037,587 (FY2010)

Organizational Structure: WMC is a stand-alone hospital. An affiliation is currently between WMC and the other two Coos County Hospitals, Androscoggin Valley Hospital (AVH) and Upper Connecticut Valley Hospital. This affiliation will result in the sharing of senior staff, including the CFO position, through the development of a shared service organization. Pending Federal approval, The Northern NH Healthcare Collaborative, (NNHHC) LLC will be formed. This new entity will be owned by the hospitals in equal shares and will have an operating Board of 9 members, 3 from each hospital.

Physician Owned Practices: WMC employs 18 physicians and 7 mid-level providers through three hospital owned RHC's. This includes primary care and several specialties.

Other Physicians: Several specialty physician services, such as Oncology, are offered on-site with DHMC & AVH providers.

Hospital: *Wentworth-Douglass Hospital (WDH)*

Location: *Dover*

Bed Capacity: *178 beds acute care, CCU, Obstetrics*

Hospital type: *Not-for-Profit, Prospective Payment*

Assets: *Hospital \$ 311,808,000 System \$324,131,000*

Organizational Structure: *WDH is the owner of the hospital and three wholly-owned subsidiary corporations:*

Wentworth-Douglass Physician Corporation (WDPC): *a not-for-profit corporation set up to own and operate physician practices*

Wentworth-Douglass Hospital and Health Foundation: *A not-for-profit corporation set up to receive charitable donations.*

Wentworth-Douglass Community Health Corporation: *This for-profit corporation does business as The Works Family and Health and Fitness Center*

*In addition there are three joint ventures corporations:*

Strafford Health Alliance – *not-for-profit with FMH which offers women’s health services and outpatient physical therapy*

Health Partners of NH, Inc. – *a physician/hospital organization*

Wentworth Home Care and Hospice, LLC – *a limited liability company in partnership with Amedisys, which offers home care and hospice services.*

*WDH has within the past two years joined the Granite Health Network, a collaboration between Concord, Elliot, LRGH, SNHMC and WDH. This affiliations has a number of future plans, but at the current time the only entity is Granite Shield Insurance Exchange, which operates a captive insurance company providing professional and general liability coverage.*

Physician Owned Practices: *WDPC employs 65 physicians and 17 midlevel providers in primary care and the following specialties:*

*Allergy*

*Cardiology*

*Endocrinology*

*General surgery*

*Hospitalists*

*Infectious Disease*

*Oncology*

*Palliative Care*

*Plastic Surgery*

*Pulmonology*

*Rheumatology*

*General Dentistry*

*Urology*

Other Physicians: *There are 232 physicians in private practice in a wide variety of specialties affiliated with WDH.*

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The following update was provided on September 18, 2014, by Maria Ryan, CEO of Cottage Hospital.

The name of the hospital, location, bed capacity and hospital type are all correct.

Net revenue in 2013 was \$29,186,349.

Organizational Structure is correct

Hospital owned physician practices: Cottage Hospital owns and operates a rural health clinic with internal medicine physicians and 2 APRN's.

Employed specialists at the Cottage Hospital include Board Certified Emergency Physicians, a gastroenterologist, three CRNA's (Anesthesia) , and two hospitalists who cover med surg/ICU care 24/7.

Many of the primary care physicians are employed by Ammonoosuc Community Health Services in Woodsville, NH and Little Rivers Healthcare with sites in Wells River, Bradford and East Corinth, VT.

A neurologist, 2 Cardiologist, Oncologist, Radiologists, 4 general surgeons, 3 orthopedic surgeons, family medicine, internal medicine, pediatrician, pulmonologist and a gastroenterologist all have privileges at Cottage Hospital.