Report on Activities and Operations of Nevada Hospitals

(Pursuant to NRS 449.450 through 449.530)

Nevada Department of Health and Human Services

Helping People
It's who we are and what we do.

Division of Health Care Financing and Policy

October 1, 2021

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AUTHORITY AND OVERVIEW

AUTHORITY

The Division of Health Care Financing and Policy (DHCFP) was created on July 1, 1997 (State Fiscal year 1998). The Division is responsible for carrying out the provisions of Nevada Revised Statutes (NRS) 449, "Medical and Other Related Facilities."

The Director of the Department of Health and Human Services (DHHS) is required to prepare a report on DHHS activities and operations pertaining to the provisions of NRS 449.450 through 449.530, inclusive, for the preceding fiscal year. The report must be transmitted to the Governor, the Legislative Committee on Health Care, and the Interim Finance Committee on or before October 1 of each year (NRS 449.520).

The functions and activities subject to NRS 449.450 through 449.530, inclusive, have been delegated to the DHCFP.

The DHCFP's responsibilities include:

- Collecting financial information and other reports from hospitals;
- Collecting health care information from hospitals and other providers;
- Conducting analyses and studies relating to the cost of health care in Nevada and comparisons with other states;
- Preparing and disseminating reports based on such information and analyses; and
- Suggesting policy recommendations and reporting the information collected.

OVERVIEW OF NRS 449.450 - 449.530

The definitions of specific titles and terminology used in NRS 449.450 through 449.530 are defined in NRS 449.450. The Director may adopt regulations, conduct public hearings and investigations and exercise other powers reasonably necessary to carry out the provisions of NRS 449.450 through 449.530, inclusive, as authorized in NRS 449.460. The Director also has the authority to utilize staff or contract with appropriate independent and qualified organizations to carry out the duties mandated by NRS 449.450 through NRS 449.530, inclusive, as authorized in NRS 449.470.

SUBMISSION OF DATA BY HOSPITALS

NRS Provisions

Each hospital in the State of Nevada shall use a discharge form prescribed by the Director and shall include in the form all information required by the Department. The information in the form shall be reported monthly to the Department, which will be used to increase public awareness of health care information concerning hospitals in Nevada (NRS 449.485).

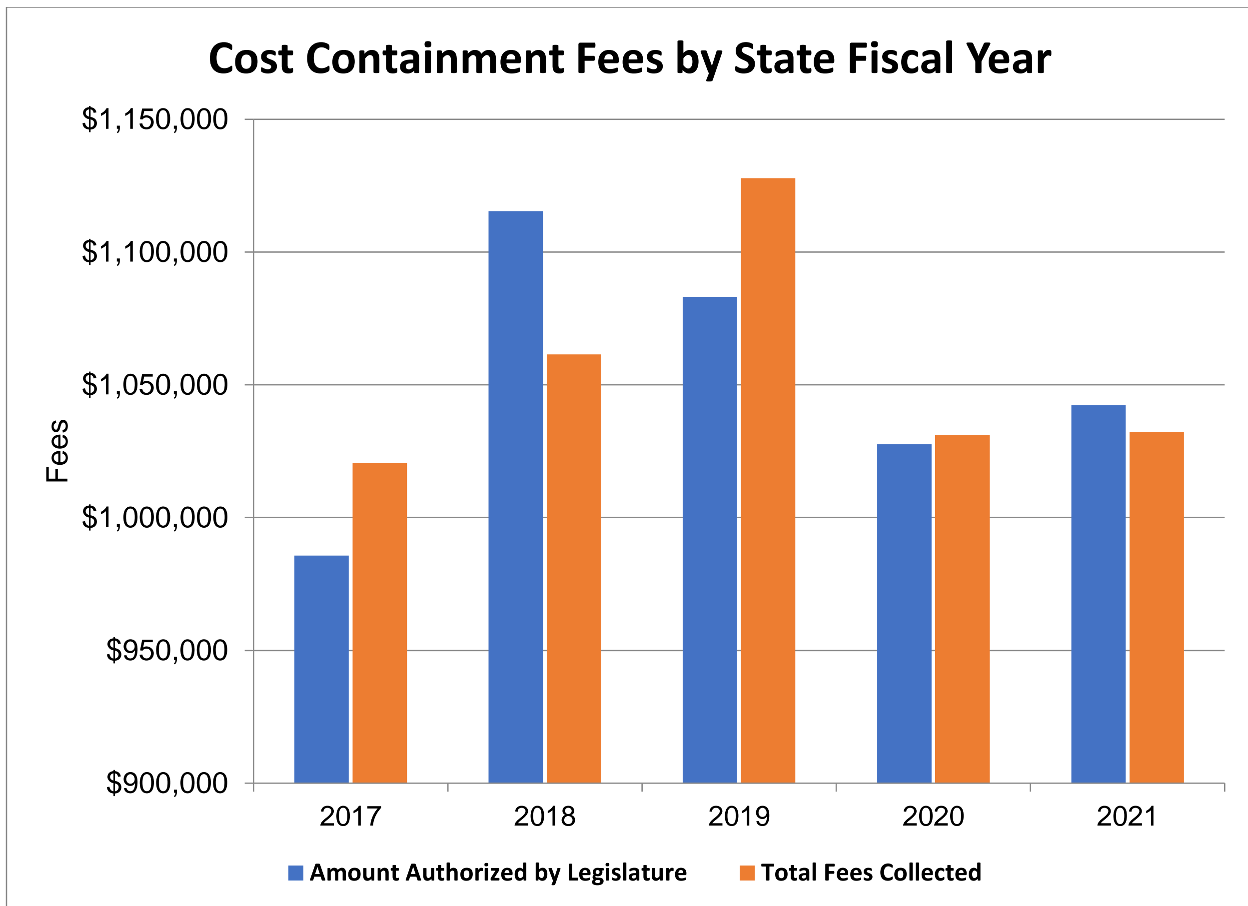
Every institution which is subject to the provision of NRS 449.450 to 449.530, inclusive, shall file financial statements or reports with the Department (NRS 449.490).

Health Care Administration Fee

The Director of Health and Human Services has the authority to impose fees on admitted health care insurers to carry out the provisions of NRS 449.450 to 449.530. The total amount authorized by the Legislature each biennium is divided by the number of admitted health insurers on the first day of the fiscal year as reported to the Commissioner of Insurance to determine the amount owed by each insurer. Under Nevada Administrative Code (NAC) 449.953, the Division has the authority to impose penalties for late payments. Penalties collected for late payments in State Fiscal Year (SFY) 2020 were $73,078.

The table below provides a five-year look at the total fees imposed and collected from admitted health care insurers.

Cost Containment Fees					
	2017	2018	2019	2020	2021
Amount Authorized by Legislature	$985,752	$1,115,424	$1,083,131	$1,027,589	$1,042,294
Total Fees Collected	$1,020,513	$1,061,511	$1,127,797	$1,031,079	$1,032,336
Number of Health Insurers to Pay	411	627	628	647	642



Manner in which Healthcare Providers are Reporting Information

Monthly Reporting

In conjunction with the University of Nevada, Las Vegas (UNLV) Center for Health Information Analysis (CHIA), DHCFP continues to maintain a statewide database of Universal Billing (UB) form information obtained from hospitals pursuant to this section. The UB database is also utilized by outside providers to analyze Nevada's health care trends. Additional information is included under the *Published Reports* section that follows.

The information reported by hospitals includes admission source, payer class, zip code, acuity level, diagnosis, and procedures. This level of detail allows for trend analysis using various parameters, including specific illnesses and quality of care issues. The detail of the UB database is also available, upon request, in an electronic medium to researchers. Researchers may receive data after approval of a Limited Data Set Use Agreement.

In the 2007 Legislative Session, the DHCFP adopted regulations to implement Assembly Bill 146 that requires greater transparency in reporting. The DHCFP contracted with UNLV CHIA to create a Transparency Website. The purpose of the Transparency Website is to increase public awareness of health care information concerning inpatient and outpatient hospitals and ambulatory surgical centers in this state. Diagnostic Related Group (DRG) diagnoses and treatments, physician name, as well as the nationally recognized quality indicators Potentially Preventable Readmissions and Provider Preventable Conditions, are information posted on the website. This information is available in both fixed and interactive reports. These reports enable the consumer and researchers to do comparative analyses between health care facilities. The website is located at:

www.nevadacomparecare.net

Quarterly Reporting

Pursuant to NAC 449.960, hospitals are required to submit quarterly reports regarding their financial and utilization information in a consistent manner. Hospitals must present these reports, referred to as Nevada Healthcare Quarterly Reports (NHQRs), in accordance with the Generally Accepted Accounting Principles (GAAP) issued by the Financial Accounting Standards Board (FASB).

Electronic submission of the NHQRs to CHIA is required. Information is submitted by the providers based on the best information available at the time the reports are entered. Revised NHQRs are to be filed when material changes are discovered. Utilization and financial reports, which include individual facilities as well as summary information, are available for both the acute care and non-acute care hospitals. Utilization reports are also available for Ambulatory Surgery, Imaging, Skilled Nursing/Intermediate Care, and Hospice Facilities. The DHCFP actively works with CHIA, the Nevada Hospital Association, and other stakeholders to continually update medical provider reporting, assure consistency, and to create a more functional tool for users. These reports may be found at:

https://nhqrnv.com/public/output_reports.php

Published Reports

The DHCFP, in conjunction with CHIA, publishes or makes available various reports deemed "desirable to the public interest" on the Transparency Website. The website allows users to download and print various reports such as statistical, utilization, sentinel events, Nevada Annual Hospital Reports, and comparative reports on DRGs, diagnosis, and procedures.

The statewide database of UB information obtained from hospitals pursuant to this section is the basic source of data used for hospital cost comparisons included in the CHIA publication *Personal Health Choices*. The latest edition for the period 2016 - 2020, published in July/August of 2021, is included as *ATTACHMENT A*. *Personal Health Choices* and additional information on the UB database may be found on the CHIA website at:

http://nevadacomparecare.net/static-choices.php

CHIA publishes a package of standard reports based upon the UB hospital billing records. These reports are currently available for calendar years 2010 - 2020.

Comprehensive summaries of the utilization and financial data reported by Nevada hospitals and other health care providers are available for download on CHIA's website at:

http://nevadacomparecare.net/static-standard-reports.php

A list of the financial and utilization reports, accessible on CHIA's website, is attached as *Exhibit 6*.

Exhibit Data

Beginning in calendar year 2013, the Exhibits and related report data contained in the *Report on Activities and Operations* will be updated annually as a result of automation in the report generator with the UNLV/CHIA/NHQR database. These updates may result in changes to prior year data as compared to previous reports.

NEVADA MEDICAID SUPPLEMENTAL PAYMENTS AND RATE CHANGES

Hospitals receive payments from the State of Nevada in accordance with provisions of the Nevada Medicaid State Plan, Titles XIX and XXI of the Social Security Act, all applicable federal regulations and other official issuance of the Department. U. S. Department of Health and Human Services methods and standards used to determine rates for inpatient and outpatient services are located in the State Plan under Attachments 4.19-A through E. Standard fee schedules are updated, at a minimum, on an annual basis. The current Nevada Medicaid Fee Schedules broken out by provider type may be found at:

http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

NEVADA MEDICAID SUPPLEMENTAL PAYMENT PROGRAMS

In order to preserve access to hospital services, Nevada Medicaid administers various supplemental payment programs that directly benefit Nevada hospitals for providing these services. A summary of total supplemental payments received by Nevada Acute Care Hospitals in SFY 2021 may be found in *Exhibit 1A*, and a five-year summary of total supplemental payments received by Nevada Acute Care Hospitals may be found in *Exhibit 1B*. These supplemental payment programs are not funded using State General Funds but are funded through county and public entity Intergovernmental Transfers (IGTs) and federal matching dollars in accordance with state law and federal regulations.

5 Year Change	Nevada Medicaid Acute Care Hospital Supplemental Payments ($M)	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
	Non-State Government Owned (Public) Hospitals	$177.2	$176.6	$185.0	$170.1	$173.0
-2.40%	% increase (decrease) from prior year	0.31%	(0.38%)	4.80%	(8.06%)	1.69%
	Private Hospitals	$89.5	$96.5	$118.2	$120.6	$93.1
4.05%	% increase (decrease) from prior year	91.09%	7.77%	22.51%	2.02%	(22.75%)
	Total Nevada Acute Care Hospitals	$266.7	$273.0	$303.2	$290.7	$266.1
-0.24%	% increase (decrease) from prior year	19.32%	2.35%	11.05%	(4.13%)	(8.45%)

Over the last five years, total supplemental payments received by Nevada Acute Care Hospitals have decreased by 0.24% (-$641.6 thousand) from $266.7 million in SFY 2017 to $266.1 million in SFY 2021. During that time, supplemental payments to Non-State Government Owned (Public) Hospitals decreased by 2.40% (-$4.2 million) and supplemental payments to Private Hospitals increased by 4.05% ($3.6 million).

Additional information regarding the supplemental payment programs administered by Nevada Medicaid may be found at:

http://dhcfp.nv.gov/Pgms/SR/SupplementalPymtMain/

Disproportionate Share Hospital Supplemental Payment Program

Title XIX of the Social Security Act authorizes federal grants to states for Medicaid programs that provide medical assistance to low-income families, the elderly and persons with disabilities. Section 1902(a)(13)(A)(iv) of the Act requires that States make Medicaid payment adjustments for hospitals that serve a disproportionate share of low-income patients with special needs. Section 1923 of the Act contains more specific requirements related to such Disproportionate Share Hospital (DSH) payments, including aggregate annual state-specific limits on Federal Financial Participation (FFP) under Section 1923(f), and hospital-specific limits on DSH payments under section 1923(g). The Nevada formula for distributing these payments is authorized pursuant to NRS 422.380 – 387 and the State Plan for Medicaid Attachment 4.19-A, Pages 21-25.

DSH allotments reflect the annual maximum amount of FFP available to the State for the DSH program. The DSH allotment is determined by the Centers for Medicare and Medicaid Services (CMS) as the higher of (1) the federal fiscal year (FFY) 2004 DSH allotment or (2) the prior year's DSH allotment increased by the percentage of change in the consumer price index for all urban consumers (CPI-U) for the prior fiscal year. The resulting amount must not exceed the greater of (1) the DSH allotment for the previous fiscal year or (2) 12% of total State Plan medical assistance expenditures during the fiscal year. CMS often updates the allotment amounts prior to finalization which results in revision of the corresponding DSH payments. The FFY 2019 and FFY 2020 DSH allotments are currently preliminary amounts and are subject to revision by CMS.

Under the Affordable Care Act (ACA), DSH allotments were scheduled to be reduced beginning in FFY 2014 and continuing through FFY 2020 due to decreases in the rate of uninsured and under-insured individuals as estimated by the Congressional Budget Office. However, subsequent legislation has postponed the timing of these reductions until FFY 2021 through FFY 2026. However, in January 2021 the allotment reduction was postponed to FFY 2024. The national aggregate allotment reductions if implemented in FFY 2024 are as follows:

- $4,000,000,000 for FFY 2024
- $8,000,000,000 for FFY 2025
- $8,000,000,000 for FFY 2026
- $8,000,000,000 for FFY 2027
- $8,000,000,000 for FFY 2028
- $8,000,000,000 for FFY 2029

Federal Regulations require CMS to allocate the ACA DSH reductions to states based on the following criteria:

1. The largest percentage of reductions must be imposed on:
   a. States with the lowest percentage of uninsured individuals.
   b. States who do not target DSH payments to hospitals with a high volume of Medicaid inpatients.
   c. States who do not target DSH payments to hospitals with a high level of uncompensated care.

The smallest percentage of reductions must be imposed on "Low DSH" states.

The preliminary DSH allotment for federal fiscal year 2021 is $54,841,822.

In SFY 2021, $74,349,874 was distributed to Nevada hospitals through the DSH program, a decrease of 11.57% from SFY 2020's distribution of $84,081,174. Due to state-level impacts of ACA, additional changes to the DSH program are anticipated in upcoming years.

Upper Payment Limit Supplemental Payment Programs

Federal Medicaid regulations allow for State Medicaid Agencies to pay hospitals under a Fee-for-Service environment an amount that would equal what Medicare would have paid for the same services. This concept is referred to as the Upper Payment Limit (UPL).

Nevada currently has Inpatient (IP) Non-State Government Owned (Public) Hospital, Outpatient (OP) Non-State Government Owned (Public) Hospital, and IP Private Hospital UPL Supplemental Payment Programs. The formulas for calculating and distributing these payments is authorized pursuant to the Medicaid State Plan Attachment 4.19-A, Pages 32-33a (IP Hospital UPLs) and Attachment 4.19-B, Page 20 (OP Hospital UPL). In SFY 2021, $48,914,822 was distributed to IP Public Hospitals, $17,086,971 to OP Public Hospitals and $18,120,880 was distributed via IP Private UPL programs. This represents an increase of 38.92% for the IP Public Hospital UPL, an increase of 7.49% for the OP Public UPL and a decrease of 16.9% for the IP Private UPL supplemental payment programs when compared to SFY 2020 distributions.

Graduate Medical Education Supplemental Payment Program

The formula for calculating and distributing these payments is authorized pursuant to the Medicaid State Plan Attachment 4.19-A, Pages 31 and 31a. The Nevada Graduate Medical Education (GME) methodology is based upon teaching hospital interns and residents, not Medicare slots. In state fiscal year 2021, $32,125,987 was distributed to Nevada hospitals through this program, an increase of 7.46% over the $29,896,721 distributed through this program in SFY 2020.

In October 2017, CMS approved a State Plan Amendment (SPA) that expanded the eligibility to participate in the GME Supplemental Payment program to all Non-State Government Owned (Public) Hospitals offering GME services in Nevada, as well as certain Private Hospitals that are located in a county in which there is no Non-State Government Owned (Public) Hospital offering GME services. This SPA also created two separate methodologies for making Fee-for-Service (FFS) GME payments separate from Managed Care Organization (MCO) GME payments.

Hospital Indigent Fund Supplemental Payment Program

The Hospital Indigent Fund (HIF), previously known as the Indigent Accident Fund (IAF) Supplemental Payment program is intended to preserve access to inpatient hospital services for needy individuals in Nevada. This supplemental payment is authorized by NRS 428.206. The formula for calculating and distributing these payments is authorized pursuant to the Medicaid State Plan, Section 4.19-A, Pages 32b-32d. In SFY 2021, $75,496,676 was distributed to Nevada hospitals through this program, a decrease of 27.66% over the $104,375,281 distributed through this program in SFY 2020.

The preliminary SFY 2022 total IAF/HIF Supplemental Payment submitted to CMS for approval at the time of this publication is $70,660,110.91.

NEVADA MEDICAID RATE CHANGES

Nevada Medicaid makes proposed changes to the Medicaid plans or payment methodologies using State Plan Amendments (SPAs). SPAs are vetted through Public Workshops and Public Hearings before being submitted to the DHCFP Administration, the Director of HHS and finally CMS for final approval. Listed below are the SPAs that have an effective date in CY 2020:

Effective Date	Title	Information
04/01/2020	GEMT Carveout	SPA 20-0006
		The DHCFP made changes to the Nevada Medicaid State Plan to align with updates regarding Ground Emergency Medical Transportation (GEMT) being carved out from the Nevada Medicaid Managed Care Organizations (MCOs) to Fee-for-Service Medicaid.
		Attachment 3.1-D, Pages 1 and 1a; Attachment 4.19-B, Page 4.
		The SPA was approved 06/29/2020 with an effecitve date of 04/01/2020.
03/01/2020		SPA 20-0009. COVID-19 National Emergency SPA #1. Medical disaster relief for the COVID-19 National Emergency.
		The SPA was approved 06/18/2020 with an effective date of 03/01/2020.
09/01/2020	ICF/IID	SPA 20-0014. An amendment to the Nevada Medicaid State Plan, Attachment 4.19-D, pages 11 through 13, to update the reimbursement methodology for Small/Private ICF/IID providers. The proposed change restructured the current reimbursement methodology. Under the proposed rate methodology, Small/Private ICF/IID providers would be paid an interim rate calculated using the provider's adjusted cost report, subject to cost settlement at 100% of the provider's allowable costs. This State Plan Amendment also corrects language included in the reimbursement methodology for Public Intermediate Care Facilities in order to reflect the correct terminology used to describe Individuals with Intellectual Disabilities.
		The SPA was approved 12/17/2020 with an effective date of 09/01/2020.
07/18/2020	Correct State Plan Pages	SPA 20-0015. Attachment 4.19-B, Pages 1e and 1e (continued): Corrections were made to the Nevada Medicaid State Plan. The changes consist of reinstating the reimbursement methodology for Community Paramedicine services and Nurse Anesthetist. The following Provider Types (PT) were affected by this change: Community Paramedicine (PT 32, Specialty 249) and Nurse Anesthetist (PT 72). The change did not affect the rates.
		The SPA was approved 09/17/2020 with an effective date of 07/18/2020.
07/01/2020	Specialized Foster Care	SPA 20-0003. 1915(i) State Plan Home and Community-Based Services Administration and Operation. A new provider type (86-Specialized Foster Care) was established.
		Services: Intensive in-home services and supports; Crisis stabilization services.
		Attachment 3.1-i2, Pages 1-45; Attachment 4.19-B, Page 18-18f; Attachemtn 2.2-A, Page 1-2
		The SPA was approved 08/07/2020 with an effective date of 07/01/2020.
Other SPAs:		
During the 31st (2020) Special Session of the Nevada Legislature, Assembly Bill 3 (AB3) was presented which would reduce the rates for Nevada Medicaid providers by 6%.		
Because of this, changes would need to be made the the State Plan to adjust the methodology used to set rates to allow for the reduction.		
Public hearing was held August 13, 2020.		
There were 13 State Plan Amendments (SPAs) submitted to the Centers for Medicare and Medicaid Services (CMS) to approve the proposed changes.		
The Nevada Legislature has deemed the 6% rate reduction implementation will not be necessary and Nevada Medicaid has withdrawn this initiative.		
CMS was notified and all SPAs related to the the rate reductions were withdrawn.		

SUMMARY INFORMATION AND ANALYSES
HOSPITALS WITH 100 OR MORE BEDS

NRS 449.490 requires reporting for hospitals with 100 or more beds. They report on capital improvements, community benefits, home office allocation methodologies, discount and collection policies and the availability of a complete current Charge Master.

CHARGE MASTER AVAILABILITY AT HOSPITALS

Pursuant to NRS 449.490, Subsection 4, a complete current Charge Master must be available at each hospital with 100 or more beds during normal business hours. This requirement is subject to review by the Director, any payer that has a contract with the hospital to pay for services provided by the hospital, any payer that has received a bill from the hospital or any state agency that is authorized to review such information.

No violations of Charge Master availability have been reported to the Division.

HOSPITAL INFORMATION

General hospital information concerning nineteen acute hospitals in Nevada with more than 100 beds is presented in *Exhibit 2*. The information includes location, corporate name, number of beds, type of ownership, availability of community benefits coordinator, availability of charitable foundation, whether the hospital conducts teaching and research, trauma center information, and whether the hospital is a sole provider of any specific clinical services in their area.

Committee on Hospital Quality of Care

Each hospital licensed to operate in Nevada is required to form a committee to ensure the quality of care provided by the hospital. Requirements for such committees are specified by the Joint Commission on Accreditation of Healthcare Organizations or by the Federal Government pursuant to Title XIX of the Social Security Act (NRS 449.476).

POLICIES AND PROCEDURES REGARDING DISCOUNTS OFFERED TO PATIENTS AND REVIEW OF POLICIES AND PROCEDURES USED TO COLLECT UNPAID PATIENT ACCOUNTS

NRS 439B.440 requires the Director to engage an auditor to conduct an examination to determine whether hospitals are in compliance with provisions of NRS 439B. The statute refers to these engagements as audits, however, in accordance with the American Institute of Certified Public Accountants promulgations, these are "Agreed Upon Procedure" engagements, not audits. Reports of engagements performed biennially by an independent contractor detail information regarding compliance of the 18 non-county-owned hospitals that have 100 beds or more in the state. Per NRS 439B.440 Subsection 3, University Medical Center of Southern Nevada in Clark County, being a county-owned hospital, is exempt from this requirement.

The engagement tests hospitals for compliance with:

- NRS 439B.260, requiring a 30% discount for uninsured patients,
- NRS 439B.410, reviewing appropriateness of emergency room patient logs, transfers into or out of the hospital, review of policies and procedure in the emergency room, and review of any complaints in the emergency room,
- NRS 439B.420, reviewing of contractual arrangements between hospital and physicians or other medical care providers; and
- NRS 439B.430, reviewing of related party transactions and ensure appropriate allocation.

SUMMARY OF COMPLIANCE ISSUES FROM REQUIRED OR PERFORMED ENGAGEMENTS

NRS 449.520 requires a summary of any trends noted from these engagements be reported. The reports covering July 1, 2017 thru June 30, 2019 show two distinct trends. Trends are noted below:

Emergency Room Services

One trend, at seven separate hospitals, was noted as an exception to NRS 439B.410, regarding transfers from emergency rooms. Trend related to hospitals not maintaining their emergency room patient logs pursuant to their policies and procedures.

Contractual Arrangements

No instances of non-conformance with rental contract provisions were identified.

Reduction of Billed Charges

One trend, at five separate hospitals, was noted as an exception to NRS 439B.260. Trend related to policies requiring maximum income levels for eligibility for self-pay patient discounts.

Corrective action plans are required of all facilities found to be out of compliance.

CORPORATE HOME OFFICE COST ALLOCATION METHODOLOGIES

Home office allocation methodologies for the hospitals that were subject to the above engagements were reviewed by the independent contractor with hospital staff. No exceptions were noted. These can be viewed at the end of the individual annual compliance reports on the Transparency Website:

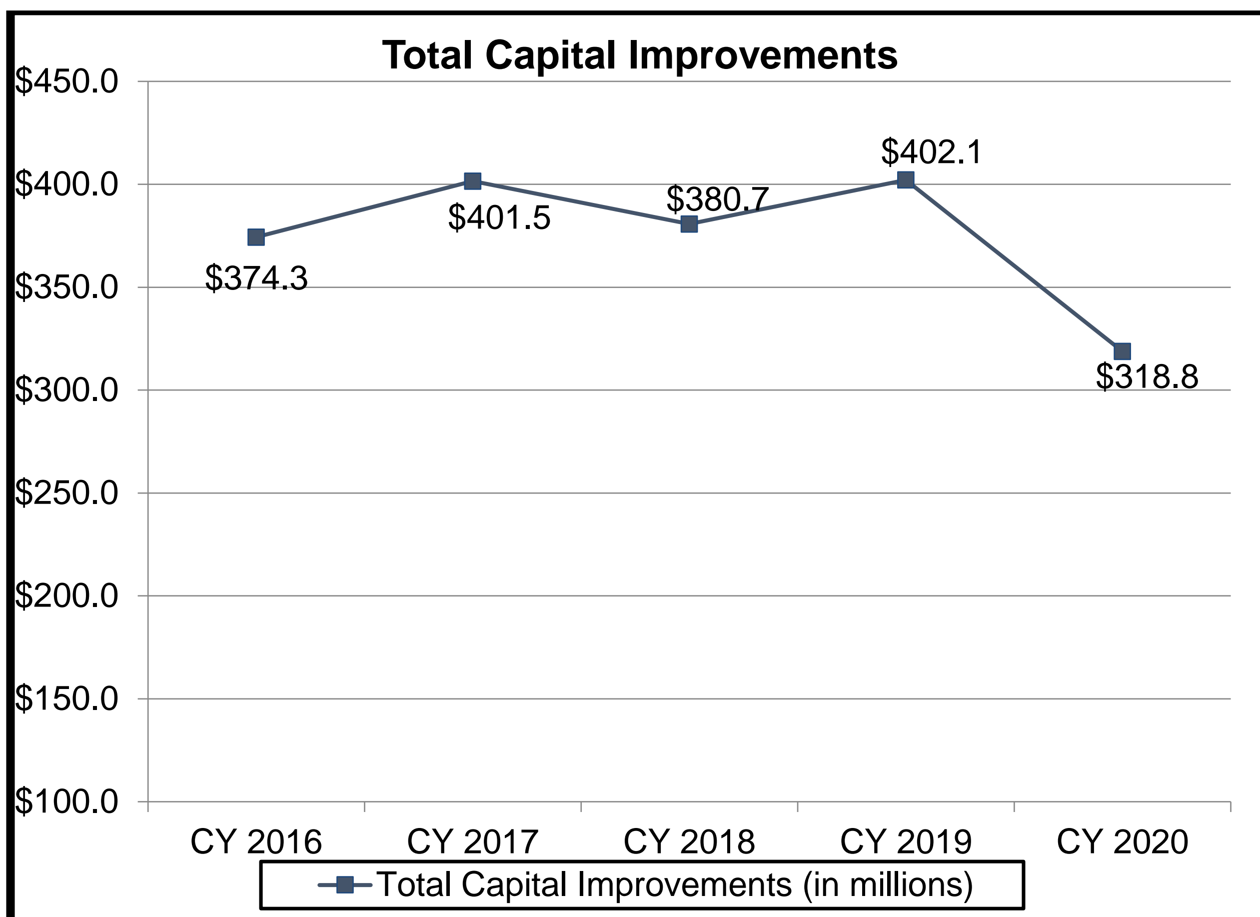
http://www.nevadacomparecare.net/nv-reports.php

A brief description of each home office allocation methodology may also be found in *Exhibit 5*.

SUMMARY OF CAPITAL IMPROVEMENT REPORTS

Capital Improvements cover three areas: New Major Services Lines, Major Facility Expansions and Major Equipment. In order to avoid duplication of reporting, no costs are reported for the addition of Major Service Lines. The costs for Major Expansions do not include equipment. A threshold of $500,000 has been established for reporting Major Equipment additions. Capital Improvements that do not meet the reporting thresholds are reported in aggregate. Hospitals reported Capital Improvement costs for 2020 as follows:

Major Expansions	**$ 131,846,937.39**
Major Equipment	**$ 60,595,945.80**
Additions Not Required to be Reported Separately	**$ 126,310,667.80**
Total	**$ 318,753,550.99**

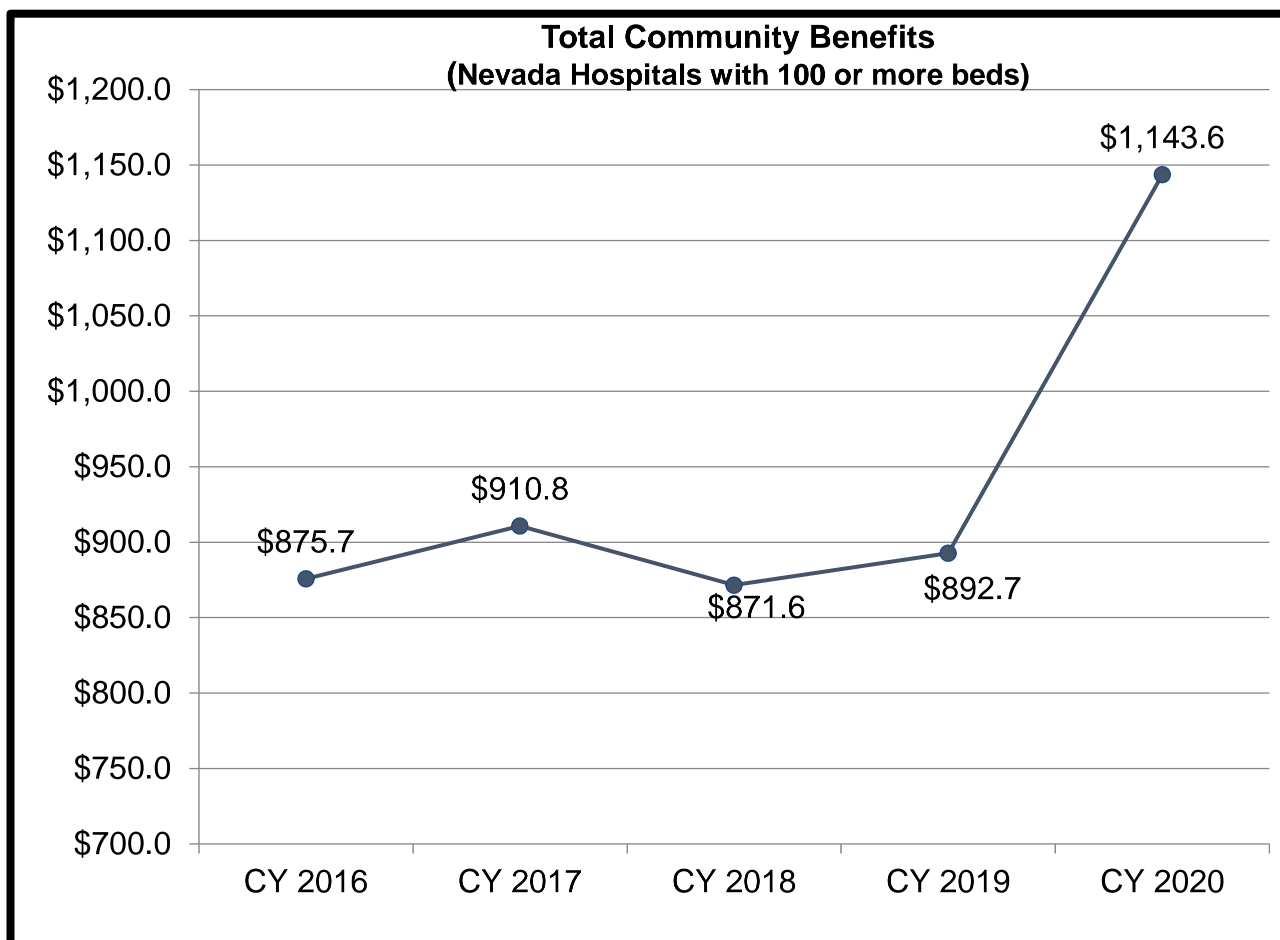


Capital Improvements					
	CY 2016	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**
Total Capital Improvements (in millions)	$374.3	$401.5	$380.7	$402.1	$318.8
Percentage Change	46.84%	7.27%	(5.18%)	5.62%	(20.72%)

See *Exhibit 3* for details.

EXPENSES INCURRED FOR PROVIDING COMMUNITY BENEFITS

The Total Community Benefits reported[1] for 2020 was $1,143,603,341. Of that total, Subsidized Health Care Services costs accounted for $1,043,293,003, providing Health Professions Education $44,661,990, Community Health Improvement Services $25,406,915, and Other Categories $30,241,433. The reported Community Benefits for 2020 increased by 28.11% from 2019 a significant increase over the average total amount for the past 5 years. For more details regarding the decrease in Capital Improvements and increase in Community Benefits, see page 19, Effects of COVID19 on Nevada Hospitals, analysis provided by the Nevada Hospital Association.



Community Benefits					
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Total Community Benefits	$875.7	$910.8	$871.6	$892.7	$1,143.6
Percentage Change	0.79%	4.01%	(4.30%)	2.42%	28.11%

See *Exhibit 4* for details.

[1] Information provided by Nevada Hospital Association

SUMMARY INFORMATION AND ANALYSES OF ALL HOSPITALS

HOSPITAL GROUPINGS

The acute care hospitals are grouped into the following categories:
Hospitals located in rural parts of Washoe (Incline Village Community Hospital) and Clark (Mesa View Regional Hospital and Boulder City Hospital) counties are included in the Rural Hospital category for CHIA reporting purposes. Data from the Rehabilitation/Specialty Hospitals and the Psychiatric Hospitals, none of which are located in a rural county, are reported separately. The CHIA website contains both financial and utilization information; the following pages summarize this data. The data on the CHIA website is self-reported.

38 Acute Care Hospitals (Orthopedic Specialty Hospital – formerly Mountain's Edge closed effective 10 Sep 2020; financial and utilization data was reported for the period they were operational. A new hospital was to have opened on the existing site but that has not happened as of the publication of this report. There may only be 37 Acute Care Hospitals in next year's report if this status does not change.), 11 Rehab/Long Term Care (LTC)/Specialty Hospitals, and eight Psychiatric Hospitals reported data to CHIA in 2020.

There are five government-operated hospitals (federal and state) in Nevada, which do not have standard private sector operating costs and revenues. Additionally, there are two maximum security psychiatric facilities in Nevada. Lake's Crossing Center is a maximum-security psychiatric facility providing comprehensive forensic mental health services, including court-ordered evaluation and/or treatment for restoration to legal competency. Lake's Crossing Center also provides outpatient evaluations of legal competency, risk assessments and recommendations for treatment. The Stein Hospital, a maximum-security forensic facility/psychiatric hospital for mentally disordered offenders in Las Vegas, NV, opened in October 2015. The Stein Hospital is one of three hospital buildings that make up Southern Nevada Adult Mental Health Services. These facilities' financial performance data is not covered in this report.

FINANCIAL SUMMARIES

The five-year financial summary in *Exhibits 7A-D* presents hospital reported condensed financial and utilization information for Acute Care Hospitals in Nevada. Detailed information for the individual Acute Care Hospitals is presented in *Exhibits 9A-E*.

Comparative Financial Indicators

The following data were utilized in calculating the indicators:

- Billed Charges and Other Operating Revenue
- Total Operating Revenue
- Operating Expenses
- Net Operating Income

The calculations for the indicators are derived by using information from the Financial Summaries for Hospital Billed Charges and Other Operating Revenue, Total Operating Revenue, Operating Expenses and Net Operating Income.

Common Size Statements

Common size statements are "vertical analyses" that use percentages to facilitate trend analysis and data comparison. The components of financial information are represented as percentages of a common base figure. Key financial changes and trends can be highlighted using common size statements. Common size statements are utilized in the Comparative Financial Summary (*Exhibit 7*). Different financial information was represented as percentages of a common base figure. Total Deductions and Operating Revenue were represented as a percentage of Billed Charges; Other Operating Revenue, Operating Expenses, Net Operating Income, Non-Operating Revenue and Non-Operating Expenses are also represented as percentages of Total Operating Revenue.

ANALYSIS

Acute Care Hospitals

The five-year Comparative Financial Summary tables (*Exhibits 7A-D*) were prepared for the Acute Care Hospitals. The Comparative Financial Summaries (2015 - 2019) report both the financial and the common size statement information (vertical analyses). *Exhibit 7* reports Billed Charges, Deductions and Operating Revenue. Operating Revenue is the amount paid by patients (or third-party payer) for services received. Other Operating Revenue and Non-Operating Revenue include non-patient related revenue such as investment income or tax subsidies.

Hospital Profitability

The Comparative Financial Summary, Statewide Acute Care Hospitals Totals, shows the Hospital Net Income/Loss[2] as a percentage of Total Revenues.[3] Nevada facilities reported Net Income from 2016 through 2020. The Net Profit Margin (Net Income ÷ Total Operating Revenue) expressed as percentages from *Exhibit 7A* are presented in the table below:

Hospital Profitability (Statewide)					
	CY 2016	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**
Net Profit Margin	7.07%	4.55%	5.44%	7.13%	2.53%

All 38 Nevada Acute Care Hospitals reported a 2.53% Net Income for 2020 and collectively earned $177,130,290 with a Total Operating Revenue of $6,909,813,942. The gains and losses ranged from a Net Income of $54,515,294 for Summerlin Hospital Medical Center to a Net Loss of ($85,286,288) for the University Medical Center of Southern Nevada.

[2] Net of *Net Operating Income, Non-operating Revenue* and *Non-Operating Expense*
[3] The sum of *Total Operating Revenue* and *Non-Operating Revenues*

11 of the 19 Clark County Acute Care Hospitals reported a Net Income in 2020. The Total Net Income for all Clark County Acute Care Hospitals was $100,564,233, a decrease of 67.89% from 2019. Summerlin Hospital Medical Center had the highest Net Income of $54,515,294 and University Medical Center of Southern Nevada had the largest Net Loss of ($85,286,288).

Four of the five Washoe County/Carson City Acute Care Hospitals reported a Net Income in 2020. The Total Net Income for all Washoe County/Carson City Acute Care Hospitals was $43,218,693, a decrease of 72.83% from 2019. Carson Tahoe Regional Medical Center had the highest Net Income at $31,300,063 and Renown Regional Medical Center had the largest Net Loss of ($25,827,615).

11 of the 14 Rural Acute Care Hospitals reported a Net Income in 2020. The Total Net Income for all Rural Acute Care Hospitals was $33,347,364, an increase of 4.74% from 2019. Northeastern Nevada Regional Hospital had the highest Net Income of $13,255,943 and Desert View Hospital had the largest Net Loss of ($4,215,610).

Many hospitals in Nevada have corporate affiliations. These parent companies help reduce costs and help absorb losses over multiple facilities.

Universal Health Services

In 2020, Universal Health Services, Inc. (UHS) operate eight Acute Care Hospitals in Nevada. Six of these are located in Clark County; Centennial Hills Hospital, Desert Springs Hospital, Henderson Hospital, Spring Valley Hospital, Summerlin Hospital, and Valley Hospital Medical Center; one, located in the Washoe/Carson City Area, Northern Nevada Medical Center; and one, located in rural Pahrump, NV, Desert View Hospital. Total number of beds in the 6 hospitals is 1,887.

In 2020, UHS completed several expansions including adding a new patient tower at Centennial Hills Hospital in Las Vegas; opened three new Freestanding Emergency Departments (FEDs); and continued construction of Northern Nevada Sierra Medical Center, the first full-service hospital to be built in Reno in nearly a century, on-target to open in 2022. Northern Nevada Medical Center was named a Top General Hospital by The Leapfrog Group. The Top General Hospitals award, given to just 29 hospitals nationally, is widely acknowledged as one of the most competitive honors American Hospitals can earn. Further, Henderson Hospital was named a Top Teaching Hospital.[4]

UHS' Nevada hospitals experienced a 5.7% gain in Net Profit Margin in 2020 on an annual Total Operating Revenue of $1.92B. Overall, in 2020, UHS experienced a 1.6% growth in Net Revenue ($11.378B in 2019 to $11.559B in 2020) and a 15.1% increase in Net Income ($827.5M in 2019 to $952.8M).[5]

[4] UHS Annual Report 2020 (10-K)
[5] UHS Annual Report 2020 (10-K)

Hospital Corporation of America

Hospital Corporation of America (HCA) operates three Acute Care Hospitals in Nevada, all located in Clark County: Mountain View Hospital, Southern Hills Hospital and Medical Center and Sunrise Hospital Medical Center. Total number of beds in the 3 hospitals is 1,452.

HCA Healthcare Nevada hospitals experienced a 5.6% gain in Net Profit Margin in 2020 on an annual Total Operating Revenue of $1.47B. Overall, in 2020, HCA experienced a 0.4% growth in Net Revenue ($51.34B in 2019 to $51.53B in 2020) and a 7.1% increase in Net Income ($3.51B in 2019 to $3.75B in 2020).[6] All three HCA Nevada hospitals reported Net Income totaling $82.3 million; Mountain View at $34.2 million and 6.4% Net Income; Southern Hills Hospital and Medical Center at $28.7 million and 10.9% Net Income; and Sunrise Hospital Medical Center at $19.4 million and 2.9% Net Income. HCA facilities are located in 20 states and in the United Kingdom.

CommonSpirit Health

CommonSpirit operates seven hospitals in Nevada, all located in Clark County; St. Rose Dominican Blue Diamond, St. Rose Dominican Craig Ranch, St. Rose Dominican Sahara, St. Rose Dominican West Flamingo designated by CommonSpirit as "Neighborhood Hospitals," along with their major facilities; St. Rose Dominican Rose de Lima Campus, St. Rose Dominican San Martin Campus, and St. Rose Dominican Siena Campus. Total number of beds in the 7 hospitals is 615.

CommonSpirit Nevada hospitals experienced a 0.6% loss in Net Profit Margin in 2020 on an annual Total Operating Revenue of $734.1M. Overall, in 2020, CommonSpirit experienced a 2.5% growth in Total Operating Revenue ($28.86B in 2019 to $29.58B in 2020) and a 123% increase in Operating Losses (-$617M in 2019 to -$1.38B in 2020). In Nevada, CommonSpirit's top performing hospital was St. Rose Dominican Siena Campus with a net income of $3.5M. CommonSpirit operates more than 700 care sites across the U.S.—from clinics and hospitals to home-based care and virtual care services—CommonSpirit is accessible to nearly one out of every four U.S. residents.[7]

Prime Healthcare

Prime Healthcare (Prime) operates St. Mary's Regional Medical Center in Reno and North Vista Hospital in Las Vegas. Total number of beds in the 2 hospitals is 557.

Prime Healthcare Nevada hospitals experienced a 6.6% gain in Net Profit Margin in 2020 on an annual Total Operating Revenue of $399.7M. St. Mary's reported a Net Income of $12.4M while North Vista reported a Net Income of $14.0M combining for a total Net Income of $26.4M. In addition to the two Nevada hospitals, Prime owns/operates 45 hospitals in 13 other states throughout the country.[8]

[6] HCA Healthcare 2020 Annual Report to Shareholders
[7] CommonSpirit Unaudited Pro Forma Annual Report for Years Ended June 30, 2020 and 2019
[8] Data extracted from Exhibits 9A-D.

Effects of COVID-19 on Nevada Hospitals

In 2020 with the beginning of the COVID-19 pandemic, the Nevada Health Association stated that Nevada Hospitals experienced significantly adverse impacts from the pandemic and the ensuing national emergency declaration. Nevada hospitals lost operating revenue from the cancellation of elective surgeries, decreased emergency room utilization and general admission avoidance. These events were only partially offset by volume increases from COVID-19 patients. Pre-COVID patient volumes have not fully recovered as the State re-opens.

As a result of supply chain interruptions and increased demand for certain supplies, hospital operating expense increased during 2020. The key drivers of expense were (1) increased (and inflated) payroll costs (contract/registry staff) to meet patient needs; (2) increased Medical Supply expenses driven by personal protective equipment (PPE), pharmaceuticals, oxygen and COVID testing supplies; (3) increased Medical Equipment such as ventilators, tents, hospital beds, respirators and tele-medicine equipment; (4) increased hospital housekeeping expenses associated with increased medical waste, garbage, and linen/laundry expenses.

Hospitals also spent to increase capacity above their normal licensed bed capacity to meet surge demand. Hospitals spent funds for tents, trailers, testing equipment and additionally made upgrades to their physical plant like additional negative pressure rooms and build-out of "shelled" bed units to address patient surges.

Nevada hospitals received funds from American Rescue Act and the CARES act, however, these funds came with robust reporting requirements and narrow opportunities for how the funds could be used including how Provider Relief Funding (PRF) could be used to offset lost revenue. Some hospitals during the year chose to return funds to HHS once distributed; and others will be returning unspent funds during 2021 and/or 2022.

Health Care Spending Growth

The American Hospital Association has stated, in recent years, health care spending growth has largely been driven by increased use and intensity of services.

- Health insurance coverage has grown to cover an additional 21-22 million people since 2010.
- An aging population uses more health care, on average.
- Today's population has a higher rate of chronic disease, with nearly half of Americans having chronic conditions such as diabetes and heart disease.
- Medical advances bring health benefits that often raise costs.

Wages and benefits account for almost 60% of inpatient hospital costs.[9]

[9] American Hospital Association, *The Cost of Caring*, *September 2019*

The table below shows the Nevada median hourly wages for two specific hospital occupations:

Nevada Median Wages					
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Registered Nurses	$40.71	$42.29	$40.97	$42.02	$42.29
Clinical Laboratory Technologists and Technicians	$34.84	$33.96	$29.19	$29.31	$29.53

From 2016 to 2020, the Nevada median wage for Registered Nurses increased only 3.88% but decreased (15.24%) for Clinical Laboratory Technologists and Technicians. 2020 witnessed a slight increase in both categories from 2019 by 0.64% and 0.75% respectively.[10]

Billed Charges, Operating Revenue and Deductions

Hospitals determine what they will charge for items and services provided to patients and these charges are the amount the hospital bills for an item or service (Billed Charges). Statewide, Billed Charges have increased by 37.81% over the last five years. This represents an increase of $13.73 billion between 2016 and 2020. Changes in Billed Charges are seen in Clark County, Washoe County/Carson City and Rural Hospitals, as outlined in the table below:

5 Year Change	Nevada Acute Care Hospital Billed Charges ($M)	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
	Clark County Hospitals	$29,118.0	$32,714.5	$36,732.8	$41,034.6	$41,601.2
42.87%	% change from prior year	14.25%	12.35%	12.28%	11.71%	1.38%
	Washoe County/Carson City Hospitals	$6,232.0	$6,927.0	$7,106.2	$7,478.8	$7,340.6
17.79%	% change from prior year	9.17%	11.15%	2.59%	5.24%	(1.85%)
	Rural Hospitals	$965.6	$987.7	$1,053.7	$1,149.4	$1,105.7
14.51%	% change from prior year	2.53%	2.29%	6.68%	9.08%	(3.80%)
	Statewide Hospitals	$36,315.6	$40,629.2	$44,892.7	$49,662.8	$50,047.5
37.81%	% change from prior year	13.00%	11.88%	10.49%	10.63%	0.77%

The Billed Charges, when compared to Operating Revenue (the amount patients or third-party payers pay) and Deductions (contractual allowances and bad debts), provide insight into the market competition among health care providers. Operating Revenue on a statewide basis has steadily decreased from 15.79% in 2016 to 13.03% in 2020. This decrease is visible across the state impacting hospitals in Clark County, Washoe County/Carson City and Rural hospitals, as outlined in the following table. Total Deductions on a statewide basis have gradually increased from 84.21% in 2016 to 86.97% in 2020.

[10] Bureau of Labor Statistics, Occupational Employment Statistics (OES) Survey.

The Total Deductions as a percent of Billed Charges for Clark County hospitals, Washoe County/Carson City hospitals and Rural Hospitals are also outlined in the table below:

	Operating Revenue (as a Percent of Billed Charges)		Total Deductions (as a Percent of Billed Charges)	
	CY 2016	CY 2020	CY 2016	CY 2020
Clark County	13.62%	11.01%	86.38%	88.99%
Washoe County/Carson City	22.89%	21.70%	77.11%	78.30%
Rural Hospitals	35.33%	33.39%	64.67%	66.61%
Statewide	15.79%	13.03%	84.21%	86.97%

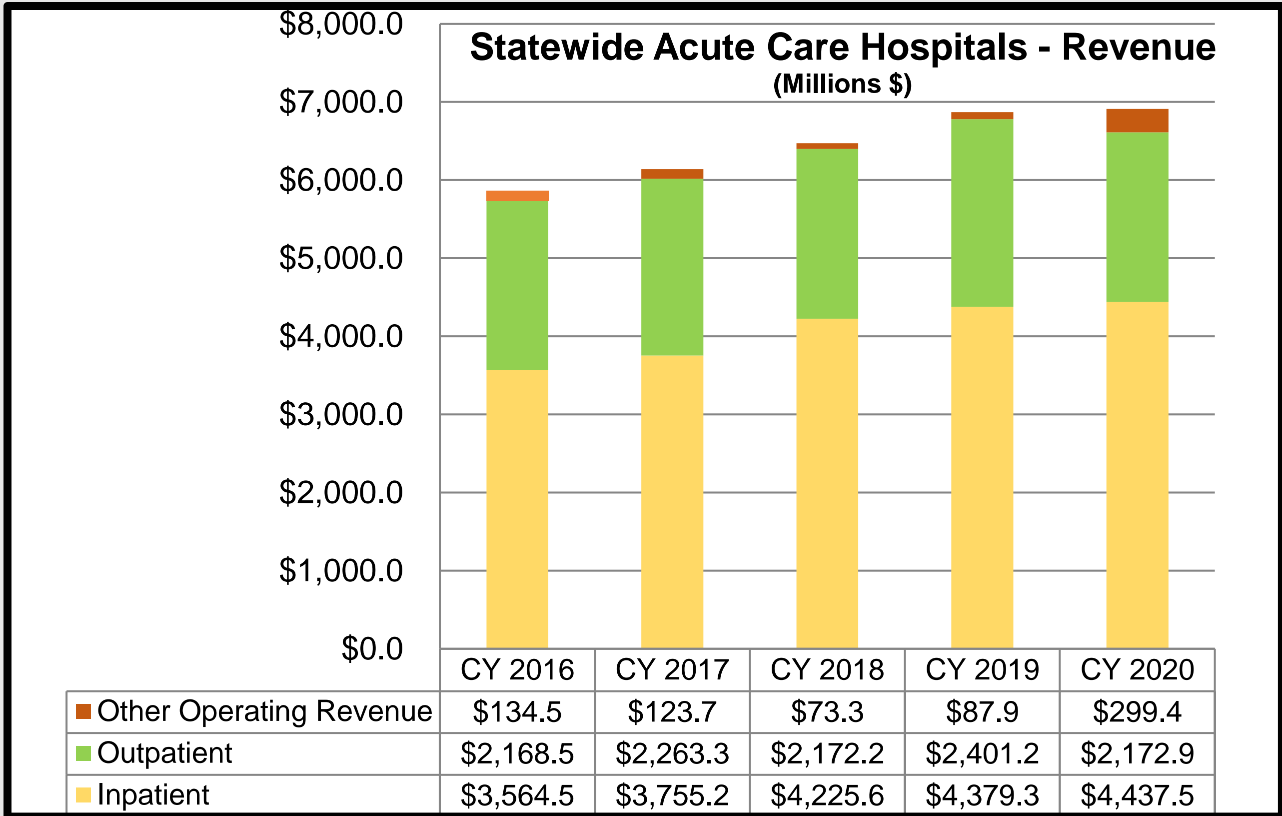
See *Exhibits 7A-D* for details.

In general, Rural hospitals are not in competition with other hospitals. As a result, Operating Revenues at Rural hospitals are a larger percentage of their Billed Charges, although the same decline seen statewide has been observed over the five-year period within the Rural hospital group. Per the above table, Clark County hospitals' Total Deductions are the highest when compared to Washoe County/Carson City and the Rural hospitals.

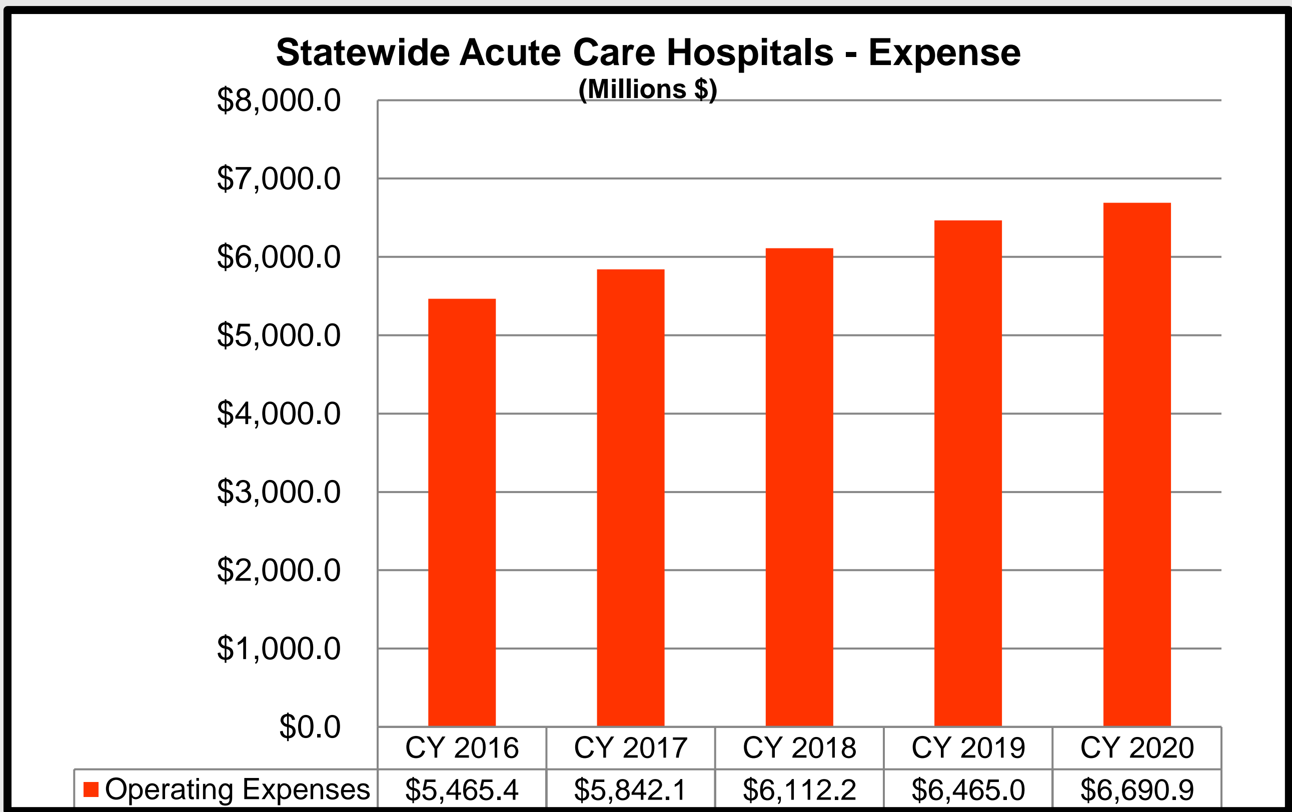
Revenue and Expenses

The following table and graphs display the financial status of Acute Care Hospital operations on a statewide basis over the five-year period. Total Operating Revenue (TOR) is comprised of its components; Inpatient Revenue, Outpatient Revenue and Other Operating Revenue. TOR and Operating Expenses have grown over the five-year period, however Operating Expenses grew at a higher pace in 2020 resulting in a decrease in Net Operating Income in CY 2020. The financial indicators listed in *Exhibit 7A* are the basis for this data.

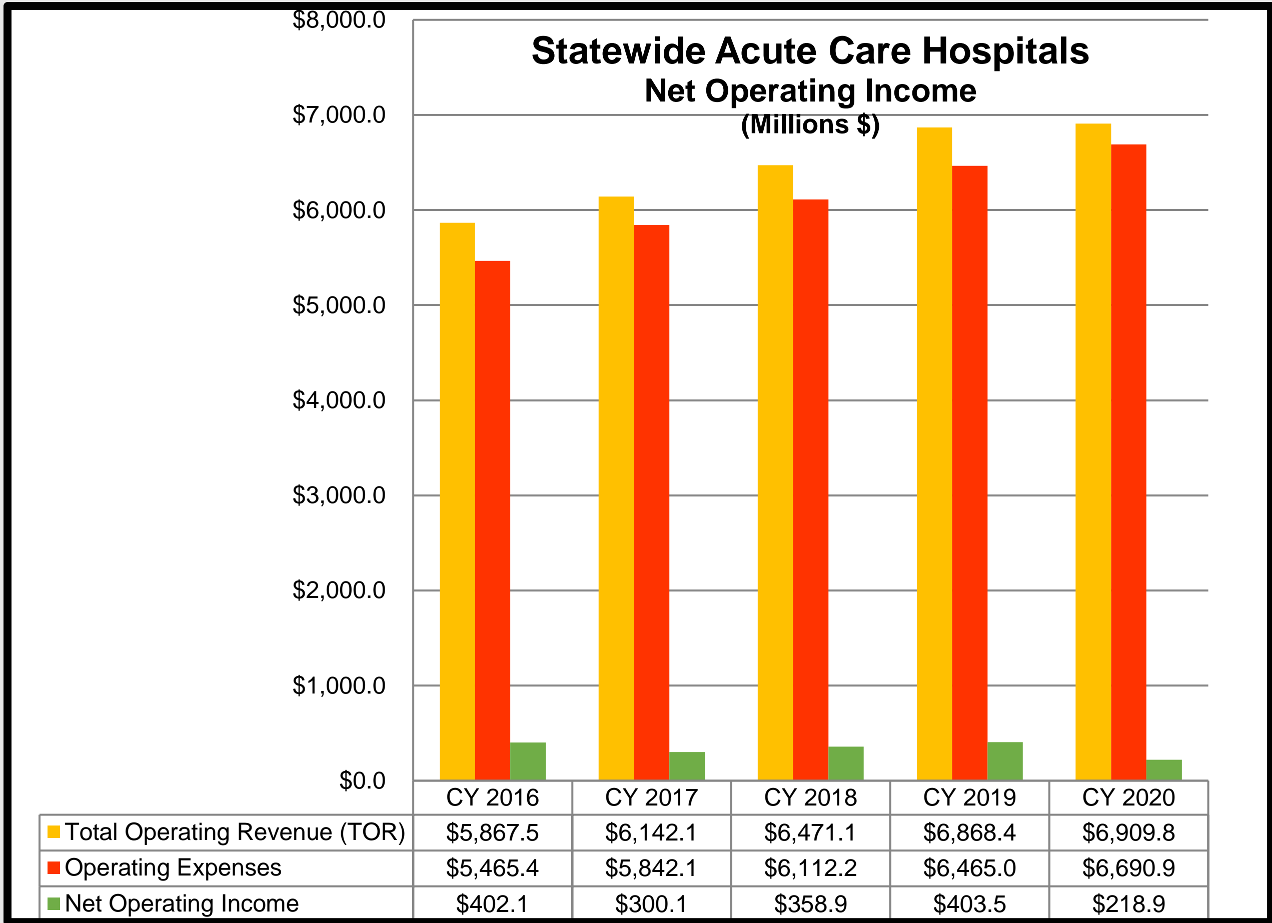
Statewide Acute Care Hospital Totals (in millions)					
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Billed Charges	**$36,315.6**	**$40,629.3**	**$44,892.7**	**$49,662.8**	**$50,047.5**
Inpatient	$23,193.3	$25,889.0	$28,543.9	$31,619.4	$32,997.4
Outpatient	$13,122.3	$14,740.2	$16,348.8	$18,043.4	$17,050.1
Deductions	**$30,582.6**	**$34,532.8**	**$38,494.9**	**$42,976.5**	**$43,526.3**
Inpatient	$19,628.9	$22,133.8	$24,318.3	$27,240.1	$28,559.9
Outpatient	$10,953.8	$12,399.0	$14,176.6	$15,736.4	$14,966.3
Operating Revenue	**$5,733.0**	**$6,018.5**	**$6,397.8**	**$6,780.5**	**$6,610.4**
Inpatient	$3,564.5	$3,755.2	$4,225.6	$4,379.3	$4,437.5
Outpatient	$2,168.5	$2,263.3	$2,172.2	$2,401.2	$2,172.9
Other Operating Revenue	**$134.5**	**$123.7**	**$73.3**	**$87.9**	**$299.4**
Total Operating Revenue (TOR)	**$5,867.5**	**$6,142.1**	**$6,471.1**	**$6,868.4**	**$6,909.8**
Operating Expenses	$5,465.4	$5,842.1	$6,112.2	$6,465.0	$6,690.9
Net Operating Income	**$402.1**	**$300.1**	**$358.9**	**$403.5**	**$218.9**
Non-Operating Revenue	$116.5	$76.7	$77.5	$202.1	$95.8
Non-Operating Expenses	$95.8	$69.6	$80.0	$101.5	$137.5
Net Income / (Loss)	**$422.8**	**$307.2**	**$356.4**	**$504.1**	**$177.1**
Percent Gain (Loss) to TOR	**6.85%**	**4.89%**	**5.55%**	**5.87%**	**3.17%**



	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Other Operating Revenue	$134.5	$123.7	$73.3	$87.9	$299.4
Outpatient	$2,168.5	$2,263.3	$2,172.2	$2,401.2	$2,172.9
Inpatient	$3,564.5	$3,755.2	$4,225.6	$4,379.3	$4,437.5



	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Operating Expenses	$5,465.4	$5,842.1	$6,112.2	$6,465.0	$6,690.9

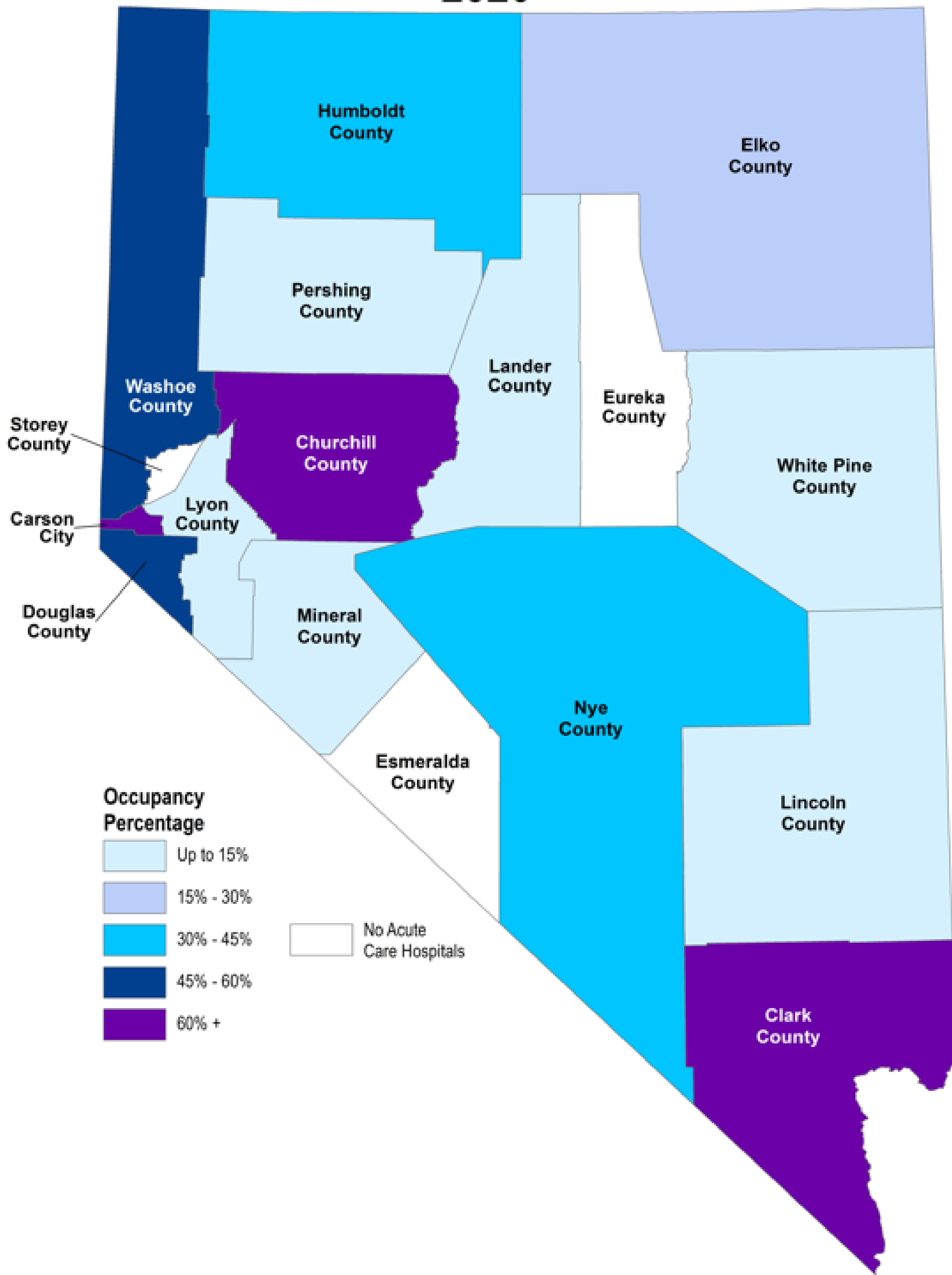


	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Total Operating Revenue (TOR)	$5,867.5	$6,142.1	$6,471.1	$6,868.4	$6,909.8
Operating Expenses	$5,465.4	$5,842.1	$6,112.2	$6,465.0	$6,690.9
Net Operating Income	$402.1	$300.1	$358.9	$403.5	$218.9

2020 Acute Care Hospital Occupancy Percentage by County

The following chart shows the occupancy rate of Acute Care Hospitals in the state. There are no Acute Care Hospitals in Esmerelda, Eureka, or Storey counties, therefore data is not applicable for those counties. The percentages of Occupancy are computed by taking the total inpatient days per hospital grouped into their respective county and dividing those numbers by the multiplication of available hospital beds times 365.

Nevada Acute Care Hospitals - Occupancy Percentage
2020



Rehabilitation/Long-Term Care/Specialty Hospitals

The Rehabilitation/Long-Term Care/Specialty Hospitals reported a Net Income of $3,587,351 from Total Operating Revenue of $239,321,407. Complex Care Hospital at Tenaya and Kindred Hospital—Las Vegas at St. Rose Dominican both closed in 2019. Eight of the 11 Rehabilitation/Long-Term Care/Specialty Hospitals reported profits in 2020. Total Operating revenue and Net Income from the last five years are as follows (in millions of dollars).

Rehabilitation/Long Term Care/Specialty Hospital Net Margin ($M)					
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Total Operating Revenue	$312.1	$306.5	$304.6	$255.0	$239.3
Net Income	$35.6	$40.7	$27.4	$26.8	$3.6
Net Margin	11.4%	13.3%	9.0%	10.5%	1.5%

Critical Access Hospitals

Critical Access Hospital (CAH) is a designation given to certain Rural hospitals by the Centers for Medicare and Medicaid Services (CMS). To ensure that CAHs deliver services to improve access to rural areas that need it most, restrictions exist concerning what types of hospitals are eligible for the CAH designation. The primary eligibility requirements for CAHs are:

- A CAH must have 25 or fewer acute care inpatient beds
- Typically, it must be located more than 35 miles from another hospital
- It must maintain an annual average length of stay of 96 hours or less for acute care patients
- It must provide 24/7 emergency care services

Nevada has 13 hospitals designated as CAHs. In Nevada, hospitals designated as CAHs by CMS are reimbursed by Nevada Medicaid through a retrospective cost reimbursement process for Fee-for-Service inpatient services. Fee-for-Service outpatient services provided by CAHs are reimbursed based on the Medicaid Outpatient Hospital fee schedule.

- Banner Churchill Community Hospital
- Battle Mountain General Hospital
- Boulder City Hospital
- Carson Valley Medical Center
- Desert View Regional Medical Center
- Grover C Dils Medical Center
- Humboldt General Hospital
- Incline Village Community Hospital
- Mesa View Regional Hospital
- Mount Grant General Hospital
- Pershing General Hospital
- South Lyon Medical Center
- William Bee Ririe Hospital

Psychiatric Hospitals

Only three of eight psychiatric hospitals reported profits for 2020. As a group, they reported a Net Loss of ($8,881,249) from Total Operating Revenue of $121,436,887 (-7.3% Net Margin). The comparison of 2016 through 2020 Net Income (Loss) for each facility is reported below:

Notes for future data:

- Red Rock voluntarily terminated in 2017 and their data will be carried for year over year comparisons.
- Montevista was involuntarily terminated in Aug 2019 and their data will be carried forward for year over year comparisons.

Psychiatric Hospital Net Income (Loss)	Net Income/(Loss)	Net Income/(Loss)	Net Income/(Loss)	Net Income/(Loss)	Net Income/(Loss)
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
BHC West Hills Hospital	$3,165,911	$829,154	($572,956)	($2,408,398)	($2,387,383)
Desert Parkway Behavioral Healthcare Hospital	$130,723	$75,347	$25,046	$115,561	$186,542
Montevista Hospital	$5,038,708	$4,521,414	$2,327,985	$0	$0
Red Rock Behavioral Health	$228,182	$0	$0	$0	$0
Reno Behavioral Heath Care	$0	$0	($2,127,596)	($2,677,438)	($2,258,018)
Seven Hills Behavioral Institute	$6,940,493	$7,172,646	$6,491,118	$2,239,617	$1,905,618
Spring Mountain Sahara	$269,756	$1,317,189	$1,391,134	$1,212,797	($18,460)
Spring Mountain Treatment Center	$1,577,742	$1,625,548	$1,808,619	$914,396	($645,680)
Willow Springs Center	$708,356	($1,468,643)	($3,729,923)	($4,614,726)	($5,663,868)
TOTAL	**$18,059,871**	**$14,072,655**	**$5,613,427**	**($5,218,191)**	**($8,881,249)**

The Total Operating Revenue and Net Income from the last five years are as follows.

Psychiatric Hospital Net Margin ($M)					
	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Total Operating Revenue	$141.4	$143.0	$151.3	$121.6	$121.4
Net Income	$18.1	$14.1	$5.6	($5.2)	($8.9)
Net Margin	12.8%	9.9%	3.7%	-4.3%	-7.3%

Exhibits