Memorial Hospital of Lafayette County

Presentation to the

Board of Trustees

Year Ended December 31, 2020

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The following information is solely for the use of Lafayette County's Board of Trustees and management. The financial information was derived from the audited financial statements for the years ended December 31, 2019, to December 31, 2020, and from other information obtained through the course of our audit.

Required Communications

Required Communications

Auditor's responsibility under auditing standards generally accepted in the United States

- To express an opinion about whether the financial statements prepared by management with your oversight are fairly presented in all material respects in conformity with accounting principles generally accepted in the United States (GAAP) as applied to government units.
- Our procedures are designed to obtain reasonable, rather than absolute, assurance about the financial statements.

Scope of audit report

- The draft audit report has an unmodified opinion on the financial statements of Memorial Hospital of Lafayette County (an enterprise fund of Lafayette County) (the "Hospital"). The opinion includes the following:
  - Emphasis of matter that financial statements are for Memorial Hospital of Lafayette County only.
  - Explanation that management has omitted the management's discussion and analysis.

Required Communications

Independence

- There are no relationships between Wipfli LLP and the Hospital that, in our professional judgment, would reasonably be thought to impair our independence.

Significant Accounting Policies

- The significant accounting policies used by the Hospital are outlined in Note 1 to the financial statements.

Management Representations

- We will obtain a management representation letter, signed by management, and dated as of the date the financial statements are issued. The letter will be attached to the required communications letter.

Errors and Irregularities

- There were no material errors, irregularities, or illegal acts noted during the audit.

Required Communications

Audit Adjustments

- There were 12 audit adjustments posted to the 2020 financial statements. The net effect of the entries increased the net position by approximately $4.2 million. The significant adjustments were as follows:

	Increase (Decrease) in Net Position
Change in net position, at audit fieldwork	$ (3,447,000)
Audit adjustments:	
To recognize revenue related to funding received due to the global pandemic	2,312,000
To adjust the third-party settlement for Medicare and Medicaid at year-end	2,080,000
To record pension activity related to Wisconsin Retirement System and Other Postemployment Benefits	(48,000)
To correct recording of CAH assessment as of December 31, 2020	(35,000)
Other	(68,000)
Total adjustments	4,241,000
Change in net position, as of December 31, 2020	$ 794,000

Required Communications

Significant Deficiencies in Internal Controls

- Financial Accounting and Reporting – preparation of audited financial statements
- Audit Adjustments
- Segregation of Duties

Review of Audited Financial Statement

Global Pandemic Funding

Global Pandemic Funding – Buckets of Money:

1. Paycheck Protection Program (PPP) – Loan that may be forgiven if certain criteria is met
2. HHS Provider Relief Payments (CARES Act) – grants from the Federal Government to be used for COVID related expenses or to supplement for lost revenue due to COVID
3. Other Funding – including funds from FEMA and the State of Wisconsin

Money Received by Memorial Hospital of Lafayette County:

1. PPP Loan **$1.9 million,** Record as a **liability** on the statements of net position (Current portion and long-term debt). Fully forgiven in May 2021.
2. CARES Act funds approximately **$4.4 million,** Record $2.4 million as a **liability** on the statements of net position (Unearned revenue that has not yet been identified as spent), record $2.0 million as **grant revenue** on the statements of revenue, expenses, and changes in net position.
3. Other Funding approximately **$240 thousand**, Record as **grant revenue** on the statements of revenues, expenses, and changes in net position.

Statements of Net Position

Assets and Deferred Outflows of Resources	2020	2019
Current assets:		
Cash and cash equivalents	$ 4,494,608	$ 1,896,821
Patient receivables - Net	2,862,388	2,908,098
Amount receivable from third-party reimbusrement programs	2,385,000	308,218
Other current assets	803,364	792,674
Total current assets	10,545,360	5,905,811
Noncurrent assets:		
Investment in unconsolidated affiiate	68,966	30,793
Restricted - Net pension assets	1,388,698	-
Capital assets - Net	6,483,749	5,996,237
Total noncurrent assets	7,941,413	6,027,030
Total assets	18,486,773	11,932,841
Deferred outflows of resources - Related to pensions and OPEB	3,551,216	3,516,054
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 22,037,989	$ 15,448,895

- Cash and cash equivalents comprised approximately 24% of total assets at December 31, 2020, compared to 16% of total assets at December 31, 2019. The increase is due primarily to government funding that was received in 2020 related to the global pandemic.
- Amount receivable from third-party reimbursement programs increased $2 million due to an estimated receivable on the Medicare and Medicaid cost reports at December 31, 2020 .
- The restricted – net pension assets and deferred outflows of resources represent the accounting for GASB 68 and 75 related to the pension plan and other post employment benefits (OPEB).
- Capital assets – net increased $500 thousand or 8% between years.
- Total assets and deferred outflows of resources increased $6.6 million or 43% between 2019 and 2020.

Statements of Net Position (Continued)

Liabilities. Deferred Inflows of Resources, and Net Position	2020	2019
Current liabilities:		
Current portion of capital lease payable and long-term debt	$ 1,878,820	$ 409,868
Accounts payable	530,432	358,791
Unearned revenue	2,450,000	-
Accrued expenses and other	420,911	604,471
Total current liabilities	5,280,163	1,373,130
Noncurrent liabilities:		
Capital lease payable and long-term debt	2,529,620	2,364,456
Compensated absences	713,535	461,887
Pension liability - Net	-	1,441,730
OPEB liability	754,802	376,442
Total noncurrent liabilities	3,997,957	4,644,515
Total liabilities	9,278,120	6,017,645
Deferred inflows of resources - Related to pensions	4,294,826	1,760,075
Total net position	8,465,043	7,671,175
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	$ 22,037,989	$ 15,448,895

- The increase in the current portion of capital lease payable and long-term debt is due primarily to the PPP loan that was received during 2020 to provide financial assistance during the global pandemic.
- The unearned revenue is the portion of the HHS Provider Relief Funds (CARES Act) that was not identified as spent as of December 31, 2020.
- The pension liability – net, OPEB liability, and deferred inflows of resources – related to pension represent the accounting for GASB 68 and 75.
- Total net position increased $794 thousand or 10%.

Statements of Revenue, Expenses, and Changes in Net Position

	2020	2019
Operating revenue:		
Net patient service revenue	$ 21,655,307	$ 21,846,411
Other revenue	19,638	12,394
Total operating revenue	21,674,945	21,858,805
Operating expenses:		
Operating expenses	22,078,965	20,360,362
Depreciation	1,107,019	819,619
Total operating expenses	23,185,984	21,179,981
Income (loss) from operations	(1,511,039)	678,824
Nonoperating revenue:		
Grant revenue	2,188,086	-
Other nonoperating revenue - Net	116,821	56,367
Income before transfers	793,868	735,191
Funds transferred to Lafayette County	-	(50,000)
Change in net postion	793,868	685,191
Net position at beginning of year	7,671,175	6,985,984
Net position at end of year	$ 8,465,043	$ 7,671,175

- Net patient service revenue decreased $191 thousand or 1% from 2019 to 2020.
- Total operating expenses increased $2.0 million or 9% from 2019 to 2020. The largest increases occurred in expenses related to the three rural health clinics and additional supply expense for PPE.
- Included in the 2020 loss from operations is approximately $48 thousand of expense related to GASB 68 and GASB 75 for pension expense and other post employment benefits.
- Prior to the recognition of any funding for the global pandemic, Memorial Hospital of Lafayette County incurred a loss from operations of $1.5 million compared to income from operations of $679 thousand in 2019.
- The loss from operations was offset by $2.2 million of grant revenue related to funding received from the federal and statement government for the global pandemic.
- The change in net position as of December 31, 2020, was $794 thousand compared to $685 thousand at December 31, 2019.

Statements of Cash Flows

	2020	2019
Increase (decrease) in cash and cash equivalents:		
Cash flows from operating activities:		
Cash received from and on behalf of patients	$ 19,325,626	$ 22,389,298
Cash payments for employee compensation and fringe benefits	(10,590,635)	(10,145,046)
Cash paid to suppliers and contractors for goods and services	(10,913,161)	(9,731,184)
Other receipts from operations other than patient services	19,638	12,394
Net cash provided by (used in) operating activities	(2,158,532)	2,525,462
Cash flows from investing activities - Investment income	1,519	1,883
Cash flows from non-capital financing activities:		
Grants and contributions	4,652,984	31,000
Proceeds from Paycheck Protection Program loan	1,952,200	-
Funds transferred to County	-	(50,000)
Distributions from unconsolidated affiliate	13,270	-
Miscellaneous income	66,078	86,113
Net cash provided by non-capital financing activities	6,684,532	67,113
Cash flows from capital and related financing activities:		
Payments on capital lease obligations	(73,160)	(69,080)
Payments on long-term debt	(337,417)	(305,184)
Interest paid	(78,175)	(93,422)
Purchase of capital assets	(1,502,038)	(864,956)
Proceeds from sale of capital assets	61,058	-
Net cash used in capital and related financing activities	(1,929,732)	(1,332,642)
Increase in cash and cash equivalents	2,597,787	1,261,816
Cash and cash equivalents at beginning	1,896,821	635,005
Cash and cash equivalents at end	$ 4,494,608	$ 1,896,821

Notes to Financial Statements

Note 2: COVID-19 (Financial Statement Page 15)

Starting in March 2020, the nation in general, and healthcare-related entities specifically, have been faced with a global pandemic. As healthcare entities prepared for the crisis, operational changes were made to delay routine visits and elective procedures and reevaluate the entire care delivery model to care for patient needs, specifically those affected by COVID-19. The complete financial impact on the economy in general and healthcare-related entities specifically is undeterminable at this time; however, it was noted and is anticipated by the Hospital that both operational performance and cash flows for healthcare-related entities have been and will be impacted in fiscal year 2020 as well as future periods until the pandemic ends.

The federal and state governments, as well as other agencies, have been assisting many healthcare organizations to prevent significant financial constraints by providing supplemental payment programs in the forms of distributions that are intended to help offset lost revenues as well as the cost of staffing, supplies, and equipment from treating patients impacted by or preparing for the pandemic's healthcare needs.

Through December 31, 2020, the Hospital received approximately $4,640,000 in funding from these programs and has deferred recognition of $2,450,000 of funds received based on the current terms and conditions of the programs as of the date of these financial statements. Funding was received from multiple sources, including but not limited to approximately $4,441,000 of provider relief funds from the HHS Coronavirus Aid, Relief, and Economic Security (CARES) Act, and the unexpended provider relief funds are included in current liabilities as unearned revenue in the accompanying statements of net position at December 31, 2020.

These funds are subject to various financial and compliance guidelines for intended uses as published by the federal and state governments. Management is continuing to monitor compliance with the terms and conditions of the Provider Relief Fund as new guidance and clarification is released from HHS and other agencies. If the Hospital is unable to attest to or comply with current or future terms and conditions as more information becomes available, the Hospital’s ability to retain some or all of the distributions received may be impacted.

In addition, the Hospital received $1,952,200 of funding from the U.S. Small Business Administration (SBA) Paycheck Protection Program (PPP) in the form of a loan as part of the CARES Act. See Note 10 for additional information on the PPP loan.

Notes to Financial Statements

Note 14: Other Postemployment Benefits – Local Retiree Life Insurance Fund

(Financial Statement Pages 33 to 37)

Notes to Financial Statements

Note 19: Subsequent Events (Financial Statement Page 42)

Global Pandemic Funds

Subsequent to year-end, the Hospital received additional funds of approximately $300,000 to be used in response to the global pandemic.

Rural Health Clinic Medicare Reimbursement

Effective April 1, 2021, the Hospital's rural health clinics are subject to new Medicare reimbursement rates based on a 2020 base rate indexed annually by the Medicare Economic Index (MEI). Management is evaluating the impact this change in reimbursement methodology will have on the Hospital.

Paycheck Protection Program

On May 6, 2021, the Hospital received notice that the PPP loan in the amount of $1,952,200 was fully forgiven. The loan forgiveness will be recorded as nonoperating revenue in the Statements of Revenue, Expenses, and Change in Net Position in 2021.

Long-Term Debt Payoff

On June 17, 2021, the Hospital paid off three general obligation promissory notes totaling approximately $2,078,000.

Cost-Based Reimbursement

Cost-Based Reimbursement

- Medicare payment methodology for a critical access hospital and provider-based rural health clinics
- Payment from the Medicare program is based on a critical access hospitals "**MEDICARE ALLOWABLE**" costs/expenses
- What does this mean:
  - Simplified illustration:

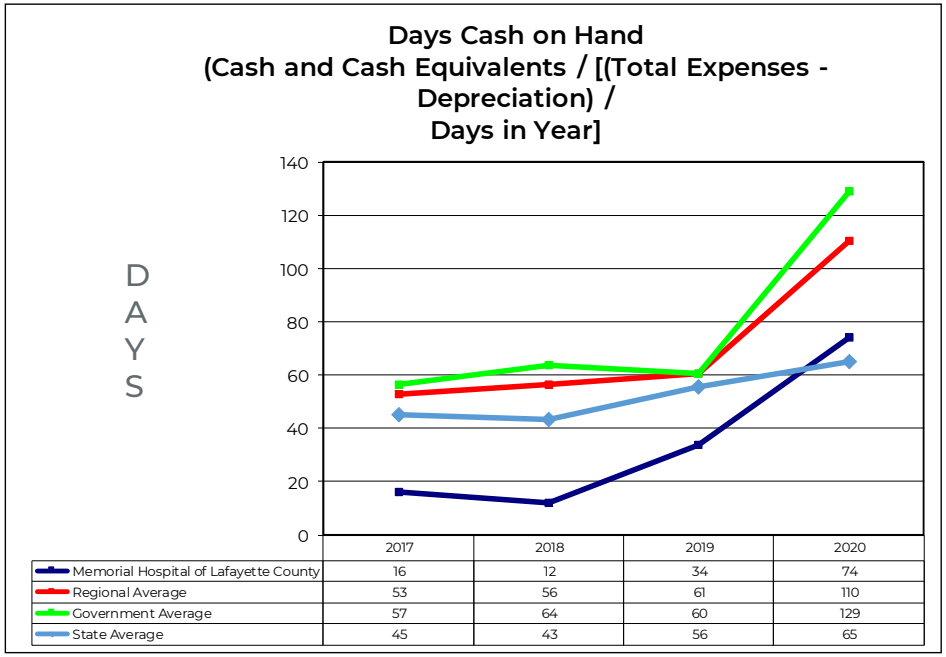
Critical access hospital total annual expenses	$ 1,000,000
Expense not allowable by Medicare:	
Advertising	(75,000)
Physician recruitment	(100,000)
Donation expense	(25,000)
Medicare allowable expenses	800,000
Percentage of Medicare volume	50%
Medicare cost-based reimbursement	$ 400,000

Ratio Analysis

Ratio Analysis

The following ratio analysis was derived from the 2017 to 2020, audited financial statements. The ratios presented compare the financial position and operating results of the Organization to historical levels and industry averages for Critical Access Hospitals in the states of Wisconsin, Michigan, Illinois, Indiana, and Ohio (“Regional Average”), for all government-local hospitals in the United States (“Government Average”), and for all hospitals within the state of Wisconsin (“State Average”) from OptumInsight Inc. Financial Benchmarks - Almanac of Hospital Financial/Operating Indicators (HCRIS 2021 Q2 Data Release as of 5/10/2021).

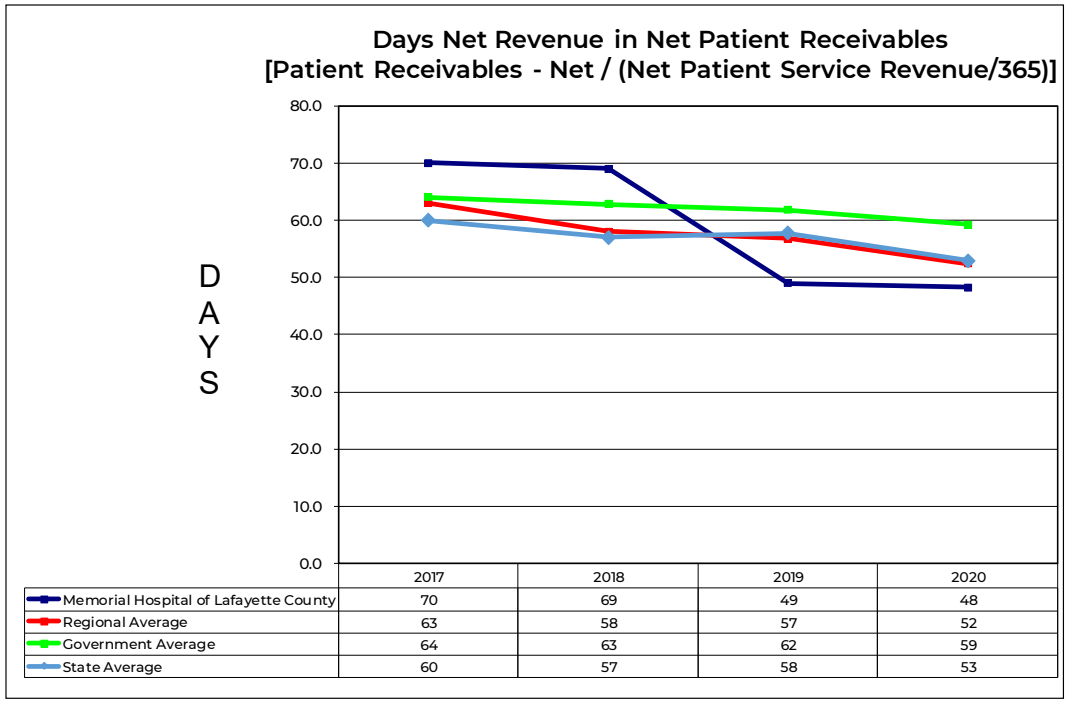
Ratio Analysis



	2017	2018	2019	2020
Memorial Hospital of Lafayette County	16	12	34	74
Regional Average	53	56	61	110
Government Average	57	64	60	129
State Average	45	43	56	65

- Days cash on hand is an indicator that reflects an organization's ability to pay for current operating costs. It is the number of days an organization could operate if no cash was collected.

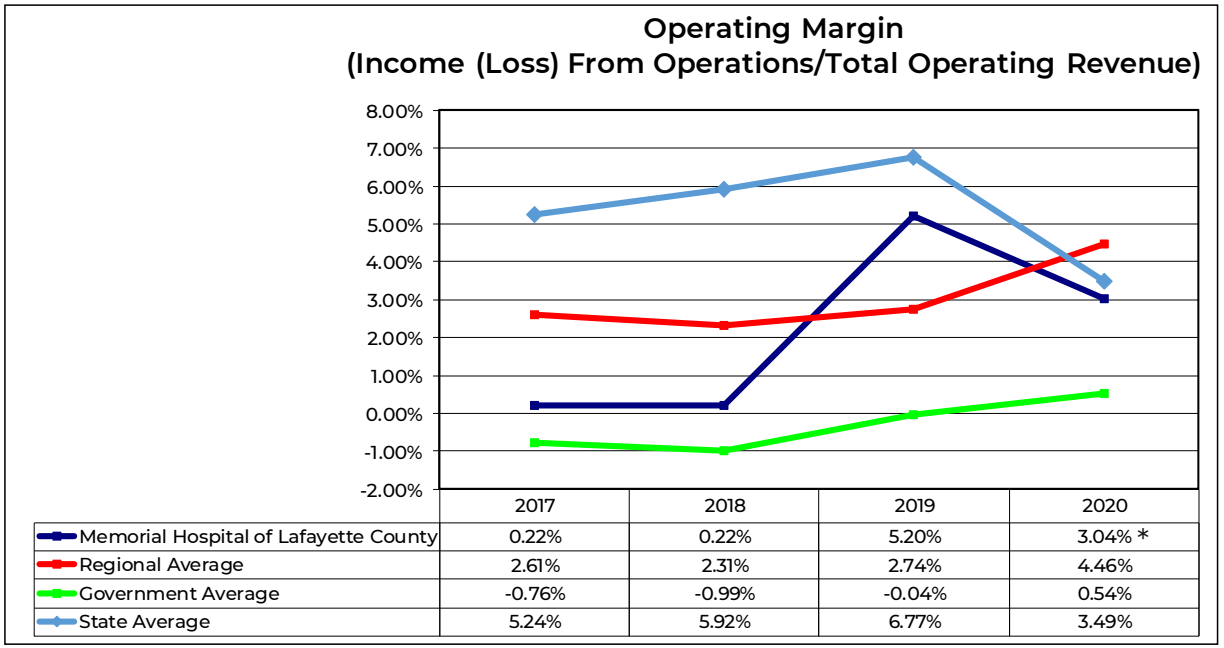
Ratio Analysis



	2017	2018	2019	2020
Memorial Hospital of Lafayette County	70	69	49	48
Regional Average	63	58	57	52
Government Average	64	63	62	59
State Average	60	57	58	53

- Days net revenue in net patient receivables measures the average time it takes to collect payments for services provided to patients.

Ratio Analysis



	2017	2018	2019	2020
Memorial Hospital of Lafayette County	0.22%	0.22%	5.20%	3.04% *
Regional Average	2.61%	2.31%	2.74%	4.46%
Government Average	-0.76%	-0.99%	-0.04%	0.54%
State Average	5.24%	5.92%	6.77%	3.49%

- The Operating Margin for Memorial Hospital of Lafayette County is calculated prior to the audit adjustments related to GASB 68 and 75.
- A primary measure of an organization's operating profitability.

* 2020 includes grant revenue related to global pandemic that is record as nonoperating revenue.

Industry Update

Industry Update

- Provider Relief Fund Updates – July 2021
- Medicare Reimbursement Update

Provider Relief Funds Updates

Updates Effective Through July 1, 2021

- The federal government released preliminary guidance in September 2020, which was updated in both October and November 2020, January 2021, and in June 2021 on the type of reporting which may be required.
- **Then finally - The Provider Relief Fund reporting portal on the HRSA website opened on July 1, 2021.**
- HHS through HRSA provided some sample supporting worksheets to assist with the reporting and providers will be able to return unused funds through the reporting portal. The definitions of support for the provider relief fund distributions were also changed in December 2020 which caused a major shift in what may be "allowable" expenses or lost revenues compared to the original definitions and updates released earlier in the year. This has been a major area of concern for many healthcare providers that run the risk that many of these funds may not be able to be retained under the current definitions. The definitions of support for the provider relief fund distributions was not changed with the most recent guidance released in June 2021; however, the deadline to use funds and reporting time period have been further defined as noted in the table below:

Period	Payments Received	Deadline to Use Funds	Reporting Time Period
Period 1	4/10/2020 – 6/30/2020	6/30/2021	7/1/2021 – 9/30/2021
Period 2	7/1/2020 – 12/31/2020	12/31/2021	1/1/2022 – 3/31/2022
Period 3	1/1/2021 – 6/30/2021	6/30/2022	7/1/2022 – 9/30/2022
Period 4	7/1/2021 – 12/31/2021	12/31/2022	1/1/2023 – 3/31/2023

Provider Relief Fund Updates

Updates Effective Through July 1, 2021 (Continued)

- Portal access information was emailed to the individual at each organization that previously registered for Provider Relief Fund (PRF) portal access with HRSA. If an organization did not receive this email, the portal can be accessed at the following website:
  - https://prfreporting.hrsa.gov/s/
- The PRF website by HRSA also includes some key information including:
  - PRF Resources and Key Links:
    - Reporting and Auditing Requirements
    - Frequently Asked Questions (FAQs)
    - Terms and Conditions
    - General Information
  - PRF Reporting Portal Resources (including portal instructions):
    - Portal FAQs
    - Registration User Guide
    - Reporting User Guide
    - Portal Worksheets

Provider Relief Fund Updates

Updates Effective Through July 1, 2021 (Continued)

- Major Changes to Terms and Conditions released in the July 1, 2021, updates (these could be subject to change in the future with updates to the FAQs also, so it will be important to check these prior to finalizing submission or even following submission of data to HRSA):
  - Basics of Portal Navigation and Any Estimated Repayments:
    - When navigating in the portal providers will need to complete the data entry in a step-by-step process. As steps are completed in the portal, future steps may be adjusted depending on the information submitted in the earlier steps of the reporting process. For example, if all funds are used with expenses attributable to coronavirus the information required to be submitted for lost revenues will change.
    - Logging into the portal requires a two-step authentication to ensure the correct reporting entity is logging into an account.
    - There are several "survey" questions related to the impact the provider relief fund had on reporting entities. For some survey questions, the reporting entity is strongly encouraged to select all the items that apply to their entity. The last survey questions require a written narrative on the impact provider relief fund payments.
    - Reporting entities must return any unspent funds to the government within 30 calendar days after the end of the applicable reporting period.

Provider Relief Fund Updates

Updates Effective Through July 1, 2021 (Continued)

- Major Changes to Terms and Conditions released in the July 1, 2021, updates (these could be subject to change in the future with updates to the FAQs also, so it will be important to check these prior to finalizing submission or even following submission of data to HRSA):
  - Coronavirus related expenses must reported by calendar quarter.
  - If COVID-19 expenses, less other reimbursements, do not account for all provider relief funds received, patient care revenue will be entered by quarter for the reporting period and this will be the basis for lost revenue computations. It is now clear that lost revenue in one quarter is not offset by increases in revenue in another quarter.
  - Other assistance received, such as but not limited to the SBA Paycheck Protection Program and/or other grants through state and local sources, will not be part of the lost revenue calculations. Providers cannot, however, report expenses which were reimbursed by other sources as coronavirus related expenses.
  - Purchases of tangible items do not need to be in the provider's possession (i.e., back ordered PPE, ambulance, etc.) to be considered an eligible expense but the costs must be incurred before the deadline to use funds. Providers using the accrual basis of accounting should follow this method.

Provider Relief Fund Updates

Updates Effective Through July 1, 2021 (Continued)

- Major Changes to Terms and Conditions released in the July 1, 2021 updates (Continued)
  - There is still a great deal of uncertainty on specific definitions or examples of what is an approved coronavirus expense. The general definitions of the prevention, detection, and treatment of COVID-19 and related conditions still apply to most general and rural distributions, but these definitions often remain vague. HHS continues to state that the burden of proof is on the reporting entity to maintain adequate documentation to substantiate that these funds were used for healthcare-related expenses or lost revenues attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them, including the purpose of the use of COVID-19 expenses.
  - Many related party reporting questions remain unanswered when transfers between parent organizations and related affiliated organizations occurred. There remains general confusion if a parent organization that did not receive funds directly can report on behalf of all subsidiaries.

Provider Relief Fund Updates

Updates Effective Through July 1, 2021 (Continued)

Single Audit/Uniform Guidance Audit Questions/General Information:

- The federal office of budget and management has also issued a funding source number to the provider relief funds issued through the Department of Health and Human Services (HHS), which indicates that a Uniform Guidance or compliance audit, in addition to a provider's regular financial statement audit, will be required if total federal funds, including pass-through funds exceed $750,000 in a year. However, as of early July 2021, no official guidance of the audit requirements have been released, and some of the reporting in the Uniform Guidance audit will be contingent on the reporting to be completed for the Provider Relief Funds.
- The federal office of budget and management has also issued extensions on reporting requirements for COVID-19 related funds received by healthcare providers. Currently, if a single audit is required for an organization that received over $750,000 in federal funds in calendar year 2020, its Uniform Guidance audit to be completed by a CPA firm, would be due to the federal government by December 31, 2021. This may be subject to change based on if it is determined that the Provider Relief Fund reporting is a triggering event to show the funds were expended, then this may delay this Uniform Guidance audit reporting dates further.
- **Based on the above information, an audit under Uniform Guidance is not required to be completed until the year ended December 31, 2021 and reported on by September 30, 2022 for payments received through December 31, 2020. The Hospital will want to carefully monitor when these reporting requirements are finalized by the federal government to ensure continued compliance with the terms and conditions of the programs.**

Reimbursement Updates

Below are some of the general reimbursement updates/topics from the past two months:

- Medicare Rural Health Clinics:
  - New Interim Rate Caps for Provider-Based Rural Health Clinics effective April 1, 2021
  - Change of address and/or change of ownership planning with new rate changes in place
  - Rural Health Clinic reimbursement for COVID-19 Administration through cost reports
    - Logs needed of COVID-19 administration for both traditional (FFS) Medicare and Medicare Advantage Plan patients.
  - Exceptions to productivity standards more likely to be approved by Medicare during the public health emergency period.
- CMS temporarily added 144 telehealth services and permanently added several telehealth services, to be covered by Medicare for federal fiscal year (FFY) 2021 which ends on September 30, 2021. These additions include group psychotherapy services, some home visits for an established patient, and care planning services. Proposed legislation is being worked on to make these permanent additions to the Medicare fee schedule as payable telehealth service codes, but no update on this is available as of early July 2021.
- Updates on Medicare bad debt accounting to ensure being able to claim on cost reports (effective for the Hospital starting January 1, 2020).

Reimbursement Update

Medicare-Medicaid Crossover Bad Debt Accounting Classifications

Effective for cost reporting periods beginning on or after October 1, 2019, providers must correctly classify unpaid deductible and coinsurance amounts for Medicare-Medicaid crossover claims in the accounting records. Amounts written off to a contractual allowance account instead of a bad debt expense account will be disallowed.

- Do not write off to a contractual allowance account
- Charge to an expense account for uncollectible accounts (bad debt)

In order to protect the reimbursement (65% of amount claimed) and appropriately recognize uncompensated care on the cost report, a review of how these amounts are recorded may be necessary.

With the implementation of the revenue recognition standard within the next year, there may also be differences between generally accepted accounting principles and CMS on how to record these amounts.

Reimbursement Update

Price Transparency

- On November 15, 2019, CMS finalized a rule requiring all hospitals (including CAHs) to make a list of gross charges, negotiated charges by payor, a self-pay "walk-in rate," and a minimum and maximum negotiated charge for all services in a charge description master (CDM) publicly available in a machine-readable format.
- This rule is effective beginning January 1, 2021. In June 2020, the American Hospital Association (AHA) attempted to block this ruling in court on behalf of hospitals; however these efforts were unsuccessful and as of the current date it does not appear that any AHA appeal will be heard before effective date.
- Requires a list of 300 shoppable services that must be publicly available in a searchable, consumer-friendly format.
- Civil monetary penalty of $300 per day for hospitals that do not comply with the rule. *(CMS is starting to check compliance with information available on hospitals' websites in July 2021.)*
- Facilities with separate off-site locations are required to publish prices for all locations if prices are different at each location.

Reimbursement Update

Price Transparency (Continued)

- "Items and services" covered by the rule are all items and services, including individual items and services and service packages that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which a standard charge is established.
- Standard charges are defined for five types of prices for CDM price list reporting:
  - Gross charge
  - Payor specific negotiated charge
  - Deidentified negotiated minimum negotiated charge
  - Deidentified negotiated maximum negotiated charge
  - Discounted cash price
- These five types of prices are also required for the posting of prices for 300 shoppable services.
- Seventy commonly shoppable services are listed in the regulation, with the balance to be provided by each hospital based on a particular hospital's common services provided.

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