REPORT ON ACTIVITIES AND OPERATIONS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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 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 Division of Health Care Financing and Policy (DHCFP).

DHCFP's responsibilities include:

1. Collecting financial information and other reports from hospitals;
2. Collecting health care information from hospitals and other providers;
3. Conducting analyses and studies relating to the cost of health care in Nevada and comparisons with other states;
4. Preparing and disseminating reports based on such information and analyses; and
5. 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.

SFY 2012 Health Care Administration Fee

The Director, by regulation, imposed fees upon admitted health care insurers to cover the costs of carrying out the provisions of NRS 449.450 to 449.530, inclusive. The legislature approves an annual amount to be collected and NRS 449.465 authorizes a $50 fee for the support of the Legislative Committee on Health Care. Under NAC 449.953, the Division has the authority to impose penalties for late payments.

Amount authorized by Legislature: $1,730,165

Number of health insurers estimated to pay: 678

Fee per admitted health insurer:	DHCFP	$2,552
	LCB	$50
TOTAL FEE PER ADMITTED HEALTH INSURER:		$2,602

Actual number of health insurers that paid: 676

Total Fees for SFY 2012	$1,758,952
Credits for Overpayments from prior fiscal year	($6,735)
Actual payment received	$1,752,217
Penalties collected by DHCFP	$187,000
Amount transferred to Legislative Committee	$33,800*

*****676 insurers paid the fee (676 x $50).

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).

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).

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 below.

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 complete detail of the UB database is also available, upon request, in an electronic medium to researchers.

In December 2008 DHCFP adopted regulations to implement Assembly Bill 146 that requires greater transparency in reporting. The purpose is to increase public awareness of health care information concerning inpatient and outpatient hospitals and ambulatory surgical centers (ASC) in this State. DHCFP contracted with UNLV CHIA to create a Transparency Website. Diagnostic Related Groups (DRG), diagnoses and treatments, as well as nationally recognized quality indicators are information posted in the website. This information is available in both fixed and interactive reports. These reports enable the consumer and researchers to do comparative analyses between hospitals. The website is located at www.nevadacomparecare.net. The hospital inpatient and outpatient data is complete and posted. The ASC data is currently being collected but is not yet complete.

Quarterly Reporting

Hospitals are required to submit quarterly reports regarding their financial and utilization information in a consistent manner. Hospitals may use different generally accepted accounting procedures as promulgated by the American Institute of Certified Public Accountants.

Electronic submission of the Nevada Healthcare Quarterly Reports (NHQR) 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 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. DHCFP continues to work 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 can be found at: http://chia.unlv.edu/NHQR/utilizationandfinancial.htm.

Published Reports

The Director shall carry out analyses and studies relating to the cost of health care; prepare and file summaries, compilation or other supplementary reports; and submit a report to the Governor and legislative committees a report of the Department's operations and activities for the preceding year (NRS 449.500 to 449.520).

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, 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 Nevada Health CHIA's publication, *Personal Health Choices*. The latest edition for the period 2007 - 2011 published in June of 2012 is included as ATTACHMENT A. *Personal Health Choices* and additional information on the UB database may be found at the CHIA website at http://chia.unlv.edu/nevadahealthchoices/html/nevadahealthchoices.htm.

CHIA publishes a package of standard reports based upon the UB hospital billing records. These reports are available for calendar years 2000 - 2011**.**

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://chia.unlv.edu/stdreports/stdreports.html.

A list of the financial and utilization reports, accessible in CHIA's website, are attached in Exhibit 5.

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.

HOSPITAL INFORMATION

General hospital information concerning the seventeen (17) hospitals with more than 100 beds is presented in Exhibit 1. The information includes location, corporate name, number of beds, type of ownership, availability of community benefits coordinator, availability of charitable foundation, if the hospital conducts teaching and research, trauma center information, and if the hospital is a sole provider of any specific clinical services in their area.

SUMMARY OF CAPITAL IMPROVEMENT REPORTS

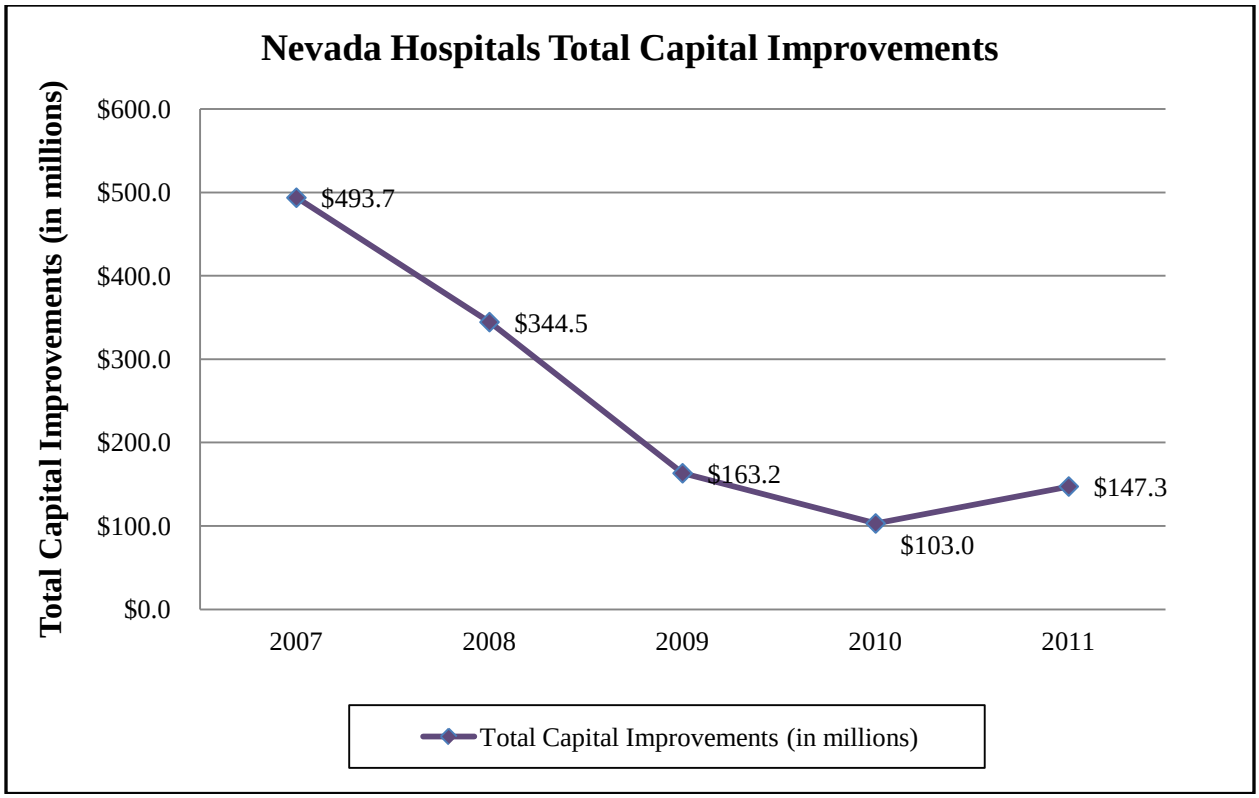
Capital Improvements cover three areas: New Major Services Lines, Major Facility Expansions and Major Equipment. In order to avoid duplication of reporting, no costs are reported for the addition of Major Service Lines. The costs for Major Expansions do not include equipment. A threshold of $500,000 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 as follows:

Major Expansions	$24,591,143
Major Equipment	$65,207,665
Additions not required to be Reported Separately	$57,469,917
Total	**$147,268,724**

Capital Improvements have been declining from 2007 to 2010. However, in 2011 there was an increase of 43.01%. Comparing the Total Capital Improvements in 2007 of $493.7 million to the $147.3 million in 2011, results in a 70.16% decrease in Capital Improvements for the past 5 years.

Capital Improvements					
Year	**2007**	**2008**	**2009**	**2010**	**2011**
Total Capital Improvements (in millions)	$493.7	$344.5	$163.2	$103.0	$147.3
Percentage Change	85.95%	-30.22%	-52.63%	-36.89%	43.01%

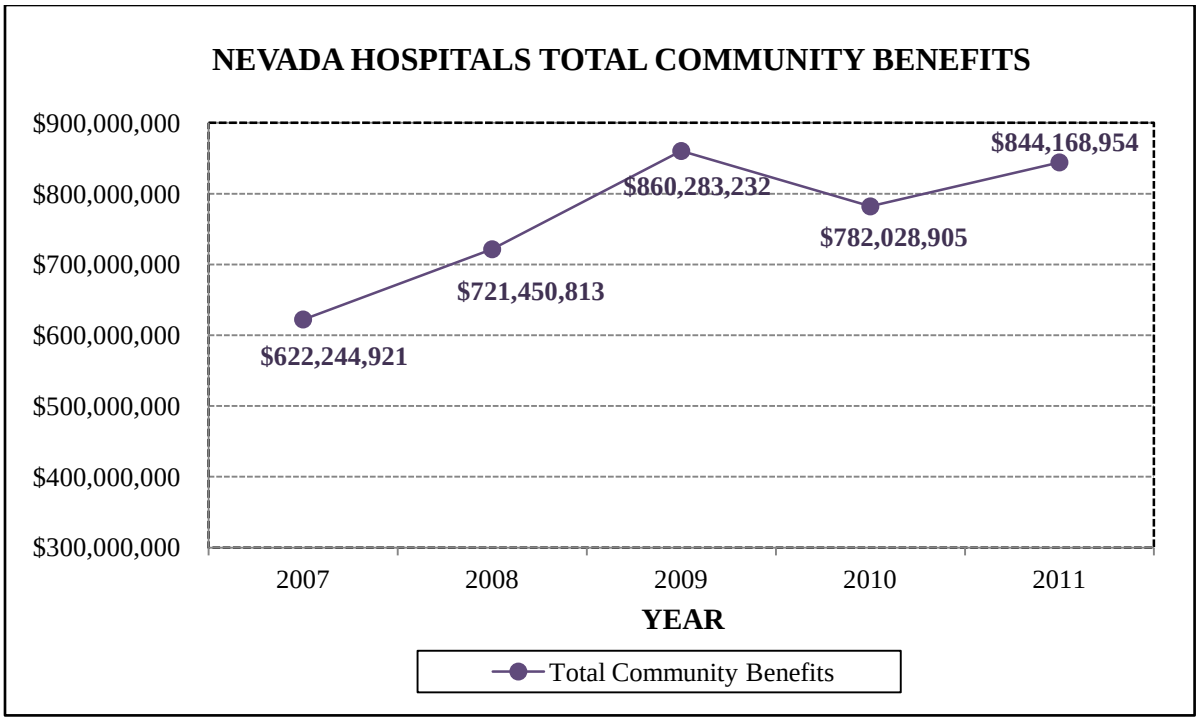


See Exhibit 2 for details.

EXPENSES INCURRED FOR PROVIDING COMMUNITY BENEFITS

The total value of Community Benefits reported for 2011 was $844,168,954. Subsidized Health Care Services costs accounted for $759,810,904 of the total; providing Health Professions Education totaled to $41,308,984; Community Health Improvement Services totaled to $33,795,233; and Other Categories totaled to $9,253,833. Reported Community Benefits increased 7.95% from 2010. The Total Community Benefits reported for 2010 was $782,028,905.

Community Benefits					
Year	**2007**	**2008**	**2009**	**2010**	**2011**
Total Community Benefits	$622,244,921	$721,450,813	$860,283,232	$782,028,905	$844,168,954
Percentage Change	10.74%	15.94%	19.24%	-9.10%	7.95%



See Exhibit 3 for details.

CORPORATE HOME OFFICE ALLOCATION METHODOLOGIES

Home office allocation methodologies for the hospitals that were subject to the "Agreed Upon Procedures" engagements were reviewed by the accounting firm of PHBV Partners LLP. No exceptions were noted. These can be viewed at the end of the individual compliance reports on the Nevada website: http://dhcfp.state.nv.us/hcfpdata.htm. A brief description of the home office allocation can also be found in Exhibit 4.

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

NRS 439B.440 allows 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. In accordance with the American Institute of Certified Public Accountants promulgations, these are "Agreed Upon Procedures" engagements, not audits. These engagements are performed biennially by PHBV Partners LLP, Certified Public Accountants & Consultants at all sixteen (16) hospitals. The last period reviewed was July 1, 2009 thru June 30, 2011. Audits for the period of July 1, 2011 thru June 30, 2013 will be completed by the end of state fiscal year 2014. Per NRS 439B.440 subsection 3, University Medical Center in Clark County, being a county owned hospital, is exempt from this requirement.

The engagement tests hospitals for compliance with NRS 439B.260, 30% discount required for uninsured patients; NRS 439B.410, 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, review of contractual arrangements between hospital and physicians or other medical care providers; and NRS 439B.430 review of related party transactions and ensure appropriate allocation.

SUMMARY OF TRENDS NOTED FROM REQUIRED OR PERFORMED AUDITS

NRS 449.520 requires a summary of any trends noted from these "audits" be reported. The audits covering July 1, 2009 thru June 30, 2011 shows no trends to note. There were no significant compliance issues; a few exceptions were noted, however, they were all within the accepted error rate.

A copy of these audits maybe found at the Cost Containment web site:
http://dhcfp.state.nv.us/hcfpdata.htm.

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 for 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.

SUMMARY INFORMATION AND ANALYSES - ALL HOSPITALS

HOSPITAL GROUPINGS

The acute care hospitals are grouped into the following categories:

- Statewide
- Clark County Hospitals
- Washoe County/Carson City Hospitals
- Rural Hospitals

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 of this report summarize these data.

All thirty-four (34) Acute Care Hospitals, thirteen (13) Rehabilitation Hospitals, and seven (7) Psychiatric Hospitals reported in 2011.

There are also five (5) government operated hospitals in the State, which do not have standard private sector operating costs and revenues. Below are the inpatient days and admissions data that have been reported to CHIA.

Facility	Inpatient Days	Admissions
Desert Willow Treatment Center	15,655	284
Ioannis A. Lougaris Veterans Administration Medical Center	18,760	3,933
Nellis Air Force Base Veterans Administration Medical Center	Not Reported	Not Reported
Northern Nevada Adult Mental Health Services	6,102	732
Southern Nevada Adult Mental Health Services	77,700	9,364

FINANCIAL SUMMARIES

The five year financial summary in Exhibit 6 presents condensed financial and utilization information for acute care hospitals in Nevada. Detailed information for the individual acute care hospitals are presented in Exhibit 8.

Comparative Financial Indicators

In order to compare hospitals across categories, financial indicators are used. The indicators used in this report are Per Adjusted Inpatient Day and Per Adjusted Admission. The following data were utilized in calculating the indicators:

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

The adjusted inpatient days and adjusted admissions are calculated by converting outpatient and other patient revenue to inpatient units. 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, and dividing those amounts by adjusted inpatient days or adjusted admissions. The amounts calculated due to the conversion are useful for comparisons and trending analyses.

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 by the use of common size statements.

Common size statements are utilized in Comparative Financial Summary (Exhibit 6). Different financial information was represented as percentages of a common base figure. Total deductions and operating revenue were represented as a percentage of the billed charges; other operating revenue, operating expenses, net operating income, non-operating revenue and non-operating expense are also represented as percentages of the total operating revenue.

ANALYSIS

Acute Care Hospitals

The five year Comparative Financial Summary tables (Exhibit 6) were prepared for the acute care hospitals. The Comparative Financial Summaries (2007 - 2011) report both the financial and the common size statement information (vertical analysis).

Exhibit 6 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.

Exhibit 6 also reports inpatient days, admissions, and other patient statistical information along with the calculated "per adjusted inpatient day" and "per adjusted admission" information.

Hospital Profitability

The Comparative Financial Summary, Statewide Acute Care Hospitals Totals, shows the Hospital Net Income/Loss[1] as a percentage of Total Revenues[2]. Beginning in 2008 and through 2011, there has been a statewide net loss reported for these facilities. The Net Profit Margin (Net Income ÷ Total Revenues) expressed as percentages from Exhibit 6A are:

2007	**2008**	**2009**	**2010**	**2011**
2.98%	(0.79%)	(0.04%)	(1.17%)	(0.07%)

The above (0.07%) reflects Nevada hospitals collectively lost $3,296,711 with a Total Revenue of $4,483,761,162 in 2011. The losses and gains ranged from a Net Income of $36,034,289 for Northeastern Nevada Regional Hospital to a Net Loss of $64,637,844 for Saint Mary's Regional Medical Center.

Six out of thirteen Clark County Acute Care Hospitals reported a net loss. The Total Net Loss for all Clark County Acute Care Hospitals was $9,492,350. Spring Valley Hospital Medical Center had the highest Net Income of $26,378,774 and University Medical Center of Southern Nevada had the biggest Net Loss of $25,817,388.

Two out of the six Washoe County/Carson City Acute Care Hospitals reported a net loss. The Total Net Loss for all Washoe/Carson City Acute Care Hospitals was $55,455,657. Carson Tahoe Regional Healthcare had the highest Net Income of $8,798,361 and St. Mary's Regional Medical Center had the biggest Net Loss of $64,637,844.

Five out of the fifteen Rural Hospitals reported a net loss. The Total Net Income for all Rural Hospitals was $61,651,296. Northeastern Nevada Regional Hospital had the highest Net Income of $36,034,289 and Mesa View Regional Hospital had the biggest Net Loss of $3,299,131.

Eleven of the fifteen rural hospitals are designated as Critical Access Hospitals (CAH). Medicare reimburses inpatient and outpatient services for these CAH at their costs and Medicaid reimburses their inpatient services at their costs. Another distinction that rural communities have is that there are fewer patients with insurance (not including Medicare, Medicaid and other government insurance). As reflected in the 2011 CHIA utilization reports, 10.94% of patients

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

have insurance in rural hospitals; as compared to 25.75% in Clark County hospitals and 27.45% in Washoe/Carson City hospitals.[3]

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

There are six Universal Health Systems Inc. (UHS) acute care hospitals in Nevada; four out of the six hospitals reported profits for 2011; this resulted to a Net Income of $26,185,610 for the six hospitals. The principal business of UHS is to own and operate, through their subsidiaries, acute care hospitals, behavioral health centers, surgical hospitals, ambulatory surgery centers and radiation oncology centers. As of February 24, 2012, UHS owns and/or operates 25 acute care hospitals and 198 behavioral health centers located in 36 states, Washington D.C., Puerto Rico and the US Virgin Islands. UHS manages and/or owns in partnership with physicians, 6 surgical hospitals and surgery and radiation oncology centers located in 4 states and Puerto Rico. In November 2010, UHS acquired Psychiatric Solutions, Inc (PSI) which operates 105 inpatient and outpatient behavioral health care facilities in 32 states, Puerto Rico and the US Virgin Islands. UHS Inc. nationally experienced a 5.3% Net Profit Margin which increased from 2010's 4.1%.[4]

There are three Hospital Corporation of America (HCA) acute care hospitals in Nevada; one out of the three hospitals reported a net loss in 2011; this resulted to a Net Loss of $717,780 for the three hospitals. HCA Holdings, Inc. is one of the leading health care services companies in the United States. As of December 31, 2011, HCA operates 163 hospitals, comprised of 157 acute care hospitals, 5 psychiatric hospitals and one rehabilitation hospital. In addition, HCA operates 108 freestanding surgery centers. These facilities are located in 20 states and England. HCA Holdings, Inc. reported a Net Profit Margin of 8.3% which increased from their Net Profit Margin of 4.3% in 2010.[5]

Catholic Healthcare West (CHW), a non-profit public benefit corporation, exempt from federal and state income taxes, operates three St. Rose hospitals in Clark County and Saint Mary's Regional Medical Center in Washoe County. Three of the four facilities had a combined reported loss of $93,787,380 in 2011; only St. Rose-Siena reported a Net Profit of $24,092,560. CHW owns and operates hospitals in California, Arizona and Nevada. CHW reported a Net Profit Margin of 8.7% which increased from a Net Profit Margin of 5.2% in 2010. [6] There are a few changes with CHW. On January 17, 2012, Catholic Healthcare West was renamed Dignity Health. Dignity Health then sold St. Mary's Regional Medical Center to Prime Health effective July 1, 2012. These ownership changes will be visible in next year's report; however, their reported financial information, for the 4th quarter of 2011, started to reflect the impact of this sale.

[3] CHIA Utilization Reports 2011
[4] UHS' Annual Report 2011 (10-K)
[5] 10-K Report - HCA Holdings, Inc. filed period 12/31/2011
[6] CHW's consolidated financial statements (years ended June 30, 2011 and 2010)

Competition, higher costs, and the current economy are all contributing factors to hospital profitability. Hospitals have high fixed costs for buildings and state-of-the-art equipment. Hospitals are limited in their ability to pass these costs on to consumers.

Labor costs often account for higher operating expenses. The following table shows the median hourly wages (from May of each year) for two Nevada specific hospital occupations.

	2007	2008	2009	2010	2011
Registered Nurses	$32.73	$34.41	$35.23	$35.95	$37.29
Medical and Clinical Laboratory Technologists	$29.99	$31.91	$32.28	$32.78	$32.95

From 2007 to 2011, the median wage increased 13.93% for Registered Nurses and 9.87% for Medical and Clinical Laboratory Technologists.[7]

Operating Revenue / Deductions (Contractual Allowances and Bad Debts)

The Billed Charges, when compared to the Deductions (contractual allowances and bad debts), provide insight into the market competition among health care providers.

Operating Revenue on a statewide basis (the amount patients or third party payers actually pay) has steadily decreased from 25.30% in 2007 to 19.30% in 2011. This decrease is visible across the State impacting hospitals in Clark County, Washoe County/Carson City and Rural hospitals.

Total Deductions on a statewide basis had gradually increased from 74.70% in 2007 to 80.70% in 2011. The Total Deductions for Clark County hospitals increased from 77.61% in 2007 to 82.97% in 2011. Washoe County/Carson City hospitals' Total Deductions increased from 67.98% in 2007 to 75.64% in 2011. The Rural Hospitals' Total Deductions increased from 45.14% in 2007 to 57.26% in 2011.

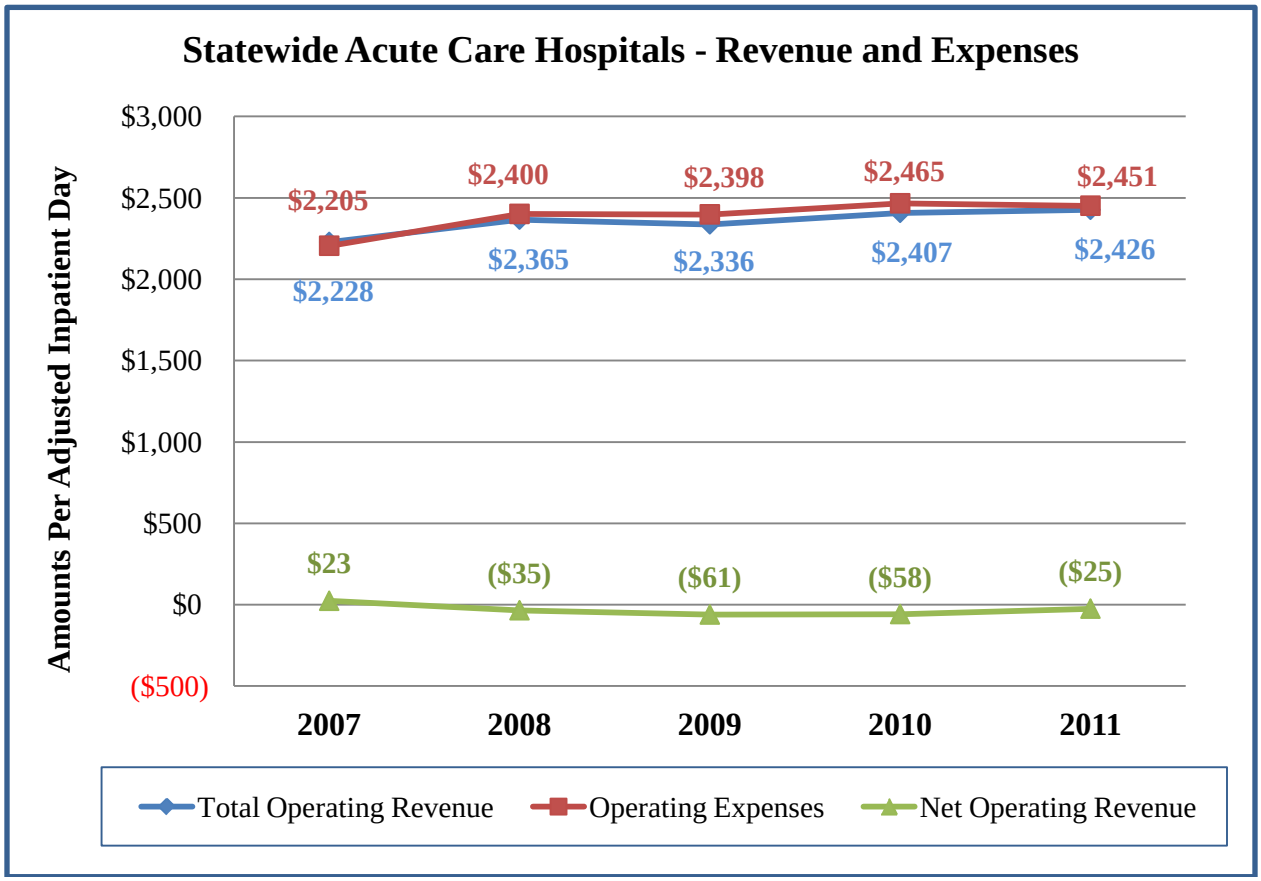
Clark County hospitals are affected the most by preferred provider contractual arrangements with large employee groups. With this, their Total Deductions are the highest when compared to Washoe County/Carson City and the Rural hospitals.

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 (see Exhibit 6D for details).

[7] Bureau of Labor Statistics, Occupational Employment Statistics.

Revenue and Expenses

Using Per Adjusted Inpatient Day information, the following graph displays the relationship of Total Operating Revenue, Operating Expenses and Net Operating Revenue from hospital operations on a statewide basis over the five year period. The financial indicators listed in Exhibit 6A are the basis for this graph.



Operating Expense and Operating Revenue Compared with the Consumer Price Index and Producer Price Index (CPI & PPI)[8]

The Operating Expenses per adjusted inpatient day has decreased 0.57% from 2010. The Total Operating Revenue per adjusted inpatient day has increased 0.79% from 2010. Both CPI-U and PPI has increased from the previous year, 3.12% and 2.13% respectively.

4 year increase	Base # / Percentage	2007	2008	2009	2010	2011
	NV Acute Hospitals Operating Expenses per Adj IP Day	$2,205	$2,400	$2,398	$2,465	$2,451
11.16%	% increase from prior year	2.80%	8.84%	(0.08%)	2.79%	(0.57%)
	NV Acute Hospitals Total Operating Revenue per Adj IP Day	$2,228	$2,365	$2,336	$2,407	$2,426
8.89%	% increase from prior year	1.64%	6.15%	(1.23%)	3.04%	0.79%
	PPI General Medical and Surgical Hospital	158.8	163.7	168.8	173.7	177.4
11.71%	% increase from prior year	3.59%	3.09%	3.12%	2.90%	2.13%
	CPI-U (all)	207.3	215.3	214.5	218.1	224.9
8.49%	% increase from prior year	2.83%	3.86%	(0.37%)	1.68%	3.12%

While both the PPI and CPI measure price change over time for a fixed set of goods and services; they differ in two critical areas: (1) the composition of the set of goods and services, and (2) the types of prices collected for the included goods and services.

The target set of goods and services included in the PPI is the entire marketed output of U.S. producers, excluding imports. The target set of items included in the CPI is the set of goods and services purchased for consumption purposes by urban U.S. households. This set includes imports.

The price collected for an item included in the PPI is the revenue received by its producer. Sales and excise taxes are not included in the price because they do not represent revenue to the producer. The price collected for an item included in the CPI is the out-of-pocket expenditure by a consumer for the item. Sales and excise taxes are included in the price because they are necessary expenditures by the consumer for the item.

The differences between the PPI and CPI are consistent with the different uses of the two measures. A primary use of the PPI is to deflate revenue streams in order to measure real growth in output. A primary use of the CPI is to adjust income and expenditure streams for changes in the cost of living.

There are slight differences in the PPI data for 2007 – 2010. The Department of Labor made changes to the industry group. The current industry group is named General Medical and Surgical Hospitals, while the prior industry group was named Hospitals.

[8] The CPI is published by the Bureau of Labor Statistics, U. S. Department of Labor.

UTILIZATION REPORTS

Ten year acute care hospital utilization information is summarized in Exhibit 7. The charts include Average Daily Census, Occupancy Percentages, Average Length of Stay, Admissions per 1,000 Population, Inpatient Days per 1,000 Population and Average Licensed Beds per 1,000 Population. The ten year trends are as follows:

Parameter	2002	2011	Change	Percent Change
Estimated Nevada Population	2,206,022	2,723,322	517,300	23.45%
Average Daily Census	2,781.1	3,302.4	521.3	18.74%
Occupancy Percentages	66.76%	56.37%	(10.39%)	(10.39%)
Average Length of Stay	4.8	4.8	0.0	0.00%
Admissions	213,379	252,255	38,876	18.22%
Admissions per 1,000 Population	96.7	92.6	(4.1)	(4.24%)
Inpatient Days	1,015,139	1,205,368	190,229	18.74%
Inpatient Days per 1,000 Population	460.2	442.6	(17.6)	(3.82%)
Average Licensed Beds	4,140	5,858	1,718	41.50%
Licensed Beds per 1,000 Population	1.9	2.2	0.3	15.79%

The estimated Nevada population in 2011 increased 23.45% compared to 10 years ago in 2002. Admissions and Inpatient Days have also significantly increased by 18.22% and 18.74% respectively. Nevada has effectively increased the Average Licensed Beds to compensate for these increases. Average Licensed Beds increased 41.50% from 2002 to 2011 and Occupancy Percentages decreased 15.56%. Nevada's Average Occupancy Percentage has been decreasing every year from 2006 to 2011.

The national average occupancy per 1,000 population for 2010 was 64.59%[9] and Nevada's average occupancy per 1,000 population for 2010 was 57.35%.

The national average number of Hospital Beds per 1,000 Population in 2010 was 2.6.[9] The Nevada average number was 2.1. Nevada's average grew in 2011 to 2.2.

Rural counties in Nevada have lower Licensed Beds per 1,000 Population. For 2011, rural counties have 1.6 Beds/1,000 Population as compared to the statewide 2.2 Beds/1,000 Population. This however is sufficient for the population in rural counties as demonstrated in their low Occupancy Percentage of 22.06% for 2011. Admissions and Inpatient Days per 1,000 Population are also lower for the rural counties. Admissions for rural counties are at 42.3 per 1,000 Population compared to statewide average of 92.6 per 1,000 Population. Inpatient Days for rural counties are 132.2 per 1,000 Population while statewide average is 442.6 per 1,000 Population.

[9] StateHealthFacts.org – Kaiser Family Foundation (source from AHA Annual Survey)

Rehabilitation/Specialty Hospitals

The Rehabilitation/Specialty Hospitals reported a net income of $60,684,316 from total revenue[10] of $306,003,047. All thirteen Rehabilitation/Specialty hospitals reported profits in 2011. The figures (in millions) from the last five years are as follows:

	2006	**2007**	**2008**	**2009**	**2010**	**2011**
Total Revenue	226.9	241.9	271.6	277.2	288.2	306
Net Income	23.9	21.1	39.5	32.2	44	60.7
Net Margin	**10.5%**	**8.7%**	**14.6%**	**11.6%**	**15.3%**	**19.8%**

See Exhibit 8D for more details.

Psychiatric Hospitals

Five of the seven psychiatric hospitals reported profits.[11] As a group they reported a net income of $6,290,792 from total revenue of $93,411,352.

The comparison of 2011 and 2010 Net Income (loss) for each facility is reported below:

	Net Income/Loss	
Facility	**2010**	**2011**
Montevista Hospital	$4,125,058	$5,780,104
Red Rock Behavioral Health	$1,965,412	$1,484,476
Seven Hills Behavioral Institute	($851,456)	$178,706
Spring Mountain Sahara	$680,100	$1,473,500
Spring Mountain Treatment Center	($1,104,816)	($82,366)
West Hills Hospital	($933,916)	($2,818,201)
Willow Springs Center	$3,627,526	$274,573
TOTAL	**$7,507,908**	**$6,290,792**

The total revenue and net income from the last five years are as follows (in millions):

	2007	**2008**	**2009**	**2010**	**2011**
Total Revenue	53.5	60.6	61.5	75.7	93.4
Net Income	3.3	5.7	2.5	6.8	6.3
Net Margin	**6.2%**	**9.5%**	**4.0%**	**9.0%**	**6.7%**

See Exhibit 8E for more details.

[10] Total Operating Revenue plus non-operating revenue – See Exhibit 8
[11] The state facilities did not report.