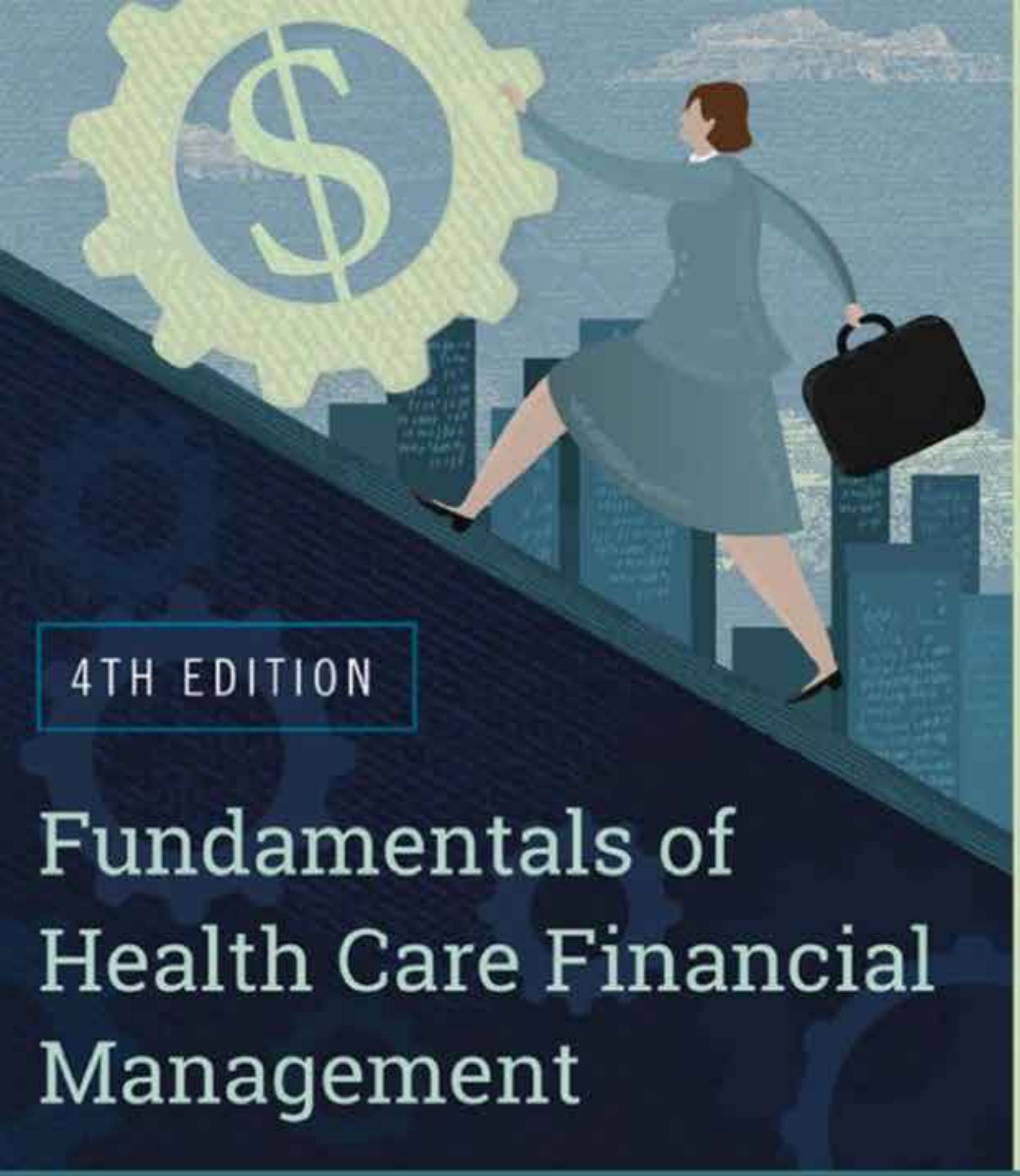

4TH EDITION

Fundamentals of Health Care Financial Management

A Practical Guide to Fiscal Issues and Activities

STEVEN BERGER

JOSSEY-BASS
A Wiley Brand

FUNDAMENTALS OF HEALTH CARE FINANCIAL MANAGEMENT

A PRACTICAL GUIDE TO FISCAL ISSUES AND ACTIVITIES

Fourth Edition

Steven Berger

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For Barbara, my wife.

Always making things better.

PREFACE

Starting now, we will embark on a journey into the interesting and compelling world of the health care financial manager. Although not on the front line of the patient's care, the health care financial manager needs to be involved in or apprised of all decisions related to the operations or planning of the facility. Because of this, the financial manager has the opportunity to develop a unique understanding of the business of health care, if he or she takes the time and effort to do so.

And whether the business is in hospitals, skilled nursing facilities, physician offices, home health agencies, psychiatric facilities, or any of the other operations doing business in this industry, the basic concepts are essentially the same. Health care and the way it is financed have several characteristics unique to this industry alone. Following are the most important:

1. The health insurance system most often separates the consumer from the buying decision. Because of this, the consumer seldom has had to make a rational choice in the amount or level of product consumption. This is the number one reason that the cost of health care is so high in America. The implementation in 2014 of the major elements of the 2010 Patient Protection and Affordable Care Act (ACA) will change this to a certain extent.
2. The health care system is pluralistic, a mixture of government and nongovernment providers and payers.
3. The payment system is technical and complex. Every payer has a different set of benefits, which often are not spelled out clearly. Consumers (patients) may believe they have a certain set of benefits, but when they finally need care, they may find out that they are in fact not covered for that particular set of illnesses or therapies. This often puts the provider in the difficult situation of denying or postponing care until these coverage issues are settled. This is another area where the ACA should help, because several new standards require minimum coverage provisions.
4. Ultimately, though, health care is personal. And it affects everyone. No other industry creates the intensity of emotions engendered in health care. The patient, whose condition may lead to death—or in the case of

maternity care, life—is always at personal risk. So are the loved ones who congregate around the patient and the provider, often with great anxiety and trepidation.

This, then, is why health care, and the way it is financed, is so important. It helps explain why the role of the financial manager takes on great importance within the industry. The financial manager is responsible for the financial reporting, the short-term financial plan (budget), and the long-term strategic financial plan, all of which summarize financial results of the organization, actual and projected. These summaries are a direct reflection of the decisions made before the fiscal year begins and day to day as the year moves along. The astute financial manager, who needs to learn as much about every aspect of the organization's operations as possible, is often in a better position than any other manager to assess the operation in an objective and nonpartisan manner.

At the same time, the health care financial manager will need to learn, understand, and absorb a series of rules, regulations, policies, and procedures that reflect the unique world of American health care and its finances. This book is dedicated to the proposition that the reader can learn much about the financial underpinnings of this industry. There is so much to know and so little time to learn it. The challenge is to make these complex ideas presentable in a basic text.

Imagine, if you will, an industry in which the billing rules for only one of its many payers, Medicare, is thousands of pages long. Then imagine that since 1997, with the advent of the Balanced Budget Act, Medicare's enforcement division has been contending that some billing mistakes constitute fraud rather than honest errors. Now further imagine an industry that has to contend with an entirely new set of laws, first established in the 2010 ACA from a two-thousand-page bill, which will lead to many more thousands of pages of rules, some still not promulgated by the time the original rules are to take effect. That makes it next to impossible to plan, manage, and succeed.

Imagine, too, an industry in which the largest group of nongovernmental payers, known as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) and commonly referred to as managed care, has attempted to limit the care given to their beneficiaries, the patients. This has been done in the name of saving money for the premium payer, usually the employer. Yet many of these same insurers generally do not provide coverage for screening tests that could either rule out or determine illness that when caught early would cost these self-same insurers less money through less-intensive treatments. Some of this is supposed to change under the ACA, but the jury is still out.

You get the idea. Crazy policies. Not always in the best interest of the patient. More than likely in the best interest of the insurer. But also ask yourself, When was the last time you reached into your own pocket to pay the full list price for your health care? Probably never. Very few employed (managed care), elderly (Medicare), or financially needy people (Medicaid) in America have done so. And they do not often ask the question, which I do ask: Why does health care cost so much? The main reason for not asking is because when a loved one gets sick, we will spare no expense (primarily the insurance company's money) to make sure that he or she gets well. The providers of care in America have therefore built their industry to respond to the needs and desires of the market.

The problem here is that what the market desires is conflicted. Because very few patients (customers) pay the full list price out of pocket, the patient's desires are often at odds with the desires of the payers and of the employers who pay the premiums. Caught in the middle are the providers, attempting to be cost-efficient, provide quality outcomes, and produce high levels of patient satisfaction while earning a positive financial return on their very substantial investments.

How this situation came to be and how a particular provider contributes to the overall industry expenditures makes for an instructive case study. This book covers all the basic health care financial management issues, but from a distinct perspective. You, the reader, will get to act like a health care financial manager for the most common financial reporting period, a year. Starting on January 1, you will experience the highs and lows of a health care finance officer as he weaves his way through busy and slow times (mostly busy) and through the conflicting issues that populate the health care financing landscape.

This particular book is written from the perspective of a finance officer for a hospital. However, many of the other primary industry providers are also profiled because the organization presented in this case study also operates a hospital-based skilled nursing facility, a home health agency, and a psychiatric unit, and it employs two dozen physicians in office practice.

Finally, this text is not intended as an academic treatise. Rather, it is designed to serve as a practical guide to demonstrate how an integrated health care finance division operates in this era, on a day-to-day basis. It is an attempt to meld practice with theory. As we go through the year, various concepts will be highlighted and highlighted again, just as often happens in reality. This will help clarify the issues that are of overriding importance to sound financial management.

An instructor's supplement is available at www.josseybass.com/go/berger4e. Additional materials such as videos, podcasts, and readings can be found at www.josseybasspublichealth.com. Comments about this book are invited and can be sent to publichealth@wiley.com.

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I would like to thank a number of people for bringing me to the point in my life when the opportunity to write this book coincided with the reality. On the professional side, I must thank two of the best bosses anyone could be lucky enough to have had, Ken Knieser and Jack Gilbert, for never telling me to stop doing what I thought was right. Thanks also go to John Dalton, for encouraging me to become a writer and editor of health care finance material more than thirty years ago now.

I would also like to thank the people whose experience and knowledge helped me improve the various editions of this book, particularly the first edition. They took the time and effort to read the entire first edition manuscript in draft and offer terrific suggestions for refinement and embellishment. They are my very good friends, who continue to offer constructive advice, Bob Carlisle and the aforementioned Jack Gilbert and Ken Knieser. The fourth reader of the first edition, Mary Grace Wilkus, has subsequently become my business partner in the firm Healthcare Insights. Her insightfulness helped make the content of this book more cogent. I would also like to thank reviewers Joseph D. Dionisio, Karen Shastri, and Susan White, who provided thoughtful and constructive comments on the complete draft manuscript.

In addition, several people with expertise in specific health care financial management areas generously agreed to review those sections of this fourth edition and offer valuable comments that improved the final text. I appreciate the time taken by Julie Micheletti, the world's greatest authority on the practical clinical and financial implications of DRGs and APCs, Max Mortensen for his insight on hospital information technology issues, and Bob Gienko for his review of the Medicare Cost Reporting section.

On the personal side, I am indebted to my family, who made the biggest sacrifice in the creation of this book. The nights and weekends I labored on the book often took me away from them. My wife, Barbara, kept the household together, maintaining a menagerie of very active children in a relative state of equilibrium. I am blessed to have four kids who keep me younger in spirit than in body. Sam, Ben, and Arlie make me smile all the time. But

I doubt I would ever have been able to finish this book without my youngest daughter, Emmalee, looking over my shoulder every day to check my progress and whispering such encouragements as, "Come on, Dad, what do you mean you've written only one page since yesterday? Let's move it, move it, move it!"

S.B.

THE AUTHOR

Steven Berger is the founder and president of Healthcare Insights, LLC (www.hcillc.com), which specializes in the teaching of health care general and financial management issues. In addition, Healthcare Insights has developed the dynamic INSIGHTS decision support software solutions for the health care industry. Prior to his role at Healthcare Insights, which began in 2000, Berger was vice president of finance for seven years at the 250-bed Highland Park Hospital in suburban Chicago and had served as a hospital or health system finance officer in New York, New Jersey, and Missouri. These many diverse organizations included urban and suburban facilities, both academic and nonteaching, ranging in size from one hundred to four hundred beds. He began his career as a Medicare auditor for the Blue Cross Blue Shield Plan of Greater New York and has also worked for a small CPA firm in New York City. Berger holds a Bachelor of Science degree in history and a Master of Science degree in accounting from the State University of New York at Binghamton. He is a certified public accountant (CPA), a fellow of the Healthcare Financial Management Association (HFMA), and a fellow of the American College of Healthcare Executives (ACHE). In his various roles with the HFMA, he has served as president of the First Illinois Chapter and a director on HFMA's National Board of Examiners. In each of these capacities, Berger was part of a team that actively strived to improve the services available to the organization's members. In addition, over the past several years, he has presented many seminars on health care finance and general management issues throughout the United States and Canada, including two-day courses such as "Fundamentals of Healthcare Financial Management," which is the basis of this book; "Turning Data into Useful Information: How to Effectively Collect, Analyze, and Report Financial and Clinical Data to Enhance Decision Making in Healthcare," which trains data users and data crunchers to understand each other's needs and practical ways in which to meet those needs; and "Hospital Financial Management for the Non–Financial Manager," which teaches clinical and operating managers how to use financial tools and techniques to improve the financial results in their own departments. His newest 2013 two-day course is "Using Business Intelligence to Improve Hospital Bottom Lines," which describes how the hospital can transform significant amounts of clinical

and financial data ("big data") into actionable information. His work has been published in *Healthcare Financial Management* magazine, including the award-winning articles, "Ten Ways to Improve Cost Management in Hospitals," in 2004 and "Treating Technology as a Luxury: Ten Essential Tools and Techniques in 2007." He also published in 2000 a commentary in *Modern Healthcare* on the lack of training in the health care industry. His books include the fourth edition of *HFMA's Introduction to Hospital Accounting*, written with Michael Nowicki (Kendall Hunt, 2002); *The Power of Financial and Clinical Metrics: Achieving Superior Results in Your Hospital* (ACHE, 2005; available at www.ache.org); and *Understanding Nonprofit Financial Statements, 3rd Edition* (BoardSource, 2008; available at www.boardsource.org). Berger and his wife, Barbara, have four active children who provide many fun-filled days. When not working, the family enjoys participating in all varieties of sports.

CHAPTER 1

JANUARY

"Daddy, what do you do all day at work?" the seven-year-old asks plaintively.

"What do you mean?" blinks Samuel Barnes, the daddy.

"You know, like when you go out so early in the morning and then don't come back until after other daddies are already home. What are you doing? Why does it take so long?" asks the curly-haired tot.

Sam has to think for a moment. "Well, honey, that's a good question. I guess I'm out there trying to make the hospital I work for as successful as it can be."

"But what do you do?"

"Susie, I'm in charge of all the money that comes into the hospital. I'm also responsible for all the money paid out to the people who work there. I also make sure that we pay all the other people who send us stuff that we use to make the sick people better, like food and medicine."

"Daddy, do you ever have any money left over after you pay these people?"

"Well, Susie, that's the whole point. To be successful, you want to have as much left over as you can."

"But what do you do with all that leftover money? Do you put it in the bank, like I do with my allowance?"

"Well, sort of. But instead of putting it into the bank, we put it into a kind of bank that lends it out to other people who need money in their businesses. They then pay us back with a little extra money to thank us for letting them use our money for a while. That's called interest."

"So the hospital has all this leftover money and then you have even more money from these other people paying you interest. I'm glad that you work at a company that's making money because I heard on the news that some

LEARNING OBJECTIVES

After reading this chapter, you should be able to

1. **Recite the massive amount of dollars that flow through the health care industry**
2. **Describe the importance of health care financial management in America**
3. **Explain the role and objective of health care**
4. **Describe the twofold purposes of financial management**
5. **Recognize the categories of providers that make up the health care industry**
6. **Determine how a hospital finance administrator begins to operate within the structure of the annual calendar of finance events**
7. **Build a hospital pro forma financial statement in order to determine if a major project should be approved**

people were losing their jobs. I guess you or any of the people you work with won't lose their jobs."

"Actually, Susie, I wish I could tell you it was that clear-cut, but it's not. Part of my job is to make sure that the hospital makes as much money as we decided we wanted to make before the year started. Sometimes that means we believe we will need fewer people working for us if we think fewer people will come to the hospital to be taken care of."

"But," Susie asks quizzically, "how can you know about all these things?"

"Ah, honey," he says, "that's a long story."

It is one minute past midnight on January 1. Outside, the New Year's revelers are swinging into full gear. Inside the bowels of the powerful computers of Ridgeland Heights Medical Center (RHMC), a fictional health care system, a different kind of ritual is taking place. At this moment, the automated pricing mechanism is executing its programming, effectively increasing the fifteen thousand or so charges related to individual services or supplies provided to patients. These increases, so carefully planned, are meant to help the organization improve its bottom line.

How these charges came to be, and why they are important, is only a small part of the story that constitutes the art of health care financial management. Financial management in practically any industry has its own policies, procedures, and practices. In most cases, generally accepted accounting principles (GAAP) and financial procedures require estimates and approximations based on the company's, and the estimator's, previous experience within the industry. This experience is often timeworn. Financial statements are produced month after month, year after year. Over time, most companies doing business in any industry report financial results in conformance with industry standards.

A standard is an approved or acceptable model as determined by an authority or by general consent. In the health care industry, standards represent the ability to properly report operating results for any particular period of time requested as well as the net assets of an organization.

For RHMC, the price increase, although not entirely desired by the organization's administration because of its possible negative effect on public relations, is vital to its continued financial success. The size of the price increase is a function of change in *volume*, *severity*, and *expense*, all forecast and budgeted by the medical center. These changes are the result of strategic planning initiatives, newly planned services, shifts in the payer mix, and demographic fluctuations. They are also related to expense increases or decreases projected as a result of the change in volume. And finally, they

are related to the community's perception of the health care organization's specific pricing for individual services and total cost of care.

This book examines these issues and many more. To begin to understand health care financial management and many of its key components, we must build a framework from which to operate. This framework takes the form of a diary and a primer. It chronicles a year in the life of one health care institution and one health care financial administrator. It explores how this organization, the board of directors, and the clinical and financial executives go about making decisions and how these decisions are then implemented. It further explores the organization through the natural life cycle of the institution, day by day and month by month, just as a real institution operates.

This book offers practical and informative points on health care decision making, usually from the financial point of view. In the end, the objective is to create greater understanding of *how* the industry operates on a detailed financial level and *why* it must do so. Our fictional medical center, Ridgeland Heights, was chosen because its bed complement of 254 falls in the range of a great many hospitals in the United States today. According to *Health, United States, 2011*, the most recent edition of the annual compilation of US health care statistics published since 1993 by the National Center for Health Statistics (NCHS) of the US Department of Health and Human Services (HHS), of the 37.5 million admissions to all hospitals in 2009, some 6.7 million were made to hospitals in the range of 200 to 299 beds. When you add up the admissions of hospitals in the range from 100 to 399 beds, the result is 18.8 million, 50.1 percent of all admissions (NCHS 2011, table 108). Consequently, this book is representative of the hospitals that typically treat slightly more than half of the inpatients annually in the country.

Before we begin to explore health care financial management systems and techniques, it is necessary to first define some terms.

What Is Health Care?

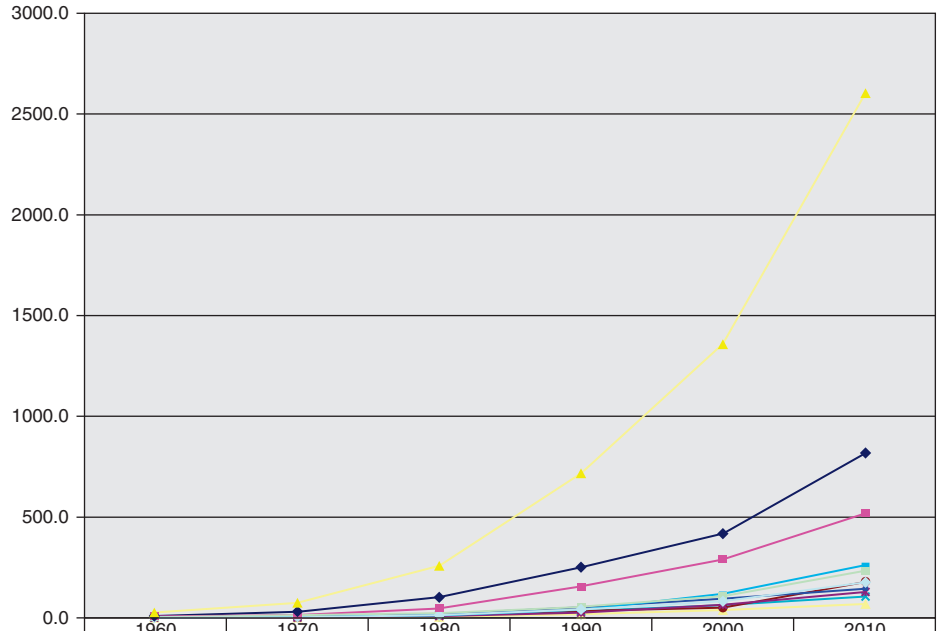
Health care is the field concerned with the maintenance or restoration of the health of the body or mind. This may seem obvious, but maybe it's not. The health care industry currently encompasses much more than just hospitals and doctors. Although together they are associated with the majority of industry expenditures, a considerable number of other reputable health care providers make up the remainder. Figure 1.1 shows the current breakdown of expenditures within the health care industry.

It is important to recognize the breadth of this nearly $2.6 trillion industry. The health care industry is huge and has grown most dramatically over the past four decades, really starting its climb in 1966 with the advent

of the Medicare and Medicaid programs. These programs are explored in greater detail in chapter 4. However, suffice it to say here that they opened the floodgates of money to the industry. At the time the programs began, the industry absorbed 5.7 percent of the gross domestic product (GDP) in the country (NCHS 2011, table 124). GDP is the market value of goods and services produced within the United States. Over forty-four years, 1966-2009, health care's percentage of GDP grew to 17.9 percent, an astonishing 314 percent increase (NCHS 2011, table 124). This means that as a nation, we have decided, either by intent or accident, to expend a considerable amount of additional national resources and wealth in the pursuit of our health. Not only is health care now the largest industry in America, but it is growing at a rate greater than general inflation, meaning that it will be absorbing an ever-greater percentage of GDP as time goes by.

It is also important to note that the 17.9 percent of US GDP absorbed by health care leads the industrialized world by a large margin. The next five highest countries are the Netherlands at 12.0 percent of GDP going toward health care, France at 11.8 percent, Germany at 11.6 percent, Denmark at 11.5 percent, and Switzerland and Canada tied at 11.4 percent. (NCHS 2011, table 124). So significantly more is spent on health care in the United States than anyplace else in the world. There are two primary reasons for this. First, Americans have more discretionary income than anyone else and have chosen to spend some of it on health care. Second, Americans have been trained since the end of World War II to expect unlimited treatment for illness. This training has come from organized medicine—defined as the American Medical Association, the American Hospital Association, the American College of Surgeons, and many more groups. Health care is big business, and major administrative services have sprung up to handle the load. We will see later in the book the impacts that the 2010 Patient Protection and Affordable Care Act (ACA) is already having and is further projected to have on these numbers.

Figure 1.1 highlights the financial scope of the health care industry. As noted, in 2010, total expenditures are almost $2,600,000,000,000—that's a lot of zeros. It is estimated that by 2015, the industry will be spending well over $3.0 trillion. This means that tremendous resources are available to the companies that service patients—and tremendous opportunities. This money should be consumed in pursuit of the best possible outcomes, offered in the most consumer-friendly way and at the least possible cost. This is the role and objective of health care. The financial manager plays a large role in trying to achieve these outcomes through involvement and leadership in budget planning and reporting, charge setting, contract negotiations, and general financial consulting to the organization's department managers.



	1960	1970	1980	1990	2000	2010
Hospital Care	9.2	27.6	101.0	251.6	417.0	814.0
Physicians	5.4	14.0	47.1	157.5	288.6	515.5
Other Prof. Services	0.4	0.7	3.6	18.2	39.1	68.4
Dental	2.0	4.7	13.3	31.5	62.0	104.8
Other Personal HC	0.6	1.2	8.5	24.3	64.6	128.5
Home Health	0.1	0.2	2.4	12.6	30.5	70.2
Nursing Home	0.8	4.0	19.0	52.6	95.3	143.1
Drugs	2.7	5.5	12.0	40.3	120.8	259.1
Other Med. Prod.	2.3	5.0	13.6	33.7	49.5	176.1
Prog. Admin.	1.2	2.8	12.2	39.2	81.2	176.1
Other	2.9	9.4	24.2	55.8	109.9	231.5
Total	27.6	75.1	256.9	717.3	1358.5	2593.6

Figure 1.1. National Health Expenditures, 1960-2010 (in billions of dollars)
Source: A.B. Martin, D. Lassman, B. Washington, A. Catlin, et al., "Growth in US Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged From 2009," *Health Affairs* 31, no.1 (2012):1208–1219, http://content.healthaffairs.org/content/31/1/208.full.html

What Is Management?

Before looking for a definition of *financial* management, it is important to define *general* management. In most for-profit, investor-owned firms, management's overarching objective is to maximize the owners' or shareholders' wealth. To accomplish this goal, management has been assigned certain roles and responsibilities, involving the skills of leading, planning, organizing, coordinating, motivating, and controlling. In the case of the health care industry, slightly more than half the hospitals are classified as not-for-profit through section 501(c)(3) of the Internal Revenue Code—2,918 out of a total

hospital count of 5,795, or 50.4 percent (NCHS 2011, table 116). Still, even though their employers are not-for-profit, health care industry managers should be required to produce the best possible bottom line. They simply need to do so in the context of providing optimal patient care outcomes in the most efficient and satisfying manner.

In the for-profit world, "management must administer the assets of the enterprise in order to obtain the greatest wealth for the owner" (Berman, Weeks, and Kukla 1994, 4). Therefore, management's goal is to find the combination of earnings and risk associated with producing those earnings that yields the highest possible value.

In the not-for-profit world, these earnings are called profits. In the case of both investor-owned for-profit and not-for-profit health care firms, the profit is what remains after expenses, or costs, are subtracted from revenues. To reiterate, the role of management is to produce the best possible financial outcomes while minimizing risk to the organization. Not-for-profit health care providers place a somewhat greater emphasis on social goals than for-profit providers, but in the end, management's success or failure—as defined by each organization's board of directors—is primarily related to the quality of its bottom line.

What Is Financial Management?

Financial management can now be defined as strategizing the organization's financial direction as well as the performance of its day-to-day financial operations.

Therefore, financial management has a dual purpose. The first is to determine the strategic financial direction of the organization. This function is usually performed at the executive level of the financial ladder by the chief financial officer (CFO). The primary job is to prepare and present the organization's strategic financial plan to the board for endorsement and approval. In many organizations, this job may also include the treasury function, which is charged with investing the organization's financial assets in the most prudent manner as set down in board-approved investment policies.

The second purpose is management of day-to-day financial operations. The organization's second-in-command finance officer, often called the vice president of finance or controller, usually carries this out. This function means making sure that the payroll and the suppliers are paid and that the revenues generated by the operation are billed out in an accurate and timely manner and collected efficiently with a minimum of write-offs. In many hospitals these days, the revenue cycle management is now often carried out by a separate vice president (or director of revenue cycle management). This

role has been substantially elevated in the past several years, due to a variety of changes in Medicare and Medicaid rules and regulations, as well as the increasingly critical nature of other third-party reimbursement payers. This topic will be covered in greater detail in chapter 5.

Financial management has a role within the overall context of general management. Sound financial management aids the general managers in carrying out their management responsibilities. According to Berman, Weeks, and Kukla (1994), "Financial management tools and techniques can aid management in providing the community with quality services at least cost by furnishing the data that are necessary for making intelligent capital investment decisions, by guiding the operations of certain hospital subsystems, and by providing the systems and data needed to monitor and control operations" (p. 4).

Making data available and helping analyze the financial implications of the information across the health care organization's setting are therefore the primary roles of financial management. Financial management involves the finance staff in a number of highly visible and important matters:

- Setting prices for the services provided (often called gross charges). In recent years, this has also meant that these list prices have to bear some resemblance to cost if the hospital wants to be able to defend its practices within the context of "transparent pricing," a trend that has taken on considerable importance in the eyes of consumer groups and, in many cases, state and federal governments. The concept of price setting and transparent pricing will be discussed further in chapters 5 and 12.
- Producing and analyzing the discounts (often called contractual allowances) taken by a third-party payer—defined as anyone other than the patient who pays for the patient's services. The large third-party payers are Medicare, Medicaid, and hundreds of managed care organizations (MCOs)-often called health maintenance organizations (HMOs), preferred provider organizations (PPOs), or point-of-service organizations (POSs)—all across the country. A brand new third-party payer emerged in 2014—the Health Insurance Exchange (HIX), an entity that is a product of the ACA. Much more will be written about this later in the book.
- Recording and analyzing cost information across the organization and at the department level. This involves comparing actual costs to budgeted costs and determining variance analysis; it may also involve a detailed cost accounting program.
- Preparing and reporting financial projections to help successfully guide the organization in its future endeavors. A short-term projection of up to a year into the future is called a budget, and a long-term projection from two to twenty years into the future is called a strategic financial plan.

Why Is Financial Management Important?

Financial management has a primary and a secondary role in the financial health of the health care organization. Its secondary role is reporting financial results periodically, usually monthly. Its primary role, however, is as a broker of information. The people who control the information usually have quite a bit of power in any organization. The finance division of most organizations, and in most industries, has generally been the collector and reporter of information.

No organization can achieve success without the proper financial information on which to base its decisions. The whole purpose of having and using information is to make the most appropriate decisions. Making decisions is every manager's number one priority. Making the *proper* decisions is a function of experience and appropriate information.

Also, keep in mind that there is a significant difference between information and raw data. Data streams inundate most managers all day long. Raw data are often useless, and sometimes harmful, in the process of making the best decision. The value of information is that it brings *context* to the data, presenting them in a format that enhances a manager's ability to understand what is happening and make a good decision.

Management has been described as the art of making decisions under uncertain and difficult conditions. Thus financial management can be said to be important because, if applied properly, it maximizes the operating manager's ability to make difficult yet good decisions in the face of uncertainty by presenting information in the best possible format. In addition, it allows the finance division to maximize reimbursement (net revenue) for the health care organization. (This is covered in chapter 4.)

Michael Nowicki (2004) provides a good description of the six major objectives of health care financial management, in addition to the accounting and reporting functions, which he identifies as the following:

1. To generate income
2. To respond to regulations
3. To facilitate relationships with third-party payers
4. To influence method and amount of payment
5. To monitor physicians
6. To protect the organization's tax status

Finally, although financial management is generally reported on by the finance team at hospitals, it is important to always remember that some of the primary stakeholders for financial management information are the clinical and operating managers. Accounting and finance personnel can

be considered advisers and "score keepers," but they make few real operating decisions, and where they do, it is in concert with operating managers. Operating managers provide the assumptions for departmental budgets and pro formas; identify capital equipment and resource needs; evaluate paybacks (in concert with finance team); hire, evaluate, and reward employees; schedule employees; compare budgets to actual reports and explain variances; provide input on the chargemaster; enter daily charges; budget and schedule full-time equivalents (FTEs); monitor paid hours; requisition supplies; maintain inventories, etc. So, readers of this book may be accounting or finance members, clinical or operating managers, executives or board members. All have their own reasons for understanding their health care organization's financial management and outcomes. It is a lot to absorb.

Ridgeland Heights Medical Center: The Primary Statistics

Ridgeland Heights Medical Center is a fictional medium-sized medical center in a northern Chicago suburb. For IRS purposes, it was classified as a community not-for-profit hospital under Internal Revenue Code section 501(c)(3) because of its charitable mission, dating back to 1925. In addition to its current complement of 180 acute care medical and surgical beds, it also has a 20-bed maternity unit, a 20-bed Medicare PPS-exempt psychiatric unit ("PPS-exempt" means that it is not subject to Medicare's prospective payment system), a Medicare-certified home health agency (HHA) and hospice, and a 30-bed hospital-based skilled nursing facility (SNF).

Ridgeland Heights also owns twenty primary care physician practice sites, which employ thirty full-time physicians. This practice is managed through a corporate-affiliated management services organization (MSO), which also manages six primary care physician practices not owned by the hospital.

In addition, RHMC is half owner of a physician hospital organization (PHO), the other half owned by an independent practice association (IPA), a group of physicians legally organized to negotiate contracts with managed care organizations. The PHO negotiates contracts on behalf of both the medical center and the IPA. In many instances, this is well received by the managed care companies because of its time-saving and cost-reducing principles. It will also prove quite useful, beginning in 2014, in billing out combined services under the new ACA reimbursement bundling provisions for billing.

Volume indicators are critical to understanding any institution. A volume indicator generally defines the level of financial viability. RHMC provides both inpatient and outpatient services. Table 1.1 highlights the inpatient volumes for the year just ended as well as the current budgeted year.