

Originally Processed With FOIA(s):
2021-0094-F

FOIA Number:
2021-0094-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the George Bush Presidential Library Staff.

Record Group/Collection: George H.W. Bush Presidential Records
Collection/Office of Origin: Cabinet Affairs, White House Office of
Series: Porter, Richard, Files
Subseries:

OA/ID Number: 07136
Folder ID Number: 07136-011

Folder Title:
Measuring the Financial Health of Hospitals

Stack:	Row:	Section:	Shelf:	Position:
G	15	16	2	

Measuring the Financial Health of Hospitals



Ernst & Whinney



HFMA[®]

HEALTHCARE
FINANCIAL
MANAGEMENT
ASSOCIATION



This monograph, “Measuring the Financial Health of Hospitals,” reports the findings of a survey conducted by the Healthcare Financial Management Association (HFMA). The survey requested financial data from hospitals whose Chief Financial Officers (CFOs) are HFMA members.

HFMA is an organization of over 26,000 members involved in the financial management of healthcare providers. HFMA members include professionals employed by hospitals and long-term care facilities, as well as others employed by public accounting and consulting firms, insurance companies, government agencies, and other organizations.

As a result of the findings of this survey, HFMA is concerned that the solvency of the nation’s hospitals may be in jeopardy, particularly if Medicare payments are not maintained at reasonable levels. While some believe that the hospital industry has been too profitable under Medicare’s Prospective Payment System (PPS), HFMA asserts that reports of profitability in the early years of PPS are misleading and not relevant to current discussions about Medicare payment rules and rates. These reports do not accurately portray the current and likely future financial position of hospitals.

HFMA believes that necessary hospital margins, particularly from providing services to Medicare beneficiaries, have declined sharply. In some cases these margins are negative. We believe these declines place the industry at unreasonable financial risk. We believe that the data and findings derived from this survey deserve the attention of hospital trustees and managers as well as elected representatives and government officials.

THE SURVEY

The survey requested data for a four-year period which were used to compute several financial measures, including:

- Overall profits or losses (margins).
- Margin from patient care services.
- Margin from services to Medicare patients.
- Percentage of uncompensated patient care.

Additionally, the survey sought comments from respondents, including their subjective assessments of two key indicators of financial health:

- Ability (inability) to meet debt service requirements in the future.
- Ability (inability) to replace assets or acquire new technology.

This survey focused on rates of return expressed as a percentage of net revenue. An overall assessment of hospital financial strength should also include the measurement of earnings in relation to hospital assets and equity (fund balance). Other considerations, such as hospitals’

ability to adequately finance working capital and debt requirements should also be made. (Quantitative measures such as liquidity and debt service coverage ratios can help in these assessments.) Although these factors are relevant to any discussion of the financial position of our nation's hospitals, this survey was limited in scope to address the key financial measure most commonly the subject of public discussion, profitability defined in relation to net revenue. The broader measures of fiscal health are analyzed in HFMA's "Hospital Industry Financial Reports."

ACKNOWLEDGEMENTS

We express our appreciation to the firm of Ernst & Whinney, which assisted with this year's survey. Ernst & Whinney provides extensive accounting and consulting services to the healthcare industry and provided financial support for this project.

We also gratefully acknowledge our CFO members for their time and effort in completing the survey document. We wish to thank them for allowing us to include their comments in this document. Without them this publication would not have been possible.

HFMA is pleased to present "Measuring the Financial Health of Hospitals" as a means of providing you with a greater appreciation of the financial issues facing the healthcare industry. After reviewing the survey results and analysis, we invite you to provide us with your comments and ideas.

Healthcare Financial Management Association

1050 17th Street, N.W.
Suite 510
Washington D.C. 20036

2 Westbrook Corporate Center
Suite 700
Westchester, IL 60153

Contents

Executive Summary	1
About This Survey	3
Findings	7
Overall Margin and Margin from Providing Patient Care Services	7
Margin from Serving Medicare Patients	10
Medicare’s Share of Revenue and Expense	12
Cost per Case and Medicare Cost and Payment per Case	13
Uncompensated Care as a Percent of Net Patient Revenue	15
Capital Cost as a Percent of Total Cost	16
Appendix A - HFMA’s Comments on the Inspector General’s Profitability Data	19
Appendix B - Survey Document	21
Appendix C - Compiled Survey Results	27
Appendix D - Additional Comments from HFMA Members	35

Executive Summary

EXECUTIVE SUMMARY

Legislation or regulations have amended Medicare's PPS system each year since its introduction in 1983. These amendments have caused Medicare's payments to hospitals to be lower than they otherwise would have been. Medicare payments have not kept pace with the costs of providing care to Medicare beneficiaries. Employers, state governments, and other payers have also sought to limit spending for healthcare services. This restricts hospitals' ability to offset the Medicare shortfall and to meet their full financial requirements. In addition, the uninsured and underinsured population continues to grow. Nevertheless, the general public still seems to expect unrestricted access to quality health care. HFMA is concerned that these factors are causing hospital margins to be inadequate. We are concerned that the long-term solvency and credit-worthiness of the nation's hospitals may be in jeopardy. HFMA believes government has an obligation, on behalf of the public good, to expect efficiency from Medicare providers. However, HFMA maintains that Medicare payments should adequately meet the financial requirements of providers who conscientiously manage their costs.

To obtain current information on the financial condition of hospitals, HFMA surveyed its CFO members. We received and used 532 responses in the survey compilation. Survey respondents provided financial data for their hospital's two most recently completed fiscal years and estimated data for the balance of their current fiscal year and next year. Respondents were also asked to provide comments and opinions on the financial data and trends they see affecting their institutions. The following table presents a summary of key information derived from the survey:

	Overall <u>Margin</u>	Gain (Loss) From Medicare <u>Services</u>	Medicare's Share Of Total Hospital <u>Costs</u>	Net <u>Revenue</u>
PPS Year 3	6.0%	3.2%	41%	41%
PPS Year 4	5.4%	(.6)%	41%	40%
PPS Year 5	4.0%	(5.5)%	42%	38%
PPS Year 6	3.3%	(9.0)%	42%	37%

The definition of "PPS Years" is included in the SURVEY METHODOLOGY section of the report.

Hospital margins, as a percent of net revenue, are expected to decline significantly during the four-year survey period. The above table shows the extent of this decline. The American Hospital Association panel survey (a statistically representative sample of hospitals) also shows a rapid decline in hospital profitability in recent years.

The most significant factor contributing to the decline in overall hospital margins is the weakening and eventual loss of earnings derived from serving Medicare patients. This margin from Medicare services declined

Executive Summary

significantly during the first two surveyed years, and the responding CFOs expect this trend to continue. In fact, the average responding hospital reported a slight loss from providing Medicare services last year (PPS Year 4). Over 75 percent of responding hospitals anticipate a loss from these services next year (PPS Year 6). Payments from Medicare currently account for 38 percent of the total net patient revenue for the survey respondents. The responding CFOs expressed concern that losses on such a significant part of a hospital's business could seriously impact their hospital's future financial viability.

Even though responding hospitals are, on average, experiencing substantial declines in overall margins, they continue to provide hospital services to indigents and to those with insufficient health insurance coverage. In fact, for the average responding hospital, uncompensated care is expected to rise from 5.2 percent to 5.7 percent of net patient revenues over the four-year survey period.

Many respondents expressed concern about their inability to finance needed renovations and equipment replacement. Others indicated that a continuation of the current Medicare policy of paying less than actual capital costs will prohibit them from keeping pace with new technology. Many respondents indicated difficulty in obtaining new financing due to declining "bottom lines." Some expressed concern, even fear, that quality of patient care will suffer without sufficient margins to provide adequate cash flow and access to capital sources.

If these trends do not reverse, the long-term financial viability of many hospitals, particularly those serving a significant share of the nation's elderly or uninsured, could be jeopardized.

About This Survey

ABOUT THIS SURVEY

HFMA undertook this survey in response to some views that the hospital industry has been too profitable under Medicare's PPS system. Many HFMA members have expressed their concerns that this viewpoint does not reflect the current financial situation at their hospitals. We believe that patient care margins have declined and in many cases are negative. To test this hypothesis, our survey requested actual and projected financial information for a four-year period. The key items requested were:

- Total Medicare payments and the components of Medicare payments (DRGs and outliers, pass-through amounts, bad debts, and other Medicare payments).
- Non-Medicare net patient service revenue.
- Nonoperating and other operating revenue.
- Amount of uncompensated care.
- Costs incurred in providing services to Medicare and other patients.
- Medicare and total acute patient discharges.

This survey has several special attributes:

- The historical information included is more recent than that available from most other data sources. In addition, we requested projected information for the current and next fiscal years. We asked the responding financial managers to reflect the impact of recent Medicare legislation and their hospital's action plans and budgets in these projected amounts.
- The cost of providing care to Medicare patients is based on the responding hospitals best available cost accounting data, rather than using the Medicare cost report allocation methodology.
- We provided an opportunity for the responding financial managers to present their views and comments on the trends and to voice their concerns and frustrations.

HFMA sent the cover letter and survey document (presented in Appendix B) to 3,380 HFMA members who are hospital CFOs. Of that total, 532 provided responses by the processing deadline. Some respondents did not answer all the questions. Inconsistent or invalid answers were excluded. Ernst & Whinney compiled the survey responses, as described in Appendix C.

Using the data provided by the survey respondents, overall profits as well as gains or losses from patient service activities were measured. Survey data was also used to isolate the effects of Medicare policy on hospital profitability. Survey results and HFMA's analysis are included in the

FINDINGS section of “Measuring the Financial Health of Hospitals.”

We also asked the CFOs responding to the survey to provide their opinions and comments on the financial trends at their hospital. We asked for specific comments on whether their credit ratings and ability to service or obtain new financing had changed. A selection of their comments are provided in Appendix D and in pertinent sections of this report.

The survey requested financial data for four hospital fiscal years. This included actual results for the two most recently completed fiscal years and projected results for the hospital’s current and next fiscal years. Hospital fiscal years end on various dates. For survey tabulation and reporting, we have grouped the responding hospitals by “PPS Year.” Medicare PPS changes are generally implemented at the beginning of the federal government’s fiscal year (October 1) or at the beginning of a hospital’s own fiscal year starting during a particular federal fiscal year. This survey covers the third through sixth federal fiscal year since the beginning of the PPS system. Consequently, references in this report are to PPS Years 3 through 6. The following chart describes hospital fiscal years included in each PPS Year.

Hospital Fiscal Years Beginning:

PPS Year 3	10/1/85 through 9/30/86
PPS Year 4	10/1/86 through 9/30/87
PPS Year 5	10/1/87 through 9/30/88
PPS Year 6	10/1/88 through 9/30/89

Any survey, regardless of methodology, has its attendant biases because of the nature of the research vehicle. Further, no attempt was made to verify survey responses. The PPS Years 5 and 6 data reflect projections made by the survey respondents. There will usually be differences between projected and actual results, because events and circumstances frequently do not occur as expected and those differences may be significant.

This survey was not designed to draw statistically valid conclusions regarding the financial position of all U.S. hospitals. The majority of responses received represent hospitals east of the Mississippi (67 percent of responses versus 54 percent of all hospitals in the U.S.A.), hospitals over 100 beds (84 percent of responses versus 55 percent of all hospitals), urban hospitals (64 percent of responses versus 49 percent of all hospitals), and non-teaching hospitals (63 percent of responses versus 76 percent of all hospitals). Results are representative only of those hospitals responding to the survey, however, the results may be indicative of national trends.

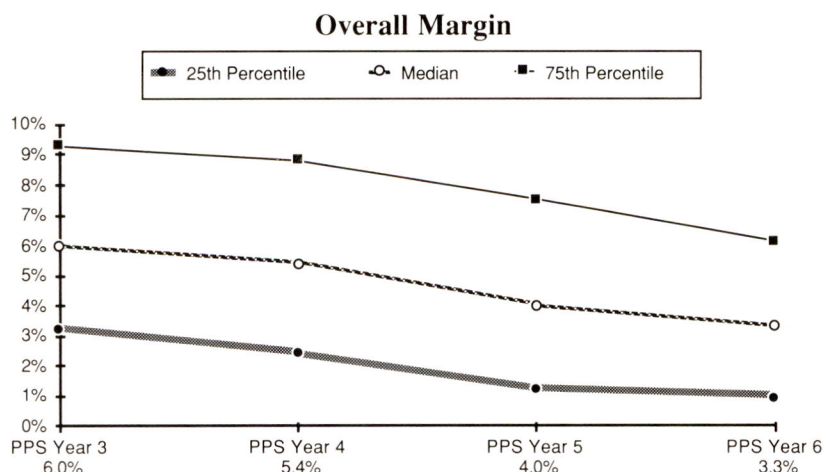
About This Survey

Respondents to this survey may be in better financial condition than the nation's hospitals on the whole. This may be due to the fact that we received a higher than average response from urban and large (over 100 beds) hospitals. Other studies have shown these hospital groups to have better than average financial results. The American Hospital Association panel survey (a statistically representative sample of hospitals) reported overall margins of 5.2 and 4.8 percent in calendar years 1986 and 1987. Respondents to this HFMA survey reported overall margins of 6.0 and 5.4 percent for PPS Years 3 and 4.

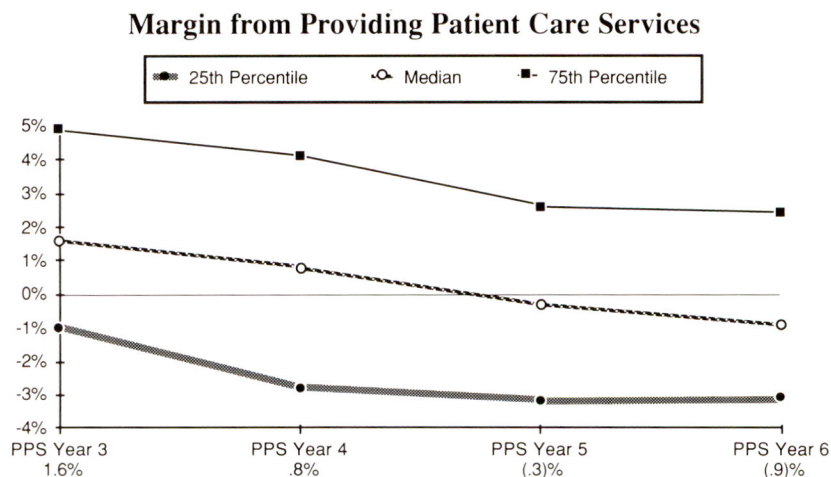
Findings

FINDINGS This section reports the key findings of the survey compilation and contains HFMA’s observations and discussions of significant trends. A complete summary of the survey findings (including calculation methodology) is included as Appendix C. Selected comments of the CFO respondents are included with each item to illustrate industry concerns and frustrations and to provide additional insight into these trends. Appendix D includes additional comments from survey respondents to further illustrate the concerns and opinions of financial leaders of the hospital industry.

OVERALL MARGIN AND MARGIN FROM PROVIDING PATIENT CARE



The definition of “PPS Years” is included in the SURVEY METHODOLOGY section of this report. Median values are noted below graph.



The definition of “PPS Years” is included in the SURVEY METHODOLOGY section of this report. Median values are noted below graph.

Overall hospital margins are declining. Overall margins reflect earnings from all operating and nonoperating activities (“bottom line”). Nonpatient service revenue, including investment income and activities such as

Findings

cafeteria sales, nursing school fees, and fund raising are included in this measure. The margin from patient care services is limited to earnings from services provided to patients.

The decline in the margin from providing patient care services reflects not only constraints on Medicare payments, but also increased discounting from established charges, increasing costs of providing services, and the shift to outpatient care settings. If this decline continues, the ability of hospitals to sustain reasonable profit margins becomes increasingly dependent on earnings from sources other than patient care.

Approximately 66 percent of the survey respondents reported a positive return from patient care services in PPS Year 3. This is projected to drop to 49 percent by PPS Year 5. Only 43 percent expect to earn a profit from patient care services in PPS Year 6. Approximately 90 percent of the survey respondents reported a positive “bottom line” in PPS Year 3. This has decreased to 86 percent in PPS Year 5 while only 83 percent expect to earn an overall profit in PPS Year 6.

Less than 34 percent of respondents expect a positive return from patient care services in every year of the four-year survey period. Giving consideration to other operating and nonoperating activities, 72 percent of respondents expect to have a positive “bottom line” for every year of the four-year period. However, 73 percent of respondents expect to incur a drop in returns from patient care services (including years with losses) during the four-year period, and 73 percent expect lower overall margins in PPS Year 6 compared to PPS Year 3.

Comments from survey respondents express anxiety that the solvency of some of the nation’s hospitals may, in the near future, be in jeopardy.

***Comments from
HFMA Members:***

The hospital’s operating margin in 1987 reflected a sharp and significant decline and an operating loss is anticipated for 1988.

Richard D. Keenan
The Valley Hospital
Ridgewood, NJ

* * *

Our operation is extremely fragile, the loss of a single doctor and/or industry in the town could accelerate the demise of Reed City Hospital.

Stanley J. Maksimowicz
Reed City Hospital
Reed City, MI

* * *

Findings

[The] hospital can only cut costs to a certain level before quality is compromised.

Daniel C. Confalone
Allentown Osteopathic Medical Center
Allentown, PA

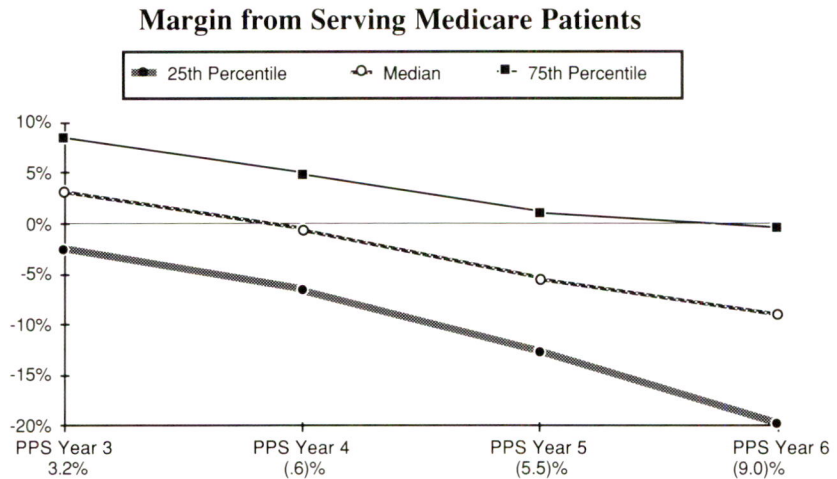
* * *

Since most of the fat has been trimmed from our budgets, any additional cost savings will have to come from elimination of services.

Gary G. Guetzko
St. Joseph Mercy Hospital
Mason City, IA

* * *

MARGIN FROM SERVING MEDICARE PATIENTS



The definition of "PPS Years" is included in the SURVEY METHODOLOGY section of this report. Median values are noted below graph.

The respondents to this survey reported a median profit margin from services provided to Medicare patients of 3.2 percent for PPS Year 3. This is a variance of 67 percent from the average “Medicare profit margins” of 9.6 percent reported by the United States Department of Health and Human Services (HHS) Office of the Inspector General (IG) for the same year. We recognize that the IG reported returns from only Medicare inpatient operating services while this survey measures the margin from all Medicare patient services. For the respondents to this survey, Medicare inpatient operating payments (DRG and outlier payments) average 77 percent of total Medicare payments in PPS Year 3. The remaining Medicare payments are for inpatient pass-through amounts, PPS-exempt services, outpatient services, and bad debts, all of which are paid on the basis of Medicare allowable costs.

We find it difficult to believe hospitals would incur such significant losses on the 23 percent of Medicare services which are paid on the basis of costs incurred. In short, there is a substantial unreconciled difference between the IG’s reported profits and those reported by the survey participants. As discussed in detail in Appendix A, the IG’s findings appear inconsistent with operating margins reported by other industry sources. The most notable industry source is HFMA’s Financial Analysis Service, which includes data from audited financial statements of 1,400 hospitals.

Margins from serving Medicare patients declined significantly from PPS Year 3 to PPS Year 4, and the CFOs responding to this survey expect this trend to continue. Recent changes in Medicare payment rules, such as DRG update factors held significantly below the hospital market basket measure of inflation, reductions in capital and medical education payments, changes in DRG weights, etc. have sharply reduced the margin from providing services to Medicare beneficiaries. In fact, the average respondent reported a slight loss from these services for PPS Year 4. Over 75 percent of responding hospitals anticipate a loss on the provision of Medicare services in PPS Year 6.

Findings

Payments from Medicare currently account for 38 percent of total net patient revenue for responding hospitals. Survey respondents expressed concerns that losses on such a significant portion of a hospital's business could seriously impact their hospital's future financial viability.

***Comments from
HFMA Members:***

By 1989 we will receive \$.82 for every dollar we spend on the treatment of Medicare patients. If this trend continues we will be unable to support the facility in the 1990s.

Ronald K. Sperling, CPA
Mercy Medical Center
Roseburg, OR

* * *

In 1986, Medicare reimbursed 84.5 percent of their share of costs; by 1989 this reimbursement rate will drop to 78.0 percent of costs.

Lillian A. Hinds
Mary Free Bed Rehab Center
Grand Rapids, MI

* * *

If Congress continues its plans to reduce reimbursement in this arena, our ability to continue our present complement of services will be severely hampered.

William E. Baecker
Clinton Memorial Hospital
Wilmington, OH

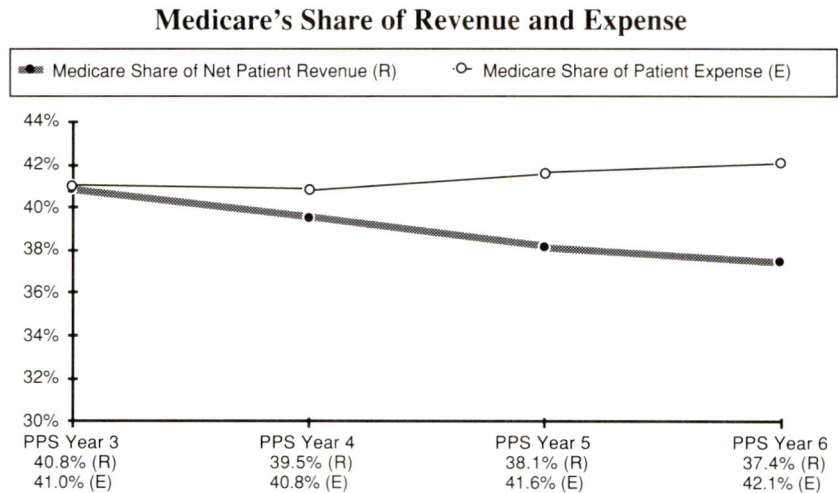
* * *

Medicare utilization in the first three months of FYE 9/30/88 has increased 10 percent over the previous year with a matching decline in non-Medicare patients. This abrupt change, coupled with inadequate rate increases for fourth-year PPS hospitals, results in a tremendous drain on the financial resources of this facility...

Michael D. Ayres, FHFMA
Lourdes Hospital
Paducah, KY

* * *

**MEDICARE'S
SHARE OF
REVENUE AND
EXPENSE**



The definition of "PPS Years" is included in the SURVEY METHODOLOGY section of this report. Median values are noted below graph.

The previous chart shows the decline in earnings from serving Medicare patients. To determine the causes of this decline we examined the trends in Medicare payments and costs. The first analysis focused on the trend in Medicare payments expressed as a percentage of total net patient revenues. We compared these percentages to Medicare costs expressed as a percentage of total patient expenses (above). The second analysis compared the trends in Medicare payments per case to Medicare costs per case (presented in the following section of this report).

We observe that Medicare's share of total patient expenses is growing, but its share of net patient revenue is falling. If this trend continues, hospitals will have to rely on other payers to subsidize the differences between the payments made by Medicare and the costs of providing services to its beneficiaries.

**Comments from
HFMA Members:**

Our charges continue to increase to compensate for lower reimbursement by governmental payers. Commercial and self-pay patients are continuing to absorb and subsidize the public patient's care.

Will L. Bishop, CPA
Community Hospital Monterey Peninsula
Monterey, CA

* * *

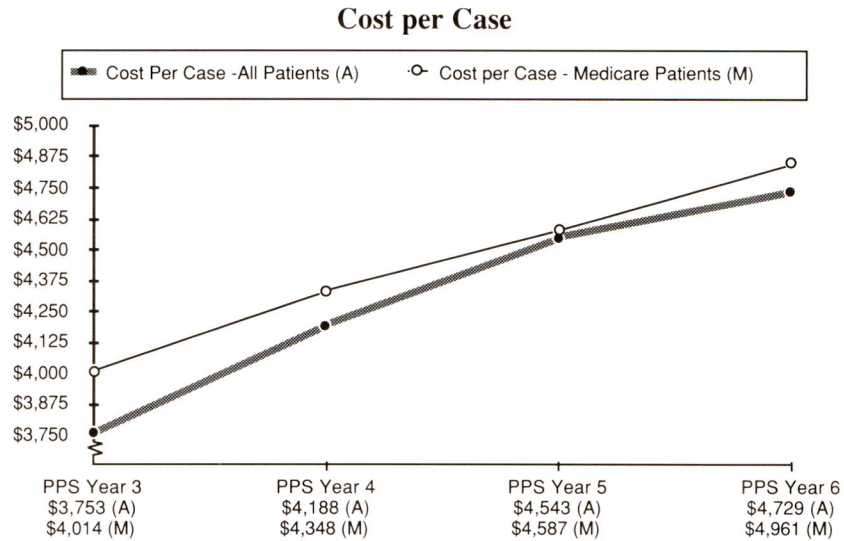
The non-Medicare patient is shouldering more and more of the cost of hospital operations, even though the Medicare patient continues to consume greater resources. Actually I view charges in a hospital now as a tax since the government pays so little of their share, yet requires the most in the manner of billing, UR, reports, PRO, etc.

James S. Rowson, FHFMA, CPA
Harrison Memorial Hospital
Bremerton, WA

* * *

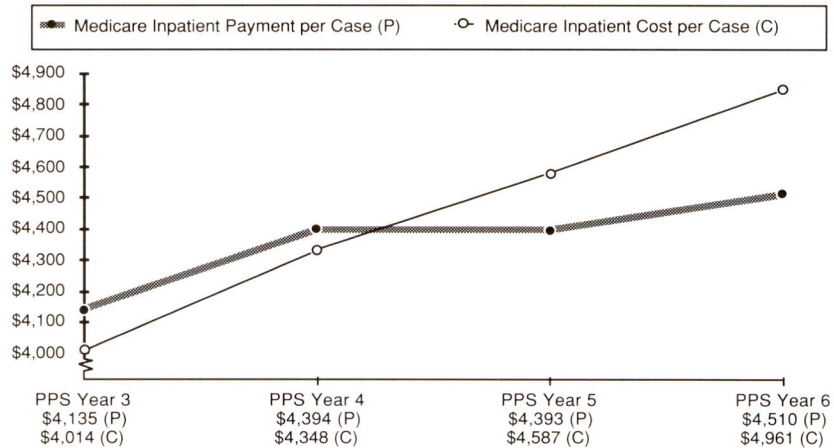
Findings

COST PER CASE AND MEDICARE COST AND PAYMENT PER CASE



The definition of "PPS Years" is included in the SURVEY METHODOLOGY section of this report. Median values are noted below graph.

Medicare Cost and Payment per Case



The definition of "PPS Years" is included in the SURVEY METHODOLOGY section of this report. Median values are noted below graph.

Total hospital as well as Medicare cost per case show an increase during the survey period. This increase reflects the impact of both rising operating costs and decreasing hospital admissions. The survey respondents expect to experience a 1.5 percent decrease in total admissions and a 1.4 percent decrease in Medicare admissions between PPS Year 3 and PPS Year 5.

A number of factors contribute to the rising costs per case. In addition to general inflation, the shift of many less serious cases to an outpatient setting leaves the more seriously ill and presumably more costly cases as inpatients. Although new technology and treatments bring many benefits to patient care outcomes, they may also result in increased costs per case.

Findings

In short, Medicare costs per case are increasing at a faster rate than Medicare payments per case. This contributes significantly to the declines in margins from serving Medicare patients, discussed earlier in this report.

The CFOs responding to this survey believe their institutions have conscientiously managed their costs, and are worried that further reductions in cost cannot be made without having an adverse impact on quality of care.

***Comments from
HFMA Members:***

Medicare cases are becoming more severe and, therefore, expensive. Also, cost per case is increasing in spite of reduced total cost because total cases have declined faster..

Jerry A. Mashburn, FHFMA, CPA
Mercy Hospital
Miami, FL

* * *

Patient service expense is increasing very rapidly, especially due to increased salary expense. Nursing salaries and those of other personnel are increasing due to staffing shortages.

Hilmon P. Waters
National Orthopedic and Rehabilitation Hospital
Fairfax, VA

* * *

Findings

UNCOMPENSATED CARE AS PERCENT OF NET PATIENT REVENUE	<u>Percent</u>	<u>Annual Change</u>	<u>3-Year Change</u>
PPS Year 3	5.2		
PPS Year 4	5.6	7.7% increase	
PPS Year 5	5.6	No Change	
PPS Year 6	5.7	1.8% increase	9.6% increase

Services to the uninsured and underinsured (generally designated as “charity care”) and the costs of bad debts on patient services are a financial burden to the nation’s hospitals. As overall margins decrease, hospitals find it difficult to find the resources to provide such services. Survey respondents indicate they expect a modest increase in the proportion of uncompensated patient care services. Comments from members emphasize the financing of these services is an increasingly difficult burden. HFMA’s task force on charity care concluded it is essential that all payers share equitably in this financial obligation.

***Comments from
HFMA Members:***

The bad debt/charity volumes are the most serious financial problems that a healthcare facility must deal with. All other payer sources are continually reducing healthcare dollar payments, leaving a smaller financial base each year to draw from to cover an expanding uncompensated care population.

Thomas F. Wells
Baptist Medical Center
Montgomery, AL

* * *

As an urban inner city hospital, our most immediate concern is the unreimbursed cost of indigent care patients and Medicaid patients.

John E. Rynard, FHFMA, CPA
Bethany Medical Center
Kansas City, KS

* * *

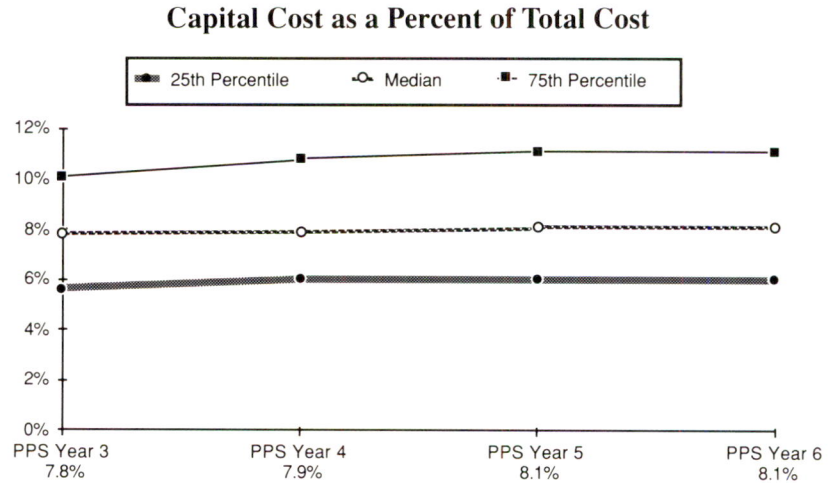
Nobody wants to acknowledge that there is a problem in caring for the medically indigent.

Patrick Rawl, CPA
Queen of Angels Medical Center
Los Angeles, CA

* * *

Footnote: Survey results do not evidence a trend to adopt the recommendation of HFMA’s Principles and Practices Board that uncompensated services should be reported as an expense rather than as a revenue deduction. About 3.5 percent of respondents currently follow this practice.

**CAPITAL COST
AS A PERCENT OF
TOTAL COST**



The definition of "PPS Years" is included in the SURVEY METHODOLOGY section of this report. Median values are noted below graph.

As hospitals make efforts to reduce all possible variable costs, fixed capital costs (depreciation and interest) grow as a percentage of overall cost. Survey respondents expect capital, as a percentage of total cost, to grow from 7.8 to 8.1 percent during the four-year survey period. The survey data also illustrates the wide variety of circumstances of individual hospitals. In PPS Year 6, 25 percent of responding hospitals will have 6 percent or less of total cost devoted to capital. Another 25 percent will have capital costs exceeding 11 percent of total cost.

Similarly, there is wide variation in the components of capital costs. For the average responding hospital, equipment costs comprise 43 to 44 percent of capital costs in each of the four years surveyed. One-fourth of responding hospitals, however, indicated equipment costs account for more than 58 percent of their total capital costs. Another quarter of the respondents indicated equipment accounts for less than 30 percent of total capital costs. These trends dramatize the need for an equitable Medicare capital methodology that recognizes differences among hospitals.

Survey respondents expressed serious concerns that their hospitals will be unable to finance needed renovations or equipment if their financial position continues to deteriorate.

***Comments from
HFMA Members:***

The continued cutbacks in capital reimbursement are a serious threat to hospital survival. The hospital facility is over 60 years old and many items will soon need repair or replacement. Cutting back reimbursement for capital additions or improvement may delay these additions or repairs and eventually patient care could be affected.

Paul A. Beaudoin
Notre Dame Hospital
Central Falls, RI

* * *

Findings

Due to the negative bottom line...it is going to be increasingly...difficult for Saint Eugene to find the funds to replace equipment and keep pace with technology.

F. J. Children, Jr.
St. Eugene Community Hospital
Dillon, SC

* * *

Hospital management is more reluctant to spend capital dollars due to the present uncertainty and the inability to budget capital cash flows. We cannot defer these expenditures indefinitely.

Gary G. Guetzko
St. Joseph Mercy Hospital
Mason City, IA

* * *

Total capital needs [are] continuing to climb dramatically coupled with Medicare's capital payment reduction. This scenario will make it increasingly difficult for institutions to maintain quality of care in use of new technologies.

Larry Kidd
Regional Medical Center
Boise, ID

* * *

We must keep our plants up to date, or health care institutions will follow the path of the steel industry.

Rudolph T. Klemens
The Uniontown Hospital
Uniontown, PA

* * *

Appendix A

HFMA'S COMMENTS ON THE INSPECTOR GENERAL'S PROFITABILITY DATA

The “Margin From Serving Medicare Patients” presented in “Measuring the Financial Health of Hospitals” shows that survey respondents experienced significantly lower margins than those reported by the HHS Inspector General (IG). Moreover, our respondents indicate they expect even lower gains (or losses) in the future. The IG reported average “Medicare profits” on inpatient operating services of 9.6 percent in PPS Year 3. Survey respondents reported total margins from serving Medicare patients of 3.2 percent for the same period. (The IG reported average profits of 14.2 percent in PPS Year 1 and 15.3 percent in PPS Year 2.) The IG’s results appear inconsistent, not only with this survey, but with other industry data, and appear to overstate actual hospital margins from providing Medicare services. For this reason, and the factors described below, we do not believe the IG reports, by themselves, should be used as a basis for making decisions about Medicare payment rates.

1. The methodology used by the IG inflates the “Medicare profit percent” by including only a portion of Medicare payments and expenses. Medicare costs and payments for capital-related, direct medical education, bad debts, and cost-reimbursed items were excluded from the IG’s calculation. If these items were included, lower profit margins would have been calculated.
2. The IG’s study used Medicare cost reports as a basis to determine “Medicare profits” or the excess of Medicare payments over costs incurred in providing Medicare services. However, the costs reported in the Medicare cost report do not fairly describe the total costs a hospital incurs in providing services to Medicare beneficiaries. Examples of shortcomings in Medicare’s definition of the costs of serving Medicare patients include:
 - Inadequate formulas for allocating malpractice, bad debt, and home office costs;
 - Failure to pay a fair return on invested capital;
 - Failure to pay a proportionate share of the costs of serving indigent patients;
 - Failure to consider higher costs of serving elderly patients; and
 - Failure to revise cost reports to include costs determined to be allowable by federal courts.

One particular example illustrates how the Medicare cost report methodology can distort the IG’s calculations. Medicare cost report instructions required that non-Medicare maternity services (“labor room days”) be used to dilute the calculation of the average daily cost of Medicare services. Many hospitals disagreed with this calculation method and appealed to federal courts for relief. During 1987, Medicare acceded to federal court decisions in favor of hospitals and made retroactive restitution for all years prior to PPS to hospitals

who had appealed this issue. However, the cost reports for PPS Year 3, which were the basis of the IG's most recent calculations, included this improper calculation of Medicare costs.

3. The IG report does not project the impact of existing rules and payment rates on future profitability. Reductions in the PPS update factors and other changes in Medicare payment methodology, enacted in years subsequent to those analyzed in the IG's report, have already reduced hospital returns. The responses to HFMA's survey considered the impact of the most current Medicare rules and payment rates on hospital financial conditions.

In an effort to determine the impact of PPS on hospitals' financial performance in the years since the IG's report, the Wisconsin Hospital Association commissioned Ernst & Whinney to study the impact of PPS on Wisconsin hospitals for the first five years of PPS. Following the IG's methodology, results for Wisconsin hospitals were found to parallel the IG's findings for the first three years of PPS. However, following this same methodology, and applying all legislative and regulatory changes to the PPS system which are currently in effect, this study showed that Wisconsin hospitals were projected, on average, to incur a 5 percent loss on providing services to Medicare beneficiaries in PPS Year 5. When this study revised the IG's methodology to include all Medicare costs and payments (per item 1) to Wisconsin hospitals, the projected average losses were even greater.

4. The IG's reports of high margins on Medicare are inconsistent with other industry data. HFMA's Financial Analysis Service, which includes data compiled from audited financial reports of approximately 1,400 hospitals, shows overall profits (measured as the Excess of Revenue Over Expenses divided by Total Net Revenues) in 1984, 1985 and 1986 of 4.5, 4.4, and 4.2 percent, respectively. These years encompass PPS Year 1 through 3. Medicare currently comprises about 38 percent of total net revenue, according to this HFMA survey. A significant loss on the non-Medicare activities comprising the remaining 62 percent of net revenue must have been incurred to result in the high Medicare profit margins reported by the IG. This result is highly unlikely and thus the IG's reported "profit margins" appear inconsistent with other data.

Appendix B

SURVEY DOCUMENT



HEALTHCARE
FINANCIAL
MANAGEMENT
ASSOCIATION

RONALD R. KOVENER
HFMA, CAE
VICE PRESIDENT

1050 17TH STREET, NW
SUITE 510
WASHINGTON, DC 20036
TELEPHONE 202/296/2920

December 5, 1987

Dear Chief Financial Officer:

IMPORTANT — RESPONSE BY JANUARY 22 REQUIRED

You have an opportunity to correct misunderstandings about the financial condition of the healthcare industry. Last year, HFMA conducted its first survey of current financial information. The report from last year's survey, released in March, and HFMA's Hospital Industry Financial Report: 1982-1986, released in October, have gone a long way toward refuting governmental reports of high hospital profits. The information has been recognized by the Prospective Payment Assessment Commission, members of Congress, the media, and others. In these days of intense budget pressure, we believe this information has helped present the true current financial condition of hospitals.

We are anxious to avoid duplicative requests for information and have determined that no other survey of all hospitals includes these essential and unique features of this HFMA survey:

1. Information is current and reflects your decisions about how to respond to fiscal pressures. We do not substitute our assumptions about the future for your action plans;
2. Medicare cost is based on your cost accounting systems rather than using the Medicare cost report formulas which understate the cost of serving Medicare beneficiaries for many providers; and
3. Opportunities are provided for your views to be included in the report. This personalizes the industry's concerns and frustrations.

We ask you to cooperate with surveys conducted by others and to respond promptly to this request. A variety of input is essential to achieve equitable payment rates by the government and others.

Appendix B

December 5, 1987
Page 2

HFMA expresses its sincere appreciation to Ernst & Whinney for its financial and technical assistance with this survey.

The information you provide in response to this request will be considered strictly confidential. We will not release data about individual organizations. Only aggregate data that does not disclose information about an individual respondent will be released. Please respond completely, accurately, and promptly to the attached survey! Thank you for speaking out on behalf of the healthcare industry.

Sincerely,

R. R. Kovener, FHFMA
Vice President

RRK/mp

CFO12-5.LT 33

Appendix B

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION SURVEY OF CURRENT HOSPITAL FINANCIAL INFORMATION Respond by January 22

Mailing label here

Correct inaccuracies on mailing label.
Leave it affixed to form, please.

		A Year Prior To Column B	B Most Recent Closed Year	C Current Fiscal Year	D Next Fiscal Year
Year-end date	1	_____	_____	_____	_____
MEDICARE PAYMENTS					
Total for DRGs & outliers	2	\$ _____	\$ _____	\$ _____	\$ _____
Cap, nurse anesth, med ed passthrough	3	\$ _____	\$ _____	\$ _____	\$ _____
Total Medicare inpatient payments	4	\$ _____	\$ _____	\$ _____	\$ _____
Medicare bad debts	5	\$ _____	\$ _____	\$ _____	\$ _____
Other Medicare payments	6	\$ _____	\$ _____	\$ _____	\$ _____
PATIENT REVENUE: NON-MEDICARE	7	\$ _____	\$ _____	\$ _____	\$ _____
PAT SERVICE EXPENSE					
Medicare inpatient	8	\$ _____	\$ _____	\$ _____	\$ _____
Other Medicare	9	\$ _____	\$ _____	\$ _____	\$ _____
Non-Medicare Total patient service expense	10	\$ _____	\$ _____	\$ _____	\$ _____
OTHER OPER/NONOPER REVENUE, NET EXCESS OF REVENUE OVER(UNDER) EXPENSE	11	\$ _____	\$ _____	\$ _____	\$ _____
OTHER INFORMATION					
Amount of charity and bad debts	12	\$ _____	\$ _____	\$ _____	\$ _____
Where shown	13	_____	_____	_____	_____
Components of passthrough:					
Capital	14	\$ _____	\$ _____	\$ _____	\$ _____
Nurse anesthetist	15	\$ _____	\$ _____	\$ _____	\$ _____
Medical education	16	\$ _____	\$ _____	\$ _____	\$ _____
Plant-related capital expense	17	\$ _____	\$ _____	\$ _____	\$ _____
Equipment-related capital expense	18	\$ _____	\$ _____	\$ _____	\$ _____
Medicare inpatient acute discharges	19	_____	_____	_____	_____
Total inpatient acute discharges	20	_____	_____	_____	_____
Medicare case-mix index	21	_____	_____	_____	_____
	22	_____	_____	_____	_____
	23	_____	_____	_____	_____

*Definitions and explanatory notes are attached.

TURN FORM OVER PLEASE

SCF11.FRM-33a

Appendix B

COMPLETE OTHER SIDE OF FORM FIRST

Name of person to contact if there is a question about this survey.

Name _____ Phone (____) _____-

Briefly comment on the trend in at least one of the items of information reported on the other side of this form. This will help analysts understand the trends.

Also please answer the following questions and explain with specific examples if possible.

- a. Has your credit rating changed or do you expect it to change? _____
(explain)

- b. Has your ability to service your debt changed or do you expect it to change? _____
(explain)

- c. Has your ability to obtain new financing changed or do you expect it to change? _____
(explain)

- d. Has there been, or do you expect there to be, a change in your ability to replace assets or acquire new technology? _____ (explain)

With your permission, we may quote a portion of your comment with attribution.

Permission to quote is granted _____.

RETURN THIS FORM BY JANUARY 22 TO:

Healthcare Financial Management Association
1050 17th Street, N.W., Suite 510
Washington, D.C. 20036

SCFI2.FRM 33a

Healthcare Financial Management Association Survey of Current Hospital Financial Information Definitions and Explanatory notes

Hospital name — If the hospital designated by the address label has more than one Medicare provider number, the information on this survey should relate to the acute care services' provider. Payments/revenue and expenses related to affiliated providers that do not provide acute care services and for exempt hospitals and excluded units should be included on lines 6, 10, and 12.

Amounts in Column A and B should be actual annual amounts and should be the same as (or can be reconciled to) the Medicare worksheet locations specified. For the current and next fiscal year (Columns C and D), amounts should be for a full year and come from management reports and budgets. If formal estimates or budgets are not available, a knowledgeable estimate by the chief financial officer is acceptable. Medicare worksheet locations are specified to help define the information requested.

Projections for the current year and next year should consider Federal budget pressure, pressures from other payers, and the impact of competition. Keep in mind that Medicare is scheduled to pay less than actual capital cost. Medicare rates are expected to increase much less than the increase in the market basket. Proposals to sharply curtail medical education payments are expected.

The trend of financial information over the 4-year survey period is very important. The relationship of payments/revenue, expense, and volume data is also very important. Payments/revenue should be net of all deductions. These amounts do not relate to charges but are the amounts someone has an obligation to pay. Significant relationships are described.

- 1 Show hospital fiscal year-end date. The columns should be chronologic with the oldest year in Column A and the most future year in Column D.
- 2 Amount you received or expect to receive in DRG payments, including outliers. This should be the amount shown on Medicare Cost Report, Form HCFA 2552-85, Worksheet E, Part A, lines 1A plus 1Bb.
- 3 Amount you received or expect to receive in inpatient capital payments, nonphysician anesthesiologist payments, and medical education payments. This should be the amount shown on Medicare Cost Report, Form HCFA 2552-85, Worksheet D, Part I, Columns 1, 2, and 3, line 101 plus Worksheet D, Part II, Column 8, total of lines 37-59.
- 4 Total of lines 2 and 3. This amount relates to expenses shown on line 8 and volume information shown on line 21.
- 5 Amount you received or expect in Medicare payments for deductible and coinsurance bad debts. This should be the amount shown on Medicare Cost Report, Form HCFA 2552-85, Worksheet E, Part A, line 13.
- 6 Medicare payment for outpatient services, ambulatory surgery, excluded units, and any other payments not included on lines 2, 3, and 5. The total of lines 4, 5, and 6 should equal the amounts shown on Medicare Cost Report, Form HCFA 2552-85, Worksheet E, Parts A and B, line 9 plus revenue from Medicare cost reports for excluded units on Worksheet E-3, Parts I and II, lines 4 and 8.
- 7 Total payments/revenue, net of deductions (see introduction) from non-Medicare services, including outpatient services. This amount relates to expenses shown on line 10. Total patient service payments/revenue on lines 4-7 relates to expenses shown on line 11 and volume information shown on line 22.
- 8-11 Use the best available cost accounting system* to identify total operating expenses that relate to Medicare and non-Medicare payments/revenue. Capital-related expense, education costs, and home office cost should be included. Expense on line 8 should relate to revenue on line 4 and volume information on line 21, expense on line 9 should relate to revenue on line 6, and expense on line 10 should relate to revenue on line 7.

Definitions and explanatory notes/page 2

If the amounts on lines 8, 9, and 10 cannot be determined reasonably accurately, leave these lines blank. Line 11 is the total of lines 8, 9, and 10. Line 11 relates to revenue shown on lines 4-7 and volume information shown on line 22.

*No single line item on the Medicare Cost Report identified Medicare inpatient service expense. Even if it did, many of Medicare's cost identification rules are subject to dispute — such as malpractice insurance. Therefore, we are asking you to tell us the best data you have available. Your response will be compared to the calculation which is made by the Health and Human Services Inspector General (IG) as one measure of the reliability of the IG's report. Therefore, your estimate is very important, but should only be provided if you have a reasonably reliable system for determining the amounts.

- 12 Income, net of expenses, from public eating facilities, parking garages, investments, and other nonpatient service activities.
- 13 The total of lines 4-7 plus 12, less line 11 should be the "bottom line" amount on the organization's general purpose financial report.
- 14 This amount is the amount of charity and bad debts included in or netted in the survey amounts.
- 15 Indicate whether charity and bad debts are shown in your financial reports as a deduction from revenue (enter "deduction") or an expense (enter "expense"). This is the place to show whether you have changed or plan to change the way this item is reported.

Note The total of lines 16-18 relates to, but is not equal to line 3. Line 3 relates to inpatient only. Lines 16-18 are the total passthrough amounts.

- 16 Amount of passthrough for capital-related cost. This should be the amount shown on Medicare Cost Report, Form HCFA 2552-85, Worksheet D, Part I, Column I, line 101 plus Worksheet D, Part II, Column 1, line 101.
- 17 Amount of passthrough for nonphysician anesthetist cost. This should be the amount shown on Medicare Cost Report, Form HCFA 2552-85, Worksheet D, Part I, Column 2, line 101 plus Worksheet D, Part II, Column 2, line 101.
- 18 Amount of passthrough for medical education cost. This should be the amount shown on Medicare Cost Report, Form HCFA 2552-85, Worksheet D, Part I, Column 3, line 101 plus Worksheet D, Part II, Column 3, line 101.
- 19 This includes depreciation, interest and other capital-related expense as shown on Medicare Cost Report, Form HCFA 2552-85, Worksheet B, Column 1, line 1. This amount is also part of expenses included on lines 8-11.
- 20 This includes depreciation, interest and other capital-related expense as shown on Medicare Cost Report, Form HCFA 2552-85, Worksheet B, Column 2, line 2. This amount is also part of expenses included on lines 8-11.
- 21 This is the number shown on Medicare Cost Report, Form HCFA 2552-85, Worksheet S-3, Column 13, line 8. It should relate to payments/revenue shown on line 4 and expense shown on line 8.
- 22 This is the total of all acute care discharges which is probably shown on Medicare Cost Report, Form HCFA 2552-85, Worksheet S-3, Column 16, line 8. It should relate to payments/revenue shown on lines 4-7 and expenses shown on line 11.
- 23 Each hospital's case-mix index is published in the Federal Register. The FY'86 index was published September 1, 1987.

We hope the above explanations are clear. If you have a question about the information requested, call HFMA's Washington office at 202-296-2920.

Appendix C

COMPILED SURVEY RESULTS

This appendix shows the formulas used to compute the survey results reported and discussed throughout “Managing the Financial Health of Hospitals.” The survey data elements used in the computation of each item are referenced to the line numbers (L) on the survey document (Appendix B). The compiled results of each item are shown. The median is defined as the midpoint of all results arranged in ascending order.

Overall Margin:

$$\frac{\text{Excess of Revenue Over Expenses (L13)}}{\text{Net Revenue (L4 + L5 + L6 + L7)}}$$

	<u>Median Values</u>
PPS Year 3	6.0%
PPS Year 4	5.4%
PPS Year 5	4.0%
PPS Year 6	3.3%

Margin from Providing Patient Care Services:

$$\frac{\text{Net Revenue minus Total Patient Service Expenses (L4 + L5 + L6 + L7 - L11)}}{\text{Net Revenue (L4 + L5 + L6 + L7)}}$$

	<u>Median Values</u>
PPS Year 3	1.6%
PPS Year 4	.8%
PPS Year 5	(.3)%
PPS Year 6	(.9)%

Margin from Serving Medicare Patients:

$$\frac{\text{Total Medicare Payments minus Medicare Patient Service Expense}}{\text{Total Medicare Payments (L4 + L5 + L6)}}$$

$$\frac{(L4 + L5 + L6) - (L8 + L9)}{(L4 + L5 + L6)}$$

	<u>Median Values</u>
PPS Year 3	3.2%
PPS Year 4	(.6)%
PPS Year 5	(5.5)%
PPS Year 6	(9.0)%

Medicare's Share of Net Patient Revenue:

$$\frac{\text{Medicare Payments (L4 + L5 + L6)}}{\text{Net Patient Revenue (L4 + L5 + L6 + L7)}}$$

	<u>Median Values</u>
PPS Year 3	40.8%
PPS Year 4	39.5%
PPS Year 5	38.1%
PPS Year 6	37.4%

Medicare's Share of Patient Expense:

$$\frac{\text{Medicare Patient Service Expense (L8 + L9)}}{\text{Total Patient Service Expense (L11)}}$$

	<u>Median Values</u>
PPS Year 3	41.0%
PPS Year 4	40.8%
PPS Year 5	41.6%
PPS Year 6	42.1%

Census Trends - All Patients:

Total Inpatient Acute Discharges - PPS 5 (L22, Col. C)

Total Inpatient Acute Discharges - PPS 3 (L22, Col. A)

Median Response

Change from PPS Year 3
to PPS Year 5

1.5% decrease

Census Trends - Medicare Patients:

Total Medicare Inpatient Acute Discharges - PPS 5 (L21, Col. C)

Total Medicare Inpatient Acute Discharges - PPS 3 (L21, Col. A)

Median Response

Change from PPS Year 3
to PPS Year 5

1.4% decrease

Total Cost per Case:

Total Payment Service Expenses (L11)

Total Inpatient Acute Discharges (L22)

Median Values

PPS Year 3	\$3,753
PPS Year 4	\$4,188
PPS Year 5	\$4,543
PPS Year 6	\$4,729

Medicare Cost per Case:

Medicare Inpatient Expense (L8)

Medicare Inpatient Acute Discharges (L21)

Median Values

PPS Year 3	\$4,014
PPS Year 4	\$4,348
PPS Year 5	\$4,587
PPS Year 6	\$4,961

Medicare Inpatient Payments per Case:

$$\frac{\text{Total Medicare Inpatient Payments (L4)}}{\text{Medicare Inpatient Acute Discharges (L21)}}$$

	<u>Median Values</u>
PPS Year 3	\$4,135
PPS Year 4	\$4,394
PPS Year 5	\$4,393
PPS Year 6	\$4,510

Percent Reporting a Positive Margin - Overall:

Of those responses to the Overall Margin (described above), percentage with a result greater than zero.

	<u>Results</u>
PPS Year 3	89.9%
PPS Year 4	86.4%
PPS Year 5	85.5%
PPS Year 6	82.5%

Percent Reporting a Positive Margin - from Patient Care Services:

Of those responses to the Margin from Providing Patient Care Services (described above), percentage with a result greater than zero.

	<u>Results</u>
PPS Year 3	65.7%
PPS Year 4	57.8%
PPS Year 5	49.3%
PPS Year 6	42.5%

Percent Reporting a Positive Margin in All Surveyed Years:

	<u>Results</u>
Percentage of responses with a positive Margin from Providing Patient Care Services in each survey year	33.7%
Percentage of responses with a positive Overall Margin in each survey year	72.1%
Percentage of responses with a lower Margin from Providing Patient Care Services in PPS Year 6 compared to PPS Year 3	73.1%
Percentage of responses with a lower Overall Margin in PPS Year 6 compared to PPS Year 3	73.3%

Uncompensated Care as a Percent of Net Patient Revenue:

$$\frac{\text{Charity and Bad Debt Expense (L14)}}{\text{Net Patient Revenue (L4 + L5 + L6 +L7)}}$$

	<u>Median Values</u>
PPS Year 3	5.2%
PPS Year 4	5.6%
PPS Year 5	5.6%
PPS Year 6	5.7%

Percent Reporting Bad Debts as an Expense:

Percentage of total respondents completing line 15 who indicated that bad debts were included with patient service expenses, rather than netted against patient service revenues.

	<u>Results</u>
PPS Year 3	3.5%
PPS Year 4	3.6%
PPS Year 5	3.5%
PPS Year 6	3.2%

Components of Medicare Payments:

DRG and Outlier Payments (L2) *or* Pass-through Payments (L3)
or Bad Debts (L5) *or* Other Medicare Payments (L6)

Total Medicare Payments (L2 + L3 + L5 + L6)

Mean Result - Percent of Total

	<u>DRG & Outliers</u>	<u>Pass-thrus</u>	<u>Bad Debt</u>	<u>Other</u>
PPS Year 3	76.4%	11.9%	.4%	11.3%
PPS Year 4	74.7%	12.2%	.5%	12.6%
PPS Year 5	73.9%	11.9%	.5%	13.6%
PPS Year 6	73.4%	11.7%	.5%	14.4%

Components of Pass-through Payments:

Capital (L16) *or* Nurse Anesthetist (L17) *or* Direct Medical
Education (L18) Pass-through Amounts

Total Pass-through Payments (L16 + L17 + L18)

Mean Result - Percent of Total

	<u>Capital</u>	<u>Nurse Anesth.</u>	<u>Med. Ed.</u>
PPS Year 3	80.8%	4.8%	14.4%
PPS Year 4	81.0%	5.0%	14.0%
PPS Year 5	81.5%	5.0%	13.5%
PPS Year 6	81.1%	5.2%	13.7%

Capital Cost as a Percent of Total Cost:

Plant-related Capital Expense (L19) plus Equipment -
related Capital Expense (L20)

Total Patient Service Expense (L11)

	<u>Median Values</u>
PPS Year 3	7.8%
PPS Year 4	7.9%
PPS Year 5	8.1%
PPS Year 6	8.1%

Plant-related Capital Costs as a Percent of Total Capital Costs:

Plant-related Capital Expense (L19)

Total Capital Expense (L19 + L20)

	<u>Median Values</u>
PPS Year 3	57.0%
PPS Year 4	56.1%
PPS Year 5	56.7%
PPS Year 6	55.6%

**ADDITIONAL
COMMENTS FROM
HFMA MEMBERS:**

Overall Margin/Margin from Providing Patient Care Services:

The trend in our facility is toward longer LOS, more cost outliers, fewer “other” revenue sources, and increased nursing shortages which require a reduction in services, or an increase in salary expense for overtime, extra pay, bonuses, and incentives.

Ronald E. Tatum
Community Memorial Hospital
South Hill, VA

* * *

Cost reduction efforts were successful in fiscal years 1986 and 1987, and expansion into new areas of services proved profitable. However, in fiscal 1988 we are experiencing an acute shortage of nurses and are having to implement salary incentive plans to attract and keep nurses. We are also using many more registry nurses than in the past. We expect this trend to continue into FY 1988.

Joan G. Wilson, CPA
St. Mary Medical Center
Long Beach, CA

* * *

The cost of new technological drugs, [e.g.,] non-ionic contrast dyes, T.P.A. and others, ever-increasing amounts of charity provided for indigent and AIDS patients will virtually reduce our bottom line to break even, if there is no relief from the government.

Russell A. Arent
Memorial Hospital of Sarasota
Sarasota, FL

* * *

Payment levels which fail to sustain operating margins will result in increased lender scrutiny and financial costs. This concern is magnified by the inability to recoup capital outlays in a manner consistent with that available to most other industries.

Ronald C. Lobb
Holy Cross Hospital
Detroit, MI

* * *

A very alarming situation.

Duane W. Francis
Mid-Columbia Medical Center
The Dalles, OR

More patients are being treated on an ambulatory basis, thus “sicker” patients are being admitted. This trend will continue and will probably mean greater losses for the hospital as rates and DRG weights remain unchanged or decrease.

Carol Renninger
Canton-Potsdam Hospital
Potsdam, NY

* * *

Margin from Serving Medicare Patients:

Costs continue to increase due to the labor intensive nature of the industry as well as ever increasing expenses for insurance, blood processing, and technologies which increase at a double-digit pace despite continued cuts in payments from Medicare and Medicaid.

Richard I. Bennett, CPA
Presbyterian Medical Center
Philadelphia, PA

* * *

The Medicare length of stay has increased...adding approximately \$1 million dollars of additional inpatient cost to the hospital. Of course additional reimbursement from Medicare for this is zero.

William Stolfus, FHFMA
Evangelical Community Hospital
Lewisburg, PA

* * *

On Medicare patients, the level of ancillary services needed, due to the severity of illness, does not match the increased payment level on assigned DRGs.

Soon W. Lee, FHFMA, CPA
The Bryn Mawr Hospital
Bryn Mawr, PA

* * *

I wish I could find one positive trend in our figures, but I can't. We will continue to sacrifice as Washington tries to manage spending reductions.

Randall C. Fay
Pershing Memorial Hospital
Brookfield, MO

* * *

Medicare is not reimbursing fairly for inpatient services. Reimbursement is being manipulated on the individual DRG level and through budgetary adjustments.

Errol A. Mitchell
Normal Regional Hospital
Normal, OK

* * *

Fortunately, Medicare is only 22% of our business.

Phillip A. Caron, FHFMA, CMPA
Harris Methodist H E B
Bedford, TX

* * *

I am tired of hospitals having to pay the price for the government refusing to pay for the services which it promises to constituents. Either funds should be appropriated to cover the cost or reduce benefits and at least let hospitals claim the cost of service as charity care.

Joseph D. Nemeth, CPA
Mercy Hospital of Janesville
Janesville, WI

* * *

Medicare's Share of Revenue and Expense:

Long term, one simply cannot be paid less than full financial requirements and expect to maintain, let alone expand, to meet the requirements of changing demographics, case mix, and technology.

Robert L. Newton, FHFMA, CMPA
Moses H. Cone Memorial Hospital
Greensboro, NC

* * *

Our hospital's [consumer] is quickly becoming an older, sicker patient.

Dennis H. Allen, FHFMA, CMPA
Mayo Regional Hospital
Dover-Foxcroft, ME

* * *

Appendix D

[Medicare] will continue to require more coding, billing, and other information including uniform reporting which will increase our administrative expense and will not reimburse us for it.

Virgil D. Guthrie
Community Hospital
McCook, NE

* * *

FY 1987 expenses were low due to labor cutbacks and lack of pension funding. However, FY 1988 & 1989 will include pension expense and abnormal increase in malpractice and other operating expenses.

Andrew Mazon
Roane General Hospital
Spencer, WV

* * *

Aging population, increase of technology (capital costs), Medicare paying less and less of its share, all the money going to the urban facilities (unjustly and unfairly).

James K. Long, CPA
Community Memorial Hospital
Hettinger, ND

* * *

New ASC [Ambulatory Surgery Center] rates will reduce Part B reimbursement by about 6% in 1988.

John F. Lowe
Olympic Memorial Hospital
Port Angeles, WA

* * *

Many Medicare patient surgery cases are going to the outpatient category.

Melvin D. Robinson, CPA
Saint Mary Hospital
Manhattan, KS

* * *

Uncompensated Care as Percent of Net Revenues:

We expect a significant increase of write-offs due to:

- (1) An increase in the number of people without any health insurance as a result of substantial increases in private health insurance premiums
- (2) Cuts in the Medicaid program will increase the number of patients who are uninsured
- (3) Poor outlook for the economy
- (4) AIDS

Robert L. Congrove
Stormont Vail Hospital
Topeka, KS

* * *

Even more alarming is the shift toward charity and bad debts.

James R. McKinney
Mercy Medical Center
Durango, CO

* * *

Heavy emphasis by our hospital to contain uncompensated care levels.

James E. Onorato
Newport Hospital
Newport, RI

* * *

Outpatient bad debts have risen as volume has become directed to this area, especially surgical volume.

Brian G. Baily
Franklin Square Hospital Center
Baltimore, MD

* * *

Capital Cost as a Percent of Total Cost:

Medicare sequestration will “double dip” on the capital sequestration imposed by Congress.

Carroll F. Craft, CPA
St. John Medical Center
Tulsa, OK

* * *

At issue is our continued ability to provide for capital needs while facing increasing demands for salaries for professional staff, reduced third-party payments, and increasing charity care.

Christopher F. Weinheimer
Medical Center Hospital of Vermont
Burlington, VT

* * *

We have been depleting acquisition and expansion funds for operational needs.

Andrew Mazon
Roane General Hospital
Spencer, WV

* * *

Due to the proposed Medicare costs in the area of capital pass-thru, I feel that the hospital will probably cut back in the area of plant equipment purchases...

Pat Boyd
Georgia Baptist Medical Center
Atlanta, Georgia

* * *

The Medicare program is cost shifting to non-Medicare patients its share of new and old asset cost.

Carroll F. Craft, CPA
St. John Medical Center
Tulsa, OK

* * *

I expect an explosion of new technology, especially in the area of cardiac care, imaging, and possibly therapeutic drugs. Furthermore, this technology will evolve requiring...cash reserves (if any) and debt capacity may not meet these requirements.

Vaughn C. Gower, FHFMA
Lehigh Valley Hospital Center
Allentown, PA

* * *

Lack of proper reimbursement by Medicare for capital makes many new asset purchases uneconomic.

Anne Martindale, CPA
Northern California Health Center
San Francisco, CA

* * *

We expect large increases in capital expenditures resulting from the replacement of high tech equipment having a shorter useful life.

Thomas A. Elliott, CPA
St. Vincent Health Center
Erie, PA

* * *

***ADDITIONAL
COMMENTS ON KEY
INDICATORS OF
FINANCIAL***

Hospital Cash Flow:

Cash flow is one of the most serious issues facing our hospital. The loss of PIP and settlement delays may begin to effect our ability to service our debt.

Paul A. Beaudoin
Notre Dame Hospital
Central Falls, RI

* * *

We have moved payables back to near 60 days and as of December 31, it looks as if there may be further delays due to cash flow shortages.

Andrew Mazon
Roane General Hospital
Spencer, WV

* * *

Pressures for PRO, malpractice suits, etc. have caused an increase in utilization in the ancillary departments. As a result, contractual allowances and bad debts have increased significantly, causing a drain on cash flow.

Nick D. Elkins, CPA
Carroll General Hospital
Berryville, AR

* * *

Due to our decreased cash flow, we have been forced to slow down payments to our creditors.

F. J. Children, Jr.
St. Eugene Community Hospital
Dillon, SC

* * *

[The hospital] has had to acquire a line of credit in order to pay monthly vendor invoices.

Pat Boyd
Georgia Baptist Medical Center
Atlanta, GA

* * *

The hospital suffers from a cash flow shortage.

Thomas E. Poccia
United Hospital
Port Chester, NY

* * *

Hospital Credit Ratings:

Rating reduced by Standard & Poors from A+ to A following a year in which a small bottom line was earned.

Christopher F. Weinheimer
Medical Center Hospital of Vermont
Burlington, VT

* * *

We've been told by underwriters that if we wanted to refinance our existing debt, the new debt would likely receive a BBB+ rating instead of an A- rating due to less net income and declining admissions.

Craig W. Sheagren, CPA
McDonough Dist. Hospital
Macomb, IL

* * *

[Credit rating] just received was definitely impacted by the decline in admissions and profitability directly related to Medicare changes.

Richard M. Reynolds, FHFMA
MidMichigan Healthcare Systems Inc.
Midland, MI

* * *

If we had [to have a credit] rating we would have no ability to borrow. Affiliate is keeping us operating.

Charles L. Schippers
Seaside General Hospital
Seaside, OR

* * *

We are utilizing the credit rating of our corporate owners.

James E. Thoen, CPA
St. Joseph's Hospital of Chewelah
Chewelah, WA

* * *

The rating agencies are becoming more cautious and restrictive in evaluating the credit risk of healthcare institutions.

Thomas F. Wells
Baptist Medical Center
Montgomery, AL

* * *

The Ability to Service Debt or Obtain New Financing:

Recently, the hospital leased a new telephone system. The leasing company approved it, but only after a more in-depth study of our financial situation.

Gordon W. Salm, CPA
Central Community Hospital
Clifton, IL

* * *

We were required to secure a letter of credit prior to borrowing from a pooled bond fund.

Daniel C. Confalone
Allentown Osteopathic Medical Center
Allentown, PA

* * *

Shrinking bottom lines and the questions of how much debt financing can be adequately handled may place some new technology at risk.

Michael Vaci
Northwestern Memorial Hospital
Chicago, IL

* * *

Capital pass-thru payments continue to be reduced. This impacts our ability to repay debt which was secured under the premise that reimbursement for capital costs would be based on costs.

Timothy J. Pollard
St. Joseph's Medical Center
Brainard, MN

* * *

If Medicare reimbursement continues to be arbitrarily reduced, then it will be very difficult for the hospital to make meaningful financial forecasts of their ability to repay bondholders.

Gene Roberts, CPA
Reid Memorial Hospital
Richmond, IN

* * *

The future plans of the Congress to balance the budget on the back of hospitals re: capital pass-through reductions and DRG rate reductions, will make it more difficult [to service our debt].

Phillip D. Johnson
Little Co. of Mary Hospital
Evergreen Park, IL

* * *

We are very concerned that the major reductions in pass-thru capital reimbursement will have long-term detrimental effects on the hospital's ability to meet its obligations.

Mark J. Blass, FHFMA
Melrose-Wakefield Hospital
Melrose, MA

* * *

The ability to service debt has become increasingly more difficult.

J. Stevens Eavenson, CPA
Holmes Regional Medical Center
Melbourne, FL

* * *

Decreased operating margins raises the cost of borrowings.

Emil C. Janko, FHFMA
Holzer Medical Center
Gallipolis, OH

* * *

I expect our ability to obtain financing to change due to our financial indicators. Although we should be able to obtain financing, it will undoubtedly be at a higher cost.

William H. Wojcik
Memorial Hospital of Easton
Easton, MD

* * *

Higher rate required due to the uncertainties.

George J. Brisson, FHFMA
Hubbard Regional Hospital
Webster, MA

* * *

Our ability to finance the current and expanding needs of our hospital requires us to pursue alternative financial methods (i.e., leased equipment as opposed to purchased equipment).

Darrell C. Shonkwiler
South Florida Baptist Hospital
Plant City, FL

* * *

Since we have been operating at a loss, [financing] sources have eroded drastically.

Mitchell T. Thomas, FHFMA, CPA
Hollywood Presby Medical Center
Los Angeles, CA

* * *

We have had some difficulty in obtaining new financing due to decreased cash flow, and unstable bottom lines.

Edward D. Luke
Jesse Holman Jones Hospital
Springfield, TN

* * *

We would like to refinance, but loss prohibits it.

Craig M. Rosi
Ballard Community Hospital
Seattle, WA

* * *

With insufficient funds on hand and the inability to borrow, we are simply limping along and applying Band-Aids along the way.

Stanley J. Maksimowicz
Reed City Hospital
Reed City, MI

* * *

Hospital anticipates difficulty in financing new construction and renovation projects previously approved.

James R. Dykeman
St. Joseph's Hospital
Nashua, NH

* * *

If this hospital were not part of a larger corporation it would not obtain credit.

Ronald L. Hulscher
St. Joseph Hospital
Aberdeen, WA

* * *



Ernst & Whinney



HFMA[®]

HEALTHCARE
FINANCIAL
MANAGEMENT
ASSOCIATION