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When the Mission Isn't Enough

How Nonprofit Health Care Organizations Drift Toward Insolvency, and the Warning Signs Hiding in Plain Sight

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Around the time of America's 200th birthday, a group of passionate community members established a nonprofit health care facility to serve their neighborhood. For decades, it thrived — anchored by its mission, rooted in trust and buoyed by a loyal donor base. But time passed and the board, often made up of well-meaning volunteers, became exhausted and disengaged. The founding members aged out or passed away and new leadership stepped in, often with less historical context or operational experience.

The building and surrounding property, once a sought-after location, is now surrounded by economically depressed areas. Building codes and licensing requirements have changed, and the facility has patient room sizes too small for today's modern equipment and contains asbestos, which prohibits essential upgrades due to the exorbitant cost of mitigation. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created national standards pertaining to privacy of information, and it affects the migration from paper-based medical charts to electronic medical records (EMRs), requiring a new level of information-technology (IT) infrastructure that did not exist when the facility was built decades ago. The facility does just enough to get by, obtaining waivers where possible, but primarily defers the needed maintenance and improvement expenditures to some future unknown date.

The payors and methods of reimbursement also changed. Historically, payors were broadly categorized as governmental (*i.e.*, Medicare or Medicaid), commercial (*i.e.*, Aetna, Blue Cross, United Health, etc.) and self-pay. Today, these payors remain, but now hybrid relationships have developed into "managed-care" organizations that cost-share between the payors. While managed care aims to control costs and improve efficiency, these models can sometimes result in lower reimbursements for providers compared to traditional fee-for-service arrangements. Managed-care organizations may negotiate lower rates with providers, or they may use alternative payment models that do not necessarily pay the same amount for the same services.[1]

Staff retention is already difficult, but now there is a critical shortage of licensed health care personnel, so contract labor is engaged. In this scenario, and many real ones like it, poor hiring decisions made under pressure lead to a cascade of problems: (1) labor costs soar due to employee overtime and contract labor rates that are significantly higher than employee rates; (2) staff injuries spike, adding to the reduced workforce and worker's compensation claims coming in; (3) there is constant staff turnover at all levels; and (4) the staff ultimately begin to make mistakes.

On the financial side, employee turnover is seen through billing errors and lost collections, further reducing the facility's reimbursements, whereas other mistakes turn into such legal issues as Office of Safety and Health Administration violations, lawsuits related to patient care, wage and hour claims, and wrongful-termination accusations. Legal fees escalate, which is money that could have been used to reinvest in staff or address needed maintenance and improvements, but is instead directed toward litigation.

It is this constant push/pull between the mission and financial health that sits at the core of the nonprofit health care crisis. Nonprofit hospitals are driven by a commitment to community service and a mission to provide accessible health care to all, regardless of a patient's ability to pay. These facilities are often founded by charitable organizations, religious groups or community initiatives, or they might be affiliated with a medical school.[2] Whether discussing a hospital or other nonprofit entity, the commitment to community presents itself in the ideology that accepts "nonprofit" as "no (or nominal) profit necessary," and fails to realize that if there is no profit, then there is no mission, so to speak.

Operating margins for nonprofit entities tell a grim story, as they average 1 percent, whereas for-profit entities approximate 10 percent.[3] Some wonder whether the COVID-19 pandemic that began in 2020 is to blame. While it had its impact, it really highlighted/accelerated existing operational and

1 "How Managed Care Contracts Impact Reimbursement," PayrHealth, payrhealth.com/blog/how-managed-care-contracts-impact-reimbursement (unless otherwise specified, all links in this article were last visited on April 25, 2025).

2 Ethan Popowitz, "What Is the Difference Between Nonprofit and For-Profit Hospitals?," Definitive Healthcare (Nov. 9, 2023), definitivehc.com/blog/the-difference-between-non-profit-and-for-profit-hospitals.

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financial issues. Those entities that were working toward their future vs. those complacent in their positions (or even worse, surviving) were impacted but were able to weather the storm and are better for it. Others, however, have filed for bankruptcy or are teetering between restructuring, finding a consolidation partner, seeking a private-equity infusion or, as a last resort, shuttering.

This has been seen playing out in communities all over the U.S. According to *Becker's Hospital Review*, 56 hospitals closed departments or ended service lines in 2023, the majority being maternity services at 24, followed by home health and clinics.[4] Health care restructuring advisory firm Gibbins Advisors recently reported that health care sector bankruptcy filings in 2024 had reached their second-highest level in six years.[5]

David Johnson, CEO of 4sight Health and a member of the Healthcare Financial Management Association's national board of directors, posed the following question: Is this the end of traditional nonprofit health care business models?[6]

Kaufman Hall's National Hospital Flash Report characterized 2022 as "one of the worst financial years on record for hospitals."[7] Even in the best of times, the nonprofit hospital business model has never been robust. Hospitals are capital-intensive, labor-intensive, highly regulated and low-margin businesses that require high-cost facilities and highly expert personnel to operate. Competing mission and business priorities make running nonprofit hospitals even more difficult. The existential question then becomes: Are current operating losses at nonprofit health systems aberrant, or do they indicate a broader collapse of their models? We believe that the answer is the latter.

Kaufman Hall referenced hospitals, but this same statement can be applied to many other nonprofit entities in the health care sector. Change in the operation of nonprofit health care is needed; however, many nonprofits are standalone or are part of a small system without the resources of the large nonprofit systems often in the news. Defining *and accepting* the items needed to be addressed are hard for many nonprofits given the make-up of the boards of directors and the management teams.

Many board members are volunteers, and management and employees are often home-grown and do not have perspective from outside their organization. Yet the survival of these entities is critical for the communities they serve. While the current environment paints a doomsday scenario, timely and focused efforts can yield positive and lasting change. There are five key points that can be discussed with clients to help them take an introspective look. While they are seemingly standalone, are all very integrated.

The Board: Hope Is Not a Strategy

Community boards are essential to nonprofit governance, yet many nonprofit boards do not thoroughly understand their roles or the financial and operational complexity of a modern health care organization. Comprised often of local leaders, family members of founders or legacy volunteers, the board might lack the depth of financial or regulatory knowledge that is needed today.

Too often, board members may only see a surface-level picture of organizational health. Budget reports might show that expenses are relatively in line with last year and revenue appears flat, but someone needs to ask the deeper questions. Are we paying recurring invoices for medical equipment or software solutions we no longer use? Are labor costs bloated due to overtime and turnover? Are we funding roles that do not directly support patient care?

Some boards delay difficult decisions in the hope that donations, grants or census will rebound. In health care, time is money. Delay compounds disaster. A disengaged or underinformed board becomes a liability — not a safeguard. Unbeknownst to many, when a nonprofit faces insolvency, its directors and officers have a potential duty to balance the interests of creditors with upholding the organization's mission.[8]

Jim Price, principal of Progressive Healthcare Inc., has compared nonprofits with the for-profit performance of 109 entities[9] and acknowledged that nonprofit health systems face a constant struggle to achieve financial sustainability. To meet this challenge, he believes that they must first understand the scope of their enterprise, then craft tactics that reflect the competitive realities of each type of service they offer.

As many health care advisors have noted, the traditional nonprofit business model can take some lessons from their for-profit cousins. Such a mindset shift allows the board to objectively evaluate business line profitability and make those hard decisions, such as what to keep and at what cost, or whether to discontinue service lines. As the community changes (population age, local industry and economics, and technology advancements), the question should become: Are we providing what the *community needs and wants* (future), or are we holding on to old beliefs of what care should look like?

In addition, nonprofit boards need to better understand the regulatory environment that affects their businesses. Not only have regulations become more complex over time, but more regulatory bodies are now involved. Those macroforces can affect licensing, reimbursement and departmental operations, as

3 Jim Price, "Not-for-Profit Health Systems Need a New Enterprise Strategy," Healthcare Fin. Mgmt. Ass'n (April 30, 2024), hfma.org/finance-and-business-strategy/not-for-profit-health-systems-need-a-new-enterprise-strategy.

4 Andrew Cass, "56 Hospitals Closing Departments or Ending Services," *Becker's Hospital Review* (Sept. 5, 2023), beckershospitalreview.com/finance/56-hospitals-closing-departments-or-ending-services (subscription required to view article).

5 "Healthcare Sector Bankruptcy Filings in 2024 Reach Second-Highest Level in Six Years," Gibbins Advisors (Jan. 23, 2025), gibbinsadvisors.com/healthcare-sector-bankruptcy-filings-in-2024-reach-second-highest-level-in-six-years.

6 David W. Johnson, "The End of Traditional Nonprofit Healthcare Business Models?," Healthcare Fin. Mgmt. Ass'n (Dec. 21, 2022), hfma.org/cost-effectiveness-of-health/david-johnson-the-end-of-traditional-nonprofit-healthcare-business-models.

7 Erik Swanson, "National Hospital Flash Report: November 2022," KaufmanHall (Nov. 30, 2022), kaufmanhall.com/insights/national-hospital-flash-report-november-2022.

8 Trinitee G. Green, Hon. Stacey G. C. Jernigan, Patrick M. Birney & Ryan T. Murphy, "The Convergence of Nonprofit Law and Bankruptcy Law," Nat'l Conference of Bankruptcy Judges 4 (Sept. 19, 2024), ncbj.org/wp-content/uploads/2024/09/Convergence-of-Nonprofit-Law-and-Bankruptcy-Law-materials-2024.pdf.

9 Price, *supra* n.3.

well as how a nonprofit sells its assets in a merger or liquidation. This knowledge allows for an open discussion on operational issues and action plans implemented by management.

Financial Illiteracy: The Story in the Numbers

The American Hospital Association emphasized that positive margins are crucial for nonprofit health systems to fulfill their missions of providing high-quality, equitable care and making necessary investments.[10] Although accounting is common in every business, health care financial reporting is very specific and often governed by not only the generally accepted accounting principles, but by state and federal regulatory bodies that assemble data for global reporting and policy-making, such as the California Department of Health Care Access and Information. There often is a disconnect between finance and operations, but the for-profit mindset is that every operational transaction has a dollar sign attached, so finance should be involved. Whether in growth or restructuring, financial management should be active in revenue-generation, reimbursement-maximation, constant cost review and raising those hard decisions for discussion with the management team (and the board).

What happens when financial management is weak or becomes complacent, and how does the board know? Having an external financial audit provides a third-party opinion, but audited financial statements are only as good as the information provided to the auditors. The more that the board understands the hospital's operations and how those results flow into the financial statements, the better questions the board can ask. When a board feels the need to manage spending at the entity, it also is time to bring in consultants to provide objective perspectives on costs, operational processes, and even potential management changes.

Revenue Cycle Management: Hidden Cracks in the Foundation

In nonprofit health care, reimbursement is everything. This, again, speaks to the need for savvy financial management and systems. The revenue cycle starts at admitting, when all patient/customer demographics are captured. It continues through each patient care department that renders services, however, and ends past discharge when the account is paid or adjusted off. A common misplaced opinion is that "billing is simple"; however, the millions of dollars stagnating aged receivables and claim denials say otherwise. Unfortunately, many nonprofits lack robust systems for monitoring denials, tracking aging accounts receivable, or optimizing diagnosis-related groups or current procedural terminology coding. Staff turnover, lack of training, weak internal processes and controls, and outdated software exacerbate these issues.

A sophisticated, well-managed revenue cycle can make or break viability. The longer an organization waits to audit its revenue cycle, the harder the correction becomes.

The Unseen Drain: Weak IT Infrastructure

Modern health care runs on data, not just compassion. Many nonprofits run outdated, patched-together systems that compromise efficiency, accuracy and compliance, while others have unknowingly allowed IT to become its own fiefdom. Poor IT infrastructure affects nearly every aspect of operations: billing, clinical documentation, outcomes tracking, patient safety and regulatory reporting. Dashboards and financial systems might not be integrated, preventing leaders from seeing real-time financial health.

Legacy systems and workarounds are costly, and an objective review of mainframe and network systems, including all data touch points, can yield cost savings and better tools for management. As technology advances, thinking like a scrappy start-up produces solutions that are robust, integrated, simple and HIPAA-compliant at a fraction of the cost and effort of legacy, patchwork systems.

Deferred Maintenance: The Time Bomb

In health care, infrastructure is not just a capital concern — it is a clinical one. Yet many nonprofit health care entities defer maintenance because they simply do not have the excess cash flow to address aging buildings, systems or equipment. The most dangerous part? Deferred maintenance costs continue compounding — hidden but always ticking.

For example, take a facility where asbestos remediation is required before any capital improvements can occur. Staff operate in environments that are deteriorating, the HVAC systems are failing, and the plumbing is unreliable. Patient safety risks rise. In many states, regulatory compliance tied to physical infrastructure can affect licensing, reimbursement and insurance eligibility. Facilities with perpetually deferred maintenance often fail not because of mission, but because the cost of doing nothing became greater than the cost of doing something.

Knowing When to Ask for Help

Many organizations wait too long to bring in professionals, either due to pride, cost concerns or lack of awareness, but timing is everything. Once payroll cannot be met or vendors stop delivering supplies, options narrow fast. There is a spectrum of external help available, including (1) outsourced revenue cycle audits and/or management for billing and coding accuracy; (2) human resource and compliance consultants to shore up policies and prevent litigation; (3) turnaround specialists or restructuring advisors who can bring objectivity; and (4) health care attorneys who understand state and federal regulatory risks.

Bringing in support does not mean surrender; it means acting in stewardship of the mission. The earlier an organization intervenes, the more options it has.

Conclusion: Mission Alone Will Not Save You

Health care nonprofits carry a sacred trust: to serve, to heal, to uplift. In today's complex, regulated and economically fragile environment, mission is not enough. The real question is not whether a nonprofit can serve, but whether it can be sustained. abi

10 "Report: Why Not-for-Profit Health Systems Need Positive Margin," Am. Hosp. Ass'n (Feb. 27, 2024), aha.org/news/headline/2024-02-27-report-why-not-profit-health-systems-need-positive-margin.