

# A Community Leader's Guide to Hospital Finance

EVALUATING HOW A HOSPITAL GETS AND SPENDS ITS MONEY



Prepared for  
The Access Project by  
Sarah Gunther Lane, MS  
Elizabeth Longstreth, BA  
Victoria Nixon, MS

Under the supervision of Nancy Kane, DBA  
Harvard School of Public Health

**The Access Project** is a national healthcare initiative supported by The Robert Wood Johnson Foundation and the Annie E. Casey Foundation. It works in partnership with Brandeis University's Heller Graduate School and the Collaborative for Community Health Development. It began its efforts in early 1998. The mission of The Access Project is to improve the health of our nation by assisting local communities in developing and sustaining efforts that improve health care and promote universal coverage, with a focus on people who are without insurance.

If you have any questions or would like to learn more about our work, please contact us.

The Access Project  
30 Winter Street, Suite 930  
Boston, MA 02108  
Phone: 617-654-9911  
FAX: 617-654-9922  
E-mail: [info@accessproject.org](mailto:info@accessproject.org)  
Web site: [www.accessproject.org](http://www.accessproject.org)

Catherine M. Dunham, Ed.D, *National Program Director*

Mark Rukavina, MBA, *Deputy Director for Programs and Policy*

Gwen Pritchard, MPA, *Deputy Director for Communication and Administration*

© 2001 by The Access Project

This publication may be reproduced or quoted with appropriate credit.

# Acknowledgments

The Access Project would like to thank and acknowledge the work of Sarah Gunther Lane, Elizabeth Longstreth and Victoria Nixon, who wrote this guide. This manual grew out of research and analysis they and their colleagues did for The Access Project under the supervision of Dr. Nancy Kane at the Harvard School of Public Health.

Dr. Kane, whose research is concerned with measures and determinants of financial and managerial performance in the health delivery system, had been working with The Access Project, analyzing the financial performance of nonprofit hospitals for local community groups. During the financial analysis project, both Dr. Kane and The Access Project realized a need for a manual that would introduce financial analysis concepts, particularly as they apply to nonprofit hospitals, to community groups. This guide is a result of this collaboration.

We would also like to acknowledge Robert J. Ciolek, Executive Director and Irene Browne, Director of Financing Programs for the Massachusetts Health and Education Facilities Authority, who reviewed earlier drafts of this manual. Their comments and suggestions made this a better product and we thank them for their time.



# Contents

	<b>Introduction</b>	<b>v</b>
<b>I.</b>	<b>Overview of the Health Services Industry</b>	<b>1</b>
<b>II.</b>	<b>Hospital Revenues</b>	<b>7</b>
<b>III.</b>	<b>Hospital Expenses: How Hospitals Spend Money</b>	<b>17</b>
<b>IV.</b>	<b>Sources of Hospital Financial Information</b>	<b>19</b>
<b>V.</b>	<b>Evaluating a Hospital's Financial Condition</b>	<b>29</b>
<b>VI.</b>	<b>Hospital Operating Environment</b>	<b>33</b>
<b>VII.</b>	<b>Basic Financial Questions</b>	<b>37</b>



# Introduction

Community members need to have a basic understanding of hospital finance to evaluate a hospital's charitable commitment to the health of their community. Hospitals demonstrate this commitment by providing services that address the community's unfunded healthcare needs. These services, often called community benefits, include charity care, health promotion, prevention and screening programs, and a range of other services that target those who otherwise would not have access to health care. For people who face significant barriers to care as a result of social inequities or lack of insurance, these services can be a lifeline and a last resort.

In some instances, a hospital may state that poor financial performance prevents it from providing higher levels of charitable community benefits. How does a person judge the accuracy of such a claim? Financial analysis is one useful tool for measuring a hospital's charitable commitment to the community and determining whether this amount is reasonable or sufficient. While this guide will not make you into a financial expert, it will provide:

- **Vocabulary to help you understand information about a hospital's financial performance;**
- **Tools that can be used to evaluate a hospital's charitable commitment to the community; and,**
- **Valuable tips on how groups can engage hospital leadership in meaningful discussions of hospital financial performance.**

## STARTING OUT

An evaluation of hospital financial performance starts with some basic questions:

- How does a hospital get and spend its money?
- Is the hospital in good financial health (able to cover its basic financial requirements and fulfill its charitable mission)?
- What types of government policies and regulations affect the hospital's financial health?
- What are the market trends and how are these forces shaping the decisions of the hospital leadership?

These are just a few of the questions that this guide will explore.

The guide is divided into the following sections:

- I. Overview of Health Services Industry by Provider and Payer**
- II. Hospital Revenues (including payment methodologies by payer)**
- III. Hospital Expenses**
- IV. Sources of Financial Information**
- V. Evaluation of a Hospital's Financial Health**
- VI. Hospital Operating Environment**
- VII. Questions to Ask Hospital Management**



# I. Overview of the Health Services Industry

## Providers

The health services industry includes many providers of service. To understand the flow of funds, or how money flows through a hospital, it is important to know the key players in the industry. These include physicians and ancillary providers, skilled nursing facilities, long-term care providers, home health care, and pharmacies, as well as hospitals.

### ■ Hospitals

Hospitals are registered with the American Hospital Association as one of the following:

Type	Description
General	Provide patient services, diagnostic and therapeutic, for a variety of medical conditions
Specialty	Provide diagnostic and treatment services for patients who have specified medical conditions, both surgical and nonsurgical
Rehabilitation and Chronic Diseases	Provide diagnostic and treatment services to disabled individuals requiring restorative and adjustive services
Psychiatric	Provide diagnostic and therapeutic services for patients who require psychiatric-related services

Hospitals are organized as **public** (nonfederal and federal), **investor-owned**, and **not-for-profit entities**.

- In general, **public hospitals** provide substantial services to patients living in poverty.
- **Federal hospitals**, such as those run by the military or the Department of Veterans Affairs, serve specific purposes or communities.

- **Public hospitals** are often funded in part by a city, county, tax district, or state.
- **Private, not-for-profit hospitals** are nongovernment entities organized for the sole purpose of providing health care. Roughly 87 percent of nonfederal community hospitals are not-for-profit. In return for providing charitable services, these hospitals receive numerous benefits, including exemption from federal and state income taxes and exemption from property and sales tax.
- The remaining 13 percent of nonfederal community hospitals are **investor-owned**, which means that they have **shareholders** that may benefit from profits generated by the hospital. For-profit hospitals do not share the charitable mission of not-for-profit hospitals (though many do provide some charity services), and they must pay taxes.

### ■ Other Providers

- **Physicians** may practice general medicine or specialize in a particular area. Some physicians are employed by managed care plans or hospitals while others may have private practices in the community.
- **Other professionals** who bill for services delivered in hospitals, including physical therapists, speech therapists, and occupational therapists.
- **Skilled nursing facilities** provide primarily subacute inpatient skilled nursing care and rehabilitation services.
- **Long-term care providers** offer services for patients with chronic illnesses.
- **Home care services** are, as the name implies, provided in the patient's home usually by a home health aide. These services may include nursing, nutritional and therapeutic aid, and the rental and sale of medical equipment. As patients are discharged to their homes sooner—due to hospitals' economizing strategies—home care plays an increasingly more important role in the health services industry.
- **Pharmacies** are found in hospitals, at managed care plan facilities, and in the community. Like home care, pharmaceuticals have become more important in the health care delivery sector as they may supplant inpatient hospital care and other treatments.

## Payers

To understand how hospitals generate revenue for patient services, it is important to understand the “payers” in the healthcare industry. Public payers include federal and state governments—which fund Medicare and Medicaid—and, to a lesser degree, local governments. Private payers are insurance companies. Both public and private payers are often referred to as **third-party payers**. Finally, there is the uninsured population, which includes people who are expected to pay for their own health care, unless they qualify for “charity care” as defined by their providers.

### ■ Public Payers

#### ***Medicare***

Medicare is administered by the Health Care Financing Administration (HCFA). This federal health program is for seniors and some disabled people. All seniors over the age of 65 are eligible for Medicare benefits, regardless of income. Medicare Part A covers mostly hospital services and is financed by payroll taxes. Medicare Part B covers physician and other nonhospital costs and is financed by enrollee premiums and general tax revenues.

#### ***Medicaid***

Medicaid is a federal and state program that pays for health services for low-income families, disabled, and low-income seniors. States run the program under federal guidelines and both the federal and state government share the costs. Medicaid is the principal payer for nursing home and other long-term care services in the United States.

The Disproportionate Share Hospital or “DSH” program provides support to hospitals serving large numbers of Medicaid beneficiaries and uninsured patients. This program will be described in Section II.

### ■ Private Payers

#### ***Health Maintenance Organization (HMO)***

An HMO is a managed care organization that provides members with a comprehensive set of services through its provider network for a monthly fee. HMOs may limit patients to seeing only particular providers, including “gatekeeper” physicians who authorize specialized and referral services. They may provide **utilization review** to ensure that services rendered are appropriate and develop discounted fee schedule rates for providers and payment methods that transfer some insurance risk to the providers.

**Preferred Provider Organization (PPO)**

A PPO is a managed care plan that contracts with networks or panels of providers to furnish services that may be paid for on a negotiated fee schedule. Enrollees are offered a financial incentive to use providers on the preferred list, but may use non-network providers as well, usually at a greater out-of-pocket cost.

**Point of Service (POS)**

A POS plan is a managed care plan that combines features of both pre-paid and fee-for-service insurance. Health plan enrollees decide whether to use network or out-of-network providers at the time care is needed. Out-of-network care usually requires greater out-of-pocket costs, as is the case with PPOs.

**Indemnity**

Indemnity insurance policies are traditional health insurance plans in which members are responsible for a portion of medical expenses. In most plans, members pay a premium and must first meet a deductible. Once the deductible is met, the members are responsible for a certain percentage of the medical expenses. For example, if a patient's bill amounts to \$600 and the patient's deductible is \$500 and coinsurance is 20 percent, then the patient would be responsible for \$520 (\$500 deductible plus 20 percent of remaining \$100). There are generally no provider restrictions within covered benefits.

**■ Uninsured Individuals****Self-Pay**

Self-pay patients include the population that is not covered by health insurance. As the name implies, these patients pay the costs of medical expenses out of pocket. Typically, hospitals "charge" these patients a higher fee than what they actually expect to collect from the organized payers described above. If an individual does not have adequate resources to pay the bill, providers can secure payment in a number of ways, including extended payment plans and liens on property. Hospitals may also have policies regarding charity care for those of little means. Some states require that hospitals not charge patients who meet stated eligibility standards. In other states, it is left to the hospitals to set their own policies.

### ■ Payers with a Twist

Public payers have turned to managed care organizations to administer health plans for their populations. For example, the state government may contract with a health plan for healthcare coverage for their Medicaid population. Under such an agreement, the state pays a private managed care plan a set amount per enrolled Medicaid recipient on a monthly basis. This fixed amount is paid regardless of the patients' use of services. Plans may also provide coverage for seniors eligible for Medicare. Under Medicare Risk plans, the federal government (via the Health Care Financing Administration) pays plans 95 percent of the Adjusted Average Per Capita Cost (AAPCC). The AAPCC is supposed to approximate what fee-for-service beneficiaries in the local area would cost Medicare. If the health plans pay out less than the AAPCC, the plan benefits.

Now that you are familiar with the payers in the marketplace, the next step is to learn the payment methodologies and other ways that hospitals generate revenue.



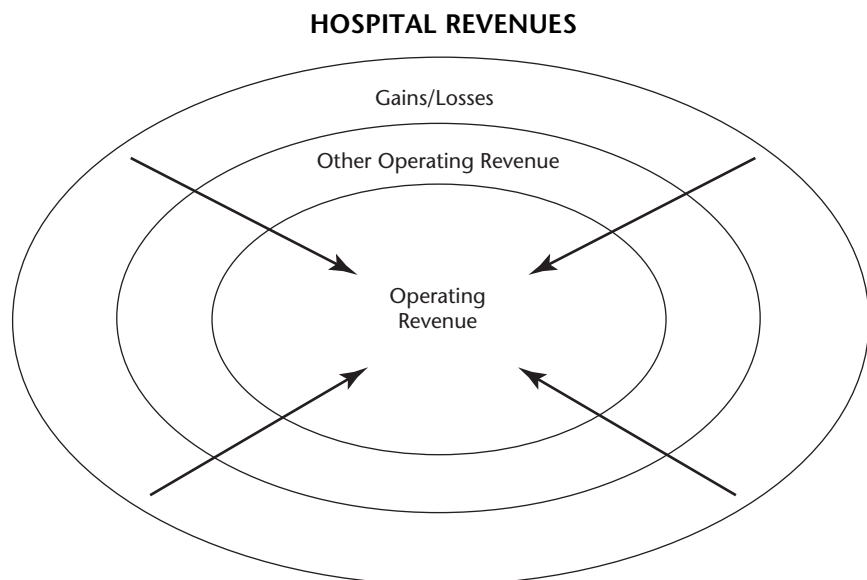
# II. Hospital Revenues

Typically, hospitals get their revenue in a variety of ways:

- By providing medical services
- By providing nonmedical services
- Through donations and grants from individuals, foundations, or the government
- Through investments

Hospitals group the way they make money into three different categories:

- Operating Revenue: delivery of patient care
- Other Operating Revenue: nonpatient care activities
- Gains/Losses: peripheral business activities<sup>1</sup>



<sup>1</sup> In the past accountants sometimes referred to “Gains/Losses” as “Non-Operating Revenue”

## Operating Revenue

Operating revenue—income earned by delivering patient care—is the first and primary way that hospitals make money. This revenue is further categorized in hospital finance terms as gross and net:

- **Gross Patient Service Revenue (GPSR).** The amount of money that hospitals would make if they were paid in full (that is, the nondiscounted rate) for the care they deliver (total inpatient and outpatient revenues before deductions). However, hospitals provide most patient care at less than full charge and never actually collect their gross patient service revenue.
- **Net Patient Service Revenue (NPSR).** The total amount of money the hospital actually collects after deducting charity care and contractual adjustments.

Adjustments to GPSR revenue to calculate NPSR include:

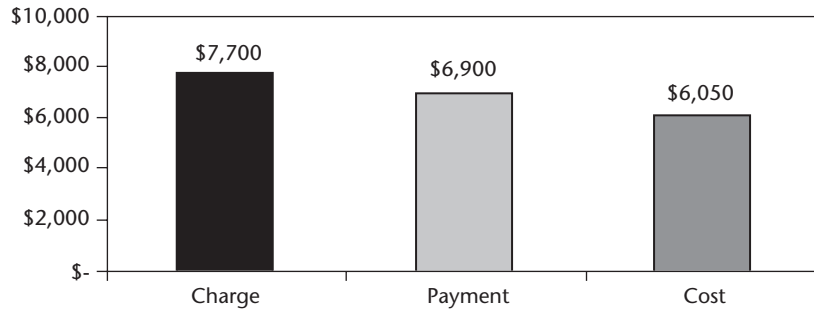
- **Free care** (also known as **charity care**) represents services provided for which payment was never expected and for which the patient is not pursued. Patient eligibility for free care varies by state and (sometimes) by hospital and is generally based on financial situation (income and assets). Hospitals value free care at full charges on their financial statements, but this does not reflect the true cost of providing the care. (Note: Free care differs from bad debt in that bad debt represents service charges for which a hospital expected to collect but ends up not getting paid. For more detail on bad debt see Section III.)
- **Contractuals** are payment arrangements with organized payers. *Different payers pay different amounts for identical services.* Medicare, Medicaid, and private insurance companies negotiate payment arrangements that are based on costs, listed hospital charges, or other criteria. The price that these groups are able to negotiate varies (they do not all pay the same discounted rate) as does the payment methodology.

### **What is the difference between “charges,” “payment,” and “cost”?**

- A **charge** is the amount the hospital lists as the price for services. Only self-payers and some private insurers pay this “sticker price.”
- **Payment** is the amount the hospital actually receives in cash for its services. Private insurers, public insurers, and the uninsured all pay different amounts for the same services. Payment can be either more or less than what it costs the hospital to provide a given service.
- **Cost** is what it actually costs the hospital to provide the services. (Costs are reported in aggregate, so you will not be able to find cost for individual procedures on financial statements.)

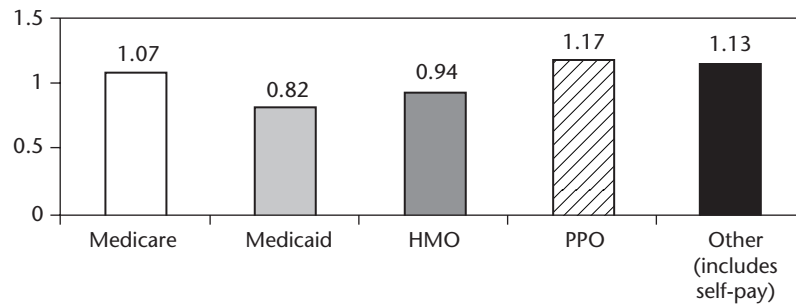


**EXAMPLE OF CHARGE, PAYMENT, AND COST OF HOSPITAL BILL**

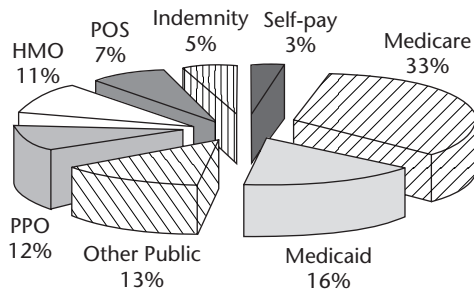


This chart illustrates the differences between charges, payment, and cost. For example, a hospital may charge \$7,700 for a particular medical procedure. The negotiated rate established between the hospital and a payer may be \$6,900, although the actual cost of the procedure—salaries, equipment, and the like—may be only \$6,050.

**1998 PAYMENT-TO-COST RATIOS FOR A SAMPLE OF MASSACHUSETTS HOSPITALS**



**1997 PAYER MIX (GROSS PATIENT REVENUES)**



Sources: <http://www.hcfa.gov/stats/NHE-OAct/>; Medical Payment Advisory commission, July 1998

The payment-to-cost ratio illustrates the amount of revenue a hospital receives relative to its costs. A payment-to-cost ratio of 1 means that the hospital is receiving payment that exactly covers its costs. A ratio greater than 1 means that the hospital is receiving more money than the cost of the service. This trend is observed in the Medicare, PPO, and other/self-pay populations. (Likewise, a ratio less than 1 means the hospital is not recovering its cost of service.)

Reviewing a hospital's payer mix is useful in evaluating hospital financial performance. The pie chart illustrates the average hospital payer mix in 1997 nationwide.

There are three general types of payers: public, private, and uninsured. It is important to understand the variety of payment methodologies by payer.

### **Public Payers**

The Medicare and Medicaid programs account for most public spending on healthcare services.

**Medicare** Medicare is the nation's largest health insurance program, providing health insurance to people 65 years and older, and also to those who have specific disabilities, such as permanent kidney failure.

Before 1983, Medicare paid for inpatient hospital care on a 'reasonable cost' basis. Medicare paid its 'fair share' of the hospital's costs, based on Medicare's share of the hospital's charges. Costs are determined by a detailed and extensive report known as the Medicare Cost Report. In 1983, the federal government created the Prospective Payment System (PPS) because the cost-based payment system gave hospitals little incentive to lower costs.

Under the PPS, Medicare pays a lump sum per case type—called a Diagnostic Related Group (DRG)—to hospitals for inpatient acute care services. Patients are sorted into these DRGs according to principal diagnosis, type of surgical procedure, presence or absence of significant comorbidities or complications, and other relevant criteria. If a hospital has low costs or is able to reduce the length of a patient's stay at the hospital, they can make a profit from the case type, but if they have high costs and longer lengths of stay, they will probably lose money under this system. For a given DRG, the payment that Medicare makes is the same at every hospital in the country, except for an adjustment for geographic variation.

Medicare pays for some outpatient hospital care through a fee schedule system but mostly through the reasonable cost method. Medicare is moving toward a system under which all outpatient care will be paid through a prospectively determined fee schedule, and expects to put this system in place by 2002.

**Medicaid** Medicaid is a federal and state funded health insurance program, run by the states, for certain low-income individuals, families, and disabled people. Payment methodologies for Medicaid vary by state. You can contact your state's Medicaid agency to find out how your plan pays for services.

Two typical ways that Medicaid pays for inpatient hospital care are:

- By diagnosis related group (DRG)
- By an all-inclusive per diem payment under which hospitals are

**Medicare payments** usually account for a significant amount of a hospital's revenue. In 1997, the average hospital received 33 percent of its gross patient revenue from Medicare.

Visit <http://www.hcfa.gov/stats/NHE-OAct/> for more information.

In 1997, **Medicaid** accounted for 16 percent of the average hospital's gross patient revenues.

**Disproportionate share payments** as well as other non-Medicaid and Medicare public payments accounted for 13 percent of the average hospital's gross patient revenues in 1997.

**HMOs** accounted for 11 percent of the average hospital's gross patient revenues in 1997.

paid a daily amount for each day the patient is in the hospital. This predetermined amount does not vary according to the hospital's actual costs or services provided.

Additionally, many state Medicaid plans have started using managed care to provide hospital services. Under this system, every month Medicaid pays a private managed care plan the same amount per Medicaid recipient enrolled for a wide array of patient services. If the patient uses a lot of services or none at all, the managed care plan is still paid the same fixed amount. This payment method is referred to as capitation. The responsibility for hospital payment then falls to the managed care plan, based on its contractual arrangements with the hospital.

Medicaid payment for outpatient hospital care varies by state. Fee schedules and cost-based reimbursements are common methods. Again, you should check how your state's Medicaid program pays for outpatient hospital care by contacting your state's Medicaid agency.

**Disproportionate Share: Medicaid** Hospitals that serve very large numbers of Medicaid and/or low-income or uninsured patients may be eligible to receive payments from the government under what is called the Disproportionate Share Hospital (DSH) adjustment. Payments to hospitals are funneled from the federal government through state governments. States have great flexibility as to how they distribute the funds. Generally, each year states determine the amount of money to be distributed among qualifying hospitals. Then, payment to each qualifying hospital is made based on the proportion of services provided to Medicaid and uninsured patients. Finally, each year each state must submit to the federal government detailed plans as to how they will distribute the money to eligible hospitals, as well as a list of payments made to each qualifying hospital.<sup>2</sup>

There is also a DSH program that is part of Medicare, but it is much smaller in dollar terms than the DSH program for Medicaid.

### **Private Payers**

The private health insurance system stands parallel to the public Medicare and Medicaid programs. These payers receive a premium—usually from an employer on behalf of employees, but sometimes from other organizations or individuals—to pay for the health care its members need. Private payers come in a variety of types:

**Health Maintenance Organizations (HMOs)** pay for inpatient hospital services by DRG, per diem, or discounted charges. They may also pay

<sup>2</sup> For a more detailed explanation on DHS payments refer to the publication "Untangling DSH" from The Access Project, which can be found at [www.accessproject.org](http://www.accessproject.org).

by negotiated capitation rates, particularly in an “integrated delivery system” where hospitals and physicians contract together.

HMOs pay for **outpatient hospital services** in two common ways:

- By capitation, where a provider is paid a certain amount per patient for a predetermined set of services. Capitation payments are often described in terms of “per-member, per-month.”
- By the fee-for-service (FFS) method, where hospitals are paid a fee for every service they perform, either on a discounted charge basis or on a negotiated fee schedule.

**PPOs** accounted for 12 percent of the average hospital's gross patient revenues in 1997.

**POS** accounted for 7 percent of the average hospital's gross patient revenues in 1997.

**Indemnity insurers** accounted for 5 percent of the average hospital's gross patient revenues in 1997.

**Self-payers** accounted for 3 percent of the average hospital's gross patient revenues in 1997.

**Preferred Provider Organizations (PPOs)** pay hospitals for inpatient and outpatient care based on a negotiated discount of the hospital's usual charges. Out-of-network care is usually paid for at the hospital's charge rate.

**Point of Service (POS)** organizations are a hybrid of PPOs and HMOs. Payment by a POS takes on different forms, depending on the particular POS plan. Some POS plans pay for services using the discounted fee-for-service method and some use capitation. Out-of-network care is usually paid at the hospital's charge rate.

**Indemnity insurance** is the traditional form of insurance. Under indemnity insurance, plans pay for inpatient and outpatient hospital care based on the hospital's charges. This method can be thought of as comparable to other forms of insurance, such as car insurance. Indemnity differs from other private insurers that use the fee-for-service method—such as PPOs and some HMOs—because indemnity insurance allows the patient to see any doctor or go to any hospital they wish. This freedom of choice and relative lack of restrictions tends to attract people with greater healthcare needs, thus indemnity plans are expensive and have greatly increased the copayment and deductible features of their benefit plans in recent years. As a result, the number of people insured by indemnity plans is decreasing.

### **Uninsured**

Those who do not have a public or private payer representing them in the healthcare marketplace represent themselves. These are the uninsured, who must find the means to finance their own care

**Self-pay** Uninsured or self-pay patients pay whatever charges the hospital posts as their charge or price. In 1996, self-payers paid, on average, 87 percent more than what their care actually cost. As a comparison, private insurers paid, on average, 22 percent above the cost of their care. Self-pay also means uninsured, so much of a hospital's potential self-pay revenue ends up as uncompensated care.

As you can imagine, these varying payment mechanisms offer an array of incentives to hospitals, which are presented in the following chart.

### PAYMENT METHODS AND INCENTIVES CREATED

Payment Method	Definition	Incentives Created for the Hospital
Fee for Service (FFS)	Providers are paid a fee for every service performed.	The FFS method rewards hospitals for providing more care. The more they provide, the more they are paid. Under this method, there is concern that FFS payments will lead to additional and unnecessary services.
Discounted FFS	Providers are paid a fee for every service performed, but at a discounted rate.	This method offers incentives similar to those described above. Although hospitals are not paid as much per service, there are still incentives to provide additional services in order to get additional payments. There is also an incentive for providers to mark-up charges to offset the discount.
Capitation	Providers are paid a certain amount per patient for a predetermined set of services.	Hospitals receive the same monthly fee whether they treat a patient or not. The capitation method of payment leads to a common concern that hospitals and other providers will not provide necessary services, since providing additional services will not increase the amount of money they receive.
Per diem	Providers receive fixed daily payments that do not vary with the level of services used by the patient.	Since a hospital is paid by the day and not by individual case, the hospital can make more money by keeping a patient in the hospital for more days than are necessary.
Diagnosis Related Group (DRG)	Providers are paid a lump sum to cover inpatient acute care operating costs. Patients are sorted into groups according to principal diagnosis, type of surgical procedure, presence or absence of significant comorbidities or complications, and other relevant criteria.	DRG payments will create an incentive for hospitals to provide services at lower cost and to shorten lengths of stay. They will also benefit from an increase in the volume of admissions.
Charges	Hospital's posted price for services.	In most states there are no limits (other than "market forces") as to what a hospital can charge. The incentive is to establish charges as high as possible to get the most from the indemnity, out-of-network PPO and POS and self-pay patients.

Payers often offset these incentives by placing restrictions on providers through the use of utilization review, medical management initiatives, and prior authorization/approval for services.

In sum, net patient service revenue is calculated as follows:

$$\begin{array}{r}
 \text{Gross Patient Service Revenue} \\
 - \text{Free Care} \\
 \hline
 - \text{Contractuals (Negotiated Discounts)} \\
 \hline
 = \text{Net Patient Service Revenue}
 \end{array}$$

## Other Operating Revenue

Hospitals also make money by providing services that are ongoing business activities, but that are not directly related to the hospital's main mission of delivering patient care. While these activities bring in significant and continuous streams of funds, the money resulting from these services and activities is called other operating revenue. Some typical categories that make up other operating revenue include:

- Cafeteria sales
- Gift shop sales
- Parking garage fees
- Space or equipment rentals
- Research grants

While it is probably obvious how a hospital benefits financially from rentals, cafeteria, gift shop, and parking garage fees, funding from research grants deserves a little more explanation. Hospitals are a valuable arena for researching new drugs, treatments, and procedures, and outside agencies fund hospitals to perform such research. The main organizations that fund medical research include the National Institutes of Health and the Centers for Disease Control and Prevention, two federal government agencies. Hospitals also receive funding from pharmaceutical companies to test new drugs and products. Money from research grants can be a significant source of funds for a hospital, particularly if it is a teaching hospital.

## Gains or Losses

Hospitals can also make (or lose) money on transactions that are considered peripheral to the regular activities of the hospital. These occurrences are called nonoperating gains (or losses) and examples include income generated from marketable securities or donations and income/losses from owning shares in affiliated organizations. Sometimes it is not clear whether an activity should be classified as other operating revenue or as a gain/loss. It is helpful to think of other

operating revenues as revenues earned through the sale of goods and services, and nonoperating gains/losses as events that are not from the sale of goods and services *and* are peripheral to the functions of a hospital.

The categories that make up nonoperating gains/losses include:

### ***Investment Income***

Investment income is becoming an increasingly important way for hospitals to make money. Categories of marketable securities include mutual funds, stocks, and bonds. Different hospitals have different investment strategies: some hospitals invest in stocks or other securities that provide higher returns at greater risk, while other hospitals invest in more conservative fixed rate return instruments such as bonds and money market funds.

It may be difficult to get a sense of the hospital's investments from their financial statements, although the general mix of stocks, bonds, and cash are often disclosed in the footnotes of the audited financial statements. Since investment income can be a "black box" because you cannot tell what a hospital is investing or what the level of risk involved is, it is important to ask management about its investment strategy.

### ***Unrestricted Donations***

Hospitals often receive monetary gifts from individuals and organizations that wish to support the hospital's mission. When these funds are not directed to a particular purpose, they are considered as nonoperating revenue (again) for the hospital and recorded as such on the income statement. Note that this revenue is not a constant or reliable source of money for a hospital.





# III. Hospital Expenses: How Hospitals Spend Money

Hospitals must spend money to function and provide patient care. The main categories of expenses include salaries, supplies, depreciation, amortization, interest, and bad debt expenses.

## **Salaries, Wages, and Employee Benefits**

Wages and salaries paid to employees are usually the largest category of expenses for hospitals. In many hospitals, salaries make up about 60 percent of total expenses. Only physicians who are employees of the hospital are included in the category. Nonsalaried physicians are paid directly by the insurer or patient. Most community hospitals do not employ physicians except in the emergency department, the radiology department, the laboratory, and often in the anesthesiology department.

## **Supplies and Other**

Supplies usually make up the second largest category of hospital expense and typically account for 30 percent of a hospital's expenses. "Other" includes a range of expenses, but often represents contract labor and lease expenses.

## **Depreciation and Amortization**

When any entity (including hospitals) buys equipment, buildings, or other fixed assets, it does not expense, or write off, the entire cost of purchasing that fixed asset in one accounting period. Instead, it recognizes the cost over the estimated life of the good, and records the appropriate portion as an expense during the current accounting period.

The process of expensing a fixed asset for its expected length of use is called depreciation. For example, if a hospital bought an x-ray machine for \$100,000 and expected it to last 10 years, using the straight-line depreciation method the hospital would record the expense of the machine at \$10,000 per year for 10 years.

Similarly, when a hospital purchases an intangible asset the process of expensing its cost over the expected length of its life is called amortization. Intangible assets consist of the nonphysical assets of a business, such as goodwill, copyrights, and patents. The entire cost is spread over the anticipated life of the asset instead of recognizing it all at once in the first year.

## Interest

Hospitals often borrow money for mortgages and other large purchases. Interest expense is the amount a hospital must pay in the current accounting period for borrowing funds.

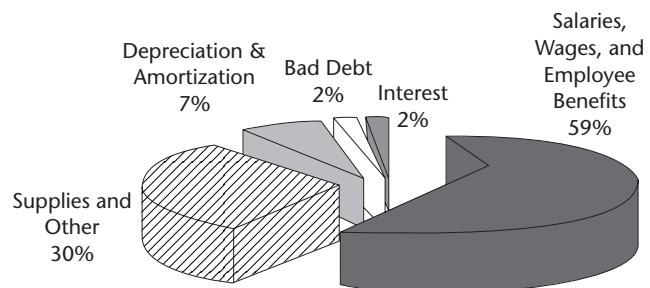
## Other Expenses

This catchall category includes any other expense not listed above. Other expenses typically include amounts spent for employee pensions and general services, such as phone system repairs.

## Bad Debt Expense

Bad debt represents service charges for which a hospital expected to collect but does not receive payment. Bad debt is valued at charges. For example, a patient is billed \$1,000 for a procedure. If the patient is only able to pay half of the cost (\$500), the hospital must write off the other \$500 as bad debt and record it as an expense.

**BREAKDOWN  
OF HOSPITAL  
EXPENSES  
(From Cleverley  
1992)**



# IV. Sources of Hospital Financial Information

Since you know how a hospital makes and spends money, now you need to learn where you can find this information. All hospitals must have complete financial statements.

## **Audited Financial Statements**

Hospitals, like other businesses or organizations, issue **financial statements**. Financial statements are reports that show the type of financial actions an organization has taken and the impact of these actions. For example, statements show where and when a hospital's money has been spent and whether the hospital is financially successful. They answer questions such as: What is the financial picture of the organization in any given year? How well did the hospital do during a given period of years?

**Audited** financial statements are prepared by an independent auditing firm according to generally accepted accounting and auditing principles. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation.

There are three major financial statements:

- The income statement
- The balance sheet
- The cash flow statement

Each statement has a distinct focus and use.

## ■ Footnotes

Important elements may be disclosed in the footnotes accompanying the financial statements. For example, indicators used to measure charitable commitment, descriptions of changes in accounting principles, and affiliate names and transfers can be found in the footnotes.

## ■ The Income Statement

The income statement (also referred to as the Profit and Loss Statement or Comparative Statement of Operations) focuses on performance over a designated period of time, usually one year. This statement provides important information about the profitability of a hospital, including information on how the hospital gets its money and how the hospital spends its money.

Here is an example of an income statement:

### INCOME STATEMENT (in Thousands)

	1999	1998
<b>OPERATING REVENUES</b>		
Gross Patient Service Revenue	\$258,125	\$263,469
Free Care	5,800	6,024
Contractuals	69,320	67,985
Net Patient Service Revenue	183,005	189,460
Other Operating Revenue	14,600	14,843
Total Operating Revenue	\$197,605	\$204,303
<b>OPERATING EXPENSES</b>		
Depreciation	13,152	13,805
Interest	3,222	5,026
Bad Debt	5,163	6,866
Other Operating Expenses	168,585	173,634
Total Operating Expenses	\$190,122	\$199,331
Net Operating Income	\$7,486	\$4,972
<b>NONOPERATING REVENUE</b>		
Investment Income	\$2,530	\$3,328
Gains/Losses	159	0
Other Income (Expenses)	470	1,112
Total Nonoperating Revenue	\$3,159	\$4,440
Excess Revenues over Expenses	\$10,645	\$9,412
<b>OTHER GAINS (LOSSES) DUE TO:</b>		
Extraordinary Gains (Losses)	0	-748
Total Surplus/Deficit	\$10,645	\$8,664

The purpose of the income statement is to provide information on hospital performance, including how much profit the hospital makes.

### **What Is Profit?**

Profit is the difference between revenue and expenses in addition to nonoperating gains and losses. Profit is sometimes referred to as the hospital's "bottom line," because the bottom line of the income statement shows the excess revenues remaining once expenses have been subtracted. Profit may also be called "total margin." For example, a 2 percent total margin means that the hospital keeps as profit 2¢ for each dollar of revenue.<sup>3</sup>

In addition to looking at the bottom line to gauge profit, financial analysts also measure the difference between operating revenue and operating expenses *without* nonoperating gains and losses. This measure of profit is referred to as net operating income and is used to measure how much profit comes from a hospital's central mission of delivering patient care.

A "not-for-profit" designation does not mean a hospital can't make money. A nonprofit may make a "profit," but it does not distribute its profit to individuals or shareholders as a for-profit organization might.

### **How Could Profit Be "Hidden"?**

A hospital may be conservative in its estimate of how much money it will earn from patient revenues. Because these numbers usually require a certain amount of estimation, bad debt and contractual settlements might be much less (or more) than the hospital's reported figures. For example, a hospital may not recognize all Medicare patient revenue because of the uncertainty regarding whether the hospital will be permitted to keep this revenue. When a hospital "settles" with an insurer at the end of the financial reporting period and it is found that the insurer overpaid the hospital, the hospital may have to give back some of the money to the insurer.

<b>HOSPITAL PROFIT</b>
Operating Revenues
– Operating Expenses
= Operating Income
+/- Nonoperating Gains/Losses
= TOTAL Surplus/Deficit

<sup>3</sup> Accountants typically use the phrase "excess revenues over expenses" instead of "profit" when referring to non-profit hospitals. However, for the purpose of making this manual as clear as possible, we have used the term "profit." Please keep in mind that both terms refer to the same concept, and if you do look at actual financial statements, you will see the phrase "excess revenues over expenses."

## ■ The Balance Sheet

The balance sheet gives a snapshot of the organization's financial health at a particular point in time, for example, as of June 30, 2000. It is also known as the statement of financial position or statement of financial condition. In general, the organization's total assets should be greater than its total liabilities, or it cannot survive for long. The kinds of assets and liabilities an organization has also affect its financial health. For instance, current assets (such as cash, receivables, and securities) should cover current liabilities (such as payables, deferred revenue, and current-year loan and note payments). Otherwise, the organization may face immediate solvency problems. On the other hand, if an organization's cash and equivalents greatly exceed its current liabilities, the organization may not be putting its resources to the best use.

There are several major elements on a balance sheet.

- **Assets** are economic resources that are expected to provide future benefits by helping to increase cash inflows or reduce cash outflows. Property, plant, and equipment (PPE) are considered assets.
- **Liabilities** are economic obligations of the organization to outsiders, or claims against its assets by outsiders. Accounts payable is an example of a hospital liability.
- **Net assets, fund balance, or owners' equity** are all different names for the same thing: they all refer to the residual interest in, or remaining claims against, the organization's assets after all liabilities have been deducted. This may be expressed as:  
$$\text{assets} - \text{liabilities} = \text{net assets}.$$

### BALANCE SHEET EQUATION

The balance sheet has two counterbalancing sections which form the balance sheet equation:

$$\text{Assets} = \text{Liabilities} + \text{Equity (or Net Assets)}$$

The Liabilities + Equity portion of the balance sheet equation represents outsider and owner "claims against" the total assets shown on the assets portion of the equation.

# HOSPITAL BALANCE SHEET

## ASSETS

<b>Current Assets</b>	A list of resources which will most likely be used within the year
<b>Cash and Investments—Unrestricted</b>	Cash, cash equivalents, and short-term investments on which no special restrictions are imposed on how they may be spent
<b>Cash and Investments—Board Designated</b>	Cash, cash equivalents, and short-term investments internally designated for use by the board of trustees
<b>Cash and Investments—Trustee Held</b>	Cash, cash equivalents, and short-term investments designated as trustee-held to be used to repay specific obligations (usually long-term debt)
<b>Net Patient Accounts Receivable</b>	Payments due from patients minus amounts subtracted for estimated uncollectible accounts and “discounts” to large purchasers
<b>Due from Affiliates</b>	Contractual obligations of affiliates due this year
<b>Third-Party Settlements Receivable</b>	Estimates of settlements to be received this fiscal year
<b>Other Accounts Receivable</b>	Includes other receivables not related to patient services, third-party receivables or amounts due from affiliates
<b>Inventories</b>	Goods being held for sale, and material and partially finished products that will be sold upon completion
<b>Prepaid Expenses</b>	Intangible assets that will become expenses in future periods when the services they represent are used up
<b>Total Current Assets</b>	Sum total value of all the current assets listed above
<b>Noncurrent Assets</b>	Assets that are expected to be of use to the hospital for longer than one year
<b>Long-Term Investments</b>	Long-term resources
<b>Pledges Receivable Over a Period Greater Than One Year</b>	A promise to give (pledge) by a donor which has not yet been received and will not be received within one year’s time
<b>Net Property and Equipment</b>	Value of land, buildings, equipment, construction in progress, and capitalized leases
<b>Other Noncurrent Assets</b>	All other noncurrent assets not listed above, including amounts due from restricted funds; deposits; other non-current unrestricted receivables; deferred financing costs and deferred charges; pension and insurance obligations or retirement programs; organization costs, etc.
<b>TOTAL ASSETS</b>	The sum total value of all current and noncurrent assets

## LIABILITIES AND NET ASSETS

<b>Current Liabilities</b>	Short-term obligations to outside parties who have provided resources (liabilities)
<b>Current Portion of Long-term Obligations</b>	Principal payments due this fiscal year on long-term obligations
<b>Accounts Payable and Accrued Expenses</b>	Includes accounts payable, accrued salaries payable, wages, payroll taxes, interest, vacation (earned time) and other accrued liabilities
<b>Current Portion of Accrual for Settlements with Third-Party Payers</b>	Current portion of amounts received from third-party payers which the hospital expects to be due back to third parties in the current year
<b>Due to Affiliates</b>	Current amounts owed to related entities
<b>Total Current Liabilities</b>	Sum total value of all of the current liabilities listed above
<b>Noncurrent Liabilities</b>	Long-term obligations which are not due within one year
<b>Long-Term Obligations, Less Current Portion</b>	Noncurrent portion of long-term debt, capital leases, and mortgage notes payable
<b>Other Noncurrent Liabilities</b>	All other noncurrent liabilities, including reserves for self-insurance, accrued pension and post-retiree health benefits, noncurrent amounts due to affiliates, amounts due to restricted funds, notes payable, deferred gift annuities, construction and retainage payable, etc
<b>Net Assets</b>	Net assets represent the difference between assets and the claim to those assets by third parties or liabilities; increases in this account balance occur from either contributions or earnings
<b>Unrestricted</b>	Includes all net assets that are not temporarily or permanently restricted by donor or grant
<b>Temporarily Restricted</b>	Includes funds temporarily restricted by donor or grantor stipulations. Includes funds called for a specific purpose; property, plant and replacement; or endowment funds
<b>Permanently Restricted</b>	Includes funds permanently restricted by donor or grantor stipulations
<b>Total Net Assets</b>	Sum total value of all net assets
<b>TOTAL LIABILITIES AND NET ASSETS</b>	Sum total value of all liabilities and net assets raised by issuing stock

## ■ The Cash Flow Statement

The cash flow statement shows the cash that has come into and gone out of an organization, after operating expenses have been met, during the accounting period. Cash flow analysis provides a reliable, valuable perspective on hospital financial performance. Because cash is not estimated, it cannot be hidden or misleadingly labeled. Over the long term, multi-year cash flow analysis provides an accurate and objective perspective of hospital financial performance.

### STATEMENT OF CASH FLOWS

For the Period Jan 1–Dec 31, 1999 (in Thousands)

<b>CASH FROM OPERATING ACTIVITIES</b>	
Net Income	\$10,645
Noncash Expenses (Depreciation & Amortization)	13,152
Working Capital Changes:	
Increase Accounts Receivable	6,480
Increase Accounts Payable	–4,295
Total Cash from Operating Activities	\$25,982
<b>CASH USED FOR INVESTING ACTIVITIES</b>	
Property, Plant, and Equipment Purchases	–7,854
Increases or Decreases in Marketable Securities	2,702
<b>CASH FROM FINANCING ACTIVITIES</b>	
Issuance or Repayment of Long-Term Debt	–7,087
Transfers to and from Affiliates	–4,300
<b>NET CHANGE IN CASH</b>	<b>\$9,443</b>

This sample shows the standard items listed on the cash flow statement. One piece of valuable information that can be gleaned from the statement is transfers to and from affiliates. Hospitals that are affiliated with other hospitals or entities often transfer funds to and from one another. For example, many hospitals are now merging or creating alliances with other hospitals. Suppose Hospital A created an alliance with Hospital B and created a parent company called Parent, Inc., to handle certain operations and other business ventures. In this typical situation, Hospital A might transfer funds to Parent, Inc., to run business operations for them.



Hospital A would then record this transaction as a transfer to an affiliated entity and record it as a negative change in net assets (equity), separate from the hospital's bottom line on the income statement. The hospital would also record the transfer of funds on the cash flow statement. It is important to understand this flow of funds between entities, as a hospital's profitability can be affected if the hospital is transferring resources to affiliates instead of investing in its own operations.

## **Borrowing: Another Way Hospitals Gain Access to Money**

In addition to earning money by delivering patient care or conducting peripheral business activities, hospitals also issue long-term debt in order to finance large projects such as building a new clinic. Known as capital financing, nonprofit hospitals raise cash for these projects by issuing bonds to the public. When the bond matures after a designated period of time (10, 20, or 30 years, for example), the hospital must repay the total amount of the bond (plus interest) to the bondholders. Hospitals record the net issuance or repayment of this long-term debt in the cash flow statement, under cash from financing activities.

## **Where to Get Your Hospital's Financial Data**

### **Audited Financial Statements**

Audited financial statements may be obtained from the hospital or from some states that centrally collect them and make them available to the public. Nineteen states centrally collect the statements. They are:

Arizona	Maine	Montana	Rhode Island
Arkansas	Maryland	New Jersey	Vermont
California	Massachusetts	New York	Washington
Florida	Michigan	Oregon	West Virginia
Indiana	Missouri	Pennsylvania	

Some audited financial statements may also be available from <http://www.muniiris.com> for \$20 per statement.

### **IRS Form 990**

Most public charities recognized by the Internal Revenue Service (IRS) must file an IRS Form 990 every year. This form reports information about a public charity's finances and operations to the federal government. This form is a public document. Typically, groups can get a hospital's 990 from four sources:

- **The hospital**

By law, a nonprofit<sup>4</sup> must show its 990 to anyone who comes to its office and asks to see it. There is also a new requirement for making 990s available on its Web site. A nonprofit is also required to send copies of its three most recent 990 filings to anyone that requests them; the nonprofit is allowed to charge a small fee for making the copies.

- **The state charitable solicitation office** (e.g., Attorney General's Office)

Many states require nonprofits that solicit donations in their state to file a 990 with this state office.

- **The Internal Revenue Service (IRS)**

By filling out Form 4506-A (available at [http://www.irs.ustreas.gov/prod/forms\\_pubs/forms.html](http://www.irs.ustreas.gov/prod/forms_pubs/forms.html)), you can request a copy of an organization's 990.

- **GuideStar**

GuideStar, a project of Philanthropic Research Inc., provides images of the 990 form from some of the organizations that file them. GuideStar only lists "charitable" nonprofits that are both tax-exempt and qualified to receive tax-deductible contributions. Their website address is <http://www.guidestar.org>.



**CAUTION!**

Although Form 990 can provide a snapshot of the financial health and expenditures of an organization at a specific time, they are virtually useless in comparing one organization to another unless the organizations are of similar size, age, geography, and field of activity. Form 990 data are most useful for examining the evolving health and financial practices of an organization over a period of time.

<sup>4</sup> A nonprofit is defined as an organization that does not have owners who receive or "inure" private benefits from the organization. A nonprofit may make a "profit," but it does not distribute its profit to individuals or shareholders as can a for-profit organization. Nonprofit does not necessarily mean tax exempt or tax-deductible. Organizations must apply to the IRS for tax-exempt status, which only means they are exempt from paying federal income taxes. However, an organization may be tax-exempt without being qualified to receive tax-deductible donations. In order for a tax exempt organization to receive tax-deductible donations, its activities must have been determined "charitable" by the IRS under the provisions of section 501(c)(3) of the Internal Revenue Code.

### ■ Medicare Cost Reports (MCRs)

Medicare Cost Reports are available from the federal government for a fee. The purpose of this report is to determine Medicare's share of allowable expenses by department. While MCRs do include a Worksheet G that gives a very rough version of the hospital's balance sheet and income statement, these reports are prone to errors. These reports are more useful for internal hospital reporting as the cost accounting information is provided at a departmental level. The audited financials and 990s are more useful as they report data at the institutional level.



# V. Evaluating a Hospital's Financial Condition

Three types of performance indicators are used to measure a hospital's financial condition:

- Ratio analysis
- Multi-year cash flow analysis
- Affiliate charts

## Ratio Analysis

The purpose of a ratio is to relate several pieces of information through one summary measure that is more meaningful. Ratios can be looked at across time, called a trend analysis, and can be compared to other hospitals or industry standards. Ratios should be used together to understand the full story of a hospital. Ratios address three aspects of financial performance: profitability, liquidity, and solvency.

- **Profitability**—How much profit has a company made? Is the hospital rolling in dough or just breaking even and covering its costs?
- **Liquidity**—A company's ability to meet its short-term obligations. Does the hospital have enough cash to pay its bills?
- **Solvency**—A company's ability to meet its long-term obligations. For example, can the hospital pay back its mortgage?

The table on the next page shows a list of common ratios used to evaluate financial performance.

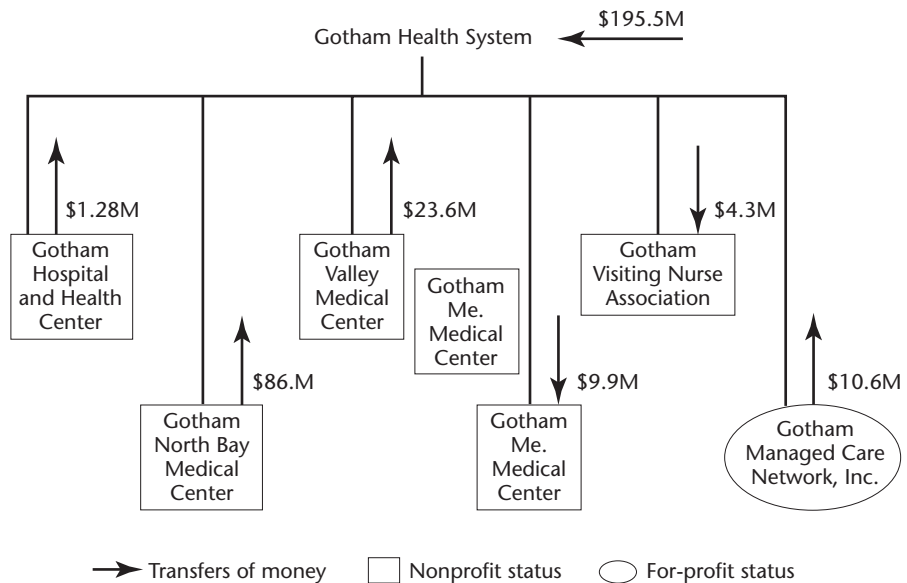
RATIO	DEFINITION	WHAT IT SHOWS
<b>Profitability</b>		
<b>Total Margin</b>	$\frac{\text{Revenues in excess of expenses}}{\text{Total Revenues}}$	Shows the percentage of revenues collected from central and peripheral activities that is kept as profit. <i>For example, a 5% Total Margin means that for every \$1.00 collected as revenue, \$0.05 is kept as profit.</i>
<b>Operating Margin</b>	$\frac{\text{Net Operating Income}}{\text{Total Operating Revenue}}$	Shows the percentage of revenues collected from central activities that is kept as profit. <i>For example, a 3% Operating Margin means that for every \$1.00 collected of patient revenues, the hospital keeps \$0.03 as profit.</i>
<b>Markup Ratio</b>	$\frac{(\text{Gross Patient Service Revenue} + \text{Other Operating Revenue})}{\text{Total Operating Expense}}$	Measures the percentage by which charges are increased above cost. <i>For example, if the hospital's cost for providing a particular service was \$10,000 and they charged \$15,000 for the service, they would have a markup of 1.5.</i>
<b>Deductible Ratio</b>	$\frac{\text{Contractual Allowance}}{\text{Gross Patient Service Revenue}}$	Measures the percentage discount that third-party payers get, on average, from listed charges. <i>For example, a 25% ratio would mean that the average third-party payer received a 25% discount off listed charges.</i>
<b>Liquidity</b>		
<b>Current Ratio</b>	$\frac{\text{Current Assets}}{\text{Current Liabilities}}$	Measures how many times the hospital is able to meet its short-term obligations with short-term resources. <i>A ratio of two would show that the hospital could pay its current liabilities twice over.</i>
<b>Days Cash on Hand, Short-Term Sources Only</b>	$\frac{\text{Current Cash and Investments}}{(\text{Other Operating Expenses}/365)}$	Illustrates the number of days the hospital could continue to operate without collecting any additional cash. <i>For example, a ratio of 150 would mean that the hospital could stop collecting revenues today and be able to continue operations for an additional 150 days before running out of cash.</i>
<b>Days Cash on Hand, with Board-Designated Investments</b>	$\frac{(\text{Current Cash and Investments} + \text{Board-Designated Investments})}{(\text{Other Operating Expenses}/365)}$	Considering all sources of unrestricted cash available for operations, this ratio illustrated the number of days the hospital could continue to operate without collecting any additional cash.
<b>Solvency</b>		
<b>Equity Financing</b>	$\frac{\text{Unrestricted Net Assets}}{\text{Total Unrestricted Assets}}$	Shows how much of the hospital's assets were paid for using equity, and how much of its assets were paid for using debt. <i>For example, a ratio of 60% would indicate that the hospital financed 60% of its assets with equity, which means the remaining 40% were paid for by debt.</i>
<b>Cash Flow to Total Debt</b>	$\frac{(\text{Revenues in excess of Expenses} + \text{Depreciation})}{(\text{Total Current} + \text{Total Noncurrent Liabilities})}$	Illustrates financial risk: Given the firm's source of total funds for the current year, how much of their total debt could they pay off this year? <i>For example, a ratio of 30% means that a hospital would be able to repay a third of their total debt in the current year, if they used all of their available funds.</i>

## Cash Flow Analysis

A cash flow analysis aggregates cash inflows and outflows over time to illustrate a pattern of cash sources and uses. Hospitals can provide services (operating activity), borrow (financing activity), or buy and sell assets (investing activity). A healthy hospital generates cash mainly from operating activities, especially operating income, nonoperating income, and depreciation. An unhealthy hospital uses debt financing as a large source of cash and uses cash for unprofitable operations. Depreciation expense is the largest source of operating cash for many hospitals.

## Affiliate Charts

Affiliate charts help to explain the organizational structure of the system to which the hospital belongs. The chart may illustrate if the hospital supports other entities or is supported by the other entities. The charts may help interpret trends in ratios and explain impacts on cash flows. The tax status of the affiliates is also important to assess. Below is an example of the type of information affiliate charts can provide.







# VI. Hospital Operating Environment

To understand the hospital's financial picture, it is also important to assess the hospital's operating environment. Both internal and external factors may affect the hospital's fiscal health.

## External

- **Regulatory Changes: Balanced Budget Act of 1997**

Regulatory changes, such as passage of this 1997 act, may greatly affect hospital finances. As the name implies, this legislation was intended to bring the government substantially closer to balancing the federal budget. Nearly three-quarters of the total savings of \$525 billion over the next decade is to be achieved through reductions in Medicare program spending. Over two-thirds of the savings will be accomplished through limiting growth in payments to general short-term acute care hospitals. Another source of savings comes from changes in the method of payment to hospital outpatient departments, chronic and rehabilitation facilities, skilled nursing facilities, and home healthcare agencies, which also results in a net decrease in payments to these organizations.

- **Changes in Payment Methodologies**

As payers change their payment methodologies, the revenues of hospitals are affected. Reimbursement is shifting from a traditional fee-for-service environment to case rate or global capitation reimbursements. In this new environment, hospitals that are most efficient and cost-conscious will most likely profit from case payments. In contrast, hospitals that experience high lengths of stay or inefficient operations may spend more than the actual reimbursement amount. Ultimately, these hospitals may experience a decline in profits and perhaps losses.

- **Investment Performance**

As described above, hospitals invest, to varying degrees, in marketable securities and money market funds. Consequently, changes in the financial markets may affect their financial picture. Hospitals may also have real estate investments in land or buildings. Thus, changes in the financial and real estate markets may affect financial health as well.

- **Donations/Gifts**

Donors may designate that their donations be used for a specific purpose, such as capital improvements. Most hospitals cannot count on this source of income as an ongoing financial strategy, as the donations are typically dependent on a few individuals or companies.

## **Internal**

- **Performance of Affiliated Entities**

The success of the hospital may be related to the performance of affiliated entities. If these entities are performing well, funds may be passed on to the hospital or parent company. Conversely, if a related entity is doing poorly (e.g., physician practices that the hospital has acquired), the hospital may transfer funds to help the fledgling entity. While these cash outflows may not affect the bottom line, these monies could have been reinvested in the hospital itself. In looking at the hospital's financial statements, it is important to determine if funds are being transferred to or from affiliated entities.

- **Management Control (Service Mix, Discharge Planning, Physician Profiling)**

The span of management control in a hospital may also have an effect on the bottom line. Hospital management may be proactive in treating a higher proportion of patients in a favorable and profitable service area. For example, cardiac cases may have a high profit margin so hospitals will promote their cardiac services. In addition, the hospital may devise strict guidelines as it relates to discharge planning. Discharge nurses or teams may be assigned to ensure the timely discharge of patients. In effect, the hospital is trying to cut the "fat" from the system or to maximize their patient "mix" based on financial criteria. Physician profiling and peer review may serve as effective tools in modifying physician behavior. These instruments will influence physicians to use "best practices" or guidelines developed by the hospital.

- **Case Mix/Level of Severity in Patients**

Most physicians and hospitals will argue that their patients are the sickest of the population and that payers' reimbursements are therefore not sufficient to meet the hospital's costs. However, the law of averages illustrates that this cannot be true. Even if this were true, hospitals that treat a high amount of sicker patients are most likely receiving more money in terms of a case payment. Remember, DRG payments take into account comorbidities and complexities along with the age of the patient. As mentioned above, an efficient hospital will benefit from having patients who are more severely ill because of the higher reimbursement, as long as it can manage the patient's length of stay and the cost per day of the stay.

- **Payer Mix**

The hospital's payer mix can also influence the financial profitability of a hospital. If a hospital treats a high percentage of wealthy self-pay patients who pay full hospital charges (highly unlikely), the hospital is likely to have favorable margins. Conversely, if a hospital sees a lot of uninsured patients, or patients under a managed care plan that has low contracted rates, the payer mix could be seen as unfavorable. As suggested above, hospitals that see a high proportion of Medicaid or Medicare SSI eligible members are eligible for disproportionate share hospital payments.



# VII. Basic Financial Questions

Short of turning yourself into an expert in hospital finance, what kinds of financial questions might community members ask of their hospitals? Some basic questions can provide you with very useful information:

- How much money does the hospital have?
- How does the hospital get its money?
  - By providing medical services?
  - By providing nonmedical services?
  - Through donations from individuals, foundations, or the government?
  - Through investments?
- What percentage of money comes from each of these sources?
- What does the hospital use the money for?
- How much cash has the hospital generated after meeting operating expenses?
- What is the hospital's investment strategy?
- What was the value of charity care provided to the community?
- What is the estimated value of a hospital's tax exemptions?
- What internal and external factors affect the hospital's financial health?

## Conclusion

By now, you have the tools to

- understand how to ask basic financial questions; and
- understand reports on hospital financial performance.

Accounting is like any language—it takes time and practice to understand it. Learning a second language can be awkward and frustrating, but practice with others and you will begin to feel more comfortable.



# Resources

- American Hospital Association Guide to the Health Care Field*. 1999, 2000 ed. (Chicago, IL: Health Forum LLC, an affiliate of the American Hospital Association).
- R. N. Anthony, *Essentials of Accounting*, 6th ed. (Reading, MA: Addison-Wesley, 1999).
- W. O. Cleverley, *Essentials of Healthcare Finance*, 3rd ed. (Gaithersburg, MD: Aspen Publications, 1992), Chapters 2, 4, and 6.
- The Access Project and Community Catalyst, *Community Benefits: The Need for Action, An Opportunity for Healthcare Change—A Workbook for Grassroots Leaders and Community Organizations* (2000).
- L. C. Gapenski, *Understanding Health Care Financial Management*, 2nd ed. (Chicago, IL: AUPHA Press/Health Administration Press, 1996), Chapter 3.
- J. Guyer, A. Schneider, and M. O. Spivey, *Untangling DSH: A Guide for Community Groups to Using the Medicaid DSH Program to Promote Access to Care* (The Access Project, 2000).
- N. M. Kane and W. H. Wubbenhorst, "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption," *The Milbank Quarterly* 78 (2000): 185–212.
- P. R. Kongstvedt, *Essentials of Managed Care*, 2nd ed. (Gaithersburg, MD: Aspen Publications, 1997).
- Managed Care Consumer Guide*, Commonwealth of Massachusetts. See [http://www.magnet.state.ma.us/dhcfp/pages/dhcfp\\_87.htm](http://www.magnet.state.ma.us/dhcfp/pages/dhcfp_87.htm) Web site for more information.
- M. O. Waid, Brief Summaries of Medicare & Medicaid, Title XVIII and Title XIX of The Social Security Act, 1999. See <http://www.hcfa.gov/medicare/ormedmed.htm> web site for more information.





# Glossary of Terms

**Adjusted Average per Capita Cost (AAPCC):** Under Medicare managed care, HCFA pays health plans 95 percent of this fixed amount, which approximates what fee-for-service beneficiaries in the local area would cost Medicare.

**Amortization:** The process by which a hospital (or any entity) recognizes the cost of purchasing an intangible asset. Instead of recognizing the entire cost in one accounting period, the hospital spreads the entire cost of the asset over the expected length of its life.

**Assets:** Valuable items that are owned or controlled by the hospital and that were acquired at a measurable cost.

**Audited Financial Statements:** Financial statements prepared by an independent auditing firm according to generally accepted accounting and auditing principles (see *Financial Statements*).

**Bad Debt:** Represents service charges for which the hospital expected to be paid but was not able to collect the amount.

**Balance Sheet:** One of the three major financial statements, the balance sheet gives a picture of the organization's financial health at a particular point in time. It is also known as the statement of financial position or statement of financial condition.

**Capitation:** A method of reimbursement, especially prominent in HMOs, whereby a provider is paid a certain amount per patient for a predetermined set of services. Capitation payments are often described in terms of "per member per month."

**Cash Flow Analysis:** Using the cash flow statement, one can perform this analysis to see how cash is being generated and spent. Cash flow analysis is

generally done using several years' worth of data, in order to get the most accurate and objective perspective of hospital financial performance.

**Cash Flow Statement:** One of the three major financial statements, the cash flow statement shows the cash that has come into and gone out of an organization, after operating expenses have been met, during the accounting period.

**Charge:** Amount the hospital lists as the price for services. Only self-payers, some indemnity insurers, and out-of-network PPO and POS plans actually pay this price.

**Charity Care:** See *Free Care*.

**Comorbidity:** A medical condition known to increase risk of death that exists in addition to the most significant condition that causes a risk of death. The number of comorbid conditions is used to provide an indication of the health status (and risk of death) of patients.

**Contractuals:** Payment arrangements with large payers. Different payers pay different amounts for identical services. Contractual amounts represent the price that certain groups (Medicare, Medicaid, and private insurance) are able to negotiate.

**Copayments:** Flat, per visit fees paid by the patient.

**Cost:** Amount it actually costs the hospital to provide a service.

**Deductibles:** Obligate beneficiary to pay the first part of any medical bill up to a certain level.

**Depreciation:** The process by which a hospital (or any entity) writes off the cost of purchasing plant, property, or equipment (fixed assets). Instead of writing off the cost of purchasing that fixed asset in one accounting period, the hospital instead recognizes the cost over the estimated life of the good and records the appropriate portion as an expense during the current accounting period.

**Diagnosis Related Groups (DRGs):** Lump sum per type of case paid to hospitals to cover inpatient acute care operating costs. Patients are sorted into groups according to principal diagnosis, type of surgical procedure, presence or absence of significant comorbidities or complications, and other relevant criteria.

**Disproportionate Share Hospital Spending (DSH):** Federal funding to assist health providers who care for very large numbers of Medicare or Medicaid beneficiaries. Medicaid DSH is funneled through state governments, though not equally, and has been a substantial source of funding.

**Fee for Service:** The predominant form of financial reimbursement prior to the emergence of managed care, whereby providers are paid a fee for every service performed, as opposed to paying capitation or salaries. The fee can either be given on a discounted charge basis or on a negotiated fee schedule.

**Financial Statements:** Reports that show the type of financial actions an organization has taken and the impact of these actions. The three major statements are the income statement, the balance sheet, and the cash flow statement.

**Fixed Assets:** Property, plant, equipment, or any other tangible, noncurrent asset.

**Free Care:** Represents services provided for which payment was never expected and is not pursued from the patient. Note that hospitals value free care at “charges” on their financial statements, which is different from the cost of providing the care.

**Fund Balance:** See *Net Assets*.

**Gains or Losses:** Money a hospital makes or loses on transactions that are considered peripheral to the regular activities of the hospital.

**Gross Patient Service Revenue (GPSR):** The amount of money that hospitals would make if they were paid their full charges for the care they deliver (total inpatient and outpatient revenues before deductions). However, hospitals provide most patient care at less than full charges and never actually receive their GPSR.

**Health Care Financing Administration (HCFA):** Federal agency that administers the Medicare, Medicaid, and Children’s Health Insurance Programs.

**Health Maintenance Organization (HMO):** A managed care organization that provides members with a comprehensive set of services through its provider network for a monthly fee.

**Hospitals, types of:**

**Federal:** Hospitals that are funded by the federal government, and which serve specific purposes (for example, hospitals run by the military or those operated by the Department of Veterans Affairs).

**Public:** Hospitals that are usually funded in part by a city, county, tax district, or state.

**Private, not-for-profit:** Nongovernment hospitals organized for the sole purpose of providing health care. In return for providing charitable services, these hospitals are exempt from federal and state income taxes and are exempt from property and sales tax.

**Investor owned:** Hospitals that are owned by shareholders who have invested in the company. In exchange for their investment, shareholders share any profits generated by the hospital. These hospitals are for-profit, do not share the charitable mission of not-for-profit hospitals, and must pay taxes.

**Income Statement:** One of the three major financial statements, the income statement focuses on performance over a designated period of time, usually one year. This statement gives information about the profitability of a hospital, including information on how the hospital gets and spends its money.

- Indemnity Insurance:** Traditional health insurance plans, where members are responsible for a portion of medical expenses. In most plans, members must pay all medical charges up to a prespecified amount (see *Deductible*). Thereafter, members are responsible for a certain percentage of medical expenses, and the insurance plan pays the remainder.
- Interest:** When hospitals borrow money for large purchases, interest is the money they must pay for the use of the borrowed funds.
- Interest Expense:** The amount a hospital must pay in the current accounting period for borrowing funds.
- Investment Income:** Money made from investments in marketable securities.
- Liabilities:** Obligations due to outside parties who have provided resources.
- Managed Care:** Any of several organizations in which measures are taken to provide care for a group of patients within a budget.
- Medicaid:** Federal/state program that finances health care services for low-income families, disabled, and elderly persons. States run the program under federal guidelines (every state's program is different) and the two levels of government share the costs. Medicaid is the principal payor for nursing home and other long-term care services in the United States.
- Medicare:** Federal health program for seniors and some disabled persons. All seniors over age 65 are eligible for Medicare benefits, regardless of income. There are two parts to Medicare:
- Medicare Part A:** Covers mostly hospital services and is financed by payroll taxes.
- Medicare Part B:** Covers physician and other nonhospital costs and is financed by enrollees' premiums and general tax revenues.
- Net Assets** (also referred to as Fund Balance or Owners' Equity): The company's retained earnings (the increase in equity that has resulted from profitable operations) and, often, outside sources of equity such as capital donations, affiliate transfers, and in the case of investor-owned hospitals, amounts raised by issuing stock.
- Net Operating Income:** The amount by which total operating revenues exceed total operating expenses for an accounting period.
- Net Patient Service Revenue (NPSR):** The total amount of money the hospital receives after deducting charity care and contractual adjustments.
- Operating Revenue:** The primary way in which an organization makes money. For hospitals, it is money made by delivering patient care.
- Other Operating Revenue:** Money a hospital makes by providing services that are ongoing business activities, but that are not directly related to the hospital's main mission of delivering patient care.
- Owners' Equity:** See *Net Assets*.

**Payment:** The cash amount a hospital actually receives for its services. Private insurers, public insurers, and the uninsured all pay different amounts for the same services. Payment can be either more or less than what it costs the hospital to provide a given service.

**Per Diem Payment:** Fixed daily payments that do not vary with the level of services used by the patient.

**Point of Service (POS):** A managed care plan that combines features of both prepaid and fee-for-service insurance. Health plan enrollees decide whether to use network of nonnetwork providers at the time care is needed and usually are charged a greater amount for selecting the latter.

**Preferred Provider Organization (PPO):** A managed care plan that contracts with networks or panels of providers to furnish services and be paid on a negotiated fee schedule. Enrollees are offered a financial incentive to use providers on the preferred list, but may use nonnetwork providers as well.

**Profit:** The difference between revenue and expenses in addition to nonoperating gains and losses. Sometimes referred to as the hospital's bottom line or excess revenues over expenses.

**Prospective Payment System:** A method of paying health care providers in which rates are established in advance. Providers are paid these rates regardless of the costs they actually incur.

**Ratios:** (See page 30 of the text for descriptions of ratios commonly used for hospital analysis.)

**Resource-Based Relative Value Scale:** This method is used to evaluate the relative costs of the resources needed to deliver services and procedures and to relate those costs to the costs of any other medical service or procedure.

**Revenue:** The income resulting from an organization's activities.

**Self-Payers:** Include patients that are not covered by health insurance. These patients pay the costs of medical expenses out of pocket.

**Transfers to and from Affiliates:** Hospitals that are affiliated with other hospitals or entities often transfer funds to and from one another. These transfers of funds are recorded both as a change in net assets on the income statement (separate from the hospital's bottom line) and as an item on the Cash Flow Statement.

**Uncompensated Care:** Charity care provided to persons who are uninsured and bad debts from underinsured persons who are unable to pay the deductibles and coinsurance that are part of their insurance arrangements.

