



CHAPTER 1

Financial Information and the Decision-Making Process

LEARNING OBJECTIVES

After studying this chapter, you should be able to do the following:

1. Describe the importance of financial information in healthcare organizations.
2. Discuss the uses of financial information.
3. List the users of financial information.
4. Describe the financial functions within an organization.
5. Discuss the common ownership forms of healthcare organizations, along with their advantages and disadvantages.

REAL-WORLD SCENARIO

In 1946, a small band of hospital accountants formed the American Association of Hospital Accountants (AAHA). They were interested in sharing information and experiences in their industry, which was beginning to show signs of growth. First published in 1947, a small educational journal was created in an attempt to disseminate information of interest to their members. Ten years later in 1956, the AAHA's membership had grown to over 2,600 members. The real growth, however, was still to come with the advent of Medicare financing in 1965.

With the dramatic growth of hospital revenues came an escalation in both the number and functions delegated to the hospital accountant. Hospital finance had become much more than just billing patients and paying invoices. Hospitals were becoming big businesses with complex and varied financial functions. They had to arrange funding of major capital programs, which could no longer be supported through charitable campaigns. Cost accounting and management control were important functions for the continued financial viability of their firms. Hospital accountants soon evolved into hospital financial managers, and so in 1968 the AAHA changed its name to the Hospital Financial Management Association (HFMA).

The hospital industry continued to boom through the late 1960s and 1970s. Third-party insurance became the norm for most of the American population. Patients either received insurance through governmental programs

Opener image: Shutterstock / A1Stock

such as Medicare and Medicaid or obtained it as part of the benefit program at their place of employment. Hospitals were clearly no longer quite as charitable as they once were. There was money, and plenty of it, to finance the growth required through increased demand and the new evolving medical technology. By 1980, HFMA was a large association with 19,000 members. Primary offices were located in Chicago, but an important office was opened in Washington, DC, to provide critical input to both the executive and legislative branches of government. On many issues that affected either government payment or capital financing, HFMA became the credible voice that policymakers sought.

The industry adapted and evolved even more in the 1980s as fiscal pressure hit the federal government. Hospital payments were increasing so fast that new systems were sought to curtail the growth rate. Prospective payment systems were introduced in 1983, and alternative payment systems were developed that provided incentives for treating patients in an ambulatory setting. Growth in the hospital industry was still rapid, but other sectors of health care began to experience colossal growth rates, such as ambulatory surgery centers. More and more, health care was being transferred to the outpatient setting. The hospital industry was no longer the only large corporate player in health care. To acknowledge this trend, the HFMA changed its name in 1982 to the Healthcare Financial Management Association to reflect the more diverse elements of the industry and to better meet the needs of members in other sectors.

In 2015, HFMA had over 39,000 members in a wide variety of healthcare organizations (HCOs). The daily activities of their members still involve basic accounting issues—patient bills must still be created and collected, payroll still needs to be met—but strategic decision-making is much more critical in today's environment. It would be impossible to imagine any organization planning its future without financial projections and input. Many HCOs may still be charitable from a taxation perspective, but they are too large to depend upon charitable giving to finance their business future. Financial managers of healthcare firms are involved in a wide array of critical and complex decisions that will ultimately determine the destiny of their firms.

This book is intended to improve decision makers' understanding and use of financial information in the healthcare industry. It is not an advanced treatise in accounting or finance but an elementary discussion of how financial information in general and healthcare industry financial information in particular are interpreted and used. It is written for individuals who are not experienced healthcare financial executives. Its aim is to make the language of healthcare finance readable and relevant for general decision makers in the healthcare industry.

Three interdependent factors have created the need for this book:

1. Rapid expansion and evolution of the healthcare industry
2. Healthcare decision makers' general lack of business and financial background
3. Financial and cost criteria's increasing importance in healthcare decisions

The healthcare industry's expansion is a trend visible even to individuals outside the healthcare system. The hospital industry, the major component of the healthcare industry, consumes about 5% of the gross domestic product; other types of healthcare systems, although smaller than the hospital industry, are expanding at even faster rates. **TABLE 1-1** lists the types of major healthcare institutions and indexes their relative size.

Learning Objective 1

Describe the importance of financial information in healthcare organizations.

The rapid growth of healthcare facilities providing direct medical services has substantially increased the numbers of decision makers who need to be familiar with financial information. Effective decision making in their jobs depends on an accurate interpretation of financial information. Many healthcare decision makers involved directly in healthcare delivery—doctors, nurses, dietitians, pharmacists, radiation technologists, physical therapists, inhalation therapists—are medically or scientifically trained but lack education and experience in business and finance. Their specialized education, in most cases, did not include courses such as accounting. However, advancement and promotion within HCOs increasingly entails assumption of administrative duties, requiring almost instant, knowledgeable reading of financial information. Communication with the organization's financial executives is not always helpful. As

TABLE 1-1 Health Care Expenditures 2008–2024*

Type of Expenditure	2008	2010	2012	2014	2016	2024
Hospital care	728.9	814.9	898.5	978.3	1,087.3	1,755.1
Physician and clinical services	486.5	519.0	565.3	615.0	666.5	1,034.8
Other professional services	64.0	69.8	76.8	85.5	96.0	155.4
Dental services	102.4	105.4	110.0	114.5	123.5	183.4
Other health, residential, and personal care	113.5	128.5	140.1	153.0	167.1	251.1
Home health care	62.3	71.2	77.1	81.9	91.7	156.0
Nursing care facilities and continuing care retirement communities	132.6	143.0	152.2	160.2	176.1	274.4
Prescription drugs	242.7	256.2	264.4	305.1	343.2	564.3
Durable medical equipment	34.9	37.0	41.3	44.2	48.2	76.9
Other non-durable medical products	49.5	51.2	53.7	58.4	62.6	98.7
Personal Health Care	2,017.3	2,196.2	2,379.4	2,596.1	2,862.2	4,550.1
Government administration	29.4	30.5	34.2	39.9	45.5	82.2
Net cost of private health insurance	140.7	152.3	165.3	200.4	235.4	384.3
Government public health activities	71.5	75.5	74.8	78.7	86.2	137.7
Health Consumption Expenditures	2,258.9	2,454.5	2,653.6	2,915.3	3,229.3	5,154.2
Research	44.0	48.7	48.0	45.9	48.7	72.0
Structures and equipment	111.2	101.0	115.7	118.9	124.7	198.9
National Health Expenditures	2,414.1	2,604.1	2,817.3	3,080.1	3,402.6	5,425.1
Gross Domestic Product	14,718.6	14,964.4	16,163.2	17,418.9	18,821.2	27,648.0
National Health Expenditures to GDP	16.4%	17.4%	17.4%	17.7%	18.1%	19.6%
Hospital Care to GDP	5.0%	5.4%	5.6%	5.6%	5.8%	6.3%

*Values are in US\$ in billions.

Centers for Medicare and Medicaid Services, Office of the Actuary

a result, nonfinancial executives often end up ignoring financial information.

Governing boards, which are significant users of financial information, are expanding in size in many healthcare facilities, in some cases to accommodate demands for more consumer representation. This trend can be healthy for both the community and the facilities. However, many board members, even those with backgrounds in business, are being overwhelmed by financial reports and statements. There are important distinctions between the financial reports and statements of business organizations, with which some board members are familiar, and those of healthcare facilities. Governing board members must recognize these differences if they are to carry out their governing missions satisfactorily.

The increasing importance of financial and cost criteria in healthcare decision making is the third factor creating a need for more knowledge of financial information. For many years, accountants and others involved with financial matters have been caricatured as individuals with narrow vision, incapable of seeing the forest for the trees. In many respects, this may have been an accurate portrayal. However, few individuals in the healthcare industry today would deny the importance of financial concerns, especially cost. Payment pressures from payers, as described in the beginning-of-chapter scenario, underscore the need for attention to costs. Careful attention to these concerns requires *knowledgeable* consumption of financial information by a variety of decision makers. It is not an overstatement to say that inattention to financial criteria can lead to excessive costs and eventually to insolvency.

The effectiveness of financial management in any business is the product of many factors, such as environmental conditions, personnel capabilities, and information quality. A major portion of the total financial management task is the provision of accurate, timely, and relevant information. Much of this activity is carried out through the accounting process. An adequate understanding of the accounting process and the data generated by it are thus critical to successful decision making.

► Information and Decision Making

The major function of information in general and financial information in particular is to oil the decision-making process. Decision making is basically the selection of a course of action from a defined list of

possible or feasible actions. In many cases, the actual course of action followed may essentially be no action; decision makers may decide to make no change from their present policies. It should be recognized, however, that both action and inaction represent policy decisions.

FIGURE 1-1 shows how information is related to the decision-making process and gives an example to illustrate the sequence. Generating information is the key to decision making. The quality and effectiveness of decision making depend on accurate, timely, and relevant information. The difference between data and information is more than semantic: Data become information only when they are useful and appropriate to the decision. Many financial data never become information because they are not viewed as relevant or are unavailable in an intelligible form.

For the illustrative purposes of the ambulatory surgery center (ASC) example in Figure 1-1, only two possible courses of action are assumed: to build or not to build an ASC. In most situations, there may be a continuum of alternative courses of action. For example, an ASC might vary by size or by facilities included in the unit. In this case, prior decision making seems to have reduced the feasible set of alternatives to a more manageable and limited number of analyses.

Once a course of action has been selected in the decision-making phase, it must be accomplished. Implementing a decision may be extremely complex. In the ASC example, carrying out the decision to build the unit would require enormous management effort to ensure that the projected results are actually obtained. Periodic measurement of results in a feedback loop, as in Figure 1-1, is a method commonly used to make sure that decisions are actually implemented according to plan.

As previously stated, results that are forecast are not always guaranteed. Controllable factors, such as

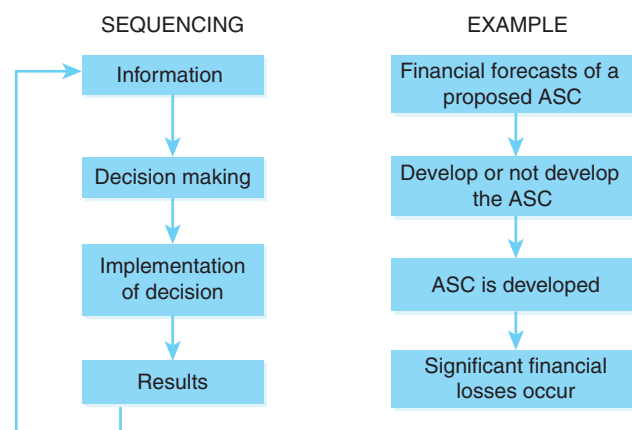


FIGURE 1-1 Information in the Decision-Making Process

TABLE 1-2 Results Matrix for the ASC

Alternative Actions	Possible Events (Utilization Percentages)		
	25% Usage	50% Usage	75% Usage
Build the ASC	\$400,000 loss	\$10,000 profit	\$200,000 profit
Do not build the ASC	0 profit	0 profit	0 profit

failure to adhere to prescribed plans, and uncontrollable circumstances, such as a change in reimbursement, may obstruct planned results.

Decision making is usually surrounded by uncertainty. No anticipated result of a decision is guaranteed. Events may occur that have been analyzed but not anticipated. A results matrix concisely portrays the possible results of various courses of action, given the occurrence of possible events. **TABLE 1-2** provides a results matrix for the sample ASC; it shows that approximately 50% utilization will enable this unit to operate in the black and not drain resources from other areas. If forecasting shows that utilization below 50% is unlikely, decision makers may very well elect to build.

A good information system should enable decision makers to choose those courses of action that have the highest expectation of favorable results. Based on the results matrix of Table 1-2, a good information system should specifically

- List possible courses of action.
- List events that might affect the expected results.
- Indicate the probability that those events will occur.
- Estimate the results accurately, given an action/event combination (e.g., profit in Table 1-2).

One thing an information system does not do is evaluate the desirability of results. Decision makers must evaluate results in terms of their organizations' preferences or their own. For example, construction of an ASC may be expected to lose \$400,000 per year, but it could provide a needed community service. Weighing these results and determining criteria is purely a decision maker's responsibility—not an easy task, but one that can be improved with accurate and relevant information.

Learning Objective 2

Discuss the uses of financial information.

► Uses and Users of Financial Information

As a subset of information in general, financial information is important in the decision-making process. In some areas of decision making, financial information is especially relevant. For our purposes, we identify five uses of financial information that may be important in decision making:

1. Evaluating the *financial condition* of an entity
2. Evaluating *stewardship* within an entity
3. Assessing the *efficiency* of operations
4. Assessing the *effectiveness* of operations
5. Determining the *compliance* of operation with directives

Financial Condition

Evaluation of an entity's financial condition is probably the most common use of financial information. Usually, an organization's financial condition is equated with its viability or capacity to continue pursuing its stated goals at a consistent level of activity. Viability is a far more restrictive term than solvency; some HCOs maybe solvent but not viable. For example, a hospital may have its level of funds restricted so that it must reduce its scope of activity but still remain solvent. A reduction in payment rates by a major payer may be the vehicle for this change in viability.

Assessment of the financial condition of business enterprises is essential to our economy's smooth and efficient operation. Most business decisions in our economy are directly or indirectly based on perceptions of financial condition. This includes the largely nonprofit healthcare industry. Although attention is usually directed at organizations as whole units, assessment of the financial condition of organizational divisions is equally important. In the ASC

example, information on the future financial condition of the unit is valuable. If continued losses from this operation are projected, impairment of the financial condition of other divisions in the organization could be in the offing.

Assessment of financial condition also includes consideration of short-run versus long-run effects. The relevant time frame may change, depending on the decision under consideration. For example, suppliers typically are interested only in an organization's short-run financial condition because that is the period in which they must expect payment. However, investment bankers, as long-term creditors, are interested in the organization's financial condition over a much longer time period.

Stewardship

Historically, evaluation of stewardship was the most important use of accounting and financial information systems. These systems were originally designed to prevent the loss of assets or resources through employees' malfeasance. This use is still very important. In fact, the relatively infrequent occurrence of employee fraud and embezzlement may be due in part to the deterrence of well-designed accounting systems.

Efficiency

Efficiency in healthcare operations is becoming an increasingly important objective for many decision makers. Efficiency is simply the ratio of outputs to inputs, not the quality of outputs (good or not good) but the lowest possible cost of production. Adequate assessment of efficiency implies the availability of standards against which actual costs may be compared. In many HCOs, these standards may be formally introduced into the budgetary process. Thus a given nursing unit may have an efficiency standard of 4.3 nursing hours per patient day of care delivered. This standard may then be used as a benchmark to evaluate the relative efficiency of the unit. If actual employment were 6.0 nursing hours per patient day, management would be likely to reassess staffing patterns.

Effectiveness

Assessment of the effectiveness of operations is concerned with the attainment of objectives through production of outputs, not the relationship of outputs to cost. Measuring effectiveness is much more difficult than measuring efficiency because most organizations' objectives or goals are typically not stated quantitatively. Because measurement of effectiveness is

difficult, there is a tendency to place less emphasis on effectiveness and more on efficiency. This may result in the delivery of unnecessary services at an efficient cost. For example, development of outpatient surgical centers may reduce costs per surgical procedure and thus create an efficient means of delivery. However, the necessity of those surgical procedures may still be questionable.

Compliance

Finally, financial information may be used to determine whether compliance with directives has taken place. The best example of an organization's internal directives is its budget, an agreement between two management levels regarding use of resources for a defined time period. External parties may also impose directives, many of them financial in nature, for the organization's adherence. For example, rate-setting or regulatory agencies may set limits on rates determined within an organization. Financial reporting by the organization is required to ensure compliance.

Learning Objective 3

List the users of financial information and their uses for it.

TABLE 1-3 presents a matrix of users and uses of financial information in the healthcare industry. It identifies areas or uses that may interest particular decision-making groups. It does not consider relative importance.

Not every use of financial information is important in every decision. For example, in approving a HCO's rates, a governing board may be interested in only two uses of financial information: (1) evaluation of financial condition and (2) assessment of operational efficiency. Other uses may be irrelevant. The board wants to ensure that services are being provided efficiently and that the rates being established are sufficient to guarantee a stable or improved financial condition. As Table 1-3 illustrates, most healthcare decision-making groups use financial information to assess financial condition and efficiency.

Financial Organization

It is important to understand the management structure of businesses in general and HCOs in particular. **FIGURE 1-2** outlines the financial management structure of a typical hospital.

TABLE 1-3 Users and Uses of Financial Information

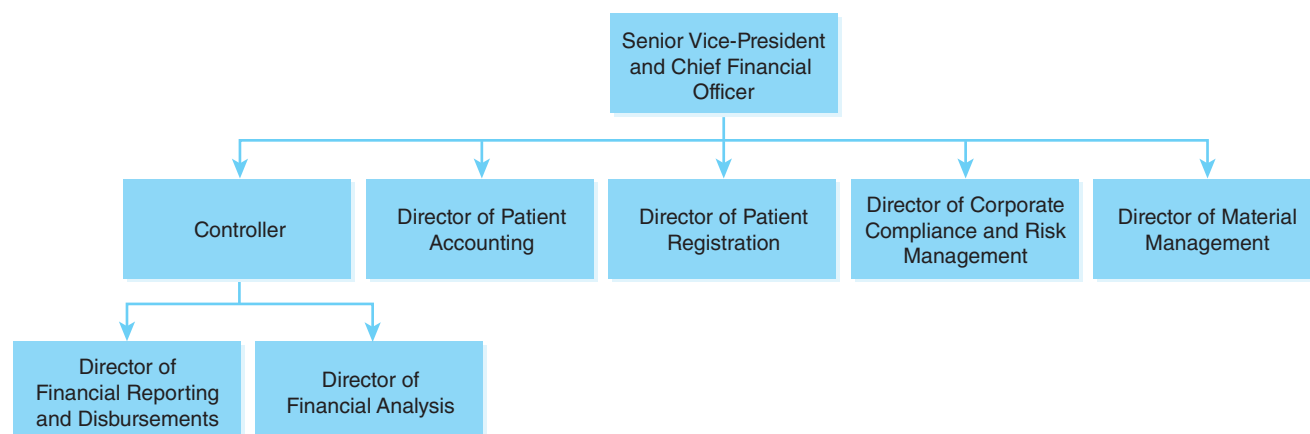
Users	Uses of Financial Information				
	Financial Condition	Stewardship	Efficiency	Effectiveness	Compliance
External					
Healthcare coalitions	X		X	X	
Unions	X		X		
Rate-setting organizations	X		X	X	X
Creditors	X		X	X	
Third-party payers	X		X	X	
Suppliers	X			X	
Public	X		X	X	
Internal					
Governing board	X	X	X	X	X
Top management	X	X	X	X	X
Departmental management			X		

Learning Objective 4

Describe the financial functions within an organization.

Financial Executives International has categorized financial management functions as either

controllanship or treasurership. Although few HCOs have specifically identified treasurers and controllers at this time, the separation of duties is important to the understanding of financial management. The following describes functions in the two categories designated by Financial Executives International, along

**FIGURE 1-2** Financial Organization Chart of a Typical Hospital

with an example of the type of activities conducted within each of these functions:

1. Controllership
 - (a) Planning for control: Establish budgetary systems (Chapters 13 and 16)
 - (b) Reporting and interpreting: Prepare financial statements (Chapter 9)
 - (c) Evaluating and consulting: Conduct cost analyses (Chapter 14)
 - (d) Administering taxes: Calculating payroll taxes owed
 - (e) Reporting to government: Submit Medicare bills and cost reports (Chapter 2 and 6)
 - (f) Protecting assets: Develop internal control procedures
 - (g) Appraising economic health: Analyze financial statements (Chapters 11 and 12)
2. Treasurership
 - (a) Providing capital: Arrange for bond issuance (Chapter 21)
 - (b) Maintaining investor relations: Assist in analysis of appropriate dividend payment policy (for-profit firms) (Chapters 20 and 21)
 - (c) Providing short-term financing: Arrange lines of credit (Chapters 22 and 23)
 - (d) Providing banking and custody: Manage overnight and short-term funds transfers (Chapters 22 and 23)
 - (e) Overseeing credits and collections: Establish billing, credit, and collection policies (Chapters 2 and 22)
 - (f) Choosing investments: Analyze capital investment projects (Chapter 19)
 - (g) Providing insurance: Managing funds related to self-insurance program

Learning Objective 5

Discuss the common ownership forms of healthcare organizations, along with their advantages and disadvantages.

► Forms of Business Organization

More so than in most other industries, firms in the healthcare industry consist of a wide array of ownership and organizational structures. In health care, there

are three main types organizations (adapted from the American Institute of Certified Public Accountants Audit and Accounting Guide *Health Care Organizations*, 2015):

- Not-for-profit, business-oriented organizations
- For-profit healthcare entities
 - Investor-owned
 - Professional corporations/professional associations
 - Sole proprietorships
 - Limited partnerships
 - Limited liability partnerships/limited liability companies
- Governmental healthcare organizations

These three main types of firms differ in terms of ownership structure. Additionally, different HCOs require slightly different sets of financial statements.

Not-for-Profit, Business-Oriented Organizations

Not-for-profit HCOs are owned by the entire community rather than by investor-owners. Unlike its for-profit counterpart, the primary goal of a not-for-profit (also referred to as a nonprofit) organization is not to maximize profits, but to serve the community in which it operates through the healthcare services it provides. Not-for-profit HCOs must be run as a business, however, in order to ensure their long-term financial viability. With an annual budget of more than \$20 billion, Ascension Healthcare is an example of one of the largest not-for-profit HCOs.

Not-for-profit organizations (described in Sec. 501(c)(3) of the Internal Revenue Code) usually are exempt from federal income taxes and property taxes. In return for this favorable tax treatment, not-for-profit organizations are expected to provide **community benefit**, which often comes in the form of providing more uncompensated care (vis-à-vis for-profit firms), setting lower prices, or by offering services that, from a financial perspective, might not be viable for for-profit firms. In addition to patient revenue in excess of expenses, not-for-profits can additionally be funded by tax-exempt debt, grants, donations, and investments by other nonprofit firms.

The primary advantage of the not-for-profit form of organization is its tax advantage. It also typically enjoys a lower cost of equity capital compared with for-profit firms. The main disadvantage of this form of organization is that not-for-profits have more limited access to capital. Nonprofits cannot raise capital in the equity markets.

While for-profit firms are becoming increasingly prevalent in many sectors of health care, not-for-profits still dominate the hospital sector. About 80 percent of hospitals are not-for-profit. In the future, however, this sector may witness the growth of investor-owned organizations, owing mainly to their easier access to capital that will be necessary for adapting to the rapid changes in the healthcare system.

For-Profit Healthcare Entities

The main objective of most for-profit firms is to earn profits that are distributed to the investor-owners of the firms or reinvested in the firm for the long-term benefit of these owners.

For-profit hospital management must strike a balance between their fiduciary responsibilities to the owners of the company and their other mission of providing acceptable-quality healthcare services to the community. For-profit firms have a wide variety of organization and ownership structures. For-profit firms that buy and sell shares of their company stocks on the open market are referred to as **publicly traded companies**. A major advantage of being publicly traded is the ability to raise equity capital through the sale of company stocks. Publicly traded firms are subject to reporting requirements and regulation by the Securities and Exchange Commission (SEC). For-profit firms may also be **privately held**, meaning the shares of the company are held by relatively few investors and are not available to the general public. Privately held companies also have far few reporting requirements to the SEC. Large for-profit firms are typically publicly traded. However, there are exceptions. For example, HCA, Inc. is a national for-profit healthcare services company headquartered in Nashville, Tennessee. Prior to 2005, HCA was the largest publicly traded hospital company. In 2005, HCA was purchased by a private equity firm and converted from a publicly traded to privately held company. HCA, Inc. returned to publicly traded status in 2010 and remains the largest for-profit hospital company, with 16 hospitals and 43,275 licensed beds. In its fiscal year ending December 31, 2015, the company had after-tax income of \$2.1 billion.

Both publicly traded and privately held for-profit firms are often referred to as “investor-owned” firms. **Investor-owned** firms are owned by risk-based equity investors who expect the managers of the corporation to maximize shareholder wealth. Most large for-profit firms use this legal form. Investor-owned firms have a relative advantage in terms of financing. In addition to debt, for-profit firms can raise funding through risk-based equity capital. They enjoy limited liability, but their earnings are taxed at both the

corporate level and the shareholder level (so-called double taxation). The company pays corporate income tax and the shareholder pays both tax on dividends paid by the company and gains made on the sale of the company's stock.

A **professional corporation (PC)**, also called a professional association (PA), is a corporate form for professionals who wanted to have the advantages of incorporation. A PC does not, however, shield its owners from professional liability. PCs and PAs have been widely used by physicians and other healthcare professionals.

Sole proprietorships are unincorporated businesses owned by a single individual. They do not necessarily have to be small businesses. Solo practitioner physicians often are sole proprietors. The main advantages are: easy and inexpensive to set up, no sharing of profits, total control, few government regulations, no special income taxes, and easy and inexpensive to dissolve. Its two main disadvantages are unlimited liability and limited access to capital.

Partnerships are unincorporated businesses with two or more owners. Group practices of physicians sometimes were set up using this form. There are now a wide variety of partnership forms. They are easy to form, are subject to few government regulations, and are not subject to double taxation. On the downside, partnerships have unlimited liability, are difficult to dissolve, and create potential for conflict among the partners.

In a **limited partnership** there is at least one general partner who has unlimited liability for the LP's debts and obligations. LPs offer limited liability to the limited partners along with tax flow-through treatment. The disadvantage to LPs is that they require a general partner who remains fully liable for the LP's debts and obligations.

A **limited liability company (LLC)**, also called a **limited liability partnership (LLP)**, is a business entity that combines the tax flow-through treatment characteristics of a partnership (i.e., no double taxation) with the liability protection of a corporation. In an LLC, the liability of the general partner is limited. LLCs are flexible in the sense that they permit owners to structure allocations of income and losses any way they desire, so long as the partnership tax allocation rules are followed.

Governmental Health Care Organizations

Governmental HCOs are public corporations, typically owned by a state or local government. They are operated for the benefit of the communities they serve. A variation on this type of ownership is the **public benefit**

organization. Assets (and accumulated earnings) of a nonprofit public benefit corporation belong to the public or to the charitable beneficiaries the trust was organized to serve. In 1999, for example, the Nassau County Medical Center (NCMC), a 1,500-bed health-care system on Long Island, New York, converted from county ownership to a public benefit corporation. The purpose of the conversion was to give NCMC greater autonomy in its governing board and decision making, so that it could compete more effectively with the area's large private hospitals and networks.

In some cases, governmental HCOs may have access to an additional revenue source through taxes—an option not available to other not-for-profit HCOs. Similar to other not-for-profits, government HCOs are not able to raise funds through equity investments and they are exempt from income taxes and property taxes.

Governmental HCOs can face political pressures if their earnings become too great. Rather than reinvesting their surplus in productive assets, the hospital

might be pressured to return some of the surplus to the community, to reduce prices, or to initiate programs that are not financially advisable.

► SUMMARY

The healthcare sector of our economy is growing rapidly in both size and complexity. Understanding the financial and economic implications of decision making has become one of the most critical areas encountered by healthcare decision makers. Successful decision making can lead to a viable operation capable of providing needed healthcare services. Unsuccessful decision making can and often does lead to financial failure. The role of financial information in the decision-making process cannot be overstated. It is incumbent on all healthcare decision makers to become accounting-literate in our financially changing healthcare environment.

ASSIGNMENTS

1. Only in recent years have hospitals begun to develop meaningful systems of cost accounting. Why did they not begin such development sooner?
2. Your hospital has been approached by a major employer in your market area to negotiate a preferred provider arrangement. The employer is seeking a 25 percent discount from your current charges. Describe a structure that you might use to summarize the financial implications of this decision. Describe the factors that would be critical in this decision.
3. What type of financial information should be routinely provided to board members?

SOLUTIONS AND ANSWERS

1. Prior to 1983, most hospitals were paid actual costs for delivering hospital services. With the introduction of Medicare's prospective payment system for inpatient care in 1983 and outpatient care in 2000, hospitals now receive prices based on diagnosis-related groupings and ambulatory patient classifications that are fixed in advance. Cost control and, therefore, cost accounting are critical in a fixed-price environment. The expansion of managed care has further restricted revenue and fostered greater interest in costing.
2. This problem could be set up in results matrix (see Table 1-2). The two actions to be charted are to accept or to reject the preferred provider arrangement opportunity. Possible events would center on the magnitude of volume changes, for example, to lose 1,000 patient days or to gain 500 patient days. A key concern in estimating the financial impact would be the hospital's incremental revenue and incremental cost positions. In short, how large would the revenue reduction and cost reduction be if significant volume were lost? Actuarial gains or losses of business would be functions of the hospital's market position.
3. Board members do not need to see detailed financial information that relates to their established plans to ensure that the plans are being met. If significant deviations have occurred more details may be necessary to take corrective action or to modify established plans.

References

Nicholson, S., Pauly, M. V., Burns, L. R., Baumritter, A., & Asch, D. A. (2000). Measuring community benefits provided by for-profit and nonprofit hospitals. *Health Affairs*, 19(6), 168.