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 and their uses for it.
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. By 1975, there were nearly 7,200 hospitals across the United States. As of the writing of this text, there are just over 6,000 hospitals in the United States. Over that same period the population has grown by nearly 120 million people. Demand for services has increased, but availability of those services has decreased, highlighting the complexity of managing these organizations. Third-party insurance became the norm for most of the American population. Health maintenence organizations (HMO) and preferred provider organizations (PPO) gained in popularity in the 1980s and 1990s,

becoming the private insurance options of choice. Patients either received insurance through governmental programs 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. Up until that time Medicare reimbursed on a cost basis, thus there was no incentive to manage costs or conduct strategic financial management. With the switch in reimbursement methodology, financial efficiencies became key to success. 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 majority of a hospital's revenue used to come from inpatient admissions, with a high of nearly 70% at one point. However, outpatient revenue has been growing into a larger share at close to one-half of all hospital revenue over the last several years. Currently the majority of the revenue of hospitals comes from outpatient services, in some cases nearly 60% to 65% of the revenue. 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 2022, HFMA had over 75,000 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. Other organizations that are focused on other functional and cross-functional areas within health care, such as the American College of Healthcare Executives (ACHE) and Healthcare Information and Management Systems Society (HIMSS), have expanded their areas of focus to also include financial management. In order to be successful, financial leaders have must have a broad knowledge base, including expertise in operational areas, performance improvement, and quality. Today's healthcare financial leaders need to be more well-rounded than ever before while still providing specific finance-related expertise within their organizations.

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 text 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. For healthcare organizations to be successful in the future, key stakeholders need to possess foundational and specialized financial knowledge, and this text is designed to provide information on a wide range of topics to provide that foundation.

Three interdependent factors have created the need for this text:

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 6.4% 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.

Table 1.1 Healthcare Expenditures 2008–2028*

Type of Expenditure	2008	2010	2012	2014	2016	2020	2024	2028
Hospital care	728.9	814.9	898.5	978.3	1,035.4	1,270.1	1,601.1	2,002.4
Physician and clinical services	486.5	519.0	565.3	615.0	675.3	809.5	1,016.3	1,267.5
Other professional services	64.0	69.8	76.8	85.5	92.2	117.4	148.5	182.6
Dental services	102.4	105.4	110.0	114.5	126.2	142.4	182.2	214.0
Other health, residential, and personal care	113.5	128.5	140.1	153.0	175.0	208.8	256.7	316.4
Home health care	62.3	71.2	77.1	81.9	93.7	123.7	148.9	198.0
Nursing care facilities and continuing care retirement communities	132.6	143.0	152.2	160.2	161.6	196.8	207.9	250.3
Prescription drugs	242.7	256.2	264.4	305.1	313.3	348.4	418.6	511.3
Durable medical equipment	34.9	37.0	41.3	44.2	50.6	54.9	65.6	80.7
Other nondurable medical products	49.5	51.2	53.7	58.4	71.9	85.7	104.4	125.6
Personal Health Care	**2,017.3**	**2,196.2**	**2,379.4**	**2,596.1**	**2,795.3**	**3,357.8**	**4,150.1**	**5,148.8**
Government administration	29.4	30.5	34.2	39.9	44.0	48.4	61.3	76.3
Net cost of private health insurance	140.7	152.3	165.3	200.4	210.2	301.4	345.2	439.4
Government public health activities	71.5	75.5	74.8	78.7	90.0	223.7	155.8	152.0
Health Consumption Expenditures	**2,258.9**	**2,454.5**	**2,653.6**	**2,915.3**	**3,139.5**	**3,931.3**	**4,712.5**	**5,816.5**
Research	44.0	48.7	48.0	45.9	47.5	60.2	77.5	94.7
Structures and equipment	111.2	101.0	115.7	118.9	118.6	132.5	172.1	209.8
National Health Expenditures	**2,414.1**	**2,604.1**	**2,817.3**	**3,080.1**	**3,305.6**	**4,124.0**	**4,962.1**	**6,120.9**
Gross Domestic Product	**14,718.6**	**14,964.4**	**16,163.2**	**17,418.9**	**18,695.1**	**20,893.7**	**27,048.1**	**31,886.5**
National Health Expenditures to GDP	**16.4%**	**17.4%**	**17.4%**	**17.7%**	**17.7%**	**19.7%**	**18.3%**	**19.2%**
Hospital Care to GDP	**5.0%**	**5.4%**	**5.6%**	**5.6%**	**4.7%**	**6.4%**	**5.6%**	**5.9%**

* Values are in US$ in billions.
Abbreviation: GDP, gross domestic product
Data from Centers for Medicare and Medicaid Services, Office of the Actuary

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, nurse practitioners, physician assistants, respiratory 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 or revenue cycle management. However, advancement and promotion within HCOs increasingly entails assumption of administrative duties, requiring almost

instant, knowledgeable reading and use of financial information. Communication with the organization's financial executives is not always helpful. As a result, nonfinancial executives often end up ignoring financial information. This creates a gap in communication that can become detrimental to the financial success of a HCO. Financial leaders often lack the clinical and operational knowledge, just as the clinical experts may lack the financial knowledge. These leaders need to rely on each other and educate one another to work as a cohesive team. The more one group understands the other, the more successful the HCO will be and the better the decision making.

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. Although some may have business backgrounds, they may have yet to learn the nuances and challenges specific to healthcare finance. 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. This is one of the reasons why healthcare executives also require a breadth of healthcare-specific financial knowledge.

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, with the constant battle of lowering costs and increasing revenue. 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 financial management process. An adequate understanding of the accounting process, strategic finance, revenue cycle management, 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. It is also critical to understand that the quality of data utilized in that decision making can make or break a HCO. If the quality of the data utilized is poor or is based on inappropriate assumptions, the HCO and its leaders could make incorrect 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. HCOs have a wealth of data; however, the conversion of that data to actional information can be a struggle. Healthcare leaders must not only have reliable data but also be able to ask the right questions. 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

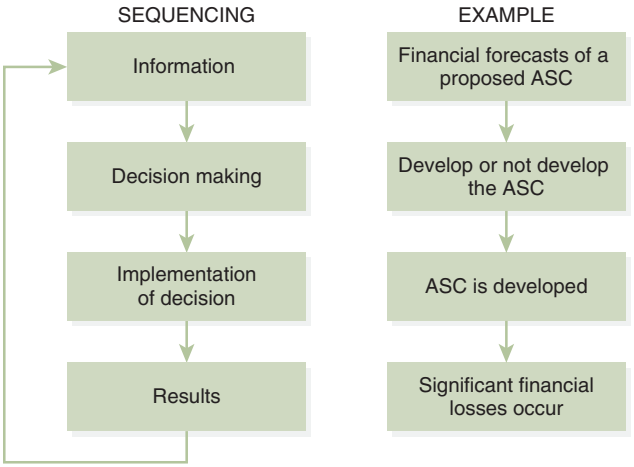

Figure 1.1 Information in the Decision-Making Process

Table 1.2 Results Matrix for the ASC

	Possible Events (Utilization Percentages)		
Alternative Actions	**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

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. The other critical portion to keep in mind is ongoing financial viability. Once the decision to move forward with the ASC has been made, constant review of the financials and key performance indicators is critical to ensure that the ASC is operating the way it was intended. Financial deviations will occur, and knowing how to handle them when they do will increase the chance of long term success.

As previously stated, results that are forecasted are based on a variety of assumptions and are not always guaranteed. Controllable factors, such as 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 at 50% utilization, the organization will 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. Although not building the ASC does not generate a profit, it is important to keep in mind that if no ASC is built, then no expenses will be incurred toward the ASC as well. The leadership also needs to be mindful of opportunity cost given that the funds will be allocated toward this project instead of another potential worthy endeavor.

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, do the following:

- 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 are purely a decision maker's responsibility—not an easy task, but one that can be improved with accurate and relevant information. Thus it is imperative to realize that the financial component of the decision making is just that, a single component. There are many factors that need to be weighed and balanced, including community benefit, in order to make the best decision for the HCO. Community benefit is discussed in Chapter 5.

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. This could be equated to the idea of no mission without a margin. If the HCO does not maintain its financial viability, it will not be able to provide the community benefit that it is intended to provide. Viability is a far more restrictive term than solvency; some HCOs may be 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. This can equate to the closing of departments, elimination of product lines, reduction in staff, and other drastic cost-cutting measures. A reduction in payment rates by a major payer may be the vehicle for this change in viability. Product or service lines that were once financially viable may no longer be viable with changes in reimbursement methodologies and reductions in revenue that occur over time and as part of the shifting U.S. healthcare policy landscape. Shifts in payer mix that also occur due to an aging population (i.e., the shift from private insurance to Medicare by a large aging segment of the population) could create a reduction in revenue based on the lower reimbursement rates.

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. Oftentimes decisions are made based on perceptions or anecdotal understandings of the financial impact. Although attention is usually directed at organizations as whole units, assessment of the financial condition of organizational divisions, departments, product lines, or other categorizations is equally if not more important. An HCO is more than the sum of its parts, but the interconnectedness of how those units function makes the understanding of their financial impact even more imperative. 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 period. Other stakeholders such as physicians, patients, insurance providers, and the community as a whole are also reliant on the long-run financial viability of the HCOs.

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. Financial stewardship is now becoming more predominantly featured in HCOs' respective mission statements, values, and other directional strategies. Operating within a challenging and competitive environment with increasing costs and reductions in revenue also necessitates the practice of financial stewardship by everyone in the organization. The funds available must be used to generate the greatest positive impact possible.

Efficiency

Efficiency in healthcare operations is becoming an increasingly important objective for many decision makers. Efficiency in its simplest definition is the ratio of outputs to inputs, not the quality of outputs (good or not good). Generating the most output with the least amount of inputs achieves efficiency. In other terms, greater efficiency is achieved by maximizing the outcome with the least resources possible. 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, oftentimes in the form of target hours or dollars over a unit of service. 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 was 6.0 nursing hours per patient day, management would be likely to reassess staffing patterns. In this example, you can see that it required additional inputs (nursing hours) to generate the output, thus creating inefficiency. Another example would be physician compensation per worked relative value unit (wRVU). If the cost per unit is higher, it indicates that the compensation for the provider is higher than the worked performed, thus potentially creating inefficiency.

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. However, this is changing across the industry as net operating income (NOI) or earnings before interest depreciation and amortization (EBITDA) and similar financial outcomes are being prioritized in the HCO's goals. 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. The growth of value-based care initiatives and the increased focus on quality-based targets are creating a shift in the industry. Having reimbursement tied to outcomes such as readmissions, return to the emergency department (ED), overutilization of the ED, underutilization of primary care providers, etc., could begin to drive financial management toward including more of an effectiveness focus.

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 period. Although a budget is developed based on assumptions at a given time, it depicts a clear plan based on what can possibly be accomplished with the resources available. Another tool utilized is the long-range financial plan. This view looks at a 3- or 5-year (typically) view of the HCO's financials. 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. This has become increasingly important with the onset of Accountable Care Organizations (ACOs), integrated delivery systems, virtual integration, and organizations taking on more risk-based agreements. Hospitals are now also required to provide pricing information to the public on an annual basis or face substantial financial penalties. (Long-range financial plans are discussed in Chapter 13.)

LEARNING OBJECTIVE 3

List the users of financial information and their uses of 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 an 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. However, understanding the importance of which tools to utilize is critical to strategic decision making. 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.

Table 1.3 Users and Uses of Financial Information

	Uses of Financial Information				
Users	**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	X
Internal					
Governing board	X	X	X	X	X
Top management	X	X	X	X	X
Departmental management		X	X	X	

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.

LEARNING OBJECTIVE 4

Describe the financial functions within an organization.

Financial Executives International has categorized financial management functions as either controllership 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 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)

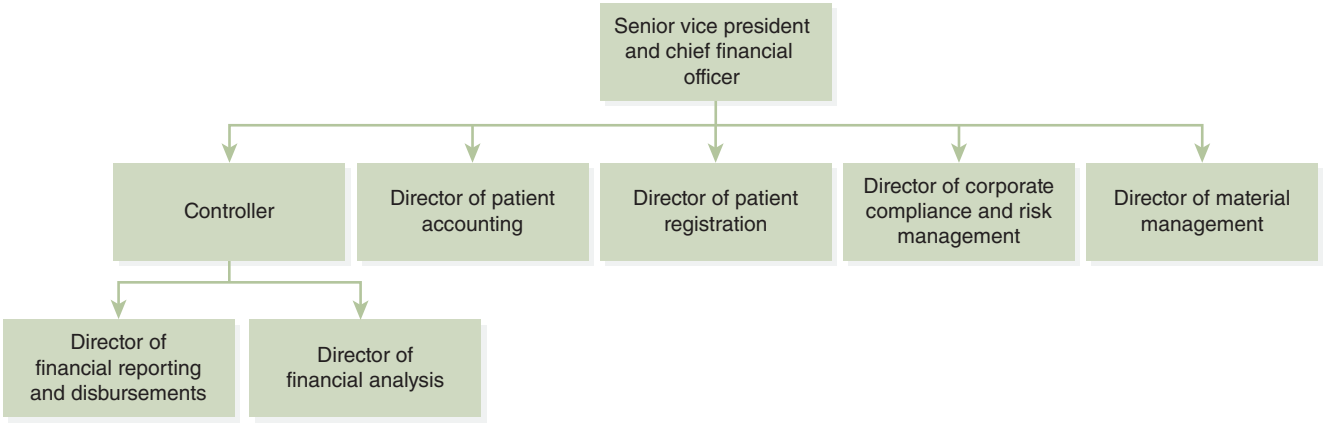

Figure 1.2 Financial Organization Chart of a Typical Hospital

   b. Reporting and interpreting: Prepare financial statements (Chapter 9)
   c. Evaluating and consulting: Conduct cost analyses (Chapter 14)
   d. Administrating taxes: Calculate 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: Manage 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. The increasingly complex set of organization structures utilized to deliver care can make it challenging to plan for, understand, and ensure financial viability. For example, hospitals continue to merge together, creating larger health systems, while insurance providers have begun owning provider-based organizations. Insurance providers have even merged with large chain pharmacies, further complicating how we understand and classify organizations. The healthcare landscape in terms of business ownership will continue to evolve as the pressures to maintain financial viability continue. In health care, there are three main types of 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 necessarily 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 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. As of 2020, approximately 58% of hospitals are not-for-profit with another 19% being controlled by state, county, or city governments. In the future, however, this sector may witness the continued 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. This trend may also continue as we see more vertical integration occurring from other nonhospital-based healthcare organizations such as insurance providers, pharmaceutical companies, and medical groups.

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 hospitals currently make up nearly 24% of hospitals across the United States.

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 184 hospitals and over 2,000 sites of care. In its fiscal year ending December 31, 2021, the company had after-tax income of $7.7 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 setup, 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 (LP)** 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 Healthcare Organizations

Governmental HCOs are public corporations, typically owned by a state or local government. These types of hospital make up about 19% of the hospitals across the United States. 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 healthcare 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. Another common version of a governmental HCO is an organization that is owned and operated by a state university. For example, Ohio State University, University of Missouri, and other public universities own and operate large HCOs.

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 regardless of their role. 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% 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?
4. Explain the importance of healthcare leaders developing high levels of financial knowledge and understanding regardless of being in a financial position (i.e., an accountant or chief financial officer).
5. Explain the difference between efficiency and effectiveness. Which is more difficult to define in financial terms and why?
6. Explain the trend in healthcare service delivery as it relates to outpatient versus inpatient services revenue.

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 a 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.
4. A number of factors necessitate healthcare leaders developing and leveraging financial information, including the rapid expansion and evolution of the healthcare industry, the general lack of business and financial background prevalent amongst some decision makers, and financial and cost criteria's increasing importance in healthcare decisions. The interconnected nature of departments and functional units requires that healthcare leaders understand the financial impact of their decisions and how to most efficiently and effectively operate within their various areas. As summarized in the text, there can be no mission (no organization, no services, no community benefit) without a margin. If the HCO does not maintain its financial viability, it will not be able to provide the community benefit that it is intended to provide.
5. Efficiency is the ratio of inputs to outputs, while effectiveness is the organization's ability to meet its goals or objectives. Efficiency can usually be calculated quantitatively by dividing an input, such as staff hours, by an output, such as laboratory tests performed. Measuring organizational effectiveness can be more difficult than measuring efficiency because most organizations' objectives or goals are typically not stated quantitatively. That is to say that objectives may not be stated in clear measurable terms or in a manner that allows an organization to say a goal is clearly met or not.
6. Over time, health care has been transferring to the outpatient setting, with more and more procedures being performed without requiring an overnight stay than ever before. The majority of a hospital's revenue has historically been from inpatient stays; however, outpatient revenue has been growing into a larger share of total organization revenue.

References

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