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

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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
Web site:
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*

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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.

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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 pro- viding services that address the community's unfunded healthcare needs. These services, often called community benefits, include charity care, health promotion, prevention and screening programs, building community infrastructure to address social determinants, and other services that target vulnerable communities in the hospital or health system service area. 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? (removed in 2020- important but must be a current assessment)

These are just a few of the questions that this guide will explore. The guide is divided into the following sections:

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, hospice, 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. As of 2020, 19 percent of nonfederal community hospitals are state or locally owned (county, city, tax district) hospitals
- **Private, not-for-profit hospitals** are nongovernment entities organized for the sole purpose of providing health care. Roughly 57 percent of nonfederal community hospitals are private 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 local property and sales tax.
- The remaining 25 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 are expected to pay taxes.

Other Providers

- **Physicians** may practice general medicine or specialize in a particular area. Some physicians are employed by insurers or health systems while others may have private practices in the com- munity.
- **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 which cannot be managed in the home.
- **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—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 effectively substitute for traditional inpatient hospital care and other treatments.
- **Hospices** provide end-of-life palliative care to patients with terminal illnesses. They focus on controlling pain and addressing emotional and spiritual needs to improve the quality of life.

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, which often directly subsidize public hospitals with local taxes not tied to a specific patient receiving services. 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, and sometimes by state laws.

Public Payers

Medicare

Medicare is administered by the Centers for Medicare and Medicaid Services (CMS). This federal health program is for seniors and some disabled people, including those with End Stage Renal Disease (ESRD). All seniors over the age of 65 are eligible for Medicare benefits, regardless of income.

Medicare Part A covers eligible institutional (hospital and skilled nursing) as well as hospice and some home care 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. Medicare Part D covers outpatient drugs through private insurance companies only.

Medicare Part C is the Medicare Advantage program which pays premiums to private managed care companies to provide Medicare Parts A, B, and D as well as other benefits to Medicare beneficiaries. Roughly 30% of Medicare beneficiaries are enrolled in Medicare Advantage plans as of 2020.

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. Medicaid in each state determines how to pay providers, and in most states, Medicaid contracts with private health plans to manage the benefits of Medicaid recipients in exchange for paying a premium to the plan.

Private Payers

Health Maintenance Organization (HMO)

An HMO is a managed care organization (MCO) that provides members with a comprehensive set of services through its provider network of member per month (capitation) fee. HMOs generally limit patients to seeing only in-network providers and may include "gatekeeper" physicians who authorize specialized and referral services. They may provide **utilization review** to ensure that services rendered are appropriate and develop provider networks at discounted rates that may or may not involve financial risk-sharing with the providers. If patient seek services outside of the HMO provider network, the HMO may not pay for those services.

Preferred Provider Organization (PPO)

A PPO is a managed care plan that contracts with networks or panels of providers to furnish services that are 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. Prior authorization may be required for coverage out-of-network. A few plans are hybrid "POS" plans that are HMO's with more limited out-of-network choice than a PPO.

Indemnity

Indemnity insurance policies are traditional health insurance plans in which members are free to choose any provider forcovered services but are also 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 choice restrictions within covered benefits. Very few people are enrolled in indemnity plans in the US, as they have become prohibitively expensive.

High-Deductible Health Plans (HDHP), with or without a Health Savings Account (HSA). All of the above plan types may be offered with a range of deductibles; the higher the deductible, the cheaper the monthly premium. A rising percentage of workers whose employers help pay for coverage are in HDHP plans. Some employers may offer the opportunity for workers to create an HSA, and may assist in funding the HSA, to help pay for the deductible.

Trends in private health insurance enrollment, costs and benefits are tracked by the Kaiser Family Foundation; the most recent report as of 2020 is here: https://www.kff.org/health-costs/report/2019-employer-health- benefits-survey/

Uninsured Individuals

Self-Pay

Self-pay patients include the population that is not covered by health insurance. As the name implies, these patients pay for medical expenses out of pocket, unless they are eligible for charity care. The Affordable Care Act (2010) limits the amount that hospitals can charge these patients and what not-for-profit hospitals can do to collect those charges. These limits generally do not apply to investor-owned health systems.

Some states require that hospitals extend to uninsured patients charity care and / or sliding scale discounts based on a state-determined level of income, usually expressed as a percentage of Federal Poverty Level (FPL). Other states leave it to hospitals/health systems to set their charity and discount eligibility policies. These policies must be disclosed in the IRS Form 990 Schedule H annually.

For patients not eligible for charity or sliding scale discounts, providers may secure payment by negotiating discounts and/or extended payment plans with the patient. If the patient does not settle a bill through obtaining discounts or extended payment, after a few months the health system may sell the bill to outside bill collectors, who may have more aggressive means of bill collection.

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

Hospitals get their revenue in four basic ways:

- By providing medical services
- By providing nonmedical services
- Through donations, grants and subsidies from individuals, foundations, or the government
- Through investment income on financial assets like cash, marketable securities, and equity investments in related and unrelated businesses.

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

- Patient Service Revenue: through the delivery of patient care
- Other Operating Revenue: ongoing non--patient care activities (parking, cafeteria, gift shop, medical education, research, etc.)
- Non-operating Revenue: peripheral activities including contributions, investment income, and one-time gains/losses

Patient Services Revenue

Patient service revenue is earned by delivering patient care. This revenue is recorded in accounting records as gross and net:

- **Gross Patient Service Revenue (GPSR).** The amount of money that hospitals would make if they were paid at gross charges - that is, the non- discounted rate - for the care they deliver. However, hospitals provide most patient care at less than full charges and never collect their gross patient service revenue, so they are not permitted to disclose gross patient service revenue on the face of their statement of operations. It is often disclosed in a footnote, or available from other sources such as the Medicare Cost Report Schedule G.

- **Net Patient Service Revenue (NPSR).** The amount of money the hospital expects to actually collect after deducting charity care, provisions for bad debt, and contractual adjustments from GPSR. This is generally the first element shown on a Statement of Operations or income statement of a hospital or health system.

  Free care (also known as charity **care**) represents services provided for which payment was never expected and for which the patient is not pursued. Current accounting standards require that hospitals not report the value of charity care within their statement of operations; however, the estimated cost and the charges foregone associated with such care may be disclosed in footnotes or in IRS Form 990 Schedule H.

  Provision for Bad Debt The reporting for bad debt and charity care has changed significantly in the last decade. The Provision for Bad Debts is no longer valued at the gross charges incurred by the patient; rather it is stated as the net amount the hospital reasonably expected to collect from the patient. The difference between charges and the amount a hospital reasonably expected to collect is called an "implicit price concession" and may not be included on the statement of operations. For more information on these changes, see https://www.hfma.org/content/dam/hfma/Documents/policies-and-practices/pp- board-statement-15-061519.pdf

  Contractual Adjustments reflect discounts off GPSR for third- party payers. *Different payers pay different amounts for identical services.* Medicare and Medicaid unilaterally determine their payment rates prospectively. Private insurance companies negotiate payment arrangements that are based on hospital costs, discounts off listed hospital charges, percentages of Medicare rates, 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. The relative market power of the hospital and the insurer has been found to be a significant influence on the rates paid – the greater the provider power, the higher the private (commercial) rates paid.

What is the difference between "charges," "payment," and "cost"?

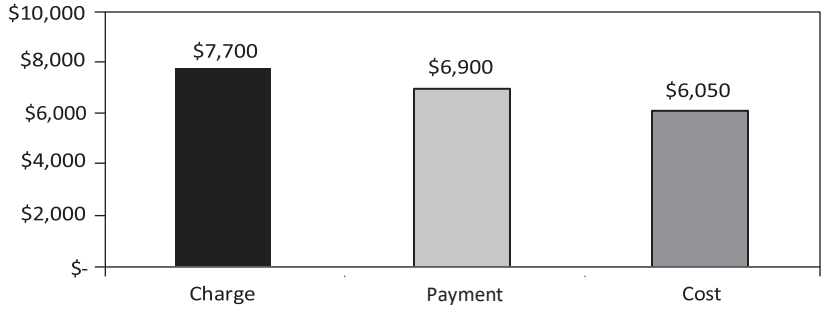
Charges, which are represented cumulatively over a period of time by GPSR, are the "List price" that a hospital publishes in its chargemaster. Individual charges are specific to the unit of service, defined in terms of billing codes, called "CPT" (Current Procedural Terminology) codes. Charges for a particular code at a particular hospital is the same for all payers.

Payment is the amount of revenue a hospital receives from a third party or patient for service provided; the
amount paid is a function of the payer's negotiated rate or a regulated amount as described earlier.

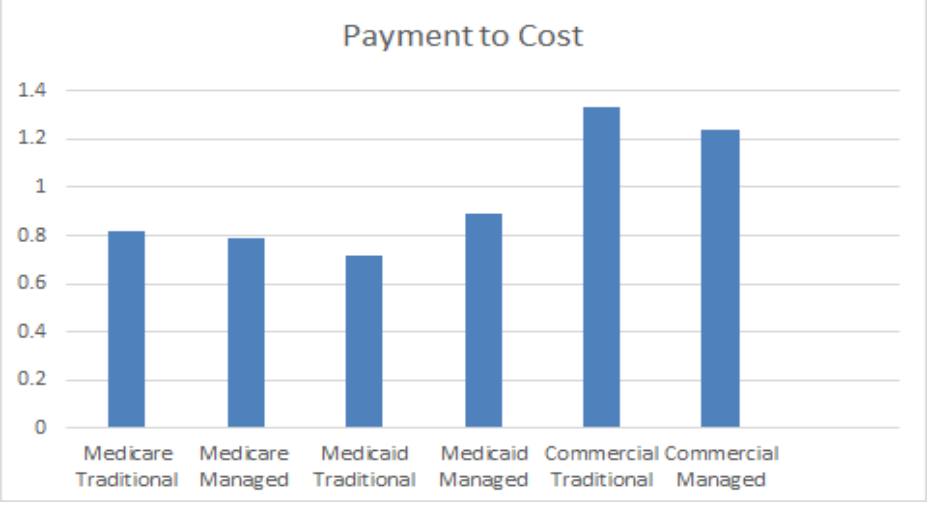
Cost is what it actually costs the hospital to provide the services. Costs are reported in financial statements as line items (salaries, supplies, depreciation) or as functional cost centers (nursing, surgery, outpatient). Costs are generally not maintained at the CPT code level. For any class of patients (e.g. charity care patients, Medicare patients), costs are generally estimated based on the overall ratio of costs to gross charges.

Hospital Revenues

EXAMPLE OF CHARGE, PAYMENT, AND COST OF HOSPITAL BILL



PAYMENT TO COST RATIOS FOR FIVE ACADEMIC HEALTH CENTERS in MASSACHUSETTS, 2018



The payment-to-cost ratio illustrates the amount of net patient service 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. A ratio less than 1 means the hospital is not recovering its cost of service from that payer group. The chart above shows a fairly typical pattern of payment to cost ratios by payer type, with Medicare and Medicaid showing payments at or below cost, and commercial insurers paying above cost.

Reviewing a hospital's payer mix is useful in evaluating hospital financial performance.

It can be helpful to also understand the variety of payment methodologies by payer.

Public Payers

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

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 and add-ons for medical education.

Medicare pays for outpatient hospital care (facility fees) and for physician services through separate prospective fee schedules. For more detail on Medicare payment methods, see http://medpac.gov/-documents-/payment-basics

Medicaid is a federal and state funded health insurance pro- gram, run by the states, for certain low-income individuals, families, and disabled people. Payment methodologies for Medicaid vary by state. Eighty-one percent of Medicaid beneficiaries are in public and private Medicaid managed care plans; the plans are paid negotiated capitation rates for a comprehensive or narrower (e.g. primary care only) set of covered services. In turn, the plans negotiate rates with providers on a variety of bases.

The majority of payments, however, are made by the traditional Medicaid Fee-for-Service (FFS) program, which is directly administered by states. A wide variety of methods are used by state Medicaid programs to pay for inpatient hospital care, including cost, all-inclusive daily rates, and case (DRG) rates. An all-inclusive per diem payment is a 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. More information on Medicaid inpatient payment is available at https://www.macpac.gov/publication/macpac-inpatient-hospital- payment-landscapes/

Medicaid payment for outpatient hospital care varies by state. Fee schedules and cost-based reimbursements are common methods.

More information is available at https://www.macpac.gov/publication/state-medicaid-payment-policies- for-outpatient-hospital-services/

In 2018, Medicare accounted for 25% percent of hospital net patient revenue; Medicaid accounted for 16 percent of hospital net patient revenue; **private health insurance**, 40%; and **other payers** (DoD, VA, other) 15%. Self-paying patients accounted for 3%.

Source:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/bench mark2014.pdf

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) adjustments. Supplemental Payments to hospitals are funneled from the federal government through state and county governments. States have great flexibility as to how they distribute the funds. As of 2018, DSH funding totaled $18 billion dollars. The Affordable Care Act of 2010 included provisions to r educe Medicaid DSH payments over time to reflect the anticipated increase in insurance coverage anticipated by the Act, but those provisions have been delayed by subsequent legislation and political uncertainty in implementation of the Act.
For more information see
https://www.macpac.gov/subtopic/disproportionate-share-hospital-payment

Private Payers

The private health insurance system covers two-thirds of the population in the US. These payers are paid a premium—usually from an employer on behalf of employees, but sometimes from other organizations or individuals—to pay for the health care of its members. Private insurance plans vary in design in terms of covered services, cost-sharing, and rating criteria for setting premiums. Some of the premium variation was reduced
by restrictions in the ACA.
Private plans pay providers in many different ways. The most common is FFS, or payment by unit of service (CPT code) such as lab tests, surgical procedures, daily rates for nursing care, and outpatient visits. The level of payment is determined through negotiation between the insurer and the provider. Increasingly, FFS payments are modified by various performance measures such as quality, patient satisfaction, and access measures.
Some states and the ACA have encouraged insurers and providers to negotiate "alternative payment mechanisms" that reward value and care that is bundled into episodes of care (across all provider sites, including physicians) or an entire period

of care (e.g. all provider types involved in primary care over a year). Some private insurance contracts with hospitals involve their taking financial risk for the care of a defined population, such as "global budgets" and capitation for specified populations. Medicare has established the CMS Innovation Center to encourage and assist providers in the design of more 'value-based' payment methods for Medicare, described here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient- Assessment-Instruments/Value-Based-Programs/Value-Based-Programs

Self-pay Since the passage of the ACA**, u**ninsured or self-pay patients who are not eligible for hospital discounts who receive "medically necessary" care from a not- for-profit hospital must pay an amount reflecting the average of what a hospital would get from its private insurance negotiated rates or what it gets from public payers (the hospital's "amounts generally billed" (AGB)). A more detailed description of the limits on what self-paying patients can be charged is available here: https://www.communitycatalyst.org/resources/publications/document/CC-ACAHospitalBillsReport-F.pdf?1434480883

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 can bring in significant and continuous streams of funds, the money resulting from these services and activities is called other operating revenue because it is not earned by providing medical services to patients. Some typical categories that make up other operating revenue include:

- Cafeteria sales
- Gift shop sales
- Parking garage fees
- Space or equipment rentals
- Research grants
- Tuition for medical educational programs

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 valuable sites 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. Generally, research grant revenues are completely offset by related research costs, and not all research costs are covered by grant revenues.

Non-Operating Revenues

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

operating revenues as revenues earned through the sale of goods and services, and non-operating 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 non-operating gains/losses include:

Investment Income

Investment income is becoming an increasingly important way for many 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. Quite a few hospitals with substantial financial assets invest in non-liquid securities such as hedge funds, real estate, and private partnerships.

Unrestricted Donations

Hospitals often receive monetary gifts from individuals and organizations that wish to support the hospital's mission. When these funds are not restricted to a particular purpose by the donor, they are considered as non-operating revenue (again) for the hospital and recorded as such on the income statement.

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, other non-capital costs, and capital-related costs, namely depreciation and interest.

Capital-related costs are generally 7– 8 % of total operating costs.

Salaries, Wages and Employee Benefits

Wages and salaries paid to employees are usually the largest category of expenses for hospitals. This category makes up 55% of total operating costs.

Professional fees, which includes employed physicians, represent another 8%.

Supplies

Supply costs (food, medical instruments, other products) constitute 13% hospital operating costs. Pharmaceutical costs are another 6.5 %.

Other Non-Capital Costs

Other hospital costs constitute 10% of operating costs, and include utilities, professional liability insurance, contract labor, and other.

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 depreciation 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.

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.

IV Understanding Audited Financial Statements

Since you know how a hospital makes and spends money, now you need to learn how this information is presented. All hospitals have audited financial statements at some level, either at the individual hospital level or the health system (consolidated with other entities) level, or both.

Audited Financial Statements

Hospitals, like other businesses or organizations, issue **audited financial statements (AFS).** AFS 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? Has the hospital been able to repay its long-term debts on time?

AFS 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 four major financial statements:

- The income statements
- The statement of changes in net assets
- The balance sheets
- 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, organizational entities included in the financial statements, and affiliate names and transfers can generally be found in the footnotes.

The Income Statement

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

A simplified version of the income statement looks like this:

	20XX	20XX-1
OPERATING REVENUES		
Net Patient Service Revenue	183,005	189,460
Other Operating Revenue	14,600	14,843
Total Operating Revenue	$197,605	$204,303
OPERATING EXPENSES		
Depreciation	13,152	13,805
Interest	3,222	5,026
Other Operating Expenses	168,585	173,634
Total Operating Expenses	$190,122	$199,331
Net Operating Income	$7,486	$4,972
NONOPERATING REVENUE		
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
OTHER GAINS (LOSSES) DUE TO:		
Extraordinary Gains (Losses)	0	−748
Total Surplus/Deficit	$10,645	$8,664

- Profit is the difference between revenue and expenses. Profit is sometimes referred to as the hospital's "bottom line," or in accounting language, the "performance indicator". However, as the example shows, the performance indicator could be calculated from the operating income, excess revenues, or total surplus, depending on what the analyst wants to know.
- The operating margin looks at the amount earned from patient care activities and is calculated as Operating Income/Total Operating Revenue, using the example above. It reflects how profitable the hospital/health system is from its central mission of delivering services to patients in exchange for payments.

- The total margin captures all financial activities of the current period, including the peripheral ones, captured in the nonoperating section. The total margin is generally calculated as the Excess Revenue (Expense) / (Total Operating Revenue plus Nonoperating Revenue). It can also be calculated using the Surplus/Deficit bottom line, which captures unusual, generally one-time events such as early debt retirement or the impact of discontinued operations. The total margin is different from the operating margin largely because of the results of the hospital's investment strategy, which is highly dependent on the performance of capital markets.
- 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 Sensitive is Profit to Managerial Discretion?

- A hospital may be conservative or more liberal in its estimate of how much money it will earn from patient revenues or how much its services actually cost. Because these numbers usually require a certain amount of estimation, elements such as 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 uncertainly regarding whether the hospital will be permitted to keep this revenue. A hospital often has not settled with every insurer at the end of the financial reporting period, and it could owe money back from some insurers, or vice versa depending on the results from a final settlement , which can take months or years after the end of the hospital' s fiscal year. Certain expenses are also subject to estimation; for instance, if the hospital has taken insurance risk on one of its payment contracts, it may not know all of its associated expenses, which may be for patient visits to non-system providers, at the time that its financial statements are created.

Statement of Changes in Net Assets

This statement reports all changes in net assets (equity) that occurred during the reporting period, for both unrestricted and restricted net assets. The surplus/deficit reported in the Statement of Operations is usually the first item in the statement of changes in Unrestricted Net Assets; other items might include unrealized gains (losses) when not reported in nonoperating revenues, valuation changes in pension funds, capital transfers from restricted funds, and transfers to affiliates/other organizations such as medical schools, physician organizations, and other affiliates existing outside the boundaries of the reporting entity. Restricted contributions, restricted investment income, including unrealized gains/losses, and transfers affecting restricted net assets are also reported in this statement.

Example of a Statement of Changes in Net Assets

$ in 000	Without Donor Restrictions	With Donor Restrictions	Total
Net Assets, Prior Year	894605	94184	988789
Deficiency of Revenues over Expenses	(19297)		(19297)
Contributions		4164	4164
Investment income		1056	
Net Assets Released from Restrictions:			
Used for purchase of property, plant and equipment	1125	(1125)	
Used for operations		(4868)	(4868)
Net realized gain on sale of investments		4572	4572
Contributions for property, plant and equipment	266		266
Change in unrealized loss on investments		(1970)	(1970)
Pension-related changes other than net periodic credit	43031		43031
Total Increase in Net Assets, Current year	25125	1829	26954

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, 20 20.
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 cur- rent 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 out-flows. Property, plant, and equipment (PPE) are considered assets.
- **Liabilities** are economic obligations of the organization to out-siders or claims against its assets by outsiders. Accounts payable is as 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:
  assets – liabilities = net assets.

BALANCE SHEET EQUATION
The balance sheet has two counterbalancing sections which form the balance sheet equation:
Assets = Liabilities + 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

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

LIABILITIES AND NET ASSETS

Current Liabilities	Short-term obligations to outside parties who have provided resources (liabilities)
Current Portion of Long-term Obligations	Principal payments due this fiscal year on long-term obligations
Accounts Payable and Accrued Expenses	Includes accounts payable, accrued salaries payable, wages, payroll taxes, interest, vacation (earned time) and other accrued liabilities
Current Portion of Accrual for Settlements with Third-Party Payers	Current portion of amounts received from third-party payers which the hospital expects to be due back to third parties in the current year
Due to Affiliates	Current amounts owed to related entities
Total Current Liabilities	Sum total value of all of the current liabilities listed above
Noncurrent Liabilities	Long-term obligations which are not due within one year
Long-Term Obligations, Less Current Portion	Noncurrent portion of long-term debt, capital leases, and mortgage notes payable
Other Noncurrent Liabilities	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.
Net Assets	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
Unrestricted	Includes all net assets that are not temporarily or permanently restricted by donor or grantor
Restricted	Includes funds temporarily or permanently restricted by donor or grantor stipulations. Includes funds called for a specific purpose; property, plant and replacement; or endowment funds.
Total Net Assets	Sum total value of all net assets
TOTAL LIABILITIES AND NET ASSETS	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 is not subject to managerial discretion. Over the long term, multi-year cash flow analysis provides an objective perspective of hospital financial performance.

Simplified Statement of Cash Flows for the Unrestricted Fund for the Period Jan 1–Dec 31, 20XX ($ in Thousands)

Cash from Operating Activities:	
Total Surplus/Deficit*	$10,645
Noncash Adjustments (mostly depreciation and amortization expense)	$13,152
Changes in Working Capital:	
Increase in Accounts Receivable	($4,295)
Increase in Accounts Payable	$6,480
Total Cash from Operating Activities	$25,982
Cash Used for Investing Activities:	
Purchase of property, plant, equipment	($7,854)
Proceeds from the sale of marketable securities	$12,000
Purchase of marketable securities	($9.298)
Total Cash Used for Investing Activities	($5,152)
Cash Used (Provided) from Financing Activities	
Proceeds from the issue of long-term debt	10,000
Repayment of long-term debt	($17,087)
Transfer to affiliates	($4,300)
Total Cash Used, Financing Activities	($11,387)
Net Change in Cash	$9,443

**
*

This sample shows some of the standard items listed on the cash flow statement. There are multiple useful items disclosed on this statement, including the cash amounts transferred to and from affiliates. Hospitals that are affiliated with other hospitals, medical groups, and other entities often transfer funds to and from one another in transactions not involving purchase of services or products. For example, hospitals may

transfer cash to a medical group to help subsidize the group's operating losses, or to a parent organization to provide the parent with funds to acquire other entities. Some hospitals may transfer funds to other hospitals or health plans within the system that are in a more precarious financial situation and need to shore up their net assets.

The cash flow statement also highlights another way (besides delivery patient care or earning investment income) that hospitals obtain outside funding, namely, by borrowing from creditors. Hospitals and health systems issue long-term debt in order to finance large projects such as building a new clinic or acquiring another entity. Known as capital financing, many nonprofit hospitals raise cash for these projects by issuing tax-exempt 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. Other forms of borrowing for long-term projects include issuing taxable debt, taking out a mortgage, or, if investor - owned, issuing stock.

Where to Get Your Hospital's Financial Data

Audited Financial Statements

AFS may be obtained directly from the hospital or health system, or from some states that centrally collect them and make them available to the public. The state agencies that may collect hospital AFS include Office of the Attorney General, or the Department of Health.

The AFS of nonprofit health systems that issue tax-exempt debt can be accessed on the municipal repository called EMMA, at
https://emma.msrb.org/

Investor-owned health systems that are publicly held must post their AFS on the SEC Edgar web site, at https://www.sec.gov/edgar.shtml

Some public (e.g. county or district-owned) hospitals post their AFS on their web sites.

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. Since 2008, nonprofit hospitals have been required to disclose extensive information on the nature and value of their community benefits, in the Schedule H of the IRS Form 990. Form 990 filings can be obtained from https://www.guidestar.org/. Only private nonprofits file IRS Form 990's.

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 share- holders 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 inaccuracies. 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
Profitability		
Total Margin	Revenues in excess of expenses / Total Revenues	Shows the percentage of revenues collected from central *and* peripheral activities that is kept as profit. *For example, a 5% Total Margin means that for every $1.00 collected as revenue, $0.05 is kept as profit.*
Operating Margin	Net Operating Income / Total Operating Revenue	Shows the percentage of revenues collected from central activities that is kept as profit. *For example, a 3% Operating Margin means that for every $1.00 collected of patient revenues, the hospital keeps $0.03 as profit.*
Markup Ratio	(Gross Patient Service Revenue + Other Operating Revenue) / Total Operating Expense	Measures the percentage by which charges are increased above cost. *For example, if the hospital's cost for providing a particular service was $10,000 and they charged $15,000 for the serv- ice, they would have a markup of 1.5.*
Deductible Ratio	Contractual Allowance / Gross Patient Service Revenue	Measures the percentage discount that third-party payers get, on average, from listed charges. *For example, a 25% ratio would mean that the average third-party payer received a 25% discount off listed charges.*
Liquidity		
Current Ratio	Current Assets / Current Liabilities	Measures how many times the hospital is able to meet its short-term obligations with short-term resources. *A ratio of two would show that the hospital could pay its cur- rent liabilities twice over.*
Days Cash on Hand, Short-Term Sources Only	Current Cash and Investments / (Other Operating Expenses/365)	Illustrates the number of days the hospital could continue to operate without collecting any additional cash. *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.*
Days Cash on Hand, with Board-Designated Investments	(Current Cash and Investments + Board-Designated Investments) / (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.
Solvency		
Equity Financing	Unrestricted Net Assets / 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. *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.*
Cash Flow to Total Debt	(Revenues in excess of Expenses + Depreciation) / (Total Current + 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? *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.*

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).

One useful way to analyze cash flow statements is to sort multiple years of data into positive cash elements, or "Sources of cash", and negative cash elements into "Uses of cash". The resulting pattern, in combination with ratios, is informative in assessing overall financial health. A healthy hospital generates cash mainly from operating activities, especially operating income and depreciation. An unhealthy hospital uses debt financing as a large source of cash and may even have to use cash to cover unprofitable operations.

The two examples below describe first a relatively healthy and next a relatively unhealthy pattern of cash sources and uses for two different hospitals

(1) This five-year aggregate cash flow profile represents a healthy pattern of cash from successful operations being reinvested in the core business in the form of plant and equipment with minimal net debt. It was able to transfer $57 million in cash (31% of total cash uses) to affiliates over the five-year period, while investment in PP&E is over 3 times its depreciation expense (most of the "non-cash expense" category), which is a very healthy investment level.

Sources	$000	%	Uses	$000	%
Operating Income	75,708	42%	Incr in BdDesigAssets	(19,272)	11%
Nonoperating revenue	27,126	15%	Investment in PP&E	(93,911)	52%
Noncash expenses	29,085	16%			
			Incr working capital	(4,482)	2%
Issue long term debt	19,674	11%	Transfer to affiliates	(57,170)	31%
Decr trustee held inv.	18,169	10%	Incr other noncurr assets	(1,203)	1%
Cash reduction	11,916	7%	Repay/refinance LTD	(5,640)	3%
Total	181,678	100%		(181,678)	100%

(2) This hospital is struggling to break even from its operations. It is repaying more than it is generating from long-term debt, and it is investing in PP&E at barely at the level of historic depreciation expense (a healthy capital expenditure/depreciation ratio is at or above 125%).

Sources (5-year)			**Uses**		
Operating and nonoperating Income	704	2%	Increase investment in PP&E	-7963	37%
Noncash expenses	7810	37%	Increase in cash	-1027	5%
Net working capital	78	0%			
Decr trustee held	1,101	5%			0%
Transfer from restricted funds	1809	8%			
Issuance of long-term debt	9505	45%	Repayment of long-term debt	-11135	52%
Other	526	2%			
Total Sources	20,125	100%	Total Uses	(20,125)	100%

VI. 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?
  - By borrowing?
  - By receiving transfers from affiliates.
- 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?

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

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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.

Contractual: 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 invest- ed 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 regard- less 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.