Chapter 11: Financial Management

Teaching Goals

Accounting and financial management (A/FM) are so important that they are usually covered in separate specific courses. The goal of this chapter is to summarize what A/FM supplies to the rest of the organization.

One way to begin is to start exactly there, with the question, “How do we know that we have an effective financial management and accounting unit in our healthcare organization [HCO]?” The best answer is, “The board and all the associates are supplied with all the information they need when they need it, and when they get it, they can rely on it.”

- Omitting the board or management from the answer is serious. The board sets the financial guidelines, not A/FM. The senior management team is responsible for financial performance, not the chief financial officer.
- Omitting “all the associates” from the answer raises not only the issue of disclosure but also of team building. Some organizations put the whole story on the intranet and find stronger positive response from their associates.
- Incomplete and unreliable information creates risks of serious error. They undermine the basic commitments of not-for-profit organizations for prudence and trust. Thus, one of the three major functions is the audit system.
- Information that is not timely is often useless.
- A/FM performance (see pp. 455 ff) should be judged against carefully negotiated goals and benchmarks, like any other HCO unit.
- “Making a profit,” “having low debt,” or “getting good interest rates” is not a good answer. A/FM does not make a profit; it simply measures profit. The goals for profit, debt, and interest rates are part of the long-range financial plan and should be set by the board, not the chief financial officer or her team.

At the end of Chapter 11, students should have a clear understanding of the operating budget process. The process is referenced frequently, beginning in Chapter 3, and is summarized in Figures 11.7 and 11.8 (pp. 433 and 435 in the book). The key points are:

- Every unit is expected to move toward benchmark on all or most measures.
- Improvement comes from performance improvement teams (PITs) and process change, not extra effort.
- The process is an ongoing part of life. This is the unit manager’s perspective: “I know I’ll have to get better next year. I need to review my OFIs

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opportunities for improvement), identify my targets, and start my PITs right now, before this year’s budget is approved, to give the PITs time to find the improvements. Then when next year’s negotiations come, they’ll be easy.”

- For the hospital as a whole, the service excellence model kicks in (Figure 4.3, p. 113). There’s growing demand and revenue, flat or near-flat costs, and money in the bank to pay for PITs, pilots, training, new equipment, and others.
- The revenue growth is shared through incentive compensation.

The third takeaway is cost analysis. Activity-based costing should be taught in an accounting course, not this one, but some principles need to be reinforced:

- Fixed and variable costs are controlled in different ways by different people.
- Direct fixed costs and variable costs per unit are controlled by the accountable team. Local process changes modify these cost structures.
- Allocated costs (even healthcare system charges) are controlled by other teams. Any associate has the right to know how well those teams are doing, how close they are to benchmark, and what their goals will be for next year.
- Allocated costs are often changed strategically by the healthcare organization as a whole, as opposed to any unit, through mergers, closures, better marketing, and planning.
- Aggressive cost analysis is fundamental to improving efficiency. It all boils down to what Jack Welch said, “If you are not [at benchmark], fix it, sell it, or close it.” If you don’t know how close you are to benchmark, you are not yet in the big leagues.

**In a Few Words**

The organization’s finance and accounting activities record and evaluate its operation for internal and external use. They provide data to understand the cost of all activities and models to analyze alternative future scenarios. They obtain and manage cash for long-term growth. They protect the information from distortion and the assets against misuse and loss. The activities are organized around controllership, which handles all the functions related to recording and analyzing costs and revenue; financial management, which manages the organization’s capital; and auditing, which ensures accuracy of information and protection of assets. Senior management and governance have a critical role ensuring that the accounting and finance functions are thoroughly and accurately carried out and that the results are effectively used throughout the organization.

**Chapter Outline**

*Supporting an evidence-based culture*

How accounting

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identifies and reports costs  
provides analysis and forecasts for performance improvement teams  
supports the annual budget process  

Providing adequate financial resources  
How finance  
identifies long-term financial needs  
manages debt and liquid assets to meet needs  
negotiates contracts with health insurers to maximize revenue  
develops ownership structures that facilitate strategic partnerships  

Promoting honesty  
How internal and external auditing  
ensure accuracy of numbers, even involving complex calculations  
support a culture where honesty is expected  
protect organizational assets  

Powerpoint Slides  
See Learning Tools.  

Questions to Debate  
Slides of the individual questions are downloadable. We have prepared some summary thoughts on the content of class discussion. Obtain this information by writing (conventional mail) on academic letterhead to:  

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(Please include an academic (dot edu) e-mail address.)  

1. Why are the numbers so complicated? Concepts like “cost per case” or “percent postoperative infections” seem simple enough. Why must we adjust the numbers, use FASB rules, do statistical analyses, and maintain internal and external audits? What would happen if we did not do these things?  

2. Why is budgeting split into two processes—operating and capital? What measures would you use to evaluate a hospital’s budgeting processes? How would you identify opportunities for improvement in the process? How would
you go about implementing improvements like faster service with budget packages, automating calculations, helping operating managers develop their goals, and matching the operators’ goals to the governing board guidelines?

3. How would you respond if a service line reports that they are unable to improve their costs next year because the burden of transfer charges and allocated overhead is too great? These managers have improved their internal operations, but the total cost is still substantially above benchmark.

4. How does the organization evaluate its capital and liquid-asset management program? What questions would you ask, and what numbers would you ask for, if you were exploring this question with the CFO and the financial management team?

5. How much should the audit functions cost? The system described is expensive; many organizations complain that it is excessive. What exactly are the benefits the organization gains from those expenditures, and how are they measured? How will the organization judge whether the investment is wise?

### Additional Discussion Questions

1. **Managerial accounting.** *(This question is a lead-in for a gradable exercise—reviewing control of fixed costs.)* The table below summarizes the cost/delivery for uncomplicated obstetrics at your healthcare organization. Reviewing data within your health system, a hospital very similar to yours, has a cost of only $4,000 per delivery. The Women’s Health service line establishes a PIT to examine its costs. What kinds of issues should the PIT consider?

<table>
<thead>
<tr>
<th>Item</th>
<th>Unit Cost</th>
<th>Quantity</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery room cost per use *</td>
<td>$1,450</td>
<td>1</td>
<td>$1,450</td>
</tr>
<tr>
<td>Postpartum care cost per day*</td>
<td>$600</td>
<td>2.5</td>
<td>$1,500</td>
</tr>
<tr>
<td>Nursery care cost per day</td>
<td>$300</td>
<td>2.5</td>
<td>$750</td>
</tr>
<tr>
<td>Laboratory cost per test</td>
<td>$10.00</td>
<td>35</td>
<td>$350</td>
</tr>
<tr>
<td>Drug (1) cost per dose*</td>
<td>$5.75</td>
<td>6</td>
<td>$35</td>
</tr>
<tr>
<td>Drug (2) cost per dose*</td>
<td>$18.50</td>
<td>10</td>
<td>$185</td>
</tr>
<tr>
<td>Indirect costs</td>
<td>Allocated</td>
<td></td>
<td>$1,200.00</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>$5,469.50</strong></td>
</tr>
</tbody>
</table>

2. **Budgets**

2.1. Budget guidelines. *(a) Why are budget guidelines set in advance of the actual preparation? Who sets them for the institution as a whole? For the individual responsibility center? (b) Why are leading institutions adding nonfinancial guidelines as indicated in the strategic balanced scorecard, Figure 3.4 (p. 183)? (c) Obviously people setting guidelines should have access to historic data and forecasts from the environmental assessment. What other kind(s) of information is (are) important?
2.2. Here are several condensed scenarios for setting budget guidelines. For simplicity, these four institutions operate in the same market, which is facing severe price reductions.

2.2.1. You must decide next year’s costs, capital expenditures, and quality and satisfaction goals. Then add a couple sentences on the priorities for next year’s capital investments. (This question can also be graded and is included in gradable exercises.)

<table>
<thead>
<tr>
<th>Scenario</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last year’s prices</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Last year’s operating costs</td>
<td>$110</td>
<td>$105</td>
<td>$96</td>
<td>$95</td>
</tr>
<tr>
<td>Last year’s routine capital</td>
<td>$5</td>
<td>$7</td>
<td>$7</td>
<td>$7</td>
</tr>
<tr>
<td>Last year’s strategic capital</td>
<td>$0</td>
<td>$10</td>
<td>$5</td>
<td>$10</td>
</tr>
<tr>
<td>Quality scores (4=Excellent)</td>
<td>3.0</td>
<td>3.5</td>
<td>3.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Satisfaction scores (4=Excellent)</td>
<td>2.0</td>
<td>3.8</td>
<td>2.8</td>
<td>3.3</td>
</tr>
<tr>
<td>Expected prices</td>
<td>$95</td>
<td>$95</td>
<td>$95</td>
<td>$95</td>
</tr>
<tr>
<td>Expected operating costs*</td>
<td>$116</td>
<td>$110</td>
<td>$101</td>
<td>$100</td>
</tr>
<tr>
<td>Funds avail. for investment**</td>
<td>$7</td>
<td>$22</td>
<td>$41</td>
<td>$32</td>
</tr>
<tr>
<td>Profit</td>
<td>($10)</td>
<td>($5)</td>
<td>$4</td>
<td>$5</td>
</tr>
<tr>
<td>Depreciation</td>
<td>$7</td>
<td>$7</td>
<td>$7</td>
<td>$7</td>
</tr>
<tr>
<td>Uncommitted funds avail.</td>
<td>$10</td>
<td>$20</td>
<td>$30</td>
<td>$20</td>
</tr>
<tr>
<td>Bond rating</td>
<td>C</td>
<td>A</td>
<td>A++</td>
<td>A+</td>
</tr>
</tbody>
</table>

* “Ceteris paribus” Equals 105 percent of last year’s operating cost.
** Equals sum of following three lines.

2.2.2. At the start of Month 2 of Figure 11.7 (p. 433), it is customary for the chief operating officer to make some brief remarks to the accountability center managers to help them understand the basis for the board’s guideline decision and the general problems the institution must solve. What are the key points that are appropriate for each of the guideline sets you have developed in 2.2.1?

3. **Financial planning**

3.1. What is the relationship between profit and capital budget expenses?

3.2. Which of the scenarios in question 2.2 do you think reflects a historically sound financial planning process? Which are unsound? Why?

3.3. Figure 3.2 (p. 71) includes a test against market realities that is often painful, requiring an agonizing reappraisal of possible strategies and priorities. Who should participate in the reappraisal? What are the criteria that should govern the outcome? What is management’s role?

3.4. How much profit?
The recurring question addressed is what profit, or return from operations, the organization should seek.... Well-run not-for-profit hospitals have tended to seek returns in the range of 5 percent of total costs.... For-profit organizations seek before-tax returns two to three times that high. (p. 438)

Many people feel that a not-for-profit healthcare organization should return value for the tax benefits it has received. How would you justify a healthy profit margin to somebody with those beliefs?

4. **Capital budgeting**

4.1. The programmatic proposal and capital budget process begins in Chapter 8, where the responsibilities of CSS (clinical support service) managers are explained; Chapter 11, where the financial implications and the final decision process are reviewed; and Chapter 14, where the role of internal consultants in preparing requests is described. Describe succinctly as you might to a new CSS manager:

4.1.1. How the process works

4.1.2. What to look for in selecting potential proposals.

4.1.3. Why having a proposal turned down isn’t really a defeat for the manager or the organization.

4.2. You are the hospital CEO. Doctors on the capital budget committee can’t agree on which equipment to recommend for purchase and for how much. They are way over budget. What do you say to them? (see Short Case H: “Doctors and the Capital Budget” in *Health Services Management Readings, Cases, and Commentary*, 8th edition, edited by A. R. Kovner and D. Neuhauser, 2004, p.254)

5. **Evaluating the finance function.** In one HCO, some of the CSS managers feel that the finance function is not as effective as it should be. Talking with them you learn that they have several specific concerns listed below. You promise to get back to them within a few days, and you do. What do you say, and what evidence do you show them, on each question?

5.1. Finance costs too much, and it’s a burden on their overhead.

5.2. Finance is slow in producing cost data and cost analyses.

5.3. There isn’t enough money for routine capital

### Questions for Examination

These questions are less ambiguous than the discussion questions. Obtain these questions and the authors’ answers by writing (conventional mail) on academic letterhead to: