First Illinois Speaks
hfma healthcare financial management association
HFMA's First Illinois Chapter Newsletter
October 2011

Believe to Achieve

Highlights and Recap First Illinois Chapter Events begins on page 18

Captured Events & Updates

In This Issue

How Much Will the Federal Fiscal Year 2012 Financial Wage Index Rule Hurt?

BY DAN YUNKER, VP & CFO, METROPOLITAN CHICAGO HEALTHCARE COUNCIL

The Final Wage Index Rule was released for Federal Fiscal Year 2012 (FFY2012) despite the unadjusted national average hourly wage (AHW) increasing at a slower pace the Chicago area hospitals' and Illinois' lost reimbursement dollars. And by how much, you may ask. The answer is astonishing. Due to an under the radar political maneuver made by the State of Massachusetts, Massachusetts hospitals are set to benefit from a wage index windfall of $275 million in additional Medicare funding in FFY2012 due to an obscure provision in federal health care reform legislation passed in 2010 as well as the state's manipulation of the inpatient payment rules concerning the wage index for inpatient prospective payment system (IPPS) hospitals. As a result, because of the zero-sum game, hospitals in 41 other states, including Illinois, will get less money. From a state perspective the Illinois Hospital Association estimates that Illinois will receive $26.3 million less in Medicare reimbursement in 2012, further widening the lower than cost revenue streams for serving the Medicare patient population.

As a market we have enjoyed tremendous success in this zero-sum game and rightfully so as we are the third largest market in the country and our wage related costs are higher than others. Unfortunately, as a market we are losing progress in our coordinated efforts. Taken as a whole, the market's coordinated efforts for wage index review have resulted in favorable reimbursement. FFY2008-2012 brought in an estimated $72 million in additional inpatient Medicare reimbursement. This does not account for the roughly $17.0 lost due to the slick political maneuver made by Massachusetts. Had we received that rightful reimbursement our total would be close to $90 million.

The move made by Massachusetts drives home the seriousness of wage index, the impact it has on hospitals and the lengths to which other markets will go to gain the upper hand. Here we are, millions of dollars leaving our market, and we are at a decision point. History demonstrates that without significant participation and structured reviews, our market will lose our edge and give up reimbursement dollars that rightfully belong to us.

The time is now to act on FFY2013. Every hospital needs to participate in a coordinated wage index review program. Wage index is much too important for any one hospital to tackle alone. Let's not fool ourselves into thinking that the capacity to manage wage index

(continued on page 2)

How Much will the Federal Fiscal Year 2012 Final Wage Index Rule Hurt?

(continued from page 1)

reviews using internal processes exists, because it doesn't. The results of uncoordinated efforts are inconsistent, and the FFY2012 data shows that those who didn't participate with the market group review experienced an average AHW decrease of 56 cents. Those who did participate in a group review had an average AHW increase of 24 cents. In our market every nickel equals to approximately $3.4 million in additional reimbursement. It's time to recommit to ourselves as a market. When it comes to wage index we are all in this together. There is no competition. The investment is minimal considering what is at stake and the market has a proven track record of success. As a market, when we collaborate we win! The ball is in your court!

Supporting Data (FFY2012):

- The Chicago-Joliet-Naperville core based statistical area's (CBSA) final AHW increased from the prior year.
- The Lake County, IL CBSA AHW decreased from the previous year.

Description	2011 Final	Est. 2012 (Unadjusted)	Est. 2012 (Adjusted)/Final
Chicago CBSA	$36.80	$38.05	$38.17
Lake County CBSA	$37.48	$36.16	$37.12
National Average	$34.97	$35.81	$36.25

- The Chicago-Joliet CBSA wage index factor decreased from the prior year.
- The Lake County, IL CBSA wage index factor decreased from the prior year.

Description	2011 Final	August PUF CORE	2012 August PUF Adjusted/Final
Chicago CBSA	1.0489	1.0626	1.0436
Lake County CBSA	1.0683	1.0100	1.0150

Chicago-Joliet- Naperville CBSA - Final

- **The average increase for participating hospitals is $0.24.**
- For non-participating hospitals, the average **decrease** is $0.56.
- The overall results show an increase of $0.01 in the AHW.

Estimated impact to Medicare **inpatient** reimbursement for all hospitals, both participating and non-participating, is based on a $0.01 increase from initial public use file (PUF) to the final PUF:

- Participating hospital's impact is estimated at $330,000.
- Non-participating hospital's impact is estimated at $352,000.

If all hospitals in the CBSA had participated in the Wage Index Program and achieved similar results as the participating hospitals, the entire CBSA would have benefited by an additional **$16 million** in inpatient reimbursement.

Editor's Letter

Dear First Illinois Chapter Members:

Happy Fall! Probably THE best season of all, Fall is upon us, at least for a day or two–then a blizzard should quickly follow, both literally and, in the case of upcoming changes due to healthcare reform, figuratively as well. If only healthcare reform was as predictable as the seasons in Chicago.

Speaking of changes, we are sure that most members of the chapter noticed the changes in the look of this issue, as well as the previous issue, of the newsletter. We recently changed the look of the newsletter to coincide with the Chapter's new website. Check it out at www.firstillinoishfma.org or catch a glimpse to the right of this article. A shining example of "alignment" and "integration" we might add.

Finally, as our Chapter continues to grow under the direction of Pat Moran – with the ultimate goal of being the #1 Chapter in the U.S. – we truly feel that the Chapter members are in an extraordinary position to "network," collaborate and navigate the uncertainties of the evolving healthcare landscape, be it 5010, ICD-10, consolidation, physician/hospital alignment/integration, reimbursement reform, etc. Subsequently, whether it is through contributing an article to First Illinois Speaks, volunteering for a committee, or attending a First Illinois webinar or seminar, actively participating in the Chapter is one of the best ways to stay informed and keep "connected."

Thank you to those that are making a difference by contributing to the Chapter, and for those who have yet to actively participate– why not?

Enjoy the cool weather.

Sincerely,

Tim Manning
Jim Watson
Newsletter Co-Chairs/Editors

New First Illinois HFMA Chapter Website Home Page

Diversify Your Networking Portfolio

BY VICKIE AXFORD AUSTIN

Any savvy financial advisor will tell you that the key to building financial success is to balance your investment portfolio. The same can be said for building your business and career success. In order for you to build your "social capital," you need to make sure you diversify your networking portfolio.

Connect With Others, Face-to-Face

The most powerful way to build relationships is to meet people face-to-face. Think about it: we do business with people we know and trust. And the way to build trust is get to know people individually over time. That's why being part of an association like HFMA is so critical. You have the opportunity to meet people live and in person.

Being on a committee is the best way to get involved in any professional association. You get a chance to interact with people in smaller groups. We tend to be more comfortable in small groups and it's easier to get to know people that way. Also, when you're on a committee you get to share your knowledge and expertise. You also have the opportunity to demonstrate your work ethic and your commitment. Show up, do the work you say you're going to do and *voila!* Pretty soon you're asked to be committee chair. (And if you're not careful, you may end up on the board.)

Years ago I committed to being involved in my professional association. At the time I was manager of communications at Scottsdale Memorial Hospital in Scottsdale, Arizona. I also was a member of the Arizona Society for Hospital Marketing and Public Relations and served on the board.

Through my board assignment I met my friend and colleague Kyle Kinder and she later recommended me for a job at Humana Hospital-Phoenix where she worked. Based on the strength of my relationship with Kyle, and the power of her recommendation, I now had this wonderful opportunity to interview at Humana where I subsequently was hired as director of marketing. I never would have been tapped as a candidate had I not met Kyle. And I later had the opportunity to work for Mike McCallister who became executive director of our hospital—he's now president of Humana, Inc. To work for and learn from a leader like Mike was a once-in-a-lifetime opportunity. And it all started from volunteering on a committee.

In addition to volunteering on a committee with the First Illinois Chapter of HFMA, perhaps you attended the Cubs game in August or the chapter's installation dinner. I hope you take advantage of all the continuing education offered both at the local chapter level and through national HFMA. Each of these events is an opportunity to not only learn but also to expand your network—what I call your "Golden Rolodex."

Conferences Offer Breadth and Depth

Another way to diversify your networking portfolio is to attend conferences and conventions. Perhaps you attended ANI this year? Large conferences are a great opportunity to practice your networking skills. You get to meet people from all over the country (sometimes the world), hear world-class speakers and share information with peers and colleagues who are often facing the same challenges as you.

The risk of these events, however, is their sheer size. When attending a conference it's important to be strategic. Pore over the agenda ahead of time and select your workshop tracks carefully. Anticipate who's going to be there and who you want to meet.

While working as director of marketing for Modern Healthcare magazine I learned there's a real art and science to "working" a conference. Our publisher Chuck Lauer and the sales team would plan weeks, even months ahead of time how they would connect with their clients. And we often hosted hospitality suites or dinners to have the opportunity to meet and greet those in the business. Invitations were extended well in advance of the conference.

When attending a conference, give yourself a "quota" so you don't get overwhelmed by the volume of people and opportunities. Commit to connecting with a certain number of people you already know and build on those relationships. Then commit to connecting with a number of new contacts. Make sure you follow up after you get back to the office. Networking isn't just about making connections—it's about keeping those connections going.

(continued on page 5)

Diversify Your Networking Portfolio

(continued from page 4)

Social Media and E-mail

LinkedIn and FaceBook have become important tools in our networking tool belts. And the power of e-mail helps us reach out and stay connected. Use social media to maintain relationships but don't ask for more than it can deliver. Think of on-line dating services: very few people go from Match.com directly to the altar. There are a lot of steps in between.

Networking is still an in-person art form. Give first, help others make connections and always be ready and willing to be the first to invite someone to coffee or lunch. Your dividends will multiply and you'll be thrilled with your return-on-investment.

Vickie Austin, founder of CHOICES Worldwide, is a business and career coach and a professional speaker based in Wheaton, IL. She turned off her phone and ignored her e-mails while writing this article. You can reach her at 630-510-1900 or vaustin@choicesworldwide.com.

Winning Under Reform: Patient Access Strategies to Reduce Financial Exposure and Improve Care

BY MARLOWE J. DAZLEY, SENIOR VP, PNC HEALTHCARE ADVISORY SERVICES

Top performing organizations have re-aligned processes to identify and manage charity care and eligibility prior to or at the time of service. Most organizations incur the highest amount of denials for errors made at the time of service. Many of these errors can be avoided before the patient arrives for care. The majority of denials stem from non-covered services, missing authorizations or no coverage identified. According to the Henry J. Kaiser Family Foundation, over 50 million Americans are uninsured. Identifying and managing uninsured patients is a challenge for nearly every healthcare delivery system in the U.S. Expansion of coverage in the current legislation will place an unprecedented increase in demand for the newly insured. It is estimated that by 2015, 19 million uninsured Americans are projected to receive coverage ("McKesson Survey: Preparing for Health Reform," HFMA's 2010 ANI: The Healthcare Finance Conference). This shift will significantly increase the financial exposure to many organizations unless they adopt new processes and policies to manage charity care and improve eligibility and coverage verification systems.

Pre-Service

Managing charity care cases is an area of financial exposure in the current delivery of care and will continue to be a challenge for hospitals and health providers to manage in the future. A critical element of success in managing this population is to strengthen the financial assistance and eligibility screening capabilities to "financially clear" services prior to arrival.

Top performing organizations shift the identification of charity care from post-service and point-of-service to pre-service or prior to the clinical encounter. This process eliminates the gaps that exist in the financial clearance process at time of service. The objective of this function is to obtain pre-certification and referrals, determine patient benefit levels and communication of the patient responsible amount, and initiate the Medicaid application process if no coverage can be identified or provide access to charity care, payment plans and discount policies available. Completion of these processes requires the patient to be "financially cleared" before services are rendered. The financial benefit of this program provides a foundation for deployment of proactive patient financial policies and manages risks from increased payer eligibility requirements. Organizations that have successfully implemented this process have reduced claim rejection rates to < 0.5% and improved net revenue by at least 1% through avoided losses and increased reimbursement in addition to improved patient satisfaction scores. Additional benefits have been achieved through leveraging technology, thereby increasing accuracy, efficiency and productivity.

Time of Service

Organizations that proactively manage the identification and management of charity care cases that arrive unscheduled or at time-of-service integrate a "right care" program in the emergency department. The emergency department is typically the front-door for the majority of charity care patients. A "right care" process identifies patients with non-urgent medical needs or low-acuity cases at the time of triage and redirects patients to a lower cost setting by way of a fast track staffed by nurse practitioners, a community clinic or scheduling a subsequent visit with an affiliated physician. Redirecting these cases moves the encounter to a lower cost setting to receive the "right care" at the right location and alleviates bottlenecks in the emergency department. Furthermore, this process assists patients in establishing a "medical home" where they can continue to receive primary care. Organizations that have adopted this process have reduced inappropriate emergency department visits by 20% in addition to cost avoidance benefits.

By implementing these practices, hospitals and health systems can reduce their financial exposure by ensuring that all patients are financially screened and cleared prior to service, avoiding costly denials, and taking a "right care" approach to ER services. Financial performance is a key pillar of strength for hospitals to consider and focus on in order to win during this era of healthcare reform.

Estates, Probate and the Deceased Patient

BY IKE SCHREIBMAN, THE LAW OFFICE OF ISAAC S. SCHREIBMAN

Probate: **The process of legally establishing the validity of a will before a judicial authority.** From the Latin *probatum*, it is proved.

Estate: **All of one's possessions, esp. the property and debts left at death. The nature and extent of an owner's rights to land or other property.** From Middle English *Estat*, meaning condition.

Estate proceedings are required where an individual is deceased or not legally competent to manage their property or affairs. In the latter case the individual could be a minor (individuals under the age of 18 are not legally competent) or an adult who has been found to be legally incompetent, after a court hearing. Where an individual under the age of 18 has been injured due to the negligence of another, a minor's estate must be opened. The appropriate court located in the jurisdiction where the minor resides will appoint a representative who will be responsible for receiving, managing and disbursing proceeds from any final judgment or settlement of a personal injury award. Proceeds from the case may not be distributed without court order.

Where an individual dies owning property in their name alone, a probate estate must be opened and a representative appointed to manage and distribute the decedent's property. If the decedent owned property in joint tenancy with another at the time of death, the property (house, automobile) will "pass outside of probate" to the surviving joint tenant. The property most commonly held in joint tenancy is real estate, automobiles, bank accounts and investment accounts.

Certain other assets can bypass the probate process. Any asset with a named beneficiary will pass directly to the beneficiary without the need for a probate proceeding. Proceeds from a life insurance policy, a trust, or a retirement account (e.g, an IRA or 401(k) plan) are all examples of assets that will be transferred directly to the named beneficiary without the need to have a probate proceeding. Since title to assets held in trust is in the name of the trustee, and not the decedent, the assets in the trust are not owned by the decedent at the time of death.

Where an estate is required, any interested party (including a creditor) may file a petition for the appointment of an estate representative. Where the decedent left a will an "executor" will be appointed. Where no will was left, the court will appoint an "administrator." The representative of an estate is responsible for identifying all assets owned in the sole name of the decedent, bringing them into the estate, managing those assets and distributing those assets according to the will, state laws of inheritance, or an order of the court.

If the decedent had a will it must be filed with the court and a hearing held to determine the will's validity. If the will is determined to be valid it will be "admitted to probate." It is at this point that other interested parties (e.g, potential heirs) can contest the validity of the will, usually on the grounds that the decedent was not legally competent at the time the will was created. Once admitted to probate, the will is controlling as to heirs and other beneficiaries of the estate.

If the decedent did not have a will at the time of death the court will hold a hearing to determine the legal heirs. This is done by having the representative of the estate (or family member) testify as to the decedent's blood relatives. After this hearing, the court will enter an order which sets forth the legal heirs of the decedent. The estate will be distributed according to state statute, which gives prefer-

(continued on page 8)

Estates, Probate and the Deceased Patient (continued from page 7)

ence to the closest living relative(s).

It is important to note that in some cases a probate estate must be filed in any county (and state) in which property was owned in the sole name of the decedent at the time of death. It is possible that multiple estates, in multiple states, must be opened in order to dispose of all assets owned by the decedent. The executor/administrator must provide all known creditors with actual notice that an estate has been opened. Therefore, a medical provider should send bills to the patient's last known address to insure that the creditor is known to the estate's representative. Once this is done, actual notice must be given to the creditor by the estate's representative.

Should a person die owing a bill for medical treatment, the creditor (provider) may seek payment from the patient's estate as well as the patient's surviving spouse under most states' family expense statutes or relevant state law. Creditors' claims must be filed in a timely manner, usually within 6 months of the appointment of an administrator or executor. Most states also have a statute of limitations which could be shorter than this 6 month period (such as 2 years from the date of death regardless of when a representative was appointed). Copies of claims filed with the court must be served on the representative of the estate as well as the representative's attorney.

Upon completion of the claims filing period, the executor (or administrator) will review all filed claims. The representative has the option to consent to, or contest, a particular claim. If a submitted claim is contested by the representative the court will schedule a hearing. At this hearing the creditor has the burden of proving the validity of the claim as well as the amount claimed to be due.

Once all claims have been resolved, either by agreement of the parties or after a hearing, the representative of the estate is responsible for liquidating the estate's assets and paying the claims. Claims filed in a probate estate are paid based on their classification. All claims with a higher classification (priority) must be paid before there is any distribution to creditors with lower priority claims. For example, claims of a surviving spouse or claims owing for unpaid taxes are given priority. In many states, medical bills arising from the decedent's last illness are paid prior to ordinary claims for medical services.

The representative of an estate is required to file an Inventory of all identified assets with the court. Claims allowed by the probate court are paid from the assets identified. If the asset is not cash (i.e. real estate, an automobile or personal property) the representative is responsible for selling that asset so that proceeds from the sale can be disbursed to creditors and beneficiaries. Once all assets have been brought into the estate and outstanding claims have been paid, the remaining assets are distributed to identified beneficiaries. At that point, the representative of the estate will file a Final Accounting with the probate court. This document must list all assets, all claims paid, all expenses incurred by the estate, as well as all amounts distributed to beneficiaries.

This article is for informational purposes only and not intended as legal advice. Please consult legal counsel in your state with questions regarding probate and estates.

Achieving Cost Transparency

JOHN ORITZ, PRACTICE LEADER, TATUM HEALTHCARE

To stay competitive in today's environment, healthcare organizations need to streamline inefficient processes and understand the types and amounts of resources required. This can only be achieved through cost transparency.

Amazingly, most healthcare entities still use costing tools that date back to an assembly line model–tools long abandoned by the manufacturing industry that created them. The result is rudimentary cost allocation that fails to match resources and related costs to their services–insufficient information to make a truly informed decision.

Consider, for example, the common practice by hospitals of allocating the cost of equipment to surgical procedures that don't use it. Allocations by their nature are arbitrary and produce distorted results. The cost of internal support services such as registration and materials management (without which patient services couldn't be delivered) is typically excluded from cost accounting systems except as an allocation to a charge on the Charge Description Master (CDM). Many costs triggered by the requirements of customers or payers are allocated instead to services.

Activity Based Methodology vs. Traditional Methods

Traditional: *What is spent*	
Labor	$525,000
Benefits/payroll taxes	90,000
Supplies	60,000
Depreciation	60,000
Other costs	40,000
Total:	**$775,000**

Activity-Based: *What is done*	
Delivery care	$225,000
Document care	115,000
Process patient orders	110,000
Transport patients	75,000
Obtain test results	70,000
Admit patients	50,000
Process transfers/discharges	30,000
Develop care plan	25,000
Performance general administration	75.000
Total:	**$775,000**

Structured Cost Methodologies

Activity-Based Management (ABM) and Activity-Based Costing (ABC) are well established methodologies that have had a positive impact on many industries. But their adoption in healthcare has been hindered by lack of understanding of their benefits and a misperception that they are more expensive and complex to deploy. Ultimately the value of being able to manage financial results far outweighs the effort of deployment.

Uncovering Hidden Costs with Activity-Based Costing

A well defined, organization-wide program to build cost transparency uses ABC to identify areas where costs are not well understood or are unproductive or excessive. This will pinpoint areas where ABM can improve financial results through analysis and restructuring.

The basic steps of an ABC effort are:

- Identify the products and services the organization produces that directly or ultimately serve customers or sustain the organization.
- Associate services with entities like patients and payers.
- Identify the range of activities that are inputs to each product or service. They are often a range of activities performed by disparate organizational units.
- Match resources (labor, supplies, equipment usage etc.) with the activities that consume them. This needs to be done at a level where the relationship between activity and cost can be established, i.e. where cost is controlled.
- Identify the less obvious but significant drivers of cost such as policies, employee training gaps and unnecessary process complexity
- Compute and (as necessary) estimate the cost of activities,

(continued on page 10)

Achieving Cost Transparency (continued from page 9)

taking into account less obvious factors impacting cost, such as facility location and layout.

- Compare costs to prices the organization is paid for its services, factoring in non-financial measures including clinical outcomes, patient functional status, cycle time, and customer satisfaction.
- Identify "suspect" areas where costs aren't well understood or activities don't appear to contribute to service delivery or other objectives.

Understanding Case and Department Costs

An immediate benefit of an ABC effort is creation of accurate costs for major processes, especially end-to-end cases. For example, the cost of a surgery extends well beyond the cost of direct supplies and the time physicians and nurses take to perform the procedure. Its true cost includes: the registration process, pre-operative testing (x-rays, blood work, etc.), assistance in recovery, patient transportation, patient counseling, patient accounting, discharge planning and post-operative activities.

Understanding these costs is essential to identifying the inefficiencies and points of vulnerability in patient service or quality of care.

Redesigning Processes with Activity-Based Management

Once possible problem areas are identified, an Activity-based Management approach can begin following these steps:

- Analyze activities in relation to their capacity usage and productive outputs (whether intermediate or patient services) to identify inefficiency and waste.
- Identify areas where staff is spending too much time on low value-add processes outside its area of responsibility and competency or where staff skills are misaligned with the activity actually being performed, e.g., an RN performing a housekeeping activity.
- Target areas where multiple functions or units are performing the same activities on a sub-scale basis without adequate communication
- Consider what could be done by lower cost resources or by sourcing processes differently

The Road to Sustainability

Recognize that Activity-Based Management will require focus and commitment. It must be undertaken as an enterprise-wide program that is seen as essential to communicating and achieving the organization's strategy. Only an enterprise approach can achieve true transparency and address systemic issues. Improving only one step in a 10 step process doesn't reduce cost and time for the 10 steps as a whole.

As wider coverage drives up revenues, organizations that can understand and manage costs will see their margins grow and their competitive position improve. They will be able to invest intelligently in the organization's future at a time when others will face financial difficulty. Our industry faces unprecedented challenges and leaders who recognize and act on the need for cost transparency will take an important step toward meeting mission-critical financial, strategic and patient outcome goals.

(continued on page 11)

Achieving Cost Transparency (continued from page 10)

About Tatum Healthcare

Tatum Healthcare is comprised of operating executives who serve a wide variety of healthcare organizations as interim and permanent CEOs, COOs and CFOs. Our advisors and consultants assist healthcare management with financial, technology, operations and compliance issues. Our services range from leading turnaround of financially troubled hospitals to revenue cycle management to performance improvement.

To learn more about Tatum's Activity-Based Management methodology, contact Tatum at 888.TATUM11 or visit www.tatumllc.com/healthcare.

50 Ways to Green Your Hospital

BY STEPHEN BLAU, ILLINOIS TRANE

The cost of energy and world consumption continues to increase. Now is the time for hospital management to work with facility engineers, maintenance staff and others to explore innovative solutions and green practices to help manage operational costs.

A smart approach is to implement green practices incrementally by exploring what can be done in the short term (0-3 years), near term (3-8 years), long term (more than 8 years), and on a going-forward basis. To help anticipate areas within facilities to look at for savings and future areas of investment, we've assembled the following "50 Ways to Green Your Hospital."

By implementing some of these tips, hospitals can easily save between 10 and 25 percent annually on their energy bill. And even small changes can add significant budget savings to the bottom line. Let's get started:

Short term payback plan: 0-3 Years

Quick changes and low or no cost facility areas to look at that can help yield instant savings. Often these tips will provide the biggest bang for your buck.

Building Envelope

1 Find and fix leaks (doors and windows)

Lighting

2 Install occupancy sensors

3 Retrofit existing lighting fixtures (T12 – T8)

Motors

4 Properly size to the load for optimum efficiency

5 Check alignment

6 Check for under-voltage and over-voltage conditions

Pumps

7 Operate pumping near best efficiency point

8 Modify pumping to minimize throttling

9 Adopt to wide load variation with variable speed drives

(continued on page 13)

10 Use booster pumps for small loads requiring higher pressures

11 Repair seals and packing to minimize flows and reduce pump power requirements

Controls/Automation

12 Check schedules, setpoint and setbacks

13 Confirm HVAC/Refrigeration control strategies are correct/operational

14 Check/inspect/repair equipment for proper operation (fans, dampers, belts, filters, VAV boxes, etc.)

15 Use "free cooling" when using your chilled water system in cold weather

Steam

16 Fix steam leaks and condensate leaks

17 Inspect steam traps regularly and repair malfunctioning traps promptly

Boilers

18 Preheat combustion air with waste heat

19 Use variable speed drives on larger boiler combustion
air fans with variable flows

20 Inspect and clean burners, nozzles

21 Close burner air and/or stack dampers when off

22 Automate boiler blow-down and recover blow-down heat

23 Use boiler blow-down to help warm the back-up boiler

24 Inspect door gaskets

25 Optimize boiler water treatment

26 Add an economizer to preheat boiler feedwater using exhaust heat- Recycle steam condensate

Water and Sewer

27 Recycle water, especially if sewer costs are based on water consumption

28 Use the lowest possible hot water temperature

29 Fix water leaks

30 Use water restrictions on faucets, showers and/or install self-closing type faucets in restrooms

31 Verify water meter readings

Near-Term Payback Plan (3-8 years)

You've looked at the easy stuff, now take a hard look. These suggestions are investments or changes that still have attractive payback, but take more time to investigate.

Equipment Change Out

32 Evaluate your chilled water system to specifically consider replacement of chiller(s) with more efficient models

33 Study gas-powered refrigeration equipment to minimize electrical demand charges

34 Assess new HVAC system

35 Replace boilers (higher efficiency, modular, etc.)

36 Consider installing: thermal storage systems, heat recovery systems

Operational Strategies

37 Determine optimum building automation/control strategies and implement

38 Consider different utility purchasing options, rate analysis and/or buying utilities on the commodity market

39 Ensure high efficiency motors are matched to size/loads

40 Optimize compressed-air equipment for maximum efficiency through leak analysis and end-use requirements assessment

(continued on page 14)

(continued from page 13)

41 Study part-load characteristic and cycling costs to determine most efficient mode for operating multiple boilers

42 Consider more efficient options (don't use the main heating boiler) for domestic hot water during the cooling season

Long-Term Payback Plan (More than 8 years)

For those looking to make a long-term investment in their facility, consider the following tips.

Equipment Change Out

43 Consider new chilled water system

44 Implement major HVAC system replacements

45 Install new or upgrade controls/facility automation system

46 Install a geothermal heat pump system

Operational Strategies

47 Assess and verify reliability/availability of utilities (on-site generation)

48 Study facility envelope (windows, doors and roof) and make necessary improvements

Renewable Energy Solutions

49 Study the benefits of adding some renewable technologies such as solar, wind, biomass

Ongoing Maintenance

50 Engage in proactive maintenance for sustained performance

Making facility improvements of any kind can help hospitals achieve better performance and have a positive effect on budgetary resources. Of course, individual results and cost savings are dependent on each unique facility situation, utility costs and specific areas of investment. And while there could be higher initial costs, green design, upgrades and operations can help create cost savings that almost always pay for the added costs. But in the end, a green facility creates healthier and more resource-efficient models of construction, renovation, operation and maintenance–not to mention a more enjoyable and productive healing environment for patients and healthcare providers.

For more information, contact: Stephen Blau, Illinois TRANE, by phone: 630-734-6083 or e-mail: sblau@trane.com.

Capitalizing on Master Planning

BY HARVEY J. MAKADON M.D. AND LARRY STERLE AT KURT SALMON

Cost cutting is a top priority for leading health care organizations responding to the industry's changing dynamics, according to a recent HealthLeaders Media survey. Yet many may be unintentionally handicapping themselves during this process due to the fact that cost cutting is only a short-term fix to a long-term problem. We have witnessed many institutions actively deferring capital expenditures and putting "band-aids" on the most pressing facility issues, potentially wasting money in the long term. By providing a complete picture of an organization's current situation and opportunities for growth, a holistic master facility plan will help rein in spending and empower leadership to make the right strategic decisions to ensure success over the long term.

In our experience, leading organizations share two hallmarks: They are continuously preparing for the future, and they are fiscally conservative. These organizations take time to develop sound strategic plans and a solid framework that defines the organization's capital strategy and incorporates its potential demand for capital, as framed in a comprehensive capital asset master plan.

A comprehensive capital asset master plan is not a promise to spend money. Quite the opposite. If done thoughtfully, it *can provide a rationale for why money should not be spent* or how it can be spent incrementally. Conversely, if there is a need to invest in capital assets, a good plan provides leadership with the rationale to commit to the required investments with a high level of confidence.

Financial executives at industry-leading organizations are raising their demand for the level of analytical rigor underpinning their capital strategies. Three primary questions are being raised:

1) **What are we doing from a strategic perspective and why?**
   Answering this question requires a well-defined strategic framework with clear and realistic strategic goals based on sound, thorough analysis.

2) **What will it take to accomplish these goals?**
   A complete understanding of capital needs and cash-management goals is necessary to get a full picture. A comprehensive capital asset master plan defines the demand for facilities, information technology and major equipment. At the same time, the plan defines at a minimum the corresponding key measure for days cash on hand and cash reserves for potential strategic investments. The plan also provides the organization with an understanding of where they need to be from an operational efficiency perspective to attain certain financial benchmarks for future capital investment.

3) **Can we afford to implement the strategy?**
   The plan will contextualize the above goals in a robust financial analysis. This analysis is more than an ROI projection for select projects, but is also a comprehensive analysis that considers the overall financial performance of the organization. Depending on the outcome, adjustments can be made to target market and volume projections, proposed capital investments and implementation timelines, and strategic goals can be adjusted to ensure affordability.

These questions are not traditionally addressed by a master plan, but leadership is expecting a higher standard, and with good reason. Leadership can make effective decisions only when they are fully informed, so to help answer the above questions, a complete capital asset master plan will have the following elements:

- **Strategic thinking** — Not reinventing the organization's strategic plan, but having the ability to interpret critical points that impact facility decisions. Beyond how much space is needed now and in the future, what are the investment's implications for physicians and service lines, market reach and opportunity, competitive positioning, prioritization of mission, medical staff development and financial positioning?

- **Operational integrity** — How care is arranged, delivered and supported underlies quality, safety, satisfaction and cost of care. Anticipating efficient (or lean) operations is a basic tenet for assessment and planning. Understanding organizational structures that deliver superior functionality and envisioning how those

(continued on page 16)

structures fit your programmatic goals is critically important when considering future care delivery models.

- **Information technology integration** — Communications across the care continuum, quality and safety of care are all premised on seamless IT services. Like facilities, these systems require significant capital investment, so it is critical to have a firm grasp on the status of the IT systems' capabilities to balance the overall demand for capital and ensure that future facility investments are capable of handling future system advancements.
- **Evolution framework** — Near-term capital asset investments are valuable only if they are integrated with the long-term direction. Saving money on a project in the short run could cost a lot more in the long run if that project leads to future workarounds in terms of capital expenditures and operating costs.
- **Financial performance** — The implications of any capital investment plan on future activity volume, reimbursement expectations, enterprise-wide capital and operating costs, philanthropy, and other sources and uses of capital must be understood and evaluated. A longitudinally modeled implementation plan will enable an organization to achieve "managed continuity," through the evolution of its investments, to achieve its goals and vision with a high level of confidence.

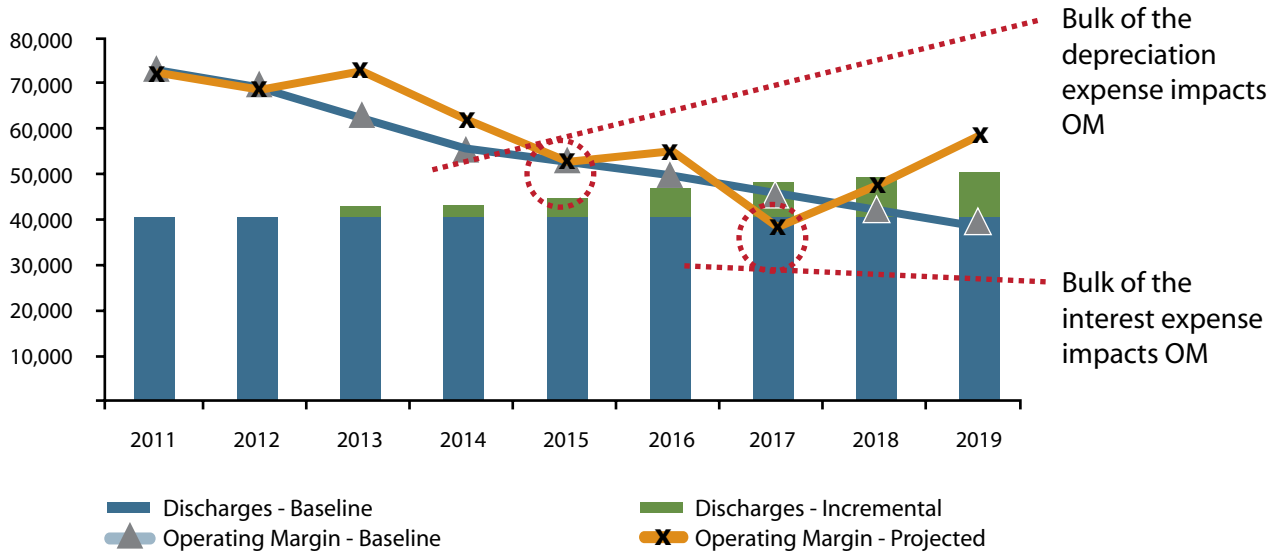
When developed correctly, a financial performance assessment can provide significant value as part of a capital asset master plan, as demonstrated by the following example. A health system comprised of ten acute care campuses was initially prepared to reinstitute investing in its capital assets as it emerged from the Great Recession. The system's plan was to pursue a sequential series of investments, one campus at a time, across three campuses over a seven- to eight-year period. A master plan was developed for each campus incorporating the elements discussed above.

Once the strategic imperatives and opportunities for each campus were fully understood, a complete financial model was developed for each campus demonstrating the impact on performance and accounting for a variety of sensitivities and assumptions about reform, payor mix, expenses and other factors.

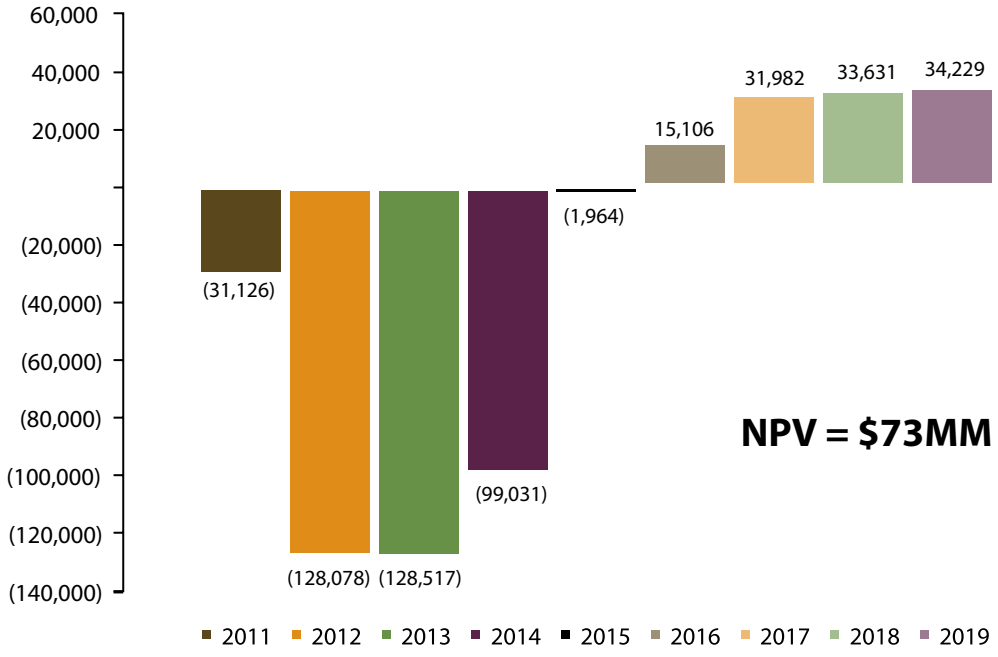
With this financial analysis in hand, the system chose to make select additional investments on a more accelerated schedule to capture strategic opportunities while they existed. The system also decided to intermix investments alternatively and incrementally across campuses to pursue the most financially advantageous projects. Armed with a complete financial analysis, the system felt more confident making tough choices to delay projects or find near-term alternatives in support of its overall financial health.

(continued on page 17)

(continued from page 16)



Discounted Cash Flow



Financial assumptions include:
- 12% discount rate
- 9% terminal cap rate
- 90% debt financing at 5.25% and 30 year tenor

Returns
- Net present value: $73MM
- Internal rate of return: 13%
- Payback Period: 12 years

As this case shows, the industry is changing, and leading organizations will equip themselves with all the facts to make decisions that position them for future success.

Kurt Salmon is the premier management consulting firm for today's leading hospitals and health systems. Harvey J. Makadon, MD, and Larry Sterle have more than 30 years of experience working with and advising the leaders of health systems and hospitals in both the academic and community settings. They can be reached at harvey.makadon@kurtsalmon.com and larry.sterle@kurtsalmon.com.

Night at Wrigley: August 22, 2011

HFMA Dinner: Fellow Awards

Mark Mitchell & Robb Micek

Annual Dinner

Outgoing FIHFMA President Patricia Marlinghaus and incoming FIHFMA President Pat Moran share a smile at the FIHFMA Annual Dinner

Brian Sinclair awarded 2011 FIHFMA Medal of Honor. Congratulations and Thank You Brian!

Golf Outing

Good time had by all at 2011 FIHFMA Golf Outing, thanks to Golf Committee co-chairs Carl Pellettieri and Colleen Murphy

Membership Drive

As you may know, we are having a Membership Drive to increase Chapter Membership. This Membership Drive is in effect from 6/1/2011 through 12/31/2011.

Our Membership Drive has a Promotion as follows:

- If you get 2 new Members – you win a very nice HFMA Dryfit Golf Shirt
- If you get 4 new Members – you win a $100 American Express Gift Certificate (plus the golf shirt)
- If you get 6 new Members - we will pay your 2012-2013 HFMA duesvalued at $275 (plus golf shirt & $100 AM Exp)
- If you get 10 new Members – 4 Cubs tickets or 4 White Sox tickets (plus the previous 3 items)

Please make sure that when a new members joins they put your name down as their SPONSOR.

Join us for ANI 2012

Mark your calendar now for next year's ANI: The Healthcare Finance Conference at the Mandalay Bay Resort and Convention Center in Las Vegas. ANI will take place June 24-27, 2012.

Fall Seminars - Chicago

Attend one of HFMA's popular seminars and walk away with information, tools, and takeaways that can be immediately applied in your facility. An in-depth workshop approach allows for group discussions and interaction, which facilitates the learning process. All levels are represented, so whether you are new to the industry, or a seasoned executive, there are sessions that you can benefit from.

Whether it is a brand-new session, or one of our popular core sessions, all programs are updated to reflect today's changing healthcare environment. The seminars are designed to reflect today's changing healthcare environment and cover two main content areas:

- Financial management strategies and operations
- Revenue cycle improvements, payment trends, managed care, and reimbursement

Date and Location:
December 5 - 7, 2011 at Embassy Suites Chicago.

Visit our New Website!

If you have not done so already, please check out our new website at **www.firstillinoishfma.org**. And, once again, a very special THANK YOU to Peter Leenhouts for making this happen!

New First Illinois HFMA Chapter Website Home Page

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter

Publication Information

Editor 2011-2012
Jim Watson ..... (630) 928-5233 jim_watson@pbcgroup.com
Tim Manning..... (630) 312-7807 timothy.manning@ahss.org

Official Chapter Photographer
Al Staidl..... (630) 724-1197

Sponsorship
Pat Moran .....(312) 218-6805 Patrick_Moran@dell.com

Design
DesignSpring Inc., Kathy Bussert kbussert@designspringinc.com

HFMA Editorial Guidelines

First Illinois Speaks is the newsletter of the First Illinois Chapter of HFMA. *First Illinois Speaks* is published 4 times per year. Newsletter articles are written by professionals in the healthcare industry, typically chapter members, for professionals in the healthcare industry. We encourage members and other interested parties to submit materials for publication. The Editor reserves the right to edit material for content and length and also reserves the right to reject any contribution. Articles published elsewhere may on occasion be reprinted, with permission, in *First Illinois Speaks*. Requests for permission to reprint an article in another publication should be directed to the Editor. Please send all correspondence and material to the editor listed above.

The statements and opinions appearing in articles are those of the authors and not necessarily those of the First Illinois Chapter HFMA. The staff believes that the contents of *First Illinois Speaks* are interesting and thought-provoking but the staff has no authority to speak for the Officers or Board of Directors of the First Illinois Chapter HFMA. Readers are invited to comment on the opinions the authors express. Letters to the editor are invited, subject to condensation and editing. All rights reserved. *First Illinois Speaks* does not promote commercial services, products, or organizations in its editorial content. Materials submitted for consideration should not mention or promote specific commercial services, proprietary products or organizations.

Style

Articles for *First Illinois Speaks* should be written in a clear, concise style. Scholarly formats and styles should be avoided. Footnotes may be used when appropriate, but should be used sparingly. Preferred articles present strong examples, case studies, current facts and figures, and problem-solving or "how-to" approaches to issues in healthcare finance. The primary audience is First Illinois HFMA membership: chief financial officers, vice presidents of finance, controllers, patient financial services managers, business office managers, and other individuals responsible for all facets of the financial management of healthcare organizations in the Greater Chicago and Northern Illinois area.

A broad topical article may be 1000-1500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables **(PDF or JPG only)** should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

Founders Points

In recognition of your efforts, HFMA members who have articles published will receive 2 points toward earning the HFMA Founders Merit Award.

Publication Scheduling

Publication Date	Articles Received By
January 2012	December 10, 2011
April 2012	March 10, 2012
July 2012	June 10, 2012
October 2012	September 10, 2012

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter

event-filhfmaorg@comcast.net

Chapter Educational and Events Calendar 2011

For a current listing of all upcoming First Illinois HFMA Chapter events, please visit:
http://firstillinoishfma.org/events/calendar-of-events/

Tuesday, November 8, 2011
Webinar: McGladrey & MCHC - 340B

Thursday, November 17, 2011
Compliance Education Program

Friday, November 18, 2011
CFO Breakfast

Thursday, December 8, 2011
Holiday Dinner

Tuesday, December 13, 2011
Webinar: PNC Bank - Winning Under Reform: Strategies to Optimize the Revenue Cycle

Thursday, December 15, 2011
Treasury Education Program
CFO Breakfast

Tuesday, January 10, 2012
Webinar: Crowe - Financial Planning in a Healthcare Reform Environment - Organizing all the Moving Pieces

Thursday, January 19, 2012
Facilities Planning Program

Friday, January 27, 2012
CFO Breakfast

Wednesday, February 8, 2012
Webinar: Winthrop Resources - Financing Technology: Mitigating the Business & Financial Risks with Technology

Thursday, February 9, 2012
Revenue Cycle Education Program

Thursday, February 16, 2012
Physician Education Program

Thursday, February 23, 2012
Dinner & Play - Social Event

Friday, February 24, 2012
CFO Breakfast

Tuesday, March 6, 2012
aIPAM

Thursday, March 8, 2012
Managed Care Education Program

Tuesday, March 13, 2012
Webinar: American Express - Maximum Efficiency: Inside the Procure to Pay Process

The First Illinois Chapter Sponsors

The First Illinois Chapter wishes to recognize and thank our sponsors for the 2011-2012 chapter year. Thank you for all your generous support of the chapter and its activities.

Platinum Sponsors-

American Express
Harris & Harris, LTD
PNC Bank

Gold Sponsors

American Appraisal Associates
Bank of America
Crowe Horwath LLP
Dell Perot Systems
Med Synergies
Plante & Moran
Professional Business Consultants, Inc. (PBC)

Silver Sponsors

Emdeon
FirstSource–MedAssist
Grant Thornton, LLP
Gustafson & Associates Inc.
Healthcare Financial Resources, Inc. (HFRI)
Kaufman, Hall & Associates
Next Recovery Source
On Target Staff
Passport Healthcare
Powers & Moon, LLC
RSM McGladrey, Inc.
Tatum
Wells Fargo Bank
Ziegler Capital Markets

Bronze Sponsors

Amerinet
Claim Assist
Cirius Group
CMD Outsourcing Solutions, Inc.
Deloitte
Ernst & Young
Fifth Third Bank
H&R Accounts, Inc.
Healthcare Insights, LLC
Healthcare Payment Specialist, LLC
ICS, Inc.
IMA Consulting
JPMorgan Chase
Leopardo Companies
Lillibridge Healthcare Services
LYNX Medical System (PICIS US)
M-Care
MedAssets
Medical Business Associates
Medical Business Bureau, LLC
MiraMed Revenue Group
Morgan Stanley
Revenue Cycle Partners
Revenue Cycle Solutions
Stratford Advisory Group, Inc.
Winthrop Resources