



Do the Right Thing

By Howard Fowler, MS, CPA, CFM, FHFMA.

Union Hospital will not be able to issue the new bonds and that may result in a sale of the hospital to buyers outside of the community. What would you advise?

Abstract

Chief executive Dr. Ronald Weaver is facing shrinking demand for services at Union Hospital. His executives are giving him conflicting opinions about how to solve the hospital's immediate cash flow problems. Examine the facts presented for Union Hospital and determine the course of action you believe Dr. Weaver should follow.

Background

Dr. Rodney Weaver has been the chief executive officer of Union Hospital for the past seven years. He has been affiliated with the hospital for the 25 years, first as a physician, then in various administrative roles and finally as CEO. Dr. Weaver had a small private practice and for many years he was quite content with simply being a family physician. He entered hospital administration because he wanted to make a difference in an area in which he felt that effective leadership was sorely lacking.

Today, Union Hospital and Dr. Weaver face a serious dilemma, one that is not unique to the hospital industry, but one that is in fact timeless. The hospital industry has excess supply and waning demand for inpatient services. Many hospitals are struggling to remain economically viable. Union's survival depends on the quality of the decisions made by its senior leadership. In the face of adversity, how will Dr. Weaver and his management team respond? Dr. Weaver takes great pride in "doing the right thing." In this case, the right choice may not be obvious.

Union Hospital is a not-for-profit hospital located in the heart of the inner city. It has a long and distinguished record of providing care to the citizens in its service area regardless of their ability to pay. The hospital generates about \$125 million annually in revenue and spends nearly all of it on patient care, community outreach and the maintenance of its aging facilities. It employs well over a thousand people in the community and it is renowned for its positive labor relations. Union actively sponsors health awareness and prevention activities and it has gained fame for its community outreach programs.

For the last few years, the number of inpatient admissions at Union has decreased by 3% to 5% percent annually. At the same time, the average payment per inpatient case has



stayed flat. This is due to the pressures associated with managed care and with tight Medicare and Medicaid regulations. Managed care is the collection of business practices adopted by insurance companies to reduce health care costs. Medicare is the federal program that provides care to senior citizens. Medicaid is a joint federal and state program that provides care to certain indigent residents. Payment rates from insurance companies, Medicare and Medicaid have been under significant pressure to remain flat or decline. At the same time, the costs of providing care have been increasing, particularly due to a nationwide shortage of nurses. Union provides free care to many area residents who do not have any health care coverage and yet are not poor enough to qualify for Medicaid. The costs of providing this charity care directly reduce Union's bottom line, but the hospital cannot curtail this service since it is an integral part of its not-for-profit mission.

Dr. Weaver has seen the hospital through many changes, including a major bond issue about 10 years ago. The \$75 million bond offering was used to renovate a significant portion of the facility as well as to purchase the latest technology for the hospital's clinical departments. Principal payments on the bonds are due over a 30-year term. Five million dollars have been paid to date. Unfortunately, health care technology continues to advance and the costs of acquiring the latest diagnostic and surgical equipment pose a serious challenge to Union's finances.

Albert Case, Union's chief financial officer, has proposed a new \$80 million bond offering to refinance the remaining \$70 million of outstanding bonds and to obtain an additional \$10 million to buy the latest clinical equipment. Case feels that although interest rates are at an all-time low they will rise in the next year. The reduced interest costs will more than pay for the debt service on the additional \$10 million of debt. If the hospital does not obtain this financing, it will have difficulty keeping its clinical equipment up-to-date and may have to shut down certain programs.

Union Hospital currently has a bond rating of BBB, just barely maintaining its investment grade status. This is a relatively high rating in comparison to hospitals of a similar size. It enables Union to receive favorable interest rates from the bond market. The BBB rating is based in large measure on the stability of Union's operating results even in difficult circumstances. While many hospitals have made poor investment decisions and suffered financial setbacks, Union has avoided many of these problems. As a result, the management team has gained significant credibility with the rating agencies and others in the bond market.

The Problem

During 20X2, Union's financial situation has deteriorated. The hospital had budgeted net income of approximately \$3 million for 20X2. With eleven months of the year completed, though, it appears that the hospital will actually suffer a net loss of approximately \$3 million. This \$6 million difference is due mainly to a shortfall in revenue associated with reduced admissions and lower payment rates. Budgeted revenue was \$125 million, while actual revenue is trending to roughly \$120 million for the year. The remainder is due to slightly higher-than-anticipated labor costs.



The forecasted net loss of \$3 million is just on the threshold of pushing Union into technical default on its outstanding bonds. A technical default would result in the acceleration of the remaining \$70 million liability and would essentially bankrupt the hospital. The bond trustee, the bondholders and the ratings agencies are not aware of the extent of Union's financial difficulties. Quarterly financial statements that Union has provided to these parties have shaded the issue, showing the hospital breaking even during the first two quarters of the year and earning just under \$1 million in the third quarter. Because of Union's historical stability, the rating agencies have not expressed significant concerns about these results. They continue to have faith that Union's management team will navigate through any difficulties.

Albert Case, the CFO, has brought a situation to Dr. Weaver's attention that may have an effect on Union's reported results for 20X2. Sharon Morella, the hospital's director of reimbursement, believes that Union is owed approximately \$5.2 million from the state Medicaid agency for the years 20X0 to 20X2. The basis of the claim is that the hospital incurred certain costs in delivering care to Medicaid patients, but the agency incorrectly applied the existing law and rejected the claims. The Medicaid agency says the state legislature did not appropriate funds for this particular matter during those years and thus it feels that the state does not owe this amount to Union. The hospital had asserted its right to the payments in prior years, but the Medicaid agency had rejected the claims. Union did not record any revenue related to this issue in prior years. Of the total amount, approximately \$1.2 million pertains to services delivered in 20X0, \$1.4 million to 20X1 and \$2.6 million to 20X2.

In November 20X2, the state courts ruled in favor of another hospital in the state in a similar claim filed against the Medicaid agency. Union's counsel feels this decision strengthens the hospital's claim. Since the case is subject to appeal, the ultimate outcome will not be settled for several years. However, Morella believes that this case is ample evidence that Union will eventually be paid and, thus, should record the \$5.2 million as revenue in 20X2.

The Options

Union's financial management team met to discuss the disputed Medicaid payments and came up with a number of differing opinions. The participants include Dr. Weaver, Albert Case, Sharon Morella, the controller and the vice president of strategic planning.

The controller, Christopher Harolds, believes that disputes with third-party payors are not uncommon. Typically, they are considered to be contingent gains until the third-party acknowledges the liability. Then a change in accounting estimate is made to recognize the revenue in the current period. Thus, Harolds believes that Union should not record the \$5.2 million in 20X2, but rather that the revenue should be recorded as soon as the litigation is resolved. Harolds does believe that Union should disclose the existence of the issue and the potential gain in the notes to the financial statements.



Sharon Morella, the director of reimbursement, takes a more pragmatic approach. Third-party payments are always subject to retroactive settlement and/or audit. Frequently the hospital will not know the final settlement for a given year until many months or years after the end of that year. In these cases, management simply makes use of all available information to prepare a good-faith estimate of the ultimate settlement. Morella sees nothing different between this approach and the current situation, other than the fact that litigation will be required to realize this particular settlement and collection might take longer than usual. The hospital should record its best estimate of the ultimate settlement regardless of whether that settlement results in a gain or a loss.

Harolds argues that financial statements should be prepared in a conservative manner. The hoped-for settlement from litigation is different from the typical third-party settlement process. Medicaid has indicated specifically that it is *not* going to pay the amount claimed. While management believes that the claim will be successful, accounting principles do not provide for recording such an uncertain claim as revenue. “The *quality* of earnings that we report is just as important as the actual *amount* of earnings that we report,” Harolds argues. “Readers of our financial statements will see that we have recorded revenue for which we have no expectation of receiving cash in the near-term. This will erode confidence in our integrity and in our ability as a management team.”

Michele Seans is the vice-president of strategic planning. She is the newest member of Union’s management team, having joined the hospital from a major consulting firm about six months ago. She is troubled by the discussion. While it is important to account for the Medicaid claim appropriately, it seems to her that there is a lack of focus on the underlying issue. “The financial problem at hand,” she says, “has its source in a very serious operating issue. Declining volumes and payment rates have resulted in lower revenue, yet our cost structure remains unchanged. The Medicaid issue is irrelevant to the goal of improving our operations and keeping our doors open. We should focus our attention on right-sizing our operations and reducing costs.”

Dr. Weaver is confused by the wide variety of opinions. While he has been involved in administration for many years, his original training was in medicine. He is not interested in the subtleties of accounting gains and losses. His main concern is that the hospital will continue to provide care to patients. Accordingly, he is worried that the forecast shows that Union will suffer a net loss of \$3 million this year. When Dr. Weaver hears Sharon Morella say that the \$3 million net loss could become net income of \$2.2 million, he is both excited by the opportunity and confused by the “fuzziness” of the numbers.

Harolds attempts to explain the revenue recognition principle to Dr. Weaver. “Revenue should be recorded in the period earned rather than in the period that cash is received. This principle is widely accepted as the basis upon which financial reports are prepared. Normally, it is easy to determine when revenue is earned. It is simply the period in which the related services are provided to the patients. In this instance, however, we know that services were provided, but we are uncertain about the amount that Medicaid will



ultimately pay us for those services.” Dr. Weaver finds it confusing that no one can pinpoint the moment that this portion of revenue becomes earned.

Albert Case, in a fit of practicality, tells the assembled group that this is more than just a theoretical discussion. If the hospital does not record the disputed Medicaid payments as revenue, it will be in default on its existing bonds. Union will not be able to issue the new bonds and will be unable to fund needed capital improvements. Case hints that this may result in a sale of the hospital to buyers outside of the community or even to a closure of the facility. “Sure,” he says, “accountants are often conservative, but there is no place for that now. This hospital needs to record the \$5.2 million of revenue to survive. We do expect to receive cash for this claim, just not for a few years. These earnings are real and we must record them. After the new bonds are issued, we will deal with our operating problems.”

The Decision

Dr. Weaver is confronted with a number of intertwined financial, operational, legal and ethical issues. As the CEO his ultimate responsibility is to ensure that Union can fulfill its mission by continuing to provide care to the residents of its service area. Dr. Weaver believes that Union should do the right thing and record only the revenue that is appropriate. But he is confronted with starkly differing opinions from the key members of his management team. In a situation this unclear, he does not know what course of action to take. How would you advise Dr. Weaver?

Comments on “Do the Right Thing”

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The most important objective in this case is that the hospital remain in operation to serve the medical needs of its community. The capital structure needed to support continued service is important, but even more important is the ability to generate sustained cash flow to fund operations, capital requirements and debt service. These executives seem to be more concerned about immediate financial measures than about sustainability of services. They should first address operating issues, then couple the communication of improved operating plans with disclosure of less-than-expected historical financial performance. It is unlikely that new capital can be raised before operating issues are effectively resolved.

My recommendation to this executive team is:

1. Develop an operating plan that will restructure services, costs and capital needs to improve profitability for the foreseeable future.



2. Follow the controller's advice on accounting and disclosure. Defer revenue recognition but disclose the matter in detail.
3. Meet privately with lenders and rating agencies to alert them of the financial issues and management's plan to improve results.
4. Seek waivers from lenders, if necessary, on the basis that current cash flow issues are being addressed and future cash flows should provide sufficient liquidity to meet debt covenants.
5. Aggressively pursue litigation to recover disputed revenue.
6. Evaluate and pursue debt restructuring alternatives supportable by the new operating plan.

This approach will likely allow the executive team to maintain its credibility with the financial community; mitigate the risk that lenders and agencies will take drastic actions; sustain medical services to a needed market; and leave the hospital better prepared for an increasingly difficult operating environment. In this case, "doing the right" thing should result in a partnering response from capital providers.

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Carol spent 10 years at Coopers & Lybrand specializing in hospitals and not-for-profit organizations, in addition to having experiences in large commercial organizations. Following her years at Cooper & Lybrand, Carol was a senior financial executive at a major hospital corporation in Northern New Jersey, before taking her current position as CFO at the Roman Catholic Archdiocese of Newark.

“Current financial results are out of line with market expectations. Dr Weaver should educate outside stakeholders regarding the current problems and management’s proposed solutions”

The situation Union Hospital finds itself in is not unique. Managed care arrangements ended the “cost-shifting” of losses from providing services to indigent patients to insured patients. This impact was felt most acutely at inner-city facilities like Union Hospital, where a greater percentage of the patients served may have been indigent. Cuts in Medicare reimbursement rates as a result of the Balanced Budget Act hit inner-city hospitals most dramatically, although Congress eventually recognized this unintended impact and provided some relief. Depending on the strengths of any specialty services Union provides, such as cardiac or oncology services, managed care companies may or may not be motivated to negotiate more attractive rates with Union.

Given these revenue challenges, the expense management issues are no easier to conquer. Union is attempting to attract and retain nursing staff as the shortage of nurses intensifies. However, the salaries needed to accomplish this are rising while revenues stay basically flat. The costs of pharmaceuticals increase annually at incredible rates and are not always recouped, particularly from the indigent patients served.



Union Hospital is unique in one particular aspect. It appears that it is unaffiliated with any other hospital or hospital/health care system. The revenue challenges brought on by all the changes in health care reimbursement motivated hospitals to merge or affiliate in an effort to reduce overhead costs, particularly in back office functions, and to achieve greater pricing preferences through combined, committed purchasing volume. It appears the acquisition of the facility and its service area is not seen as a strategic “plus” to a competitor or investor. As a result of this unaffiliated status, Dr. Weaver’s fears could become reality: The community Union Hospital currently serves will be left without local access to inpatient hospital care if the hospital should cease to exist.

What should Dr. Weaver do? It is true that health care reimbursement is a highly complex and everchanging area. Significant estimates of future receipt of disputed items are common on the balance sheets and income statements of health care institutions. The regulations concerning reimbursement from governmental payors are subject to interpretation and providers at times take stances that are as aggressive as those taken regarding tax regulations in the for-profit arena. It can take years for the cases and their appeals to be resolved.

The management team at Union, specifically those from the financial areas, at this point need to have a discussion with their outside auditors. Accounting firms providing services to hospitals have expertise in the assessment of hospital reimbursement issues. The complexities of the issues and the material impact of the estimates required by hospital management make this area perhaps the most critical in the conduct of a hospital audit. Locally, the accounting firms with the greatest health care client presence stay very close to the progress of appeals and have opinions as to the eventual outcome. Full reserves on receivables may be adjusted as an outcome becomes clearer. The Medicaid issue being discussed is obviously not unique to Union and the hospital’s auditors will be taking a position with all their clients on the recognition of a possible gain. Union needs to get involved in the dialogue.

There are risks in choosing not to obtain the outside auditor’s concurrence and recording the receivable anyway. Should Union’s auditors disagree with the hospital’s recognition of the \$5.2 million receivable and adjust the financial statements, eliminating the \$5.2 million from revenue, the management team loses its credibility with the rating agencies, investment community, the board of directors and the auditors.

It would be naïve for the Union management team to believe that the losses would not become apparent in any due diligence process in connection with the bond issue. The losses will soon be felt in the cash balance, negatively affecting days in accounts payable. The statistical analysis used in any required projections of revenues will highlight the declining income versus the more aggressively increasing expenses.

Dr. Weaver and the management team need to discuss the facility’s challenges with its board and begin a discussion with the state regarding the potential technical default issues and concerns over the risk of the community becoming “medically underserved” should



Union close. This would be the best way to ensure the mission is preserved over the long term.

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Note: Martin's comments are based on a fictitious case, any resemblance to person living or dead is coincidental.



“By overstating its financial strength, Union would be acting like a fruit peddler who sells a bag of mostly spoiled cherries by placing a few juicy, ripe specimens on top.”

Dr. Weaver's temptation to recognize the disputed Medicaid payments as revenue stems from commendable motives. Indeed, it is in some sense refreshing to see an executive contemplating an accounting misdeed for a reason other than naked financial self-interest. Booking the \$5.2 million item would be unethical, all the same, and unlikely to achieve its purpose, to boot.

The moral objection arises from the harm that would be done to a party not mentioned in the financial management team's discussion. Purchasers of Union Hospital's bonds rely on the obligor's financial statements to estimate the risk and value of their investment. By overstating its financial strength, Union would be acting like a fruit peddler who sells a bag of mostly spoiled cherries by placing a few juicy, ripe specimens on top.

A further objection to the proposed aggressiveness in revenue recognition relates to the dissemination of misleading financial statements. If Union misrepresents its financial condition and investors consequently suffer unexpected losses, the victims will become more risk-averse. Other bond issuers will then be forced to pay higher interest rates than would otherwise be required. This increase in the cost of capital, in turn, will produce some small degree of underinvestment in the economy at large. To be sure, the impact of Dr. Weaver's decision will be infinitesimally small in an economy measured in trillions of dollars. The principle is the same for a small transgression as for a large one, however.

In this case, even the accounting "solution" to the revenue problem is unlikely to save Union Hospital. If Union's survival were threatened by a truly temporary cash flow problem, it would probably be feasible to obtain interim financing to avert a crisis. The



fact is, however, that managed care and tightened Medicare/Medicaid regulations are relentlessly driving down revenues by 3% to 5% a year, while costs are rising. Dr. Weaver cannot reverse these trends by any amount of accounting legerdemain. He can only destroy the fine reputation that he has built up over many years.

No doubt Dr. Weaver feels responsible for the hospital's thousand-plus employees. He also shows a praiseworthy concern for low-income members of the community who have no other health care providers besides Union. Attempting to cover up the cost-revenue squeeze at Union Hospital will not help those individuals over any extended period, however. Instead of becoming engrossed in "the subtleties of accounting gains and losses," Dr. Weaver should broaden his thinking about strategies for maintaining services in the face of changing economics in health care.

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The first thing that Dr. Weaver should do is ignore Albert Case's simplistic distinction between "conservative" accounting and what the hospital really needs. Institutions consistently misapprehend the range of options available to them for reaching their goals by ignoring risks inherent in the most obvious alternative. Thus, Mr. Case's admonition to ignore the "conservative" accountants in order to "do the right thing" misses the point—both because he takes no account of the serious risks inherent in his proposal and because he does not spend the time to consider the nuanced source of his problem and the potential solutions.

In spite of the hospital's difficult circumstances, Dr. Weaver cannot rush into making a decision. He first should initiate a number of steps designed to get him and the other decision makers the information they need to make a reasoned choice. To accomplish that, Dr. Weaver should establish consensus regarding:

- The hospital's mission.
- The hospital's principal users.
- Those users' chief needs.
- The resources necessary to satisfy those needs.

Only once Dr. Weaver and the rest of the management team have agreed on those critical elements will they be prepared to decide how best to achieve their operational goals.



After Dr. Weaver and the management team have defined their operational goals, they should determine how the broader economic and social trends will impair or enhance their ability to achieve them. For example, if the hospital's in-patient admissions and patient revenue were to continue to fall, maintenance of the same physical plant--even assuming few improvements--would take a larger share of revenue, hindering the hospital's ability to continue to maintain up-to-date technology and hire necessary staff. Similarly, management should identify the factors that have led to its past success (e.g., the trust of the financial community). Thus, the management team will need to determine how the institution's long- and short-term missions can best be achieved in its economic and social setting.

Only after all that analysis will Dr. Weaver and the management team be prepared to decide how to deal with potential revenue from historical Medicaid payments and whether to seek refinancing of its bond issue. In reaching their decision, Dr. Weaver and management should probably consult with other stakeholders, such as the nurses' union and representatives of the local and financial communities. A solution that appears to satisfy all of management's goals might very well disappoint other stakeholders, thereby causing unanticipated problems that will overwhelm whatever good was going to come of management's solution.

In the immediate case, it appears that:

1. The hospital needs an infusion of cash to maintain its current standard of care.
2. It is too large for its current needs.
3. Its operating costs are increasing as its revenue is decreasing.
4. Current financial results are out of line with market expectations.

Further, no matter what benefit can be had from the \$5.2 million in revenue from historical Medicaid payments potentially owed by the state, the long-term trend seems to be toward disappointing financial results, regardless the one-time bump up were the revenue recognized in the current year.

Even assuming that recognizing the \$5.2 million was permissible in the current year, it would merely mask what would likely be poor future financial results. Even worse, were the hospital to use the financial results--including the \$5.2 million--as the basis for filing a new bond registration, without adequate disclosure (which would nullify the utility of applying the \$5.2 million in the current year), the hospital, its directors and managers at least might be liable in the event of a future default and at worst might have committed fraud.

The questions of whether and when to recognize the \$5.2 million in revenue are just the tip of the iceberg. To make a reasonable decision about the \$5.2 million, he and management need to be in a position to assess the characteristics and consequences of their revenue situation. Only then can they approach other stakeholders and determine how to proceed. Using a deliberative process (even if they are under time pressure), management will likely reach a better long-term solution and will minimize the likelihood that they or the hospital will be subject to future liability.



Dr. Weaver would do well to think like both a doctor and a coach. To arrest the hospital's decline, he should ask management to identify how to realign goals so that they are consistent with the circumstances in which it finds itself. He should then educate other stakeholders regarding the current problems and management's proposed solutions.