

BoardBrief

Prepared for Colorado Hospital Association Trustees

Financial Basics for Trustees

The board is responsible for the financial success of the hospital. In order to fulfill this fiduciary responsibility, trustees must have a solid grasp of the indicators of the hospital's financial health, and be knowledgeable about key financial interrelationships.

For the lay person, or the person with limited knowledge of financial statements and financial statement analysis, the issue of corporate governance and oversight as they relate to financial statement analysis can be an intimidating task. In order to effectively serve as a board member, trustees must begin by understanding their responsibility as a board member, and then learn the financial basics necessary to fulfill their role.

The Board's Role in Financial Oversight

The board is responsible for the financial success of the hospital, and fulfills a fiduciary responsibility that is defined as: a duty of organizational loyalty; a duty of care through application of business judgment; and a duty of obedience in abiding by laws, regulations and standards of hospital operations. Given past fiascos such as the Enron, WorldCom and HealthSouth governance failures, which led to charges against board members entrusted to protect the corporation's assets, the accountability of hospital board members is greater than ever.

Applying firm and consistent ethical practices to decision-making responsibilities is a necessary hallmark of the hospital board. An abiding interest in utilizing a "moral compass," well-established ethical principles to be used when deciding about board actions that concern ethical/moral dilemmas of services provided to the community served, provides the necessary balance to board decisions.

Boards have a broad responsibility to protect the limited resources of the hospital to ensure optimum services and benefit to the community. The board must ensure the cost-effective utilization of resources and the establishment of both long-range and short-range financial plans. The board should regularly review meaningful and understandable financial

reports, ensure that adequate capital is available for the hospital's investment strategies, and actively participate in and encourage regular philanthropic efforts.

One of the most critical functions of the governing board is protecting the hospital's financial status. The board should establish financial goals in a variety of key areas including growth, debt capacity, return on equity and other areas that define financial success. The board approves the annual operating and capital budgets, receives and approves a variety of budget reports throughout the year, primarily through a finance committee, and oversees the hospital's investment policies and goals.

In addition, boards of trustees are typically involved in assessing the impact of the hospital's pricing strategies and discount policies, and become involved in discussing and approving contractual arrangements and other determinants of financial performance. Boards also determine policy on

Key Financial Questions for Boards to Consider

When reviewing the hospital's finances, the board should know answers to questions such as:

- What is your organization's payer mix? How is it changing?
- How has/will health care reform and the subsequent payment incentives impact the organization's financial viability?
- What are the organization's major investments, and are they financially sound?
- What are the major drivers behind changes in the organization's key financial metrics over the past 3 years?
- What are the organization's financial projections for the future, and what assumptions were used?
- Does the board have a sufficient financial understanding to review and analyze financial statements, trends and projections and identify warning signs and the potential need for a change in the organization's course?

Actions Boards of Trustees Can Take: Financial Focus and Leadership

- Ensure that annual operating and capital budgets are developed and approved, and that rolling 3-5 year financial forecasts are produced
- Identify, review and approve targets for debt, liquidity, ROI, profitability, and other important measures of financial and operational performance needed by the board to monitor organizational performance and make timely, informed decisions
- Ensure that key financial ratios are monitored at least quarterly, and that financial and operational implications and corrective measures are developed by management, when appropriate
- Develop a reporting style that is easy to understand, highlights major trends, and stimulates creative discussion
- Exercise broad authority to protect the limited resources both of the institution and the community
- Ensure the cost-effectiveness utilization of resources
- Lead the development of long-range and short-range financial plans, performance evaluation against the plans, and regular financial reports to the board
- Review the types and scope of services being offered
- Ensure that adequate capital is available for the organization's investment strategies
- Actively encourage philanthropic support
- Approve the budget and provide for day-to-day cash needs
- Determine fiscal policy relating to insurance coverage, discount policies and third-party reimbursement
- Determine policy on the provision of needed community services

uncompensated care, provision of needed community services that may not be financially viable, and development of diversified revenue streams.

Over the years, Medicare and Medicaid payments have not kept pace with inflation and hospitals have increasingly experienced financial difficulties. One of the primary objectives of the ACA is to shift the nation's health care delivery system from one that is paid based on volume (the number of services received/fee-for-service) to a payment system based on value (payment for high quality, cost-effective care). Enactment of new payment systems under the ACA may drive further reductions in revenue if hospitals fail to prevent readmissions, have a high incidence of hospital-acquired conditions, or fail to achieve or improve value-based quality scores.

Furthermore, boards are responsible for ensuring that the hospital consistently complies with all applicable laws and regulations. With the federal government's emphasis on detecting and punishing health care fraud, trustees must ensure that an ethical business climate always exists in the hospital, and in particular that financial procedures and processes are conducted in an ethical manner.

Compliance

A strong and effective compliance plan is a comprehensive strategy that ensures that the hospital consistently complies with all state and federal laws governing its activities and the

delivery of health care. It also ensures that the hospital consistently complies with the applicable laws relating to its business practices.

A key board responsibility is determining the hospital's financial goals and monitoring its operations to ensure the attainment of those goals. The annual budget is the primary vehicle for the board and administration to establish financial objectives. Board members must clearly understand the assumptions upon which the budget is based. Budget assumptions should be reasonable and clearly understood, and should tie directly to service development and to the hospital's mission, vision and strategies.

The governing board also has a responsibility to engage external auditors to perform an annual audit of the hospital's financial records. This audit helps the board determine if the financial position and operations are accurately and fairly presented, and are in accordance with generally accepted accounting principles. The board should use the audited financial statements to determine whether the hospital is reaching its established financial and operational targets; it should be a tool in helping to determine progress and assess whether goals and strategies require modification.

The board's financial planning direction and decisions should flow out of the hospital's long-range strategic planning initiatives. Studies of the financial feasibility of new programs or

capital acquisitions should be regularly performed and reported to the board. The board should then use financial performance against budget and compared to peer groups as a tool for gauging organizational progress and effectiveness.

Financial Basics

As a general overview, there are three basic statements that board members should review. These statements, the Balance Sheet, Statement of Operations and the Statement of Cash Flows, should be reviewed together, rather than on a stand-alone basis, since they are all interrelated. Problems that might be masked by looking at one or two statements become easier to identify when examining all three together.

The Balance Sheet

The balance sheet lists the assets, liabilities, and equity of the hospital. It also classifies those assets which are expected to be turned into cash within one year (identified as “current assets”), and those debts which are going to be due for payment to the lender within one year (identified as “current liabilities”).

The Statement of Operations

The statement of operations (or “income statement”) identifies the sources and amounts of revenue after they have been adjusted for contractual allowances, as well as the operational and non-operational expenses of the organization. It provides the reader with the “bottom line” of the organization, from both an operating and non-operating basis.

The Statement of Cash Flows

The statement of cash flows is without a doubt the statement that provides the most confusion in financial statement analysis. This is unfortunate, since it can in certain circumstances be the most important statement reviewed. The statement of cash flows identifies the sources and uses of cash. It attempts to explain to the reader where the cash is coming from, and what it is being used for.

What is your organization’s cash balance? What is that cash being used for? Is there a declining balance? Are large payments due to be paid on debt which will reduce the amount of cash further, and which will strain the organization? How can you find the answers to these questions?

These questions can be answered by looking at the statement of cash flows and the balance sheet. The balance sheet lists the cash balance as the first item. On comparative statements (statements with balance information from prior periods listed for comparative purposes next to the current information) you can see if the cash has increased or decreased since that time. But the most important question to ask is what is causing the

Financial Warning Signs

Below are several key warning signs boards must watch for when reviewing hospital financial statements. When these warning signs occur, trustees must ask management for more information, and develop an action plan to address the problem.

1. More accounts receivable and/or accounts payables
2. Shrinking operating margin
3. Less cash
4. Decreased market share
5. Loss of key admitting physicians
6. Organizational inability to measure monthly financial and operating performance, and report in a timely manner to the board
7. Negative variations from approved budgets
8. Organizational inability to respond to regulatory actions
9. Advisor turnover (especially legal or accounting advisors)
10. Rating agencies’ debt downgrades and/or change to negative outlook
11. Violations of restrictive covenants in borrowing and credit enhancement agreements
12. Executive compensation and benefits packages that are controlled by management and not the board
13. Management recommendations to diversify in order to increase revenue when internal operations are not well-controlled

Source: Best Financial Practices for Trustees, James S. Vaughan, Principal, Catherine J. Robins, VP, Cain Brothers. Trustee Magazine. March 2001.

cash balance to go up or down. This can be answered by reviewing the statement of cash flows. This statement tells the reader where the cash is coming from and where it is going. For instance:

- If the source of the increase or decrease in cash is from the operations of the organization, then there will be an increase or decrease in the line “Net increase (decrease) in cash from operating activities”
- If the source of the increase or decrease is from purchases or sales of fixed assets or from purchases or sales of investments of the organization, there will be an increase or decrease in the line “Net increase (decrease) in cash from investing activities”

- If the source of the increase or decrease in cash is from incurring debt or repayment of debt, or from equity related activities, then there will be an increase or decrease in the line “Net increase (decrease) in cash from financing activities”

The question to ask is “why is our cash balance increasing or decreasing?” Just because a hospital has more or less cash than it had in the prior month is not necessarily a cause for alarm. The reasons are many and varied, good and bad. Did you refinance or incur new debt? Did you make a large debt payment? Is operations using cash, or providing cash to the organization? Did you purchase fixed assets or property?

Another question to ask related to cash is “what is our cash balance anticipated to be in the future?” Do we have any large debt payments or other obligations that we are going to be required to pay in the near future? This can be answered by looking at the balance sheet and seeing if the current liabilities are large, or if they have increased over the prior comparative balances.

Accounts Receivable and Revenue

Most of the revenue derived from patients is received based upon contractual arrangements with payers. The hospital records revenue for the services at a standard amount, called the Gross Revenue amount, and then adjusts this amount down through a Contractual Allowance or Adjustment to record the actual amount which it will receive. The corresponding accounts receivable for the balance due is based upon the adjusted or Net Revenue amount.

Investments

Investments by the organization are a critical area to monitor. When the organization invests in an affiliated or unaffiliated entity, such as a medical office building or a partnership with a medical imaging organization, the income and losses of those investments need to be recorded by the investing organization.

Those persons responsible for oversight of the organization need to be aware of the results of operations of these investments and management’s level of responsibility in the investment. Is your organization responsible for debt of the investee organization if the investment becomes insolvent? Ask management for details of all material investments. Ask if the organization is liable for losses. Ask if all losses are being recorded properly.

Liabilities

Management is required to record a liability when they become aware of the liability and when the amount of the

liability can be determined. Management is given some leeway in estimating the amount of liability to record, based upon their judgment of the likelihood of occurrence of the event or the degree to which changes in the amount due could change over time.

Increases in accounts payable on the balance sheet should be understood by those responsible for oversight. An understanding of why there have been increases is necessary for proper governance. Is management holding back payment to increase cash balances? Has the aging of accounts payable increased and are large repayments going to be required in the near future?

Current and Long Term Debt

Current and long term debt is a very important area to understand and monitor. Increases in debt without increases in investments or fixed assets could signal borrowings being used for operational purposes. Understanding the dates that the debt facilities are due to be paid off is critical for cash management. Shortfalls in cash balances should be forecasted by management and discussed. Are bond repayments anticipated in the cash flow model of the organization? Could existing debt be refinanced to obtain better interest rates and repayment terms? A review of the statement of cash flows will reveal how much cash is being paid out for principal repayment, as well as the amount of new debt which has been incurred by the organization during the period.

Understanding Financial and Operating Ratios

Deconstructing your hospital’s financial statements into a number of financial and operating ratios enables trustees to better analyze financial performance. In addition, it enables the board to benchmark the hospital’s performance compared with a variety of peer groups (other hospitals with similar revenues, geographic locale, highest performance, etc.). A good starting point in using the ratios is to graph a 3-5 five year historical trend line for each. Below is a list of ratios, what they measure, and the implications of each.²

Profitability Ratios

Total Margin. Total margin is the excess of revenues over expenses divided by total revenues, net of allowances and uncollectables. It reflects profits from both operations and non-operations. Hospitals in the high-performance group realize significant improvements in their total margins. Improving total margins are a reflection of success in cost management efforts. *Implications: An up trend is considered positive.*

Free Operating Cash Flow to Revenue. Free operating cash flow to revenue is cash flow from operations less capital expenditures, divided by revenue. Free operating cash flow to revenue is a measure of profit often used in valuations because it better reflects the available cash return. A value less than zero most likely indicates an operating loss. The primary strategy for correcting a low free operating cash flow situation is tight cost management. *Implications: An up trend is considered positive.*

Free Operating Cash Flow to Assets. Free operating cash flow to assets is defined as cash flow from operations less capital expenditures, divided by assets. A value less than zero most likely indicates an operating loss. The primary strategy for correcting a low free operating cash flow situation is tight cost management. *Implications: An up trend is considered positive. A free operating cash to asset less than zero most likely indicates an operating loss.*

Return on Equity. Return on equity is the amount of net income earned per dollar of net assets or equity. High values for return on equity indicate a hospital's ability to add new investment in plant, property and equipment without adding excessive levels of new debt. Return on equity values are significantly lower in smaller hospitals. *Implications: An up trend is considered positive.*

Liquidity Ratios

Current Ratio. Current Ratio is the number of dollars held in current assets per dollar of current liabilities. It is the most widely-used measure of liquidity. More profitable hospitals are likely to have higher current ratio values. *Implications: An up trend in this area is positive.*

Days in Patient Accounts Receivable. Days in patient accounts receivable is the average time that receivables are outstanding, or the average collection period. Higher collection periods lead to greater AR short-term financing requirements. High-Performance hospitals maintain lower days in AR, which leads to better overall asset efficiency and return on total assets. Reductions in days in patient AR translates into higher values of cash and investments. *Implications: A down trend in this area is positive. Reductions in accounts receivable reflect improved hospital management in the receivables area. High performance hospitals routinely and aggressively focus on collecting cash as quickly as possible.*

Average Payment Period. Average payment period is a measure of the average time that elapses before current liabilities are paid. High values may indicate potential liquidity problems. *Implications: A down trend is considered positive.*

Days Cash on Hand. Days cash on hand, all sources measures the number of days of average cash expenses that the hospital maintains in cash and marketable securities. It is a measure of total liquidity, both short-term and long-term. *Implications: An up trend is considered positive. High-performance hospitals have higher days cash on hand, from all sources than low-performance hospitals. Low-performance hospitals may face major liquidity problems. High-Performance hospitals maintain needed, but not excessive, cash positions.*

Capital Structure Ratios

Equity Financing Ratio. Equity financing ratio measures the percentage of total assets financed with equity. High values imply that the hospital has used little debt financing in its asset acquisition, and has relatively low financial leverage. *Implications: An up trend is considered positive.*

Long Term Debt to Capitalization. Long-term debt to capitalization is the proportion of long-term debt divided by long-term debt plus net assets or equity. Higher values imply a greater reliance on debt financing, and may imply a reduced ability to carry additional debt. High-Performance hospitals rely less on debt and more on equity. Higher bond ratings are usually associated with lower long-term debt-to-capitalization values. *Implications: A down trend is considered positive.*

Cash Flow to Total Debt. Cash flow to total debt is the percentage of cash flow to total liabilities, current and long-term. It is an important indicator of future financial problems. High-performance hospitals show an increasing trend in cash flow to total debt. *Implications: An up trend is considered positive. Low performance hospitals have a dangerous declining trend in Cash Flow to Total Debt.*

Debt Service Coverage. Debt Service Coverage measures total debt service coverage (interest plus principal) from the hospital's cash flow. Higher values for debt service coverage indicate better debt repayment ability. *Implications: An up trend is considered positive.*

Cushion Ratio. The cushion ratio measures the relationship between total debt service, both interest and principal, and total cash reserves, both current and non-current. A high value means that the hospital is less likely to default on debt service payments because it has the cash reserves to meet its expected obligations. *Implications: High-performance hospitals have higher cushion ratios than low-performance hospitals.*

Asset Efficiency Ratios

Total Asset Turnover. Total asset turnover provides an index of the number of operating revenue dollars generated per dollar of asset investment. Higher values for this ratio imply greater generation of revenue from the existing investment in assets. *Implications: High-performance hospitals have lower total asset turnover ratios than low-performance hospitals.*

Fixed Asset Turnover. Fixed asset turnover measures the number of operating revenue dollars generated per dollar of fixed asset investment. High values imply good generation of revenues from the existing fixed asset base and are a positive indicator of operating efficiency. Rural hospitals have higher fixed asset turnover values than urban hospitals due to older plants in the rural sector and less investment in capital-related assets. *Implications: An up trend is considered positive. Fixed asset turnover is a good measure of hospital utilization.*

Current Asset Turnover. Current asset turnover measures the number of revenue dollars generated per dollar of investment in current assets. Higher values imply a greater efficiency in the employment of current assets than do lower values. Higher investments in cash and accounts receivable will reduce current asset turnover. High-performance hospitals have lower investments in patient accounts receivable, and therefore more cash. *Implications: Increasing values are desirable.*

Other Financial Ratios

Average Age of Plant. Average age of plant provides a measure of the average age in years of the hospital's fixed assets. Lower values indicate a newer fixed asset base and, thus, less need for near-term replacement. Average age of plant may also be indirectly associated with the quality of care provided. *Implications: Higher values for Average age of plant are negatively correlated with most measures of debt financing. High-performance hospitals have significantly newer plants than low-performance hospitals.*

Depreciation Rate. Depreciation rate provides a measure of the rate at which the organization is depreciating its physical assets. Increases in this rate often imply that newer assets are being added to the organization's depreciable asset base. Larger hospitals have a higher Depreciation rate than smaller hospitals. This is an indication that greater capital expenditures have taken place in larger hospitals and also that they have newer physical facilities. Rural hospitals have lower depreciation rates than urban hospitals. Less capital is being expended in the rural hospital sector. *Implications: Hospitals that curtail capital expenditures will see the average age of their physical facilities rise and their depreciation rates fall.*

Depreciation rates for high-performance hospitals have been stable over the past five years, while they have decreased for low-performance hospitals.

Capital Expenditure Growth Rate. The Capital expenditure growth rate is defined as the percentage of the organization's total gross property, plant and equipment that was added in a given year. This percentage will vary greatly over time as capital expenditures fluctuate. Higher values for this indicator imply an active capital expenditure program of additions and replacements. Rural hospitals have lower capital expenditure growth rate values than urban hospitals due to less intense use of newer technology. *Implications: Financial inability to fund capital expenditures in low-performance hospitals. Further declines will result in even older physical facilities and the absence of state-of-the-art technology. This may further compound the problems of low-performance hospitals by driving away needed customers, especially physicians.*

Price Indicators

Gross Price Per Discharge. Gross price per discharge measures the average charge per unadjusted discharge. Gross price per discharge (adjusted for case mix & wage index) adjusts for differences in case mix complexity and differences in prices that may be a result of cost of living differences among regions. Rural hospitals have gross price per discharge values that are lower than those of urban hospitals on both an adjusted and unadjusted basis. However, when hospitals are categorized by size, rural hospitals and urban hospitals have similar prices. *Implications: High-performance hospitals have historically had higher gross prices than low-performance hospitals. High-performance hospitals maintain higher net prices than low-performance hospitals.*

Gross Price Per Visit. Gross price per visit measures the average amount of charges per unadjusted visit. Contractual allowances, bad debts and other discounts are not subtracted in this price measure. It reflects what a patient might pay if there were no discounts or allowances granted. *Implications: High-performance hospitals make more money from outpatient operations than low-performance hospitals. High-performance hospitals appear to generate their profit through higher prices and lower costs. This may reflect differences in complexity. It may also reflect greater ability to charge higher prices in these areas.*

Medicare Payment Percentage. Medicare payment percentage provides a relative measure of the hospital's reliance on Medicare patients. Rural hospitals have consistently reported higher values for Medicare Payment Percentage than

urban hospitals. Some of this difference may be related to size, as larger hospitals are more likely to have a greater range of services than smaller hospitals. **Implications:** Medicare is a desirable payer for many hospitals, especially those with high percentages of managed care patients.

Contractual Allowance Percentage. Contractual allowance percentage defines the percentage of gross patient revenue that is discounted to third-party payers. Increasing values for this indicator put tremendous pressure on hospital prices in those limited areas in which fuller recovery of rate is possible. Significant negative pressure on hospital profitability has been increasing contractual allowance percentages. Much of the increase in contractual allowance percentage results from inadequate increases in Medicare and Medicaid payments, and to increasingly larger discounts granted to managed care payers. **Implications:** High-performance hospitals have similar gross prices on a case mix-adjusted basis, but they have higher net prices. Lower write-offs in high-performance hospitals are either a reflection of a better payer mix, especially private insurance, with lower discounting, or better coding of cases. High-performance hospitals may do a better job of optimizing the DRG codes assigned to Medicare patients than low-performance hospitals. Coding can have a pervasive impact upon payment.

Volume Indicators

Average Daily Census. Average daily census provides a measure of inpatient volume. Average daily census is a function of both discharges and length of stay. Increases in average daily census should ideally come from increases in discharges rather than from increases in length of stay. Urban hospitals have much higher values for average daily census than rural hospitals due to larger number of beds and greater lengths of stays. **Implications:** Average daily census is expected to decline as the focus of care continues to shift to outpatient facilities.

Occupancy Percentage. Occupancy percentage provides a measure of facility utilization based on licensed beds. The use of beds to measure capacity does not reflect the substantial amount of hospital capacity that is not involved with inpatient care. **Implications:** Occupancy is higher in high-performance hospitals. It is not a filled bed which generates revenue, but rather a new admission. High-performance hospitals have much higher discharges per bed than low-performance hospitals.

Occupancy for Staffed Beds. Occupancy for staffed beds provides a measure of facility utilization based on staffed beds.

Implications: High-performance hospitals have lower values for occupancy for staffed beds than low-performance hospitals. This may indicate that low-performance hospitals have plants that are less utilized, but they are more willing to designate beds as not staffed.

Length of Stay Indicators

Length of Stay. Length of stay measures the average time an inpatient spends in the hospital. In today's environment of fixed payment per case, a reduction in length of stay is usually desirable. The reduction in length of stay is a reflection of cooperative relationships between hospitals and physicians. **Implications:** High-performance hospitals have been able to achieve slightly lower values for length of stay than low-performance hospitals.

Efficiency Indicators

FTEs Per Adjusted Occupied Bed. FTEs per adjusted occupied bed is a traditional measure of inpatient productivity. As Length of Stay declines, the amount of service per day increases because a significant amount of hospital service is front-loaded.

Implications: Controlling FTEs per occupied bed is an important element of total labor productivity. Control over total case cost is the primary objective. High-performance hospitals have reported lower values for FTEs per adjusted occupied bed than low-performance hospitals.

Total Revenue Per FTE. Total revenue per FTE is defined as total revenue, (or net patient revenue plus other operating and on-operating revenue), divided by the number of FTEs. Total revenue per FTE is a useful measure of productivity in an increasingly diversified industry. **Implications:** High-performance hospitals have higher values for total revenue per FTE than low-performance hospitals, and the gap appears to be widening. The ultimate measure of productivity is value created per FTE.

Focus on the Financial Future

Trustees must pay close attention to the financial impacts and implications that the forces and trends of transformation may have on their hospitals and health systems. Moody's Investment Services, Standard & Poor's Financial Services LLC and Fitch Ratings are the "Big Three" ratings agencies. They closely monitor the financial performance of hospitals, frequently issuing financial analyses and projections for the

health care field. Ratings agencies and others have projected a financially difficult time for hospitals as the nation's health care system advances through transformation. Hospital boards should be vigilant to the concerns cited by financial experts, engaging in the oversight, discussions and actions necessary to ensure the hospital's or health system's financial stability and sustainability.

Some of the critical concerns cited for not-for-profit hospitals in 2014 include:

- The annual growth rate of expenses is outpacing the growth rate for revenue
- Payer mixes are shifting from commercial payers towards government payers
- Reimbursement cuts in Medicare and Medicaid programs
- Commercial payers are tightening rate increases
- High-deductible plans are increasing, shifting greater percentages of costs to patients and thereby increasing bad debt incurred by hospitals
- Shifts in care delivery from hospitals to outpatient or ambulatory settings

- Declining patient volumes and increased competition for patients
- Increased demand for capital investment in IT and other infrastructure needs
- Declines in operating margins and cash flow

Sources and Additional Information

1. James S. Vaughan, Principal, Catherine J. Robins, VP, Cain Brothers. Best Financial Practices for Trustees. *Trustee Magazine*. March 2001.
2. Almanac of Hospital Financial and Operating Indicators. Optum. 2013.
3. Moody's Investors Service. Moody's: Preliminary Medians for Not-For-Profit Hospitals Show Expenses Growing Faster Than Revenues. April 23, 2014. www.moody.com.
4. Outlook Negative for Not-for-Profit Hospitals. Healthcare Financial Management Association (HFMA). January 2, 2014. www.hfma.org.