

# VIKINGLAND VIEWPOINT

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## Predicting the Future Demand of Rural Health in a Troubled Economy

By Cory R. Rutledge, CPA, Manager Health Care , Larson Allen

It is official: Our country is in a recession. The news is filled with talk of bailouts of Wall Street and the US automobile makers. On a personal level, you may be experiencing a shrinkage in your retirement account and a reduction in your home value. From a professional perspective, you are seeing decreased reimbursement, higher levels of uninsured, and a growing need for capital investment. This feels like a good time to stick our heads in the sand and wait for better times.

As healthcare leaders, however, it is more critical now than ever to create strategies that will promote the growth and financial viability of the healthcare organization in your community. A critical step in the development of these strategies is to survey the environment and determine which elements will influence the demand for healthcare. There are several factors that impact rural areas in a unique way, and the exploration of these factors can assist in the implementation of strategies that will encourage the prosperity of healthcare in rural Minnesota

### Demographic Factors

It is common knowledge that the population of the US is living longer. In fact, Minnesota is ranked second in the nation in

terms of life expectancy at 78.8 years. These elderly Minnesotans are in much higher concentrations in rural areas. Benton, Sherburne, Carver, and Anoka counties are the only counties in the state with under 15% of the population under the age of 65. With very few exceptions, all counties that are north of Lake Mille Lacs, and all counties west of the St. Cloud area have elderly populations that make up between 23% and 35% of the total population. Also, Minnesota has the highest projected percentage of population growth of individuals age 85+ between the years 2010 and 2020 in the entire upper Midwest.

As the population ages, healthcare use rates increase exponentially. Individuals aged 65 to 74 are more than twice as likely to require an inpatient stay as their counterparts aged 55 to 64. Once these individuals are aged 75+, they are nearly four times as likely to require an inpatient hospital stay. Moreover, the average person aged 55 to 64 visits a clinic 4.5 times per year. This increases to over 6 visits per year for the 65 to 74 population and to nearly 7.5 times per year for those over age 75.

In addition to the challenges rural healthcare providers face in caring for an aging popula-

tion, another demographic change in rural Minnesota, childhood poverty, will also require the attention of rural healthcare leaders. Rural areas are facing much higher instances of childhood poverty. For example, half of the 152,000 children living in poverty are living in rural areas, and the eight Minnesota counties with the highest rates of childhood poverty are all rural counties. Minnesota has historically enjoyed very low instances of childhood poverty, but rates have risen by 35% from 2000 to 2005, which is more than double the national increase of 12%. The number of children living in "extreme poverty", which is defined as 1/2 of the poverty income level, has increased by 67% over the same period. This increase is nearly five times the national average of 14%.

### Community Health Factors

The overall health of Americans is diminishing due to higher instances of inactivity and poor diet. Although Minnesota is one of the healthiest states in the union, our ranking recently dropped from second to fourth, according to the United Health Foundation.

*Continued on Page 4*

### INSIDE THIS ISSUE:

Red Flag Rules: 2  
A Good Idea for Healthcare

What Do We Do With Our Nursing Home? 3

Daschle to Head Health and Human Services 6

A Message from President Ken 13

Up Coming Events 13

January 29th Winger Institute Promises To Be Excellent! 14

Certification Update 15

New Members 15

Job Postings 16



## Red Flag Rules: A Good Idea for Healthcare

By Bruce Nelson, Vice President, SearchAmerica

If you are like most healthcare financial professionals, you have first-hand knowledge of countless patients who used another identity to procure their medical services. Perhaps they stole an insurance card from a family member, or simply borrowed a stranger's driver's license to cover the costs of elective surgeries, or much worse. Either way, your organization and the rightful owner of the identification were violated, and most likely left with a large hospital bill that would never be recovered.

Identity theft is prevalent and on the rise. The Federal Trade Commission (FTC) is taking an important step to combat this trend, not only in healthcare, but across financial and lending institutions with its Red Flag Rules and its deadline of November 1, 2008. The Rules apply to any organization, not just healthcare, that extends

credit to individuals through a multi-payment plan or covered account.

Some view this regulation as yet another government requirement. I urge you to instead view the Rules as a catalyst to implement changes in your hospitals that will protect you and your patients from identity theft and is an impact on your bottom line.

To comply with the Rules, companies must submit their written program to identify and manage 'red flag' accounts by November 1, 2008. Each program needs to meet certain details on how your organization will **identify, detect and respond** to patterns, practices, or specific activities — known as "red flags."

*Continued on Page 7*

# Reimbursement SERVICES GROUP



**“Believe it or not, many standalone nursing homes make money. Some make lots of money!”**

## What Do We Do With Our Nursing Home?

By Kimberly Heller, Partner, Wipfli LLP

David Brenne, Director Health Care, Wipfli LLP

If your critical access hospital includes a nursing home, you have probably asked yourself “What do we do with our nursing home?” When you look at the nursing home financial statement (if you create a separate nursing home financial statement), it undoubtedly appears the nursing home is drowning in a sea of red ink. Unfortunately, while this may be the case, organizationally coexisting critical access hospitals and nursing homes often have a textbook love-hate relationship. They can’t live with each other and they can’t live without each other!

This article will explore some of the myths and realities in this relationship, provide some hope for the weary, and in the end, provide some insight to assist management and governance in making educated decisions rather than uninformed and emotional decisions on this important topic.

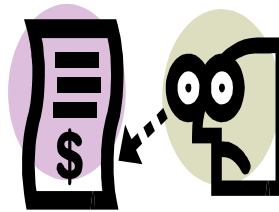
**Myth: Our nursing home has a “sea” of red ink.**

**Reality: It may actually be just a river or a stream.**

There’s value and danger in creating a separate financial statement for the nursing home. The value is that a separate nursing home financial statement encourages an understanding of the nursing home financial challenges and operation. On the other hand, the danger is that a

separate nursing home’s financial statement can promote the notion that the organization as a whole could have tremendously improved financial performance if the nursing home were closed or sold.

In reality, a careful financial and operational analysis by knowledgeable professionals must be completed to quantify the effect of any decision to close, sell, or downsize a hospital-based nursing home. In some cases, closing the nursing home could make the financial situation of the remaining operation better, but in other cases, it could actually become worse! In addition to understanding the nursing home financial statement, all of the following issues must be taken into account in deciding whether to close, sell, or downsize a nursing home operation:



*Continued on Page 8*

**THE NEW CPAs and Consultants**

Cover Story - Predicting the Future Demand of Rural Health in a Troubled Economy

The Minnesota Department of Health states that rural Minnesota is trailing metro Minnesota in the majority of health measures, including alcohol and tobacco use, obesity, inactivity and injury rates, and dental care. These risk factors are linked to chronic illness, which is an enormous burden on our healthcare system.

**Role of Family Care giving**

In addition to serving a population that is aging, increasingly impoverished and less healthy, rural providers are also seeing the demand for care increase as a result of lower instances of family care giving. Historically, when a loved one fell ill, a family member would care for them. With elders living longer and family members moving away from their hometown in increasing numbers, family care giving is decreasing sharply. The percentage of family care giving has dropped by six percent from 1998 to 2001. Each one percentage point drop in the family care giving ratio requires approximately \$30 million in additional public funds for the State of Minnesota.

**Housing Choice Factors**

As family care giving decreases, older Minnesotans are requiring assistance in living. In the past, this assistance has come in the form of skilled nursing facilities (SNFs). Currently, older Minnesotans are demanding more community and home based services in lieu of long-term stays in SNFs. In fact, the demand for skilled beds in Minnesota is expected to decline by 7,300 beds by the year 2030. This decrease in SNF beds will require an additional 16,600 assisted living units over the same time period. SNF admissions for short stay recovery and rehabilitation are expected to double over the next 25 years, and this category of stay is expected to make up 70% to 80% of all resident days by 2030.

**What can be Done to Flourish in Such an Environment?**

There is no doubt that several challenges are evident as we strive to provide healthcare services in rural areas. A review of the financial performance of critical access hospitals (CAHs) shows that larger and mid-sized CAHs are performing fairly well, where smaller CAHs are having less favorable financial results. We also see that, generally speaking, Minnesota CAHs are performing better than national medians, as shown in the table below.

	All CAHs Median (2004)	All CAHs Median (2005)	All CAHs Median (2006)	All MN CAHs Median (2004)	All MN CAHs Median (2005)	All MN CAHs Median (2006)
<b>Profitability</b>						
Operating EBIDA Margin	4.9%	5.2%	6.6%	8.1%	8.2%	10.7%
Operating Margin	-0.8%	-0.6%	1.0%	2.0%	1.7%	2.9%
Total Margin	1.5%	2.3%	3.4%	2.5%	3.1%	4.5%
Debt Service Coverage	2.49x	2.74x	2.94x	2.62x	2.52x	3.35x
<b>Liquidity</b>						
Net Days in Accounts Receivable	58	57	58	55	56	61
Days Cash on Hand (All Sources)	44	49	51	70	72	87
Cushion Ratio	5.0x	6.2x	5.7x	5.7x	6.4x	8.7x
Cash To Debt	68%	74%	72%	79%	53%	83%
<b>Capital &amp; Leverage</b>						
Debt Service as a % of Revenues	2.7%	2.6%	2.9%	3.2%	3.8%	3.9%
Average Age of Plant	10.2	9.8	9.7	8.6	9.2	9.2
Debt to Capitalization	29%	30%	31%	29%	35%	38%

Continued on Page 5

“As healthcare leaders, however, it is more critical now than ever to create strategies that will promote the growth and financial viability of the healthcare organization in your community.”

**“Successful rural hospitals have demonstrated that, to preserve and strengthen health care services, they must also be active in community economic development.”**

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Cover Story Continued from Page 4 - *Predicting the Future Demand of Rural Health in a Troubled Economy*

Successful rural hospitals have demonstrated that, to preserve and strengthen health care services, they must also be active in community economic development. The continued success of a rural hospital is dependent on five critical factors:

- \* Successful rural hospitals will recruit and retain high quality health care providers. Acquiring family practice physicians, pediatricians, surgeons, and other providers is critical to the financial viability to a hospital. Since it is more difficult for rural areas to recruit providers, and it is very expensive to recruit such providers, the retention of providers for several years is critical to the viability of a hospital.
- \* The growth of the economic base of a rural hospital's community is imperative. Overall levels of uninsured and poverty will be lower when there are employers that provide jobs and benefits to those in the community. These employers will

also bring families to the community, and this age diversity is key to the long-term viability of the community.

- \* Developing innovative programs that serve high numbers of uninsured patients economically is important. Regardless of the economic base, all communities have uninsured portions of their population. By serving these individuals in an innovative and economical way, it may be possible to prevent them from becoming acutely ill and requiring emergency care, which is very harmful to the financial wellbeing of a hospital.
- \* It is critical to expand the boundaries and definitions of health care beyond traditional hospital and ambulatory care to meet the unique needs of frail elders in our communities. Home and community based options are very popular, and these services provide cost effective options for the elderly in our communities.
- \* Finally, it is essential to assure that a clinically competent nursing workforce is available to care for older adults as family structures change and younger working-aged adults move away. With the role of family care giving declining, other care givers will be required to step in and care for the older adults.

The demand for healthcare services in rural Minnesota is expected to be strong in the future, and this demand will be challenging to many providers due to demographic elements such as an increased number of elders and higher rates of uninsured patients. Other issues such as higher instances of chronic illness, lower instances of family care giving, changes in the desired method of healthcare delivery for the older population, and other factors also influence the demand of healthcare in rural areas. By analyzing these dynamics and determining how they may impact the distinctive characteristics of their rural community, healthcare leaders can be better equipped to make strategic decisions that will help position their hospitals to continue successfully and profitably delivering high quality care in the years to come.

**“Daschle suggests the creation of a Federal Health Board similar to the Federal Reserve Board that oversees our banking system.”**

## Daschle to Head Health and Human Services

By Ken Cornish, FHFMA, Director of Finance, River's Edge Hospital & Clinic

President-Elect Barack Obama has asked former South Dakota Senator, Tom Daschle to head up the Department of Health and Human Services and to be the point person for his healthcare reform efforts as Head of the Whitehouse Office of Health Reform. We might gain a little insight into what to expect from Senator Daschle on healthcare reform by looking at his recent book “Critical – What we can do about the healthcare crisis”.

Daschle suggests the creation of a Federal Health Board similar to the Federal Reserve Board that oversees our banking system. This Board would regulate our very complicated healthcare delivery and payment systems. One big advantage and reason why congress may embrace this idea is that it would de-politicize the efforts to reform and regulate. Right now there are too many special interest groups influencing the decision making process. Putting healthcare under the direction of an apolitical Board would allow decisions to be made presumably without the influence of these special interest groups. Congress should



jump at the chance to get out from beneath this pressure.

This Health Board would recommend or approve drugs and procedures that are backed by sound evidence that they are not only medically effective but also cost effective. The Board would expand access by making medical coverage mandatory while dismissing the idea of a single payer. This seamless, value oriented system would support our current multi-payer system and not steer us toward a single payer thus gaining the support of the insurance industry.

The way you look at it, the next few years in healthcare are going to be filled with change and excitement. It is not going to be a time for the faint of heart.

Grant Thornton 

 The text "Grant Thornton" is written in a large, black, serif font. To the right of the text is the Grant Thornton logo, which consists of a blue stylized 'G' and 'T' symbol.

**“Identity theft is prevalent and on the rise. The Federal Trade Commission (FTC) is taking an important step to combat this trend, not only in healthcare, but across financial and lending institutions with its Red Flag Rules and its deadline of November 1, 2008.”**

From Page 2 - *Red Flag Rules: A Good Idea for Healthcare*

#### Step One: Identification / Detection of Red Flags

Hospitals need to accurately identify **every** patient by validating their demographic information (address, age, social security number, etc.) using a reliable third party source. Inconsistencies can constitute a 'red flag' and immediately notify the registrar that something is amiss with this patient account.

Likewise registrars should be able to view accurate patient information, such as age, to make a visual validation. For example if the patient appears to be in their 20s, but the validated patient information is that of a 60-year old, the registrar should 'red flag' this account.

Over the years, our customers have found that using outsourced financial clearing solutions at registration identifies problem (or red flag using the FTC's terminology) accounts and also provides more accurate information for billing and collection purposes. These systems can correct information that is simply keyed into the system incorrectly or data that mistakenly offered without motive, as well as those trying to perpetuate identity theft.

Complying with the rules and automating this step provides the independent, unbiased, consistent process to validate the identity of each and every patient that enters the hospital.

However, detection is just the first step.

#### Step Two: Response to a Red Flag

Once a 'red flag' is detected due to inconsistent patient information, each hospital must have a policy stating its response processes. The processes should include an automated workflow that is launched when inconsistent data is given, whether it is recognized and identified by a system (e.g., wrong address) or the registrar (e.g. patient doesn't fit the age specified). In either case, a scripted process that walks the hospital staff through this situation is necessary.

Responses should consist of both trained staff and automated systems to aid them in their workflow. The system should prompt them to ask pointed questions to ascertain if the error is innocent or not, and they should be appropriately trained on how to manage the conversations in a professional manner, directing the patient to the appropriate manager or authority as needed. Healthcare networks will likely find that these processes may differ by hospital, patient type (self-pay, insured, etc.), or service center.

#### Next Steps

Once these steps are completed, a hospital needs to provide administrative oversight of its Red Flag Rules response by its Board of Directors, and have a plan to periodically reevaluate its identity theft processes and the effectiveness of its current process.

The FTC's Red Flag Rules provide a smart and rationale framework for organizations to minimize identity theft within their customer base. This is good for consumers/patients and their providers alike.

Compliance with this government regulation will extend additional benefits to your organization through reduced bad debt and less account aging due to accurate patient information (or identity theft detection) at the onset of your financial relationship.

For more information on the FTC's Red Flag Rules, visit <http://www.ftc.gov/opa/2007/10/redflag.shtm>.

“There are no cookie cutter or clear solutions to challenging long-term care finances. ”

From Page 3 - *What Do We Do With Our Nursing Home?*

- \* For shared departments, such as dietary, laundry, maintenance, administration, and many others, much of the cost currently allocated to the nursing home would simply be reallocated to the hospital rather than eliminated.
- \* Certain, and in some cases many, hospital admissions and hospital ancillary services such as physical, occupational, and speech therapy, laboratory, and pharmacy are directly related to nursing home residents. These services, revenue, and income may be lost to other area health care providers, including standalone nursing homes, which would be happy to provide additional services.
- \* If the nursing home is sold or “spun off” but the hospital continues to provide dietary, laundry, or other shared services to the new nursing home entity, Medicare reimbursement will still be negatively affected.
- \* If the people in the community don’t understand this business decision, they may think the organization is not fulfilling its role as the community health care provider. In addition, closing the nursing home may mean certain workers will be terminated. Both of these situations may cause community residents to choose other health care providers resulting in reduced hospital volumes.
- \* Alternative uses for the space currently occupied by the nursing home would need to be identified. Leaving this space vacant for too long can have costly environmental ramifications to the organization.
- \* If the former nursing home space is not productively utilized, much of the related utility and maintenance costs would continue even if the space is not being utilized.

**Myth:** Getting rid of the nursing home through closure, sale, downsizing, or reorganization is the only way we can eliminate the unfavorable Medicare reimbursement effect.

**Reality:** While it is true that a nursing home siphons reimbursable dollars out of the hospital’s Medicare cost-based reimbursement, simply eliminating the nursing home is not always the best or the only answer.

*Continued on Page 9*



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From Page 8 - *What Do We Do With Our Nursing Home?*

Long before making that difficult decision, CFOs should be absolutely certain they are minimizing amounts allocated to the nursing home by evaluating operational practices and cost reporting methods and statistics. In many cases, the organization can achieve the same improved reimbursement by modifying a few practices including the following:

The first strategy is to understand opportunities associated with provision of Medicare Part A services. In some states, organizations can establish policies and practices regarding the most appropriate placement for Medicare Part A residents. Typically, a critical access hospital swing bed unit will receive substantially more reimbursement than a nursing home would receive for the same identical resident and services. There are, of course, many other considerations when determining where to treat these residents, including quality of care and patient choice. However, a well-thought-out and crafted policy that has the support of hospital and nursing home patient care staff, management, and the physicians can result in improved quality of care and financial performance. It is very important when establishing such a policy that appropriate monitoring tools be implemented to be sure the organization does not revert to "old ways!"

The second important strategy is to have an independent examination of cost reporting opportunities. One opportunity that may be identified through this type of examination is related to the allocation of business office costs. Often business office costs are allocated to all revenue-producing departments based on charges. A nursing home resident, however, typically has only one bill per month and this bill is typically fairly easy to collect. There will be many more hospital bills each month, and hospital services are much more complex due to the myriad of payors, charges, and billing requirements. Identifying a more appropriate statistic and cost allocation to reflect the collection effort and billing complexity of hospital services can improve hospital reimbursement by appropriately allocating less to the nursing home.

*Continued on Page 10*

**"While it is true that a nursing home siphons reimbursable dollars out of the hospital's Medicare cost-based reimbursement, simply eliminating the nursing home is not always the best or the only answer. "**

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“Some organizations may decide they are committed to ensuring the community has a nursing home, but they are not the best operator.”

From Page 9 - *What Do We Do With Our Nursing Home?*

Even administration and general, which has a prescribed allocation statistic, is worth reviewing. We have seen situations where the nursing home received a double allocation of costs because nursing home administrator compensation and benefits were charged directly to the nursing home and a portion of the hospital administrator compensation and benefits was also being charged to the nursing home through the cost reporting allocation process. This type of situation can be corrected by ensuring that all similar costs are being handled consistently between the hospital and the nursing home.

**Myth: There’s really nothing we can do—nursing home finances are hopeless!**

**Reality: Believe it or not, many standalone nursing homes make money. Some make lots of money!**

So how do they do it? There are just a few critical ingredients to the recipe of long-term care success—manage, manage, and manage!

**1. Manage staffing levels**

Unlike a hospital that provides a myriad of very different types of services, nursing home services can be relatively consistent between residents and facilities. In addition, for the most part, many nursing homes’ staffing levels are variable. It is absolutely critical that “per-resident-day” staffing levels be monitored on a real-time basis and the nursing home schedulers and management team be held accountable for staffing levels that exceed desired levels.

**2. Manage compensation levels**

This is often the toughest pill to swallow in a hospital-based nursing home environment. Unfortunately, the nursing home industry survives on slim margins and this pinches staff compensation levels. Often, hospital-based nursing home staff compensation levels significantly exceed their standalone nursing home counterparts. While this may have been acceptable in the past when hospital-based nursing home losses were marginal, increased nursing home losses caused by state and federal fiscal reimbursement policies are causing some hospital systems to reevaluate this policy and establish separate pay scales for nursing home staff.

**3. Manage reimbursement**

Historically, nursing home reimbursement has been relatively uncomplicated. Since the inception of the Medicare nursing home prospective payment system and with many states currently anticipating reimbursement systems based on resident acuity, coding patterns and practices now can mean the difference between financial success and failure.

Providing appropriate education to clinical coders and having periodic independent audits of coding practices are nursing home management best practices well worth the cost.

**4. Manage payor mix and pricing**

It’s a sad reality that, in virtually every state, Medicaid reimbursement is far below the cost of care for Medicaid nursing home residents. Without substantial external support or subsidy from some source, a nursing home could not continue to operate if they only provided care to Medicaid residents. Understanding the financial ramifications of payor mix and making responsive management decisions to ensure the organization’s long-term viability are critical.

*Continued on Page 11*

“Typically, a critical access hospital swing bed unit will receive substantially more reimbursement than a nursing home would receive for the same identical resident and services. There are, of course, many other considerations when determining where to treat these residents, including quality of care and patient choice.”

From Page 10 - *What Do We Do With Our Nursing Home?*

Managing payor mix could mean restructuring the organization’s license, designating certain facility sections as private pay or Medicare only, and understanding the long-term payor for short-term admissions that may ultimately end up remaining in the facility. Managing pricing means remaining competitive and not under pricing services compared to area competitors and capturing private room dollars when possible.

**Myth: There is no future in long-term care—we should just get out now!**

**Reality: While this may seem to be the case, long-term care services will boom in the coming years, and being in the game may be important to your critical access hospital for a competitive advantage.**

Long-term care professionals and the nursing homes they work for provide compassionate care to our elderly residents who have devoted their whole lives to family and community. These elderly residents deserve the best we have to offer, even if it comes at a cost. Changing demographics and an aging population will certainly increase demand for long-term care services in the future. On the other hand, the long-term care organization of tomorrow will certainly be different than it is today. Today’s providers must be prepared for the changes ahead. Upon careful evaluation of current and future long-term care market trends and strategic implications, some hospital-based organizations are even deciding to expand long-term care services by adding assisted or independent living projects to supplement or replace a part of their nursing home operation.

Some organizations may decide they are committed to ensuring the community has a nursing home, but they are not the best operator. In these situations, the organization may consider identifying a partner to continue operating the nursing home either in its existing location or in a new facility to be constructed. While this can be a very difficult decision, identifying an interested partner may seem nearly impossible, and the transition can get lengthy and painful, finding a partner to operate the nursing home can result in a “win-win” for the hospital, the community, and the new service provider.

If your organization decides to pursue this route, consider involving a professional who understands both the hospital and nursing home operational and strategic implications. Just a few of the considerations are as follows:

- \* Will you subsidize the new organization in any manner in return for no longer being responsible for nursing home services?
- \* What is the “value” of the nursing home operation?
- \* How will the transfer of residents be handled?
- \* Will existing employees be guaranteed employment at the new facility?
- \* Will existing employees receive their current compensation and benefit levels?
- \* How will the decision and related changes be communicated to the public?
- \* Will your organization have any oversight over the new organization to ensure high quality services continue to be provided?
- \* Will the new organization be required to continue operating for any designated period of time in the existing location or in a new location within the community?

*Continued on Page 12*

“If you decide to remain in the long-term care business, you may want to consider a separate governance structure for the long-term care operation to ensure it receives the operational focus it deserves to improve financial performance, quality of care, and long-term strategic excellence. ”

From Page 11 - *What Do We Do With Our Nursing Home?*

- \* If leasing the existing nursing home:
  - \* What will be included in the lease?
  - \* Will dietary and laundry continue to be operated by the hospital or will they also be transitioned to the new entity or provider?
  - \* Are HVAC services separately metered?
  - \* Will certain staff continue to be shared by the two organizations, and if so, how will related costs be allocated?
  - \* What do legal documents such as bond financing documents say about this type of arrangement?
  - \* Will the tenant properly maintain the physical facility or will the hospital be left with a “lemon” if the arrangement falls apart?
  - \* How will the arrangement be terminated if it is not successful?

If you decide to remain in the long-term care business, you may want to consider a separate governance structure for the long-term care operation to ensure it receives the operational focus it deserves to improve financial performance, quality of care, and long-term strategic excellence. We sometimes find that hospital management teams are consumed with addressing the myriad of complex, competing, and difficult hospital issues they face and are left with little time to devote to the nursing home “stepchild.” A separate governance structure can help each organization receive appropriate management focus, which will improve the chances of achieving excellence. A separate governance structure could establish a formally separate organization, hiring an executive-level professional to oversee long-term care services and/or setting up a task force within the current board of directors.

### Conclusion

There are no cookie cutter or clear solutions to challenging long-term care finances. By looking at individual situations and evaluating critical data in light of the changing health care environment, management and governance can make better choices. With proper and timely communication, they will also garner community support.

In closing, Wipfli has many resources with years of experience guiding organizations through these types of decisions. By working side by side with our clients, we add value and assist in providing a safe and secure future for those they serve. You do not need to work through this process alone, simply give us a call.

### Author Biographies

Kimberly Heller works extensively with senior living organizations, critical access, prospective payment, and psychiatric hospitals to provide value added audit and consulting services and to identify opportunities for operational improvements, reimbursement enhancement, and service expansion. Contact Kim at 715.843.8336 or [kheller@wipfli.com](mailto:kheller@wipfli.com).

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# A MESSAGE FROM PRESIDENT KEN



As I sit here and look out my office window, the snow is coming down at a rate that reminds me of winters past.

All in all, as the pundits say, we have been pretty lucky these past

few years. They are probably correct but I still don't care for a lot of snow. I just hope that these pundits continue to be correct when they predict that our overall winter will be milder than average. Nice travel weather for our upcoming HFMA Winter Institute would help us all participate in the education being offered.

Terry Currie and Kara Carpenter have put together a great program for this event and I thank them for their hard work. We will gain insights into the upcoming changes to the Medicare program that may come about as President Obama takes steps to improve the system and assure its viability. There

will be information on how to enhance your revenue cycle processes to meet the challenges of the lagging economy, and other session next step in the movement to patient friendly billing.

On the lighter side Terry and Kara have invited John Wodele to give us a refreshing look at our healthcare system and possibly give us a humorous solution to our dilemma. We will also be offered information on collecting up front from our patients instead of waiting until after the service when it's more difficult and on get some new strategies on gaining collective efforts to deal with medical necessity.

During lunch we have a special treat for several MN HFMA members. We have seven members who have worked hard for HFMA and their respective employers and will be presented with various awards from HFMA. The recognition and honor these members receive will

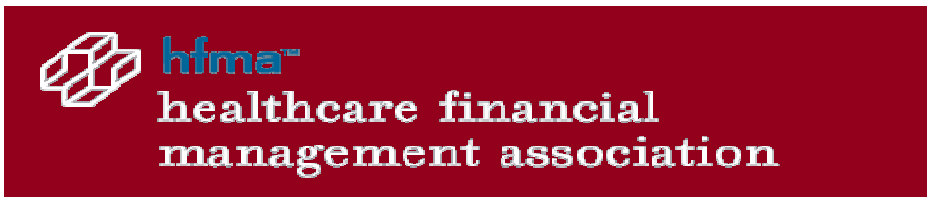
receive should be an inspiration to us all to get involved.

This issue of Viking Land Viewpoint has something of interest just about everyone in healthcare. There is an interesting article on the future of rural healthcare in our troubled economy. I think we are all concerned about this without regard to the size of our particular facility or whether we are a provider or have other interests in healthcare. There is a little insight into what we might expect in the way of healthcare reform as Tom Daschle, President-elect Obama's juice for HSS Secretary. Plus, Bill Fenske has an update on the chapter's efforts to make certification easier for you to pursue.

I hope to see you all at the Winter Institute, January 29<sup>th</sup> at the Four Points Sheraton.

**Have a very Happy and Prosperous New Year!**

## UP COMING EVENTS



**January 29th**—Winter Institute (Sheraton Mpls)

**April 2nd - 3rd**—Concordia Institute (Fargo)

**April 19th - 21st**—Leadership Training Conference (Fort Lauderdale, FL)

**June 14th - 17th**—Annual National Institute (Seattle, WA)

# JANUARY 29<sup>TH</sup> WINTER INSTITUTE PROMISES TO BE EXCELLENT!

By Terrie Currie, Winter Institute Chair , HFMA MN Chapter

Start the New Year off with a great learning and networking opportunity! The Winter Institute Committee is excited about the line-up of topics and speakers that have been secured for the upcoming event!

The theme of this year's Institute is ***"Managing the Economic Impact on the Healthcare Industry"***. It will be held at The Four Points by Sheraton, 1330 Industrial Boulevard, Minneapolis, on **January 29<sup>th</sup>, 2009**.

Topics include:

- \* A Medicare 2009 Update – Is it Back to the Future?
  - o Larry Goldberg will provide insight on potential changes to the Medicare program in the Obama presidency.
- \* Patient Liability Trends – Revamping the Revenue Cycle to Thrive in Today's Healthcare Model
  - o Tina Eller from SearchAmerica will highlight best practice Revenue Cycle redesigns and how they achieved success. Learning objectives include analyzing rising bad

debt, changing charity policies, finding automated tools available to financially clear patients, and more.

- \* Consumerism: Patient Friendly Billing Project Most Recent Phase
  - o Brenda Snow from First-Source NA, Inc. (also highly active in Patient Friendly Billing from the start of the project) will provide us with additional understanding of how consumerism is affecting health care and what policies and approaches providers are using.
- \* There's a Semi Coming, But I Think We Can Make It!
  - o This promises to be a fun and very interesting session. John Wodele, an "observer of communicators", says he "didn't just come down with the rain yesterday". He has been on some interesting journeys including run-ins with the Mayo Brothers and Jesse Ventura. He may suggest a solution to the health problem!
- \* Real World Practices and Processes for Upfront Collections

o Julie Waddell from Accuro and Hamilton Todd from Mayo Clinic will address standards related to determining the true cost of services, identifying insurance liability, presenting accurate estimates of patient liability, collecting from alternative sources such as HSAs and more.

- \* Medical Necessity
  - o Mark Weber from 3M Health Information Systems will share the latest information about NCDs and LCDs, identify strategies for engaging physicians in achieving clean orders, and assess key steps for implementing an effective medical necessity validation process.

Brochures with registration information will be sent out sometime next week and registration can also be done on-line at <http://www.hfma.org/site/emeetreg/main/MtgInfo.cfm?mtgcode=0912MN1>.

**Hope to see you there!**

# RSM! McGladrey

Accounting | Tax | Business Consulting

# CERTIFICATION UPDATE

By Bill Fenske, VP Education, HFMA MN Chapter

The 2009-2010 Certification study guides are now available for checkout. The MN Chapter has purchased study guides for its members to check out to prepare for taking the test. As a reminder, the MN Chapter will also reimburse you for your exam fees once you have successfully passed the exam. For further information on Certification or to check out a study guide(s), please contact Bill Fenske at 320-231-4009 or

fenskeb@rice.willmar.mn.us

## NEW MEMBERS

### September 2008

K Jaworski

### October 2008

Diane Howard, Operations Director  
MMSI

Ronald T. Woessner, CPA, Vice President  
Woessner & Assoc.

### November 2008

Nathan S. Oliver, Manager  
McGladrey & Pullen

Nathan Hancock, Sales Representative  
3M Company

### December 2008

Zach Hedge, Business Development  
Carol Corporation



**hfma** minnesota  
healthcare financial management association

# JOB POSTINGS

## Director of Patient Financial Services

Freeman Health System, JOPLIN, MISSOURI

The successful candidate will manage all billing and collection activities for multi-hospital system. Ideal candidate will possess strong people skills, excellent customer service skills, and strong analytical and planning skills. Five years experience in a hospital business office with a minimum of two years management responsibility preferred. Must possess or be in process of earning bachelor degree in business administration, finance, or accounting. Knowledge and working experience with Charge Master and demonstrated understanding of complete Revenue Cycle preferred. Experience with computerized billing systems, ability to understand and apply Medicare and Medicaid rules and regulations, detail oriented, and understanding of private insurance and workers compensation payor arrangements required.

Freeman Health System is a 404-bed, three-hospital system providing comprehensive healthcare and behavioral health services to an area that includes more than 450,000 residents from Missouri, Arkansas, Oklahoma, and Kansas. Excellent benefits beginning day one of employment and relocation assistance. EOE For more information, contact Jamie Hirshey, 417-347-8900

## Director of Finance/Controller

The Melrose Area Hospital, a 28-bed community hospital with an attached 75-bed skilled nursing home and 42-unit senior apartment building, is seeking a Director of Finance/Controller. This key position is responsible for overall financial management, day-to-day operations of all finance related functions throughout the facility, presenting financial results to leadership and assisting in budget and long range financial planning. In addition, the Director of Finance will manage accounting, business office, HIS and coordinate information services with the health system. Being part of a multi-hospital-integrated system, the Director of Finance coordinates and also functions within the system's finance team.

**Desired Minimum Qualifications:** Bachelor's degree in accounting, finance, business or related field. CPA or Master's degree preferred. Five years of progressive experience in a position of financial management within a hospital setting. Such experience must include the day-to-day financial operations in a health care setting including accounting, business office and related functions. Prior supervisory responsibility of finance related functions is required.

Applicants may apply on line at [www.centracare.com](http://www.centracare.com)

## Vice President of Finance

The Northfield Retirement Community, an award winning leader in providing care to a retirement community is currently seeking a Vice President of Finance.

The Vice President of Finance has oversight for all financial reporting (internal and external), budgeting, financial analysis, and monitoring of managed care contracts, preparation of various cost reports, general ledger accounting, and experience with Medicare billing. Candidate should have knowledge of cooperatives and town home associations. The Vice President of Finance is a key member of the senior management team.

Qualified applicants must have strong organizational skills, be detail oriented, and must possess three+ years of experience in health care financial management or auditing. Experience with Long-Term Care computer software is preferred.

We offer competitive wages and benefits with credit for related experience.

Individuals interested in this position should contact:

Tom Nielsen, Administrator  
Northfield Care Center, 900 Cannon Valley Drive, Northfield, MN 55057, 507-645-9511 or e-mail resume to [tniel-sen@northfieldretirement.org](mailto:tniel-sen@northfieldretirement.org) EOE

## HEALTHCARE FINANCIAL PROFESSIONAL / CPA

A growing, dynamic healthcare consulting firm seeks an individual to join our team as a Reimbursement Consultant. Responsibilities include assisting in audits and with monitoring and implementing regulatory changes within cost reports, analyzing and resolving issues for governmental appeals, actively participating in analyzing data and developing recommendations and action plans within defined procedures and practices, and acting as a significant information resource for our clients. Successful candidate will be confident, productive, and able to work well independently. Minimum of 3 years of accounting or finance experience, preferably working with third party reimbursement and/or health care decision support, effective written and verbal communication skills, time management, follow-through, organizational skills, and excellent computer skills. We offer a challenging work environment, a high level of professional interaction and strong earning potential. Please forward resumes in strictest confidence to:

E-mail: [hr@theybargroup.com](mailto:hr@theybargroup.com)  
Mail: Human Resources  
The Rybar Group  
1495 Dauner Road  
Fenton, Michigan 48430  
Fax: 810.750.6733  
Web site: [www.therybargroup.com](http://www.therybargroup.com)

### **The following is an overview of the comprehensive benefits offered to our employees:**

- Term Life Insurance in the amount of \$20,000
- Profit Sharing Plan (100% Employer Contributable)
- 401(k) Plan (Discretionary match of 50% of the 1<sup>st</sup> 2% contributed by the associate)
- Voluntary Long-Term/Short Term Disability Insurances
- AFLAC Supplemental Insurance Plans
- Vacation
- Paid Holidays
- Health/Vision Insurance
- Bonus Programs
- Opportunity for growth
- Challenging and exciting careers
- Ongoing training
- Competitive wages
- Business casual dress code
- Flexible work hours
- Employee events

*This information briefly highlights the benefits programs available to eligible employees. Any statements made are general summaries; you will find more detailed information through the interview process and upon employment at The Rybar Group, Inc.*

*The Rybar Group, Inc. does not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, national origin, age, disability, sexual orientation, height, weight, or any other characteristic protected by law.*

**For More Job Posting Go  
To Our Web Site:  
<http://www.mnhfma.org>**

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**Other Valuable Web Sites**

**HFMA—**[www.hfma.org](http://www.hfma.org)

**AAHAM—**[www.aaham.org](http://www.aaham.org)

**HCCA—**[www.hcca-info.org](http://www.hcca-info.org)

**AHA—**[www.aha.org](http://www.aha.org)

**NMHCC—**[www.nmhcc.org](http://www.nmhcc.org)

**ACHE—**[www.ache.org](http://www.ache.org)

**MHA—**[www.mnhospitals.org](http://www.mnhospitals.org)

**AHIAM—**[www.ahiam.org](http://www.ahiam.org)

**VHA—**[www.vha.com](http://www.vha.com)

**AHLA—**[www.healthlawyers.org](http://www.healthlawyers.org)

**AHIP—**[www.ahip.com](http://www.ahip.com)

**The Vikingland Viewpoint is the official newsletter of the  
Minnesota Chapter of the Healthcare Financial Management Association.**

Our objectives are to provide members with information about chapter and national HFMA activities and to provide a forum for reporting state and national issues relating to the healthcare industry.

Vikingland Viewpoint is published two-four times annually for the members of the Minnesota Chapter of the Healthcare Financial Management Association as part of the communication series including Month End Entries. No part of Vikingland Viewpoint may be reprinted without receiving prior consent from the Editor. Responsibility for the content of Vikingland Viewpoint lies solely with the Chapter's Communications Committee. The Editor welcomes and encourages the submission of material for publication. Articles should be e-mailed in Microsoft Word and may include a short biography of the author. The Communications Committee reserves the right to edit material and to accept or reject contributions, whether solicited or not.

Opinions expressed in Vikingland Viewpoint are those of the authors, and do not necessarily reflect the view of the Communications Committee, HFMA Minnesota Chapter Leadership, or the members of the Minnesota Chapter. Any questions or comments may be directed to the VP of Communications.

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