

healthcare services is anticipated to increase. The area's economy is largely supported by manufacturing, with service companies and agriculture accounting for 35 percent. Unemployment is typically 6 percent, although it ranges from 5.5 percent to 7.5 percent. The overall poverty rate is 12.4 percent. A recent study revealed that 40,000 city residents are below 125 percent of the established federal poverty level.

### HEALTHCARE COSTS

Healthcare costs in the region are high in comparison to healthcare costs in most other areas in the state. In response to what they feel are excessively high healthcare costs, county businesses recently formed a business coalition, hired a full-time executive, and publicly stated their intent to achieve reduction in healthcare costs. The local press has expressed its concern about the high cost of healthcare in the local community and consistently bashes the area's hospitals and physicians. The coalition refused to allow the three major medical centers in the area to join, despite that each is a major employer.

### THE COMPETITION

CMC has two major competitors. Johnson Medical Center (JMC) is the larger of a two-hospital for-profit healthcare system, and Lutheran Medical Center (LMC) is the larger of a two-hospital faith-based not-for-profit healthcare system. JMC is located less than two miles from CMC and is a 430-bed tertiary care facility. JMC owns four nursing homes, two assisted living facilities, a durable medical equipment company, a wellness center, an ambulance service, and an industrial medicine business. These facilities are located in the tri-county area and are within a 30-minute drive of the main CMC facility. JMC's parent company, Johnson Health System, also owns one small hospital in the region.

JMC has 1,920 **full-time equivalents (FTEs)**, which translates to 5.2 FTEs per **adjusted occupied bed**. JMC recently used a consultant to reduce FTEs, flatten its structure, broaden its control, and improve its operations in general.

JMC has been averaging an occupancy rate of 74 percent. Outpatient revenues are 40 percent of total revenues and have grown at about 6 percent per year for the past two years. JMC had a bottom line (i.e., net income) of \$15 million last year. Bottom lines for the two years prior to last year were \$11 million and \$14 million. **Profit margins** have exceeded 5 percent or better the past three years. In essence, JMC is a major strong competitor. The organization is reported to have a "war chest" of reserves exceeding \$70 million.

LMC is a 310-bed acute care hospital located outside the city limits but within the tri-county area. It does not offer tertiary, intensive services to the extent that CMC and JMC do, but it is a highly regarded general hospital that enjoys an occupancy rate of 75 percent. It is especially strong in obstetrics, pediatrics, general medicine, and ambulatory care. It attracts well-insured patients from the affluent suburban area.

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#### **Full-time equivalent (FTE)**

the total number of full-time and part-time employees, expressed as an equivalent number of full-time employees

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#### **Adjusted occupied bed**

the number of inpatient occupied beds, adjusted (increased) to account for the bed occupancy attributed to outpatient services, partial hospitalization, and home services

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#### **Profit margin**

the difference between how much money the hospital brings in and its expenses

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LMC has 1,180 FTEs and typically operates at 6.1 FTEs per adjusted occupied bed. LMC provides a great deal of indigent care and, in accordance with the philosophy of the church, its budgets are set to generate only a 2 percent annual profit margin.

### HIGHLIGHTS OF COASTAL MEDICAL CENTER

As a referral center, CMC offers almost every level of care, including a number of tertiary care services, with the exception of neonatology and severe burn unit services. Many of its patients require high-intensity services. For this reason, its costs are the second highest in the entire state. The average length of stay of a patient at CMC is 9.2 days, compared to a statewide average of 6.4 at hospitals of similar size and services. This difference is probably attributable to the intensity of services CMC offers. CMC's expenses per patient day are also the highest in the state, with the exception of two large university-affiliated teaching medical centers. Its FTEs per adjusted occupied bed (7.5), paid hours per adjusted patient day (35.20), and paid hours per patient discharge (238.5) all greatly exceed those of competitors and the norms of comparable facilities. CMC is presently authorized 2,240 positions but actually employs 2,259 FTEs. Salary expenses per adjusted discharge and adjusted patient day are \$2,760 and \$491, respectively.

A recent one-year market share analysis for the broader eight-county region revealed the data presented in Exhibit Case.1.

CMC has market advantage in substance abuse, psychiatrics, pediatrics, and obstetrics. JMC has a decided market advantage in adult medical and surgical care.

At a recent administrative meeting, the following CMC utilization figures were reviewed:

- ◆ Admissions are down 14 percent for the year.
- ◆ Medicaid admissions are up 11 percent for the year.
- ◆ Ambulatory care visits are down 10 percent for the year.
- ◆ Surgical admissions are down 6.7 percent for the year.

Facility	Discharges	Percentage of Total
CMC	7,819	18%
JMC	8,989	21%
LMC	6,820	16%
All others	19,546	45%
Total	43,174	100%

**EXHIBIT CASE.1**  
One-Year Market  
Share Analysis

A recent auditor's report included the following notes:

- ◆ A significant adjustment was required at year-end to correctly reflect contractual allowance expense (i.e., the amount of money spent in hiring outside contractors). (The data used at the beginning of the year to estimate contractual allowance expense was grossly inaccurate.)
- ◆ Insurers were not billed for services by certain hospital-based employed specialists (\$7 million for the past year) as a result of incompetence on the part of the hospital billing staff.
- ◆ A total of \$1.7 million of Medicaid reimbursement was not authorized. No follow-ups were done and no claims were resubmitted.

### **HISTORICAL PERSPECTIVE**

CMC was founded just after World War II using a Hill-Burton grant (see Highlight Case.1) and funds raised locally. From a modest beginning with 100 beds and a limited range of acute care service offerings, the medical center has grown to its present size of 450 beds and now offers a full range of services. Credit for the major growth and past success of CMC has



#### **HIGHLIGHT CASE.1 Hill-Burton Act**

In the mid-1940s, many hospitals in the United States were becoming obsolete because they did not have money to invest in their facilities after the Great Depression and World War II. To combat this lack of capital and help states meet the healthcare needs of their populations, senators Lister Hill and Harold Burton proposed the Hospital Survey and Construction Act, also known as the Hill-Burton Act. This act provided federal grant money to build or modernize healthcare facilities. In exchange, hospitals receiving the grant were obligated to provide uncompensated (free) care to those who needed care but could not pay for it.

The Hill-Burton Act expired in 1974, but in 1975 Congress passed Title XVI of the Public Health Service Act. Title XVI continues the Hill-Burton program by providing federal grant money for healthcare facility construction and renovation but more clearly defines requirements the facility must meet. For example, facilities receiving grant money must prove they are providing a certain amount of uncompensated care to populations that meet particular eligibility requirements.

been given to Don Wilson, who served as chief executive officer (CEO) from 1990 until his retirement in early 2008. Wilson was a visionary and was successful in transforming the medical center to its present status as a tertiary care facility offering high-intensity care including open-heart surgery and liver and kidney transplants.

Wilson's successor was Ron Henderson. During the past two years, Mr. Henderson practiced a loose, informal style of management. He seemed to sit back and enjoy himself while others ran the medical center. He was often characterized as a caretaker. The medical center made \$15.4 million in 2008 following Mr. Wilson's retirement (due to an excellent revenue stream and a strong balance sheet), so he was not pressed to make major changes. Mr. Henderson encouraged the board of trustees, medical staff members, and his administrative staff to submit new ideas for improved community healthcare services using CMC as the focal point for delivery. An avalanche of ideas was submitted during the first two years of Mr. Henderson's tenure. He moved quickly on these ideas and established himself as a person who made swift decisions on new ventures and kept things rolling. He simply let other executives "do their thing" and neither discouraged nor evaluated their work. His strategy was apparently rapid growth and diversity in new businesses. He made major fund commitments to new ideas, but he did little to evaluate the ideas with respect to their compatibility with CMC's mission and its strategic direction, and he usually did not consider the financial implications of these ventures. His approach was "let's do it."

Before 2008, CMC was in good financial shape and faced few financial problems. In 2008, however, expenses began to skyrocket while utilization and revenues failed to keep pace. In addition, a hospital census indicated that, on average, 58 percent of CMC's patients were Medicare patients and 18 percent were Medicaid patients. As a result, the medical center suffered from reductions in reimbursement. Notable among CMC's excessive costs are labor, material, and purchased services. The chief financial officer (CFO) is convinced that a major part of this problem is the presence of three unions, including unionized employees in support services and unionized employees throughout nursing services. Added to this cost burden is the more than \$5 million being transferred to subsidize other CMC subsidiary companies.

During the second year of his tenure, Mr. Henderson began to receive criticism from the board of trustees. Henderson had added 127 new positions despite solid evidence that utilization was experiencing a steep decline. His reasoning was that the declines were temporary and that business would soon be back to normal.

In late 2009, the medical center suffered a deficit of \$8.6 million (see Appendix B). Surprised by this major loss, the board of trustees fired Mr. Henderson. They contended that they should have been informed of these serious problems. They felt that there should have been a better strategic planning process in place for the selection of projects, on which millions of dollars had been spent. The board of trustees could not understand how overall corporate net income could drop to a loss of \$8.6 million when \$15.4 million in profit had been made the previous year.

### GOVERNING BOARD

CMC's governing board has 27 members. All of its trustees are prominent, influential, and generally wealthy members of the community. The board is self-perpetuating. The same chair has served for ten years. Average tenure on the board is 17 years. Committees of the board are detailed in Exhibit Case.2.

One physician-at-large is also included on the board. The chief of staff and the CEO attend all board meetings but are not allowed to vote on board decisions. There are no minority members despite that racial minorities account for about 12 percent of the service area population. Only one of the 27 members of the board is a woman. The average age of the trustees is 66.

### PARENT CORPORATION

The parent corporation of CMC is Coastal Healthcare Incorporated. This parent board was created through corporate restructuring several years ago, but its role has never been clear. The parent board is made up of "friends" of the most powerful among the trustees of the CMC board. In essence, when corporate restructuring was the "in thing" to do,

#### EXHIBIT CASE.2

Committees of  
the Coastal  
Medical Center  
Board

Committee	Size	Meeting Frequency
Executive	16	Monthly
Joint Conference	24	Monthly
Finance	13	Monthly
Budget	18	Quarterly
Executive Compensation	9	Annually
Construction	13	Monthly
Strategic Planning	16	Monthly
Quality Assurance	9	Monthly
Patient Care	11	Monthly
Ambulatory Care	11	Monthly
Public Relations	9	Monthly
Personnel	11	Monthly
Material and Equipment	11	Monthly
Audit	9	Quarterly

this holding company was formed. By appointing a few CMC trustees to also sit on the parent board and by appointing friends of present CMC trustees, it was believed that the two boards would function as one happy family. However, there has been constant conflict from the beginning regarding the relative powers and roles of the two boards.

The parent company board has 19 members, all of whom are white and male. Backgrounds of the parent board of trustees tend to mirror those of the medical center trustees in that they are prominent and mostly wealthy. Membership includes bankers, attorneys, business executives, business owners, developers/builders, and prominent retired people.

Committees of the Coastal Healthcare Inc. (parent) board are detailed in Exhibit Case.3.

The following are some of the conflicts that have occurred between these two boards over the years:

- ◆ The parent board refused to approve the appointment of a new hospital CEO selected by the CMC board.
- ◆ In 2006, the two boards hired separate consultants to develop a long-range strategic plan. Two plans were produced but were never integrated and never really implemented.
- ◆ Various committees from the parent board often request information about functions of the medical center, which creates conflict because the parent board has a tendency to micromanage CMC's routine operations.
- ◆ Separate committees of both boards have worked more than two years trying to revise CMC's mission statement.

## MEDICAL STAFF

The medical staff at CMC has historically been a difficult group when it comes to cooperation with the board and administration. Patient length of stay is excessively high in most specialties, yet the physicians refuse to be educated on reimbursement and the need to reduce length of stay, excessive tests, and so on. Approximately 90 percent of the medical staff also has privileges at one or more competing hospitals in town.

Committee	Size	Meeting Frequency
Executive	11	Monthly
Finance	11	Monthly
Strategic Planning	11	Quarterly

### EXHIBIT CASE.3

Committees of the Coastal Healthcare Inc. Board

A number of the medical staff members have set up their own diagnostic services, especially the radiologists and neurologists, despite that they have been granted exclusive service contracts at CMC.

In recent years, there has been considerable dissatisfaction among the specialists who represent the majority of the medical staff. They complain that their referrals are decreasing or flat and that CMC is not doing enough to help them establish and maintain a sufficient number. Hospital admissions for specialty services are declining drastically. To compound the problem, the competing medical centers are courting these specialists aggressively with attractive offers, such as priority scheduling in surgery and other special arrangements, all of which are legal.

The medical staff also rated various aspects of medical center operations unsatisfactory in a recent survey. The subjects of their complaints were across the board and included key areas such as the following:

- ◆ Dissatisfaction with nursing services and especially the nurses' attitudes (Nurses have formed themselves into shared governance councils and are taking issue with both physicians and administration regarding their autonomy.)
- ◆ Excessive delays in every aspect of operations (e.g., late starts in the operating room, lack of supplies or equipment when it is needed, excessive patient processing time [for example, over three hours for pre-surgical testing for outpatient surgery])

The medical staff also feel they should have more voice in both financial and operational matters, especially in capital budgeting. They feel they are asked to provide free services too frequently (e.g., by committees), and many have refused to serve without compensation to offset the practice income they have lost.

There are also quality problems. Two physicians probably should have their privileges revoked, three apparently have substance abuse problems, and several are obsolete in their practices and should be asked to retire. The problem is getting their peers to act in these cases. It has also been difficult to get physicians to hold elected offices and accept committee responsibility. Payment of honoraria has helped, but support is still difficult to procure. Over \$200,000 is being paid out to entice doctors to serve on committees.

### **SUBSIDIARY COMPANIES**

Including CMC, there are 24 subsidiary corporations of Coastal Healthcare Inc.:

- ◆ **Medical Enterprises** is a for-profit joint venture with physicians. The company is developing computers that enhance imaging services. Thus far, CMC

has invested \$18 million in this company. No cash flow is expected for three to four years.

- ◆ Coastal Healthcare Inc. has **three nursing homes**. Collectively, these long-term care facilities are losing almost \$1 million annually. **Debt service** on two of them is very high. Only one is within patient transfer distance of CMC. The second is 70 miles away, and the third is 82 miles away. All three have unions. Almost all of the residents of the two facilities losing the greatest amount are Medicaid patients; there are only a few self-pay patients.
- ◆ **CMC Management Services** was formed to sell management and consulting services. The company lost \$360,000 last year, which was its third year of operation.
- ◆ **Regional Neuroimaging** is a joint venture with physicians. The company lost \$920,000 its first year of operation. Capital invested by the hospital to date totals \$9 million.
- ◆ **American Ambulance** is a local ambulance company. Financially, it breaks even, but it does increase admissions to CMC, especially through trauma pick-ups.
- ◆ **Home Health, Inc.** provides home health care services in an eight-county area. Its operating loss last year was \$290,000. The company has considerable difficulty attracting and retaining professional personnel, especially nurses and physical therapists.
- ◆ **Industrial Services Inc.** provides health services to industrial companies throughout the state. Only one of the six operating locations is close enough to generate referrals. None of the operating sites is making a profit despite that the company is five years old.
- ◆ **MRI Enterprises** is a successful mobile magnetic resonance imaging (MRI) joint venture with a physician group. It has a consistent, positive bottom line.
- ◆ **Textile Enterprises** is a large, high-tech laundry completed three years ago. It was intended to serve the medical center and many other companies in the region. Because of its debt service, union wages, and remote location, the laundry has yet to break even. After three years, it still does not have its first non-CMC service contract.
- ◆ Coastal Healthcare Inc. owns **three hospitals: Caroleen Hospital** (60 beds), **Grant Hospital** (74 beds), and **Ellenboro Hospital** (90 beds). All are small

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**Debt service**

cash required over a given period for the repayment of interest and principal on a debt

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rural hospitals purchased to feed patients to CMC. All are unprofitable. Collectively, the three of them require \$2.5 million in subsidies annually.

- ◆ **Health Partners** is a health maintenance organization joint venture with 20,000 subscribers. After three years of operation, its costs are still rising. Last year, it required \$2 million in subsidies.
- ◆ **Northeast Clinic** is a large multispecialty group of 11 physicians who were fed up with government red tape and sold out to CMC last year. CMC now employs these physicians and is responsible for all medical group operations. It is too early to determine the success of this venture.
- ◆ **Imaging Venture** is a recently formed radiology joint venture. Until/if it becomes successful, it will cost just under \$1 million in debt service annually.
- ◆ **North Rehabilitation**, a 60-bed inpatient rehabilitation facility, was just opened. It is expected to be successful because CMC will refer all of its rehabilitation patients to this facility and there is no other rehabilitation facility in the region.
- ◆ **Center for Pain** has been a successful outpatient facility and is expected to remain successful. Its space is leased. Overhead is kept low. The physicians are salaried.
- ◆ **Coastal Wellness**, a fitness and wellness center, was developed five years ago at a cost of \$10 million. It is located in a coastal community and is intended to attract those from the wealthy areas. A significant number of CMC employees and their family members use Coastal Wellness at a lower monthly rate, which is subsidized by CMC. Coastal Wellness is currently underutilized, so CMC subsidizes it with \$220,000 annually.
- ◆ **Central Billing** was formed to attract patient billing contracts from health facilities and physician groups. It has been moderately successful and reached the break-even point this past year.
- ◆ **City Contractors**, a separate, small general contracting company, was just formed. It will require about \$200,000 annually in subsidy.
- ◆ **Bay Enterprises** is a land acquisition and holding company.

## EXECUTIVES AND MIDDLE MANAGEMENT

CMC employs 20 executives. (*Executives* are defined as positions above the administrative director level.) Total annual executive compensation is \$2.2 million. Each executive has an

executive secretary. The annual average compensation among the 20 secretaries is \$35,000, which amounts to an executive-level support cost of \$700,000.

Each of the other 23 subsidiary companies also employs executives and support personnel in addition to regular employees. This executive overhead is a drain on CMC because many of the subsidiary companies do not break even and thus must be subsidized.

CMC employs 15 administrative directors, who function between vice president and department directors. Their principal purpose is to handle problems at the department level so these problems do not escalate to the vice president.

There are also 67 director-level positions in the organization. Directors are responsible for a particular department or function. Managers are the next level down the line of supervision. There are 31 managers. Collectively, these managers have 68 supervisors working for them.

The compensation and benefits policy of CMC appears to deviate substantially from industry norms. For example, the directors' annual salaries range from \$85,000 to over \$170,000.

### **CORPORATE STAFF**

The parent corporation consists of the following offices:

- ◆ Office of the CEO, who has five "assistants to the president" (i.e., an administration, board, ethics, community, and staff assistant)
- ◆ Office of the senior vice president for finance (three people)
- ◆ Office of the senior vice president for corporate affairs (four people)
- ◆ Office of the senior vice president for corporate development (three people)
- ◆ Office of the vice president for legal affairs (five people)
- ◆ Office of the vice president for medical affairs (two people)
- ◆ Office of the vice president for marketing (two people)
- ◆ Office of the vice president for strategic planning (two people)

The corporate staff serve as advisers and coordinators, oversee their functional areas at CMC, and, where needed, oversee the various subsidiary companies.

Total FTEs for the parent company corporate staff are 29. Total costs of corporate overhead are \$2.3 million annually. In addition, during the past year the corporate officers of the parent company purchased the consulting services listed in Exhibit Case.4.

**EXHIBIT Case.4**

Consulting  
Services  
Purchased by  
Parent Company

<b>Consultant Purpose</b>	<b>Cost</b>
Conduct board retreat	\$35,000
Prepare restructuring recommendations	\$65,000
Write organization history	\$60,000
Provide policy advice	\$25,000
Lobbying	\$50,000
Compensation (wage/salary) study	\$72,000
Labor negotiations	\$120,000
Management development	\$90,000
Managed care study	\$47,000
<b>Total</b>	<b>\$564,000</b>

**DUPLICATION OF FUNCTIONS**

Throughout CMC, functions were duplicated as the organization grew. For example, there are three education departments and three transportation departments. There is both an inpatient and outpatient pharmacy, each with its own director. CMC and 12 of the larger subsidiary companies have separate human resources management functions.

There are 24 boards, one for each subsidiary company, and each board has a large number of committees. Executives from CMC and the parent corporation sit on these boards and their committees.

**SERVICE/PROFESSIONAL CONTRACTS**

CMC contracts with many service providers. Service contracts include housekeeping, food service, record transcription, biomedical maintenance, security, and many others. These contracts are renewed regularly with the same firms. CMC also contracts with countless health professionals. For example, the contract for coverage of CMC's pediatrics clinic by two physicians is \$380,000, and CMC furnishes the facilities and professional and support personnel. Numerous physicians have negotiated arrangements through which they regularly receive checks for committee service, advice, and so on. Many of these negotiations are not documented in written contracts.

The hospital-based specialists' contracts are based on a percentage of gross earnings, with no provision for any type of adjustments to the gross. Several of these arrangements are long-standing but unwritten agreements.

## **MATERIAL MANAGEMENT**

CMC is organized traditionally, meaning there is no centralized material management function. Purchasing is done throughout the organization from a large number of vendors. The pharmacy, laboratory, and other services do their own ordering, arrange contracts, and handle other supply and equipment matters. For example, the laboratory recently purchased a large computer software package without the knowledge of the purchasing agent or the information services department.

Large stores of inventory can be found throughout the facility. CMC also harbors excessive and obsolete equipment. Central storage occupies a huge amount of space and carries what appears to be an overabundance of many items.

## **SPECIAL PROJECTS**

Fifty-three “special projects” in various stages of progress are underway at CMC, ranging from the addition of a new education center to renovation of the food service department. A large number of start-ups are also under development. For example, CMC is considering a joint venture with physicians to build an ambulatory surgery center offering the latest robotic surgery technology. Analysis of the projected costs of these projects, and of the working capital many of them will need before they become profitable, if they ever do, revealed that the organization will suffer severe financial distress if these projects continue. Moreover, there is considerable uncertainty regarding the financial feasibility of many of them. Finally, these projects have not been centrally coordinated, nor has their potential impact on the organization’s mission and strategic direction been discussed. These projects were simply developed on the basis of individual interests of various executives and managers. By his inaction and lack of leadership, Mr. Henderson gave everyone free rein to do their own thing—and they did.

## **NEW CEO ARRIVES**

CMC hired an executive search firm specializing in healthcare to look for a new CEO. After a nationwide search, the board of trustees decided to hire Richard Reynolds. Mr. Reynolds appeared to be a no-nonsense CEO who had the knowledge and skills to determine the problems at CMC and resolve them. During his first few weeks in the new position, Mr. Reynolds did an exhaustive analysis of CMC with the assistance of a transition consultant and the executives and managers of the organization. The following list highlights his findings:

1. Compared to national personnel standards, a large percentage of the departments at CMC are grossly overstaffed. More than 100 new positions were

added during the most recent fiscal year, despite that utilization did not justify these positions. The overall administrative structure is top-heavy.

2. Fifty-eight general contracts were identified, many of which are standing contracts with consultants who appear to be receiving large monthly retainers but are not providing services. In addition, a total of 121 contracts with physicians were identified. Again, these physicians appeared to be providing few services. The prior CEO apparently made numerous agreements to subsidize various physicians and pay them large sums for performing administrative services that are normally done on a voluntary basis by members of the medical staff.
3. Fifty-three major new service projects in the planning or construction phase were identified. An analysis indicated that they would require over \$100 million in future commitments, and Mr. Reynolds was not sure that CMC would be able to service the necessary debt. No project priorities existed and no feasibility studies had been done for most of the projects, so there was no way to project the financial impact of these "innovative ideas" on the organization.
4. A large number of duplicate departments were identified. Mr. Reynolds pinpointed many departments and services that could be consolidated.
5. Sixty-six "special" programs are collectively accounting for a \$6 million outflow of cash from CMC. These programs are not directly related to CMC's tertiary care mission. CMC seemed to have developed every type of program conceivable from one end of the care continuum to the other without considering whether the programs supported its mission or generated a positive cash flow.
6. In material management, Mr. Reynolds found nearly \$8 million in "unofficial" inventory stored throughout various facilities of the medical center. There is no centralized material management system for purchasing, storage, distribution, and accountability of materials.
7. While the median operating margin for medical centers of similar size and service was about 2.5 percent the past year, CMC had experienced a multimillion-dollar loss. In addition, the medical center's return on equity was a major problem. The number of **days accounts receivable** (i.e., average number of days it takes to collect payments that clients owe to the organization) in other medical centers averaged 68 days during the past year; CMC's accounts receivable days were far greater. Most alarmingly, CMC's cash on hand at any given time represented only 22 operating days. Finally, the hospital's major bond issue was recently downgraded to the lowest credit rating.
8. Medicare has just notified the CFO that recovery of \$4 million is forthcoming due to past errors in the Medicare Cost Report.

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**Days accounts receivable**

average number of days an organization takes to collect payments on goods sold and services provided, calculated as follows:  

$$\frac{\text{average accounts payable (in dollars)} \times 365 \text{ (days per year)}}{\text{sales revenue}}$$
 (The "normal" average range is 40 to 50 days. A number significantly greater than 50 days indicates that the organization is having difficulty collecting payments from its clients; a number significantly lower than 40 indicates that the organization has overly strict credit policies that might be preventing it from taking in higher sales revenue.)

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9. The business coalition is becoming well established and intends to aggressively pursue discounted services through direct contracting.
10. The parent company (Coastal Healthcare Inc.) is not structured nor functions as a local healthcare system. Clinical services and administrative support are not integrated. For this reason, Coastal Healthcare Inc. does not meet the classic definition of a healthcare system provider.
11. Nationally, capitation payment arrangements have not been successful for many hospitals. CMC is not in a favorable position to become an accountable health plan. To become an accountable health plan, CMC would have to partner with primary care and specialty physicians to meet the total healthcare needs of a defined patient population.
12. No value-oriented efforts have been initiated at CMC (e.g., continuous quality improvement, benchmarking).
13. There has been no leadership development for the board of trustees, medical staff, and administration.
14. No formal strategic planning process is in place at the CMC or Coastal Healthcare Inc. (holding company) level.
15. There are no existing physician–hospital organizational arrangements.

### GENERAL CONDITIONS

Mr. Reynolds also quickly learned that he had taken a position in an organization with a governing board that was generally content to approve anything the previous CEO recommended. The medical staff appears no better in that they are principally focused on their own self-interests and show little interest in the affairs of the medical center.

Control systems are lacking, and CMC does not have a comprehensive information system. Moreover, quality of care appears low; a large number of legal cases against the medical center are pending.

With respect to material management, several suppliers have refused to deliver supplies because of delays in accounts payable. Mr. Reynolds summed up the medical center's situation by reporting to the members of the board that there is an immediate cash flow problem, people-related expenses are far too high, material-related expenses are well above those expected, plant-related expenses are excessive, contract amounts are excessive, and accounts receivable are too high. He also remarked that CMC seems to have no sense of direction or overall corporate strategy.

With the help of his transition consultant, Mr. Reynolds surveyed and interviewed his department heads. Given the financial situation and the results of the survey, Mr. Reynolds knew he faced a difficult challenge.

Mr. Reynolds concluded that the prior CEO had engaged in the "one man rule" concept and had failed to build necessary knowledge and management skills among the vice presidents. Thus, when difficulties occurred in the organization, inertia set in. The reaction of executives and managers was that of indecisiveness and unwillingness to take risk for fear of compromising their job security. He also reported that there are an excessive number of administrative positions.

An examination of CMC's balance sheet (see Appendix C), financial ratios (Appendix D), and structure led Mr. Reynolds to conclude that the corporation was over-expanded, over-leveraged, and over-dependent on a narrow market. The organization is too expensive to operate, bloated with bureaucracy, inefficient in its services, and unimaginative in its approach to strategic planning and change.

From his discussion with the leadership team and other hospital staff, Mr. Reynolds believes there is no clear organizational mission and that there is considerable dissatisfaction among the leaders. To confirm his beliefs, he had the transition consultant administer a brief leadership survey. Appendix E reports the results of this survey, providing detailed information on corporate culture and job satisfaction. Mr. Reynolds has already decided to do a similar survey of all hospital staff within the next six months to obtain more baseline data on the organization's corporate culture and its ability to deal with the changes he knows are coming.

### **NEW BUSINESS INITIATIVES**

To expand its physician staff, CMC has constructed a hospital-owned medical office building in a growing community five miles from the hospital. This effort has been successful and has attracted a prominent group of orthopedic physicians who are now referring their surgical procedures to the hospital. As part of this expansion and with the growing orthopedic workload, CMC is exploring the financial feasibility of opening a physical therapy clinic at this new location.

On the basis of current physician referral patterns, CMC anticipates \$250,000 in outpatient physical therapy net income at the new location during the upcoming 12 months.

### **CONCLUSION**

As Mr. Reynolds ponders the many problems he had uncovered upon arrival at CMC, he wonders what other problems might be beneath the surface. Every day he uncovers additional major problems. At this point, Mr. Reynolds is so overwhelmed by the problems that he is unsure of how to proceed. He does know, however, that priorities need to be

set, the deteriorating situation needs to be turned around, and a strategic plan needs to be developed to chart the future of the organization.

## EXERCISES

Assume you are Mr. Reynolds. Being new to the position, you are faced with major challenges.

The questions and exercises listed at the end of each chapter provide an opportunity to gain leadership experience in managing change in a healthcare organization. Most important, you will gain experience in developing a strategic plan.

## APPENDIX A: POPULATION AND HOUSEHOLD DATA

	Riverside County	Metro City	Rural County	Ocean County
<b>POPULATION AND HOUSEHOLD</b>				
Square miles	609	775	601	485
Population density per square mile	214	1,028	245	111
Population 1992	83,829	672,971	105,986	28,701
Population 2004	129,832	794,569	146,739	53,506
Population 2009	148,289	842,179	163,082	63,543
% Population growth 1992–2004	54.88%	18.08%	38.45%	86.43%
% Population growth forecast 2004–2009	14.22%	5.10%	11.14%	18.76%
Households 1992	33,431	256,772	36,664	11,882
Households 2004	52,322	310,603	52,448	22,904
Households 2009	59,895	331,539	58,623	27,305
% Household growth 1992–2004	56.5%	20.97%	43.05%	92.76%
% Household growth forecast 2004–2009	14.5%	6.75%	11.77%	19.21%
Average household size	2.48	2.57	2.8	2.34
Families	35,793	205,123	40,907	16,766
% Urban population	56.5%	98.7%	59.6%	59.9%
% Rural population	43.5%	1.5%	40.4%	40.1%
% Female population	51.2%	51.5%	50.7%	51.5%
% Male population	48.8%	48.7%	49.3%	48.5%
% White population	91.1%	67.4%	88.6%	87.9%
% Black population	6.5%	28.5%	7.3%	9.5%
% Asian population	1.4%	3.8%	3.0%	1.6%
% Hispanic origin population	2.7%	4.3%	4.4%	5.2%
Other population	1.4%	2.1%	3.1%	2.3%
% Population 0–5 years	6.5%	8.7%	8.0%	4.9%
% Population 6–11 years	8.1%	9.1%	9.6%	6.0%
% Population 12–17 years	8.2%	8.7%	10.2%	6.7%
% Population 18–24 years	6.4%	8.9%	7.2%	4.4%
% Population 25–34 years	9.7%	14.4%	11.6%	7.3%
% Population 35–44 years	17.8%	18.1%	18.7%	12.9%
% Population 45–54 years	17.0%	14.6%	15.9%	14.3%
% Population 55–64 years	10.2%	7.7%	8.9%	14.4%

% Population 65-74 years	8.8%	5.7%	5.6%	17.2%
% Population 75 years and over	7.3%	5.1%	4.3%	11.9%
Median age	41.3	35.5	36.8	50.5

## INCOME AND EDUCATION

Total household income (\$US)	\$5,145,536,895	\$20,994,962,608	\$3,656,788,183	\$1,650,526,132
Median household income (\$US)	\$49,103	\$41,410	\$49,270	\$42,975
Per capita income (\$US)	\$39,632	\$26,423	\$24,920	\$30,847
High income average (\$US)	\$474,930	\$430,207	\$348,177	\$450,993
Education—% less than high school (age 25+)	11.2%	13.6%	11.5%	12.6%
Education—% high school (age 25+)	31.6%	33.9%	35.4%	36.6%
Education—% some college (age 25+)	25.5%	26.9%	29.9%	27.1%
Education—% college (age 25+)	22.1%	19.3%	16.8%	15.4%
Education—% graduate degree (age 25+)	9.6%	6.4%	6.5%	8.3%

## EMPLOYMENT AND OCCUPATION

Males employed (age 16+)	35,604	201,461	40,722	12,093
Females employed (age 16+)	29,337	169,863	30,949	9,654
Total employees (age 16+)	64,941	371,324	71,671	21,747
% White-collar occupations	62.9%	63.1%	61.8%	57.3%
% Blue-collar occupations	22.8%	23.6%	25.9%	27.5%
% Service occupations	14.3%	13.3%	12.4%	15.2%
% Local government workers	7.6%	7.0%	7.4%	7.7%
% State government workers	3.2%	2.4%	2.2%	1.6%
% Federal government workers	1.8%	3.5%	6.3%	0.9%
% Self-employed workers	9.0%	5.2%	6.3%	9.2%

## CONSUMER EXPENDITURES

Annual expenditures per capita (\$US)	\$18,211.60	\$16,580.10	\$16,226.00	\$18,322.00
Healthcare expenditures per capita (\$US)	\$2,347.20	\$2,183.90	\$2,105.70	\$2,390.30
Healthcare insurance expenditures per capita (\$US)	\$428.00	\$385.00	\$370.00	\$482.20

## COST OF LIVING

Consumer price index	147.1	147.1	147.1	147.1
Medical care consumer price index	211.3	211.3	211.3	211.3

### APPENDIX B: COASTAL MEDICAL CENTER: STATEMENT OF INCOME (IN THOUSANDS OF DOLLARS)

	2008	2009
Operating revenue		
Inpatient	130,775	131,470
Outpatient	28,923	31,211
Other operating revenue	2,604	2,225
Gross operating revenue	162,302	164,906
Less provisions for allowances		
Third-party reimbursement programs	(31,422)	(42,081)
Doubtful accounts	(5,112)	(7,320)
Charity care	(2,705)	(2,993)
Total provision for allowances	(39,239)	(52,394)

Net operating revenue	123,063	112,512
Expenses		
Salaries, payroll taxes, and fringe benefits	61,757	64,858
Dietary, pharmaceutical, and other supplies	17,450	18,534
Purchased services	12,971	14,306
Depreciation and other capital costs	7,281	7,929
Medical specialists	4,091	5,893
Insurance	3,112	3,722
Interest expense and amortization of financing costs	2,408	2,560
Utilities	2,257	2,268
Other	2,336	2,203
Total expenses	113,663	122,271
Income from operations	9,420	(9,759)
Nonoperating revenue		
Interest income	1,268	1,040
Other	81	58
Total nonoperating revenue	1,349	1,098
Net income	10,769	(8,661)

### APPENDIX C: COASTAL MEDICAL CENTER: BALANCE SHEET (IN THOUSANDS OF DOLLARS)

	2008	2009
ASSETS		
Current assets		
Cash and cash equivalents	2,337	2,964
Accounts receivable	23,781	25,345
Inventories	2,251	2,638
Current portion of assets	3,030	3,947
Prepaid expenses and other assets	1,678	1,729
Total current assets	33,077	36,623
Facilities and equipment		
Land and land improvements	3,209	3,279
Buildings and improvements	44,053	46,369
Equipment	36,024	38,400
Construction	4,389	15,774
Less accumulated depreciation	(36,036)	(41,222)
Total facilities and equipment	51,636	62,600
Assets of limited use		
Funds held by trusts	40,475	29,469
Assets segregated for capital purposes	970	10
Donor restricted funds	2,045	2,049
Investment in deferred compensation annuities	6,058	6,212
Total assets of limited use	48,545	37,740
Less assets of limited use and required for current liabilities	(3,030)	(3,947)
Total assets of limited use	45,516	33,793

Other noncurrent assets		
Deferred financing costs	2,740	2,536
Due from affiliated organizations	1,587	1,865
Other	326	1,417
Total other noncurrent assets	4,653	5,818
<b>TOTAL ASSETS</b>	<b>134,882</b>	<b>138,833</b>
	2008	2009
<b>LIABILITIES AND FUND BALANCES</b>		
Current liabilities		
Current portion of long-term debt	1,156	1,073
Advance from donations	2,405	5,155
Accounts payable	2,440	6,690
Accrued expenses	3,030	3,947
Payroll and related fringe benefits	7,647	7,926
Interest payable	2,600	2,228
Other liabilities	1,302	3,074
Total current liabilities	17,549	26,148
Other liabilities		
Deferred compensation	5,056	6,212
Estimated malpractice liabilities		
Deferred reimbursement program liabilities	1,978	1,669
Retirement incentive liabilities		
Subtotal	7,034	7,881
Long-term debt, less current portion		
Commitments and contingencies	53,717	52,745
Donor restricted fund balances	2,045	2,049
Unrestricted fund balances	54,537	50,010
<b>TOTAL LIABILITIES AND FUND BALANCES</b>	<b>134,882</b>	<b>138,833</b>

#### APPENDIX D: COASTAL MEDICAL CENTER: FINANCIAL RATIOS

Liquidity ratios	2008	2009
Current ratio		
Days in patient accounts receivable	1.885	1.401
Average payment period ratio	70.5	82.2
Days cash on hand	42.7	58.3
	10.9	13.3
Capital structure ratios		
Equity financing ratio		
Long-term debt to equity	0.404	0.360
Fixed asset financing ratio	0.985	1.055
Times interest earned ratio	0.613	0.508
Debt service coverage ratio	5.47	(2.38)
Cash flow to debt ratio	5.74	0.503
	0.657	0.413

Activity ratios		
Total asset turnover ratio	1.203	1.188
Fixed asset turnover ratio	3.143	2.634
Current asset turnover ratio	4.907	4.503
Profitability ratios		
Deductible ratio	24.55	32.20
Markup ratio	1.42	1.34
Operating margin ratio	0.077	0.087
Return on assets	0.08	0.062

## APPENDIX E: COASTAL MEDICAL CENTER LEADERSHIP SURVEY

### PERCEIVED CORPORATE CULTURE

Item	Positive %	Neutral %	Negative %
1. Leadership	28	9	63
2. Structure	22	14	64
3. Control	66	20	14
4. Accountability	20	7	73
5. Teamwork	26	7	67
6. Organization identity	31	17	52
7. Work climate	17	17	66
8. Risk taking	15	9	76
9. Conflict management	24	24	52
10. Perceived autonomy	51	12	37
11. Results oriented	29	20	51
12. Mutual trust	36	8	56
13. Communication	24	7	69
14. Team spirit	7	21	72
15. Attitudes	21	22	57
16. Vision	19	5	76
17. Reward system	36	27	37
18. Group interaction	20	45	35
19. Value of meetings	26	7	67
20. Faith in organization	28	6	66

### SELF-EVALUATION OF POSITION

Item	True %	Partly true %	Not true %
1. Sufficient decision-making authority	34	50	16
2. Clear understanding of role	43	30	27
3. Clear understanding of performance expectations	26	44	30
4. Fully use training and experience	27	33	40
5. Mix of management and routine is correct	33	30	37
6. Amount of work is reasonable	28	32	40
7. Work offers challenge, satisfaction, and growth	30	30	40
8. Performance is recognized	38	32	30
9. Compensation is satisfactory	45	35	20
10. Quality work is recognized and rewarded	29	41	30
11. Upward communication is effective	21	40	39
12. Downward communication is effective	17	50	33

13. Cross communication is effective	15	55	30
14. Operations problem solving is timely and thorough	17	43	40
15. Strategic decisions are timely and effective	26	30	44

**APPENDIX F: HOSPITAL COMPARE QUALITY DATA**

CMS ID	11111X	22222Y	33333Z	State average	National average
HospitalName	CMC	JMC	LMC		
Accreditation	Yes	Yes	Yes		
EmergencyService	Yes	Yes	Yes		
HeartAttackPatientsGivenACEInhibitororARBforLeftVetri	78%	82%	91%	82%	83%
HeartAttackPatientsGivenAspirinatArrival	92%	97%	100%	91%	94%
HeartAttackPatientsGivenAspirinatDischarge	95%	98%	96%	94%	95%
HeartAttackPatientsGivenBetaBlockeratArrival	90%	91%	97%	85%	86%
HeartAttackPatientsGivenBetaBlockeratDischarge	92%	97%	93%	92%	94%
HeartAttackPatientsGivenPCIWithin120MinutesofArrival	49%	52%	66%	65%	68%
HeartAttackPatientsGivenSmokingCessationAdviceCounseling	83%	98%	98%	98%	99%
HeartAttackPatientsGivenThrombolyticMedicationWithin30Mi	63%	33%	100%	40%	50%
HeartFailurePatientsGivenACEInhibitororARBforLeftVentr	81%	82%	89%	73%	75%
HeartFailurePatientsGivenanEvaluationofLeftVentricularS	93%	97%	96%	92%	93%
HeartFailurePatientsGivenDischargeInstructions	46%	37%	58%	39%	49%
HeartFailurePatientsGivenSmokingCessationAdviceCounseling	71%	78%	100%	87%	97%
PneumoniaPatientsAssessedandGivenInfluenzaVaccination	58%	59%	77%	43%	45%
PneumoniaPatientsAssessedandGivenPneumococcalVaccination	44%	60%	83%	39%	49%
PneumoniaPatientsGivenInitialAntibioticswithin4HoursAf	53%	61%	81%	72%	73%
PneumoniaPatientsGivenOxygenationAssessment	98%	98%	99%	98%	99%
PneumoniaPatientsGivenSmokingCessationAdviceCounseling	76%	77%	100%	92%	95%
PneumoniaPatientsGiventheMostAppropriateInitialAntibiotic	75%	81%	90%	81%	85%
PneumoniaPatientsWhoseInitialEmergencyRoomBloodCultureWa	80%	85%	81%	80%	90%
SurgeryPatientsWhoReceivedPreventativeAntibioticsOneHou	62%	75%	74%	80%	81%
SurgeryPatientsWhosePreventativeAntibioticsareStoppedWi	62%	75%	74%	80%	81%