COLUMBIA MEMORIAL HOSPITAL

6

BREAK-EVEN ANALYSIS

COLUMBIA MEMORIAL HOSPITAL, an acute care hospital with 300 beds and 160 staff physicians, is one of 75 hospitals owned and operated by Health Services of America, a for-profit, publicly owned company. Although two other acute care hospitals serve the same population, Columbia historically has been highly profitable because of its well-appointed facilities, fine medical staff, reputation for quality care, and the amount of individual attention it gives to patients. In addition to the standard range of inpatient and outpatient services, Columbia operates an emergency department within the hospital complex and a stand-alone walk-in clinic located across the street from the area's major shopping mall, about two miles from the hospital.

Patients who need immediate care for injuries or illness, be it a nail-gun puncture or a sore throat, are increasingly turning to walk-in clinics (urgent care centers). These clinics aim to fill the gap between the growing shortage of primary care physicians and already crowded (and expensive) emergency departments. Walk-in clinics are staffed by physicians, offer wait times as little as a few minutes, and charge $60 to $200, depending on the procedure. Furthermore, no appointments are necessary and evening and weekend hours are frequently available. Finally, many offer discounts to the uninsured, and for those with coverage, copayments are typically much less than for emergency department visits. Currently, 8,000 of these clinics exist around the country, including about 1,200 affiliated with hospitals.

Mike Reynolds, Columbia's chief executive officer (CEO), is concerned about the clinic's overall financial soundness. About ten years ago, all three area hospitals jumped onto the walk-in-clinic bandwagon, and within a short time, there were five such clinics scattered around the city. Now, only three are left, and none of them appears to be a big money maker. Mike wonders if Columbia should continue to operate its clinic or close it down. The clinic is currently handling a patient load of 45 visits per day, but it has the physical capacity to handle many more visits—up to 85 a day. Mike's decision has been complicated by the fact that Rose Daniels, Columbia's marketing director, has been pushing to embark on a new marketing program for the clinic. She believes that an expanded marketing effort aimed at local businesses would bring in the number of new patients needed to make the clinic a financial winner.

Mike has asked Brent Williams, Columbia's chief financial officer, to look into the whole matter of the walk-in clinic. In their meeting, Mike stated that he visualizes three potential outcomes for the clinic: (1) the clinic could be closed; (2) the clinic could continue to operate as is—that is, without expanding its marketing program; or (3) the clinic could continue to operate, but with the expanded marketing effort. As a starting point for the analysis, Brent has collected the most recent historical financial and operating data for the clinic, which are summarized in Exhibit 6.1. In assessing the historical data, Brent noted that one competing clinic had recently (December 2009) closed its doors. Furthermore, a review of several years of financial data revealed that the Columbia clinic does not have a pronounced seasonal utilization pattern.

Next, Brent met several times with the clinic's director. The primary purpose of the meetings was to estimate the additional costs that would have to be borne if clinic volume rose above the current January/February average level of 45 visits per day. Any incremental usage would require additional expenditures for administrative and medical supplies, estimated to be $3.00 per patient visit for medical supplies, such as tongue blades and rubber gloves, and $0.50 per patient visit for administrative supplies, such as file folders and clinical record sheets.

Because of the relatively low volume level, the clinic has purposely been staffed at the bare minimum. In fact, some clinic employees have started to grumble about not being able to do their jobs well because of overwork. Thus, any increase in the number of patient visits would

require immediate administrative and medical staff increases. Furthermore, as the number of visits increase, the clinic would have to hire additional staff members. The incremental costs associated with increased volume are summarized in Exhibit 6.2.

In addition, Brent learned that the building is leased on a long-term basis. Columbia could cancel the lease, but the lease contract calls for a cancellation penalty of three months' rent ($37,500) at the current lease rate. Brent was startled to read in the newspaper that Baptist Hospital, Columbia's major competitor, had just bought the city's largest primary care group practice, and Baptist's CEO said that more group practice acquisitions are planned. Brent wondered whether Baptist's actions would influence the decision regarding the clinic's fate.

Finally, Brent met with Rose (Columbia's marketing director) to learn more about the proposed expansion of the clinic's marketing program. The primary focus of the new marketing program would be on occupational health services (OHS). OHS involves providing medical care to local businesses, including physical examinations for managers and employees; treatment of illnesses that occur during work hours; and treatment of work-related injuries, especially those covered by Workers' Comp. Although some of the clinic's current business is OHS related, Rose believes that a strong marketing effort, coupled with specialized OHS record keeping, could bring additional patients to the clinic. The proposed marketing expansion requires a marketing assistant who will run the clinic's OHS program. Additionally, the new marketing program would incur costs for newspaper, radio, TV, and Internet ads as well as for brochures and handouts. The incremental costs associated with the new marketing program are also summarized in Exhibit 6.2. (To learn more about OHS, start at the American College of Occupational and Environmental Medicine website at www.acoem.org.)

With a blank spreadsheet on the screen, Brent began to construct a model that would provide the information needed to help the board make a rational, informed decision. At first, Brent planned to conduct a standard capital budgeting analysis that focused on the profitability of the clinic as measured by net present value or internal rate of return. Then he realized that the expanded marketing program requires no capital investment. He also realized that no valid data are available on the incremental increase in visits that would be generated either by an increasing population base or by the expanded marketing program.

Finally, he remembered that Mike requested that the analysis consider the inherent profitability of the clinic without the expanded marketing program.

With these points in mind, Brent thought that a break-even analysis would be very useful in making the final decision. Specifically, he wanted to develop answers to the following questions posed by Mike:

1. What is the projected profitability of the walk-in clinic for the entire year if volume continues at its current level?
2. How many additional visits per day would be required to break even without the new marketing program?
3. How many additional visits per day would be required to break even assuming that the new marketing program is undertaken?
4. How many additional daily visits would the new program have to bring in to make it worthwhile, regardless of the overall profitability of the clinic?

In addition, Brent wonders if the clinic could "inflate" its way to profitability; that is, if volume remained at its current level, could the clinic be expected to become profitable in, say, five years, solely because of inflationary increases in revenues? Finally, Brent is concerned about whether or not the analysis gave the clinic full credit for its financial contributions to the hospital. Brent does not want to change the spreadsheet at this late date, but he does want to make sure that any additional financial value is at least considered qualitatively. Overall, Brent must consider all relevant factors—both quantitative and qualitative—and come up with a recommendation regarding the future of the clinic.

				Monthly Averages		
	CY 2009	*Jan 2010*	*Feb 2010*	*2009*	*Jan/Feb 2010*	*Total*
Number of visits	14,522	1,365	1,335	1,210	1,350	1,230
Net revenue	$548,747	$55,028	$54,748	$45,729	$54,888	$47,037
Salaries and wages	$154,250	$13,540	$13,544	$12,854	$13,542	$12,952
Physician fees	192,000	18,000	18,000	16,000	18,000	16,286
Malpractice insurance	31,440	3,215	3,215	2,620	3,215	2,705
Travel and education	5,365	538	665	447	602	469
General insurance	8,112	843	843	676	843	700
Subscriptions	189	0	0	16	0	14
Electricity	11,820	1,124	1,029	985	1,077	998
Water	1,260	135	142	105	139	110
Equipment rental	1,260	105	105	105	105	105
Building lease	155,745	12,500	12,500	12,979	12,500	12,910
Other operating expenses	103,779	8,152	7,923	8,648	8,038	8,561
Total operating expenses	$665,220	$58,152	$57,966	$55,435	$58,059	$55,810
Net profit (loss)	($116,473)	($ 3,124)	($ 3,218)	($ 9,706)	($ 3,173)	($ 8,773)
Gross margin (%)	–21.2%	–5.7%	–5.9%	–21.2%	–5.8%	–18.7%

EXHIBIT 6.1
Columbia Walk-In Clinic: Historical Financial Data

EXHIBIT 6.2
Columbia Walk-In Clinic: Monthly Incremental Cost Data

	Number of Additional Visits per Day				
	0	*1–10*	*11–20*	*21–30*	*31–40*
Variable Costs					
Medical supplies			$3.00 per visit		
Administrative supplies			0.50 per visit		
Total variable costs per visit			$3.50 per visit		
Semifixed Costs					
Salaries and wages		$ 4,000	$ 5,000	$ 6,000	$ 7,000
Physician fees		10,000	10,000	10,000	20,000
Total monthly semifixed costs	$ 0	$14,000	$15,000	$16,000	$27,000
Fixed Costs					
Marketing assistant's salary	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
Advertising expenses	4,000	4,000	4,000	4,000	4,000
Total monthly fixed costs	$ 7,000	$ 7,000	$ 7,000	$ 7,000	$ 7,000