Care CEUs

Continuing Education for Nursing Home Administrators

Finance and Management

Introduction

In the current health care climate, financial management is absolutely essential to the success of a health care organization. Therefore, health care administrators of nursing homes and assisted living facilities should be familiar with financial management. This course provides insight into financial management, while highlighting the essential elements of financial management. This course also outlines concepts central to understanding revenue, reimbursement, and budgeting.

Section 1: Financial Management

A health care administrator takes an opportunity to manage the finances of an assisted-living facility. The health care administrator's first order of business is to gather financial documents, payroll information, and resident satisfaction surveys. After reviewing the aforementioned documentation, the health care administrator notes that the assisted living facility requires additional staff, renovations, and more activities for residents. After contemplating some options, the health care administrator considers the essential elements of financial management.

The scenario outlined above can occur in both assisted living facilities and nursing homes - the question is, what is financial management, and what are the essential elements of financial management? This section of the course will answer that very question, while providing insight into the main objectives of financial management.

What is financial management?

Financial management may refer to the process of overseeing an organization's profitability, expenses, cash, and credit.

Why is financial management important?

Financial management is important because it can keep a company or organization solvent (note: a company or organization is solvent when it can meet its financial obligations).

Financial management is also important because it can help a health care organization meet its financial goals, as well as its resident goals (e.g., optimize resident care; increase resident satisfaction).

What are the essential elements of financial management?

- **Invoicing** - one of the first essential elements that may come to mind when considering financial management is invoicing (note: invoicing may refer to the process of providing an individual or entity with documentation for provided goods or services). It is argued that invoicing is one of the "pillars" of financial management because it supports the other essential elements, as well as the company or organization itself. Essentially, without efficient or effective invoicing, an organization cannot receive payment, and ultimately, an organization cannot stand. Therefore, health care administrators must ensure that their invoice/billing system is both efficient and effective. An efficient and effective invoice or billing system is one that enables organizations to receive all payments within a desired time period.

- **Receivables** - receivables often go hand and hand with invoicing. A receivable is an asset owed to a company or organization for rendered services. Much like with invoicing, health care administrators must ensure their organizations' method of obtaining receivables is both efficient and effective. An efficient and effective receivable system is one that enables organizations to obtain receivables within a desired time period.

- **Payables** - on the other end of the spectrum, from invoicing and receivables, are payables. Payables are money and/or assets a company owes to its vendors and suppliers. A health care organization must ensure that it delivers payables in full, and on time. Any delay could lead to supply and inventory problems and, ultimately, to issues concerning resident care. For example, if a health care organization does not deliver its payables for medications, the medication vendor could stop delivering medications, which in turn could lead to inventory issues, which in turn could lead to issues concerning resident care (e.g., a resident is unable to receive a required antibiotic in the necessary time frame).

- **Bank transactions** - a bank transaction is exactly what it sounds like, the movement of money in and/or out of a bank. Those engaged in financial management must ensure every bank transaction is processed correctly. In other words, those engaged in financial management must make sure that the desired or correct amount of money is moved into a bank account or out of a bank account every time a transaction occurs. Ensuring that every bank transaction is processed correctly can help avoid discrepancies (note a discrepancy, within the context of financial management, may refer to a difference between two figures).

- **Reconciliation** - to build on the previous element, financial management often includes reconciliation. Reconciliation, otherwise referred to as

account reconciliation, is a process that can be used to compare two sets of records to ensure that figures are in agreement. Health care administrators can use reconciliation to determine the accuracy of bank and credit account statements. Health care administrators can also use reconciliation to prevent balance sheet errors on their financial accounts, and fraud. One of the most tried and tested methods to carry out reconciliation is double-entry bookkeeping. Double-entry bookkeeping may refer to a process where a transaction is entered into a general ledger in two separate places. Health care administrators should note the following: double-entry bookkeeping records transactions in two ways (e.g., by entering both debits and credits for each transaction); double-entry bookkeeping can be used to create a balance sheet made up of assets, liabilities, and equity; a balanced sheet occurs when a company's assets equal its liabilities plus equity; assets include all of the items that a company owns (e.g., inventory, cash, medical devices, and buildings) (Drury, 2023).

- **Payroll** - payroll may refer to the compensation a company or organization must pay to its employees for a set period on a given date. It is often said that payroll is vital to the success of a health care organization. After all, an adequate health care staff cannot exist without an adequate payroll, and adequate health care cannot exist without health care staff. Therefore, health care administrators must ensure that their health care organizations' payroll can support adequate staff to fulfill the needs and requirements of residents in a safe and effective manner. The aforementioned sentiment is increasingly important in the post-coronavirus disease (COVID-19) pandemic era. Health care administrators must ensure that their health care organizations' payroll can accommodate staffing needs even in the wake of the impact of COVID-19. When managing payrolls, health care administrators should consider Section 6106 of the Affordable Care Act.

Section 6106 of the Affordable Care Act requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data to the Centers for Medicare and Medicaid Services (CMS). Specific requirements outlined in Section 6106 of the Affordable Care Act may be found below. The information found below was derived from materials provided by the Centers for Medicare and Medicaid Services (CMS) (Centers for Medicare and Medicaid Services [CMS], 2022).

- Mandatory submission of staffing information based on payroll data in a uniform format is required. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (note: direct care staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being; direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long-term care facility [e.g., housekeeping]).

- The health care facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: the category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); resident census data; and information on direct care staff

turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date [as applicable], and hours worked for each individual).

- When reporting information about direct care staff, the health care facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

- The health care facility must submit direct care staffing information in the uniform format specified by CMS.

- The health care facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.

- Reporting shall be based on the employee's primary role and their official categorical title; it is understood that most roles have a variety of non-primary duties that are conducted throughout the day (e.g., helping out others when needed); health care facilities should report just the total hours of that employee based on their primary role.

- CMS recognizes that staff may completely shift primary roles in a given day; for example, a nurse who spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse. In the aforementioned cases, health care facilities can change the designated job title and report four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties).

- If a health care professional from the corporate office is in the health care facility and is performing duties involving resident care, the hours spent performing that care can be reported, even though the person may be paid through the corporate payroll, rather than the facility's payroll; this would include instances when a corporate nurse is filling in for the Director of Nursing when she/he is on vacation. However, health care facilities should not include hours that a corporate nurse spends performing monitoring tasks, such as helping the facility prepare for a survey or resident chart reviews; additionally, only hours paid to work on-site shall be reported.

- All staff (direct employees and contract staff) must be entered into the reporting system by assigning each staff member an Employee ID; employee names and any personally identifiable information (PII) will not be stored in the system; the ID must be a unique identifier and not duplicated with any other current or previous staff; this ID shall also not contain any PII, such as a Social Security Number (SSN).

- Staffing information is required to be an accurate and complete submission of a health care facility's staffing records.

- **Financial statements and accounting** - financial statements are formal records of the financial activities and position of a company or organization. Accounting may refer to a process that is designed to collect, categorize, and transform data into detailed financial records and reports. Financial statements are typically the product of accounting. Specific information regarding financial statements and related accounting may be found below.

    - Financial statements are typically prepared quarterly and/or annually.

- The main types of financial statements include the following: balance sheets, income statements, cash flow statements, and statements of equity.
- All of the aforementioned types of financial statements are related, and are used together to provide a complete overview of a company's financial state (note: to best evaluate and understand financial statements, health care administrators should analyze all types of financial statements with the understanding that they are related).
- Balance sheets provide an overview of assets, liabilities, and equity over a given period of time; assets are things that a company owns that have value; liabilities are amounts of money that a company owes to others; equity often refers to capital or net worth (Murphy, 2023).
- An income statement primarily focuses on a company's revenues and expenses during a particular period of time; once expenses are subtracted from revenues, income statements produce a company's profit figure called net income (Murphy, 2023).
- Cash flow statements measure how well a company generates cash to pay its debt obligations, fund its operating expenses, and fund investments (Murphy, 2023).
- A statement of equity records how profits are retained within a company for future growth or distributed to external parties (Murphy, 2023).

- The Generally Accepted Accounting Principles (GAAP) are typically used to prepare financial statements.
- GAAP is typically used in the U.S.; GAAP is the set of accounting rules set forth by the Financial Accounting Standards Board (FASB) that U.S. companies are expected to follow when putting together their financial statements; the goal of GAAP is to ensure that a company's financial statements are complete, consistent, and comparable (Fernando, 2023).
- The 10 main principles of GAAP include the following: (1) GAAP must always be followed by accountants and businesses when handling financial information - at no point can a company or financial team choose to ignore or modify any of the regulations; (2) accountants are responsible for using the same standards and practices for all accounting periods - if a method or practice is changed, or if a new accountant is hired with a different system, the change must be fully documented and justified in the footnotes of the financial statements; (3) any accountant or accounting team hired by a company is obligated to provide the most unbiased, accurate financial report possible; (4) accountants should use the same reporting method procedures across all the prepared financial statements; (5) all negative and positive values on a financial statement, regardless of how they reflect upon the company, must be clearly reported by the accounting team - accountants cannot try to make things look better by compensating a debt with an asset or an expense with revenue; (6) formally reported data must be fact-based and dependent on clear, concrete numbers; (7) when compiling reports, accountants must assume a business will continue to operate regardless of the status of the company; (8) accountants should only

report financial information in the relevant accounting period; (9) accountants must, to the best of their abilities, fully and clearly disclose all the available financial data of a company; (10) any person or party involved in, or responsible for, the financial side of a business must be honest in all reports and transactions (Crail & Main, 2022).

- **Taxes and business expenses** - according to the Internal Revenue Service (IRS), business expenses are ordinary and necessary costs incurred to operate a business (Internal Revenue Service [IRS], 2023). Specific information regarding business expenses and taxes may be found below. The information found below was provided by the IRS (IRS, 2023).
    - To be deductible, a business expense must be both ordinary and necessary; an ordinary expense is one that is common and accepted in a given industry; a necessary expense is one that is helpful and appropriate for the related trade or business (note: an expense does not have to be indispensable to be considered necessary).
    - Typically, companies must capitalize, rather than deduct, some costs; these costs are a part of an investment in a business and are called capital expenses; capital expenses are considered assets in a business.
    - Typically, companies must fully capitalize the cost of business assets, including installation charges (note: examples of business assets include the following: land, buildings, and medical devices).
    - Typically, companies must capitalize the costs of making improvements to a business asset if the improvements result in a betterment to the unit of property, restore the unit of property, or adapt the unit of property to a new or different use.

- Regarding roads and driveways, the cost of building a private road on a business property and the cost of replacing a gravel driveway with a concrete one is a capital expense that one may be able to depreciate; the cost of maintaining a private road on a business property is a deductible expense.

- Regarding machinery parts, unless the uniform capitalization rules apply, the cost of replacing short-lived parts of a machine to keep it in good working condition, but not to improve the machine, is a deductible expense.

- Regarding heating equipment, the cost of changing from one heating system to another is a capital expense.

- When deductions occur, an expense depends on the accounting method. An accounting method is a set of rules used to determine when and how income and expenses are reported. The two basic accounting methods are the cash method and the accrual method.

- Under the cash method of accounting, one generally deducts business expenses in the tax year they are paid.

- Under the accrual method of accounting, one generally deducts business expenses when both of the following apply: all-events tests are met; economic performance occurred; one generally cannot deduct or capitalize a business expense until economic performance occurs; if the expense is for property or services provided, economic performance occurs as the property or services are provided, or the property is used.

- Regarding prepayment, one cannot deduct expenses in advance, even if they are paid in advance; this applies to prepaid interest, prepaid insurance premiums, and any other prepaid expense that creates an intangible asset.

- Gross income from a not-for-profit activity includes the total of all gains from the sale, exchange, or other disposition of property, and all other gross receipts derived from the activity; gross income from the activity also includes capital gains and rents received for the use of property that is held in connection with the activity.

- Regarding employee pay; the COVID-19 related credit for qualified sick and family leave wages is limited to leave taken after March 31, 2020, and before October 1, 2021; generally, the credit for qualified sick and family leave wages, as enacted under the Families First Coronavirus Response Act (FFCRA) and amended and extended by the COVID-related Tax Relief Act of 2020, for leave taken after March 31, 2020, and before April 1, 2021, and the credit for qualified sick and family leave wages, as enacted under the American Rescue Plan Act of 2021 (the ARP), for leave taken after March 31, 2021, and before October 1, 2021, expired.

- The COVID-19 related employee retention credit expired - the employee retention credit enacted under the Coronavirus Aid, Relief, and Economic Security (CARES) Act and amended and extended by the Taxpayer Certainty and Disaster Tax Relief Act of 2020 was limited to qualified wages paid after March 12, 2020, and before July 1, 2021.

- An organization can generally deduct the amount paid to employees for the services they perform; the pay may be in cash, property, or services, and may include wages, salaries, bonuses, commissions, or

other noncash compensation such as vacation allowances and fringe benefits.

- To be deductible, employees' pay must be an ordinary and necessary business expense.
- Organizations can generally deduct a bonus paid to an employee if the organization intended the bonus as additional pay for services, not as a gift, and the services were performed.
- If an organization pays or reimburses education expenses for an employee, the organization can deduct the payments if they are part of a qualified educational assistance program.
- A welfare benefit fund is a funded plan (or a funded arrangement having the effect of a plan) that provides welfare benefits to employees, independent contractors, or their beneficiaries; welfare benefits are any benefits other than deferred compensation or transfers of restricted property; deductions for contributions to a welfare benefit fund is limited to the fund's qualified cost for the tax year.
- If an organization transfers property (including company stock) to an employee as payment for services, the organization can generally deduct it as wages.
- Organizations can generally deduct the amount they pay or reimburse employees for business expenses incurred for their business.
- Organizations can deduct amounts they pay to their employees for sickness and injury, including lump-sum amounts, as wages; however,

the deduction is limited to amounts not compensated by insurance or other means.

- In general, companies and/or organizations can deduct rent as an expense only if the rent is for property used in trade or business (note: if a company or organization receives equity in or title to the property, the rent is not deductible).

- Interest paid with funds borrowed from the original lender - under the cash method of accounting, organizations cannot deduct interest paid with funds borrowed from the original lender through a second loan, an advance, or any other arrangement similar to a loan.

- Deductible real estate taxes are any state or local taxes, including taxes imposed by U.S. possessions, on real estate levied for the general public welfare; the taxing authority must base the taxes on the assessed value of the real estate and charge them uniformly against all property under its jurisdiction; deductible real estate taxes generally do not include taxes charged for local benefits and improvements that increase the value of the property.

- A corporation or partnership can deduct state and local income taxes imposed on the corporation or partnership as business expenses.

- If a company or organization has employees, the company or organization must withhold various taxes from employees' pay. Most employers must withhold their employees' share of social security, Medicare taxes, and Additional Medicare Tax (if applicable), along with state and federal income taxes.

- **Forecasting** - forecasting may refer to a process that uses historical data to predict future financial developments and trends. Essentially, forecasting involves making predictions about the future; in finance, forecasting is often used by companies or organizations to estimate earnings or other data for subsequent periods (Tuovila, 2023).
    - Business forecasting is a specific type of forecasting that is often used to make informed predictions about the future state of business metrics, such as sales growth or economy-wide predictions; business forecasting typically relies on different types of forecasting techniques to improve accuracy; health care administrators may use business forecasting for internal purposes to make capital allocation decisions and determine whether to make acquisitions, expand, or diversify (Tuovila, 2023).
    - As previously alluded to, there are different techniques that can be used to forecast future financial developments; one such technique is called time series analysis. Time series analysis is a technique characterized by the analyses of historical data and various variables to outline a statistical relationship that can be used to generate forecasts; the forecasts generated by time series analysis can be used to understand the likelihood of the actual outcomes within a specific confidence interval (Tuovila, 2023).
    - Economic analysis is another technique that may be used to determine financial development. Economic analysis is a quantitative approach that can be used to examine cross-sectional data to identify links among variables (Tuovila, 2023).
- **Closing the books** - closing the books is a term that refers to the act of returning the balance of specific accounts back to zero. Typically,

organizations close the books on a specific date, and tally transactions from a given time period to reconcile accounts and, to ultimately, report on its financial position (note: the act of closing the books can occur at an organization's discretion [e.g., at the end of a month, quarter, or year]).

- **Reporting** - at some point, those engaged in financial management will have to report their specific organization's financial performance to a chief executive officer (CEO), a board of directors, investors, and/or shareholders. Health care administrators should have a complete understanding of their health care organization's financial state before reporting occurs.

- **Effective communication** - all aspects of financial management, in some way, require effective communication, especially reporting. Communication may refer to the process of transmitting information and messages from one individual or party to another individual or party in order to obtain meaning and a common understanding. Effective communication occurs when information and messages are adequately transmitted, received, and understood. In an organization, individuals may be required to engage in both vertical communication and horizontal communication.

    - Vertical communication may refer to the flow of communication between individuals associated with the same organization who are on different levels of the organization's hierarchy. Vertical communication may flow in a downwards or upwards manner. Downward communication occurs when organizational leaders, managers, and/or administrators share information with lower-level employees (e.g., a nurse manager gives a nurse instructions). Upward communication occurs when lower-level employees share information with organizational leaders, managers, and/or administrators (e.g., a health care professional informs a health care

manager of a financial issue). Vertical communication is often essential to creating and maintaining a shared understanding between organizational leaders, managers, administrators, and employees.

- Horizontal communication may refer to the flow of communication between individuals and/or departments that are on the same level of a given organization (e.g., a health care manager provides information to another health care manager). Horizontal communication can be a key aspect of effective teamwork within a given health care facility, especially when it comes to financial management. For example, two health care administrators may need to compare notes and figures when carrying out reconciliation.

What are the main objectives of financial management?

- **Profit maximization** - depending on the health care organization, one of the first objectives of financial management is profit maximization. Profit maximization may refer to the process of ensuring the best output and price levels in order to maximize returns. In other words, profit maximization is the process health care organizations use to achieve a profit and, ultimately, remain operational. Key aspects of profit maximization are revenue and reimbursement. Revenue is the total amount of earnings brought in by a company or organization under normal operations over a specific period of time (i.e., revenue is money brought into a company or organization by its business activities); reimbursement may refer to the payment received by a health care provider, hospital, long-term care facility, or other type of health care organization for providing services and care (Hayes, 2023). One of the oldest reimbursement models, within the health

care system, is the fee-for-service (FFS) model. The fee-for-service (FFS) model is exactly what it sounds like, a health care provider or organization provides a service for a fee (note: the FFS model is typically based on volume).

- **Reduce risks** - it is vital that an organization generate capital to either make a profit or simply remain in business. With that said, it is just as vital for an organization to reduce risks. Within the context of financial management, reducing risks can mean avoiding high-risk situations or opportunities and opting for calculated options that were well planned, researched, and evaluated. Forecasting can help a health care organization reduce risk. Essentially, forecasting can help those engaged in financial management identify financial situations that should be avoided.

- **Develop a budget** - developing a budget can either make or break a health care organization, which is why it is a main objective of financial management. The term budget may refer to a spending plan based on revenue and expenses. In health care organizations budgets can be used to establish staffing patterns, as well as obtain supplies and materials for resident care. In essence, a budget can be a driving force in a health care organization's ability to provide care for residents.

- **Financial planning** - another key objective of financial management is financial planning. Financial planning is the process of assessing finances in order to meet both short-term and long-term goals (e.g., a short-term goal for a nursing home may be to enhance the resident experience by adding more activities; a long-term goal for a nursing home may be renovations). Essentially, financial planning can be used to allocate resources in order to meet needs and achieve desired outcomes.

- **Resource optimization** - along the lines of developing a budget and financial planning, resource optimization is a main objective of financial management. Resource optimization may refer to the process of allocating available resources in an efficient manner to achieve desired outcomes. In health care settings, resources can range from capital to medical devices to even specific health care professionals. Optimizing resources can help an organization maintain stability and maximize resident outcomes.

- **Ensure compliance** - adhering to state and federal laws is integral to the operations of a health care organization, which is why ensuring compliance is a key objective of financial management. Within the context of financial management, ensuring compliance can apply to accounting, record keeping, taxes, and payroll.

- **Stability and survival** - last, but certainly not least, the main objectives of financial management include stability and survival. Stability is a state in which a company or organization can continue to operate in a regular and successful way without unexpected, detrimental changes. Survival, within the context of financial management, is a state where a company or organization maintains operations. Maintaining stability and survival are the main objectives of any cooperation, business, organization, or enterprise. However, it is especially vital in health care. If a health care organization fails, the health, overall well-being, and quality of life of its patients and/or residents may be placed in jeopardy.

Section 1 Summary

Financial management is absolutely essential in the current health care climate. Financial management can help a health care organization remain operational, as well as help a health care organization meet both financial and resident goals.

Health care administrators should be familiar with financial management to ensure the stability and survival of their health care organization.

Section 1 Key Concepts

- The essential elements of financial management include the following: invoicing, receivables, payables, bank transactions, reconciliation, payroll, financial statements, taxes and business expenses, forecasting, closing the books, reporting, and effective communication.
- The main objectives of financial management include the following: profit maximization, reducing risks, developing a budget, financial planning, resource optimization, ensuring compliance, stability, and survival.

Section 1 Key Terms

Financial management - the process of overseeing an organization's profitability, expenses, cash, and credit

Invoicing - the process of providing an individual or entity with documentation for provided goods or services

Receivable - an asset owed to a company or organization for rendered services

Payables - money or assets a company owes to its vendors and suppliers

Bank transaction - the movement of money in and/or out of a bank

Discrepancy (within the context of financial management) - a difference between two figures

Reconciliation (otherwise referred to as account reconciliation) - a process that can be used to compare two sets of records to ensure that figures are in agreement

Double-entry bookkeeping - a process where a transaction is entered into a general ledger in two separate places

Payroll - the compensation a company or organization must pay to its employees for a set period on a given date

Direct care staff - individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being (CMS, 2022)

Financial statements - records of the financial activities and position of a company or organization

Accounting - a process that is designed to collect, categorize, and transform data into detailed financial records and reports

Generally Accepted Accounting Principles (GAAP) - the set of accounting rules set forth by the Financial Accounting Standards Board (FASB) that U.S. companies are expected to follow when putting together their financial statements (Fernando, 2023)

Business expenses - ordinary and necessary costs incurred to operate a business (IRS, 2023)

Ordinary expense - an expense that is common and accepted in the related industry (IRS, 2023)

Necessary expense - an expense that is helpful and appropriate for the related trade or business (IRS, 2023)

Accounting method - a set of rules used to determine when and how income and expenses are reported (IRS, 2023)

Welfare benefit fund - a funded plan (or a funded arrangement having the effect of a plan) that provides welfare benefits to employees, independent contractors, or their beneficiaries (IRS, 2023)

Welfare benefits - any benefits other than deferred compensation or transfers of restricted property (IRS, 2023)

Deductible real estate taxes - any state or local taxes, including taxes imposed by U.S. possessions, on real estate levied for the general public welfare (IRS, 2023)

Forecasting - a process that uses historical data to predict future financial developments and trends

Business forecasting - a specific type of forecasting that is often used to make informed predictions about the future state of business metrics, such as sales growth or economy-wide predictions

Time series analysis - a technique characterized by the analyses of historical data and various variables to outline a statistical relationship that can be used to generate forecasts (Tuovila, 2023)

Economic analysis - a quantitative approach that can be used to examine cross-sectional data to identify links among variables (Tuovila, 2023)

Closing the books - the act of returning the balance of specific accounts back to zero

Communication - the process of transmitting information and messages from one individual or party to another individual or party in order to obtain meaning and a common understanding

Vertical communication - the flow of communication between individuals associated with the same organization who are on different levels of the organization's hierarchy

Horizontal communication - the flow of communication between individuals and/or departments that are on the same level of a given organization

Profit maximization - the process of ensuring the best output and price levels in order to maximize returns

Revenue - the total amount of earnings brought in by a company or organization under normal operations over a specific period of time

Reimbursement - the payment received by a health care provider, hospital, long-term care facility, or other type of health care organization for providing services and care

Budget - a spending plan based on revenue and expenses

Financial planning - the process of assessing finances in order to meet both short-term and long-term goals

Resource optimization - the process of allocating available resources in an efficient manner to achieve desired outcomes

Stability - a state in which a company or organization can continue to operate in a regular and successful way without unexpected, detrimental changes

Survival (within the context of financial management) - a state where a company or organization maintains operations

Section 1 Personal Reflection Question

What is adequate financial management, and how can it be used to improve a health care organization?

Section 2: Revenue and Reimbursement

Revenue and reimbursement are key aspects of profit maximization, which is an important objective of financial management. With that in mind, this section of the course will highlight information central to understanding revenue and reimbursement. The information found within this section was derived from materials provided by the National Academies of Sciences, Engineering, and Medicine and the National Institute on Aging unless, otherwise, specified (National Academies of Sciences, Engineering, and Medicine, 2022; National Institute on Aging, 2023).

Revenue and Reimbursement

- As previously mentioned, revenue is the total amount of earnings brought in by a company or organization under normal operations over a specific period of time; reimbursement may refer to the payment received by a health care provider, hospital, long-term care facility, or other type of health care organization for providing services and care. One of the oldest reimbursement models within the health care system is the fee-for-service (FFS) model; within a FFS model, a health care provider or facility provides a service for a fee (note: the FFS model is typically based on volume).

- Many older adults pay for part or all of their long-term care with their personal money, also known as personal or “out of pocket” funds; these older adults may use personal savings, a pension or other retirement fund, income from investments, or proceeds from the sale of a home to pay for long-term care.

- Professional care in assisted living facilities and continuing care retirement communities is almost always paid for out of pocket.

- In addition to personal funds, older adults may pay for long-term care with private payment options, including: long-term care insurance, reverse mortgages, certain life insurance policies, annuities, and trusts.

- Long-term care insurance covers services and support for individuals needing long-term care, including help with the activities of daily living; policies cover a wide range of benefits in a variety of settings, including the individual’s home, an assisted living facility, or a nursing home; the exact coverage depends on the type of policy and the services it includes.

- A reverse mortgage is a type of home loan that allows homeowners to convert part of the ownership value in their home into cash without having to sell the home; unlike a traditional home loan, no repayment is required until the borrower sells the home, no longer uses it as a main residence, or dies; there are no income or medical requirements to get a reverse mortgage, but this option is only available to those age 62 or older; the loan amount is tax-free and can be used for any expense, including long-term care; however, if individuals have an existing mortgage or other debt against their home, they must use the funds to pay off those debts first.

- Some life insurance policies can be used by individuals to help pay for long-term care; policies with an “accelerated death benefit” provide tax-free

cash advances while an individual is still alive; the cash advance is subtracted from any proceeds that beneficiaries receive after the individual dies; individuals can get an accelerated death benefit if they live permanently in a nursing home, need long-term care for an extended time, are terminally ill, or have a life-threatening diagnosis.

- Some individuals may sell their life insurance policy for its value in order to pay for long-term care; this option is known as a "life settlement;" it is usually available only to women age 74 and older and men age 70 and older; the proceeds are taxable and can be used for any reason, including paying for long-term care; a similar arrangement, called a "viatical settlement," allows terminally ill individuals to sell their life insurance policy to an insurance company for a percentage of the death benefit on the policy; a viatical settlement is typically used by individuals who are expected to live two years or less.

- An annuity is a contract with an insurance company that can help pay for long-term care services; in exchange for a lump sum contribution or series of contributions, the insurance company will provide regular payments over a specified period (e.g., the annuity can provide monthly income to cover long-term care costs).

- Some residents may use a trust to pay for long-term care; a trust is a legal arrangement that allows individuals to transfer assets (e.g., cash, property, or insurance benefits) to another person, called the trustee; the trustee then manages the assets for that individual's benefit (note: a trust can provide flexible control of assets for an older adult or a person with a disability).

- Older adults may be eligible for some government health care benefits; several federal and state programs provide help with health care-related

costs (e.g., Medicare and Medicaid) (note: over time, the benefits and eligibility requirements of these programs can change, and some benefits differ from state to state).

- Federal government health insurance programs can help pay some medical costs for people age 65 and older, and for people under 65 with certain disabilities and serious health conditions; covered services include hospital stays, doctor visits, some home health care, hospice care, and preventive services such as vaccinations; some older adults qualify for Medicaid, a combined federal and state program for low-income people; Medicaid covers the costs of medical care and some types of long-term care for people who have limited income and meet other eligibility requirements.

- Medicaid is the dominant payer for long-stay residents, who typically are individuals with chronic illness and who have an average length of stay in a nursing home setting of approximately two years; care for the aforementioned population consists largely of providing assistance with activities of daily living such as bathing, dressing, eating, toileting, and walking; to qualify for Medicaid-funded nursing home care, an individual must meet state-established medical eligibility criteria and satisfy income and asset thresholds.

- Medicare is the dominant payer for post-acute care nursing home residents, also referred to as short-stay residents, who have an average length of stay of approximately 25 days; Medicare-certified nursing homes also provide skilled, rehabilitative care to individuals following an acute-care hospital stay; the goal of this care is to help people achieve and maintain their highest level of functioning; to qualify for services, a Medicare beneficiary covered by the traditional fee-for-service (FFS) Medicare program must require daily skilled nursing or rehabilitative therapy services, generally

within 30 days of an inpatient hospital stay of at least three days in length as an inpatient and must be admitted to the nursing home as a result of a condition related to that hospital stay.

- Under traditional FFS Medicare, Part A covers inpatient hospital care, SNF care, some home health care, and hospice care (note: hospice care may refer to a public agency or private organization or subdivision that is primarily engaged in providing hospice care; hospice care is a comprehensive set of services, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care); Medicare Part B covers physician visits, outpatient services, preventive services, and some home health services; Medicare covers all necessary services for post-acute care patients, including room and board, nursing care, and ancillary services such as medications, laboratory tests, and physical therapy; Medicare covers up to 100 days of nursing home care for an episode of acute illness and recovery; for the first 20 days of a benefit period, Medicare pays 100 percent of the cost of care; from day 21 on, most residents become responsible for a substantial daily copayment.

- The Medicare Advantage (MA) program, also known as Part C, provides an alternative to traditional Medicare; through the MA program, Medicare beneficiaries can sign up for coverage through a health maintenance organization or preferred provider organization and receive coverage for Medicare Part A and Part B benefits, as well as Part D (outpatient prescription drug benefits).

- In October 2019, Medicare implemented a new payment system for nursing home care known as the patient-driven payment model (PDPM); this new

payment system replaced the case-mix model, which was based on resource utilization groups that heavily weighted payments according to the volume of therapy use (e.g., number of weekly therapy minutes provided to residents); the PDPM shifts the emphasis away from volume and towards value, and takes into account factors related to the resident's underlying complexity of condition and clinical needs; this change is designed to be budget neutral and to align payment incentives with quality incentives.

- Medicare provides a separate hospice benefit for beneficiaries who are expected to live six months or less; it is important to note that Medicare will not pay for nursing home care and hospice care in a nursing home simultaneously; Medicare pays hospice agencies a per-person daily rate to provide a range of palliative care services that reflect residents' preferences for end-of-life care as specified in their care plans.

- Medicare's daily per-beneficiary rate is paid to hospice agencies irrespective of the amount of services provided to the patient on a given day; hospice agencies may find caring for patients in nursing home settings more profitable than caring for patients in home settings because of the efficiencies of treating patients in a centralized location, the overlap in responsibilities between the hospice and the nursing home, and the ability of nursing homes to serve as referral sources for new residents.

- Medicaid is the federal-state program for low-income individuals who meet the program's eligibility requirements; Medicaid provides coverage to 20 percent of the U.S. population; Medicaid covers a range of long-term services and supports (LTSS) including home- and community-based services (HCBS) that enable individuals to live in community settings as well as institutional care provided in nursing home settings.

- Medicaid pays a fixed daily rate to cover the cost of care, room, meals, and medical supplies; states are guaranteed federal matching funds for services provided to Medicaid-eligible individuals; the federal match rate is determined by a formula and varies by state, ranging from a match of at least 50 percent, to a high of 75 percent in poorer states.

- As an incentive for nursing homes to control costs, states will set rates prospectively using prior year (or years) cost reports; states typically group costs from the cost reports into a series of cost centers including direct care, indirect care, administration, and capital; each cost center has an associated cap or spending limit; the incentive to control costs increases when states do not update rates using more recent cost reports but instead adjust rates over time for inflation using an exogenous measure of price changes; most states allow bed-hold payments when a resident takes a short leave of absence from the facility for an inpatient hospital stay or a therapeutic leave (visit with family); the majority of states adjust their Medicaid payment rates for case-mix to ensure access for residents with more extensive care needs; the adjustments may be for individual residents or may be tied to the average case-mix of a nursing home.

- To qualify for Medicaid coverage for nursing home care, individuals must meet both income and asset thresholds; the asset standard is often the key barrier to qualifying for Medicaid, because individuals can treat medical expenditures against the income standard in most states; individuals can have no more than $2,000 in assets if single and no more than $3,000 if married; for married individuals, there are also spousal impoverishment provisions that protect a certain amount of the couple's combined resources for the spouse living in the community in determining Medicaid eligibility; some assets are also set aside and not counted when determining Medicaid nursing home eligibility such as the value of a home

(up to state-set limit), one vehicle, burial space, and life insurance policies (up to a limit); if individuals have assets above the limit, they must “spend down” their assets until they qualify for Medicaid.

- Traditionally, the most common approach to paying for U.S. health care services is the FFS payment system, which pays for the quantity or intensity of services rendered, regardless of patient outcomes; payment systems based on quantity were called out as a key barrier to quality improvement, and various approaches to improving the quality of care in long-term care facilities focused on shifting from paying for quantity to paying for quality using a strategy known as value-based payment (VBP).

- Recent Medicare and Medicaid programs implemented alternative payment models (APMs) for nursing home care; APMs are a type of VBP that holds providers financially accountable for the quality and cost of care delivered to residents.

- A common APM implemented in long-term care facilities is an accountable care organization (ACO); an ACO typically consists of a group of clinicians, hospitals, and other health care professionals who work together to provide coordinated, high-quality care to their Medicare patients; the goal of establishing an ACO is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors; when an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program.

- One of the largest Medicare ACOs is the Medicare Shared Savings Program; Medicare ACOs affect long-term care facilities in three main ways: (1) when a long-term care facility is a provider in an ACO; (2) when a long-term care facility’s residents are attributed to an ACO; and (3) when a long-term care

facility leads an ACO, focusing on managing all care for long-term care residents (note: in theory, ACOs aim to reduce unnecessary long-term care facility use to reduce costs and, in cases when individuals do use long-term care facilities, to coordinate care across hospitals and nursing homes).

- State Medicaid programs are also beginning to offer ACO programs that, in addition to primary and acute medical care, may also be responsible for long-term care.

- Managed care in the Medicare program takes the shape of what are known as Medicare Advantage (MA) plans, which cover chronic care and post-acute care services.

- MA does not typically pay directly for long-stay care in a nursing home. However, Medicare special needs plans (SNPs) are a subcategory of coordinated care plans limited to beneficiaries with specific diseases or characteristics; these SNPs customize benefits, provider choices, and medication formulations to align with the specific needs of their beneficiaries.

- There are three types of SNPs; the first type, the chronic condition SNP (C-SNP), is limited to Medicare beneficiaries with severe or disabling chronic conditions; the second type of SNP, the institutional SNP (I-SNP), is a specialized form of MA that is limited to Medicare beneficiaries who are long-term residents of a nursing home; these plans were designed to facilitate the alignment of financial incentives for nursing homes and Medicare with the companion goal of improving care delivery across various health care settings; the third type of SNP is the dual SNP or D-SNP; nearly 90 percent of SNP enrollees are in D-SNPs; the Affordable Care Act of 2010 authorized a type of D-SNP known as the fully integrated dual eligible (FIDE) SNP; FIDE SNPs give states expanded authority and flexibility to more

closely integrate Medicare and Medicaid services; FIDE SNPs are required to provide Medicaid LTSS as well as Medicare benefits and are required to have established arrangements to promote alignment between the two programs; FIDE SNPs are the most integrated delivery model outside of the Program of All Inclusive Care for the Elderly and the Financial Alignment Initiative demonstrations, and they are the only D-SNP plans that are financially at risk for all Medicare and Medicaid services (note: the Affordable Care Act of 2010 is a comprehensive reform law that increases health insurance coverage for the uninsured and implements reforms to the health insurance market).

- MA plans cover post-acute SNF care for beneficiaries with a demonstrated need. These plans, unlike FFS plans, are able to negotiate contracts with nursing homes; MA plans pay for beneficiaries' services out of the monthly payments the plans receive for each covered member; MA plans have a greater ability to manage their enrollees' use of nursing homes and can restrict the enrollees' choice of providers to those considered to be high-value providers.

Section 2 Summary

In October 2019, Medicare implemented a new payment system for nursing home care known as the patient-driven payment model (PDPM). Health care administrators should be aware of such changes when engaged in financial management. Health care administrators should also be aware of how their health care organizations receive revenue and reimbursement. Such information can prove to be invaluable when managing the financial state of a health care organization.

Section 2 Key Concepts

- Many older adults pay for part or all of their long-term care with their personal money, also known as personal or “out of pocket” funds; in addition to personal funds older adults may pay for long-term care with private payment options, including: long-term care insurance, reverse mortgages, certain life insurance policies, annuities, and trusts.
- Medicaid is the dominant payer for long-stay residents, who typically are individuals with chronic illness and who have an average length of stay in a nursing home setting of approximately two years.
- Medicare is the dominant payer for post-acute care nursing home patients, also referred to as short-stay residents, who have an average length of stay of approximately 25 days.

Section 2 Key Terms

Reverse mortgage - a type of home loan that allows homeowners to convert part of the ownership value in their home into cash without having to sell the home

Annuity - a contract with an insurance company that can help pay for long-term care services

Trust - a legal arrangement that allows individuals to transfer assets to another person, called the trustee

Long-stay residents - individuals with chronic illness and who have an average length of stay in a nursing home setting of approximately two years

Short-stay residents - individuals who have an average length of stay in a nursing home setting of approximately 25 days

Hospice - a public agency or private organization or subdivision that is primarily engaged in providing hospice care

Hospice care - a comprehensive set of services, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care

Accountable care organization (ACO) - an organization that typically consists of a group of clinicians, hospitals, and other health care professionals who work together to provide coordinated, high-quality care to their Medicare patients

Medicare special needs plans (SNPs) - a subcategory of coordinated care plans limited to beneficiaries with specific diseases or characteristics

Affordable Care Act of 2010 - a comprehensive reform law that increases health insurance coverage for the uninsured and implements reforms to the health insurance market

Section 2 Personal Reflection Question

How can value-based payment (VBP) impact a health care organization?

Section 3: Developing a Budget

Developing a budget is one of the main objectives of financial management. It is also essential to the financial state of a health care organization, especially in the post-COVID-19 pandemic era. With that in mind, this section of the course will focus on budgeting. The information found within this section was derived from materials provided by the Harvard Business School unless, otherwise, specified (Cote, 2022).

What is budgeting?

Budgeting may refer to the process of preparing and overseeing financial documents that can be used to estimate income and expenses over a specific period of time.

What are the main components of a budget?

A typical budget consists of projected income and expenses for a specific period of time (e.g., a quarter; a year).

Why are budgets important?

- **Budgets can ensure resource availability** - first and foremost, budgets can be used to help a health care organization ensure it has the resources available to achieve a specific goal. For example, if a nursing home wants to add resident activities to help improve resident satisfaction scores, a budget can be used to determine if the nursing home has the resources to do so; or if an assisted-living facility wants to hire additional employees, a budget can be used to determine if the assisted-living facility is able to do so.
- **Determine objectives and goals** - to build on the previous reason why budgets are important, budgets can be used to help health care organizations determine specific objectives and goals. For example, if the administrators of a nursing home want to renovate a unit, a budget can be used to determine what type of renovations may be carried out (e.g., the nursing home only has enough resources to paint and repair existing structures).

- **Prioritize projects** - budgets can be used to help prioritize projects. For example, a budget can reveal that an assisted-living facility only has enough resources to complete five out of eight potential projects; the assisted-living facility can use that information to then prioritize the top five projects.

- **Provide a base on which to pivot** - pivoting, within the context of financial management, is the act of changing the direction of a specific plan based on the availability of resources and other contributing factors. Essentially, a budget can serve as a foundation a health care organization can stand on, and then use as support to move in a different direction if circumstances change, as they often do in health care. The best example of how circumstances can change in health care is the COVID-19 pandemic. The COVID-19 pandemic created havoc within the health care system and in the greater world of which it is a part. During the pandemic, health care organizations had to pivot in order to meet the needs of those impacted by COVID-19. Policies and procedures needed to change, and staffing patterns required adjustments. Without a budget to provide a base, the changes required during the pandemic could have been even more difficult. With that in mind, health care administrators should use their budgets in times that require change as a starting point to then pivot to meet new demands and challenges.

- **Create opportunities** - it may not be the first reason that comes to mind when considering why a budget is important - however, a budget can be used to create opportunities for a health care organization. For example, if a health care organization wants to partner with a specific company, a budget can show the company that the health care organization is financially responsible, and, subsequently, attractive to the potential partner.

- **Generate adequate staffing patterns** - as previously alluded to, in the current climate of health care, one of the most important aspects of care is adequate staffing. After all, health care cannot exist without health care professionals to administer care to those in need. Budgeting can help a health care organization generate adequate staffing patterns to meet the needs of residents during times of normal operating conditions, and during times that require additional staffing (e.g., an emergency).

- **Allocate resources obtained through loans** - budgeting can help a health care organization allocate resources obtained through loans, such as those provided by the U.S. Small Business Administration's (SBA) 7(a) program. Specific information regarding the SBA 7(a) program may be found below. The information found below was derived from materials provided by the U.S. Small Business Administration (SBA) (U.S. Small Business Administration [SBA], 2023).

    - The SBA 7(a) program provides loan guarantees for financial institutions that loan funds to small businesses; the loans are a potential option for small health care practitioners and facilities.

    - Funds for the SBA 7(a) program may be used to purchase land or buildings; cover construction costs; repair existing capital; purchase or expand an existing business; refinance existing debt; purchase machinery, furniture, fixtures, supplies, or material.

    - The 7(a) program offers flexibility, longer terms, and potentially lower down payments compared to other financing options.

    - The maximum loan amount for a 7(a) loan is $5 million.

- To be eligible, the business must be operated for profit and fall within the size standards set by the SBA; the business must also be located in the U.S.

- Privately owned health care facilities including hospitals, clinics, and emergency outpatient facilities are eligible; recovery and nursing homes are also eligible, provided that they are licensed by the appropriate government agency and they provide more services than just room and board.

- Most 7(a) term loans are repaid with monthly payments of principal and interest from the cash flow of the business; payments stay the same for fixed-rate loans because the interest rate is constant.

- **Allocate resources obtained through grants** - budgeting can also help a health care organization allocate resources obtained through grants, such as those provided by the U.S. Department of Health and Human Services (note: the U.S. Department of Health and Human Services is the largest grant-making agency in the U.S.). Specific information on how a health care organization can obtain a grant from the U.S. Department of Health and Human Services may be found below. The information found below was derived from materials provided by the U.S. Department of Health and Human Services (U.S. Department of Health and Human Services, 2022).

    - First, a health care organization must register with the system for Award Management (SAM) to obtain a Unique Entity Identifier (UEI); the UEI is a 12-character alphanumeric identifier assigned to all entities (public and private companies, individuals, institutions, or organizations) to do business with the Federal Government; organizations will also need to designate an E-Business Point of Contact (EBiz POC) (note: it can take seven to ten business days to

complete the registration process; there is no fee for registering with SAM).

- Second, health care organizations should register with Grants.gov; Grants.gov is where health care organizations can find and apply for grants; health care organizations should be sure to register with Grants.gov after the SAM registration is fully completed; Grants.gov registration is usually completed by the end of the session (note: there is no fee for registering with Grants.gov).

- The application evaluation activities include the receipt and review of grant applications submitted by potential recipients; the Grants Management Office oversees the review and evaluation of grant applications to ensure outside reviewers and agency personnel comply with management policies and regulations, and with sound business management practices.

- The Program Management Office evaluates grant applications for their programmatic value and determines which applications best meet program goals and offer maximum potential for success.

- Receipt and screening involve receiving and officially logging incoming grant applications; applications are screened (usually against a checklist) to ensure they are properly completed; the Grants Management Office receives and screens the grant applications for completeness and eligibility of the applicant.

- An objective review then takes place, which involves evaluation of the technical aspects of grant applications through the objective review process; after the technical evaluation is completed, a preliminary decision is usually made and documented on a technical

merit rankings list; the Grants Management Office advises objective review groups and individuals in the proper procedures to follow in conducting the independent/objective review and/or checks for violations of procedures; the Program Management Office provides technical experts who participate in the independent/objective review and develop the technical or merit rankings list, unless the evaluation is performed by an individual office (e.g., NIH Center for Scientific Review).

- The award process involves the preparation of the Notice of Award (NoA) and officially obligates funds for the grant; the NoA describes all terms and conditions of the award, including reporting requirements; the NoAs are usually generated through an automated system and electronically transmitted to the budget office to obligate funds for the grant; a printed copy of the NoA is distributed to the recipient; as part of this step, required files (usually an official grant file and an institutional file) are created and/or updated for each grant/recipient.

- The Grants Management Office prepares and signs the grant award, certifying that the award complies with all legal, regulatory, and internal policy requirements and that it is a sound business agreement into which the Department should enter; the NoA is then distributed to the appropriate key offices; the Program Management Office, although not required by Departmental policy, usually signs the grant award, certifying that the award will contribute to the programmatic goals and that the activities funded under the award are technically and programmatic sound.

- **Prevent overspending** - budgeting can keep health care organizations on financial track and prevent overspending on various endeavors and/or projects. For example, if an assisted-living facility only has enough resources to create an outside sitting area for residents, a budget can help the assisted-living facility allocate those resources to develop the sitting area without exhausting funds that may be required for other needs.

- **Achieve short-term and long-term goals** - to build on the previous reason why budgeting is important, budgeting can help health care organizations achieve short-term and long-term goals by preventing overspending and by providing organizations the opportunity to forecast financial trends and allocate resources accordingly.

- **Establish financial stability** - finally, and perhaps most importantly, a budget can help a health care organization establish financial stability. Simply put, by tracking expenses and following a plan, a budget makes it easier for a health care organization to pay bills on time, meet payroll demands, and save for major expenses that may arise (Bell, 2023).

What are the different types of budgeting methods?

- **Zero-based budgeting (ZBB)** - zero-based budgeting (ZBB) is a type of budgeting that starts at a zero base, and requires that all expenses are justified for a specific time period. ZBB allows top-level strategic goals to be implemented into the budgeting process by tying them to specific functional areas of the organization, where costs can be first grouped and then measured against previous results and current expectations (Kagan, 2023). A disadvantage of ZBB is that it is time consuming (Kagan, 2023). The advantages of ZBB include the following: focused operations, lower costs, budget flexibility, and strategic execution; ZZB can also help health care

administrators identify the highest revenue-generating operations by focusing their attention on how each dollar is spent (Kagan, 2023).

- **Static budgeting** - static budgeting is a type of budgeting that incorporates anticipated values regarding inputs and outputs, which are evaluated before a specific time period begins (e.g., before the next quarter). In other words, static budgeting uses data to add or subtract a percentage from the previous period's budget to create the upcoming period's budget. Static budgets are typically used by accountants, finance professionals, and the management teams of companies looking to gauge the financial performance of a company over a specific period of time (Kagan, 2021). A static budget is intended to be fixed and unchanging for a specific time period, regardless of fluctuations that may affect outcomes; a static budget can be used by health care administrators to target expenses, costs, and revenue; a static budget may also be used as a financial forecasting tool (Kagan, 2021). A disadvantage to static budgeting is that it is reliant on the ability of an organization to accurately forecast its needed expenses, how much to allocate to those costs, and its operating revenue for a specific time period (Kagan, 2021). The advantages of static budgeting include the ability to help monitor expenses, sales, and revenue, which can allow organizations to achieve optimal financial performance (note: a static budget based on planned outputs and inputs for each of an organization's divisions or units can help a health care administrator track revenue, expenses, and cash flow needs) (Kagan, 2021).

- **Performance budgeting** - performance budgeting may refer to a type of budgeting that reflects the input of resources and the output of services for each department or unit of an organization; the goal of performance budgeting is to identify and score relative performance based on goal attainment for specified outcomes (Hayes, 2021). Performance budgets are

typically designed to motivate employees, and enhance their commitment to producing positive results (Hayes, 2021). A disadvantage to performance budgeting is a lack of unified cost standards (Hayes, 2021). An advantage of performance budgeting is that it can help health care administrators quantify particular goals (Hayes, 2021).

- **Activity-based budgeting** - activity-based budgeting may refer to a type of budgeting that records, researches, and analyzes activities that lead to costs for a company or organization; in other words, activity-based budgeting is a type of budgeting that scrutinizes every activity in an organization that incurs a cost in order to develop efficiencies (Liberto, 2020). Activity-based budgeting can be used by a company or organization to help decrease costs. The disadvantage to activity-based budgeting is that it is expensive to implement and maintain when compared to other types of budgeting (Liberto, 2020). The advantage of activity-based budgeting is that it allows for more control over the budgeting process (Liberto, 2020).

- **Value proposition budgeting** - value proposition budgeting is a type of budgeting that focuses on the evaluation of every line item included in a specific budget. Value proposition budgeting takes into account every line item included in a budget to help individuals identify the value of an item. Value proposition budgeting suggests that a line item should not be included in a budget unless it directly provides value to a company or organization. The disadvantage to value proposition budgeting is that it can be time consuming. The advantage of value proposition budgeting is that it can help health care administrators determine the value of line items, while providing the option to remove line items from a specific budget that do not add value to an organization.

How can health care organizations effectively develop budgets?

Health care organizations can effectively develop budgets by taking stock of resources, selecting a type of budgeting method, using techniques such as SWOT analysis, and by establishing a budgeting system.

What is SWOT analysis?

SWOT stands for **S**trengths, **W**eaknesses, **O**pportunities, and **T**hreats. Specific information regarding SWOT analysis may be found below. The information found below was derived from materials provided by Business News Daily (Schooley, 2023).

- A SWOT analysis may refer to the process of assessing an organization's strengths, weaknesses, opportunities, and threats (note: a SWOT analysis can help a health care organization assess strengths, weaknesses, opportunities, and threats, which, in turn, can help a health care organization develop a budget or budgets).
- One of the main goals of a SWOT analysis is to help an organization become self-aware so it can grow and thrive.
- Another main goal of a SWOT analysis is to help administrators and leaders within an organization make informed decisions that lead to positive outcomes, such as budgets that meet residents' needs.
- A SWOT analysis can help health care administrators discover aspects of an organization that should be maintained and included in a budget. For example, if an assisted living facility receives high resident satisfaction scores due to specific activities, then those activities should be included in a budget.

- On the other side of the coin, a SWOT analysis could reveal the weakness of a health care organization and the aspects of an organization that should be improved. For example, if an assisted living facility receives low resident satisfaction scores due to specific activities, then those activities should not be included in a budget.

- A SWOT analysis can help health care organizations recognize opportunities for growth and expansion. For example, while conducting a SWOT analysis a health care organization may recognize that they may be able to expand through a diversified growth strategy (note: the term diversified growth strategy may refer to a method of organizational growth that is characterized by the acquisition of new capabilities that expand operations and services). The resources required for growth and expansion could be included in a budget.

- A SWOT analysis can enable health care organizations to identify obstacles to resident care. For example, a SWOT analysis may reveal staffing as an obstacle to resident care. When a SWOT analysis reveals obstacles, health care organizations should work to remove such obstacles. For example, if staffing is an obstacle to patient care, then health care organizations should start to recruit health care professionals to fill staffing needs, and expand staffing budgets.

- In addition to obstacles, a SWOT analysis can enable health care organizations to identify external threats, and develop budgets accordingly.

- A SWOT analysis can help a health care organization analyze and work out the implications of a decision by providing insight into what may occur once a decision is made. For example, the administrators of a nursing home may elect to limit recreational therapy due to budget concerns. Such a decision could negatively impact resident care, overall health, and quality of life. It

could also put increased stress on health care professionals who utilize recreational therapy to address the social, mental, and physical needs of residents. Through the process of conducting a SWOT analysis, health care administrators may identify the aforementioned effects of limiting recreational therapy before the decision is made, and thus, avoid making such a decision.

- Health care administrators can effectively conduct a SWOT analysis by following the steps found below.
    - **Identify strengths** - first health care administrators should identify the strengths of a health care organization. To identify the strengths of a health care organization, health care professionals should attempt to answer the following types of questions: what does our health care organization do well; what makes our health care organization unique; what resources does our health care organization have; what are our assets. Examples of potential strengths of a health care organization include the following: positive health care outcomes, high resident satisfaction scores, good location, personalized care, and a talented and dedicated health care professional staff.
    - **Recognize weakness** - secondly, health care administrators should recognize the weakness of a health care organization. To identify the weaknesses of a health care organization, health care professionals should attempt to answer the following types of questions: what does our health care organization lack; what do other health care organizations do better; what resources does our health care organization require. Examples of potential weaknesses of a health

care organization include the following: poor health care outcomes, low resident satisfaction scores, and high staff turnover.

- **Discover opportunities** - next health care administrators should examine external factors to identify opportunities. To identify opportunities, health care professionals should attempt to answer the following types of questions: how can we expand; how can we grow; how can we increase resident satisfaction scores; what are our residents' needs; how can we better meet residents' needs; how can we attract needed health care professionals; how can we diversify staff; how can we get our message out to the public. Examples of potential opportunities for a health care organization include expanding to an underserved area.

- **Determine threats** - finally, health care administrators should continue to examine external factors to identify threats. To identify threats, health care professionals should attempt to answer the following types of questions: what is our competition; is our health care organization experiencing staff dissatisfaction; what is causing staff dissatisfaction; what is causing resident dissatisfaction. Examples of potential threats to a health care organization include the following: other health care organizations, a negative public perception, and infectious diseases that could negatively impact resident care (e.g., increasing cases of COVID-19 within the surrounding community).

What is a budgeting system?

- A budgeting system may refer to practices and procedures that can be used to analyze and evaluate resources, goals, operations, financial projections, and value to ensure the stability and survival of a company or organization.

- A budgeting system often consists of the following five components: budget objectives, capital budget, statistical projecting, revenue budget, and operating budget.

- Budget objectives are the specific goals of a company or organization that require funding. In essence, budget objectives often provide the reason(s) a budget is developed.

- Capital budgeting may refer to a process that can be used to determine the value of a specific plan, project, investment, and/or financial endeavor. Capital budgeting can be used to evaluate an investment in a large-scale project (e.g., renovating an entire unit).

- Statistical projecting may refer to the process of estimating the volume of services and procedures required for a specific period of time. Statistical projecting can be used to assist with revenue projection, as well as staffing and resource planning.

- A revenue budget is the estimated gross revenue. For example, a nursing home may estimate its revenue budget by evaluating revenue from various sources.

- An operating budget is an estimate of a company's or organization's revenue and expenses over a specified period of time.

Section 3 Summary

Budgeting is absolutely essential to the success of a health care organization. Budgeting can help a health care organization survive, thrive, and meet resident goals. Health care administrators should note that health care organizations can effectively develop budgets by taking stock of resources, selecting a type of budgeting method, using techniques such as SWOT analysis, and by establishing a budgeting system.

Section 3 Key Concepts

- Budgets are important because they can ensure resource availability; determine objectives and goals; prioritize projects; provide a base on which to pivot; create opportunities; generate adequate staffing patterns; allocate resources obtained through loans; allocate resources obtained through grants; prevent overspending; achieve short-term and long-term goals; establish financial stability.
- The different types of budgeting methods include the following: zero-based budgeting (ZBB), static budgeting, performance budgeting, activity-based budgeting, and value proposition budgeting.

Section 3 Key Terms

Budgeting - the process of preparing and overseeing financial documents that can be used to estimate income and expenses over a specific period of time

Pivoting (within the context of financial management) - the act of changing the direction of a specific plan based on the availability of resources and other contributing factors

Zero-based budgeting (ZBB) - a type of budgeting that starts at a zero base, and requires that all expenses are justified for a specific time period

Static budgeting - a type of budgeting that incorporates anticipated values regarding inputs and outputs, which are evaluated before a specific time period begins

Performance budgeting - a type of budgeting that reflects the input of resources and the output of services for each department or unit of an organization

Activity-based budgeting - a type of budgeting that records, researches, and analyzes activities that lead to costs for a company or organization

Value proposition budgeting - a type of budgeting that focuses on the evaluation of every line item included in a specific budget

SWOT analysis - the process of assessing an organization's strengths, weaknesses, opportunities, and threats

Diversified growth strategy - a method of organizational growth that is characterized by the acquisition of new capabilities that expand operations and services

Budgeting system - practices and procedures that can be used to analyze and evaluate resources, goals, operations, financial projections, and value to ensure the stability and survival of a company or organization

Budget objectives - the specific goals of a company or organization that require funding

Capital budgeting - a process that can be used to determine the value of a specific plan, project, investment, and/or financial endeavor

Statistical projecting - the process of estimating the volume of services and procedures required for a specific period of time

Revenue budget - the estimated gross revenue

Operating budget - an estimate of a company's or organization's revenue and expenses over a specified period of time

Section 3 Personal Reflection Question

How can a health care administrator install or improve upon a budgeting system within their specific health care organization?

Conclusion

Financial management can help a health care organization remain stable, as well as grow and meet resident needs. In other words, financial management can be the mechanism health care organizations use to remain operational, and improve the health, overall well-being, and quality of life of residents in need. Health care administrators should strive towards efficient and effective financial management to achieve desired goals and outcomes within their health care organization.

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