

# The E-Beacon

*Official publication of the McMahon-Illini Chapter,  
Healthcare Financial Management Association*



May

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- <http://www.mcmahon-illini.org/index.htm>

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- <http://www.mcmahon-illini.org/classifieds.htm>

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## A Message from the President

*By: Ron Snyder, FHFMA  
President, McMahon-Illini Chapter*



### LAST CALL

I would like to take this occasion to thank you for allowing me to serve as your chapter President for the past year. Now that my term is coming to a close, I realize

how quickly this year has flown by. While progressing through the seats of chapter leadership has been a part of my life for the past 5 years, it just seems like yesterday that I was first honored with the opportunity to serve. The years have definitely been a learning experience and I've truly enjoyed working with my fellow Officers, Board of Directors and Committees. Your thoughtful leadership and dedication gave me the confidence to lead our chapter, and I will cherish your friendship forever.

The past year has also been one of enormous challenges for the healthcare industry. In addition to facing a major financial crisis, our industry has and will continue to struggle with decreasing volumes and increasing costs. Access to capital remains a major concern to all healthcare executives and providers are still addressing pricing issues to be more transparent. But our industry is stronger because of you and your efforts on both a local and national level. Healthcare financial professionals make a difference in the business of caring. All of you have gone above and beyond to continue to deliver quality healthcare in a personal way while demonstrating courageous leadership in these difficult times.

## Contact Us

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**OUR** McMahan-Illini chapter is full of gifted and talented individuals who volunteer and give their time to make our chapter a thriving organization and the professional resource of choice for the healthcare industry in Illinois. I would like to personally thank all of these members for their time and support this past year. At the same time, the unwavering financial support of our Corporate Partners has allowed our organization to flourish while affording our membership with quality educational programs and tremendous networking events.

Michelle Carrothers will continue the tradition of exceptional leadership, taking over the reins June 1<sup>st</sup>. She is dedicated to her family, hospital, and profession, and she shall further the vision of the McMahan-Illini chapter. I wish her nothing but the best and I hope that you will give her your continual support throughout her term as your new President.

In closing, I encourage us all to continue to make it count in our dealings with each other and the facilities/companies that we serve. "Making it Count" was this year's national theme and I believe it is especially important during these times that we are able reach out to each other to accomplish that goal. My thanks to all of you that have made my past several years on the board so rewarding and successful. It has been an honor to serve the healthcare professionals of the McMahan-Illini chapter and I look forward to seeing you at our future meetings.

Your Prez and friend in HFMA,

Ron Snyder, FHFMA

### **FUTURE HFMA EVENTS**

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*Members on the Move.....*

*Welcome to our New Members*

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## Board Member Bingo Winner!

Congratulations to **Jean Ruthe** from **Rosecrance Health Network**.

Jean played Board Member Bingo at the January meeting and her "board" was drawn as the \$50 winner. *Thanks for playing Jean!!*

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HC9005

## **Proposal Would Make Significant Change in Health Care Providers' Accounting for Lease Arrangements**

In March 2009, the Financial Accounting Standards Board (FASB) released a discussion paper titled, *Leases: Preliminary Views*. The discussion paper presented the preliminary views of FASB on significant components of an accounting model for lease arrangements. The changes proposed in the discussion paper could have a significant impact on the way health care providers treat many common lease arrangements, especially as it relates to real estate and equipment rental agreements.

In the paper, FASB discussed a proposed change in lease accounting that effectively eliminates the "operating lease" treatment that applies to many of the leases used by health care providers today. As drafted, the paper would require a lessee to recognize an asset to represent its right to use the leased item and a corresponding liability for its obligation to pay rentals under the agreement. For many leases, the ability to expense lease payments as incurred, with no asset or liability recognized, would cease. This approach aims for leases to be accounted for consistently across sectors and industries. The proposals are intended to improve the transparency, credibility, and usefulness of lease accounting.

### ***Accounting for Leasehold Obligations***

Current U.S. GAAP guidance classifies leases in two categories – capital leases and operating leases. Such classification is determined by four key tests:

- Does title of the asset transfer at the end of the lease?
- Does the lease contain a bargain purchase option?
- Is the term of the lease at least 75 percent of the economic useful life of the asset?
- Is the present value of the future minimum lease payments at least 90 percent of the fair market value of the asset?

If the answer is "yes" to any of these questions, then the lease is required to be capitalized and recorded on the balance sheet. The asset is recorded at cost and the lessee's obligation to pay is measured by discounting the future minimum lease payments. If the answer to all four questions is "no", then the lease is classified as an operating lease and lease payments are expensed in the statement of operations.

### ***Proposed Approach***

If adopted, the proposed guidance would essentially mean all leases would be capitalized. As with current guidance, FASB has maintained the lessee's right-of-use asset would initially be measured at cost. FASB has proposed that measuring the lessee's obligation to pay rentals should be discounted using the lessee's incremental borrowing rate. Also discussed was whether to require the lessee to revise its

obligation to pay rentals to reflect changes in the incremental borrowing rate. FASB tentatively decided not to require reassessment of the lessee's incremental borrowing rate.

Under current U.S. GAAP, capital leases are recorded based on the fixed non-cancelable term of the lease. The accounting treatment for leases with optional extension periods would change. Under the proposed guidance the lessee would consider the most likely outcome of an extension option based on contractual, non-contractual, and business factors.

For example, a ten-year lease with a five-year option would be recorded either as a ten-year or fifteen-year lease depending on the lessee's particular business factors. Lessees would reassess the terms of each lease at each reporting date on the basis of any new facts or circumstances. Changes in the obligation to pay rentals arising from reassessment of the lease term would be recognized as an adjustment to the carrying amount of the asset. The following example demonstrates the difference between an operating lease, under current guidance, versus any lease, under the proposed guidance:

Operating lease	Lease term: 5 years Rent: \$10,000/year		Asset	Liability	Expense	Effect on Profits
		Year 1	\$0	\$0	\$10,000	(\$10,000)
		Year 2	\$0	\$0	\$10,000	(\$10,000)

Capitalized lease	Lease term: 5 years Rent: \$10,000/year 6% incremental borrowing rate with annual compounding  *Initial liability of \$44,651 reduced by initial \$10,000 lease payment		Asset	Liability	Expense	Effect on Profits
		Year 1	\$44,651	\$34,651*	Interest \$2,079 Depreciation \$8,930	(\$11,009)
		Year 2	\$35,721	\$26,730	Interest \$1,604 Depreciation \$8,930	(\$10,534)

This proposed treatment will require more monitoring and record keeping and will generally result in higher expenses during the initial years of the lease term. Providers should start summarizing existing operating lease agreements and assess the impact of the proposed change on your financial statements once the exposure draft of the proposed standard is released. This will help limit the effort needed to implement the proposal when finalized.

For many health care providers with tax-exempt revenue bonds and other debt obligations, the proposal will affect many ratios used in debt covenants. Common ratios such as debt-to-capitalization, debt service coverage and day's cash on hand may be affected. The proposal may also affect providers with covenants that limit additional borrowing in any given year, as many of these covenants include capital leases in the debt definition. Providers should consider this potential accounting change when issuing new debt or negotiating new leases. Once the exposure draft is released, many providers may need to discuss current debt agreements with bond counsel, underwriters, and lenders to ascertain how current covenants could be renegotiated once this change is implemented.

At its current pace, FASB could release an exposure draft in late 2010, and a formalized standard could be in place before 2012. If the final standard corresponds with the preliminary views document, it would affect all leases in existence at the effective date of the standard. Lessees would recognize an obligation to pay rentals and the right-to-use asset for all outstanding leases at the effective date, using the current incremental borrowing rate to discount lease payments.

Updates to this proposed guidance can be monitored on the FASB project webpage at <http://www.fasb.org/>.

***About the author: Fred Helfrich, CPA, is a partner in the St. Louis office of BKD, LLP. Fred provides accounting, auditing and consulting services for health care providers. His fourteen years of experience includes internal control reviews, preparing financial forecasts and projections, debt capacity analyses, and consulting on bond issues; as well as, implementing new auditing standards, Financial Accounting Standards Board and Governmental Accounting Standards Board pronouncements for the audit clients he serves.***

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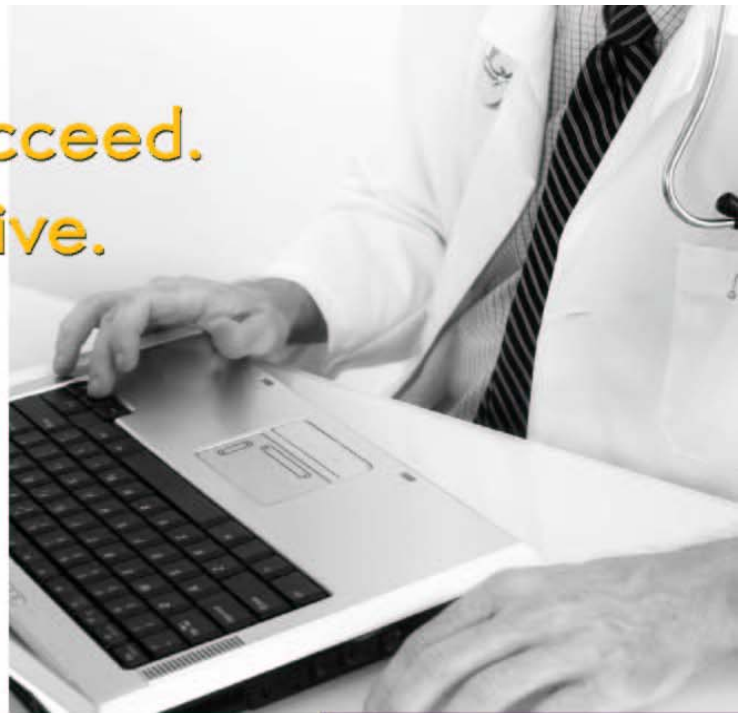
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# Spring Meeting March 25-26, 2010

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Moises Eilemberg  
President of H & R Accounts receives his  
CHFP Certification from Ron Snyder.



Patrick Coffey  
Attorney giving an  
update on the  
“Provena” case.



Phil Stavers  
encouraging practical  
IT contingency  
planning.

## Officers and Board Members for the 2010-2011 Chapter Year



Jennifer Vorreyer, David Bittner, Betty Marschang, Penny Cermak,  
Michelle Carrothers, Fred Helfrich, Charlotte Bye, Connie Ziegler



Rob Quinn gives the “30,000” foot overview of the new Point of Service Collections program Methodist Medical Center began in March 2010.



Steve Marshall describes where the rubber meets the road details of development and implementation of POS at Methodist.



Tony Hatch describes the life of a claim form and revenue cycle standards.

Craig Pederson and Cordell Mack  
tell us how to maximize value with our  
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Susan Davis prepares us  
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# Effective Cost Modeling for Service Line Planning

Michael Scott  
Robert Stephen

A process-based cost model can permit accurate cost and resource modeling for service line planning at the process and the patient levels.

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## At a Glance

- **Healthcare executives have struggled to have accurate, timely information about cost and resources to model and monitor service line performance.**
  - **Process-based cost modeling has been used successfully in other industries, but is relatively new in health care.**
  - **Understanding costs and resources at process and patient levels can make the difference between a service line having a positive or negative margin.**
- 

As the nation's healthcare providers begin sorting out the impact of the newly passed healthcare reform legislation, many questions remain to be answered regarding where they should best focus their efforts. One thing is certain: Healthcare reform will only increase the need for providers to thoughtfully evaluate the business climate in search of new opportunities to improve both care delivery and financial performance. Providers that achieve such improvements will likely realize a significant competitive advantage in the new environment that emerges after the effects of reform have taken hold.

Service line planning is one important means to this end. Effective service line planning comprises four essential steps:

- Define the service lines
- Set the provider organizational strategy
- Implement the strategy
- Manage and continuously improve the service line strategy

One challenge that has consistently faced healthcare leaders in their service line planning is understanding true costs and resource needs—information that is critical to each step of the planning process. Process-based cost (PBC) modeling is a proven tool that healthcare executives can use to better understand cost and resource needs to understand the financial impact of service line planning scenarios.

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## 4 Key Service Line Planning Steps

To set the stage for a discussion of how best to incorporate PBC modeling into service line planning, let's first consider what is involved in each of the essential planning steps.

**Define the service lines.** With this step, the healthcare provider first identifies the patient population for each service line and then develops a market and performance view of each population. To this end, the provider's strategic view of the business needs to be patient focused rather than departmentally focused. To identify growth opportunities, the provider typically performs a market assessment that looks at service demand projections, competitor strength, and physician demographics. The provider then benchmarks its performance with a review of current market share, profitability, and costs, while assessing a variety of internal metrics around quality, physician leadership, and customer service.

**Set provider organizational strategy.** With the insights gained from the first step, the provider's executive team typically analyzes the potential impact of each service line on the provider organization's overall performance and prioritizes the service lines according to strategic objectives (e.g., "grow" or "protect" market share and, in some instances, even "exit the market"). This process allows the executive team to determine which service lines to pursue and in what order. The executive team can then begin to establish and communicate to management the strategic goals and performance targets for the provider organization.

**Implement the strategy.** Management is charged with developing and enacting a plan to meet the identified goals and targets. This effort may require identifying specific improvement opportunities for existing service lines or launching a new service line that ideally can rapidly achieve best practice performance levels. Typically, several strategic options are identified and the impacts of these options are assessed prior to implementation.

For instance, consider a provider organization that is evaluating growth options for surgical services. Is growth limited by existing capacity and facility constraints? If so, are there alternatives related to developing new surgical space or redeploying space already existing in other parts of the facility (e.g., relocating endoscopic services to an adjacent medical office building in order to free up scheduling problems in the surgical suites)?

Once the strategic choices are made, an important focus for management becomes implementing and monitoring action items to ensure successful outcomes. In the surgical services example, this may mean developing new or redeployed space, or the focus could be on process improvement opportunities such as improving turnaround times, minimizing delays, and reducing case time.

## **Manage and continuously improve service line performance.**

Once strategic options are implemented, success depends on the degree to which the provider organization continually strives for peak performance in its service lines. Ideally, managers will select and manage to the right benchmarks and metrics, continually adjusting operations to ensure performance targets are being met.

In each one of these steps, PBC modeling can contribute essential information in a way unmatched by other tools and techniques, making it an essential tool for successful service line planning.

### The Advantages of PBC Modeling

A healthcare provider's ability to accomplish the four basic service line planning steps depends on how well it delivers the right financial information to understand the service line, and how well it can perform accurate, real-time analytical modeling of strategies, strategic options, and performance. Financial tools that healthcare providers typically use for such efforts tend to be inadequate, often because information is lacking sufficient accuracy or precision, or modeling is not in real time.

PBC modeling, however, can effectively meet these requirements. It has been used extensively in other industries, including banking and manufacturing, to model customer and product profitability. Only in recent years, however, has it gained significant acceptance by healthcare provider organizations as a tool to assist in benchmarking and improving performance. Simply put, PBC modeling can provide all the critical financial information needed to complete the four planning steps.

Instead of classifying resources into departments, PBC modeling matches them with the patients actually "consuming" or using the resources. This patient-centered view of costs aligns well with other improvement initiatives addressing, for instance, clinical quality or customer service. The patient care process, rather than the functional department, then becomes the relevant perspective for measuring the provider's performance around quality, service, and cost.

PBC modeling provides a clearer understanding of the flow of services through a healthcare provider organization. Resources are consumed (that is, costs are incurred) as value is added through the various business and patient care processes.

Exhibits 1 and 2 present a simple hypothetical example for MS-DRG 470 (major joint replacement/reattachment). Each MS-DRG 470 case will "consume" a surgical procedure, comprising labor hours and time in the surgical suite. Similarly, each case will also consume acute care labor and room resources. As the number of patients under MS-DRG 470 increases, additional resources are "pulled" through the care delivery process to accommodate their needs. This example is simplified for illustrative purposes; in reality, actual care of patient under MS-DRG 470 requires

scores of “process outputs.” Nonetheless, the exhibit accurately depicts how the PBC model is constructed.

## Exhibit 1



## Exhibit 2



Thus, as demonstrated in the exhibits, PBC modeling increases the visibility and understanding of costs by focusing on the process outputs that are required by patients, the resources used to perform the various processes, and ultimately, the aggregation of individual patient costs and service volumes into service lines.

In similar fashion, revenues are matched at the patient level, instead of the department, thereby offering a complete financial view of patients and service lines. The complexities of the provider organization are not buried in allocations or assignments typical of cost accounting systems or pro forma analyses contained in spreadsheets. Shared and overhead output costs are allocated to departments and patients in a rational and transparent manner.

PBC uses output volume and resource capacity to automatically calculate consumption drivers, resulting in a faster and more accurate financial model in which the consumption drivers provide a basis for accurate assessment of cost flow.

The MS-DRG 470 example above demonstrates how this occurs. Each additional MS-DRG 470 admission results in an additional surgical procedure. This requires, on average, an additional 14.5 hours of labor in the surgery room and six hours of surgery room time. Until the incremental MS-DRG 470 cases cause hours used (consumed) to exceed hours available, no additional resources are required because the needs are being met from available capacity. (Note: The capacity and utilization numbers shown in the above exhibit represent total capacity and utilization for all cases, not just MS-DRG 470.) Similarly, the acute nursing care and rooms have available capacity. Patients are placed in one room of a three-room suite (process output). However, because the suites have an average census of 2.1 patients per day,

there is also available capacity to handle a certain number of additional MS-DRG 470 cases without incurring any incremental costs. The opportunity under PBC modeling to model these circumstances is a powerful component of its value.

A significant advantage of PBC modeling is that it can be used to model the entire provider organization, making it possible to evaluate virtually all business (and service line) opportunities using a single tool. Because consumption rates are such an integral part of the PBC model, strategic scenarios are much easier to understand and evaluate. Furthermore, PBC accurately models both financial and nonfinancial metrics, including product/customer profit margin, productivity, resources (e.g., labor hours and capacity), infrastructure capacity, and utilization.

## Application of PBC to Service Line Planning

To illustrate how PBC modeling fits into the service line planning process, let's consider how the model should be applied during each of the four essential steps of service line planning described previously.

**Define the service lines: Build the baseline model.** The baseline PBC model is intended to provide a view of the provider organization's revenues and expenses, looking at volumes for specific patient groups and presenting this information from a number of different dimensions—e.g., patient type (inpatient, outpatient, etc.), service line, payer, zip code, etc. This dimensionality helps the provider to assess its current business and financial situation. It also sets the stage for the identification of performance drivers and the prioritization of strategic questions.

Exhibits 3, 4, and 5 demonstrate the importance of dimensionality. In the example, the orthopedic service line is profitable overall, but as Exhibit 3 shows, inpatient services are not profitable. In Exhibit 4, we note that 500 of the total cases (603) are MS-DRG 470. Clearly this MS-DRG has the greatest impact on inpatient volumes, but it is not profitable. Exhibit 5 presents MS-DRG 470 with the added dimension of profitability by payer. This significantly alters the strategic dialogue, since the provider has income of roughly \$6,800 per commercial case, but it is losing nearly \$7,300 per Medicare case (note that the Medicare cases are also more costly).

### Exhibit 3

	Inpatient	Outpatient	Total
Revenues	\$1,200,000	\$1,200,000	\$2,400,000
Expenses	\$1,500,000	\$1,200,000	\$2,700,000
Total	-\$300,000	\$0	-\$300,000
Volume	400	400	800

### Exhibit 4

## Exhibit 5

Although building this baseline model requires a modest up-front investment in time and resources, this initial effort ultimately will deliver significant value through more accurate, precise information and more timely decision making. The resources required include software that supports the PBC approach and data typically contained within a provider organization's existing information systems, including billing data, usage data by department, and provider organization expenses contained in the general ledger trial balance. Typically, it falls to the finance department (or financial management function), with the assistance of the service line team and other department managers, to facilitate the development and understanding of the PBC model.

**Set provider organizational strategy: Understand profit and cost drivers.** The value of a financial model relying on the PBC approach is especially apparent at the strategy phase. As was noted earlier, a significant advantage of PBC modeling is that it can be used to model the entire provider organization, enabling the contemporaneous evaluation of all service line strategies in an almost real-time setting. Furthermore, the mapping of revenues at the patient level and the incorporation of consumption drivers permit the model to more reliably depict strategy scenarios.

To evaluate the change case (e.g., "grow," "protect," "exit"), the service line team then uses the PBC model to establish benefits from potential strategic options as a way to ascertain whether a strategic investment in a particular service line could realize a positive return. This is accomplished with minimal adjustment to the model inputs because the relevant consumption rates are calculated by the model. Moreover, the utilization of additional dimensions permits further segmentation of service lines and strategic choices.

In the actual circumstances that provide the basis for the example described above, the dimensions of zip code and payer were leveraged in setting the orthopedic service line strategy. Based on the additional segmentation available in the model, the provider was able to determine that greater profitability was associated with specific demographic patient groups in certain zip codes. Using market data, the provider estimated the volume changes needed to achieve targeted profitability within different patient groups. Based on this estimate, the provider set a strategy around focused

growth and invested heavily in a marketing strategy aimed at increasing brand awareness and volume growth with prospective patients enrolled in commercial health plans, targeting specific demographic groups and zip codes. As a result, the provider was able to expand its geographic market for this service line to far beyond its customary service area, substantially improving profitability.

**Implement the strategy: Model improvements and growth.** We have previously discussed how valuable a PBC model is in modeling the impact of growth on profitability, especially targeted growth in a specific service line. The PBC model also can be effectively used to plan and to model process improvement opportunities. The debate leading up to healthcare reform prompted many hospital provider organizations to increasingly ask the question, “What cost reductions would we need if all payers reimbursed us at Medicare levels?” Exhibit 6 is a continuation of the orthopedic service line example presented in Exhibits 3, 4, and 5. In this case, the PBC cost model allowed the provider to focus on cost drivers that could lead to improved financial performance, such as minimizing surgeon variation across the entire patient process, better utilizing existing capacity, and leveraging other process improvement opportunities to drive down unit costs. It is reasonable to assume that physicians will be much more likely to become engaged in service line planning when PBC modeling is employed, because the patient and process focus of PBC model closely aligns cost dialogue with corresponding quality and service discussions.

### Exhibit 6

In the exhibit, the service line team utilized physician segmentation to understand the variation occurring throughout the patient care process—time in surgery, the types and costs of implants, length of stay. The team also mapped the patient experience and used the PBC model to understand the cost of resources consumed throughout the stay. The end result is that the provider modeled a targeted reduction in unit costs of 4 to 5 percent. Again, because the PBC model is patient-focused, cost metrics align with the corresponding patient care processes.

**Manage and continuously improve service line performance: Develop metrics.** The final step in service line development is ongoing management, striving for continual improvement. Critical to this phase is monitoring the right metrics. The PBC cost model permits management to determine benchmarks around unit costs, cost drivers, and profitability. It then allows management to consider variances around expectations and to take corrective action where necessary.

Consider again the example above of the provider organization that was able to determine specifically which patients were most profitable. In this case, strategies focused on growing that population meant there was a need to monitor growth from specific zip codes or payer groups as well as monitor unit costs for variances from expectations.

In cases where improvement is needed, it is again possible to be precise in monitoring the right improvement activities. Regarding Exhibit 6, the provider is refreshing its PBC model every six months to identify the impact of its process improvement initiatives on costs, and what new initiatives may be warranted based on the results seen. Once again, a PBC model offers the advantage of providing precise, reliable comparisons not available from other costing methods. Certainly, a service line's performance should be examined using a balanced set of metrics that go beyond finance, but the PBC model provides a focus on the right financial measures, in addition to those other measures that reflect clinical quality and patient satisfaction.

## The Imperative of Best-Practice Service Line Planning

The impending effects of healthcare reform coupled with current state of the economy and the healthcare market are only adding to the importance of service line planning for the nation's hospitals and health systems. And as provider organizations fiercely compete to capture the same opportunities for profitable growth, time-to-market and sound decision-making are also essential. The use of a PBC cost model during the service line planning and development phases provides a competitive advantage. Borrowing from other industries, PBC models lead to better insights into performance and performance drivers, and allow for real-time modeling of service line strategies and improvements. Provider organizations using this approach can realize an advantage in terms of both the quality of their decisions and the speed at which they can move in the market.

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## PBC: A CFO's Perspective

Vernon Memorial Hospital in Viroqua, Wis., is an integrated healthcare system with revenues of \$100 million annually. Under the direction of Mary Koenig, CFO, the provider organization has been using a PBC model to support its service line business

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development for the past four years. Vernon Memorial has utilized its models to better understand its business and to quickly model options.

“We now know that if we are contemplating expansion or contraction of a certain service, we have solid cost and profitability data to support our decision,” says Koenig. “In our orthopedic service line planning group, we have been able to easily evaluate the profitability of the procedures we provide and answer many other strategic questions.”

The provider organization is also using the PBC model to focus management, using this approach to create stronger budgets. Koenig says, “We will continue to use the cost model to evaluate cost and profitability of the services we provide now or hope to provide in the future. I can see us using the model more extensively in our budgeting process and also in pricing. With accurate cost and margin data, it will be possible to establish prices that will stand up to the increasing scrutiny of patients and payers. Budgeting will also be facilitated by having accurate cost data. Once we have volume estimates, we can plug in net revenue and costs using data from the model. We can then easily tell what effect a change in procedure volumes will have on our budget.”

By refreshing its PBC models annually, the provider organization is also able to evaluate the financial impact of key process improvements initiated within service lines.

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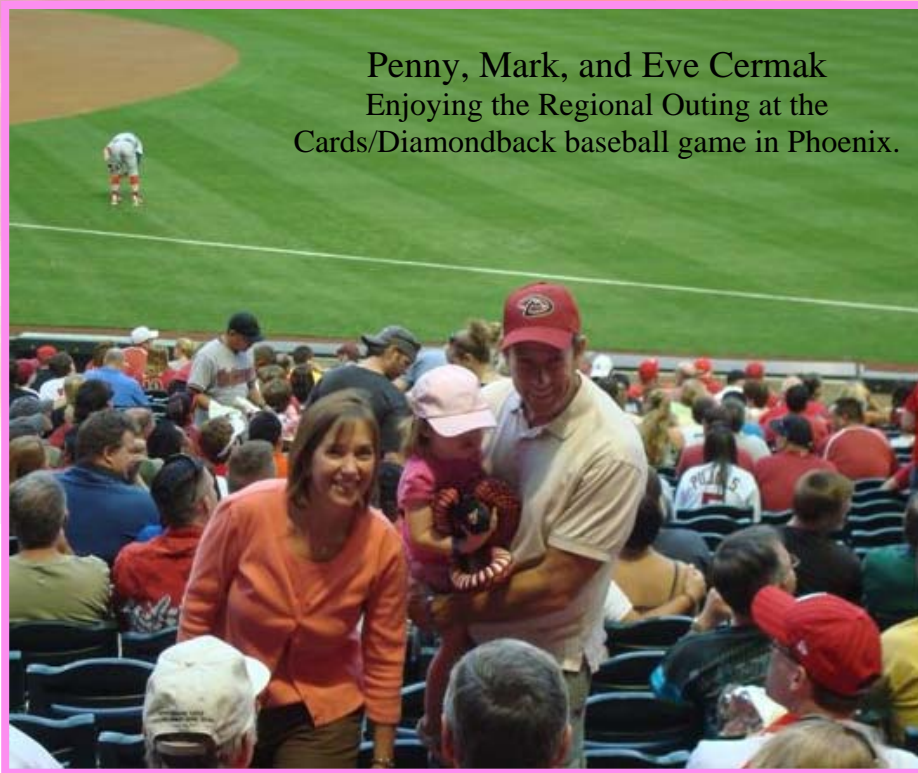


Dan, Michelle, Suzie, and Mark waiting for their taste of rattlesnake at the Rustler's Roost, Steak 'n Shake of Phoenix.





Michelle, Eatons, Rachelle, Connie, Cermaks, Gehigs, and Dan  
Everyone is happy after a great dinner at the Rustler's Roost - Steak 'n Shake.



Penny, Mark, and Eve Cermak  
Enjoying the Regional Outing at the  
Cards/Diamondback baseball game in Phoenix.



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New members who do not receive their certificate within 60 days of joining the Chapter should contact **Bill Eaton at (217) 636-7304**.

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We welcome the submission of material for publication. Articles may be e-mailed to Bill Eaton at: [WLE2000@aol.com](mailto:WLE2000@aol.com) Material should be in WORD format. The Newsletter Committee reserves the right to edit any submission for length or clarity, and to accept or reject any submission.

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Deadline for submission of materials and advertisements for the next **E-Beacon** is July 15, 2010. The next **E-BEACON** is scheduled to be published on August 1, 2010. If your e-mail address changes, please notify **Mark Windsor (309-671-5331 or [mark.d.windsor@osfhealthcare.org](mailto:mark.d.windsor@osfhealthcare.org))**.

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