

# The Buckeye Connection

March 2005



h f m a



## Inside This Issue

President's Message ..... 1

Sole Community and Medicare Dependent Hospitals Eligible for Additional Reimbursement ..... 3

Hospital Options for Managing Uninsured and Underinsured ..... 8

Programming Calendar ..... 10

*Interested in assisting with the newsletter? Please contact Tara-Ann McElhearn (614-232-7165) or Mark Kosarko (614-232-7138).*

*This fall HFMA announced that the Central Ohio Chapter received the C. Henry Hottum Award for Educational Performance Improvement!*

### **President's Message** *By John Miller, Chapter President*

On February 15th, the Chapter co-sponsored the Uninsured/Underinsured Conference program at the Villa Milano. Charles Cataline of the Ohio Hospital Association facilitated the discussion. The turnout for this program was outstanding demonstrating the high level of interest in this topic. The event was the first co-sponsored by our Chapter and Central Ohio Patient Accounting Managers (COPAM) in several years. We look forward to other opportunities to work with COPAM to bring value to our members. I would like to personally thank Ken Stoll, Karin Cain, Margaret Schuler, and Jackie Nussbaum for their efforts working with COPAM to arrange this program and obtaining corporate sponsorship.

**Chapter Officers**

**CHAIRMAN OF THE BOARD AND CHIEF**

**EXECUTIVE OFFICER**

Luke Brown

**PRESIDENT AND CHIEF OPERATING OFFICER**

John Miller

**PRESIDENT-ELECT**

Lola Popcevski

**SECRETARY**

George Gevas

**TREASURER**

Margaret Schuler

**Chapter Directors (2004-2005)**

**DIRECTORS WITH TERMS EXPIRING**

**MAY 31, 2005**

George Gevas

Robert Martin

William Melvin

Bernard Ostrowski

Frank Phillips

**DIRECTORS WITH TERMS EXPIRING**

**MAY 31, 2006**

Randy Allen

Spence Fisher

Susan Nelson

Ken Stoll

**EX OFFICIO BOARD MEMBER**

John Callender

**REGIONAL EXECUTIVE**

Ted Anderson

**Committee Chairs**

**PROGRAM COMMITTEE**

Lola Popcevski, Chairperson

Karin Cain, Co-Chairperson

**SOCIAL COMMITTEE**

Preston Belding, Chairperson

Brad Chelton, Co-Chairperson

**NEWSLETTER EDITORS**

Tara-Ann McElhearn, Chairperson

Mark Kosarko, Co-Chairperson

**CORPORATE SPONSORSHIP COMMITTEE**

Jackie Nussbaum, Chairperson

Ken Stoll, Co-Chairperson

**MEMBERSHIP SERVICE PLAN/DIRECTORY COMMITTEE**

Rick Kolaska, Chairperson

Jackie Nussbaum, Co-Chairperson

**MEMBERSHIP COMMITTEE**

John Miller, Chairperson

Tamara Gawrilow, Co-Chairperson

**AWARDS COMMITTEE**

Heather Dolen, Chairperson

**AUDIT COMMITTEE**

Will Sharp, Chairperson

**CONSTITUTION AND BYLAWS COMMITTEE**

Michael K. Gire, Chairperson

**NOMINATING COMMITTEE**

John Miller, Chairperson

Lola Popcevski, Co-Chairperson

**WEBSITE COMMITTEE**

Margaret Schuler, Chairperson

Luke Brown, Co-Chairperson

**JOB REFERRAL COMMITTEE**

Luke Brown, Chairperson

**CERTIFICATION COMMITTEE**

Eric L. Young, Chairperson

**President's Message (continued)**

Upcoming programming events include the following:

- On March 1st, the Health Care Advisory Board will present Elevating Hospital Performance. This event will consist of a morning presentation entitled "The Great Unfunded Mandate" and an afternoon presentation entitled "The New Medical Enterprise". The event will be held at the OSU Ross Heart Hospital Auditorium.
- On March 18th, we offer an opportunity to mix education with networking. In the morning, representatives of AHC, Inc. and Ernst & Young LLP will present "Reimbursement Law & Managed Care Contracting." The program will be held at the Buckeye Hall of Fame Café. Following the program, all members (including those not attending the program) are invited to enjoy the first round of the NCAA Men's Basketball Tournament.
- On April 14th, Diane Egbers will present a professional leadership training seminar. This event is an all-day event and will be held on Mount Carmel's East Campus.

Please contact Karin Cain at (614) 232-7120 or [karin.cain@ey.com](mailto:karin.cain@ey.com) with any questions about these events or to register.

Looking ahead to spring, mark your calendars for the Central Ohio HFMA Spring Golf Outing on May 23rd at Riviera Country Club.

As always, the Chapter continues to look for new ideas and new leaders to better serve the Chapter. Please contact me or any of the officers or committee chairs if you have interest in getting involved.

GO BUCKS!

**Willis of Ohio, Inc.**  
**Central Ohio's Premier**  
**Healthcare Insurance**  
**Broker**

***Sole Community and Medicare  
Dependent Hospitals Eligible for  
Additional Reimbursement***

***By Lisa Ballard CPA and  
Ron Rybar FHFMA, CMPA***

***Background***

A hospital qualifying as a Sole Community Hospital (SCH) or Medicare Dependent Hospital (MDH) for Medicare purposes which experiences a minimum 5% decrease in total discharges may be eligible for a payment adjustment. This article focuses on SCH payment, but the same opportunity exists for MDHs as well.

To qualify for SCH status under the prospective payment system, a hospital must be the sole source of inpatient hospital services reasonably available to Medicare Part A beneficiaries in the geographic area. The factors that are considered in making this determination are isolated locations, weather and travel conditions, and the absence or inaccessibility of other hospitals in the area.

Sec. 6003(e) of 1989 OBRA revised the payment methodology for SCHs effective with cost reporting periods beginning after March 1990. SCHs are paid whichever of the following rates yields the greatest aggregate payment for the cost reporting period: (1) the federal national rate applicable to the hospital, (2) the updated hospital-specific rate based upon fiscal year 1982 cost per discharge, or (3) the updated hospital-specific rate based upon FY 1987 cost per discharge.

Section 405 of Public Law 106-113, which amended section 1886(b)(3) of the Act, provided that an SCH that was paid for its cost reporting period beginning during 1999 on the basis of either its updated FY 1982 or FY 1987 cost per discharge (the hospital-specific rate as opposed to the Federal rate) could elect to receive payment under a methodology using a third hospital-specific rate, based on the hospital's FY 1996 costs per discharge. This amendment to the statute meant that, for cost reporting periods beginning on or after October 1, 2000, eligible SCHs could elect to use the allowable FY 1996 operating costs for inpatient hospital services as the basis for their target amount, rather than either their FY 1982 or FY 1987 costs.

***HFMA Central Ohio Chapter***

***Corporate Sponsors***

***Platinum Sponsors***

***Ernst & Young***

***National City***

***Gold Sponsor:***

***MedAssist, Inc.  
Plante & Moran***

***Silver Sponsor:***

***United Collection Bureau, Inc.***

***Bronze Sponsors:***

***Blue & Company***

***OHA Data Services***

***OSI Healthcare Services***

***Professional Collectors & Billing  
Service Center***

***Willis of Ohio, Inc.***

## ***Sole Community and Medicare (continued)***

Section 213 of Public Law 106-554, extended to all SCHs the option to rebase using their FY 1996 operating costs. That is, in order to rebase using its allowable FY 1996 operating costs, it was not necessary that the SCH was paid for its cost reporting period beginning during 1999 on the basis of either its FY 1982 or FY 1987 costs. The provision was effective as if it were included in the enactment of section 405 of Public Law 106-113. Therefore, it applied to all SCHs for cost reporting periods beginning on or after October 1, 2000. This option was phased in over four years.

Congress is directed by law to provide for an exception and adjustment for the prospective payment system (PPS) when events beyond a hospital's control or extraordinary circumstances create a distortion in the increase in costs for a cost reporting period. Congress may also provide other appropriate exceptions and adjustments to PPS, including those necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals that results in a significant distortion in the operating costs of inpatient hospital services.

### ***Payment Adjustment***

For any cost reporting period beginning after September 30, 1983, a payment adjustment will be provided for an SCH in any cost reporting period during which the hospital can demonstrate that the decrease in volume resulted from an unusual situation or occurrence externally imposed upon the hospital and beyond its control. The same opportunity exists for an MDH in any year that it holds this classification.

There are two basic criteria that qualify an SCH or MDH for the payment adjustment. The first criterion involves the decrease in discharges. The hospital must experience a decrease of greater than five percent when comparing a cost reporting period to the immediately preceding cost reporting period. The second criterion is that the decrease in volume must be due

to circumstances beyond the hospital's control. This could include unusual situations or occurrences such as strikes, inability to recruit essential physician staff, floods, unusual prolonged severe weather conditions, or other similar occurrences.

The maximum amount of payment adjustment possible is the difference between Medicare inpatient operating costs excluding passthrough amounts and the DRG amount including outliers. The inpatient operating costs used in the comparison are subject to the limitation equal to the prior year operating costs and updated by the PPS update factor.

A payment adjustment will be made for the fixed costs a hospital incurs in the period in providing inpatient services including the cost of maintaining core staff and services, but not to exceed the difference between Medicare inpatient operating cost and total DRG related payments. Many costs in a hospital are neither specifically fixed nor variable, but are semi-fixed; that is, there are costs that are necessary to maintain operations but also may vary somewhat with volume.

Whether costs are considered fixed or variable will depend to a large extent upon the length of time that a hospital has experienced a decrease in utilization. For a short period of decreased utilization, semi-fixed and variable costs may be considered fixed as the hospital has not yet had time to respond to the decrease in utilization. However, as the period of decreased utilization continues, it is expected that a cost-effective hospital would take measures to decrease unnecessary operating costs. It is for this reason that costs are limited to updated prior period costs.

To qualify, an adjustment request must be filed with Medicare within 180 days following the Notice of Program Reimbursement (NPR) date. A request may also be filed for a cost report that has not yet been finalized to allow the request to be incorporated into the audit cycle.

The number of Hospitals qualifying for this adjustment has been reduced in recent years because many SCH and MDH facilities have converted to Critical Access Hospital status and full cost reimbursement. However, the size of the potential adjustments have increased because most of the remaining SCHs and MDHs are of a larger size.

### **Required Documentation**

The required items in the adjustment request include:

1. **General Information.** Information including hospital name, address, provider number, and date of classification as an SCH or MDH.
2. **Discharge Data.** Data must be submitted on the number of discharges in the cost reporting period for which the payment adjustment is requested and the number of discharges in the cost reporting period immediately preceding the period in question. Discharges may be annualized for cost reporting periods of less than 12 months.
3. **Circumstances.** The request must include a narrative outlining the circumstances that resulted in the decrease in discharges, including description of occurrence, date of onset, and how number of discharges was affected.
4. **Cost Data.** The request must demonstrate that the total program inpatient operating cost, excluding passthrough costs, exceeds DRG payments, including outlier payments. If DRG payments exceed program operating cost, no payment will be allowed. Copies of applicable cost reports must be submitted.
5. **Semi-fixed costs.** The request must include a narrative of actions that are taken by the hospital to reduce semi-fixed costs.
6. **Core Staff and Services.** The requesting hospital must submit a comparison, by cost center, of full time equivalent (FTE) employees and salaries in both cost reporting periods. The hospital must identify its core staff and services in each cost center and justification of the selection of core staff and services. Minimum staffing requirements imposed by an external source must be used in justifying the minimum staffing requirements.

Core nursing staff is determined by comparing FTE staffing to FTE staffing in the prior year and FTE staffing in peer hospitals. Peer hospital information can be obtained from Hospital Administrative Statistics (HAS) Monitrend Data Books for hospitals of the same size, geographic area (Census Division), and period of time. The American Hospital Association (AHA) Hospital Statistics is also a source for peer hospital had a volume decline is the lesser of actual staffing in that year, actual staffing in the prior fiscal year or core staff for the prior fiscal year as determined for HAS data from peer hospitals.

If the nursing FTEs for the year in which the volume decline occurred are greater than the calculated acceptable nursing staff, an adjustment will be made to reduce the costs in excess of the core nursing staff. The cost report will then be rerun using the lesser costs and the payment adjustment will be calculated using these revised costs.

### **Payment Adjustment Issues and Strategies**

An issue has arisen when intermediaries are reviewing these adjustment requests and in PRRB hearings as to the use of Monitrend Data. After 1990, Monitrend discontinued publishing the data specified in the regulation for the core nursing staffing comparison. Since 1990, the hours per patient day utilized by SCHs and MDHs has generally increased due to smaller inpatient volumes and fixed staffing. This fact has tended to decrease the amount of allowable FTE for the calculation and therefore reduce the ultimate payment adjustment. At this point, there is no substitute for the Monitrend Data. Additionally MDHs are being held to similar standards even though the regulations do not call for application of this payment limiter specifically.

A further issue, which has arisen, relates to defining “circumstances beyond the Hospital’s control.” It is fairly clear that the circumstances detailed in the regulation are clearly beyond the control of the hospital. There are numerous other circumstances beyond the Hospital’s control which are not detailed in

## Sole Community and Medicare (continued)

the regulation. They include:

1. Loss of OB Services
2. Change in technology
3. Movement of services to outpatient
4. Issues and circumstances related to Emergency Room staffing and admissions
5. CRNA recruitment and retention
6. Other physician related issues
7. Changes in travel patterns

Proving that these circumstances existed and the impact on admissions is sometimes difficult.

It is also important to make sure that all cost related issues, allocation methodologies offsets and audit adjustments are handled effectively for both the year of the request and the year immediately proceeding the request. Our review with numerous of these payment situations indicates that the prior year Medicare inpatient operating cost increased by the PPS update factor is the limiter to the current year payment amount.

### Summary

The two criteria necessary in filing for a payment adjustment are as follows:

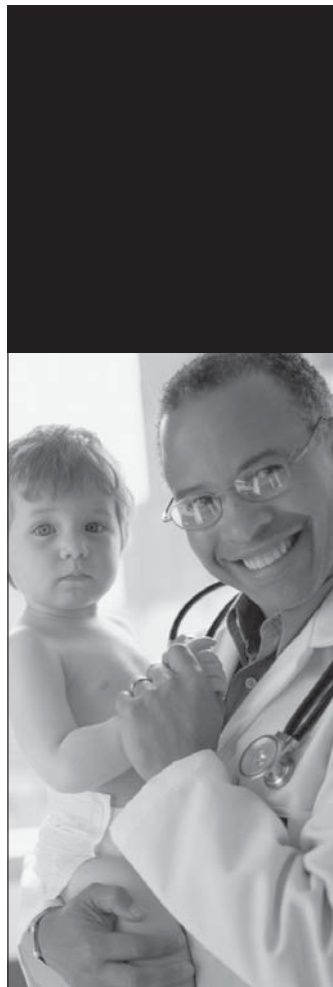
1. The decrease in total discharges must be greater than five percent; and,
2. The decrease must be due to circumstances beyond the hospital's control.

In addition, to receive a payment adjustment, the Medicare cost for the period, excluding passthrough amounts must be greater than the Medicare revenue received.

For a more in-depth analysis of the payment adjustment methodology, please see Provider Reimbursement Manual, Part 1, Section 2810.1.

### Contact Information

The Rybar Group, Inc.  
p. 810-750-6822  
f. 810-750-6733  
[www.therybargroup.com](http://www.therybargroup.com)



# Take a deep breath...exhale. Again.

At National City, we're experts at relieving financial stress – for hospitals, senior living facilities and physician groups. We understand the challenges you face and have remedies that reduce a lot of the work and worry.

As a premier health care lender and one of the nation's largest financial services companies, we're able to help with:

- Underwriting bond issues
- Letters of credit, lines of credit and term loans
- Equipment leasing
- Treasury management services
- Managing cash and investments
- Private banking for physicians and administrators

Why not put our expertise to work for you?

To learn more, contact:

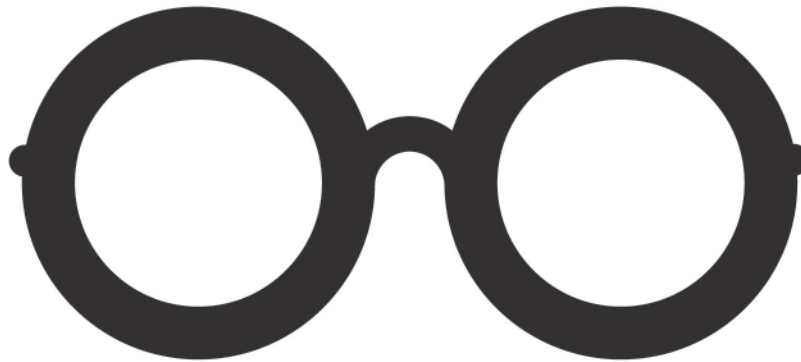
**George Gevas**  
Senior Vice President and Regional Manager  
614-463-7346  
[george.gevas@nationalcity.com](mailto:george.gevas@nationalcity.com)

You'll be breathing easier in no time.

## National City®

NationalCity.com  
Member FDIC  
©2004, National City Corporation®  
CS-16708

**Hearing improves vision.**



To find an approach in health care you must be willing to examine the problem. Our global network of problem solvers has a finger on the pulse of the health care industry and can help you walk through any issue unscathed. So take a look. We're listening. [ey.com](http://ey.com)

For more information, contact Lynne Parrott at (614) 232-7110 or [lynne.parrott@ey.com](mailto:lynne.parrott@ey.com); or Mark Bainbridge at (614) 232-7319 or [mark.bainbridge@ey.com](mailto:mark.bainbridge@ey.com).

Audit • Tax • Transaction Advisory Services

 **ERNST & YOUNG**  
*Quality In Everything We Do*

## Hospital Options for Managing Uninsured and Underinsured

### Co-Authors:

Neil Johnson, Lawrence, Evans & Co., LLC  
614-448-1304 x103 njohnson@lawrenceevans.com  
Lawrence, Evans & Co., LLC is a national healthcare finance and management consulting firm working with non-profit and for profit middle market healthcare providers. We provide merger and acquisition advisory, debt and equity placement as well as advise on capital market transactions.

Mark Huebner, CSI Financial Services  
858-200-2064 mhuebner@csifinancial.com  
Since 1992, CSI Financial Services has provided hospitals throughout the nation with easy to implement patient financing programs that meet the needs of both hospitals and their patients.

The number of Americans that have no health insurance coverage continues to climb. It is estimated that nearly 50 million nationwide are uncovered while millions more have inadequate coverage. This lack of sufficient coverage places additional stress on our healthcare system, particularly on the healthcare administrators and managers that are continually pressured with limited resources to collect these service bills. The growing number of self pay receivables from individuals who can not afford to pay for their healthcare costs typically ends up with collection agencies after only a few months of being “worked”. This results in a reduced collection return for the hospital and a negative experience for the patient.

There will always be large percentage of individuals who received healthcare services that cannot or do not pay their bills. The bill is usually too much and patients may believe that the amount of their final medical bill is “unfair” – particularly for the uninsured who do not receive discounted negotiated rates that the insured pay.

The first step in channeling the collections from uninsured and underinsured is to verify Medicaid, charity care eligibility, or other state subsidized health programs. Of course, administering an effective

## MEDASSIST



helping healthcare providers  
focus on patient care

MedAssist brings a commitment to patient dignity, compassion and integrity to patient eligibility and revenue cycle management.

Our core deliverable is the professional excellence required to improve cash flow, maximize reimbursement and reduce bad debt.

[www.medassistgroup.com](http://www.medassistgroup.com)

patient services | eligibility services | receivables management | allied collections

verification process requires disciplined staff in several different departments within the hospital. Registration, admissions, emergency department, and the business office are tasked with gathering various bits of information prior to patient discharge. Indigent care hospitals sometimes have dedicated staff to handle charity care patients.

Many hospitals are deploying statistical screening models as a method to optimize the collector work flow around the probability of Medicaid/charity care qualification. Screening is usually accomplished by an outside vendor that can quickly download patient credit bureaus and pull out useful bits of information such as home ownership, debt/income ratios, zip code, and credit score. Medicaid and charity care eligibility is the most important first step in collecting from the uninsured, and can save you much time and money by strategically reducing case volume for your financial counselors and collections staff.

After screening for Medicaid/charity care, you are usually left with a very large portion of uninsured and underinsured patients that do not qualify for any federal, state, or local subsidy programs. While a concerted effort should be made to get payment in full or at least a down payment before the patient leaves the hospital, healthcare providers may be understaffed and unable to handle the full volume of its patient discharges and its revenue management activities. As such, the hospital is left with a large chunk of accounts that need to be billed – commonly called “day one accounts”. Your day one accounts will typically carry a lot of low hanging fruit that can be easily collected by one letter with a statement for payment. Prompt payment discounts ranging between 5% and 30% are becoming increasingly popular especially in light of the recent lawsuits for gross billing to the uninsured. Most providers outsource the day 1 letters and statement to an early out agency that either only sends a letter, or sends a letter and handles the phone calls all for a contingency fee or per account fee. Day one accounts are usually worked internally up to 30-45 days for payment, depending on the amount of available staff.

Internal payment plans are very common in almost every hospital since there is a tremendous amount of pressure to accommodate the patient’s ability for repayment. Most internal plans are interest free with varying terms, usually for whatever the patient can afford to pay each month. Most patients will agree to an interest free \$20 - \$50 monthly bill for a typical service that costs up to \$2,500. However, such payment plan can actually be a money losing service given costs to administer the program and the hospital’s internal cost of capital. For example, it would take 50 months to pay off a \$2,500 medical bill with a \$50 monthly, interest free payment. However, monthly statements, late notices, and phone calls can cost over \$5 per account per month. Industry assumptions are that an average call (including follow-up work after the call’s completion) costs \$5 alone. This means that it may cost in total \$250 to administer the \$2,500 payment plan for the patient. Additionally, since it is an interest free payment plan, you will need to perform

a present value of the expected cash stream at the hospital’s weighted average cost of capital (typically around 8%) to get the true cost of the program. For example, when discounting the \$50 annuity less monthly overhead of \$5 (net \$45) over the fifty-month term at 8%, the present value (total cash to the hospital in today’s dollars) is \$1,873. This is a 25% net discount, and that is only if the patient pays as agreed over the lengthy 50 months or 4.16 years. See Chart 1 below.

Many hospitals are now offering application based bank or finance company payment plans. These plans give the hospital immediate cash for the self-pay accounts and relieve the hospital of administering a letter and call campaign. The advanced funds are usually 90 cents on the dollar for qualified bills. As you can see in Chart 1 below, when compared to a payment plan, this returns approximately 20% or \$377.04 more than the \$1,873 received by the Hospital. However, it can be extremely difficult to get patients to fill out the application, especially if you are understaffed with financial counselors and collectors. Many of the patients that fill out the application and truly wish to be placed on a payment plan do not qualify for the loan. Additionally, qualified patients will need to apply for additional payment plans for future services.

CHART 1

HOSPITAL PAYMENT PLAN				PATIENT FINANCING			
Medical bill	\$2,500.00			Medical bill	\$2,500.00		
Payments of \$50 per month made by patient for 50 months				Sell account to finance company at 90%			
INCOME				INCOME			
Monthly payments	\$ 50.00	\$2,500.00	100%	Sell account @ 90%	\$2,250.00	90%	
Interest Income	\$ -	\$ -	0%	Total Income	\$2,250.00	90%	
Total Monthly Income	\$ 50.00	\$2,500.00	100%				
EXPENSES				EXPENSES			
Overhead - monthly avg	\$ 5.00	\$ 250.00	10%	Overhead	\$ -	0%	
Net Collections		\$2,250.00	90%	Net Collections	\$2,250.00	90%	
*Cost of Capital	8.0%						
PV of Net Collections		\$1,872.96	75%		\$2,250.00	90%	
DIFFERENCE				DIFFERENCE			
					\$ 377.04	15%	

\*avg cost of capital

Through the use of new automated technology, new payment plan concepts are entering the healthcare market. Automation with credit agencies have created non-application based payment plans that also offer immediate cash for self-pay accounts. These programs are usually set up as revolving lines of credit (which means future services can be linked into one account)

**Hospital Options (continued)**

and can be used anywhere in the revenue cycle, from admission to day 120. The use of such programs significantly increase the amount of qualified and sold accounts. Financial counselors and admitting staff can simply code a patient for a payment plan in the billing system upon the patient’s verbal agreement to take a loan. For patients that the hospital could not screen prior to discharge, the self-pay debt can be automatically sold to the financing institution without patient consent. This is typically done immediately after the hospital has attempted to collect once or twice. Of course, it is very important to inform patients in advance what they should expect if their hospital bill is not paid in a timely fashion. The most effective collection strategy will include a late notice explaining that the patient’s account may be sold to a financial institution if the debt goes unpaid.

Hospitals have more choices these days as it relates to their uninsured and underinsured self pay accounts. The growing self pay receivable balances coupled with limited internal resources for collections has forced many organizations to seek alternative solutions to maximize returns while accelerating cash flow. Advances in technology has not only created efficiencies within the revenue cycle but has also created new solutions to this mounting problem.

Selecting a finance company to work with you on your self pay receivables, as discussed above and seen in Chart 1, will yield higher returns while creating a patient friendly atmosphere for the hospital’s “client” when compared to the alternatives. When reviewing a collection strategy make sure you evaluate all of your options.



**PROGRAMMING CALENDAR**

Date	Topic	Speaker	Location	Program Length	Attendee/ Org. Fee
August 26, 2004	Social Event- Happy Hour	N/A	Brazenhead	TBA	TBA
September 22, 2004	Hospital / Physician Joint Ventures and Stark II	Mike Gire, Diane Signoracci, Bricker & Eckler	Children's Hospital	Half-day 7.30am-11:30 pm	\$250 - organization \$30 - per person
October 4, 2004	Fall Golf Outing	N/A	Marion Country Club	Full-day	TBA
October 5, 2004	OHA Regulatory Update	Larry & Larry	Villa Milano	Full-day	OHA fees
October 22, 2004	Capital Financing	National City and Peck Schaffer & Williams	Ohio State University	Half-day 8am-12 pm	\$250 - organization \$30 - per person
November 16-17, 2004	OSCPA Healthcare Conference	Various	Ramada Plaza Hotel	2-day	OSCPA fees
December 2, 2004	Accounting & Auditing Update/ Happy Hour	Ernst & Young	Columbus Athletic Club	A&A 3-5 pm Happy Hour 5pm	\$125 - organization \$20 - per person
February 15, 2005	Uninsured/ Underinsured - Co-sponsored with COPAM	Various	Villa Milano	Full-Day 8am - 3 pm	\$30 - per person
March 1, 2005	Trends in Healthcare- The Great Unfunded Mandate and Beyond Reactive Growth	Healthcare Advisory Board	OSU, Ross Heart Hospital	Full- Day 8am - 3 pm	TBD
March 18, 2005	Reimbursement Law & Managed Care Contracting/ NCAA Tournament	Reimbursement Law - AHC Managed Care Contracting -Ernst & Young	Buckeye Café	Full-day 8am - 4 pm	\$500- organization \$60 - per person
April 14, 2005	Professional Leadership Training Seminar	Diane Egbers	Mt Carmel East	Full-day 8am - 4 pm	TBD
May 19-20, 2005	Co- Sponsorship of Gerry Haggarty Event	Various	Glenmoore Country Club- Canton, Ohio	2-day	\$300 + room
May 23, 2005	Spring Golf Outing	N/A	Riviera CC	Full-day	TBA
June 20-21, 2005	OHA Annual Meeting (HFMA Luncheon - June 21)	Various	Easton Hilton	2-day	OHA fees

Lola Popcevski - Chair (614)-722-5117

Karin Cain - Co-Chair (614)-229-5120

If you would like to sign up for a program please contact Karin Cain at [karin.cain@ev.com](mailto:karin.cain@ev.com)

Register for the OHA Regulatory Update of OHA Annual Meeting through the OHA website at [www.ohanelt.org](http://www.ohanelt.org)



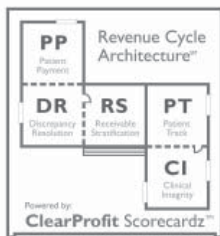


Don't just wish for a more financially sound hospital.  
**Plan on it.**

**Success requires planning and the right tools.** Building a well structured financial framework for your hospital takes rigorous planning, extensive expertise, and the right tools. Zimmerman has 18 years of experience helping hospitals like yours master their revenue cycle, turning financial wishes into fiscal realities.

**Plan on financial success. Plan on Zimmerman.**

Zimmerman's proven expertise and tools will give your hospital the blueprint for financial success.



Zimmerman Revenue Cycle Architecture™  
powered by: **ClearProfit Scorecardz™**

Blueprints	Tools
PP - Patient Payment	ClearSight™
DR - Discrepancy Resolution	ClearPact™
RS - Receivable Stratification	ClearPriority™
PT - Patient Track	ClearPath™
CI - Clinical Integrity	ClearCode™

**zimmerman**  
Your margin. Our mission.

[www.zimmermanrcm.com](http://www.zimmermanrcm.com)

**THERE ARE  
HUNDREDS OF  
WAYS WE HELP  
HOSPITALS.  
HERE ARE  
SEVEN OF THEM.**

- Corporate compliance
- Assurance services
- Financial projections
- Reimbursement
- Billing and coding
- Information technology
- HIPAA compliance

Dave Scheffler 614.849.3060  
Matthew Weekley 614.849.3073  
plantemoran.com



CPAs / Business Advisors

**THRIVE.**

**Newsletter Editors**

**Tara-Ann McElhearn**  
(614) 232-7165  
tara.mcelhearn@ey.com

**Mark Kosarko**

(614) 232-7138  
mark.kosarko@ey.com

**Newsletter Design and  
Layout**

**Laura Dutton**  
(614)232-7279  
laura.dutton@ey.com

**Ernst & Young LLP**

1100 Huntington Center  
41 South High Street  
Columbus, Ohio 43215

The statements and opinions appearing in articles are those of the authors and not necessarily those of the Central Ohio Chapter HFMA. The staff believes that the contents of *The Buckeye Connection* are interesting and thought provoking, but the staff has no authority to speak for the Officers or Board of Directors of the Central Ohio Chapter HFMA. Readers are invited to comment on the opinions the authors express. Letters to the editors are invited but subject to condensation and editing. All rights reserved.

Central Ohio Chapter  
Healthcare Financial Management Association  
Ernst & Young  
1100 Huntington Center  
41 South High Street  
Columbus, Ohio 43215