Agenda-Two Key Aspects of the CFO’s Role

• **Financial Services Delivery**
  – Historic Hospital Finance Functions
  – Integrated Health System Functions
  – Emerging Needs/Functions

• **Strategic Financial Planning**
  – Goals
  – Process
  – Tools
A Little Personal Background


- **Full-Time/Long-Term CFO Roles:**
  - 1981 – 1990: 440-bed Sacred Heart Medical Center (OR)
  - 1990 – 1995: 657-bed Saint Joseph Medical Center (CA)
  - 2005 – 2009: Oregon Health & Science University (OR)

- **Interim CFO Roles:**
  - 300-bed Pikeville Medical Center (KY) – twice
  - 250-bed Ashtabula County Medical Center (OH)
  - 715-bed Hennepin County Medical Center (MN)
  - Department of Mental Health (DC), including 305-bed St. Elizabeth’s Hosp.
  - University Hospital (OR), 510-bed adult hosp., 112-bed childrens hosp.
  - 110-bed Proctor Hospital (IL)

- **Consultant** – M&A, bond issue “independent consultant,”
general strategic & managed care planning, special projects
Group Background-Who’s here today?

• Current or past **Chief Financial Officers**?
  – At Critical Access Hospital?
  – At standalone independent community hospital?
  – At not-for-profit multi-hospital system?
  – At a for-profit system-owned hospital?

• Current or past **Controllers**?
  – At Critical Access Hospital?
  – At standalone independent community hospital?
  – At not-for-profit multi-hospital system?
  – At a for-profit system-owned hospital?

• Current or past **Revenue Cycle VPs/Dirs**?
  – At Critical Access Hospital?
  – At standalone independent community hospital?
  – At not-for-profit multi-hospital system?
  – At a for-profit system-owned hospital?
Historic Functions

• For the **hospital**

1. **Budgeting** – volumes, rate increases, cost inflation
2. **Patient Financial Services**
   ◦ Charging - chargemaster, payor contracting
   ◦ Billing
   ◦ Collecting
3. **Financial Reporting** (internal & external fin. stmts., 990)
   ◦ Net revenue – inpatient & outpatient
   ◦ Patient service costs
   ◦ Support and administrative costs
   ◦ Nonoperating revenue/expense
   ◦ Net income/loss
4. **Payroll**
   ◦ Heavy interaction with human resources
Historic Functions (Cont’d)

• For the hospital
  5. Treasury Function
    ◊ Cash management
    ◊ Debt management
  6. Asset Management (property, plant & equipment)
  7. Purchasing
    ◊ Ordering, receiving & accounts payable
    ◊ Inventory management
  8. Cost Reporting (Medicare & Medicaid)
  9. Tax Reporting (990)

• Sometimes also included
  10. Medical Records (particularly post-DRG; coding)
  11. Information Systems (due to heavy financial systems focus)
Historic Finance Organization

CFO

- Dir., Pat Acctg
  - Hospital Billers
  - Internal Collectors
  - Collection Agency

- Controller
  - G/L Bookkeeper
  - A/P Clerks
  - Purchasing

- Payroll
  - Chargemaster & Mgd Care

- Budgeting, Cost Acctg., Reimb.

- Dir., I.T.
  - Fin. & Admin Sys. Mgr.
  - Clin. Sys. Manager
  - Medical Records?
  - Admitting & Pat. Regist?
Historic Finance Team

- Strong **Controller/GL Bookkeeper** (depending on hospital size)
  - Prior audit/accounting experience
  - Most likely internal CFO candidate

- Strong **Director of Patient Accounting**
  - Financial counselors
  - Billers
  - Collectors
  - Interface w/external collection firm

- **Director of Information Systems**, perhaps outsourced
  - Focus on financial applications (general accounting, payroll, charge capture, patient accounting, and purchasing/materials management)
  - “Dumb terminals,” performing specific functions
Status Check

• How well has your hospital historically done these things?
  – Have needs been met on a timely basis?
  – Have there been major subsequent corrections or restatements?
  – How well has your hospital benchmarked on key financial indicators
    ◊ labor productivity?
    ◊ Overall cost per case?
    ◊ Pricing mark-up ratios?
    ◊ Days cash on hand?
    ◊ Debt service coverage?
  – Adequate tools, people, expertise?
Health System Integration

- **Historic finance functions**
- **Plus**
  - Physician office finance functions
    - Physician services chargemaster
    - Managed care contracting
    - Billing & Collection
    - Financial reporting
    - Physician compensation calculations
  - Home health, hospice, skilled nursing facility finance functions
    - Unique chargemasters
    - Unique reimbursement, contracting, billing & collection
    - Unique cost reporting
    - Financial reporting
  - Joint venture, merger & acquisition analysis
Health System Integration (Cont’d)

• **Plus**
  
  – Electronic health records (& meaningful use stages)
    ◊ Hospital, home health & hospice, ambulatory centers, physician offices, skilled nursing facilities

• **Other Changes**
  
  – From Patient Accounting > Revenue Cycle Management
    ◊ Adding
      • Admitting & Patient Registration
      • Point-of-service collection
      • Health Information Management (documentation & coding)
    ◊ Medicare RAC audits
  
  – *Expanded 990 reporting* (community health needs assess.)
  
  – *Sometimes*
    ◊ Detailed procedure level cost accounting
    ◊ Physician practice management services
    ◊ FQHC’s, RHC’s
Integrated Health System Finance Organization

CFO

VP, Rev Cycle
- I/P Admit & O/P Pat. Regist.
- Hosp. Coders
- Hosp. Billers
- Internal Hosp. Collectors
- Collection Agency

Dir. of Finance
- MD Office Schedulers
- MD Office Coders
- MD Billers
- Internal MD Collectors
- Chargemaster Maintenance

- Dir., Fiscal Services
- Financial Reporting
- A/P Clerks
- Payroll

- Dir., Matls. Mgmt
- Purchasing
- Inventory Mgmt.
- Dir., Budget & Cost Acct.

Dir., Mgd. Care & Reimb.
- Dir., Mgd Care Contract
- Reimb. Mgr.
- Tax Mgr

CIO

- Fin & Admin Sys Mgr
- Clin Sys Mgr
- Dir Data Analytics
- Dir I.T. Security
Integrated Health System Finance Team(s)

• Multiple Controllers/CFOs
  – By type of delivery
  – By region

• VP, Revenue Cycle & Patient Access
  – Specialty revenue cycle managers
    ◊ Hospital revenue cycle
    ◊ Physician revenue cycle
    ◊ Home health & hospice revenue cycle
    ◊ Skilled nursing facility revenue cycle

• Dir. Of Materials Management/Logistics
  – Working with sophisticated GPO & tools

• Dir., Reimbursement & Managed Care
Status Check

• How well is your hospital or system doing these things?
  – Are the necessary additional services being provided?
  – Have needs been met on a timely basis?
  – Have there been major subsequent corrections or restatements?
  – How well does the overall Southeastern Health system benchmark on key financial indicators (productivity, cost per case, pricing mark-up ratios, days cash on hand, etc.)?
  – Adequate tools, people, expertise?
Emerging Needs

- Historic & Integrated System Finance Functions
- **Plus**
  - Costing & pricing changing payment methodologies, such as
    - Value-based care
    - Bundled payments
    - Global package pricing
    - Accountable care organizations
    - Primary care medical homes
    - High deductible plans
    - Other “innovations”
  - Enhanced negotiating skills
  - Population health management
    - Data analytics
    - Actuarial expertise
CMS Bundled Payment Initiatives: BPCI Models

Timeline

- **Nov. 2012 – Sept. 2014:** Phase One: No-risk prep period.
- **Oct. 1, 2014:** Final Phase 2 Go-Live Date
- Risk Bearing Implementation Period

- **Model 1** – Acute Care Hospital Stay Only (Retrospective): 3 participants representing 32 organizations
- **Model 2** – Acute Care Hospital Stay + Post Acute Care Episode (retrospective): 55 participants representing 192 organizations.
- **Model 3** – Post Acute Care Only (Retrospective): 14 participants representing 165 organizations
- **Model 4** – Acute Care Hospital Stay Only (Prospective): 37 participants representing 75 organizations

Source: The Advisory Board: “What are BPCI participants bundling?” by Rob Lazerow dated February 1, 2013
Emerging Needs (Cont’d)

• **Plus:**
  - Dedicated regulatory monitoring and management
  - **Increased managed care complexity**
    - Health insurance exchanges
    - Payor network monitoring (exclusive and narrow network plans)
    - Medicare advantage plan changes
  - **Increased Medicare reimbursement complexity**
    - Sequestration
    - SGR remediation
    - Home health (and other) payment reductions
    - 2 midnight rule, HAI, readmissions, etc.
  - **Larger system acquisition approaches**
  - **Information systems security**
Emerging Needs (Cont’d)

- **Increased Payment Uncertainty**
  - Value-based purchasing withholds
  - EHR meaningful use criteria (stage-by-stage)
  - RAC audits
  - Demonstration projects performance
  - ICD-10 Implementation

- **Even some uncertainty re. costs**
  - 340(b) pricing on pharmaceuticals threatened
Emerging Finance Organization

CFO

- VP, Rev Cycle
  - I/P Admit & O/P Pat. Regist.
  - Hosp. Coders
  - Hosp. Billers
  - Internal Hosp. Collectors
  - Collection Agency
  - MD Office Schedulers
  - MD Office Coders
  - MD Billers
  - Internal MD Collectors
  - Chargemaster Maintenance
- Dir. of Fin./Controller
  - Dir., Fiscal Services
  - Financial Reporting
  - A/P Clerks
  - Payroll
  - Dir., Budget & Cost Acct.
- Dir., Mgd. Care & Govt. Prog.
  - Dir., Mgd Care Contract
  - Purchasing
  - Inventory Mgmt.
  - Dir., Budget & Govt. Prog.
- Dir. Fin. & Admin
  - Fin. & Admin Sys Mgr
  - Dir. Data Analytics
  - Dir. Bus. Intelligence
  - Dir I.T. Security

CIO

- Dir., Mgd Care Contract
  - Govt. Prog. Mgr.
  - Tax Mgr
- Dir. Mgd Care Contract
  - Fin. & Admin Sys Mgr
  - Clin Sys Mgr
  - Dir. Data Analytics
  - Dir. Bus. Intelligence
  - Dir I.T. Security
Emerging Finance Team

• **Absolutely Key**
  
  – Very strong VP Revenue Cycle/PFS Director
    ◊ May be centralized at regional or national level
    ◊ Dir. of Patient Access?
  
  – Dir., Cost Accounting, Financial Planning & Budgeting?
    ◊ Financial modelling capabilities (“what-ifs”)
  
  – **Medical Economics Capabilities**
    ◊ Strong/frequent CMO interaction
    ◊ CMFO (Chief Medical Finance Officer) – MD?
    ◊ Medical data analytics
Status Check

• How well positioned is your Hospital Finance Team to do these things?
  – Are the necessary additional services being provided?
  – Have needs been met on a timely basis?
  – Have there been major subsequent corrections or restatements?
  – How well does your overall system benchmark on key financial indicators (productivity, cost per case, pricing mark-up ratios, days cash on hand, etc.)?
  – Adequate tools, people, expertise?
Strategic Financial Planning
The Long Range Financial Planning Process

1. Determine long-term financial goals
2. Establish a historical baseline
3. Analyze financial impact of strategic plan strategies and tactics
4. Layer financial impacts on historical baseline
5. Test results against long-term financial goals
6. Modify iteratively as necessary to accomplish long-term financial goals
Long Range Financial Goals

• Most commonly – Attain specific credit rating
  – Examples
    ◊ Income from Operations – 3%
    ◊ Total Margin – 5%
    ◊ Debt Service Coverage – 1.25+
    ◊ Days Cash On Hand – 150+
  – Generally minimum target = BBB+
  – More desirable = A
Establishing the Baseline

- Trending based on prior two – three years and current year-to-date performance
- Core assumptions:
  - Patient service volume
  - Payor mix, pricing & payment levels
  - Labor productivity & salary expectations
  - Other expense inflation rates
  - Any financial impact of significant known future events
Analyzing Strategic Plan Impact
(Tactic by Tactic)

<table>
<thead>
<tr>
<th>Strategy Lead</th>
<th>Name:</th>
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<tr>
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<td>Title:</td>
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<td>Phone #:</td>
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<table>
<thead>
<tr>
<th>Strategy - Brief Description</th>
<th>Resource Requirements</th>
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<tbody>
<tr>
<td>Major Individual Tactics</td>
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<table>
<thead>
<tr>
<th>Brief Description</th>
<th>Incremental Revenue</th>
<th>FTE Change (#)</th>
<th>Estimated Annual Cost (of FTEs)</th>
<th>Non-Staff Operating Expenses</th>
<th>Capital Costs (Acquisition Cost)</th>
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</thead>
<tbody>
<tr>
<td>Estimated New Revenue Generated</td>
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<th>Staffing Reasoning/Description</th>
<th>Total Resources Required</th>
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<table>
<thead>
<tr>
<th>Other Operating Expenses (if changing)</th>
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<thead>
<tr>
<th>Capital Costs (if changing)</th>
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Incremental Revenue Generated:

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<tr>
<th>Total Resources Required</th>
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</table>

Staffing:

- FY2014:  
- FY2015:  
- FY2016:  
- FY2017:  

Other Operating Expenses:

- FY2014:  
- FY2015:  
- FY2016:  
- FY2017:  

Capital Costs:

- FY2014:  
- FY2015:  
- FY2016:  
- FY2017:  

FTE Change (#): 

- FY2014:  
- FY2015:  
- FY2016:  
- FY2017:  

Estimated Annual Cost (of FTEs): 

- FY2014:  
- FY2015:  
- FY2016:  
- FY2017:  

Non-Staff Operating Expenses: 

- FY2014:  
- FY2015:  
- FY2016:  
- FY2017:  

Capital Costs (Acquisition Cost): 

- FY2014:  
- FY2015:  
- FY2016:  
- FY2017:  

- Incremental Revenue Generated
- Total Resources Required
# Analyzing Strategic Plan Impact (Tactic by Tactic)

## Strategy Lead

<table>
<thead>
<tr>
<th>Name:</th>
<th>Brad King</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>CLA Principal</td>
</tr>
<tr>
<td>Phone #:</td>
<td>704-998-5291</td>
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## ESTIMATED IMPACT OF TACTIC

<table>
<thead>
<tr>
<th>Tactic Description</th>
<th>Incremental Revenue</th>
<th>FTE Change from Current Staff (#)</th>
<th>Estimated Annual Cost (of FTEs)</th>
<th>Non-Staff Operating Expenses</th>
<th>Capital Costs (Acquisition Cost)</th>
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<tbody>
<tr>
<td>Improve and leverage information technology</td>
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<tr>
<td>Acquire &amp; Implement New Electronic Health Record</td>
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<tr>
<td>Medicare Meaningful Use Incentive Payments-Hospital</td>
<td>- 2,400,000</td>
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<tr>
<td>Meaningful Use Incentive Payments-Physicians</td>
<td>- 720,000</td>
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<tr>
<td>Staffing - Position/Justification</td>
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<tr>
<td>I.T. System Implementer</td>
<td>0.50 1.00 0.50</td>
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<td>I.T. Business Analyst</td>
<td>0.75 1.00</td>
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<tr>
<td>I.T. Programmer/Analyst</td>
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<td>Other Operating Expenses (if changing)</td>
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<tr>
<td>Training</td>
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<td>16,000</td>
<td>8,000</td>
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<td>Travel</td>
<td></td>
<td></td>
<td>3,200</td>
<td>4,800 1,600</td>
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<td>Professional Meetings</td>
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<td>1,200</td>
<td>1,800 600</td>
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<td>Office Supplies</td>
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<td>1,000</td>
<td>1,500 500</td>
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<td>Telephone</td>
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<td>2,400</td>
<td>3,600 1,800</td>
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<td>Capital Costs (if changing)</td>
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<td>3,000,000</td>
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<td>EHR system application</td>
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<tr>
<td>Servers &amp; peripherals</td>
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<td>-</td>
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<tr>
<td>Staff laptops/desktops</td>
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<td>-</td>
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<tr>
<td>Incremental Revenue Generated</td>
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<td>- 3,120,000 2,880,000 2,720,000</td>
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<td>Total Resources Required</td>
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<td>Staffing</td>
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<td>Other Operating Expenses</td>
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<td>$ 23,800 19,700 3,900 $</td>
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<td>Capital Costs</td>
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<td>$ 3,424,000 1,712,000 $</td>
<td>- $</td>
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</table>
Layer Tactics Impact on Baseline

- Add incremental financial impact of each tactic to prior baseline
- Calculate cumulative impact
Test Results Against Long-Term Financial Goals

- Compare modified financial performance against key/bond issue-required long-term financial goals
  - Gain/loss from operations
  - Total margin
  - Debt service coverage
  - Days cash on hand
Modify Iteratively

- First run of modified projections almost always fails to meet long-term financial goals
  - Natural desire to accomplish individual responsibilities as soon as possible
  - Capital needs often exceed available capital
    - Inadequate cash on hand
    - Limited philanthropy available
    - Limited additional debt capacity
  - (benchmarked, specific related plans)
- Prioritize accomplishment of tactics
  - Mandated due dates (such as EHR & ICD-10 implementation)
  - Return on investment of each
Key Tool – Financial Modeling Program

• Various options, such as:
  – Kaufman Hall
  – CLA Intuition
  – Others

• Different Approaches
  – Remote processing versus internal use
  – Cost differences
  – Degree of external assistance required
## Assumptions Summary with Action

<table>
<thead>
<tr>
<th>Description</th>
<th>Historical Information (If applicable)</th>
<th>Current Assumption</th>
<th>Assumption Action:</th>
<th>Assumption Low Range</th>
<th>Assumption High Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Using the year-to-date activity to project year 2014</td>
<td></td>
<td>June YTD Annualized</td>
<td>Update with management 2014</td>
<td></td>
<td></td>
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<tr>
<td>2) Projecting 2015</td>
<td></td>
<td>Calculating per volume, payer mix, and inflation assumptions</td>
<td>Should we book year 2014 to the 2014 Budget?</td>
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<tr>
<td>3) Net Assessment Impact</td>
<td></td>
<td>No add-back to margin</td>
<td>Should we add $1.3 million for a number of years?</td>
<td></td>
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<tr>
<td>4) Volume Growth</td>
<td></td>
<td>Volume Growth Percentages</td>
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<td></td>
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<tr>
<td>Inpatient</td>
<td></td>
<td>Acute admissions (%variance was -1.0% 2008-to-2009 and -6.1% 2009-to-2010)</td>
<td>1.0%</td>
<td></td>
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<tr>
<td>Outpatient</td>
<td></td>
<td>OP surgery cases (%variance was -4.7% 2009-to-2010)</td>
<td>1.0%</td>
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<tr>
<td>Clinic</td>
<td></td>
<td>n/a - no historical data</td>
<td>1.0%</td>
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<td>Volume Growth Percentages</td>
<td></td>
<td>n/a - no historical data</td>
<td>50% variable expense</td>
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<td>5) Physician Growth</td>
<td></td>
<td>No additional margin being added from physician growth</td>
<td>Please see &quot;Physician Development&quot; Worksheet</td>
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<td>Section</td>
<td>Details</td>
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<tr>
<td>6) Inflation / Health care reform</td>
<td>Reimbursement</td>
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<td>Medicare</td>
<td>n/a - no historical data</td>
<td>-2.0%</td>
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<td>Medicaid</td>
<td>n/a - no historical data</td>
<td>-2.0%</td>
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<td>True Self-pay</td>
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<td>3.0%</td>
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<td>Commercial and Other</td>
<td>n/a - no historical data</td>
<td>3.0%</td>
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<tr>
<td>Health Care Reform</td>
<td>25% in years 2013-2016 to 100% Medicaid Rates</td>
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<tr>
<td>DSH Reimbursement</td>
<td>Reduced</td>
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<tr>
<td>Market Basket</td>
<td>Reduced - MCR inflation reduced 0.25% and 0.10% beginning 10/1/11</td>
<td></td>
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<tr>
<td>IP Coding</td>
<td>Not Included</td>
<td></td>
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<tr>
<td>Quality Add-on</td>
<td>Included at 70-80th Percentile</td>
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<td>Productivity Adjustment</td>
<td>Not Included</td>
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<tr>
<td>Readmission / HAI Penalty</td>
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</tr>
<tr>
<td>Expense Cost of Living</td>
<td>n/a - no historical data</td>
<td>3.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) OP / OP Project</td>
<td>Capital Cost</td>
<td>$7,200,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interest Rate</td>
<td>4.90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8) HITECH EMR</td>
<td>Amount</td>
<td>$4,800,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9) Routine (Replacement) Capital Expenditures</td>
<td>Capital expenditures of $2.56m in 2012, $2.42m in 2013, and $2.20m for all years in forecast</td>
<td>$2,400,000 per year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10) Contributions / Grants</td>
<td>Including temporarily restricted, there were contributions of $142k in 2012, $201k in 2013, and $193k in 2014</td>
<td>$150,000 per year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11) Investment Income</td>
<td>$406k in 2012, $130k in 2013, and $531k in 2014</td>
<td>1.50% of average cash/investments ($370K in year 2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Conclusion

- So, overall, how financially prepared is your hospital or system to meet needed future financial services?

- Can you still “go it alone?”