

# ***NSI* NURSING SOLUTIONS, INC.**

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## **2009 TOP CFO CONCERNS**

**(Networking Assistance and CFO Job Lead Information,  
Recruiter Lists, Resume Writing, Networking Articles,  
CFO Compensation, Turnover/Tenure,  
and Causes for Turnover)**

and

## **CFO ECONOMICS**

**(Top Issues Facing Staffing, Causes of Contract Labor Costs)**

## **REPORT**

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# CFO

## TENURE AND TURNOVER RATES

N=183

### CFO TENURE

Average Tenure

Median Tenure

### YEARS

5.2 years

4.8 years

### CFO TURNOVER

2008

2009 (forecast)

### PERCENTAGE

28%

26%

Source: Amalgamation Analysis from: HFMA; Watson Wyatt; Modern Healthcare; HealthLeader; AHA; William M. Mercer; SSI Search Solutions; HR Strategic Solutions, Inc

# TOP REASONS FOR CFO TURNOVER

<b>Anticipating Job Change within 5 years</b>	<b>43%</b>
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**For Free Networking Assistance,  
CNO Job Leads, Network Contacts, Salary Data, or Sample  
CNO Employment Contracts, call  
Marco Colosi at 717-471-7404**

<b>CFO REASONS FOR TURNOVER</b>	<b>%</b>
<b>Pursuing Advancement</b>	<b>34%</b>
<b>Conflict with CEO</b> (CFO Resignation Requested)	<b>25%</b>
<b>Dissatisfaction with Job</b>	<b>13%</b>
<b>Retirement</b>	<b>11%</b>
<b>Family/Personal</b>	<b>9%</b>

Sources: Amalgamation Analysis from: HFMA, William M. Mercer, HR Strategic Solutions

# CFO COMPENSATION 2009 FORECAST

NET REVENUES				
	\$50M to \$150M	OVER \$200M	OVER \$300M	ALL HOSPITALS
BASE SALARY/TOTAL COMPENSATION				N-201
CFO	\$162.3/\$191.8	\$221.0/\$237	\$261.1/\$299.6	\$184.9/\$231
% INCREASE TOTAL COMPENSATION				
CFO	4.5%	6.5%	7.1%	6.2%
Bonus Program Prevalence				
Bonus Type	Hospitals Using	Systems Using	Effectiveness	
Group Incentives	9%	17%	41%	
Lump Sum	31%	13%	53%	
Gain Sharing	42%	16%	55%	
Non-Cash Recognition	12%	2%	24%	
Key Contributor	14%	0	30%	
Profit Sharing	8%	7%	52%	
Source: Amalgamation Analysis from: Towers Perrin; William M. Mercer; Watson Wyatt; Segal & Co; Hay Surveys				

# CFO CHALLENGES

ISSUES	2009
Revenue Stream	66%
Reimbursements (Medicare/Commercial):	61%
Managing Uncompensated Care:	49%
Revenue Cycle:	45%
Credit Market Access-Debt Refinancing:	43%
Physician Office Competition:	34%
<b>Contract Labor Costs:</b> (Nursing/Pharmacy/M.D.):	<b>31%</b>
IRS and Congressional Reporting Changes:	23%
Capital Financing:	21%

Sources: Amalgamation Analysis from: HealthLeaders; Modern Healthcare; HFMA; AHA

# CEO CHALLENGES

ISSUES	2007	2008	2009
❑ Financial challenges	72%	69%	74%
❑ Physician/hospital relations	41%	55%	54%
❑ <b>Personnel Shortages</b>	<b>39%</b>	<b>48%</b>	<b>52%</b>
❑ Care for the uninsured	37%	43%	44%
❑ Quality	30%	33%	37%
❑ Patient safety	28%	32%	34%
❑ Governmental mandates	22%	21%	24%
❑ Patient satisfaction	15%	18%	23%
❑ Capacity	10%	14%	14%

**Staffing is identified as a major workforce trends issue (especially in nursing and allied professions) that is leading to an industry crisis. Driven by a staffing shortage, salaries and healthcare costs are continuing to accelerate...** Fitch Ratings

Sources: Amalgamation Analysis from: Modern Healthcare; AH; ACHE; HR Strategic Solutions

# **MOODY'S NOT-FOR-PROFIT OUTLOOK**

**Moody's Investors Services revised its outlook for the worse due to the worsening economy and shaky financial markets. Moody's lowered its outlook since the, "disruptions in the credit and liquidity markets have worsened and the prospects of a protracted recession have increased."**

- Tumultuous debt markets have made it more expensive and more difficult to borrow, a problem for the capital-intensive healthcare industry, the report said. Not-for-profit hospitals in short-term debt markets also face heightened risk that bonds must be rapidly repaid or that deals to hedge interest rates will go sour.**
- Stock market volatility in recent months rapidly compounded losses to investment portfolios that not-for-profits rely on for cash reserves. Poor investment performance may also force hospitals to pour more cash into defined-benefit pension plans.**
- Broader economic threats include a growing number of uninsured patients, state cuts to funding for the safety net insurer Medicaid, and stress on revenue from private payers seeking to control costs and patients who delay care.**

# IRS SHOWS HAND FOR NOT-FOR-PROFITS

Gregg Blesch, Daily Dose, December,1,2008

- The Internal Revenue Service's Exempt Organizations Division continues to dig into not-for-profit governance, suggesting the IRS' take on hospital community benefits issues and executive compensation according to a 2009 report.
- According to the 2009 work plan, the Division intends to generate a checklist that will help agents determine when governance is a factor in compliance issues.
- The division will also comb its Form 990 for information, on executive compensation and diversion of exempt assets, that could be used in compliance initiatives.

# CFO PREDICTIONS

## PREDICTIONS

## RESPONSE

2009 Commercial Reimbursement will increase slightly :	61.8%
2009 Commercial Reimbursement will be cut slightly:	29.5%
2009 Medicare Reimbursement will increase slightly:	22%
2009 Medicare Reimbursement will be cut slightly:	60.3%
Medicare 5 Year Forecast:	
1) will be at risk based on performance measures:	74.8%
2) current level of at risk reimbursement:	17.3%
Trends affecting Revenue Stream over the next 5 Years:	
1) Migration of profitable services to physician competition:	35.2%
2) Consumer discretionary/out of pocket services to bottom line:	32.9%
3) Consumer Driven Healthcare:	29.9%
4) Pay for Performance:	24.5%

# CFO PREDICTIONS

<b>2009 Capital Spending Plans:</b>	
<b>1) Flat/Incremental Increase:</b>	<b>36.2%</b>
<b>2) Significant Increase:</b>	<b>34.4%</b>
<b>EBIDA/EBITDA:</b>	
<b>1) More than 5%</b>	<b>54.9%</b>
<b>2) 3.5% to 5%</b>	<b>12.9%</b>
<b>3) Zero to 3.5%</b>	<b>12.9%</b>
<b>4) Less than Zero</b>	<b>7.6%</b>
<b>Impact of non-affiliated OP Centers or Physician Owned Entities:</b>	
<b>1) Very Little:</b>	<b>49.6%</b>
<b>2) Slight to None:</b>	<b>44.5%</b>
<b>3) Significant:</b>	<b>32.4%</b>
<b>Debt Vehicle Use;</b>	
<b>1) Interest Rate Swaps:</b>	<b>33.1%</b>
<b>2) Variable Rate Debt:</b>	<b>33%</b>
<b>3) Off Balance Sheet Financing/Arbitrage:</b>	<b>32.8%</b>

# DEPARTMENTAL ACTIVITIES

<b>Finance Functions Out Sourced to Vendors:</b> 1) Bad Debt Collection: 2) Self-pay Collection: 3) None:	<b>67.9%</b> <b>42.2%</b> <b>19.1%</b>
<b>Other Functions Out Sourced:</b> 1) Laundry: 2) No Out Sourcing: 3) Pharmacy: 4) Food Service:	<b>35.5%</b> <b>30.1%</b> <b>20.1%</b> <b>24.6%</b>
<b>Finance Department:</b> 1) will remain flat grow minimally: 2) Number of FTEs: a) Less than 10 b) 10-20 c) 21-50+	<b>92.6%</b>  <b>52%</b> <b>15%</b> <b>33%</b>
<b>Sources: HFMA; HealthLeaders</b>	

# MEMO: CFO FOCUS ON THE ED

Caral Edelberg, *Senior Vice President with TeamHealth for HealthLeaders Media,*

## Where can you search for potentially overlooked revenue?

- **The ED is wrongly considered an unavoidable drain on revenues and resources.** Increasing volumes of indigent and uninsured patients, difficult managed care contracts and pervasive caregiver shortages can leave hospital administrators frustrated. The ED can be a great place to start a revenue cleanup because of its hospital-wide affect. Take a quick scan of the ED using the following actions.
  - 1) Examine the frequency of your ED billing levels.** If your ED bills on a five-level system and the majority of patient visits are billed at levels one, two, and three, your billing is probably "left of center." You may have unclear definitions of your levels, or your coding staff may not understand how to apply the coding criteria. Accurately capturing payment for higher acuity patients is an essential of ED financial success. In addition, coding and billing data may be your only method to evaluate your ED patient acuity patterns, which can be valuable information. Higher acuity may require higher resources, particularly during night shifts when volume decreases but acuity increases.

# MEMO: CFO FOCUS ON THE ED

continued

**2) Determine if levels are appropriately tiered.** Do they accurately reflect patient care from lowest acuity to highest? In general, patients with the lowest acuity receive no diagnostic tests or treatments other than simple bandages and ointments. Mid-level visits often consist of one or two diagnostic studies, injection of medication and simple nursing support. High-level visits may involve longer, more resource-intensive stays for complicated procedures—these patients may be admitted or require follow-up. If your ED coding reflects a different pattern, take a closer look.

**3) Find out if nurses and coders participated in criteria development.** Ask around. Medicare allows individual hospitals to design their own ED evaluation and management criteria. If clinicians weren't involved in this process, a disconnect may exist between caregiver documentation and the coding process. If nurses are unclear what documentation is necessary, services rendered may not match services billed. Coders need to understand how various nursing services reflect resources that can only be captured in the coding of the appropriate ED level.

# MEMO: CFO FOCUS ON THE ED

continued

**4) Investigate billing for the clinical decision or observation unit.** This is a time-intensive process, and if clinical staff members don't understand the amount and type of documentation that needs to be recorded, billing and compliance are compromised. Coding observation services requires such detailed documentation that you need to use a dedicated form. Correct payment depends on whether the patient was first seen in the ED or clinic or received critical care. Services: EKG and breathing treatments are often overlooked. Unless you have a designated form for capturing all services, your nurses and physicians may find it difficult to meet the documentation requirements.

**5) Ensure every service performed in the ED is listed on the "Charge-Master".** Services should be listed even if Medicare does not reimburse the service. Other payers might reimburse and, in fact, Medicare requires that certain services be listed regardless of payment. As a general rule, if you have fewer than 300 E/M levels, surgical, and diagnostic procedures on your ED Charge-Master, you may be missing some valuable services.

- Addressing ED coding, billing, and compliance often requires concerted efforts, but the ROI is significant.

# CFO RN STAFFING ECONOMICS...

<b>RN Turnover Rate: (NSI FY annualized 6.3%)*</b>	<b>21%</b>
<b>New Employee First Year Turnover Rate:*</b>	<b>30% to 45%</b>
<b>Cost of RN Turnover:</b>	<b>\$66,778 to \$133,556</b>
<b>RN Retention Rate: (NSI FY annualized 93.7%)</b>	<b>79%</b>
<b>RN Vacancy Rate Ranges:</b>	<b>6.1%-23.2%</b>
<b>Average RN Salary: (\$32.10 per hour)</b>	<b>\$66,778</b>
<b>Travel RN Cost per year/RN:</b>	<b>\$98,840 to \$156,000</b>
<b>Travel RN Cost Saved per 29 RNs employed:</b>	<b>\$1,809,600</b>
<b>RN Cost-per-Hire: Vanderbilt University School of Nursing Dean Welch reports RN Cost per hire at \$40,000 to \$90,000 (The Tennessean, June 7, 2007)</b>	<b>\$29,278- \$34,168</b>
<b>RN Recruitment Difficulty Rating:</b>	<b>84.4%</b>
<b>RN Average Time-to-Fill: (NSI 32 days)</b>	<b>109.9 days</b>

Sources: AHA; Modern Healthcare; Daily Dose; HealthLeaders; HFMA;

# HEALTHCARE COSTS ACCELERATING RAPIDLY

Type of Cost	2009 Healthcare Costs N-510		
	2006	2007	2008
Labor & Benefit Costs per Staff Occupied Bed	\$435,123	\$455,147	\$475,111
Labor & Benefit Expense per FTE	\$74,208	\$81,168	\$83,450
RX Costs per Adjusted Discharge at 50%	\$574	\$631	\$694
Cost of Benefits Increase	7.7% - 9.6%	8.7% - 10.1%	6% - 9%
Nurses Working in Agencies*	109,354	111,798	101,387 (represents a shrinking pool)

**\*Represents an estimated \$12,000,000,000 in Industry Cost compared to \$6,000,000,000, with RNs as employees. This represents cost savings of \$76,573/employed RN or an average hospital cost savings of \$1,531,460.**

Sources: Amalgamation Analysis from: William M. Mercer; Hewitt Associates; Watson Wyatt; Hay Group; Segal & Co; Towers Perrin; ACHE; AONE; HFMA; Staffing Industry Analyst; and HR Strategic Solutions surveys, etc.

# EXPENSES PER INPATIENT DAY

Source: Thomson Reuters, June, 2008; HealthLeaders Media, August, 2008

STATE	EXPENSE PER INPATIENT DAY	STATE	EXPENSE PER INPATIENT DAY
AK	\$2,246	CO	\$1,751
WA	\$2,143	MA	\$1,751
OR	\$2,062	RI	\$1,719
CA	\$1,994	DE	\$1,715
DC	\$1,910	CT	\$1,713
MD	\$1,831	NV	\$1,685
UT	\$1,823	OH	\$1,673
NJ	\$1,797	IL	\$1,637
NM	\$1,780	TX	\$1,636
AZ	\$1,769	NH	\$1,627

# EXPENSES PER INPATIENT DAY

Source: Thomson Reuters, June, 2008; HealthLeaders Media, August, 2008

STATE	EXPENSE PER INPATIENT DAY	STATE	EXPENSE PER INPATIENT DAY
IN	\$1,569	VA	\$1,394
MO	\$1,560	OK	\$1,332
NY	\$1,539	NC	\$1,320
ME	\$1,528	MN	\$1,300
PA	\$1,500	LA	\$1,293
FL	\$1,497	AK	\$1,238
ID	\$1,484	TN	\$1,234
SC	\$1,465	GA	\$1,202
MI	\$1,464	AL	\$1,198
WI	\$1,458	KY	\$1,194

# EXPENSES PER INPATIENT DAY

STATE	EXPENSE PER INPATIENT DAY	STATE	EXPENSE PER INPATIENT DAY
VT	\$1,166	MS	\$1,021
WV	\$1,113	ND	\$898
NE	\$1,066	MT	\$814
KS	\$1,055	WY	\$805
IA	\$1,036	SD	\$733

□ Interest on variable-rate debt: 3% to 10%

Source: Thomson Reuters, June, 2008; HealthLeaders Media, August, 2008; AHA

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## ***NEED NURSES?***

- ***NSI* NURSING SOLUTIONS, INC** is a 9 year old national high volume U.S. nurse recruitment firm; that recruits only within the continental U.S. for American *Experienced Nurses*, as your core employee staff, in an average **time-to-fill of 32 days**.
- ***NSI*** is not a foreign recruiter nor a travel or temporary agency.

The partnership is "RISK FREE,  
since you must hire the nurses BEFORE ***NSI*** is paid.

- The relationship is also a "WIN-WIN", since not only are the nurses guaranteed for 6 months, ***NSI*** provides "On-Boarding Coaching" for the nurses, for 365 days.

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