

# **Financial Performance of Specialty Hospitals versus General Hospitals**

A study by:

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# Financial Performance of Specialty Hospitals versus General Hospitals

## Summary

The recent growth of specialty hospitals has created concerns about their impact on neighboring full-service hospitals. This study was conducted to investigate the financial performance of specializing hospitals versus general, acute care hospitals. The study examines hospitals with high degrees of specialization irrespective of physician ownership.

Specialty hospitals typically concentrate on cardiovascular services, orthopedic services, or other clinical specialties. A hospital's degree of specialization may range from a comparatively small proportion of its overall admissions to virtually all of its admissions. Specialty hospitals are thought to achieve more favorable results through economies of scale and efficiencies of specialization. This study, however, finds that most specializing hospitals are not more profitable than their peers and that a hospital's financial performance does not necessarily improve with the degree of specialization.

Please refer to Attachments B and C for a detailed summary of the data reported in this study.

## Background

Due to the recent growth in specialty hospitals, especially physician-owned specialty hospitals, there have been growing concerns about the impact such hospitals may have on neighboring full-service hospitals. The chief concern is that physician-owned specialty hospitals may be able to attract only the most desirable patients while leaving medically complicated and uninsured patients to be treated by general hospitals in the community. If such skimming occurred it could disrupt community care and even create conflicts of interest for referring physicians. Specialty hospitals counter that they are creating more physician-centric and efficient operations in order to achieve optimal quality and clinical outcomes.

Responding to concerns, Congress imposed an 18-month moratorium on any new physician-owned specialty hospitals and directed MedPAC to study these hospitals and report its recommendations. MedPAC issued its report in March, 2005 with several findings and recommendations:

- Physician-owned specialty hospitals do not have lower costs for Medicare patients even though their patients have shorter lengths of stay;
- They treat patients who are less severe and concentrate on particular DRGs, both of which are expected to result in higher than average profit margins;
- They tend to have lower shares of Medicaid patients;
- Their financial impact on competitor hospitals has been limited thus far; and
- Many of the differences in profitability across and within DRGs can easily be addressed with regulatory changes in the DRG system.

MedPAC's findings were based on a small number of physician-owned specialty hospitals that have not been in operation long enough to enable a complete evaluation of their impact on other hospitals. MedPAC therefore recommended that Congress continue the moratorium, until January 1, 2007, and make the changes to the DRG system to ensure that Medicare payments are more reflective of a patient's severity of illness.

Hospital industry groups have also expressed their concerns about the effects of specialty hospitals. The Federation of American Hospitals has encouraged an extension of the moratorium and the American Hospital Association has recommended that Congress permanently ban physicians from referring patients to new limited-service hospitals they own. Conversely, the American Medical Association has expressed strong support for competition as a means of promoting high-quality, cost-effective health care.

## The Data

This study is based on the most recently available public data obtained from the Centers for Medicare and Medicaid Studies (CMS). The Medicare Provider Analysis and Review (MedPAR) Limited Data Set (LDS) contains billing records for all Medicare beneficiaries using hospital inpatient services. The MedPAR LDS file for federal fiscal year 2003 was used in the study to identify and compare hospitals specializing in cardiovascular and orthopedic services. Medicare claims data can be used to approximate overall utilization patterns because Medicare generally represents more than one-third of total admissions in the specialties being studied.

In addition to claims data, hospitals that participate in Medicare are required to submit annual financial reports that detail their operations. These cost reports are subsequently made available in electronic form by the Centers for Medicare and Medicaid Services (CMS). The Healthcare Cost Report Information System (HCRIS) dataset contains data elements from the most recent version (i.e. as submitted, settled, or reopened) of each cost report filed.

This study uses each hospital's most recent Medicare cost report in order to profile financial operations. For most hospitals the most recently available cost reporting period is fiscal year 2003. Table 1 summarizes the most recent reporting periods for all hospitals studied.

Table 1 – Most recently available Medicare cost report data by hospital fiscal year

	Number of Cardiovascular Hospitals	Number of Orthopedic Hospitals
FY 2004	521	665
FY 2003	1250	1639
FY 2002	74	101
TOTAL	1845	2405

For purposes of the study, only short-term, acute care hospitals in urban areas were analyzed. Other types of hospitals such as hospitals in rural areas, Critical Access hospitals, children's hospitals, rehabilitation hospitals, and psychiatric hospitals were excluded. Hospitals outside the

United States that participate in Medicare (i.e. those in Puerto Rico and Guam) were also excluded.

Urban hospitals were identified on the basis of metropolitan and micropolitan statistical areas adopted by the Office of Management and Budget in 2003. Metropolitan statistical areas have at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration. Micropolitan statistical areas are a new set of statistical areas that have at least one urban cluster of at least 10,000 but less than 50,000 population, plus adjacent territory that has a high degree of social and economic integration. Metropolitan and micropolitan statistical areas are defined in terms of whole counties or county equivalents. Social and economic integration is defined in terms of commuting ties.<sup>1</sup> Among the 387 statistical areas defined, there were hospitals providing cardiovascular services in 359 and hospitals providing orthopedic services in 362. Rural hospitals were excluded from the study because they typically would not influence utilization patterns for the specialty services being analyzed.

Though hospitals that participate in Medicare are legally required to submit accurate and timely cost reports, data are sometimes incorrect or incomplete. Twenty-two hospitals were omitted from the cardiovascular study group and fifty-three hospitals were omitted from the orthopedic study group because their cost reports did not include total revenue, total expenses, Medicare DRG payments information, and/or Medicare discharges and days of care.

Some hospitals that generally do not provide Medicare fee-for-service care do not file complete cost reports. Examples include HMO facilities such as those operated by Kaiser Health Foundation. Such hospitals were consequently omitted from the study groups.

### **Limitations of Data**

There were other constraints related to the timeliness and availability of data. Though most industry concern is focused on physician-owned specialty hospitals, it was not possible to identify such hospitals. It was possible, however, to distinguish among for-profit, not-for-profit, and governmental hospitals. Comparisons between for-profit and not-for-profit hospitals should reveal any operational differences related to type of ownership.

Because many specialty hospitals are new, their financial information may not yet be publicly available. The study is based on the most currently available cost report data but may not include these newer hospitals.

Though cost report data can be used to measure profit margins for Medicare business and for overall business, further breakdowns are not possible. For purposes of this study, however, gross measures of profitability should be meaningful.

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<sup>1</sup> U.S. Census Bureau, Housing and Household Economic Statistics Division, *Core-Based Statistical Areas*, [www.census.gov](http://www.census.gov), December 06, 2004

## Determination of Specialty Hospitals

Two study groups were chosen based on predominant industry interests and the availability of public data. One group included only hospitals that provide cardiovascular services. The other group included only hospitals that provide orthopedic services.

Medicare claims data for each hospital were analyzed in order to determine whether the services were provided. Attachment A details the specific diagnosis related groups (DRGs) that were used to identify cardiovascular and orthopedic services. Hospitals with ten or fewer specialty admissions were assumed to not provide the service on a regular basis.

Based on Medicare billing data for the twelve months ending September 30, 2003, there are 1,845 hospitals in the US that provide cardiovascular services. Their proportions of Medicare cardiovascular admissions range from less than 1% to nearly 65% of total Medicare admissions, with an average of 8.1%. Of these there are 161 hospitals with 15% or more of their Medicare admissions for cardiovascular services. While only 13% of the nation's total Medicare admissions are to these hospitals, more than 30% of national cardiovascular admissions are admitted to them.

Table 2 – Characteristics of hospitals that provide cardiovascular services.

Cardiovascular Percentage	Number Facilities	Beds	Average Bedsize	Medicare Cases	Total Cases
% Range: 0.0 - 9.9	1,403	330,777	236	5,851,112	16,834,410
% Range: 10.0 - 14.9	281	101,613	362	1,905,124	5,348,336
% Range: 15.0 - 19.9	99	37,514	379	768,857	2,047,612
% Range: 20.0 - 24.9	28	10,073	360	228,672	584,494
% Range: 25.0 - 29.9	12	3,304	275	62,899	153,600
% Range: 30.0+	22	2,335	106	67,136	120,696
Totals	1,845	485,616	263	8,883,800	25,089,148

Similarly, there are 2,405 hospitals that provide orthopedic services. Their proportions of orthopedic admissions range from less than 1% to 100% of total Medicare admissions, with an average of 11.0%. Of these there are 112 hospitals with 20% or more of their Medicare admissions for orthopedic services. While only 2% of the nation's total Medicare admissions are to these hospitals, more than 5.5% of national orthopedic admissions are admitted to them.

Table 3 – Characteristics of hospitals that provide orthopedic services.

Orthopedic Percentage	Number Facilities	Beds	Average Bedsize	Medicare Cases	Total Cases
% Range: 0.0 - 9.9	1,146	240,146	210	3,951,608	11,622,335
% Range: 10.0 - 14.9	914	226,429	248	4,340,840	11,916,002
% Range: 15.0 - 19.9	233	51,454	221	936,846	2,715,621
% Range: 20.0 - 24.9	39	6,811	175	123,466	359,859
% Range: 25.0 - 29.9	15	1,828	122	25,265	73,141
% Range: 30.0+	58	2,781	48	39,796	119,393
Totals	2,405	529,449	220	9,417,821	26,806,351

## Determination of Hospital Characteristics and Financial Statistics

The most recently available Medicare cost report data were used to determine utilization statistics and profitability.

- Utilization Statistics

Utilization statistics were taken from worksheet S-3, Part I. This worksheet provides a hospital's bedsize, its number of Medicare discharges and patient days, and its number of total discharges and patient days for the cost reporting period.

- Medicare Operating Margins

Medicare operating margins were developed from two worksheets:

1. Medicare Net Revenue -

Worksheet E, Part A, was used to determine Medicare net revenue. This worksheet calculates the Medicare Reimbursement Settlement for Inpatient Hospital Services under the Prospective Payment System (i.e., DRGs). Line 16 represents the total Medicare reimbursement amount due from all sources (i.e., the Medicare "net revenue" amount) for each hospital.

2. Medicare Costs -

Worksheet D-1, Part II was used to determine Medicare costs. This worksheet calculates Medicare Inpatient Operating Costs, including capital costs. Line 49 represents the total Medicare inpatient operating costs for each hospital.

The Medicare Operating Costs were subtracted from the Medicare Net Revenues to determine the Medicare Margins for each hospital. This represents the amount hospitals made or lost from treating Medicare patients during the cost reporting period. It is sometimes referred to as the hospital's "bottom line" from Medicare.

- Total Operating Margins

Total operating margins were taken from worksheet G-3. Line 3 represents Total Patient Revenues from all sources including Medicare. Line 4 represents Total Operating Expenses, including capital costs, for all patients, including Medicare. Line 5 represents the difference between Lines 3 and 4, or Net Income From Service To Patients. This is sometimes referred to as the "total margin" for each hospital, or the "bottom line" from treating all patients for the cost reporting period.

The study's chief purpose was to determine whether economies of scale, efficiencies of specialization, advantageous patient selection, or other factors are reflected in a specialty hospital's financial performance. The study considered a hospital's Medicare and total "bottom lines" to be the most important measures of its operations. Other studies have focused on individual diagnoses, market shares within small areas, and subtle differences in patient characteristics. While these perspectives can be valuable, this study focuses strictly on whether hospitals with higher levels of specialization realize more favorable bottom lines.

## Relationship between Specialization and Profitability

There appears to be no consistent relationship between a hospital's degree of specialization and its overall profitability. This is somewhat surprising since specialty hospitals are expected to benefit from economies of scale and efficiencies of specialization. Few hospitals with high levels of cardiovascular specialization were more profitable than their peers. Only about half of the hospitals with high levels of orthopedic specialization were more profitable than their peers. These findings indicate that levels of specialization alone are not predictors of profitability.

Table 4 – Hospital Profitability versus Degree of Cardiovascular Specialization (\$000).

Cardiovascular Percentage	Number Facilities	Medicare Cases	Medicare Margin/Case	Total Cases	Total Margin/Case
0.0 - 9.9	1,403	5,851,112	353	16,834,410	(312)
10.0 - 14.9	281	1,905,124	844	5,348,336	(62)
15.0 - 19.9	99	768,857	542	2,047,612	(15)
20.0 - 24.9	28	228,672	1,075	584,494	(289)
25.0 - 29.9	12	62,899	426	153,600	(49)
30.0+	22	67,136	529	120,696	1,030
Totals	1,845	8,883,800	495	25,089,148	(226)

Table 5 – Hospital Profitability versus Degree of Orthopedic Specialization (\$000).

Orthopedic Percentage	Number Facilities	Medicare Cases	Medicare Margin/Case	Total Cases	Total Margin/Case
0.0 - 9.9	1,146	3,951,608	1,021	11,622,335	(664)
10.0 - 14.9	914	4,340,840	173	11,916,002	(50)
15.0 - 19.9	233	936,846	(223)	2,715,621	141
20.0 - 24.9	39	123,466	(589)	359,859	999
25.0 - 29.9	15	25,265	(285)	73,141	236
30.0+	58	39,796	(913)	119,393	1,430
Totals	2,405	9,417,821	474	26,806,351	(275)

Data also indicate remarkably different margins for Medicare versus total. This was especially true for higher levels of orthopedic specialization. Hospitals with levels of orthopedic specialization of more than 30% averaged a loss of \$913 per case for Medicare versus a profit of \$1,430 per case overall. The reasons for such a discrepancy are beyond the scope of this study but could include such possibilities as:

- All hospitals are paid under the same prospective payment system for Medicare patients but may be able to charge commercial patients more.
- There may be systemic underpayment by Medicare for some orthopedic services.
- As suggested by MedPAC, there may be a need for DRG refinement to pay hospitals more equitably based on patient severity.

## Relationship between Type of Ownership and Profitability

There are concerns in the industry that physician-owned specialty hospitals may be able to attract only the most desirable patients while leaving medically complicated and uninsured patients to be treated by general hospitals in the community. It was not possible to test the effects of physician ownership because specific ownership information was not readily available. It was, however, possible to compare for-profit and not-for-profit hospitals.

Data do not reveal any significant difference in margins for specialty services between for-profit and not-for-profit hospitals. Data is detailed in Attachment B for cardiovascular services and in Attachment C for orthopedic services.

## Other Measures

Other factors were also examined to determine whether they might influence financial performance within a medical specialty.

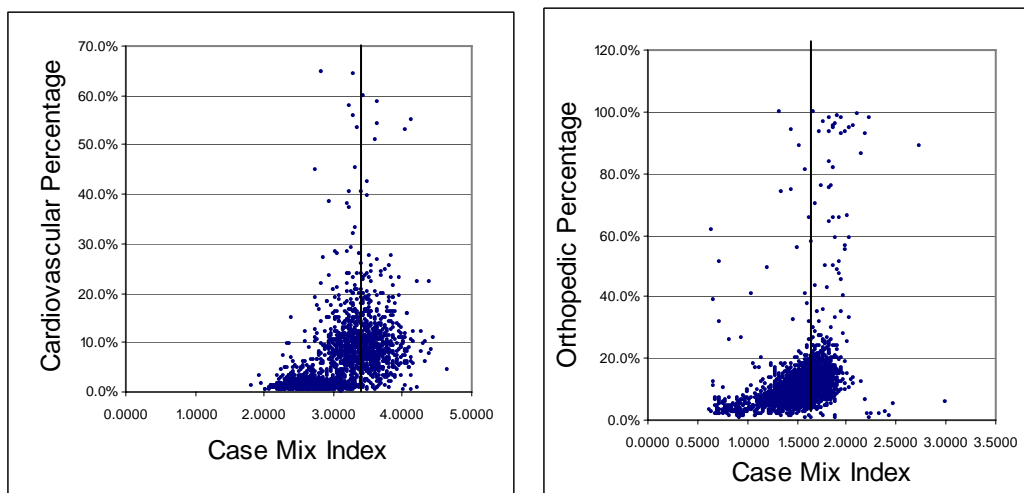
- Location

Hospitals were organized both by state and by CMS region in order to analyze any relationships between a hospital's location and the profitability of specialty care. No discernable relationships were identified. Summaries of the data are included in Attachments D, E, and F.

- Case Mix Index

Medicare billing data were used to calculate the case mix index for each hospital's specialty care. Some criticism of specialty hospitals has contended that specialty hospitals attract a less intense mix of patients. There was no measurable relationship, however, between the case mix index and the degree of specialization.

Table 6 – Case Mix Index versus Degree of Cardiovascular and Orthopedic Specialization



- Bedsizes

There appeared to be direct relationships between hospital bedsize and profitability.

Larger hospitals tended to have higher Medicare margins in both cardiovascular and orthopedic specialties. The relationship was less pronounced for total margins, with largest hospitals actually showing lower margins for orthopedic services.

The relationship between bedsize and profitability is most likely due to general economies of scale. Since physician owned specialty hospitals tend to be smaller, they would not be expected to be more profitable as their opponents contend.

Table 7 – Hospital Bedsize versus Profitability for Cardiovascular Hospitals

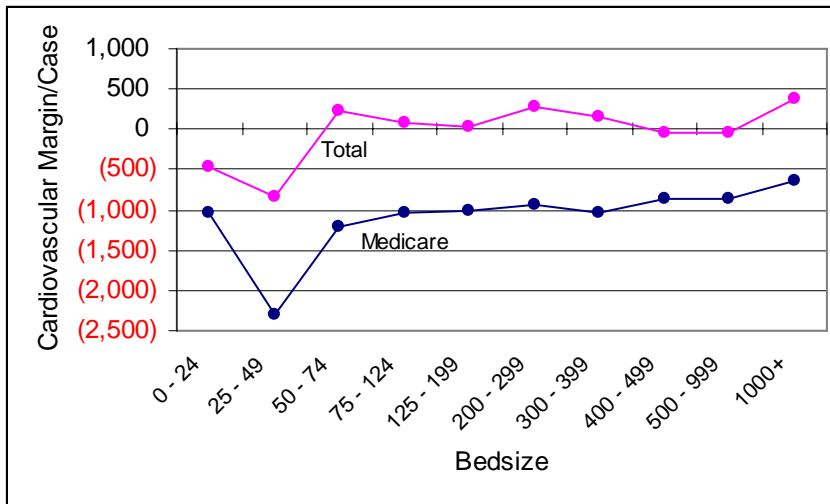
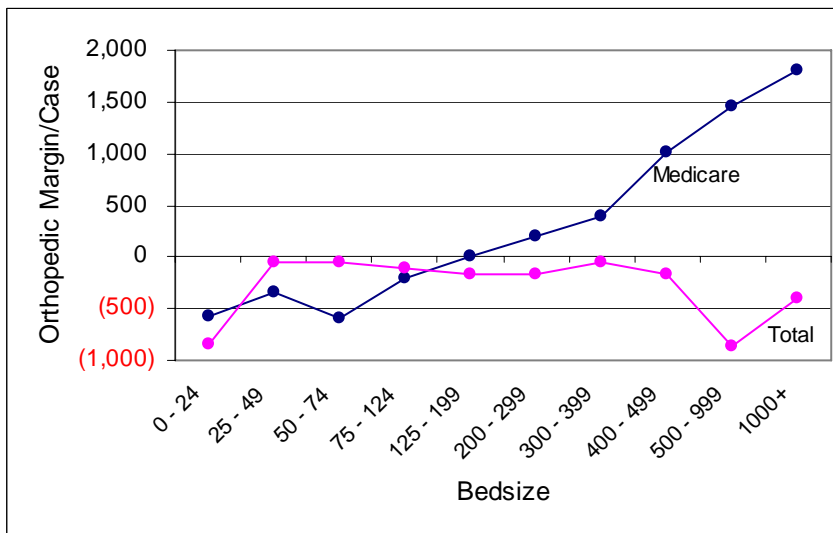


Table 8 - Hospital Bedsize versus Profitability for Orthopedic Hospitals

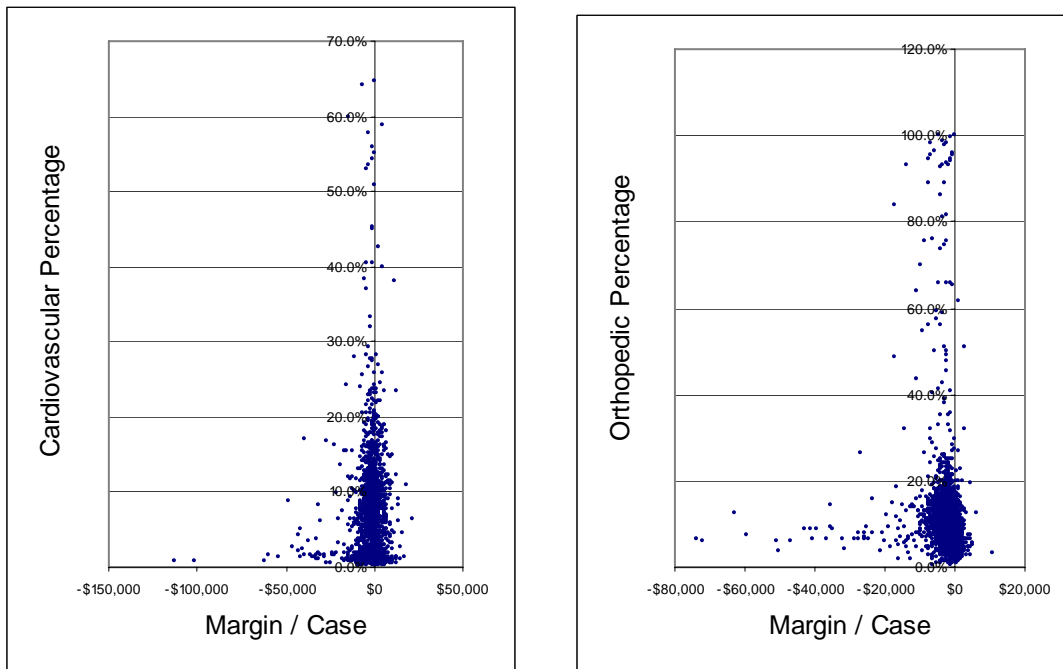


- Estimate of Profitability for Specialty Services Only  
 Financial performance within a medical specialty might be obscured in measures based solely on a hospital's overall bottom line. To test this possibility, the profitability of each specialty was tested using Medicare claims data. The amount of DRG reimbursement for patients within a specialty represented net revenue. Costs within a specialty were

allocated using a hospital's departmental ratios of costs to charges (RCCs) from its corresponding cost report. The departmental charges on each patient's claim were multiplied by corresponding RCCs in order to allocate costs to each claim. The "profitability" of a patient was the difference between DRG reimbursement and the allocated costs.

The profitability of Medicare patients in a specialty did not appear to change in relation to a hospital's degree of specialization. In other words, profit did not improve as a hospital's degree of specialization increased. The scatter diagrams in Table 4 illustrate the observation.

Table 9 – Medicare Margin/Case for Cardiovascular and Orthopedic Specialties vs Level of Specialization



## Conclusion

The desirability of physician-owned specialty hospitals will continue to be examined within the industry. There are legitimate questions about their competitive effects, their efficiency in relation to community hospitals, the appropriateness of self-referrals, etc. This study, however, was unable to identify a relationship between higher levels of specialization and profitability.

## Attachment A

Specialty Services as defined by Medicare DRGs

### Cardiovascular Services

DRG	DESCRIPTION
103	HEART TRANSPLANT
104	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH
105	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH
106	CORONARY BYPASS W PTCA
107	CORONARY BYPASS W CARDIAC CATH
108	OTHER CARDIOTHORACIC PROCEDURES
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH
110	MAJOR CARDIOVASCULAR PROCEDURES W CC
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC
115	PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GN
116	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT
118	CARDIAC PACEMAKER DEVICE REPLACEMENT
514	CARDIAC DEFIBRILLATOR IMPLANT W CARDIAC CATH
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH
516	PERCUTANEOUS CARDIOVASC PROC W AMI
517	PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI
518	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI
525	HEART ASSIST SYSTEM IMPLANT
526	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI
527	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI

### Orthopedic Services

DRG	DESCRIPTION
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS
209	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE
218	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC
219	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC
220	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC
224	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC
225	FOOT PROCEDURES
226	SOFT TISSUE PROCEDURES W CC
227	SOFT TISSUE PROCEDURES W/O CC
228	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR

231 LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR  
 232 ARTHROSCOPY  
 233 OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC  
 234 OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC  
 235 FRACTURES OF FEMUR  
 236 FRACTURES OF HIP & PELVIS  
 237 SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH  
 238 OSTEOMYELITIS  
 239 PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY  
 240 CONNECTIVE TISSUE DISORDERS W CC  
 241 CONNECTIVE TISSUE DISORDERS W/O CC  
 242 SEPTIC ARTHRITIS  
 243 MEDICAL BACK PROBLEMS  
 244 BONE DISEASES & SPECIFIC ARTHROPATHIES W CC  
 245 BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC  
 246 NON-SPECIFIC ARTHROPATHIES  
 247 SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE  
 248 TENDONITIS, MYOSITIS & BURSITIS  
 249 AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE  
 250 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC  
 251 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC  
 252 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17  
 253 FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC  
 254 FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC  
 255 FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17  
 256 OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES  
 285 AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS  
 441 HAND PROCEDURES FOR INJURIES  
 471 BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY  
 485 LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA  
 491 MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY  
 496 COMBINED ANTERIOR/POSTERIOR SPINAL FUSION  
 497 SPINAL FUSION EXCEPT CERVICAL W CC  
 498 SPINAL FUSION EXCEPT CERVICAL W/O CC  
 499 BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC  
 500 BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC  
 501 KNEE PROCEDURES W PDX OF INFECTION W CC  
 502 KNEE PROCEDURES W PDX OF INFECTION W/O CC  
 503 KNEE PROCEDURES W/O PDX OF INFECTION  
 519 CERVICAL SPINAL FUSION W CC  
 520 CERVICAL SPINAL FUSION W/O CC











## **Attachment G**

### About the Authors and the Company

#### **Thomas M. Schuhmann, CPA, JD**

Vice President

Cost Report Data Resources, LLC

Tom Schuhmann, a CPA and attorney, has been in the healthcare field since 1975. He has experience in public accounting, auditing hospitals and nursing homes; in the private practice of law representing doctors, hospitals, nursing homes, and other healthcare companies; and in building and running the reimbursement departments for two of the nation's largest and most diversified healthcare companies (Humana Inc. and Vencor, Inc.).

For almost 30 years, Tom has concentrated his efforts in the areas of Medicare/Medicaid reimbursement and appeals, healthcare finance, compliance, mergers and acquisitions, and lobbying on a federal and state level. Tom has advised numerous legal, accounting and healthcare trade associations including the Federation of American Health Systems, the Healthcare Financial Management Association, and various state accounting and legal associations.

He received his BA from Bellarmine University in 1976 and his JD from the University of Louisville in 1986. He is a frequent public speaker on healthcare issues.

#### **Paul Shoemaker, FACHE**

President and CEO

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Mr. Shoemaker is a graduate of the University of Kentucky and a Certified Computing Professional (CCP). He is also a Fellow of the American College of Healthcare Executives and active in numerous professional organizations.

His professional experience includes sixteen years with Humana Inc. where he served as Vice President of Prospective Payment Systems. He was also co-founder and president of MetriCor Inc., a consulting company specializing in patient medical record coding and management. He currently serves as co founder and president of both Cost Report Data Resources and American Hospital Directory, Inc., an online source for comprehensive information about hospitals.

Mr. Shoemaker has authored numerous professional articles related to health information and is a frequent public speaker. His professional career has been centered on the collection, management and analysis of health care information. He has extensive experience in the use of such information for health policy analysis, strategic planning and operational management.

## **Attachment G**

About the Authors and the Company  
(continued)

### **Cost Report Data Resources, LLC**

Cost Report Data Resources ([www.CostReportData.com](http://www.CostReportData.com)) is the industry's first provider of on-line hospital financial information from the Medicare Cost Report. Data are continually updated upon release by CMS. Standard format cost reports are available individually or by subscription.

Information in cost reports includes income statements, balance sheets, utilization statistics, departmental costs and charges, and other important and relevant data. At [CostReportData.com](http://CostReportData.com), worksheets can be viewed online, printed and downloaded in either pdf or Excel formats. The price for a single report is about the same as a fiscal intermediary's charge for providing one – with the advantage of instant access to data.