Letter from the President

In Kentucky, Spring means one thing... it’s Derby time! This time of year not only marks the world’s most dramatized horse race, it also means another HFMA fiscal year is about to end. This also means, my tenure as your President is officially coming to an end. Twelve years ago, I had never even heard of HFMA. When I was introduced to HFMA for the first time, I never had any intention of getting involved, and certainly never contemplated being President. Rather than drafting up a sentimental goodbye, I want to simply say THANK YOU! Thank you to all the members who support the Chapter by maintaining your membership and attending events. Thank you to all the sponsors who provide us with the funding to provide quality education at reasonable rates. Thank you to all the past Presidents and leaders who shaped this Chapter into what it is today. But most importantly, I want to thank the 2011-2012 HFMA Board Members and Committee Chairs. Not only are these folks great friends of mine, many of them have gone above and beyond to make sure this was a successful year for the Chapter. Please continue to support these leaders in the 2013 fiscal year.

For those of you that attended the Spring Institute, you had the opportunity to listen to Steve Gilliland talk about “Enjoying the Ride.” His message was about living in the now, not being so focused on the next task or meeting. Most of us tend to live life too fast, not taking time to enjoy what is really important. In other words, we forget to “check our passions.” If you haven’t already done so, I would encourage you to read or listen to Steve’s message and start enjoying what really matters.

For the last several years, HFMA has been a true passion of mine. Where else can you get quality education, and make a few good friends along the way. My only goal as President was to leave the Chapter just a little better off than it was before. I truly believe our efforts have paid off and I hope you, as the real “owners” of the Chapter, feel the same. This year, some Chapters are struggling. Attendance is down, membership is declining, and they are struggling just to meet any of their goals. I couldn’t be happier to report that our Chapter has met all of its goals and is expecting to receive numerous awards at this year’s ANI. In keeping with the theme of my previous messages, I want to provide you with one final “report card.” The table below illustrates were the Kentucky Chapter fell relative to the metrics established by National HFMA:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Goal</th>
<th>Estimated FY2012</th>
<th>Over/(Short)</th>
<th>Goal Status</th>
<th>Award Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education hours</td>
<td>8,307</td>
<td>9,441</td>
<td>1,134</td>
<td>Achieved</td>
<td>Silver</td>
</tr>
<tr>
<td>Membership</td>
<td>590</td>
<td>603</td>
<td>13</td>
<td>Achieved</td>
<td>Silver</td>
</tr>
<tr>
<td>Certified Members</td>
<td>7.9%</td>
<td>8.4%</td>
<td>0.5%</td>
<td>Achieved</td>
<td>Bronze</td>
</tr>
<tr>
<td>Days cash on hand</td>
<td>150 days</td>
<td>314 days</td>
<td>164 days</td>
<td>Achieved</td>
<td>N/A</td>
</tr>
<tr>
<td>Membership satisfaction</td>
<td>55% very or extremely satisfied</td>
<td>64%</td>
<td>9%</td>
<td>Achieved</td>
<td>N/A</td>
</tr>
</tbody>
</table>

In addition to the awards mentioned above, the Chapter also expects to receive the “Henry Hotrum Award for Educational Performance Improvement.” This award is given to Chapters that increase their total education hours by more than 6% over the prior year. Suffice it to say, the Chapter had an outstanding year. We went from 38 members short of our goal on January 31st, to 13 members over as of April 30th. To increase total membership by 9% in the last quarter of the fiscal year is a pretty amazing feat. Thanks to everyone who contributed to our membership efforts.

Thanks again for all your support. I wish the incoming officers and directors the best in 2013. Rest assured that I will continue to stay involved in the Chapter and do whatever I can to ensure its continued success. I hope to see you all at the Mid-Atlantic Institute in August.

Chris Woosley – President
Kentucky Chapter – HFMA
2011-2012
A Zero-Cost Approach to Reducing Costly Registration Errors

Author: Dave Owens, Manager, Virtua HomeCare Rehabilitation Services, Marlton, N.J.; Black Belt for this project at Virtua

Many Virtua staff thought they knew why registration errors were being made. Then a performance improvement initiative disclosed and fixed three unsuspecting issues—saving $170,000 to date.

Healthcare organizations continue to search for ways to strengthen their balance sheets and remain competitive amid massive healthcare reforms. Virtua, the largest healthcare system in southern New Jersey, realized incorrect identification of patient payer status was costing it significantly. In 2010, Virtua took a Six Sigma approach to develop a zero-cost solution to improve its patient registration process. The changes generated savings of $170,000 in just nine months.

This project demonstrates that, even after years of cost-control initiatives, organizations still have opportunities to manage costs and improve efficiency using zero-cost solutions.

Understanding the Process
Typically the first step to receiving healthcare services is completing the registration process. Wrong or omitted demographic and insurance information can contribute to incorrectly identifying the payment status of patients, which can cost the organization time and money as it corrects the information and resubmits bills to the appropriate entity.

Many healthcare organizations contract a third-party vendor to manage accounts classified as self-pay. When a patient registered as self-pay is found to have insurance, the vendor helps collect payment from the insurer and takes a percentage of the payment for its work. In Virtua’s case, many patients who were registered as self-pay actually had insurance coverage—meaning Virtua was paying the vendor to collect insurance payments that Virtua could have collected directly on its own. Leaders suspected that the issue was costing Virtua significantly and discussed it with members of the organization’s process-improvement team. An initial analysis demonstrated this flaw in the registration process could potentially result in an unnecessary $670,000 annual expense.

Assessing the Issue
A team was assembled to address this costly issue. The assistant vice president for patient business services (PBS) sponsored the project and recruited team members representing a wide range of functions within PBS (e.g., patient access and accounting, account collections, accounts receivable, and the PBS training coordinator) and front-line staff.

The team met weekly for approximately six months. Many team members were already familiar with Six Sigma methodology from either their involvement in other projects or standard training to Virtua leaders. For those new to the methodology, the Black Belt conducted education sessions before using new tools or concepts.

The team employed the Six Sigma DMAIC methodology (Define, Measure, Analyze, Improve, Control) to systematically identify points of failure in the patient registration process, develop responses specific to the errors, and quantify outcomes. The scope of the project included all types of inpatient accounts and five types of outpatient accounts that followed the same insurance verification process as the inpatient accounts (e.g., same-day surgeries and observation cases). The team also identified stakeholders who needed to be informed about the project and its potential impact on their work. Stakeholders included areas such as registration, PBS educators, and PBS auditors.

Another important stakeholder was the third-party vendor. As fewer errors in patient registration were made, the vendor would experience a significant decrease in volume and revenue. Throughout the project, the team was mindful of the potential impact on its valued business partner, which would continue to manage “true” self-pay accounts no matter the outcome of this project.

Virtua’s Management Toolkit

Virtua developed a management toolkit—including Six Sigma and Lean principles—that gives leaders and staff the skills and approaches they need to improve performance and attain organizational goals. Virtua requires all of its managers to be trained as Six Sigma yellow belts, so they can apply Six Sigma approaches to their daily work. The Six Sigma belts are yellow, green, black, and master black. To read more about Virtua’s management toolkit, read “Creating a Culture of Collaboration” in HFMA’s Leadership (hfma.org/Templates/InteriorMaster.aspx?id=20425).
The DMAIC process required the team to use cause-and-effect diagrams and detailed process maps to identify potential failure points in the registration process. Team members reviewed historic patient accounts and collected real-time data on current registrations, using a gauge to ensure that data were collected in a uniform manner. Although many team members thought they knew how and why errors were being made, data disclosed that three unsuspecting issues triggered incorrect registration of patients (see the exhibit at hfma.org/rcs):

- The admission code in Virtua’s information system
- The age of the patient
- The time of day

For example, newborn babies (identified under admission code “babies”) frequently were registered as self-pay because new parents did not know it was necessary or simply forgot to add the newborn to their insurance plan. Another source of errors centered on patients over 65 years of age. Mistakes associated with this age group were typically the result of communication barriers. Data also showed that information for patients registered during the evening and night shifts had a higher level of mistakes than information for patients registered during the day.

With this information in hand, the team recruited front-line staff to develop solutions specific to each source of errors. Solutions included the following:

- Developing detailed standard operating procedures for registrars, insurance verifiers, and admission staff
- Creating scripting
- Educating staff
- Increasing auditing to monitor compliance

The exhibits below describe the improvement strategies and the standard operating procedures. (See a standard operating procedure for correct identification of self-pay accounts at hfma.org/rcs.)

### Stakeholder Strategies

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registrars</td>
<td>• Created scripting to share with new parents to add baby to insurance</td>
</tr>
<tr>
<td></td>
<td>• Created standard operating procedures</td>
</tr>
<tr>
<td></td>
<td>• Educated staff on project, potential impact on their area</td>
</tr>
<tr>
<td></td>
<td>• Educated staff on proper use of tools</td>
</tr>
<tr>
<td>Auditors</td>
<td>• Added new standard operating procedure elements to audit</td>
</tr>
<tr>
<td></td>
<td>• Recognized staff who followed the new process</td>
</tr>
<tr>
<td></td>
<td>• Increased number of areas audited</td>
</tr>
<tr>
<td>Labor and Delivery Managers</td>
<td>• Educated managers on project, potential impact on their area</td>
</tr>
<tr>
<td></td>
<td>• Had auditors meet with managers for education and training</td>
</tr>
</tbody>
</table>

### Standard Operating Procedures

**Registrar:**
1. Use translator phone if language is a barrier to communication.
2. Work with guardian while present to complete demographics.
3. If HDX system shows no insurance, initiate search with subscriber’s Social Security Number.
4. Run generic insurances (Aetna, Horizon, AmeriHealth, Medicaid) for any self-pay when unable to get good information from patient.
5. If patient is > 65 years old, run a Q01 to check for Medicaid and Medicare on every registration.

**Admission Staff:**
1. If selecting the Q01 plan code, use HDX (benefit confirming software) to check against typical insurers.

**Insurance Verifier:**
1. Call Medicaid or patient’s insurance to verify if baby has been added to plan.
2. Call insurance company with mother’s ID.
3. Check all patient self-pay and all outpatient insurance before handing over information to third-party vendor.
4. Contact social work.

Continues on page 4
Enacting Solutions
A three-month pilot was scheduled to assess whether the solutions truly corrected the problems. (The timeframe was determined by the time required to clear the revenue cycle.) The team determined that a 90-day timeframe was necessary to capture the full revenue cycle, which encompasses the process of the patient receiving service, Virtua issuing a bill, and the insurance company paying Virtua. Only after that process was completed could the team accurately determine if a patient was registered correctly.

The solutions were implemented across the enterprise, and data analysis (via Chi-square). The team used Chi-square testing to calculate and compare the expected rate of errors to the actual rate of errors and identify errors occurring at a statistically significant level. The data analysis demonstrated that a statistically significant reduction in errors had occurred during the pilot phase.

Data also showed that a reduction in the number of mistakes did not always correlate to a high level of cost reduction due to the variation in cost associated with each account. For example, an error could be associated with a $25,000 inpatient hospital stay or with a $25 copay. The difference in errors from baseline to pilot was multiplied by a “savings constant,” which was established by corporate finance using the actual payments to the vendor for inpatient and outpatient account types. The calculation showed that the improved process generated savings of more than $42,000 during the three-month period.

Sustaining Gains
The team developed and implemented a control plan to sustain the results of the pilot. Data are incorporated into a control chart and analyzed monthly. A critical component of the control process is accounting for the continual updating of patient accounts in the system warehouse. As new insurance information becomes available, a patient’s account is updated, which in turn affects data collection and analysis.

To address the fluid nature of the data warehouse, data and monthly invoices are assessed immediately on receipt with clear timelines listed in the control plan standard operating procedures. This manual audit process requires the team to filter the third-party invoice so that only those accounts included in the improvement project are reviewed. Then Virtua accounting data are used to further filter the invoice by factors such as inpatient and outpatient status.

Systematic auditing is conducted to identify compliance gaps. If monthly updates or audits show the process is not functioning as designed, the team will enact its response plan, which includes step-by-step instructions for evaluating data to determine if the process is being followed or if new issues are causing errors. In addition, “defect reductions” is now a standard component of the PBS’s annual goals and objectives, which are reported to senior leadership quarterly and are part of department leaders’ annual performance reviews.

Ensuring Future Success
This new, zero-cost solution has been in place for more than nine months, and results have exceeded expectations. Between October 2010 and June 2011, the project saved Virtua more than $170,000, as shown in the exhibit above. Virtua expects savings to continue each month because each registration is unique.

As healthcare reform provides millions of additional Americans with access to health care, organizations need to ensure that their PBS processes are reliable and consistent with minimal opportunities for error. When the processes prove otherwise, leaders should address the issues immediately. Virtua’s experience of revising its patient registration process to minimize errors and their associated expenses is a sound example of how zero-cost solutions can be successful.
Since the inception of the 340B drug purchasing program in the early 1990s, program compliance has been the responsibility of participating organizations with relatively little oversight. It appears those days are quickly coming to an end. The program’s exponential expansion in recent months has caused many stakeholders and legislators to look more closely at compliance with the program. Much of the recent expansion is a result of the health care reform law passed in March 2010, including:

- Allowing all critical access hospitals (CAHs) to participate in the program
- Reducing the Medicare Disproportionate Share (DSH) criteria for sole community hospitals and rural referral centers to 8 percent from 11.75 percent
- Allowing covered entities to contract with multiple retail pharmacies to provide prescription drugs for covered outpatients

Recent communications from the Health Resources and Services Administration (HRSA) and its Office of Pharmacy Affairs (OPA) discuss the plans in place to oversee compliance with certain areas fundamental to the program. These plans include:

- Requiring compliance testing of the 340B drug purchasing program in A-133 federal grant audits
- Increasing the number of targeted and random audits of covered entities
- Requiring covered entities to annually recertify enrollment forms for participation in the program
- An expectation that all covered entities with contract pharmacy arrangements perform some form of annual compliance audit of the program

Participation in this program can yield significant financial benefits for providers. With so much at risk, providers must review their compliance with key elements of the 340B program, including verification of the following:

- All patients provided drugs purchased through the 340B program comply with HRSA’s definition of a “covered patient”
- Covered patients are receiving services included as reimbursable on the hospital’s Medicare cost report
- A double discount has not been paid by the drug manufacturers through reduced prices on purchased drugs for the covered entity and inclusion of those drugs in the state’s Medicaid drug rebate calculations
- Contracted pharmacies are following appropriate procedures as instructed by the covered entities, and the DSH percentage continues to exceed the required thresholds after the recent release of the updated Social Security Income percentages

For more information on complying with the federal regulations surrounding the 340B program, contact a healthcare advisor.
Use HFMA’s MAP Keys to Improve Patient Success
An HFMA Extra

HFMA’s MAP Keys are key performance indicators for the revenue cycle. Developed by industry leaders led by HFMA, MAP Keys define the essentials of revenue cycle performance in clear, unbiased terms and set the standards for the healthcare industry. MAP Keys allow revenue cycle leaders to track performance and to compare results among peers and with the industry. Use HFMA’s MAP Keys for patient access to improve your registration process (hfmap.org/mapkeys/definitions/patient-access).

Future Financial Leaders Award
An HFMA Extra

The Future Financial Leaders Award recognizes those future leaders who provide innovative and exemplary performance resulting in organizational performance improvement.

Award winners are recognized for their ability to inspire individual and organizational excellence, create and attain a shared vision, and successfully manage change to achieve the organization’s strategic ends and successful performance. The Future Financial Leaders Award will be presented at ANI: The 2012 HFMA National Institute. (http://www.hfmaconference.org)

Submit a nomination by May 17, 2012.

Who is eligible - Mid-level healthcare managers in provider organizations

How the winners are selected - A review panel comprised of recognized healthcare financial leaders select recipients based on the established criteria.

Award Winner Recognition
- Highlighted in hfm magazine. A special section in hfm will feature profiles of the award winners.
- Announced in electronic communications. Information will be included in HFMA’s website, HFMA’s Weekly News e-newsletter, online news section of hfm magazine, and a press release.
- Presented with an award at ANI. Award winners will be recognized during a special session at ANI: The 2012 HFMA National Institute.

For more information or questions, please contact Joseph Abel, HFMA Professional Resources Director at (708) 492-3335 or jabel@hfma.org.
The Potential Importance of Worksheet S-10
By Daniel Schoenbaechler, CPA, CHFP

The Centers for Medicare & Medicaid Services (CMS) has made several changes to the Medicare cost report through the issuance of 2552-10. One particular worksheet that dramatically changed is worksheet S-10. This worksheet is now required for all acute care and critical access hospitals and is an auditable component of the Medicare cost report for fiscal years ending after May of 2011.

There are 3 major components of Worksheet S-10. These components include uncompensated care, charity care and bad debt. It is important for one to begin reviewing the requirements of worksheet S-10. It is essential that each hospital has existing processes in place that adequately capture all the necessary data requested on the new S-10.

The new worksheet S-10 has 31 lines. Unlike the former S-10 which only required completion of lines 17 - 32, all 31 lines of the new S-10 must be completed. While some of the 31 lines are automatic calculations, some lines require one to carefully gather data to calculate net revenues (actual payments received or expected to be received from payers including co-insurance payments from the patient) and charges from various sources. Line 2 for net revenue from Medicaid includes Medicaid inpatient and outpatient payments received or expected, SCHIP program expansion payments (recipients who would have been eligible under Title XIX), Medicaid managed care payments, and Medicaid Disproportionate Share (DSH) and supplemental payments (reported on either line 2 or 5). Line 6 for Medicaid charges should include all Medicaid covered charges from hospital records charges from all areas reported under Line 2. Line 9 for Net Revenue from stand-alone SCHIP includes SCHIP payments received or expected including Managed Care for covered services where recipient would NOT have been eligible under Title XIX. Payments for Physicians or other professional services should be excluded. Line 10 for stand-alone SCHIP Charges includes SCHIP gross charges for services under the definition for line 9. Lines 13 and 14 include net revenues (line 13) and charges (line 14) for other state and local indigent care programs other than Medicaid and SCHIP. The remaining lines request amounts relating to uncompensated care, charity care and bad debts.

Glenn Hackbarth, Chairman of Medicare Payment Advisory Commission (MedPAC), provides, “The revised form allows the separation of uncompensated care into charity care for the uninsured, charity care for the underinsured, and the cost of bad debts. This detailed level of information will be critical for evaluating policies that consider linking DSH payments to hospital’s uncompensated care costs, as well as analyses of the distribution of uncompensated care costs among hospitals. CMS has proposed requiring that all providers use the same cost-to-charge fields from their cost reports when computing the reported costs of charity care and bad debts. We agree that requiring a consistent methodology across hospitals is necessary to allow comparison of charity care costs across facilities. In addition, the use of a cost to charge ratio that reflects Medicare allowable costs provides the fairest and most consistent method for calculating patient care costs across facilities. This will make costs more comparable across facilities by removing some costs that hospitals incur that are not necessary for patient care such as interest expense that is offset by interest revenue. We fully support the changes (CMS has) made to the S-10.”

Continues on page 8
The calculation of your hospital’s DSH payments will change beginning in FFYE 2014. Even though CMS has not yet defined uncompensated care in the federal regulations, uncompensated care will likely be an important component of the DSH calculation and will certainly be used for the more recent Medicare incentive payments beginning in federal fiscal year 2011 for eligible acute care inpatient hospitals that are meaningful users of certified electronic health record (EHR) technology provided by the American Recovery and Reinvestment Act of 2009. At a recent session at the American Health Lawyers conference on Medicare and Medicaid Issues, members of CMS and the United States Department of Health and Human Services (HHS) would not commit that worksheet S-10 would be the sole source of calculating the uncompensated care portion of the 2014 DSH payments. Both CMS and HHS also provided they are currently reviewing comments from the provider community regarding this calculation and that it was too early to say what could and should be used. CMS also stated that they are aware of many different sources for uncompensated care and would need to evaluate each before any final determination is decided. The 2552-10 version of worksheet S-10 has changed from the previous year. These changes could impact the amount of uncompensated care applied to the new DSH calculation, as it is currently one of the controllable variables in future DSH calculations. Therefore, it is important to review this worksheet before submission.

As noted above, the worksheet S-10 reports the charity care provided by your hospital. Charity care is also a component of the Medicare Share, which is one of the three factors utilized in calculating Medicare hospital-based EHR incentive payment for eligible hospitals participating under both the Medicare fee for service and MA incentive programs.

Certified Healthcare Professional Examination
By Dan Schoenbaechler, CPA, CHFP

The CHFP exam is designed for mid-level healthcare finance professionals who aspire to the executive level or desire confirmation of financial management expertise in US healthcare. CHFP certification demonstrates your qualifications to senior management, co-workers, and the industry highlighting your commitment to the profession and to maintaining up-to-date skills and knowledge. One can register for the exam through the HFMA website at www.hfma.org. It is highly recommended to purchase the online study guide materials, also available on the HFMA website for $195. The study materials are only accessible online for one calendar year from the date of purchase.

The requirements to obtain CHFP designation include a minimum of three to five years of healthcare financial management experience, successful completion of the CHFP certification exam, and current and active regular or advanced HFMA membership.

The Kentucky chapter still provides 100% reimbursement for the cost of the examination ($395) and the online study guide upon successful completion of the exam.

Picture provided by: Steve Robinson, Controller, Ephraim McDowell Regional Medical Center

HFMA friends lined up with their cars at the Spring Institute Meeting in Lexington, KY on March 22 - 23.
From left to right:
Mercedes - Randy Shafer, Divisional President, First Source
Transam - Bobby Rumer, VP of Sales, Credit Solutions
Mustang - Bob Moreland, Blue & Co., LLC
Nissan 350Z - Theresa Scholl, Director, PFS at Clark Memorial Hospital
Camero - Bill Brown, Sales Consultant, Credit Adjustments, Inc.
The Spring Institute was held at the Embassy Suites in Lexington, KY on March 22 – 23. This conference was the inaugural provider appreciation event as registration fees were discounted 50% for all healthcare providers (excluding consultants and vendors). The keynote speaker on Thursday morning was Steve Gilliland, one of the most in-demand and top rated speakers in North America. Steve provided insight on how to open doors to success in our careers, relationships and lives.

The first breakout sessions on Thursday morning were provided by Regan Tankersley from Hall Render Killian Heath & Lyman and Andrew Grome and Justin Kubly from Harshaw Trane. Regan discussed when outpatient services are treated as inpatient services. Andrew and Justin discussed ways in which your facility’s infrastructure impacts the environment of care and financial performance. The second breakout session was provided by Dan Hobbs from Quorum Health Resources, Bill Leachman from BKD, and Patsy Schwenk from CGS Medicare Administrators. Dan discussed patient access processes and how those processes can improve your revenue cycle outcomes. Bill provided the audit and accounting update. Patsy provided an update on Medicare Part B.

Following lunch and the installation of the new officers for the Kentucky chapter of HFMA, Richard Cooper from McDonald Hopkins and James Nugent from Mesirow Financial Consulting provided strategies to turnaround financially distressed hospitals. The afternoon breakout sessions were provided by Dan Bergantz from PNC Healthcare, LeAnne Moran from East Alabama Medical Center, Bob Moreland from Blue & Co., Mark Guilfoyle from DBL Law, and Jill Hunter from the Cabinet for Health and Family Services. Dan and LeAnne provided more insight on the revenue cycle. Bob and Mark discussed hospital politics. Jill provided an important update on the Kentucky Medicaid managed care organizations.

Thursday’s final session was provided by Ed Klein and Paul Shoemaker from American Hospital Directory with a discussion on value based purchasing.

Friday’s sessions were provided by Jim Molpus of HealthLeaders Media, Jim Lester from RelayHealth, John Britt from Mountjoy Chilton Medley, LLP, and Tim Gritton from Securitas Security Services. Jim Molpus discussed leadership in healthcare. Jim Lester provided strategies for success in a 5010 world. John Britt provided instruction on disclosing your greatest assets. Tim Gritton concluded the conference with a discussion on the true cost of security in healthcare.
NEW MEMBERS

George E. Ellis-Griffith
Assistant Professor
Western Kentucky University

Rhonda Adams
Information Manager
King’s Daughters Medical Center

Natalie K. Erlenwein
Manager, Provider Finance
King’s Daughters Medical Center

Kerry Pappas
Consultant
BKD, LLP

Crystal R. Witkowski
Manager, Budget and Reimbursement
Methodist Hospital

Brian C. Hite
Director of Finance
Merit Health Systems

Brent Stice
Consultant
Humana

Walter E. Reed, IV
Internal Auditor
Norton Healthcare

Michael A. Shea
Cheryl Davidson
Manager
Central Kentucky Management Services

Kim Posadas
Manager
Central Kentucky Management Services

Charles A. Bohn
System VP, Chief HR Officer
Norton Healthcare

Amanda Jo Hall, CPA
Manager of Assurance Services
Dean Dorton Allen Ford, PLLC

Jodi Garrison, CPA
Supervisor of Assurance Services
Dean Dorton Allen Ford, PLLC

Richard Snapp, CFO
Nicholas County Hospital

Melissa M. Witt
Financial Analyst
Saint Joseph Health System

Darleen Poe
VP Financial Services
SNF Management

Jane McClelland
Revenue Cycle Educator
King’s Daughter Health System

Laura Werner
Catholic Health Initiatives

Kent Rowe
Vice President Sales
ZirMed

Heather Shults
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UHC Passport Health Plan

Lori Gondry
Finance Manager
Baptist Healthcare System

Mary Ann Hastings
Director, PFS
Ephraim McDowell Regional Medical Center

Michael Shoemaker
Director of Patient Registration
Highlands Regional Medical Center

Harrison White
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Amanda Ellis
Controller
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Financial Analyst
Owensboro Medical Health System

Ken Edwards
Senior Vice President of Operations
ZirMed

Lisa M. Parson
Client Support Manager
NPAS

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Charge Master Analyst
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Lisa Schwarz
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St. Elizabeth Medical Center

Stacey Huff, CPA
Mountjoy Chilton Medley LLP

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Adrian Tillman
Contract Analyst Managed Care
Norton healthcare

Stephen Yates
Sr. Reimbursement Analyst
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Kristi Edwards
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Timothy Kozeny
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Commerce Bank

Tim Jarm
President
Alliant Management

Zach Graham
Account Executive
Alliant Purchasing

Don A. Hartley
Accounts Payable Manager
Jewish Hospital & St. Mary’s Healthcare

Mark Finney
Director of Operations
NPAS

Megan Herde, CPA
Specialist in Assurance Services
Dean Dorton Allen Ford, PLLC

Julie A. Napper
Business Consultant
Humana
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2011 - 2012
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Clark Memorial Hospital

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Don Frank
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Jeanene Whittaker
Bottom Line Systems, Inc.

Treasurer
Kourtney Nett
Mountjoy Chilton Medley LLP

KHA Liaison
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EDITORIAL MISSION
The Financial Diagnosis supports the mission of the Kentucky Chapter by serving as a key source for individuals involving in or interested in the financial management of healthcare.

PUBLICATION OBJECTIVE
The Financial Diagnosis is the official publication of the Kentucky Chapter HFMA and is written and edited principally to provide members with information regarding Chapter and national activities, current and useful news of both national and local significance, information about seminars and conferences and networking with colleagues, and to serve as a forum for the exchange of ideas and information.

ARTICLE SUBMISSION
The Financial Diagnosis encourages submission of material for publication. Articles should be typewritten and submitted electronically to the Editor by the deadlines listed below. The Editor reserves the right to edit, accept or reject materials whether solicited or not.

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