

APPROVED BY THE FACULTY OF HEALTH CARE ACTIVITIES
ARMY

A STUDY TO EVALUATE THE EXTENT
OF INSTITUTIONAL PLANNING BEING
ACCOMPLISHED BY HEALTH CARE ACTIVITIES
WITHIN THE ALAMO AREA PLANNING REGION

APPROVED BY THE THESIS COMMITTEE:

A Problem Solving Thesis

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Hospital Administration

APPROVED BY THE GRADUATE COUNCIL:

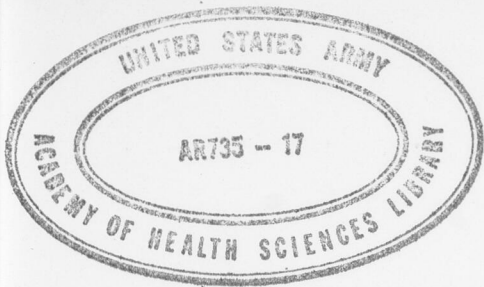
by

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DATE: August 16, 1975

August 1975



ACKNOWLEDGEMENTS

APPROVED BY THE ACADEMY OF HEALTH SCIENCES, U.S. ARMY:

The writer wishes to acknowledge the assistance provided by the Health Planning unit of the Academy of Health Sciences, and, in particular, to the Director of Health Planning, Mr. Don Dietz, and to his Associate, Mr. Gene Shannahan. They

Donald P. Callaghan
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APPROVED BY THE THESIS COMMITTEE:

painstakingly condensed years of comprehensive health planning history and experience into a crash course. Their patience and total commitment to the project to its accomplishment. A special thanks is extended to Mr. Bruce Sorenson and Dr. Ruskin C. Norman for their invaluable advice and recommendations concerning the design and content of the survey questionnaire used to provide a data base for this study. And, finally, a sincere "Thank you" to my wife, Lela, for her support and assistance throughout the many weeks of this project. No one else, was responsible for seeing it through to its successful conclusion.

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And, finally, a sincere "Thank you" to my wife, Lela, for her support and assistance throughout the many weeks of this project. No one else, was responsible for seeing it through to its successful conclusion.

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DATE: August 16, 1975

ACKNOWLEDGEMENTS

The writer wishes to acknowledge the support and assistance provided by the members of the Comprehensive Health Planning unit of the Alamo Area Council of Governments; and, in particular, to the Director of Health Planning, Mr. Don Dietz, and to his Associate, Mr. Gene Shannahan. They painstakingly condensed years of comprehensive health planning history and experience into a short, meaningful, two-week crash course. Their patience, encouragement, suggestions, and total commitment to the project contributed significantly to its accomplishment. A special note of thanks is extended to Mr. Bruce Sorenson and Dr. Ruskin C. Norman for their invaluable advice and recommendations concerning the design and content of the survey questionnaire used to provide a data base for this study. And, finally, a sincere "Thank you" to my wife, Lela, for her continued support and optimism throughout the many weeks of this study. She, more than anyone else, was responsible for seeing it through to its successful conclusion.

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In hearings that were held prior to passage of United States Public Law 92-603, the Senate Committee on Finance concluded that, contrary to sound business practices, health care facilities often did not prepare detailed budgets and operating plans.² This deficiency led to many management inefficiencies that were incompatible with the responsibilities owed to the patients treated by the facilities and the

CHAPTER I

INTRODUCTION

General Information

The delivery of quality health care is dependent upon a vast array of professional services, institutions, allied health organizations and agencies, educational programs, research activities, and community health projects. Every component of the delivery system is comprised of many individual elements and organizational entities. Supporting each one is a financial structure which is usually made up of multiple sources of funding with a variety of control and procedural requirements. In order to profitably optimize both the quality of health care provided and the utilization of the funding obtained, it should be incumbent upon all health care institutions to adequately plan and budget for their financial needs.¹

In hearings that were held prior to passage of United States Public Law 92-603, the Senate Committee on Finance concluded that, contrary to sound business practices, health care facilities often did not prepare detailed budgets and operating plans.² This deficiency led to many management inefficiencies that were incompatible with the responsibilities owed to the patients treated by the facilities and the

agencies and individuals who provided the monies for the treatment.

The recognition by the Senate Committee on Finance of the relative lack of planning and budgeting by health care facilities was not unique. This fact had been noted, but had been virtually ignored for many years. One aspect of the eleemosynary sector, into which most health care facilities fall, had been that you could not account for the cost of services provided. You could not because the value of the services was thought to be qualitative and intangible. In addition, you did not need to because funds were provided by gifts, grants, endowments, and other benefactors or payers who seldom inquired about where their money ever was applied. For the past several years, however, this approach has been increasingly called into question. The desire for cost information and accountability has grown with the advent of more and more governmental health programs and the increased use of private health insurers.³

Events Leading to the Problem

On October 17, 1972, the Social Security Amendments of 1972 were passed by Congress as Public Law 92-603. Section 234 of that Public Law stated that in order for health care institutions to qualify for reimbursement under Medicare they

must have an overall plan and budget in effect.⁴ For the first time, institutions participating in Medicare were required to show evidence of some sort of fiscal planning. This evidence was the existence of both operating budgets and capital expenditures plans.⁵ The complete text of Section 234 is contained in Appendix B.

Section 234 was the first concrete indication of Congress' concern with the planning and budgeting efforts being accomplished by individual health care institutions. Although it specifically prohibited review of the plan's substance by the Government or any of its agents, it did provide the mechanism for denying payment of Medicare reimbursements if an institution did not possess a planning and budgeting document, regardless of its content. This initial step alerted the health care industry of the need for it to begin planning in earnest and not to be too surprised if, at some later date, provisions were made for outside review of its efforts. This legislation was also viewed as a move by the Federal Government towards the establishment of realistic rates for Medicare reimbursements rather than to continue to rely upon the method of payment for costs which were incurred.⁶

The comprehensive health planning staff of the Alamo Area Council of Governments (AACOG) became increasingly

concerned with the implications that Section 234 might have for the health care institutions within their service region. The wide disparity in size and staffing of the various institutions seemed to indicate varying degrees of capabilities for complying with the planning provisions. Since the responsibilities of an areawide planning agency include assisting the institutions in its area "in organizing their own internal planning units and developing the process of planning to meet community health needs,"⁷ AACOG was interested in providing whatever assistance was needed. They wanted to assure, however, that the assistance given was both necessary and directed towards those institutions requiring it. These considerations, therefore, prompted this study. Any assistance efforts which might result from needs identified by the study would have the practical effect of improving data input to AACOG for inclusion in comprehensive health planning. This would then lead to the ultimate aim of improving the delivery of health care throughout the Alamo Area Planning Region served by the AACOG.

Footnotes

¹American Hospital Association, Statement on the Financial Requirements of Health Care Institutions and Services (Chicago: American Hospital Association, 1969), p. 1.

²U.S., Congress, Senate, Committee on Finance, Social

Security Amendments of 1972, S. Rept. 92-1230, 92nd Cong., 2d sess., 1972, To Accompany H.R. 1, p. 204.

³Roderick K. Macleod, "Program Budgeting Works in Non-profit Institutions," Harvard Business Review, September-October 1971, p. 46.

⁴Social Security Amendments of 1972, Statutes at Large, LXXXVI, sec. 1329, 85 (1972), U.S. Code, Vol. XLII, sec. 1395x (1973).

⁵American Nursing Home Association, An Analysis and Partial Legislative History of Title II of Public Law 92-603 (H.R. 1) "The Social Security Amendments of 1972" (Washington, D.C.: American Nursing Home Association, 1973), pp. 82-83.

⁶Roger Witalis, "The State of the Budgeting Art: Survey Shows Many Hospitals are not Prepared to Comply with the Law," Modern Hospital, CXXI (December, 1973), 53-6.

⁷American Hospital Association, Financial Requirements, p. 26.

Limitations

The following factors represent limitations or obstacles for the execution of this study:

CHAPTER II

THE PROBLEM

Statement of the Problem

The problem is to evaluate the extent of institutional planning being accomplished by health care activities within the Alamo Area Planning Region.

Objectives

In order to solve the problem addressed by this study, the following objectives must be met:

1. Determine the type of institutional planning that should be performed by health care activities.
2. Ascertain the amount of institutional planning being accomplished by the health care activities within the Alamo Area Planning Region.
3. Evaluate the deviations found between the existing institutional planning and that which should be done.
4. Recommend actions that should be taken to alleviate any deficiencies in planning which are found.

Limitations

The following factors represent limitations or obstacles for the execution of this study:

Assumptions

The following assumptions were made for this study:

1. The subjects of this study included ninety-six institutions in an area of over 11,000 square miles. The time and geographical limitations presented by this large target area precluded on-site survey of every activity; therefore, a questionnaire was used to gather the required information.

2. In order to be compatible with the scope of Section 234 of Public Law 92-603, this study was limited to short-term, acute care hospitals; extended care facilities; and home health agencies. Nursing homes were included in the definition of extended care facilities.

3. The questions regarding the type and degree of planning and budgeting being accomplished by individual institutions were potentially embarrassing, especially for those who were not doing these more fundamental management functions. In order to encourage participation, the constraint of anonymity for all respondents was imposed.

4. The lack of established national standards for health care institutional planning resulted in the criteria for such planning being limited to the requirements stated in Section 234 of Public Law 92-603. This limitation was due to the fact that the Section 234 requirements constituted the only nationally recognized, legislated standards in existence.

Assumptions

The following assumptions were made for this study:

1. The requirements for institutional planning contained in Section 234 of Public Law 92-603 represented the most acceptable set of criteria for evaluating the extent of such planning in the Alamo Area Planning Region. The acceptability of the Section 234 criteria was due to the absence of national standards for the type and degree of planning that health care institutions should accomplish and the broad application of Section 234 guidelines to the many health care activities that receive reimbursement under Medicare.

2. The respondents to the questionnaire used in this study were assumed to be representative of the health care institutions in the region. Although there were a large number of participants in the survey, it was not possible to prove that they were completely representative of the entire population. There were many unknown variable relationships which prevented an objective, statistically accurate determination.

Review of the Literature

Although many accounting, budgeting, and financial management texts stress the need for institutions to plan and budget for the future, there have been few attempts to determine how much of such planning is actually being done by health care activities. In 1973, Roger Witalis reported the results of a survey he made of the short-term, acute care general hospitals

on the Modern Hospital circulation list. Of an unspecified number of questionnaires sent out, there were 1500 replies, of which 1140 were determined to be qualified for inclusion in the study. Two of the observations made by Witalis, based upon the answers to his survey, were:

1. Although 85 per cent of the respondent hospitals perform some form of budgeting, fewer than 50 per cent prepare capital budgets, a specific requirement of the law.
2. Fewer than 40 per cent of the hospital respondents directly involve the medical staff or governing board in the preparation₁ of budgets, another specific requirement of P.L. 92-603.¹

This relative lack of definitive studies in the area of health care institutional planning was added impetus for the need of such a study for the Alamo Area Planning Region. The study was viewed as an essential prelude to any assistance efforts, because of the uncertainty regarding demonstrated need. Witalis' study may indicate that the uncertainty of need and lack of information shield a probable deficiency in planning.

Criteria for Institutional Planning

The Statement on the Financial Requirements of Health Care Institutions and Services, published by the American Hospital Association, sets forth guidelines for a program to overcome many of the financial shortcomings which have plagued health care institutions for many years.² Other publications of the American Hospital Association, such as Budgeting Proce-

dures for Hospitals³ and Chart of Accounts for Hospitals,⁴ provide additional guidance for implementing and upgrading institutional planning programs. However, the most concise and comprehensive criteria for determining whether an institution has a minimally acceptable program were expressed in Section 234 of Public Law 92-603. The Section 234 requirements were consistent with the various recommendations by the American Hospital Association literature and did not contradict any of them. These criteria were selected, therefore, for use by this study in determining the adequacy of institutional planning being accomplished by health care activities in the Alamo Area Planning Region. The selected criteria were considered to be essential components of a viable planning program.

According to Section 234, institutional planning of a hospital, extended care facility, or home health agency should consist of an overall plan and budget which:

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget, an item-by-item identification of the components of each type of anticipated expenditure of income);

(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of \$100,000 related

to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(3) provides for review and updating at least annually; and

(4) is prepared, under direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.⁵

For the purposes of this study, the "generally accepted accounting principles" referred to in Section 234 were taken to be those accepted by the American Hospital Association (AHA). This was done because of two factors: all of the hospitals surveyed and four of the extended care facilities surveyed are registered with the AHA, and the principles accepted by the AHA are representative of those contained in other financial publications. The AHA considers expenses as being expired costs; that is, costs that have been used or consumed in carrying on some activity and have no benefit which will extend beyond the present.⁶ Income is usually considered as being simply the excess of revenues over expenses; however, in the context of Section 234, income is used as a synonym for revenue. Hospital revenue consists mainly of the value of all hospital services rendered to patients, regardless of the amounts actually paid to the hospital by or on behalf of patients. Revenues may also arise from sources not directly associated with patient care.⁷

And, finally, capital items are defined as being those items whose useful life exceeds the current operating year; however, the determination of exactly what should fall into this category is best resolved on a practical rather than a theoretical basis. No single standard for capital items, in terms of dollars or useful life, can be applied to all hospitals. Each should develop realistic standards based upon its own experience and then follow them consistently.⁸

The foregoing criteria from Section 234 of Public Law 92-603, with the inclusion of the generally accepted accounting principles from the AHA, were used in this study as the bases for evaluating the extent of institutional planning within the Alamo Area Planning Region.

Problem-Solving Methodology

The methodology followed for this problem-solving study began with a general review of the literature pertaining to the types of budgeting and planning that should be performed by health care activities. This review resulted in the establishment of a set of criteria for use in evaluating the institutional planning being done within the Alamo Area Planning Region.

Measurement of the planning actually accomplished was achieved by comparing the responses to a questionnaire with the predetermined criteria. The questionnaire was designed in

accordance with the criteria and recommendations contained in the book, Questionnaire Design and Attitude Measurement, by Abraham Neftali Oppenheim.⁹ Before the questionnaire was sent to the institutions to be surveyed, it was discussed with Dr. Ruskin C. Norman, owner and operator of a number of nursing homes in San Antonio and a member of the Health Coordinating Committee of the AACOG, and Mr. Bruce D. Sorenson, Administrator of the Southwest Texas Methodist Hospital in San Antonio and also a member of the Health Coordinating Committee. Their suggestions, from the point of view of both prospective questionnaire recipients and concerned regional planners, were used to modify the questionnaire to assure its understanding and acceptance.

The final revised questionnaire was submitted to thirty-two short-term, acute care, general hospitals; sixty-one extended care facilities; and three home health agencies. The returned questionnaires were reviewed and the responses extracted and tabulated. The results were then analyzed and compared with the criteria for institutional planning which had been established earlier in the study process. Deficiencies were identified and recommendations for resolving them were developed. These recommendations were based upon a thorough study of the identified needs, existing capabilities of the Alamo Area Council of Governments, and methods suggested in

planning and financial literature.

Footnotes

- ¹Witalis, "The State of the Budgeting Art," 56.
- ²American Hospital Association, Financial Requirements, p. iii.
- ³American Hospital Association, Budgeting Procedures for Hospitals (Chicago: American Hospital Association, 1971).
- ⁴American Hospital Association, Chart of Accounts for Hospitals (Chicago: American Hospital Association, 1966).
- ⁵Social Security Ammendments of 1972, Statutes at Large, LXXXVI, sec. 1329, 85 (1972), U.S. Code, Vol. XLII, sec. 1395x (1973).
- ⁶American Hospital Association, Chart of Accounts, p. 21.
- ⁷Ibid., p. 18.
- ⁸Ibid., p. 22.
- ⁹Abraham Naftali Oppenheim, Questionnaire Design and Attitude Measurement (New York: Basic Books, 1966).

The Alamo Area Council of Governments (AACOG) was formed in 1967 by the many local governments in the Alamo Area Planning Region to effect a joint effort in planning. In accordance with state legislation, membership in AACOG by any governmental unit is strictly voluntary; policies of the Council are established by the elected officials who represent the member governments; and, AACOG has no authority

CHAPTER III

DISCUSSION

The Alamo Area Planning Region

The Alamo Area Planning Region is one of twenty-four such areas in Texas which have been designated by the State as "regional communities." It was established as a means of providing a form of governmental unity for the diverse activities within the region. The Alamo Area consists of twelve counties, covering over 11,000 square miles. The counties in this "regional community" are Atascosa, Bandera, Bexar, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, Medina, and Wilson. A map of the region is contained in Appendix C. The major metropolitan center of the region is Bexar County and its largest city is San Antonio; but, there is close interaction between all twelve counties and the residents of the entire region.¹

The Alamo Area Council of Governments (AACOG) was formed in 1967 by the many local governments in the Alamo Area Planning Region to effect a joint effort in planning. In accordance with state legislation, membership in AACOG by any governmental unit is strictly voluntary; policies of the Council are established by the elected officials who represent the member governments; and, AACOG has no authority

to levy taxes, pass ordinances, or otherwise regulate the governments in dealing with their own constituencies. The Council does provide the only organization, open to all units of government in the twelve counties, which is dedicated to the mission of program coordination and development. It strengthens local governments and involves the citizenry by providing a continuing forum for areawide communications, planning, policy-making, and coordination.²

The federal and state governments have designated the AACOG as the regional "clearinghouse" for coordinating all of the planning and development activities with regional implications. This includes serving as the areawide planning agency in accordance with Section 314(b) of the Public Health Service Act³ and functioning as the review and comment authority stipulated by the Office of Management and Budget Circular Number A-95.⁴ Health Planning within the AACOG is accomplished through the Health Coordinating Committee, a voluntary advisory group comprised of both providers and consumers of health care. This committee is supported by the AACOG's full-time, paid Comprehensive Health Planning Staff, consisting of four professional health planners and other support personnel.

The AACOG plays an important role in bringing doctors, nurses, dentists, hospital administrators and others who provide health services together with consumers of these services,

so that each can become aware of the problems of the other. Through this mutual exchange of ideas, plans are developed to bridge the gaps in the health delivery system. In addition to this exchange of ideas, the AACOG also serves as a center for information concerning manpower, health facilities, health transportation, and other related areas. To this end, the AACOG is charged with the responsibility of assisting the health care activities within the region to assure the effective interrelationship between their planning efforts and those of the Council.⁵

The responsibility for coordinating and advising the individual medical activities within the region on their institutional planning programs caused the AACOG staff to become interested in the provisions of Section 234 of Public Law 92-603. Before coordination and assistance could be provided, however, the need for such help had to be determined. This need led to the request for this study.

Survey of Institutions

There are a total of ninety-six health care activities in the Alamo Area Planning Region which fall within the scope of this study. The questionnaire method of survey was selected as the most appropriate for use in determining the type and degree of planning being done by these activities. The

TYPE OF INSTITUTION	NUMBER OF INSTITUTIONS	PERCENTAGE
Total	96	48%

questionnaire was designed to evaluate whether or not institutional planning was being accomplished, and if so, the extent to which it was being done.

With the increased interest and involvement of outside agencies, all health care institutions have been besieged with surveys, reporting requirements, and various other queries, each of which requires time and effort to answer.⁶ In order to encourage replies, therefore, everything possible was done to make the questionnaire easy for the addressees to complete and return. Most questions required only a simple yes or no answer; only eighteen questions were asked; and a stamped, self-addressed return envelope was provided. The complete questionnaire is contained in Appendix D.

The following Table shows a comparison between the number of questionnaires sent out and the number returned:

TABLE 1

SURVEY RESPONSE BY TYPE OF INSTITUTION

TYPE OF INSTITUTION	QUESTIONNAIRES MAILED	REPLIES RECEIVED	RATE OF REPLY
Hospitals	32	22	69%
Extended Care Facil.	61	23	38%
Home Health Agencies	3	1	33%
Total	96	46	48%

Survey Findings

The results obtained from the questionnaires returned by participating health care institutions are shown on Tables 2 through 9. Generally, these results showed a relative lack of compliance by Alamo Area health care activities with the basic requirements for institutional planning. Of the forty-six responding institutions, only fourteen satisfied all four of the necessary criteria elements. This tendency was also true for the twenty-four responding institutions who participate with Medicare. Even though Section 234 of Public Law 92-603 states that these institutions must have overall plans and budgets in order to qualify for reimbursement, only eleven of them had the minimum prerequisites.

Hospitals exhibited considerably more planning efforts than extended care facilities. Eleven out of twenty-two hospitals met the minimally acceptable standards, as opposed to three out of twenty-three extended care facilities. But, even the 50 per cent compliance rate for hospitals was totally unsatisfactory, as would be anything less than complete compliance. Institutional planning is essential for effective decision making and improved patient care. Such planning is also mandatory for reimbursement under Medicare. It also provides accurate, constructive input to the areawide planning efforts of

TABLE 2

INSTITUTIONAL PLANNING BY TYPE OF INSTITUTION

TYPE OF INSTITUTION	NUMBER OF RESPONDENTS	NUMBER WHO:								NUMBER WHO SATISFY ALL CRITERIA	
		HAVE A BUDGET PROGRAM		HAVE A CAPITAL EXPENDITURE PLAN		HAVE A BUDGET COMMITTEE		HAVE ANNUAL REVIEWS			
			%		%		%		%		
Hospitals	22	18	82	15 ^a	68	17	77	18	82	11	50
Extended Care Facil.	23	13	57	7 ^b	30	7	30	12	52	3	13
Home Health Agencies	1	1	100	0	0	1	100	1	100	0	0
Total	46	32	70	22	48	25	54	31	67	14	30

^aFour of the fifteen hospitals plan capital expenditures for one year only.

^bThree of the seven extended care facilities plan capital expenditures for one year only.

TABLE 3

INSTITUTIONAL PLANNING BY MEDICARE PARTICIPANTS

TYPE OF INSTITUTION	NUMBER OF RESPONDENTS/ NUMBER WHO ARE MEDICARE PARTICIPANTS	NUMBER WHO:								NUMBER WHO SATISFY ALL CRITERIA	
		HAVE A BUDGET PROGRAM		HAVE A CAPITAL EXPENDITURE PLAN		HAVE A BUDGET COMMITTEE		HAVE ANNUAL REVIEWS			
			%		%		%		%		%
Hospitals.	22 / 18 ^a	14	78	12 ^b	67	13	72	14	78	9	50
Extended Care Facil. .	23 / 6	5	83	2	33	3	50	4	67	2	33
Home Health Agencies .	1 / 0	-		-		-		-		-	
Total	46 / 24	19	79	14	58	16	67	18	75	11	46

^aAll four of the responding hospitals that did not participate in Medicare were government operated.

^bThree of these twelve hospitals plan capital expenditures for one year only.

^cThis one hospital had a capital expenditures plan for one year only.

^dOne of these two hospitals plans capital expenditures for one year only.

^eTwo of these five hospitals plan capital expenditures for one year only.

TABLE 4

HOSPITALS' INSTITUTIONAL PLANNING BY SIZE OF FACILITY

NUMBER OF BEDS	NUMBER OF RESPONDENTS	NUMBER WHO:								NUMBER WHO SATISFY ALL CRITERIA	
		HAVE A BUDGET PROGRAM		HAVE A CAPITAL EXPENDITURE PLAN		HAVE A BUDGET COMMITTEE		HAVE ANNUAL REVIEWS			
			%		%		%		%		%
1 - 50 Less than \$500,000	6	3	50	1 ^a	16	2	33	3	50	0	0
50 - 100 \$500,000-2,500,000	3	2	67	2 ^b	67	2	67	2	67	1	33
100 - 250 \$2,500,000-10,000,000	1	1	100	1	100	1	100	1	100	1	100
250 - 500 Over \$10,000,000	5	5	100	5 ^c	100	5	100	5	100	3	60
Over 500	7	7	100	6	86	7	100	7	100	6	86
Total	22	18	82	15	68	17	77	18	82	11	50

^aTwo of these four hospitals plan capital expenditures for one year only.

^aThis one hospital had a capital expenditures plan for one year only.

^bOne of these two hospitals plans capital expenditures for one year only.

^cTwo of these five hospitals plan capital expenditures for one year only.

TABLE 5

HOSPITALS' INSTITUTIONAL PLANNING BY SIZE OF ANNUAL OPERATING BUDGET

SIZE OF BUDGET	NUMBER OF RESPONDENTS	NUMBER WHO:								NUMBER WHO SATISFY ALL CRITERIA	
		HAVE A BUDGET PROGRAM		HAVE A CAPITAL EXPENDITURE PLAN		HAVE A BUDGET COMMITTEE		HAVE ANNUAL REVIEWS			
			%		%		%		%		%
Less than \$500,000	5	2	40	0	0	1	20	2	40	0	0
\$500,000-2,500,000	5	4	80	4 ^a	80	4	80	4	80	2	40
\$2,500,000-10,000,000	3	3	100	3 ^b	100	3	100	3	100	2	67
Over \$10,000,000	9	9	100	8 ^c	89	9	100	9	100	7	78
Total	22	18	82	15	68	17	77	18	82	11	50

^aTwo of these four hospitals plan capital expenditures for one year only.

^bOne of these three hospitals plans capital expenditures for one year only.

^cOne of these eight hospitals plans capital expenditures for one year only.

TABLE 6

HOSPITALS' INSTITUTIONAL PLANNING BY SOURCE OF OPERATING CONTROL

OPERATING CONTROL	NUMBER OF RESPONDENTS	NUMBER WHO:								NUMBER WHO SATISFY ALL CRITERIA	
		HAVE A BUDGET PROGRAM		HAVE A CAPITAL EXPENDITURE PLAN		HAVE A BUDGET COMMITTEE		HAVE ANNUAL REVIEWS			
			%		%		%		%		%
Government	7	6	86	5 ^a	71	6	86	6	86	2	29
Church	5	5	100	4	80	4	80	5	100	4	80
Not-For-Profit Corp.	5	4	80	4 ^b	80	4	80	4	80	3	60
For-Profit Corp.	3	3	100	2	67	3	100	3	100	2	67
Private Ownership	2	0	0	0	0	0	0	0	0	0	0
Total	22	18	82	15	68	17	77	18	82	11	50

^aThree of these five hospitals plan capital expenditures for one year only.

^bOne of these four hospitals plans capital expenditures for one year only.

TABLE 7

EXTENDED CARE FACILITIES' INSTITUTIONAL PLANNING BY SIZE OF FACILITY

NUMBER OF BEDS	NUMBER OF RESPONDENTS	NUMBER WHO:								NUMBER WHO SATISFY ALL CRITERIA	
		HAVE A BUDGET PROGRAM		HAVE A CAPITAL EXPENDITURE PLAN		HAVE A BUDGET COMMITTEE		HAVE ANNUAL REVIEWS			
			%		%		%		%		%
Less 1 - 50,000	6	4	67	1	16	1	16	3	50	0	0
\$500 50 - 100,000	7	1	14	1 ^a	14	0	0	1	14	0	0
\$2, 100 - 250,000,000	9	7	78	5 ^b	56	5	56	7	78	3	33
Over 250 - 500,000	1	1	100	0	0	1	100	1	100	0	0
Over 500	0	-	-	-	-	-	-	-	-	-	-
Total	23	13	57	7	30	7	30	12	52	3	13

25

^aThis one extended care facility plans capital expenditures for one year only.

^bTwo of these five extended care facilities plan capital expenditures for one year only.

TABLE 8

EXTENDED CARE FACILITIES' INSTITUTIONAL PLANNING BY SIZE OF ANNUAL OPERATING BUDGET

SIZE OF BUDGET	NUMBER OF RESPONDENTS	NUMBER WHO:								NUMBER WHO SATISFY ALL CRITERIA	
		HAVE A BUDGET PROGRAM		HAVE A CAPITAL EXPENDITURE PLAN		HAVE A BUDGET COMMITTEE		HAVE ANNUAL REVIEWS			
			%		%		%		%		%
Less than \$500,000	13	5	38	2 ^a	15	1	8	4	31	0	0
\$500,000-2,500,000	10	8	80	5 ^b	50	6	60	8	80	3	30
\$2,500,000-10,000,000	0	-	50	-	0	-	50	-	50	0	0
Over \$10,000,000	0	-	67	-	44	-	33	-	67	2	2
Total	23	13	57	7	30	7	30	12	52	3	13

^aOne of these two extended care facilities plans capital expenditures for one year only.

^bTwo of these five extended care facilities plan capital expenditures for one year only.

^cOne of these two extended care facilities plans capital expenditures for one year only.

TABLE 9

EXTENDED CARE FACILITIES' INSTITUTIONAL PLANNING BY SOURCE OF OPERATING CONTROL

OPERATING CONTROL	NUMBER OF RESPONDENTS	NUMBER WHO:								NUMBER WHO SATISFY ALL CRITERIA	
		HAVE A BUDGET PROGRAM		HAVE A CAPITAL EXPENDITURE PLAN		HAVE A BUDGET COMMITTEE		HAVE ANNUAL REVIEWS			
			%		%		%		%		
Government	0	-		-		-		-		-	
Church	3	3	100	1	33	3	100	3	100	1	33
Not-For-Profit Corp.	2	1	50	0	0	1	50	1	50	0	0
For-Profit Corp.	9	6	67	4 ^a	44	3	33	6	67	2	22
Private Ownership	9	3	33	2 ^b	22	0	0	2	22	0	0
Total	23	13	57	7	30	7	30	12	52	3	13

^aTwo of these four extended care facilities plan capital expenditures for one year only.

^bOne of these two extended care facilities plans capital expenditures for one year only.

the AACOG. All of these factors lead to the conclusion that institutional planning efforts are deficient and will remain so until all institutions meet the requirements established by this study.

No valid conclusions could be drawn regarding the institutional planning efforts of home health agencies, since there was only one respondent out of the three that were surveyed. The agency that did respond was a not-for-profit corporation with an annual operating budget of less than \$500,000. The respondent reported that it had a budget program, a budget committee, and an annual review; however, it had no capital expenditures plan.

More detailed analysis of the survey responses revealed additional disparities between the planning being accomplished and that which should be done. One deficiency was noted in the number and types of budgets prepared. The term "operating budget" normally refers to "three separate parts of the overall plan: (1) the statistics budget; (2) the expense budget; and (3) the revenue budget."⁸ In addition, a cash budget should be prepared as a summarization of expected cash receipts and expenditures for cash planning and control.⁹ Table 10 shows the types of budgets being prepared by the thirty-two institutions which indicated on the questionnaire that they had a formal budget program. Of the thirty-two, only nineteen

TABLE 10

DETAILED BUDGETS PREPARED BY TYPE OF INSTITUTION

TYPE OF INSTITUTION	NUMBER WITH A FORMAL BUDGET PROGRAM	NUMBER WHO:								NUMBER WHO PREPARE ALL BUDGETS	
		PREPARE A STATISTICAL BUDGET		PREPARE AN EXPENSE BUDGET		PREPARE A REVENUE BUDGET		PREPARE A CASH BUDGET			
			%		%		%		%		%
Hospitals	18	15	83	18	100	16	89	13	72	12	67
Extended Care Fac. . . .	12 ^a	7	58	12	100	11	92	7	58	7	58
Home Health Agencies . .	1	0	0	1	100	0	0	1	100	0	0
Total	31	22	71	31	100	27	87	21	68	19	61

^aThirteen extended care facilities have a formal budget program, but one of them neglected to identify what detailed budgets were prepared.

prepared all four of the detailed budgets. Of the others, twelve prepared expense budgets but did not make full use of the other budgeting tools available. The thirteenth failed to identify what detailed budgets it prepared. The twelve which did not utilize all four budgets failed to realize that expenses are not the sole concern. They also must be interested in the volume of services to be provided, the revenues generated from these services, and their ability to meet cash payment requirements. To do less than this severely limits the effectiveness of any formal budget program.¹⁰

Another measure of effectiveness of the planning process is how closely the capital expenditures plan is followed. Since these types of plans entail large commitments of funds and their impact extends over relatively long periods of time, they should be carefully developed based upon thorough analysis and planning. Inadequate managerial attention to capital additions may cause either overinvestment or underinvestment of resources. Mismanagement of resources could result in a subsequent deterioration of the institution's quality of patient care.¹¹

As shown in detail on Table 11, this study measured the adherence to established capital expenditures plans by responding institutions in two ways: the percentage of items

TABLE 11
EFFECTIVENESS OF CAPITAL EXPENDITURES PLANS

TYPE OF INSTITUTION	NUMBER WITH A CAPITAL EXPENDITURE PLAN	ITEMS OUT OF PRIORITY SEQUENCE:				ITEMS NOT ON CAPITAL EXPENDITURES PLAN:			
		00-10 %	10-25 %	25-50 %	Over 50%	00-10 %	10-25 %	25-50 %	Over 50%
Hospitals	13 ^a	8	4	1	0	10	3	0	0
Extended Care Facil.	7 ^b	4	1	1	1	4	2	0	0
Home Health Agencies	0	-	-	-	-	-	-	-	-
Total	20	12	5	2	1	14	5	0	0

^aOut of fifteen institutions with capital expenditures plans, only thirteen answered the questions which pertained to this analysis.

^bOne of the seven extended care facilities with capital expenditures plans failed to answer the question regarding the procurement of items not on the plan.

produced out of the priority sequence included in the plan and the percentage of capital items purchased which never even appeared in the plan. Of the twenty institutions which have capital expenditures plans, eight procure more than 10 per cent of the items out of their predetermined priority sequence. For five of the institutions, more than 10 per cent of the capital items purchased never appeared on their plan. This significant nonadherence to supposedly well developed capital expenditures plans raises many questions about the validity and usefulness of the plans as tools for managerial action.

All of the results of the survey conducted for this study showed an overall deficiency in institutional planning by the responding activities. Generally, hospitals did a great deal more planning than did extended care facilities. Although no category of institution satisfied all of the minimally accepted standards for institutional planning, the hospitals with over five hundred beds or budgets in excess of ten million dollars had a much greater percentage of compliance. This study showed that all three types of institutions, hospitals, extended care facilities, and home health agencies, are prime targets for assistance by the comprehensive health planning staff of AACOG. These assistance efforts could either be educational or informational.

Footnotes

¹Alamo Area Council of Governments, "General Information," undated informational brochure.

²Ibid.

³U.S., Senate, Committee on Labor and Public Welfare, and House, Committee on Interstate and Foreign Commerce, Compilation of Selected Public Health Laws (Washington, D.C.: Government Printing Office, 1969), p. 45.

⁴Office of Management and Budget, Evaluation, Review and Coordination of Federal and Federally Assisted Programs and Projects, Circular Number A-95 (revised) (November 13, 1973), p. 1.

⁵Alamo Area Council of Governments, A Blueprint for Health (San Antonio: Alamo Area Council of Governments, 1973), pp. 5,6.

⁶Personal interview with Bruce D. Sorenson, Administrator of the Southwest Texas Methodist Hospital, San Antonio, Texas, March 11, 1974.

⁷Block, McGibony + Associates, Inc., The Comprehensive Health Plan (Silver Spring, Md.: Block McGibony + Associates, Inc., November 1972), p. 4.

⁸American Hospital Association, Budgeting Procedures for Hospitals (Chicago: American Hospital Association, 1971), p. 1.

⁹Ibid.

¹⁰Ibid.

¹¹Glenn A. Welsch, Budgeting: Profit Planning and Control (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1971), p. 362.

CHAPTER IV

CONCLUSION

Summary

An essential ingredient for effective areawide comprehensive health planning is the knowledge of the extent of planning being accomplished by the individual health care institutions within the service region. The Alamo Area Council of Governments (AACOG) recognized this need and requested that such a determination be made for the Alamo Area Planning Region. The design, execution, analysis, and evaluation of the resultant study have been presented in earlier chapters. This summary will highlight the major findings of the study in view of its established objectives, limitations, and assumptions.

The term "institutional planning" has a variety of meanings, most of which involve a description of optimum budgeting and planning programs. The only definition pertaining to health care institutions with the force of law behind it is the one contained in Section 234 of Public Law 92-603. Due to its legal applications for institutions which receive reimbursement under Medicare and because its criteria are fair representations of the many other definitions available, Section 234 was used as the basis for evaluation in

this study. Generally, the criteria encompasses four basic requirements: (1) an overall operating budget; (2) a capital expenditures plan; (3) use of a budget committee; and (4) an annual review. An acceptable institutional planning program must include all four components.

A questionnaire was used to collect the information from the institutions in the Alamo Area Planning Region. Of the ninety-six questionnaires sent out, forty-six were returned.

Of the forty-six participants in the survey, only fourteen, or 30 per cent, satisfied all four of the established criteria elements. The most predominant deficiency was the lack of a capital expenditures plan. Hospitals satisfied the requirements more than extended care facilities or home health agencies. Of the twenty-two responding hospitals, eleven fulfilled all of the basic requirements, while only three out of the twenty-three extended care facilities were in compliance. The only responding home health agency, out of three to which questionnaires were mailed, also did not meet the criteria. In all three cases, however, the number of institutions with even minimally acceptable budgeting and planning programs was considered to be unsatisfactory. The importance of institutional planning as a management tool, as a federal requirement for Medicare reimbursement,

and as a mechanism for assuring accurate input to comprehensive health planning has been established by management authorities and public law. As such, all institutions should have plans in effect; and those that participate in Medicare must have them. But, even among the twenty-four activities which said they accept patients under Medicare, only eleven comply with the conditions for reimbursement established by Public Law 92-603.

Conclusions

The Alamo Area Council of Governments is charged with the responsibility of assisting the institutions in the region with their planning efforts. This assistance can significantly improve the quality of patient care being delivered by encouraging the optimum utilization of resources within individual institutions and providing better input data to AACOG, thereby improving their comprehensive health planning activities for the entire region. It is, therefore, in the best interests of both AACOG and the regional community for member institutions to initiate new planning and budgeting programs, or to upgrade existing ones to acceptable standards. AACOG should act in their own self-interest towards these ends.

Effective institutional planning doesn't just happen.

The Alamo Area Council of Governments must aggressively address the deficiencies identified by this study if they hope to improve the quantity and quality of planning being done by the institutions in the region. Such an improvement will make positive contributions to the comprehensive health planning efforts performed by the Council.

Recommendations

In order to achieve the increased institutional capabilities necessary and the resultant meaningful programs for planning and budgeting, the Alamo Area Council of Governments should:

1. Create a need for such programs in the minds of member institutions by publicizing the contents of Section 234 of Public Law 92-603 through the use of newsletters, meetings, and other appropriate means. The fact that the law exists and that enforcement may be forthcoming should be sufficient impetus for those activities which participate in Medicare and want to continue to receive reimbursement for their services. For those that do not participate, the Public Law should show them the Federal Government's concern with and the potential for further action in the future that might affect all health care institutions.

2. Coordinate with the Texas Hospital Association

and the Texas Nursing Home Association regarding the establishment of educational programs for instructing member institutions on the subject of planning and budgeting. This may be accomplished by either supplementing existing courses of instruction or by developing entirely new programs.

3. Include questions about institutional planning with the semi-annual workload questionnaire sent by AACOG to the health care activities in the region. These questions should be designed to evaluate whether or not formal budget programs exist, whether capital expenditures plans are developed, whether a budget committee is used, and whether all budgets and plans are reviewed at least annually. To maintain a continuity of information between the results obtained by this study and the semi-annual questionnaire, the most practical method is for AACOG to incorporate all eighteen questions asked by this study into their questionnaire.

4. Promote the subject of and the need for effective institutional planning in all AACOG publications which are primarily addressed to the regional health care institutions. This constant reminder should stimulate review of their existing programs or establish the awareness of the necessity and desirability for having such programs.

DEFINITIONS

Capital Expenditures Plan: a financial budget which serves as an estimate of future requirements for capital expense items. Capital expense items are those whose useful life exceeds the current operating year and which can reasonably be expected to benefit future periods in time.

Extended Care Facility: any medical establishment which provides treatment for patients who: (1) require inpatient care but are not in an acute phase of illness, and who currently require primarily convalescent or restorative services, or (2) require long-term care but do not currently require continuous hospital care. This specifically excludes long-term psychiatric care facilities and custodial care activities. It encompasses those establishments which are variously known as extended care facilities or nursing homes.

APPENDIX A

DEFINITIONS

Home Health Agency: an establishment with permanent facilities and with medical services, including nursing services and other professional and technical services, to provide treatment for patients in their places of residence.

Hospital: an establishment with an organized medical staff; with permanent facilities that include inpatient beds; and with medical services, including physician services and

DEFINITIONS

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Home Health Agency: an establishment with permanent facilities and with medical services, including nursing services and other professional and technical services, to provide treatment for patients in their places of residence.

Hospital: an establishment with an organized medical staff; with permanent facilities that include inpatient beds; and with medical services, including physician services and

continuous nursing services, to provide diagnosis and treatment for patients. For the purposes of this study, it includes only short-term, acute care, general facilities.

Institutional Planning: the organizational planning and budgeting activity which: (1) provides for annual operating budget, (2) includes a capital expenditures plan, (3) utilizes a budget committee, and (4) is reviewed and updated at least annually.

Operating Budget: a budget projecting operating revenue and expenses for a forthcoming period of time, most often for at least one year. In addition to estimates of future revenues and expenses, it also forecasts statistical data pertinent to the future operations and necessary as a basis for determining the levels of revenues and expenses.

SECTION 234 OF PUBLIC LAW 92-603

INSTITUTIONAL BLENDED FINANCIAL ASSISTANCE

Sec. 234. (a) The first sentence of section 1881(a) of the Social Security Act is amended—

- (1) by striking out "and" at the end of paragraph (7);
- (2) by redesignating paragraph (8) as paragraph (7); and
- (3) by inserting after paragraph (7) the following new paragraph:

"(8) has in effect an overall plan and budget that meets the requirements of subsection (c); and"

(b) Section 1881(f) (2) of such Act is amended to read as follows:

"(2) satisfies the requirements of paragraphs (2) through (8) of subsection (a)."

(c) Section 1881(g) (1) of such Act is amended to read as follows:

"(1) satisfies the requirements of paragraphs (2) through (8) of subsection (a)."

APPENDIX B

SECTION 234, PUBLIC LAW 92-603

- (1) by redesignating paragraph (8) as paragraph (7); and
- (2) by inserting after paragraph (6) the following new paragraph:

"(7) has in effect an overall plan and budget that meets the requirements of subsection (c); and"

(b) Section 1881(a) of such Act is amended—

- (1) by striking out "and" at the end of paragraph (6);
- (2) by redesignating paragraph (7) as paragraph (6); and
- (3) by inserting after paragraph (6) the following new paragraph:

"(7) has in effect an overall plan and budget that meets the requirements of subsection (c); and"

(f) Section 1881 of such Act is further amended by adding at the end thereof the following new sentence:

SECTION 234 OF PUBLIC LAW 92-603 (Continued)

INSTITUTIONAL PLANNING UNDER MEDICARE

Sec. 234. (a) The first sentence of section 1861(e) of the Social Security Act is amended—

- (1) by striking out "and" at the end of paragraph (7);
- (2) by redesignating paragraph (8) as paragraph (9); and
- (3) by inserting after paragraph (7) the following new paragraph:

"(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(b) Section 1861(f) (2) of such Act is amended to read as follows:

"(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);".

(c) Section 1861(g) (2) of such Act is amended to read as follows:

"(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);".

(d) The first sentence of section 1861(j) of such Act is amended—

- (1) by striking out "and" at the end of paragraph (9);
- (2) by redesignating paragraph (10) as paragraph (11); and
- (3) by inserting after paragraph (9) the following new paragraph:

"(10) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(e) Section 1861(o) of such Act is amended—

- (1) by striking out "and" at the end of paragraph (4);
- (2) by redesignating paragraph (5) as paragraph (6); and
- (3) by inserting after paragraph (4) the following new paragraph:

"(5) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(f) Section 1861 of such Act is further amended by adding at the end thereof the following new subsection:

SECTION 234 OF PUBLIC LAW 92-603 (continued)

"Institutional Planning

"(z) An overall plan and budget of a hospital, extended care facility, or home health agency shall be considered sufficient if it—

"(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget, an item-by-item identification of the components of each type of anticipated expenditure or income);

"(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of \$100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

"(3) provides for review and updating at least annually; and

"(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency."

(g)(1) Section 1814(a)(2)(C) and section 1814(a)(2)(D) of such Act are each amended by striking out "and (8)" and inserting in lieu thereof "and (9)".

(2) Section 1863 of such Act is amended by striking out "subsections (e)(8), (f)(4), (g)(4), (j)(10), and (o)(5)" and inserting in lieu thereof "subsections (e)(9), (f)(4), (g)(4), (j)(11), and (o)(6)".

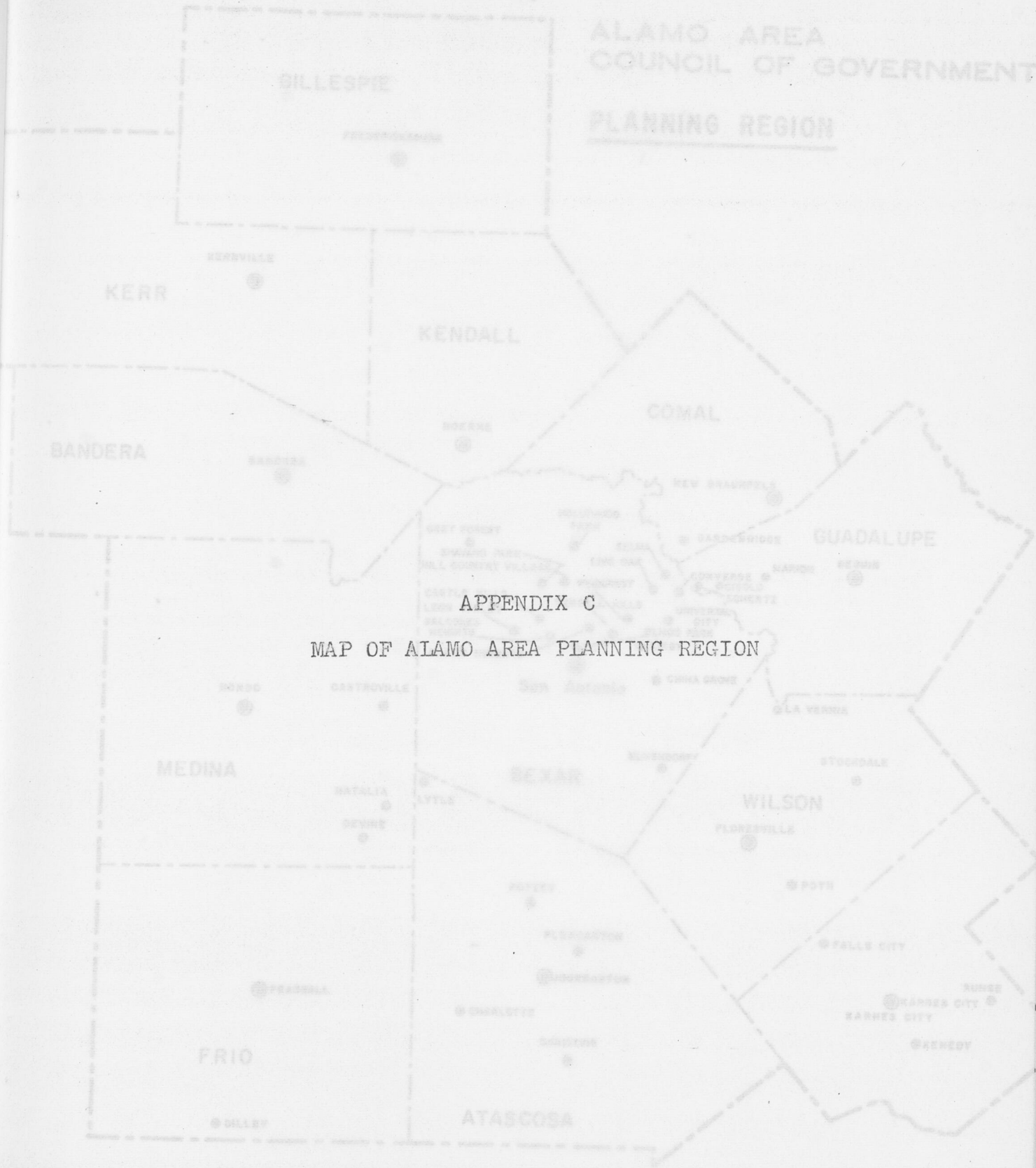
(h) Section 1865 of such Act is amended—

(1) by striking out "(except paragraph (6) thereof)" in the first sentence and inserting in lieu thereof "(except paragraphs (6) and (8) thereof)", and

(2) by striking out the second sentence and inserting in lieu thereof the following: "If such Commission, as a condition for accreditation of a hospital, (1) requires a utilization review plan as defined in section 1861(k) or imposes another requirement which serves substantially the same purpose, or (2) requires institutional plans as defined in section 1861(z) or imposes another requirement which serves substantially the same purpose, the Secretary is authorized to find that all institutions so accredited by the Commission comply also with section 1861(e)(6) or 1861(e)(8), as the case may be."

(i) The amendments made by this section shall apply with respect to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month in which this Act is enacted.

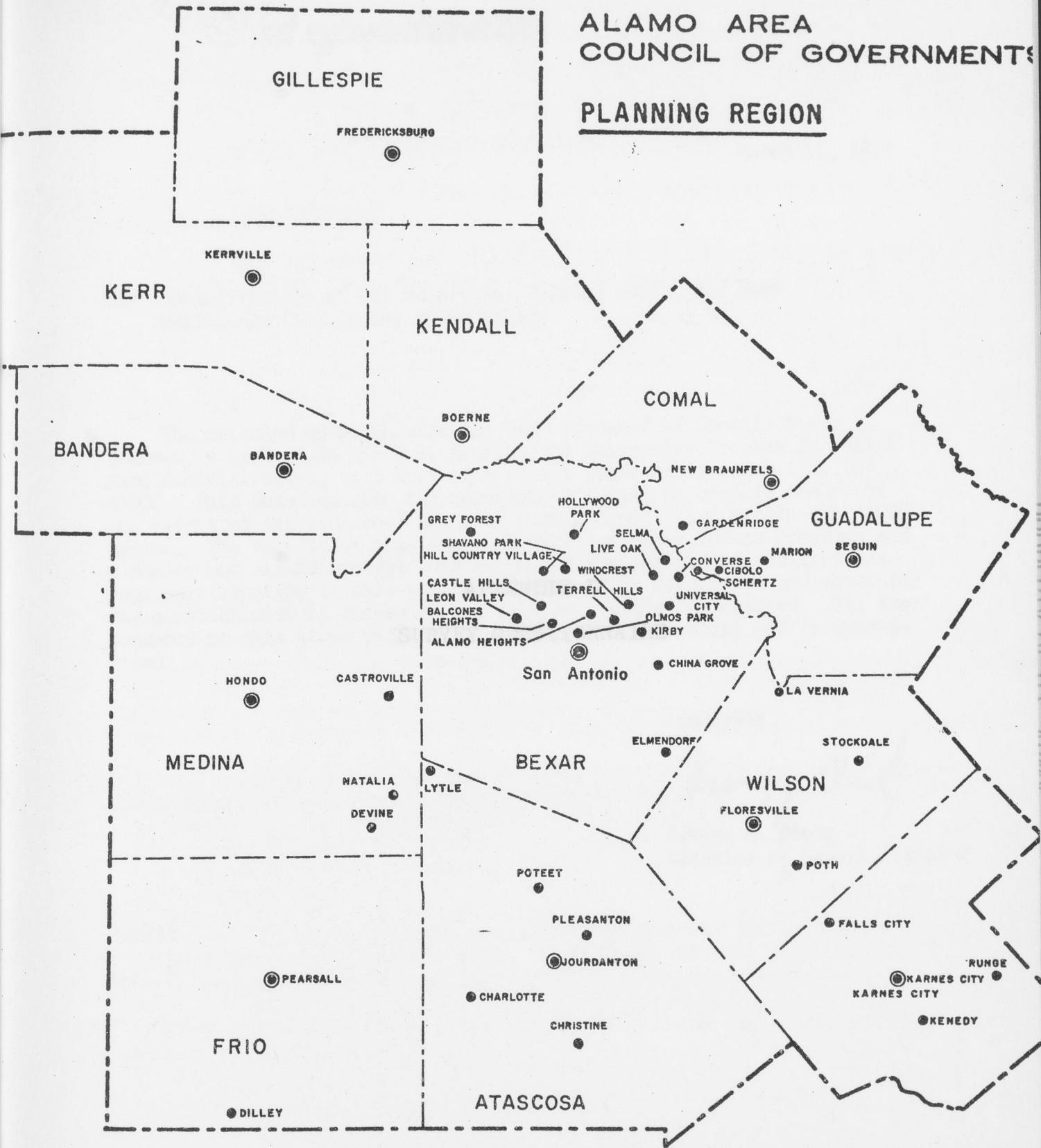
ALAMO AREA
COUNCIL OF GOVERNMENT
PLANNING REGION



APPENDIX C

MAP OF ALAMO AREA PLANNING REGION

ALAMO AREA COUNCIL OF GOVERNMENTS PLANNING REGION

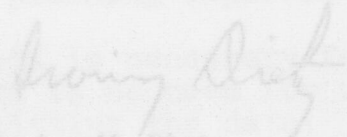


March 15, 1974

TO: Administrators of all Hospitals, Nursing Homes, and Home Health Agencies in the AACOG Region

The attached questionnaire has been prepared by Captain Steve Coleman, a student in the U.S. Army/Baylor University Program in Health Care Administration, as a part of a thesis study he is conducting for AACOG. Data obtained from the questionnaire will be used in analyzing the extent of institutional planning being accomplished within the AACOG Region. The results of this analysis will influence future programs and planning and should benefit both AACOG and the individual institutions. Your participation in this work **APPENDIX D** by completing and returning the questionnaire is requested and will be greatly appreciated. All respondents to this study will receive **SURVEY QUESTIONNAIRE** results and recommendations.

Sincerely,



Irving M. Dietz
Director of Health Planning

IMD/ir

Att.



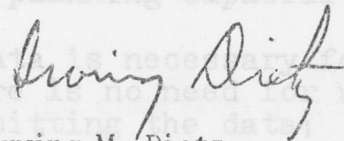
March 15, 1974

GENERAL INFORMATION

TO: Administrators of all Hospitals, Nursing Homes, and Home Health Agencies in the AACOG Region

The areawide health planning responsibility of AACOG relies heavily upon the quantity and quality of planning activities within the region. The so-called "institutional planning" is further supported by Section 234 of Public Law 92-603, which states that, in order for hospitals, extended care facilities, or home health agencies to qualify for reimbursement under Medicare, they must have overall plans and procedures for health planning. The attached questionnaire has been prepared by Captain Steve Coleman, a student in the U.S. Army/Baylor University Program in Health Care Administration, as a part of a thesis study he is conducting for AACOG. Data obtained from the questionnaire will be used in analyzing the extent of institutional planning being accomplished within the AACOG Region. The results of this analysis will influence future programs and planning and should benefit both AACOG and the individual institutions. Your participation in this worthwhile project by completing and returning the questionnaire is requested and will be greatly appreciated. All respondents to this study will receive a copy of its results and recommendations.

Sincerely,

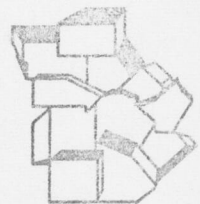


Irving M. Dietz
Director of Health Planning

IMD/ir

Att.

In order to meet required submission dates for the thesis that will result from this study and to provide AACOG with timely information for program development, please return the completed questionnaire in the envelope provided before April 15, 1974. Thank you very much for your cooperation and participation.



CLASSIFIED AACOG INSTITUTIONAL PLANNING QUESTIONNAIRE

GENERAL INFORMATION ion reporting

The areawide health planning responsibility of AACOG relies heavily upon the quantity and quality of planning being accomplished by the individual health care activities within the region. The need for so-called "institutional planning" is further supported by Section 234 of Public Law 92-603, which states that, in order for hospitals, extended care facilities, or home health agencies to qualify for reimbursement under Medicare, they must have overall plans and operating budgets which meet certain minimum requirements. This questionnaire is designed to aid AACOG in determining the extent to which facilities in the region have programs which satisfy these requirements, and thus support areawide planning activities. Although the public law applies only to those who accept patients under Medicare, the standards contained therein are felt to be excellent measures for evaluating the planning being done by all institutions in the area. The information obtained from this questionnaire and the resultant analysis that is done will be used by AACOG for determining the effectiveness of institutional planning activities as they interrelate with the areawide plans and for developing assistance programs which will aid the institutions and improve the overall regional planning capabilities.

Since only the raw statistical data is necessary for the analysis that will be performed, there is no need for us to identify the specific institution submitting the data; therefore, please do not put the name of your institution on the questionnaire. Anonymity is an essential ingredient to this study.

3. Do YES NO
 In order to meet required submission dates for the thesis that will result from this study and to provide AACOG with timely information for program development, please return the completed questionnaire in the envelope provided before April 15, 1974. Thank you very much for your cooperation and participation.

5. Do you follow a set sequence and calendar YES NO
 of events in your budget cycle?

CLASSIFICATION DATA INFORMATION (continued)

1. Type of institution reporting: budgets:
- Hospital _____ Extended Care Facility _____ YES NO
 Home Health Agency _____ Nursing Home _____ YES NO
2. Number of beds:
- 1-50 _____ 50-100 _____ 100-250 _____ 250-500 _____ Over 500 _____
3. Size of annual operating budget:
9. Less than \$500,000 _____ \$500,000-\$2,500,000 _____ YES NO
 \$2,500,000-\$10,000,000 _____ Over \$10,000,000 _____ YES NO
4. Source of operating control:
- Government _____ Church _____ For-Profit Corporation _____ YES NO
 Not-For-Profit Corporation _____ Private Ownership _____ YES NO

PLANNING AND BUDGETING INFORMATION Other _____ (please specify)

1. Do you have a formal budget program? YES NO
 (If your answer is "NO", please go on to question 10.)
2. Is your budget program based upon written guidance from the governing body? YES NO
3. Do you have a budget committee? YES NO
4. Does your budget committee consist of representatives from the governing body, administrative staff, and medical staff (if any)? YES NO
5. Do you follow a set sequence and calendar of events in your budget cycle? YES NO

PLANNING AND BUDGETING INFORMATION (continued)

6. Do you prepare the following budgets:
- | | | |
|------------------------|-----|----|
| a. Statistical Budget? | YES | NO |
| b. Expense Budget? | YES | NO |
| c. Revenue Budget? | YES | NO |
| d. Cash Budget? | YES | NO |
7. Do you have a cost accounting system? YES NO
8. Are your budgeting and accounting systems compatible? YES NO
9. Are your budgets compared with actual results as a basis for evaluating performance? YES NO
10. Do you prepare a capital expenditures plan?
(If your answer is "NO", please go to question 16.) YES NO
11. For what period do you plan capital expenditures?
1 year _____ 3 years _____ 5 years _____ Other _____
(please specify)
12. Does your plan include the anticipated sources of funding? YES NO
13. What do you define as a capital expenditure? _____

14. How many capital expenditures items are procured out-of-cycle with the priorities in the plan?
Less than 10% _____ 10-25% _____ 25-50% _____ Over 50% _____
15. How many capital expenditures items are procured which do not appear in the plan?
Less than 10% _____ 10-25% _____ 25-50% _____ Over 50% _____

PLANNING AND BUDGETING INFORMATION (continued)

- | | | | |
|-----|---|-----|----|
| 16. | Do your department heads actively participate in the planning and budgeting process? | YES | NO |
| 17. | Are your operating budget and capital expenditures plan reviewed and updated at least annually? | YES | NO |
| 18. | Do you accept patients under Medicare? | YES | NO |

APPENDIX E

LIST OF HOSPITALS SURVEYED

HOSPITALS SURVEYED

ATASCOSA COUNTY

Jourdanton:

Mercy Hospital
Whitefield Heights, Highway 97, Box 428
Jourdanton, Texas 78026
Administrator: Sister M. Ronolda, R.N.

Pleasanton:

Pleasanton Hospital and Clinic
310 W. Oaklawn Road, Drawer P
Pleasanton, Texas 78064
Administrator: John D. Austin, M.D.

BANDERA COUNTY

APPENDIX E

No Hospitals LIST OF HOSPITALS SURVEYED

DEXAR COUNTY

San Antonio:

Baptist Memorial Hospital
111 Dallas Street
San Antonio, Texas 78286
Administrator: Paul H. Roper

Northeast Baptist Hospital
8611 Village Park
San Antonio, Texas 78286
Administrator: Joseph F. Morrison, Sr.

Southeast Baptist Hospital
4214 Southcross Blvd.
San Antonio, Texas 78286
Administrators: Robert B. Adams

Source: Listing prepared by the Alamo Area Council of Governments as of July 15, 1973.

HOSPITALS SURVEYED

BEXAR COUNTY (con'd)

ATASCOSA COUNTY

Journalton:

Mercy Hospital
Whitefield Heights, Highway 97, Box 428
Journalton, Texas 78026
Administrator: Sister M. Ronolda, R.N.

Pleasanton:

Pleasanton Hospital and Clinic
310 W. Oaklawn Road, Drawer P
Pleasanton, Texas 78064
Administrator: John D. Austin, M.D.

BANDERA COUNTY

No Hospital Facilities

BEXAR COUNTY

San Antonio:

Baptist Memorial Hospital
111 Dallas Street
San Antonio, Texas 78286
Administrator: Paul H. Roper

Northeast Baptist Hospital
8611 Village Drive
San Antonio, Texas 78286
Administrator: Joseph F. Morrison, Sr.

Southeast Baptist Hospital
4214 Southcross Blvd.
San Antonio, Texas 78286
Administrator: Robert B. Adams

Source: Listing prepared by the Alamo Area Council of Govern-
ments as of July 15, 1973.

BEXAR COUNTY (con'd)

San Antonio:

Bexar County Hospital
4502 Medical Drive
San Antonio, Texas 78284
Administrator: Warren G. Harding

Lutheran General Hospital
701 S. Zarzamora Street
Mailing Address: P.O. Box 2059
San Antonio, Texas 78207
Administrator: Henry J. Rockstroh

Southwest Texas Methodist Hospital
Louis Pasteur & William Mayo Drives
San Antonio, Texas 78229
Administrator: Bruce D. Sorenson

Metropolitan General Hospital
1310 McCullough
San Antonio, Texas 78212
Administrator: Charles M. Sanders

Nix Memorial Hospital
414 Navarro Street
San Antonio, Texas 78205
Administrator: Robert Read

San Antonio Community Hospital
8026 Floyd Curl Drive
San Antonio, Texas 78229
Administrator: Robert C. Benson

Santa Rosa Medical Center
519 W. Houston Street
Mailing Address: Box 7330, Station A
San Antonio, Texas 78207
Administrator: Sister Angela Claire Moran

Park North General Hospital
4330 Vance Jackson
San Antonio, Texas 78230
Administrator: Joseph P. O'Brien

BEXAR COUNTY (con'd)

San Antonio:

Saint Benedict Hospital
 323 E. Johnson
 San Antonio, Texas 78204
 Administrator: Sister Mary John

San Antonio Osteopathic Hospital
 210 West Ashby Place
 San Antonio, Texas 78212
 Administrator: Peter Prodejko

Twin Park Eye and Ear Hospital
 105 E. Laurel Street
 San Antonio, Texas 78212
 Administrator: B. Sotoodeh, M.D.

Brooke Army Medical Center
 Fort Sam Houston, Texas 78234
 Executive Officer: Col. Donald F. Callaghan
 Commander: Col. John W. White

Wilford Hall USAF Medical Center
 Lackland AFB, Texas 78236
 Administrator: Col. Morrison E. Chamberlin
 Commander: Brig. General Paul W. Myers

Audie L. Murphy Memorial Veteran's Hospital
 7400 Merton Minter Blvd.
 San Antonio, Texas 78284

COMAL COUNTY

New Braunfels:

McKenna Memorial Hospital
 162 East Austin Street
 New Braunfels, Texas 78130
 Administrator: John F. Svoboda

Karnes Hospital
 700 Highway 96
 Karnes, Texas 78118
 Administrator: Leonard L. Deskin

FRIO COUNTY

Dilley:

Winter Garden Medical Center
 Highway 85 W., Box 29
 Dilley, Texas 78061
 Administrator: John M. Wade, M.D.

Pearsall:

Frio Hospital
 320 Berry Ranch Road
 Pearsall, Texas 78061
 Administrator: Dorothy Wauson

GILLESPIE COUNTY

Fredericksburg:

Hill Country Memorial Hospital
 1020 Kerrville Road
 Mailing Address: P.O. Box 835
 Fredericksburg, Texas 78624
 Administrator: Jerry L.L. Durr

GUADALUPE COUNTY

Seguin:

Guadalupe Valley Hospital
 1215 E. Court Street
 Seguin, Texas 78155
 Administrator: Mrs. Luella H. Brown

KARNES COUNTY

Karnes City:

Karnes Hospital
 700 Highway 80
 Karnes, Texas 78118
 Administrator: Leonard L. Deskin

KARNES COUNTY (con'd)

Kenedy:

Kenedy Clinic and Hospital
330 W. Liveoak Street
Kenedy, Texas 78119
Administrator: C.C. Quillian, M.D.

KENDALL COUNTY

Comfort:

Comfort Community Hospital
Box 338
Comfort, Texas 78013
Administrator: Mrs. Jo Ellen Burmann

KERR COUNTY

Kerrville:

Sid Peterson Memorial Hospital
710 Water Street
Kerrville, Texas 78208
Administrator: Eugene J. Bartels

Veteran's Administration Hospital
San Antonio Highway
Kerrville, Texas 78028
Administrator: G.M. Hague

MEDINA COUNTY

Castroville:

Castroville Hospital
Box N
Castroville, Texas 78009
Administrator: Bernard Yanity

MEDINA COUNTY (con'd)

Hondo:

Medina Memorial Hospital
Highway 462
Hondo, Texas 78861
Administrator: Melvin Finger

WILSON COUNTY

Floresville:

Memorial Hospital
1301 Hospital Blvd.
Floresville, Texas 78114
Administrator: Sister Laverne Mettlach

APPENDIX F

LIST OF EXTENDED CARE FACILITIES SURVEYED

EXTENDED CARE FACILITIES SURVEYED

ATASCOSA COUNTY

Jourdanton:

Retama Manor Nursing Center, Inc.
Jourdanton, Texas 78026

Lytle:

Rest Haven Nursing Home
614 Oak Street
Lytle, Texas 78052

Pleasanton:

Retama Manor Nursing Center
905 Oaklawn
Pleasanton, Texas 75064

APPENDIX F

LIST OF EXTENDED CARE FACILITIES SURVEYED

Poteet:

Poteet Nursing Home
101 W. School, P.O. Box 305
Poteet, Texas 78065

BANDERA COUNTY

Bandera:

Purple Hills Nursing Home
Montague Drive, Box 836
Bandera, Texas 78003

BEXAR COUNTY

San Antonio:

American Nursing & Convalescent Center, INC.
1939 Bandera Road
San Antonio, Texas 78213

Source: Directory of Nursing and Convalescent Homes in Texas
(Austin: Texas State Department of Health, August
1973).

BEXAR COUNTY EXTENDED CARE FACILITIES SURVEYED

ATASCOSA COUNTY

Jourdanton:

Retama Manor Nursing Center, Inc.
Jourdanton, Texas 78026

Lytle:

Rest Haven Nursing Home
614 Oak Street
Lytle, Texas 78052

Pleasanton:

Retama Manor Nursing Center
905 Oaklawn
Pleasanton, Texas 78064

Poteet:

Poteet Nursing Home
101 W. School, P.O. Box 305
Poteet, Texas 78065

BANDERA COUNTY

Bandera:

Purple Hills Nursing Home
Montague Drive, Box 836
Bandera, Texas 78003

BEXAR COUNTY

San Antonio:

American Nursing & Convalescent Center, INC.
1939 Bandera Road
San Antonio, Texas 78213

Source: Directory of Nursing and Convalescent Homes in Texas
(Austin: Texas State Department of Health, August
1973).

BEXAR COUNTY (con'd)

San Antonio:

Broadway Lodge
 1841 Flamingo
 San Antonio, Texas 78209

Carriage Square Nursing Home Inc.
 8020 Blanco Road
 San Antonio, Texas 78212

Evergreen Nursing Home
 110 W. Evergreen
 San Antonio, Texas 78212

Ferguson Nursing Home, Inc.
 815 Grayson Street
 San Antonio, Texas 78208

Four Seasons Nursing Center of San Antonio -
 Babcock
 1975 Babcock Road
 San Antonio, Texas 78229

Four Seasons Nursing Center of San Antonio -
 Pecan Valley
 5027 Pecan Grove
 San Antonio, Texas 78222

Friendship Villa North
 7703 Briaridge Drive
 San Antonio, Texas 78230

Friendship Villa South
 1338 Chavaneaux Road
 San Antonio, Texas 78214

Golden Manor - Jewish Home for Aged
 130 Spencer Lane
 San Antonio, Texas 78201

Hardy's Nursing Home
 406 Sharmain
 San Antonio, Texas 78223

BEXAR COUNTY (con'd)

San Antonio:

Highland Nursing Home
5819 Pecan Valley Drive
San Antonio, Texas 78223

Hillside Manor Nursing Home, Inc.
8310 Gault Lane
San Antonio, Texas 78209

House of Dismukes Nursing Home
323 E. Carson
San Antonio, Texas 78208

La Hacienda Care Center
636 Cupples Road
San Antonio, Texas 78212

Laurelwood Nursing Home
2717 N. Flores
San Antonio, Texas 78212

M & S Nursing Home
903 Leahy Street
San Antonio, Texas 78221

Manor Square Convalescent Home
414 N. Hackberry
San Antonio, Texas 78202

Memorial Medical Nursing Home
315 Lewis Street
San Antonio, Texas 78212

Morningside Manor, Inc.
602 Babcock Road
San Antonio, Texas 78201

National Living Center, Inc.
San Antonio Convalescent Center
921 Nolan
San Antonio, Texas 78202

BEXAR COUNTY (con'd)

San Antonio:

Normandy Terrace, Inc.
841 Rice Road
San Antonio, Texas 78220

Oak Hills Haven
7302 Oak Manor Drive
San Antonio, Texas 78229

Oak Hills Haven - Annex
7602 Louis Pasteur Dr.
San Antonio, Texas 78229

St. Benedict Nursing Home
323 E. Johnson Street
San Antonio, Texas 78204

San Pedro Manor Convalescent Center
616 W. Russell
San Antonio, Texas 78212

The Sarah Roberts French Home
1315 Texas Avenue
San Antonio, Texas 78201

Southern Manor Nursing Home
2730 N.W. Loop 410
San Antonio, Texas 78230

Southside Nursing Home
4611 S. Flores
San Antonio, Texas 78214

T.D. Iglehart Nursing Home
502 W. Mistletoe
San Antonio, Texas 78212

Wood Nursing Home
2700 Pleasanton Road
San Antonio, Texas 78221

Brown's Nursing Home, Inc.
Kerr Route, Box 12
Fredericksburg, Texas 78624

BEXAR COUNTY (con'd)

San Antonio:

Woodlawn Hills Nursing Home, Inc.
3031 West Woodlawn Avenue
San Antonio, Texas 78228

Wright Nursing Home
328 W. Mayfield Blvd.
San Antonio, Texas 78221

COMAL COUNTY

New Braunfels:

Colonial Manor Nursing Home
821 U.S. Highway 81 West
New Braunfels, Texas 78130

Eden Home for the Aged, Inc.
631 Lakeview Blvd.
New Braunfels, Texas 78130

Oak Crest Inn
1310 IH 35 West
New Braunfels, Texas 78130

FRIO COUNTY

Pearsall:

KARNES COUNTY Baker's Convalescent & Rest Home
320 South Ash
Pearsall, Texas 78061

GILLESPIE COUNTY

Fredericksburg:

Brown's Nursing Home, Inc.
Kerr Route, Box 12
Fredericksburg, Texas 78624

GILLESPIE COUNTY (con't)

Fredericksburg:

Fredericksburg Nursing Home, Inc.
1117 S. Adams
Fredericksburg, Texas 78624

Knopp Nursing Home, Inc.
Route 1, Box 311
Fredericksburg, Texas 78624

GUADALUPE COUNTY

Seguin:

Guadalupe Valley Nursing Home
1219 Eastwood Drive
Seguin, Texas 78155

Nesbit Nursing Home
312 Blanks Street
Seguin, Texas 78155

Seguin Convalescent Home
1637 N. King Street
Seguin, Texas 78155

Virley's Nursing Home, Inc.
433 N. Goodrich
Seguin, Texas 78155

KARNES COUNTY

Karnes:

Colonial Hills Nursing Home
209 Country Club Drive
Karnes, Texas 78118

Kenedy:

Green's Rest Home
505 W. Main Street
Kenedy, Texas 78119

KARNES COUNTY (con't)

Kenedy:

Larkwood Convalescent Center
 215 Tilden
 Kenedy, Texas 78119

Restful Acres Nursing Home, Inc.
 Highway 181 South
 Kenedy, Texas 78119

KENDALL COUNTY

Boerne:

Hill Top Nursing Home
 200 Ryan Street
 Boerne, Texas 78006

Town & Country Manor
 625 N. Main
 Boerne, Texas 78006

KERR COUNTY

Kerrville:

Colonial Nursing Home, Inc.
 1213 Water Street
 Kerrville, Texas 78028

Hilltop Village
 Hilltop Circle
 Kerrville, Texas 78028

MEDINA COUNTY

Devine:

Devine Nursing Home, Inc.
 307 Briscoe Avenue
 Devine, Texas 78016

MEDINA COUNTY (con't)

Hondo:

Brown's Nursing and Convalescent Center
2001 Avenue E
Hondo, Texas 78861

WILSON COUNTY

Floresville:

Floresville Nursing Home
1811 6th Street
Floresville, Texas 78114

Stockdale:

Stockdale Nursing Home, Inc.
300 Solomn Street
Stockdale, Texas 78160

LIST OF HOME HEALTH AGENCIES SURVEYED

HOME HEALTH AGENCIES SURVEYED

BEXAR COUNTY

San Antonio:

Alamo Nursing Personnel Services
915 W. Alamo Road
San Antonio, Texas 78212

Homeside Home and Health Care Services
1222 N. Main, Suite 321
San Antonio, Texas 78212

Visiting Nurses Association
294 Dexter Avenue
San Antonio, Texas 78205

APPENDIX G

LIST OF HOME HEALTH AGENCIES SURVEYED

HOME HEALTH AGENCIES SURVEYED

BEXAR COUNTY

San Antonio:

Alamo Nursing Personnel Services
915 W. Hildebrand
San Antonio, Texas 78212

Homemakers Home and Health Care Services
1222 N. Main, Suite 321
San Antonio, Texas 78212

Visiting Nurses Association
214 Dwyer Avenue
San Antonio, Texas 78205

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- _____. Cost Finding and Rate Setting for Hospitals. Chicago: American Hospital Association, 1968.
- _____. The 1973 AHA Guide to the Health Care Field. Chicago: American Hospital Association, 1973.
- _____. The Practice of Planning in Health Care Institutions. Chicago: American Hospital Association, 1973.
- _____. Statement on the Financial Requirements of Health Care Institutions and Services. Chicago: American Hospital Association, 1969.
- American Nursing Home Association. An Analysis and Partial Legislative History of Title II of Public Law 92-603 (H.R. 1), The Social Security Amendments of 1972. Washington, D.C.: American Nursing Home Association, February 1, 1973.
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He attended the Ohio State University for three years before enlisting in the United States Air Force in 1962. Upon completion of basic training and technical school, he was assigned to the Air Force Special Communications Center at Kelly Air Force Base, San Antonio, Texas. In 1965, then Staff Sergeant Coleman reentered Ohio State under the Airman Education and Commissioning Program. In 1966, he was awarded a Bachelor of Science Degree in Business Administration and received a commission as a Second Lieutenant after graduation from Officer Training School.

Following assignments at Headquarters Air Force Systems Command and the Rome Air Development Center as a Management Engineering Officer, Captain Coleman transferred to the Medical Service Corps. He received his initial training in hospital administration at Sheppard Air Force Base, Texas, and was then assigned to USAF Hospital Tachikawa, Japan. At Tachikawa, he first served as the Administrator of the 20th Aeromedical Wing Flight and then as the Assistant Administrator for Resource Management. He entered the U.S. Army-Baylor University Program in Health Care Administration in August 1973.

ABSTRACT

A STUDY TO EVALUATE THE EXTENT OF INSTITUTIONAL PLANNING BEING ACCOMPLISHED BY HEALTH CARE ACTIVITIES WITHIN THE ALAMO AREA PLANNING REGION

A Problem-Solving Thesis Submitted to the
Faculty of Baylor University in Partial
Fulfillment of the Requirements for the Degree of
Master of Hospital Administration

by
Captain Steven L. Coleman, USAF, MSC

August 1975

75 Pages

A copy of this document may be obtained from University
Microfilms, University of Michigan, Ann Arbor, Michigan 48108.

The purpose of this study was to determine the extent to which the health care activities in the Alamo Area Planning Region of Texas satisfied minimum standards for institutional planning. The evaluation was prompted by passage of Section 234 of Public Law 92-603, which stated that in order to qualify for reimbursement under Medicare, institutions must meet certain planning and budgeting requirements. The study was not restricted, however, to only Medicare participants; but surveyed all short-term, acute care, general hospitals, extended care facilities, and home health agencies in the twelve-county planning region. Determination of the amount and type of planning in the region was accomplished through the use of a comprehensive questionnaire. Questionnaires were mailed to ninety-six institutions. There were forty-six responses. The replies were compared with the guidelines for institutional planning contained in Section 234 of Public Law 92-603. These guidelines were used as the criteria for determining the acceptability of the planning performed. Multiple comparisons and analyses were made. Overall, only 30 per cent of the respondents satisfied all four of the criteria necessary for acceptable programs. Data was shown in eleven tables, by type of institution, number of beds, size of annual budget, and source of operating control. Recommendations were presented for use by the areawide planning agency.