

President's Message

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It's not too late to **ACT** – Assist, Commit, and Take part in our 2004 fiscal year activities.

The last newsletter provided you with our vision statement and a summary of our strategic plan for the 2004 fiscal year to culminate on May 31. While we will be strategically planning for the 2005 year, let's recap where the chapter is at this point.

Our sponsorship program was overhauled in January based on feedback from those who financially support the chapter – *our Corporate Sponsors*. Louise Littlejohn, Sponsorship Committee Chairperson, met with our sponsors and solicited their feedback. The biggest enhancement, depending on their level of sponsorship, provides the sponsor/vendor with provider coupons. Each provider coupon can be redeemed in lieu of the registration fee, for a member or non-member, for the meeting designated on the coupon. Join us in inviting your vendors to participate in the OHFMA sponsorship program. (continued on page 2)

Save the Date!



The annual meeting of OHFMA is scheduled for April 1 & 2 in Oklahoma City at the Renaissance Hotel. In addition to the installation of officers for the upcoming year, we will have a special recognition luncheon on Thursday, April 1, for all members with more than 20 years in the chapter. Information on speakers and the agenda will be out shortly – hope to see you there!

Any organization sending three or more individuals on a single registration form will be given a \$100 discount on registration.



President's Message (continued)

Volunteerism and participation, another of our focuses for 2004, continues to encourage the OHFMA leadership team. Our Friday, January 23, meeting was well attended and was a successful event based on the evaluations, despite the temperature of the room. On Thursday, January 22, we held our second Leadership Training Conference (LTC) for this fiscal year. We had five new faces join us for this event. Thanks to Kathy Decker, Nancy Leachman, Peggy Noble, Shasta Manuel, and Shane Wells for your input and participation. We had breakout sessions for educational programming, membership, and management practices. Educational programming focused on the April 1-2, 2004, meeting to be held in Oklahoma City at the Renaissance Hotel. We will be honoring folks who have been a member of HFMA for 20 plus years and presenting two Medal of Honor awards. The membership committee made contact with prospective members, shared the benefits of membership in HFMA, and invited them to join. The management practices committee worked on our annual award applications to submit to National HFMA for awards to be presented at the Annual National Institute in Nashville, Tennessee, in June 2004.

Certification is another area of special interest to the OHFMA leadership team. Part of our October 2003 educational program included the certification coaching course. Thanks to Steve Dorsett and Arkansas HFMA member Joe Wewers for teaching the course. We have had several members complete the exams and applications necessary for certification designation, including Bryan Bodnar, Karen Hendren, and Becky Speight. Connie Proctor is just an application away from being designated as a Certified Healthcare Financial Professional, and several other individuals are on track for taking the exams before the end of our fiscal year. We will be offering an opportunity for taking the exams before the April meeting and will get those details out to you as soon as they are confirmed.

Contact any of the 2003-04 leadership team to share your ideas, offer suggestions, or to volunteer. We have opportunities available at all commitment levels. Thank you for your continued support and attendance. We hope to see you at the April meeting.

Best regards,

Members in the News....

- ✓ Steve Mattachione, FHFMA and past-President of the Oklahoma chapter, has been named vice president – enterprise resource planning at Mercy Health System in Oklahoma City. In his new role, Steve will be responsible for providing leadership as Mercy undertakes the implementation of the financial, human resources and revenue aspects of their system-wide information system.
- ✓ Lex Anderson has joined St. John Health System as executive vice president after 26 years with KPMG LLP. Lex will oversee St. John Health System's business functions, including business office, medical records, contract negotiations and capital and operating budgets.

Appearing Now on the World Wide Web – OHFMA.ORG

As a result of the Chapter's planning sessions last winter, it was determined that a Chapter web site would be an effective and efficient method to communicate with members. The planning process, vendor selection and site development process is complete and the new web site is now up and running. It is expected that the site will evolve and expand over time as new opportunities for enhancements are identified. Please take a moment to browse our new Oklahoma Chapter site at www.ohfma.org for information concerning the chapter, resource links and corporate sponsors. As this is a new site, the web site committee is anxious to receive feedback from the chapter. If you have suggestions or comments, please go to "Contact Us" from the main menu and send us a note.

Edwin Casteel
Web Site Committee Chair

The Medicare Prescription Drug Bill: Will Hospitals Shoulder the Cost of this New Program?

By: Mark W. Liston, C.P.A.

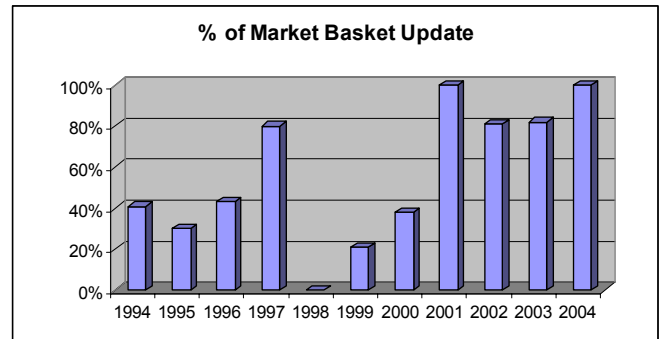
The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (“MMA”) was signed into law this past November and marked the largest-ever expansion of Medicare. Hospitals, primarily rural and critical access hospitals, scored a significant victory given that this legislation included some extremely beneficial payment provisions which are very good news for an industry that has continually been a target of payment cuts.

Although many, including myself, are extremely ecstatic over these payment reforms, I caution all of us not to count our chickens just yet. Based on the recent flurry of newspaper articles and other media broadcasts, the Congressional Budget Office is now estimating that MMA will actually cost the taxpayers an estimated \$534 billion over the next ten years which is \$139 billion or 36% more than what was presented to lawmakers at the time this bill was passed. Fingers of lawmakers are now being pointed accusing the other of taking bribes from the pharmaceutical industry for passage of MMA. To make matters even worse, the budget recently proposed by the White House projects a federal deficit this year of approximately \$520 billion.

As you can logically conclude, President Bush and his administration along with Congress will have tremendous pressure to take action. Given the significant and escalating costs the government is experiencing from the war in Iraq and Afghanistan coupled with this country’s economic woes, the federal deficit continues to climb and undoubtedly, tightening the reigns on government spending will be a hotly contested issue during the upcoming presidential election.

One must note that when looking at the breakdown of where the federal government spends money, the Medicare program is one of the more significant. Right or wrong, Medicare and Medicaid are targets when it comes to looking for spending cuts. To go a step further, when looking at the composition of Medicare expenditures, hospitals comprise the largest percentage of the payments. More specifically, based on 2002 data published by the Centers for Medicare and Medicaid Services (“CMS”), over 31% of the nation’s healthcare expenditures went to hospitals with physicians receiving 22%.

Every one of us recalls that fateful day in August 1997 when the *Balanced Budget Act of 1997* (“BBA”) came into play. Unquestionably, the BBA wreaked havoc on the healthcare industry and it took major lobbying efforts to convince lawmakers to enact legislation in subsequent years to mitigate the drastic payment cuts experienced by hospitals and other healthcare providers. Granted, the past several years have improved from a reimbursement perspective; however, as you can see from the following chart, a pattern definitely emerges when one looks at the rate of payment increases provided to hospitals over the past ten years.



Let’s take a look back to the year 1997:

- Hospitals had experienced three years of strong payment updates;
- Congress reconvenes after the presidential election facing a tremendous deficit; and
- Hospital rate increases are frozen in 1998.

Now, here we are in 2004:

- Hospitals have experienced four years of strong payment updates; and
- Congress is set to reconvene after the presidential election later this year and will face a tremendous deficit.

Now, based on the above, some out there may accuse me of being a pessimist but I tend to think of myself as a “cautious optimist” or one who sees the glass as half full but with a very slight leak at the bottom. The truth of the matter is you can see the pattern evolving here and it is not a very pretty one to say the least.

In essence, hospitals must be wary of the above and keep this in the back of their minds when planning for the future. No, I am not advocating a “doomsday” type attitude, but I believe it is prudent for hospital financial managers and other members of its administrative staff to be on guard for what may happen in the years to come.

Other Items to Note –

Additionally, it is extremely important to keep in mind other provisions of MMA that may have a negative financial impact on hospitals in the future. These items are explained in more detail below.

- Through the *Medicare Advantage* program (formerly *Part C*), Medicare is encouraging plans to participate by increasing payments by an estimated \$1.3 billion over a 3-year period. Under the current managed care program, payment increases were capped at 2% and many managed care plans dropped out of the program. Presently, these managed care plans only enroll about 10% of all Medicare beneficiaries and it is estimated that this may increase to as high as 35%. Given the anticipated boost in managed care plans, hospitals may see more of their patient volume tied to these managed care

networks which could result in lower payments. Also, the more dominant these managed care programs become, the less leverage hospitals will have in negotiating rates.

- Hospitals have the option to participate in the CMS-sponsored *Hospital Quality Initiative* program that includes the reporting of 10 quality measures of quality for heart attacks, heart failure and pneumonia. To entice hospitals to take part, participating hospitals will be granted the full market basket update for federal fiscal years 2005 through 2007. However, non-reporting hospitals will only receive the market basket less .4%. This quality data reporting mechanism is believed by many to be the onset of a “pay for performance” system in the Medicare program.
- Under MMA, physicians will see increases in payments rather than the payment cuts that were originally anticipated. Measures for calculating the annual payment updates are being modified to help eliminate the volatility in future updates, bonus payments will be paid to physicians providing care in rural/scarcity areas and geographic adjusters will be changed to increase payments to physicians in those areas with work adjusters less than 1.00. These physician payment reforms are costly and may lead to a reduction of the hospital’s piece of the pie for future Medicare spending.

In conclusion, it must be emphasized that the above is not an attempt to frighten anyone, rather it is an attempt for hospitals to be cognizant of the potential impact that MMA may have on the industry and to be adequately prepared in the event that any financial repercussions are experienced in the next several years.

Mark Liston is the Managing Principal of <i>Mark W. Liston, P.C.</i> and is also a principal and the Executive Vice President and C.F.O. of <i>Community Partners, LLC.</i>

Hospital Quality Initiatives

Hospitals that wish to qualify for the full market basket update to their PPS payments in FY05 must sign up with the Quality Improvement Organizations' data warehouse by June 1, 2004, and transmit the required data by July 1, 2004, according to hospital data submission guidelines issued on January 28.

The data required are 10 quality measures related to heart attack, heart failure, and pneumonia for patient discharges during the most recent quarter available. Hospitals that commit to the process but haven't completed the data submission by July 1 will be allowed a 30-day grace period to complete their submission.

"Aligning payment with superior quality is a major focus of this agency, and today's guidance is one important piece of that," said CMS acting administrator Dennis Smith. Section 501 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides that hospitals that submit data get the full update, while those that don't will receive market basket minus 0.4 percent.

Currently, only 22 hospitals in Oklahoma are reporting their data. To find out more information about the initiative, go the CMS website at www.cms.hhs.gov/quality/hospital/.

Donald R. Plant Memorial Professional Advancement Award

OHFMA is actively recruiting interested qualified individuals to apply for the 2003-2004 Donald R. Plant Memorial Professional Advancement Award. The Oklahoma Chapter of HFMA will be awarding four individuals with an advancement scholarship through the OHFMA Donald R. Plant Memorial Professional Advancement Award program.

The advancement award consists of a cash award of \$500, HFMA student membership for one year and all OFHMA program fees waived for one year. This award is intended to benefit students or professionals pursuing careers in healthcare finance and is funded through corporate sponsorships and the annual golf tournament in August of each year. The

scholarships are awarded each year in the spring. If you know anyone who is interested in applying for the 2003-2004 scholarship, please contact Regan Calhoun at (918) 494-7359 or e-mail rdecalhoun@saintfrancis.com for an application or additional information. The application is due to Regan by Friday, March 12, 2004.

Hospitals in the News.....

Oklahoma Heart Hospital was recently ranked in the top 1 percent nationally for patient satisfaction, according to Press Ganey Associates-the health care community's top satisfaction measurement and improvement firm.

Of more than a half million patients and 859 hospitals that participate nationwide, including Duke University Medical Center, The Johns Hopkins Hospital, Newark Beth Israel Medical Center and Scripps Mercy Hospital, the Oklahoma Heart Hospital was among only a handful who ranked in the top 1 percent.

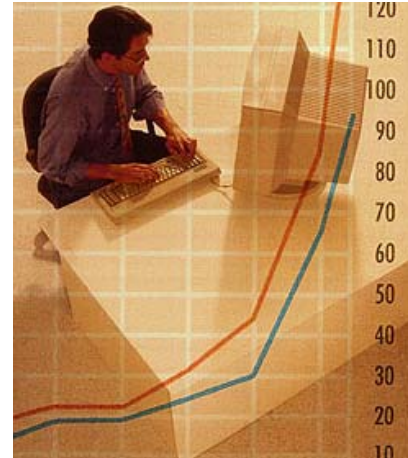
"This survey tells us that our patients are scoring us very high in the care we provide, the skill of our physicians and nurses and the overall friendly atmosphere," said Peggy Tipton, RN, vice president of clinical services at Oklahoma Heart Hospital. "We focus on our patients here at the Oklahoma Heart Hospital, and these results testify to that fact. We are committed to providing care you can't find anywhere else."

Oklahoma Heart Hospital, the first all-digital hospital in the nation, is a partnership between Oklahoma Cardiovascular Associates and Mercy Health Center, along with other cardiovascular physicians.

Zimmerman & Associates Revenue Cycle Benchmark Report

Report Highlights:

- Nationally, just 14% of dollars due at time of service are collected at time of service. This is a major problem area for hospitals.
- Forty-eight percent of scheduled patients are pre-registered. This shows hospitals have huge improvement potential in this area.
- By three-to-one, better performing hospitals have a centralized pre-access unit in place. This shows centralization is key to pre-access results.
- The clean claim submission percentage for hospitals is just 54%. With HIPAA now underway, this should be an improvement target for hospitals.
- Almost 20% of hospital outstanding receivables are unbilled, which equates to 11 gross days of accounts receivable.
- The national average for gross days revenue outstanding is 64. However, the report shows that the “real average” is 75 GDRO. This is because 84% of the nation’s hospitals are partially netting down their AR via contractual allowances at time of billing. This artificially reduces GDRO.
- Collection agencies recover 24% of referrals. In early outsourcing situations, the recovery percentage is much higher.
- Denials and underpayments are a major problem area for hospitals. Five percent of gross revenue is currently lost to these two key areas.
- Hospital staffing for collections is poor. The ratio of open accounts per FTE collector is 6,924.



This new report has key performance indicators as well as performance driven indicators. The report is designed so hospitals can emulate the best practices identified. Zimmerman & Associates believes implementation of this report’s benchmarks would save the hospital industry billions of dollars each year.

For questions or comments on this new report, you may contact Bruce Nelson at 800.525.0133.

Managed Care in a Rural Setting: An Interview with John D. Matthew, MD

By Rebecca L. Bowen, MBA, MHA, FHFMA

Managed care processes have created incentives for primary care physicians to be more assertive in caring for patients enrolled in managed care organizations. However, barriers to services may still exist, especially in rural settings. Managed Care Forum Advisory chair Rebecca L. Bowen asked John D. Matthew, MD, to discuss his views on managed care for rural providers.

Bowen: Is there a future for managed care in a rural primary care practice?

Matthew: Managed care has created "assertive primary care." It has given the physician incentives to investigate more thoroughly, creates incentives for the patient to change their behavior, and between the two creates economies of care that haven't been evaluated. (continued on page 7).

Managed Care in a Rural Setting: An Interview with John D. Matthew, MD (continued)

Bowen: Can practices survive in the current environment?

Matthew: Yes, if they have good contracts, avoid capitation contracts and poorly thought-out risk arrangements. Perhaps the greatest risk isn't reimbursement, but the time taken for referral management and disease management that is not reimbursed by the MCO. Managed care takes more time with the patient and in coordination and requires more staff. Most insidious are the "HMO-lite" plans that operate like an HMO but do not have any care management stipends to cover the work.

Personal income has decreased, even with higher Resource-Based Relative Value Scale (RBRVS)-based systems. Overhead has increased at a higher rate than RBRVS. Specialists have been affected less than primary care physicians.

Patients are better informed, better motivated to stay healthy. There will always be the patient who insists on driving his or her own care. This is not new to managed care, it was just accommodated under the indemnity system. The majority of patients appreciate the necessity of boundaries.

Specialists work better with primary care physicians in managed care contracts. Access to services has improved (perhaps grudgingly on the part of facilities). The structure forces collaboration between physicians, perhaps at the expense of former controls by the hospitals. Under the indemnity system, the hospitals ruled; under managed care, there is more balance. Risk-share

contracting has forced both sides to the table, with some good results.

MCOs create barriers to disease management when they try to force their own so-called best practices onto physicians. Physicians do not know from patient to patient what health insurance coverage the patient carries, and aren't able to apply anything other than their own evaluated best practices to their care. Local care patterns work better than those decreed by insurance company home offices.

MCOs can facilitate patient compliance with disease management protocols by providing access to such benefits as durable medical equipment and different therapies. These benefits change behavior as well as improve outcomes.

Perhaps the best example of well care is one of the managed Medicaid requirements. Charts are evaluated on an annual basis, with a plan of care developed for an annual fee. Many problems are identified, not the least of which may be that the patient has not had follow-up care. This is identified and corrected. Often, the patient has not been seen in a year.

Pay-for-performance plans work best if used to improve patient care systems. Differentials for after-hours patient care, for weekend hours, for increased access to care, have an immediate positive effect on patient health. Measuring outcomes does not work because of the problem of "norming" for aging populations, patient migration between plans, and small numbers in rural practices.

John D. Matthew, MD, FACP, is director of The Health Center, Plainfield, VT. He is board-certified in internal medicine and family practice.

Rebecca L. Bowen, MBA, MHA, FHFMA, is executive director, Central Vermont Physician Hospital Organization, Barre, VT., and chair of HFMA's Managed Care Forum. She can be reached at (802) 371-5370 or via email Rebecca.Bowen@Hitchcock.org .

Member Get a Member Campaign

Just a reminder that we are in the middle of a new campaign to increase chapter membership and provide more networking and relationship-building opportunities for our current members. The grand prize is free registration to the HFMA Annual National Institute in Nashville, Tennessee, June 27-July 1, 2004. ANI is attended by more than 1,500 HFMA members nationwide!

The contest is open to the following:

1. New members who join during the contest period.
2. All members sponsoring at least one new member during the contest period.

Everyone who qualifies will be entered in a drawing for the grand prize estimated at \$700.

Here are the rules:

1. On their membership application, the new OHFMA member must list you as their sponsor. National HFMA must have you listed as the sponsor.
2. To be considered a "new" member, they must not have been a member for the HFMA 2002-2003 fiscal year (June 1, 2002 through May 31, 2003).
3. The new OHFMA member must sign up after the start date of the contest but no later than March 31, 2004.
4. Due to time constraints, the grand prize is non-transferable.

The Board of Directors will be responsible for resolving any disputes and any questions about contest rules should be forwarded to Lloyd Haggard or Meegan Carter.

New Members

Since November 2003 Newsletter

Marianna Burnett
Norman Regional Hospital

Nancy Leachman
Seiling Hospital

Diane Downard
Hurley Health Center

Todd Little
Orthopaedic & Reconstructive Health System

Wendi Kinnamon
Stillwater Medical Center

Jonnetta Selvidge
St. John Medical Center

Rebecca Herring
LaDonna Howell
BKD, LLP

Donna Frazier
Saint Francis Heart Hospital

Craig King
GE Healthcare Financial Services

Marlon Jones
Isaih Owens
Student

Peggy Noble
Claremore Regional Hospital

Jan Rizley
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Debra Score
Hillcrest Specialty Hospital

Kay Naifeh
INTEGRIS Marshall Memorial Hospital

Katie Greer
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**HFMA
Oklahoma
Chapter
Corporate
Sponsors
2004**

(Paid through February 15, 2004)

Platinum Level

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HCFS, Inc.....Don McCown....(800) 394-4237
Madole Wagner, PLLC....Rick Wagner....(918) 299-8833

Gold Level

MASH....Cheryl Kaufmann....(800) 880-6274

Silver Level

American Collection Services, Inc.....Louise Littlejohn....(405) 682-8088
D-MED Corporation....Dudley Medlock....(800) 695-2404
QUE Financial....George Finefrock....(800) 285-7791
The Midland Group....Ryan O'Hara....(785) 840-9676

Bronze Level

CAC Financial Corp.....Jim Peters....(405) 425-1590
Central States Recovery....Chuck Lyon....(800) 779-0419
Credit Bureau Services Association....Teresa Axton....(405) 707-3442
FMA Alliance, Ltd.....Robert Hall....(888) 467-7121

We value and appreciate our participating corporate sponsors. If you or your organization is interested in becoming a corporate sponsor for OHFMA, please contact Louise Littlejohn, Corporate Sponsors committee, at (405) 682-8088 ext. 121.



**Thanks corporate sponsors —
we couldn't do it without you!!!**

And now a word from our sponsors...

Okay, admit it. You see the list of corporate sponsors in the newsletter each quarter, you see their representatives at each of our meetings, but do you really know what they do?? In the next couple of newsletters, we hope to give you an introduction to our corporate sponsors and how they define their business. The corporate sponsors are very important to the health and vitality of our chapter and next time you have a chance, tell them how much you appreciate their participation!

BKD, LLP is the nation's 9th largest full-service CPA and consulting firm with offices in eleven states. Health care is the largest niche within the firm, combining a comprehensive knowledge of Medicare, Medicaid and other third-party payers, reimbursement and health care financing with practical experience in developing and implementing strategies for your success.

D-MED Corporation is a healthcare consulting and management company founded in 1987 in Dallas, Texas, by Dudley Medlock, CPAM.

D-MED specializes in accounts receivable, patient access, and the business office for all types of healthcare providers. D-MED's services include Business Office Assessment, Process Improvement, Interim PFS Directors, Implementation, Training, On-Site Patient Account Reps, Backlog Cleanups, Early Out Programs, etc.

Madole Wagner, PLLC
Certified Public Accountants
Audit and Consulting services for the health care industry
web site: madolewagner.com

Medical Advocacy Services for Healthcare (The MASH® Program) is an eligibility service provider employing seasoned social services and government program staff with over 1,200 collective years of experience and expertise. MASH screens and processes patients for public benefits such as Social Security Disability and Medicaid, creating new revenue for hospitals.

QUE Financial specializes in providing high-touch, professional management of current self-pay accounts receivables to healthcare facilities. Our PayCareT approach treats patients with respect while significantly increasing cash flow and reducing the need for bad debt collection activity.

American Collection Services, Inc. is a full service collection agency, specializing in medical accounts receivables, including: early outs, insurance filing and follow-up, and special and clean-up projects. American has been an Oklahoma owned and operated corporation since 1977, and is currently among the top ten largest women-owned businesses in the Oklahoma City area.

CAC Financial Corp. has been in business for over sixty years and is licensed nationally. Some of their product lines include: early out outsourcing, third-party contingency collections and collection litigation

**OHFMA Leadership
2002-2003**

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Linda Short
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HFMA & THE INFORMATION AGE

Are you currently receiving "HFMA Wants You to Know," a weekly email for HFMA members? If not, and you would like to receive a free subscription, send an email to memberservices@hfma.org.

The Oklahoma Chapter has implemented email distribution of the chapter newsletter and other updates. We will continue to mail newsletters to those members for which we have no email address. If you do not receive the email version and would like us to have your email address on file, please email Becky Speight at rspeight@bkd.com.

If you need to change your member demographic information, including your email address, contact memberservices@hfma.org.

WE WANT YOUR FEEDBACK!

Do you have ideas on topics for upcoming educational programs? Are there ways we can serve you better either through networking opportunities or educational initiatives? Other comments or suggestions?

Call or e-mail:

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The statements and opinions appearing in articles are those of the author and do not necessarily reflect the view of the Oklahoma Chapter, the Healthcare Financial Management Association, or the editor. The editor reserves the right to edit material and accept or reject contributions whether solicited or not. All correspondences are assumed to be released for publication unless otherwise indicated.

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