Singer and Evangelist Joe Melashenko is Dead at 91

As paterfamilias of a dynasty of musically gifted Adventist pastors and evangelists, Joe Melashenko was known as the ever-debonaire grandfather figure whose rumbling bass resonated as the broadcast voice of God to many generations of Americans. He passed quietly to his rest Friday....(read more)

Unfolding the Revenue Stream at Loma Linda University Medical Center
(Second in a Series on the Finances of Adventist Health Care Institutions)

Adventist health care institutions have fielded their share of hard questions about the high salaries some executives accept from "non-profit" resources of the church's system. Within that context and the high cost of medical care in the US today, how does a "teaching hospital" like Loma Linda Medical Center (LLMC) fare in comparison with similar institutions, such as top-rated UCLA Medical Center and Massachusetts General?

Does LLMC see more or fewer patients, and are its administrators paid on a scale consistent with these other hospitals' executives?

This report continues an exclusive series from Adventist Today, written by T. Joe Willey, Ph.D., to provide a contemporary but historically contextualized look at where Adventist health care finds itself today, as exemplified by one of its flagship centers, Loma Linda Medical Center....(read more)
Singer and Evangelist Joe Melashenko is Dead at 91

Submitted: Jun 22, 2013

By AT News Team
In 1948 the Canadian son of immigrants from Russia joined the King's Heralds quartet as their bass. He was music director for George Vandeman for many years and an evangelist with the Voice of Prophecy media ministry for more than two decades. H. M. S. Richards called him the “basso profundo in excelsis.” He passed away Friday morning (June 21) at age 91, his son Lonnie Melashenko, retired director of the Voice of Prophecy, has told Adventist Today.

"He left like he lived," Pastor Melashenko said of his father. "Quietly. Graciously. With gentle dignity. Without demands or harsh words or even a frown, he surrendered himself, a tired, frail, humble gentleman; into the waiting arms of his Savior."

Growing up on a farm in Saskatchewan, Joe milked a dozen cows by hand twice a day and would sing to pass the time. By his early 20s, he had won numerous amateur hours and talent show awards. He was heard on coast-to-coast radio in Canada as the "Voice of the Deep."

With his wife Anne, Joe had five sons – Lonnie, Joedy, Dallas, Eugene and Rudy – and taught them to sing at an early age. The family has performed together countless times and the sons have become Seventh-day Adventist ministers. Joe spoke both Russian and Ukrainian fluently and one of the great thrills of his life was returning to the former Soviet Union to preach in an evangelism campaign.

"Jeannie and I are weeping, but we thank God for 'The Blessed Hope' without which we would be most miserable," stated Pastor Melashenko. He thanked God for his father's long life in testimony to this hope. Memorial services for Elder Joseph Melashenko will be held at the Paradise Seventh-day Adventist Church in northern California on Sunday, July 21, at 4 p.m.

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Unfolding the Revenue Stream at Loma Linda University Medical Center

Submitted: Jun 24, 2013

By T Joe Willey

Second in a Series on the Finances of Adventist Health Care Institutions

"Private nonprofit hospitals enjoy government-conferred advantages, including exemption from corporate income and property taxes, access to tax-exempt bond financing, and eligibility for private donations. Until the end of the 19th century, U.S. hospitals were almost exclusively donative institutions. Before that, the more affluent received care in physicians’ offices and at home." -- Frank A. Sloan, Handbook of Health Economics (Elsevier Science, 2000)

When Jerry Fields (not his actual name) experienced loss of motor control in his right leg he wondered if it was from cancer in his spine. Then one night he sat bolt upright in bed at three in the morning. The bottoms of his feet were itching and he couldn’t move his toes. Maybe he had a brain tumor, he worried. He was afraid to go to a doctor. His fears took on more personalities than the state hospital for the insane. After a couple of months he no longer felt safe driving his eighteen-wheeler truck on the Interstate. It was the dispatcher at the trucking company, out of kindness, who convinced Jerry to go see a doctor, if he wanted to keep his job.

The doctor ordered an MRI scan of his lower back and reassured Jerry to stop worrying until he knew for sure what the problem was. Worrying never fit Jerry right.

A few days later the doctor's assistant called to make an appointment for Jerry to see a neurosurgeon. It was a simple obstruction, not a tumor. The MRI showed a small osseous “bubble about the size of a pea” growing slowly around the exit point of one of his lumbar motor nerves. This pea-sized foreign body was pressing against the nerve to cause the tingling, weakness, and pain in Jerry’s leg. The procedure to remove the growth involved minimal invasive surgery. It could be done as an outpatient procedure by inserting a scope into a small incision in his back and chipping away the growth.

A week later Jerry entered the hospital at six in the morning and two hours later was wheeled into the operating room. As he came through the door he saw a nurse standing over him ready to inject a sleep-inducing drug into his drip line. After that he did not remember anything. By noon he was awake; a bit groggy and unable to urinate. The neurosurgeon came by the recovery room and told Jerry that within a week he could return to work if there were no complications.

Back home he was soon feeling great and wondered why he had let fear like a scarecrow shadow his mind for so long. Later, while sitting on the porch with his grandchildren and watching them play in the front yard, he became fascinated with his own toes.

The hospital bill related to his lumbar surgery was $39,734. This did not include the surgeon’s bill for $3,200 and $1,400 from the anesthesiologist. The total for this minimal invasive surgery came to $44,334 — more than the down payment for his home. Fortunately, Jerry was covered by Blue Shield health insurance. Jerry paid a $500 deductible and Blue Shield negotiated the hospital bill to $6,200.

After passing through the experience Jerry believed what people were saying about the health care industrial complex costing more than three times what the military-industrial complex spends in Washington. Another view is that of the economists who say that hospitals need a substantial margin to maintain the essential public services which communities depend on. Hospitals
have to cope with cost shifting and higher rates for insured patients. Obviously, there is more to the story.

In a nutshell, the operation of a hospital is capital intensive. Put another way, hospitals are engaged in a high-velocity money business. Diagnostic equipment, instruments, devices and supplies are expensive, generally with a short half-life. Also, nearly every aspect of hospital operations is government regulated. And the level of regulations is increasing (e.g. The Emergency Medical Treatment and Active Labor Act). Government payments for health care often fall short of actual costs and therefore represent a “cost” that is increasing. A portion of the cost of caring for Medicare and Medicaid patients must be passed on to fee-for-service payers whose rates are negotiable.

Also, hospitals are labor intensive. The cost of hospital workers represents nearly two-thirds of the total expenses. In addition, the makeup of the workforce is changing. There are long-term shortages of qualified and certified personnel. Recruitment of skilled workers means competitive pay rates. To top it off, pressures are mounting from the government to provide more charity for the uninsured and poor while at the same time to improve quality, accountability, transparency, efficiency and affordability.

**Nonprofit Tax-exempt Hospitals**

According to the American Hospital Association there are 2,903 not-for-profit hospitals in the country. These “nonprofit hospitals,” as I shall refer to them, represent approximately 60 percent of all U.S. hospitals. The primary advantage for nonprofits is that they pay no property or sales taxes and are able to acquire capital at low interest rates (usually through the tax-exempt bond markets). Nonprofits are often affiliated with religious groups or a particular faith is a key feature of their identity. Another 20 percent are public hospitals (belonging to some government) and the rest are for-profit hospitals.

The nonprofit status began during the infrastructure boom of the 1950s and 1960s when the Federal government offered subsidies to build hospitals. Getting the money required the hospitals to acquire a nonprofit status and promise to provide “community benefits.” The IRS standards allow broad latitude as to what is defined as a community benefit. In addition, hospitals, particularly ones run by a religious denomination, were somewhat better protected from litigation under the “doctrine of charitable immunity,” although this shield is another thing that is changing. The fundamental nature of the nonprofit hospital has evolved. Consolidations have taken place with excess revenues in the millions and many are now run by professional administrators using sophisticated computer models and consultants from the for-profit world. Today, many hospitals appear to run like large profit-making corporations, even though their intent is nonprofitability.

In an upcoming article in this series we will discuss how much “community benefit” Loma Linda University Medical Center (LLUMC), and a few other teaching hospitals provide to meet the standards for tax-exempt status and how it is accounted for. This is one area where nonprofit hospitals have drawn the ire of the public. There are a growing number of class action lawsuits against hospitals that fail to meet their charity care requirements because of aggressive debt collection practices against uninsured patients or the use of the facilities of a tax-exempt hospital to derive profits by physician groups. We will come back to this topic in the future.

Nonprofit hospitals come in three forms. They can be operated by a community, a government or a faith-based organization. LLUMC is a faith-based hospital affiliated with the Seventh-day Adventist Church. The church does not directly operate the hospital since LLUMC is recognized by the IRS as a separate 501(c)3 organization with its own members (stakeholders identified in the bylaws) who elect the board of trustees. There are some occasions when the administration may attempt to legally claim religious exemption to certain laws that govern labor relations. [1] And even though LLUMC receives all of its service fees from the government, private insurance, related parties and donations, and is a teaching hospital with a commitment to scientific and research activities, its religious affiliation with the Adventist Church makes it a unique institution.

LLUMC is incorporated as a charitable organization under California’s Nonprofit Benefit Corporation law. The law requires religious corporations to not make any distribution of assets to members at any time (e.g., siphoning off charity’s excess revenues) and not lobby to influence legislation. The law allows LLUMC to discriminate in its hiring practices. For instance, the corporation can place only members of the Adventist Church in positions as executives and pastoral care personnel under
the immunity provided by the California statute.

Furthermore, the California law allows LLUMC as a denominational institution to apply its religious doctrines, tenets and teachings in all positions connected with the provision of health care. [2] But it is quite likely that a patient can leave the hospital after inpatient or outpatient care without knowing the fundamental beliefs of the Adventist Church. Many staff physicians and the majority of the employees, including nurses, are not members of the church. Contrary to what you may have heard, there are many instances when staff and chaplains extend a spiritual hand to patients during their time of distress.

LLUMC’s parent company is Loma Linda University Adventist Health Sciences Center or LLUAHSC. The name was recently shortened to Loma Linda University Health. The LLUH board determines policies, salaries, and other matters for LLUMC. The board is composed of 20 members, all of whom are Seventh-day Adventist. Half are Union Conference presidents, officials or administrators of the denomination. They include Pastor Ted Wilson, president of the General Conference, and Pastor Lowell C. Cooper, a General Conference vice president who is chairman of the board. Another 16 denominational officials serve as board advisors. The actions of the board are published and consist mainly of progress reports, information about Federal and state initiatives in health care and new appointments. Dr. Richard H. Hart is president and chief executive officer of LLUH. Ruthita Fike is CEO and vice president for medical affairs of LLUMC.

The stated mission of the hospital “is to continue the healing ministry of Jesus Christ, ‘To Make Man Whole,’ in a setting advancing medical science and to provide a stimulating clinical and research environment for the education of physicians, nurses, and other health professionals.” [3] Many faith-based institutions like LLUMC refer to some type of religious heritage and ministry of healing.

Revenues and Expenses

The report that follows explains the revenues and expenses of LLUMC. We will use audited financial statements, the IRS 990 tax report and a few other sources such as U.S. News and World Report. No single calculation tells the whole story of a hospital’s performance. We will simply take a broad view of revenues and expenses to show the hospital’s ability to create value and other assets. So we are not looking for trends or creating financial ratios that might provide deeper insights. [4]

For comparison purposes (to make the story more interesting) a snapshot will be made of the revenue (related to patient services) and expenses from a few other teaching medical centers, including UCLA, Stanford University, The Mayo Clinic, Baylor University, Massachusetts General (Harvard University) and The Cleveland Clinic. You see that all of these teaching medical institutions are afloat in money. [5]

How different is the Adventist brand name from these other teaching institutions when looking at the balance sheet? To begin, we will look at the input side in Table 1. The first column displays the number of licensed beds, and there may be some inaccuracy in these numbers because of consolidations. The "patient" column is the percentage of satisfied patients summarized from ten survey questions administered by The Centers for Medicare and Medicaid Services after they have left the hospital. [6]

In this list of teaching hospitals, LLUMC certainly has a good reputation in the community and many would even say a great reputation. According to U.S. News & World Report, LLUMC was ranked number one among the 41 hospitals in Riverside and San Bernardino counties. This was the third time in a row that LLUMC achieved this ranking. The hospital serves a metropolitan area encompassing more than four million residents, many of whom are vulnerable and medically underserved. They turn to LLUMC as a safety net for healthcare. UCLA was ranked number one for the entire state of California and Massachusetts General ranked number in the nation. Table 2 displays the revenues and expenses for these institutions as reported on the IRS 990 forms for 2011.

LLUMC purchased the membership interests of physician investors in a new 106-bed hospital in Murrieta, California, for
$39 million and this expenditure reduced excess revenues to 2.05 percent. The salaries of the CEO of each institution are shown in the last column. **The Medicare Component**

Medicare is a national social insurance administered by the Federal government. This program provides access to health insurance for Americans over sixty-five and younger individuals with disabilities. It pays for about 47 percent of all provided care in America. Medicaid is a health program for families with low incomes. This is the largest source of health care funding for the poor in the United States. Individuals who appear at LLUMC for treatment and are at 200 percent of the poverty line (defined by the Federal government) are eligible to participate in the program which is jointly funded by the state and Federal governments. Patient revenues for these two programs are shown for LLUMC in Graph 1. The government programs make up a significant part of LLUMC revenues. Graph 1 also includes the private insurance contributions and revenues from self-pay by uninsured patients.

If you add up all the highly inflated charges in the charge master from Stanford Hospital provided in the giant spreadsheet by Medicare it shows that Medicare only accounts for about 18 percent of the revenues for this teaching hospital. In 2011, the audited statement from Stanford showed a combined revenue from all government programs of only 23 percent, but 65 percent from managed care health insurance programs and another 11 percent from the uninsured. There are differences in revenues among the teaching hospitals in this report which can be the results of many different influences, including adverse populations, community affluence, hospital policies, electronic health record technology, etc.

For comparison purposes, Graph 2 shows the same information for Baylor University, UCLA Medical Center and The Cleveland Clinic. The government component (Medicare and Medicaid) is nearly equal in all three teaching hospitals, and slightly less than the national average. (Nationally, Medicare pays for 47 percent of patient care.) The Centers for Medicare and Medicaid contract with “fiscal intermediaries” to oversee billing and payments to hospitals. Consequently there are extensive auditing hoops each hospital has to pass through to get the reimbursements.

Teaching hospitals like LLUMC train future health care professionals, including physicians and nurses. These unique institutions also conduct research and improve diagnostic and treatment methods. Highly specialized services are concentrated in teaching hospitals. Patients with complications are often transferred to these hospitals. In general, teaching hospitals account for more than 50 percent of the overall cost of uncompensated hospital care and 50 percent of all Medicaid hospitalizations. As the economy worsens and health-care funding shrinks, these trends place more burden on these hospitals to provide for the low-income population. Teaching hospitals directly employ 2.7 million people and are often the largest employer in a community. There are 13,181 employees at the LLUMC. [8]

Special payments are given by Medicare to cover the costs of the educational and research role of these institutions. Medicare is the largest single program providing support for post-graduate medical education (not students in medical school). These Medicare payments are based on numbers of residents and interns during a base period at each institution. In 2011, a total of $3.2 billion was directed into graduate medical education (DGME) and another $15 billion directed into related, indirect costs of medical education (IME) based on the ratio of residents to hospital beds. [9] These payments are based on historical costs and directed to the institution, not individual residents. Beyond this brief description the program gets complicated. [10] In addition, because of its unique role in basic and clinical research, the National Institutes of Health award over two billion in research funding to teaching hospitals.

**The Expense Side of the Ledger**

We would like to think of hospitals in terms of compassion, patient care and dedication to community benefits. In fact, they are
like businesses concerned with obtaining revenues to match expenses and looking for excess left over to improve patient services, etc. Graph 3 displays the major categories of expense for LLUMC. Related categories were combined in some instances and other less significant expenses left out.

Conclusion

At least one conjecture can be made from the financial information presented here. The community has a possible impact on the revenues and excess earnings of nonprofit hospitals. As an example, Stanford University Hospital uses a higher charge master than the other teaching hospitals. [11] In the 100 most common DRG procedures at Stanford, Medicare payments only represents 17 percent of the possible payments listed on the table supplied by Centers for Medicare and Medicaid Services. According to the 2011 data in this report, Stanford is the smallest teaching hospital with 477 beds compared to 815 at LLUMC (although there are other hospitals affiliated with Stanford). Yet Stanford generates $2.1 billion compared to LLUMC at $1.2 billion. Stanford shows the highest performance at 16.55 percent. Stanford's government reimbursements are the lowest at 22.59 percent and compare to 62 percent at LLUMC. The majority of revenues at Stanford come from managed care (with an inflated chargemaster) representing 65.57 percent after discounted fees for services. By keeping revenues up and expenses down Stanford in 2011 created an excess of $415 million compared to $24 million at LLUMC. These results may simple reflect less aversive populations in the Bay Area. The uninsured patients who were able to self-pay for medical care was higher at Stanford (11.45 percent) than at LLUMC (8 percent). Baylor University had even higher revenues from self-pay patients than either Stanford or LLUMC. One observer quipped, "clearly LLUMC is performing as a nonprofit, benevolent corporation as expected by the government."

One thing is clear, "Each nonprofit hospital has its own values and challenges" in the complex world of delivering health care. Many of the forces and influences involved are difficult to manage.

T Joe Willey is the author of the recent Adventist Today article titled "Million-dollar Salaries in Adventist Healthcare" and "Tax-exempt Bonds and Secularization in Adventist Education."

-------- 1. www.aaup.org/sites/default/files/loma-linda-university.pdf. 2. Arriaga v. Loma Linda University, 10 CAL. App. 4th 1556 (1992). See also Catholic Charities of Sacramento, Inc. v. Superior Court for the State of California in and for the County of Sacramento. Third Appellate District, Case No. C037025. 3. See the 990 Form filed with the Internal Revenue Service for 2011. 4. From 2000 to 2008 LLUMC's revenues grew approximately forty-five percent. 5. Baylor University Hospital replaced USC Keck in this series because USC medical school is consolidated with the university financial statements. 6. Studies reported in the New England Journal of Medicine have been unable to identify significant relationship between patient satisfaction and quality of clinical care. (October, 2008). 7. Centers for Medicare and Medicaid Services of the Department of Health and Human Services. Ratio obtained by adding up Medicare payments and the charges for the 100 common procedures. 8. Becker's Healthcare. 10 things to know About Loma Linda University Medical Center. July 25, 2012. 9. In Loma Linda University Medical Center v. Kathleen Sebelius, Secretary United States Department of Health and Human Services Case 1:08-cv-01520-HHK. Filed 02/06/2010 the medical center was given the opportunity through summary judgment to apply for funds that apparently were improperly filed or overlooked with the fiscal intermediary. The court determined that LLUMC's failure to properly file claims was a likely flaw in the Provider's internal process to ensure timely billing (In LLUMC v. Blue Cross Blue Shield Association/United Government Services. Dated May 9, 2008). 10. AAMC. Medicare Payments for Graduate Medical Education. What Every Medical Student, Resident, and Advisor Needs to Know. January, 2013. 11. T Joe Willey. “To Make Man Whole” But It May Cost an Arm and a Leg. Adventist Today.

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