

The Math Doesn't Work

Health System Economics and the Governance of Financial Sustainability

Featuring Michael A. Slubowski, FACHE, FACMPE
President and Chief Executive Officer, Trinity Health

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The Governance Takeaway

Meaningful cost discipline can coexist with a narrow operating margin—the percentage of operating revenue remaining after operating expenses. Trinity Health's fiscal year 2025 results illustrate the challenge: adjusted cost per unit of care rose 2.4 percent, while operating margin before impairment and restructuring items was 0.8 percent. After those items, the operating result was approximately breakeven.¹

For Mike Slubowski, the question is how long efficiency gains can offset persistent pressure on the economics of care. His analysis invites boards to consider what explains financial performance and whether it leaves sufficient capacity to renew assets, support the workforce, and sustain access.²

In This Insight

A closer look at Trinity's experience, the role of operating margin in sustaining mission, and questions for board–management discussion about performance, financial capacity, and public responsibility.

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Educational resource. The Scope and Use statement at the end applies throughout.

When Payment and Cost Diverge

Mike Slubowski's argument begins with a patient who needs a replacement heart valve. In his analysis, the device can, in some cases, cost as much as—or more than—Medicare's hospital payment for the procedure. That payment also has to support nursing, operating-room resources, supplies, and other facility costs.²

The example reveals a broader mismatch in healthcare economics. Hospitals receive payments shaped by government policy and commercial negotiations, yet purchase labor, supplies, equipment, and other essential resources in markets with different pricing pressures. Regardless of those constraints, hospitals remain responsible for maintaining the people, facilities, and around-the-clock readiness required to deliver care.

Trinity Health illustrates the scale of this challenge. Slubowski reports that roughly 80 percent of Trinity's services are provided to people covered by government programs. Each year, he says, the system faces a gap of more than \$1 billion as costs rise faster than payments. Trinity works to close that gap through productivity improvement, process redesign, cost management, and growth.²

THE GOVERNANCE QUESTION

His argument does not diminish the importance of continued improvement in hospital performance. Rather, it raises a more fundamental question: **Can those improvements keep pace with rising costs while preserving the financial capacity to invest in the future?**

Costs Beyond the Bedside

The financial pressures facing hospitals extend beyond the direct cost of delivering care. Reimbursement processes, contracted services, and the economics of relationships with insurers and suppliers can materially affect how much revenue remains available to support operations and future investment.

Slubowski reports that Trinity spends \$120 million annually appealing denied claims, most of which he says are ultimately overturned. He also cites supplies and contracted services that exceeded plan by \$172 million, with contracted hospital-based physician services another \$92 million above plan.²

He also examines how financial returns are distributed across the healthcare system. Applying assumed industry margins to Trinity's largest commercial relationships, he estimates at least \$245 million in profit for its seven largest commercial insurers and approximately \$474 million for its 15 largest suppliers from Trinity-related business.²

These are illustrative estimates, rather than profits those companies have disclosed on individual Trinity contracts. They express Slubowski's concern about how payment, pricing power, and financial return are distributed across the organizations involved in a patient's care.

MIKE SLUBOWSKI'S PERSPECTIVE

"The math doesn't work for not-for-profit providers like Trinity Health."²

For trustees, the distinction between operational execution and broader economic conditions matters. Both can shape the same financial result, and both can affect the organization's ability to meet its commitments.

What Trinity Health’s Results Show

Trinity Health’s fiscal year 2025 results illustrate the distinction between improving operating performance and achieving a sustainable operating margin. The system reported \$25.4 billion in annual revenue, approximately 133,000 colleagues, and operations across 23 states. Its \$2.9 billion in total community impact included \$1.4 billion in community benefit as defined by the Internal Revenue Service.³

Operating revenue grew 6.6 percent, compared with 6.0 percent growth in operating expenses. Patient volume, adjusted for complexity, increased 1.9 percent, while spending on salaries and wages rose 5.1 percent, employee benefits 8.4 percent, and supplies 9.0 percent. These spending changes reflect activity and other factors as well as prices.¹

Despite those pressures, Trinity limited adjusted cost growth per unit of care to 2.4 percent. Its operating margin before impairment and restructuring items improved from 0.3 percent to 0.8 percent, demonstrating progress while remaining narrow.¹

TRINITY HEALTH | FY2025

<div>2.4%</div> <div>Increase in adjusted cost per unit of care</div>	<div>0.8%</div> <div>Operating margin before impairment and restructuring items</div>
Operating income before impairment and restructuring items	\$197 million
Operating result after those items	\$12.2 million loss
Purchases of property and equipment	\$1.2 billion
Total community impact	\$2.9 billion

Sources: Trinity Health FY2025 financial results and facts and figures.^{1,3} Adjusted cost per unit of care refers to adjusted operating cost per case-mix-adjusted equivalent discharge. Impairment and restructuring items include accounting charges related to reductions in asset values and organizational changes. The operating loss was approximately breakeven relative to revenue.

Operating Performance and Financial Strength

Trinity’s operating margin also tells only part of its financial story. The system reported a 4.8 percent net margin, reflecting both operating results and financial activity outside core operations, including investment-related income and expenses. Operating performance, investment returns, liquidity, and access to capital all contribute to an organization’s financial capacity.¹

The distinction matters for governance: improving operating performance can coexist with a narrow operating margin, even when the organization’s broader financial position remains strong.

What Operating Margin Makes Possible

For a not-for-profit health system, operating margin is not an end in itself. It helps provide the financial capacity to renew facilities, replace equipment, invest in technology, support the workforce, meet debt obligations, and sustain services the community needs.

Slubowski proposes an operating margin of **2 to 3 percent** as a reasonable expectation for a sustainable provider. At Trinity's reported revenue scale of \$25.4 billion, that range represents approximately **\$508 million to \$762 million** a year. One percentage point represents about **\$254 million**.^{1,2}

Those amounts are substantial, as are the obligations they help support. Trinity purchased \$1.2 billion in property and equipment in fiscal year 2025. Capital investment can be funded from multiple sources, not just operating earnings. The figure illustrates the scale of reinvestment required to sustain a health system of Trinity's size.¹

The appropriate operating margin varies with an organization's capital needs, debt, payer mix, service commitments, growth plans, and exposure to risk. Slubowski's proposed range offers a perspective on financial sustainability, rather than a universal benchmark.

Financial Pressure and the Capacity to Serve

Trinity's experience raises a broader question about the financial capacity of hospitals and health systems to sustain care over time. National evidence illustrates the pressures facing providers, although their financial circumstances and obligations vary considerably.

The American Hospital Association reports that total hospital expenses increased 7.5 percent in 2025, more than twice the 3.3 percent growth in hospital prices. It also estimates that approximately 56 percent of hospital costs are associated with service lines where reimbursement falls short of the cost of delivering care.⁴

A federal review of five urban hospitals that closed in 2022 or 2023 found financial decline at every hospital. Aging infrastructure and the anticipated cost of maintaining or upgrading facilities also contributed to those closures. The selected cases illustrate how financial pressure can affect future access; they do not establish a margin threshold for other organizations.⁵

For governance, the connection becomes concrete when financial performance is considered alongside the condition of facilities, workforce capacity, service availability, and the resources committed to future care. A margin target has more meaning when the board and management share an understanding of what it is intended to support.

A QUESTION FOR BOARD-MANAGEMENT DISCUSSION

What must this organization be able to fund and withstand to remain dependable to its community?

Considerations for Governance

01 — Distinguishing Performance from Structural Pressure

Management's operating performance and external economic conditions can affect the same financial result. Reporting that places productivity and quality measures alongside reimbursement trends, denials, workforce costs, and supplier prices may help trustees distinguish what management can control, influence, or respond to. Structural pressure does not remove accountability for execution.

02 — Connecting Financial Results to Future Capacity

An operating-margin discussion becomes more meaningful when linked to capital renewal, debt obligations, service commitments, and risk. Expressing one percentage point in dollars can help boards and executives consider the investments it could support, the tradeoffs involved, and the resilience of the financial plan.

03 — Recognizing Advocacy as Part of Stewardship

Slubowski sees advocacy for access, quality, affordability, and sustainability as part of not-for-profit providers' public responsibility.² Boards may consider how that perspective relates to their mission and policy priorities. The governance discussion concerns strategic assumptions and institutional commitments, while contract negotiation, claims administration, and execution of advocacy activities generally remain management responsibilities.

Questions for Board Discussion

- 1. Do we share an understanding of what is driving our financial results?** How much reflects operational performance, reimbursement, market conditions, or other pressures beyond the organization's control?
- 2. What must our operating margin make possible?** What financial capacity do we need to renew facilities, support our workforce, sustain access, and invest in the future?
- 3. Are we balancing today's financial performance with tomorrow's needs?** How can we distinguish efficiency gains that strengthen the organization from reductions that may compromise future capacity?
- 4. Which economic assumptions should concern us most?** Where could changes in reimbursement, labor costs, supplier pricing, or nonoperating income materially affect our financial outlook?
- 5. How can the board and management advance our mission together?** Where might a shared understanding of financial pressures strengthen our approach to advocacy, affordability, access, and long-term sustainability?

About This Governance Insight

The Governance Institute developed this Insight from ideas and evidence in Michael A. Slubowski's *Healthcare Industry in the United States—A “Public Trust” or “Profit Taker”?* Additional public sources provide financial and policy context. The governance considerations and discussion questions are TGI-developed educational material.

About Mike Slubowski

Michael A. Slubowski, FACHE, FACMPE, is president and chief executive officer of Trinity Health and serves on its Board of Directors. He previously served as the system's president and chief operating officer and as president and CEO of Sisters of Charity of Leavenworth Health System (SCL Health). His earlier executive roles include positions at Henry Ford Health System in Detroit, Samaritan Health Services in Phoenix, and Providence Hospital in Southfield, Michigan.⁶

Sources and Notes

1. Trinity Health. [Summary and Management's Discussion and Analysis of Financial Condition and Results of Operations, June 30, 2025](#). September 26, 2025, pp. 1–2 and 6–8. Margin-dollar illustrations use rounded revenue of \$25.4 billion.
2. Michael A. Slubowski. *Healthcare Industry in the United States—A “Public Trust” or “Profit Taker”?* 2026. Source for the author's examples, estimates, proposed margin range, and views on sustainability and advocacy.
3. Trinity Health. [Facts & Figures: Financial Strength](#). FY2025 figures unless otherwise noted; geographic reach updated January 2026. Community impact includes IRS-defined community benefit.
4. American Hospital Association. [Costs of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026](#). March 2026, pp. 2 and 7. Expense and service-line figures draw on Strata benchmark data; hospital price growth uses BLS data. Total expense growth reflects activity and acuity as well as prices and is not an input-price or unit-cost measure.
5. U.S. Government Accountability Office. [Urban Hospitals: Factors Contributing to Selected Hospital Closures and Related Changes in Available Health Care Services](#). GAO-25-106473, August 20, 2025; publicly released September 19, 2025. Five selected cases; findings are not generalizable.
6. Trinity Health. [Michael A. Slubowski](#). Official executive biography. Current title, credentials, board service, and prior roles verified against Trinity's official profile.

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