

Fall 2001



Financial / Indicators

Fiscal Year **2000**

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ABOUT THIS REPORT ON FINANCIAL INDICATORS

INTRODUCTION

Significant change occurred in the District of Columbia's health care delivery system during 2000, when initial steps were taken to privatize the city's public hospital and ambulatory clinics. The impact of this change can be seen in some of the charts and graphs in this *Financial Indicators Report*. While the full effect on the system will not be known until 2001 and beyond, private hospitals began to see the impact throughout the latter half of 2000 with an increase in unsponsored care.

This report is intended to provide a financial picture of the health of the hospital community in the District of Columbia over time. The public payors – Medicare and Medicaid – make up nearly 50 percent of District hospital business. As a result, changes in public reimbursement and eligibility can dramatically affect District hospitals' financial situation.

District hospitals largely reflect national trends with respect to Medicare. Operating margins dropped during the initial implementation of the Balanced Budget Act of 1997 (BBA), when Medicare reimbursements were slashed. BBA relief measures approved by Congress in 1999 and 2000 minimized Medicare losses for some hospitals in their 2000 reports. The State Children's Health Insurance Program, known as *DC Healthy Families*, and the Medicaid program both have enhanced eligibility so that more individuals can enroll in these programs. However, private coverage has decreased during the last three years.

These changes make 2000 a transition year for hospitals in the District of Columbia.

SOURCE

The data in this report come from the DCHA Annual Hospital Survey, which gathers standard audited information from the hospitals in the District. The information in this report is based on each hospital's own 2000 fiscal year. The charts and graphs on the financial condition of hospitals provide collective (and some individual) information about eleven of the sixteen DCHA member hospitals. During 2000, Hadley Memorial Hospital began to transition from a full-service community hospital to a long-term acute care hospital. Providence Hospital converted its fiscal year and could only submit financial data for a six-month period; consequently, Providence's information was annualized for the purposes of this report. The following hospitals were not members of DCHA during 2000 and are not included in this report: Columbia Hospital for Women, MedLINK Hospital and Hospital for Sick Children. The five DCHA member hospitals excluded from the aggregate data are three facilities providing only psychiatric services and the two that are federally owned.

Data are reported to DCHA directly by individual hospitals that follow the accounting guidelines defined in the *Audits of Providers of Health Care Services* of the American Institute of Certified Public Accountants (AICPA). AICPA guidelines require health care providers to classify bad debt as a part of operating expense, and to establish and disclose their policies regarding charity care along with the amount of charity care provided. These rules went into effect in 1990 and two related rules also went into effect during 1995. For analysis purposes, DCHA has classified bad debt as a separate line item.

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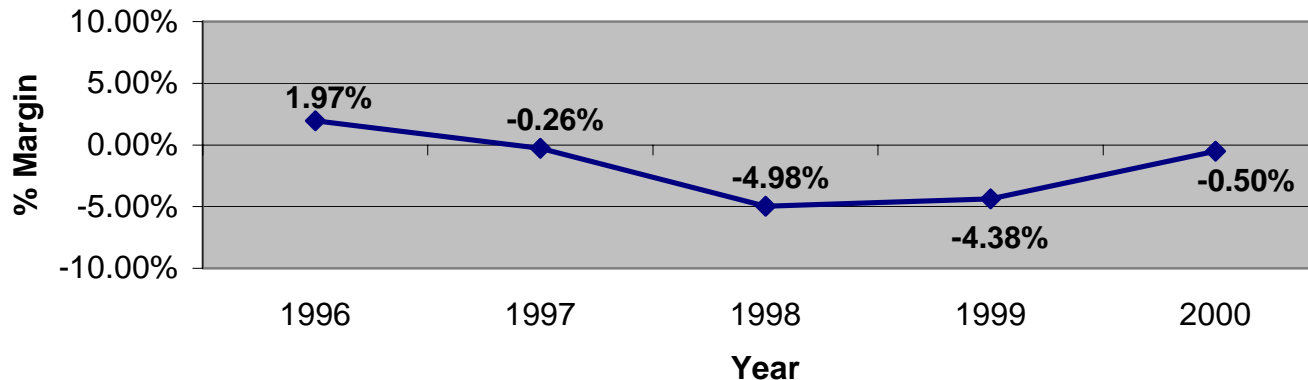
Aggregate Operating Margin Percent

District of Columbia Hospitals

Although 2000 was characterized by major changes in health care system planning in the District of Columbia, hospitals experienced a rebound in operating margins. Among the influences that explain this upturn in hospital operating margins are several legislative fixes to the Balanced Budget Amendment of 1997, which corrected a number of unanticipated financial consequences created by the BBA. It must be noted that although there appears to be a recovery in District total operating margins, the aggregate hospital Medicare operating margin in 2000 was still very low: negative 6.78 percent. As the effects of continued BBA reform measures are passed and hospitals implement aggressive cost reduction programs and budgetary and planning discretion, operating margins may stabilize. However, hospitals continue to be concerned about the access, delivery and cost of health care services for the District of Columbia's Medicaid and the uninsured and under-insured populations.

Note: New 1998 and 1999 financial figures became available for Howard University Hospital and operating margins were recalculated.

Aggregate Operating Margin Percent, 1996-2000



Thus, the aggregate operating margins differ from the 1998 and 1999 DCHA Financial Indicators Reports.

Note: Columbia Hospital for Women's financial information was included in the 1996, 1997, 1998 and 1999 operating margin calculations.

Note: Calculations exclude psychiatric and federal hospitals.

Source: 2000 DCHA Financial Indicators Survey.

Operating Margin Percent by Hospital

District of Columbia Hospitals

While 2000 seemed to bring some operating margin relief to hospitals, none of the District hospitals' margins approach the operating margin levels needed to invest in technology upgrades or infrastructure and capital improvements, typically above four percent. Again, the BBA legislative fixes seem to have had an impact in 2000 operating margins, and for many hospitals, the expansions of the Medicaid and the D.C. Healthy Families programs have further influenced individual hospital operating margins. With these expansions, hospital efforts to enroll patients in these programs have been stepped up, and insurance coverage is now provided to many patients that have traditionally inappropriately relied on hospital emergency rooms for primary care and the treatment of ambulatory sensitive conditions.

	Operating Margin Percent		
	1998	1999	2000
Children's National Medical Center	-1.86%	-11.22%	0.04%
District of Columbia General Hospital	5.81%	-8.64%	-12.10%
George Washington University Hospital	-2.54%	-1.39%	-7.24%
Georgetown University Hospital	-14.15%	-14.77%	-6.52%
Greater Southeast Community Hospital	-51.94%	-28.63%	1.45%
Hadley Memorial Hospital	NA	-41.73%	8.73%
Howard University Hospital	-23.17%	-0.52%	-1.26%
National Rehabilitation Hospital	5.18%	2.36%	2.36%
Providence Hospital	3.28%	2.61%	2.71%
Sibley Memorial Hospital	5.05%	3.25%	3.75%
Washington Hospital Center	3.02%	4.14%	3.87%
Aggregate Percentage	-4.98%	-4.38%	-0.50%

Note: New 1998 and 1999 financial figures became available for Howard University Hospital and operating margins were recalculated. Thus, the aggregate operating margins differ from the 1998 and 1999 DCHA Financial Indicators Reports.

Note: Columbia Hospital for Women's financial information was included in the 1998 and 1999 operating margin calculations.

Note: Aggregate Operating Margin Percent is computed by calculating the percentage difference between aggregate operating expenses and aggregate operating revenues.

Note: Calculations exclude psychiatric and federal hospitals.

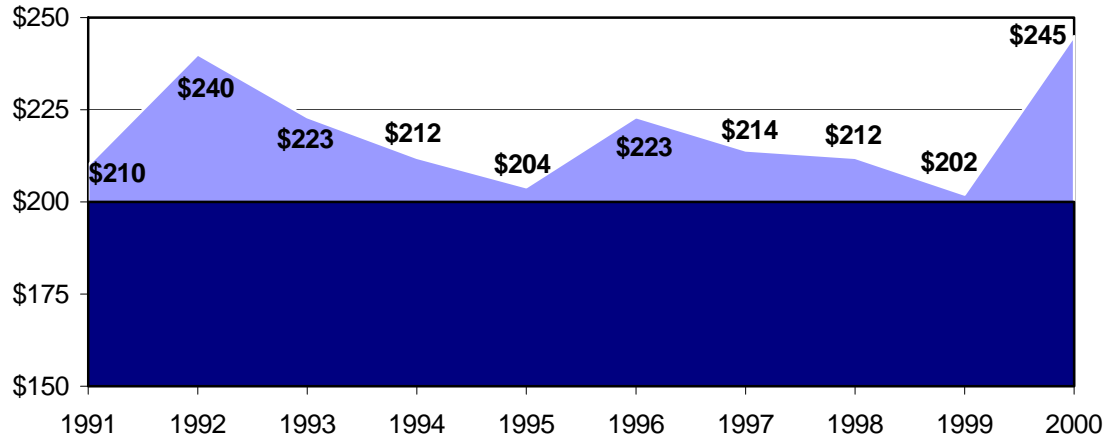
Source: 2000 DCHA Financial Indicators Survey.

Dollar Cost of Un-sponsored Care

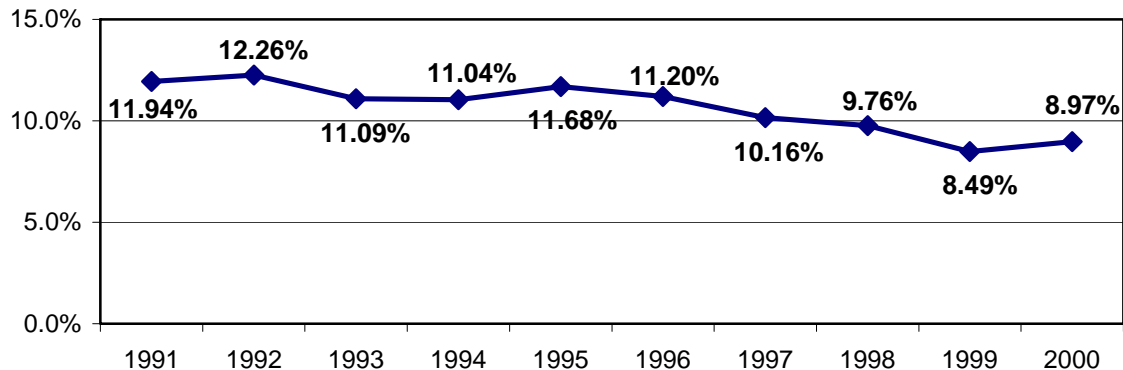
District of Columbia Hospitals

Ten-Year Trend: 1991 - 2000

Dollar Cost of Un-sponsored Care



Un-sponsored Care as a Percent of Total Hospital Care Provided



Note: Hadley Memorial Hospital did not report in 1995 or 1998 and data on Columbia Hospital for Women was included through 1998.

Note: Calculation excludes psychiatric and federal hospitals.

Source: 2000 DCHA Financial Indicators Survey.

In 2000, hospitals provided approximately \$245 million dollars in care to uninsured and underinsured persons. Over \$2 billion has been provided by District hospitals during the past decade. Last year, private hospitals increased their un-sponsored care by 3.25 percent over 1999. Ninety-one percent of the increase in un-sponsored care from 1999 to 2000 was due to the drastic increase in un-sponsored care at D.C. General Hospital (DCGH), much of which may be attributable to the resolution of longstanding debts at DCGH. As the privatization of the delivery of health care to the uninsured takes place in the District, the challenge will be now to fund care for the uninsured throughout the system.

D.C. hospitals' collective dollar contribution to un-sponsored care has been consistent over the past 10 years, although it has declined as a percent of total hospital care provided. This is the result of an increase in the value of total hospital care, thus reducing the proportion of un-sponsored care as a percent of the total hospital care rendered.

Un-sponsored Care

Cost and Percentage of Individual Hospital Total Care

District of Columbia Hospitals

Private hospitals in the District continued to demonstrate their commitment to the uninsured in 2000 by providing over \$132 million, or approximately 54 percent, of the un-sponsored care provided to under- and uninsured patients. D.C. General Hospital (DCGH), the city's only public acute care facility, provided the remainder of the care to the uninsured. 2000 was DCGH's last full year in operation and its increase in unreimbursed care may reflect ongoing debts from prior years. With the closure of inpatient care at DCGH in mid-2001, the impact on the remainder of the health care system is yet to be determined.

	<u>1999</u>		<u>2000</u>	
	Cost of Un-sponsored Care	Percent of Total Care	Cost of Un-sponsored Care	Percent Of Total Care
Children's National Medical Center	\$30,896,000	13.32%	\$33,032,000	15.16%
District of Columbia General Hospital	\$73,834,000	43.96%	\$112,365,000	57.04%
George Washington University Hospital	\$7,527,000	5.08%	\$9,568,000	6.36%
Georgetown University Hospital	\$6,220,000	2.64%	\$9,169,000	3.95%
Greater Southeast Community Hospital	\$12,250,000	10.10%	\$6,528,000	5.93%
Hadley Memorial Hospital	\$1,069,000	2.99%	\$490,000	2.09%
Howard University Hospital	\$25,685,000	13.43%	\$24,891,000	12.10%
National Rehabilitation Hospital	\$1,349,000	2.97%	\$1,575,000	3.12%
Providence Hospital	\$6,998,000	5.22%	\$7,951,000	5.73%
Sibley Memorial Hospital	\$4,197,000	3.75%	\$3,636,000	2.88%
Washington Hospital Center	\$32,346,000	5.63%	\$35,868,000	5.99%
District Total	\$202,371,000	8.49%	\$245,073,000	8.97%

Note: Children's National Medical Center, Howard University Hospital and Providence Hospital submitted revised 1999 data that changed their un-sponsored care numbers from DCHA's Fiscal Year 1999 Financial Indicators Report; in addition, Columbia Hospital for Women is not included in the 1999 or 2000 un-sponsored care calculations.

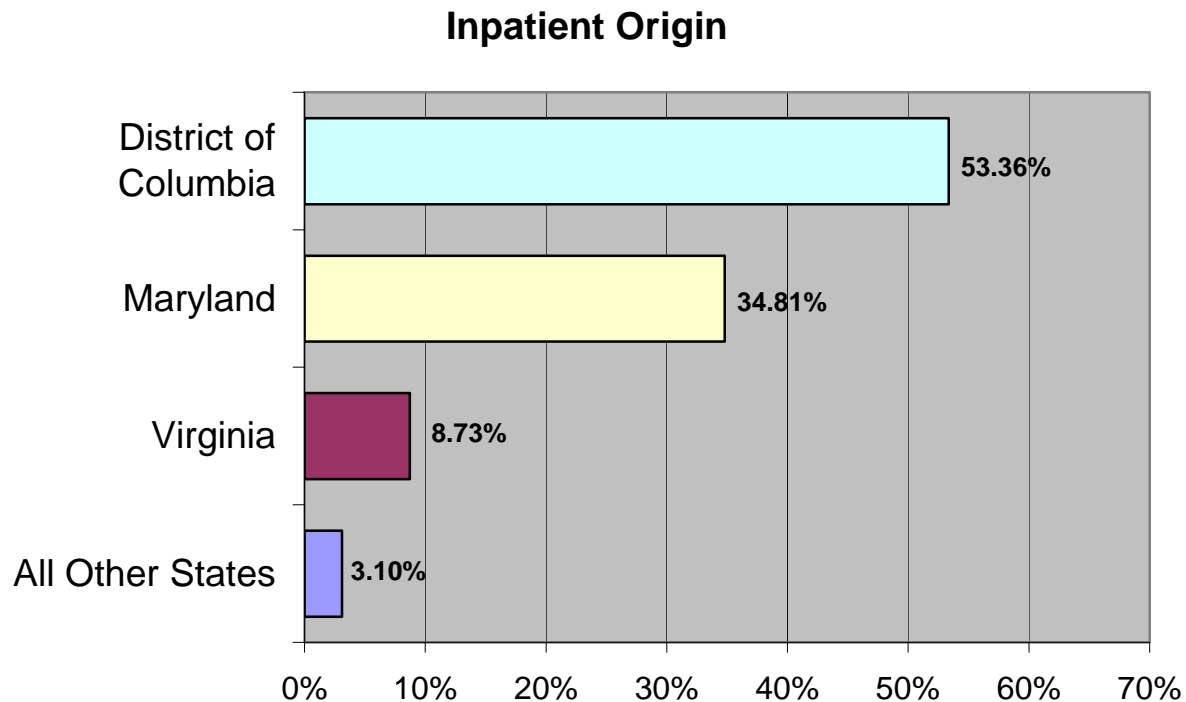
Note: Calculation excludes psychiatric and federal hospitals.

Source: 2000 DCHA Financial Indicators Survey.

Inpatient Origin

District of Columbia Hospitals

While the District of Columbia has a relatively small population (572,059 as of April 2000, according to the U.S. Census Bureau) District hospitals serve patients from throughout the region – over 3.5 million people. Only about half of the patients served in D.C. hospitals actually live in the city. Many D.C. hospitals are Centers of Excellence for such services as cardiology, cancer, pediatrics, and organ transplantation, and physicians throughout the Maryland-D.C.-Virginia region continue to refer their patients to these centers.

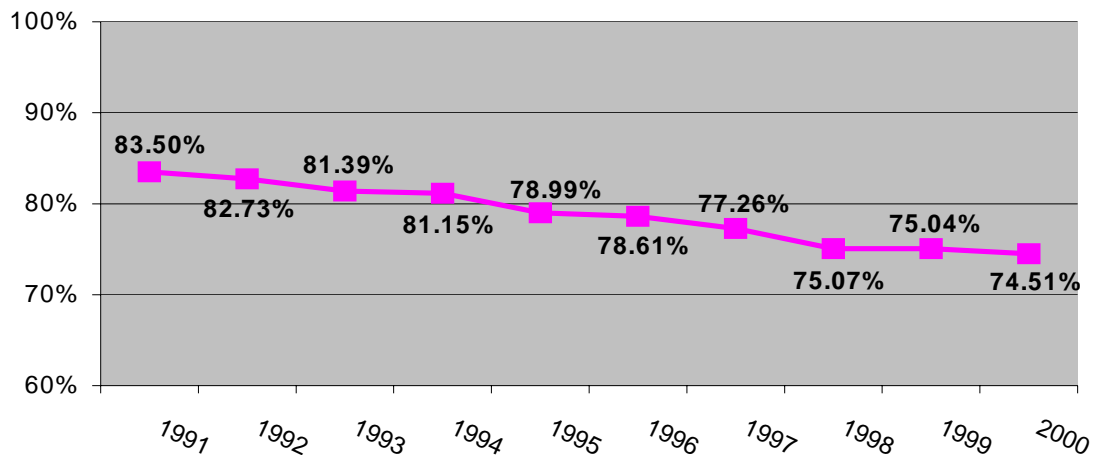


Source: DCHA Patient Data System, 2000. Hospitals in this database include Children's National Medical Center, D.C. General Hospital, George Washington University Hospital, Georgetown University Hospital, Greater Southeast Community Hospital, Hadley Memorial Hospital, Howard University Hospital, National Rehabilitation Hospital, Providence Hospital, Sibley Memorial Hospital, Veterans Affairs Medical Center and Washington Hospital Center.

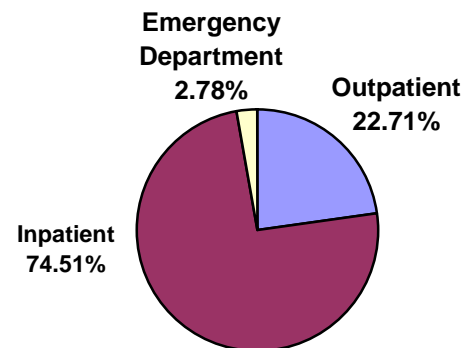
Inpatient, Outpatient and Emergency Department Revenue as a Percentage of Total Gross Patient Revenue

District of Columbia Acute Care Hospitals

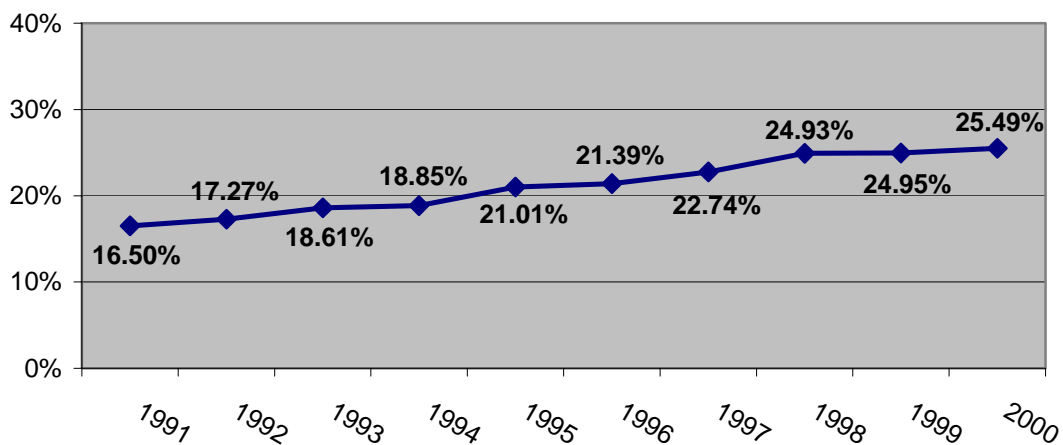
Inpatient Revenue



2000 Revenue Breakdown



Outpatient and Emergency Department Revenue



Until 1999, District hospitals reported only inpatient and outpatient revenues, with emergency department revenue included in each hospital's outpatient revenues. Beginning in fiscal year 1999, hospitals have begun to extract their Emergency Room revenue from Outpatient revenues. The pie chart shows the 2000 breakdown of District hospital revenues in these three categories. Outpatient and Emergency Department revenue continued to increase slightly in 2000 while inpatient revenue continued to decline.

Since 1991, inpatient revenue has been declining due to the shift of many services from an inpatient setting to the outpatient side. Conversely, outpatient and emergency room revenue has steadily increased over the past ten years.

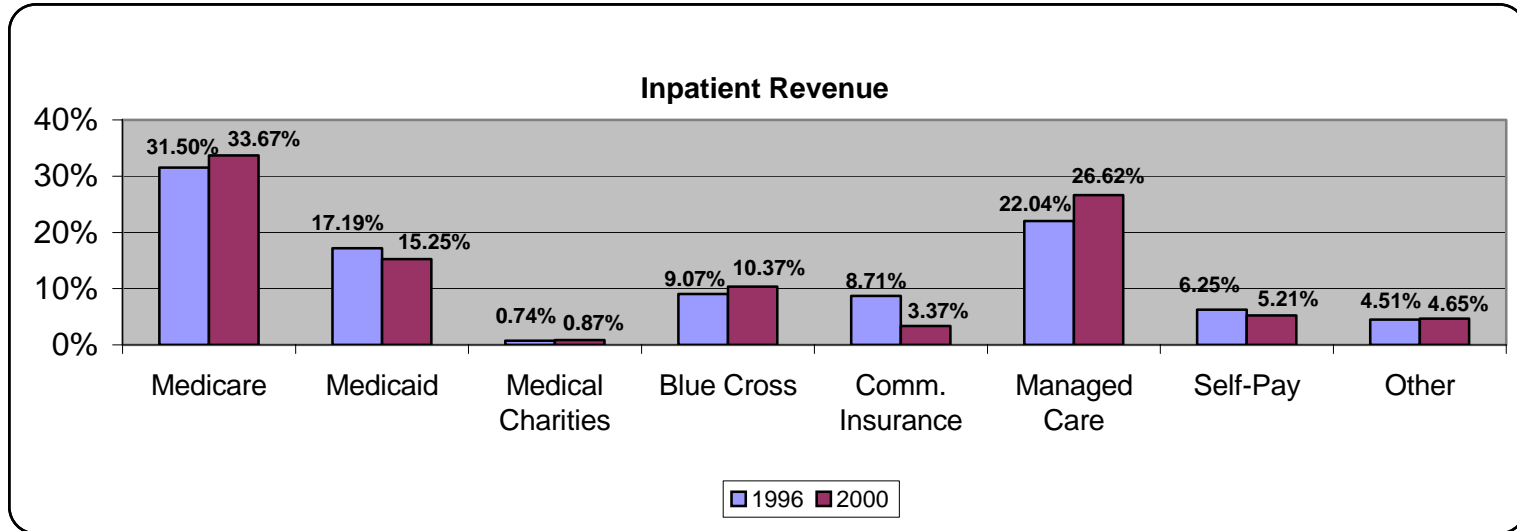
Note: Calculations excludes rehabilitation, psychiatric and federal hospitals.

Source: 2000 DCHA Financial Indicators Survey.

Inpatient Revenue & Discharges by Payor Class

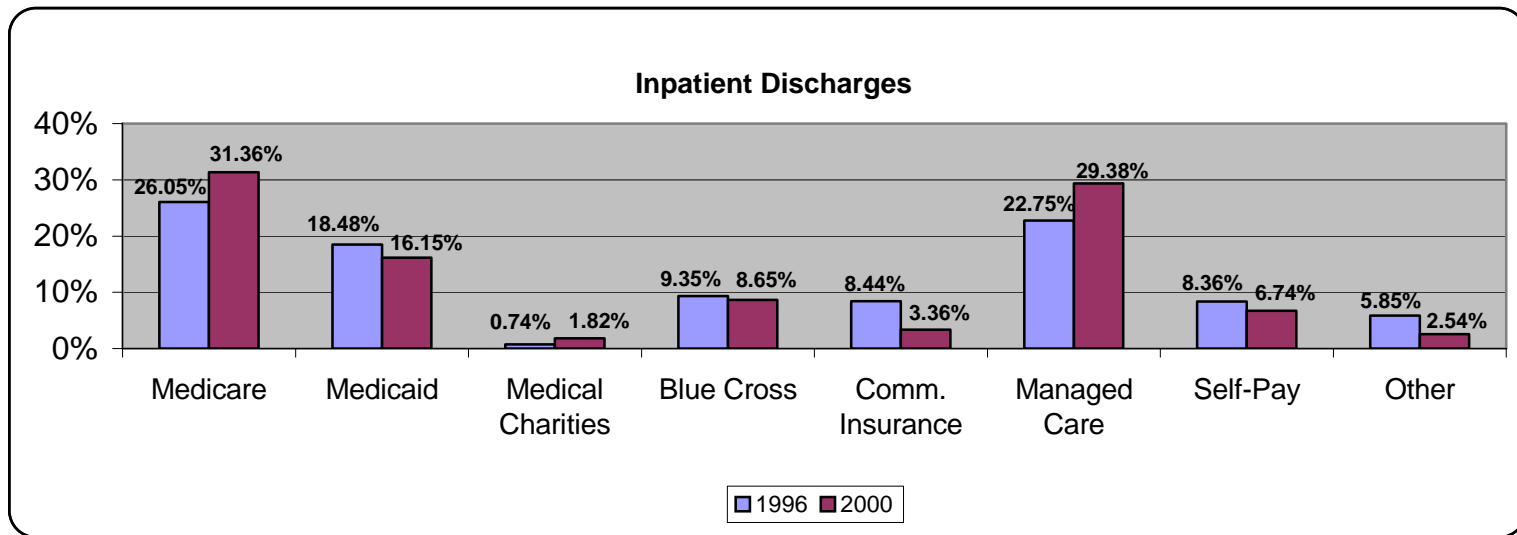
Five-Year Comparison: 1996 v. 2000

District of Columbia Hospitals



Note: Calculation excludes federal and psychiatric hospitals.

Source: 2000 DCHA Financial Indicators Survey.



Note: Calculation excludes federal and psychiatric hospitals.

Source: 2000 DCHA Financial Indicators Survey.

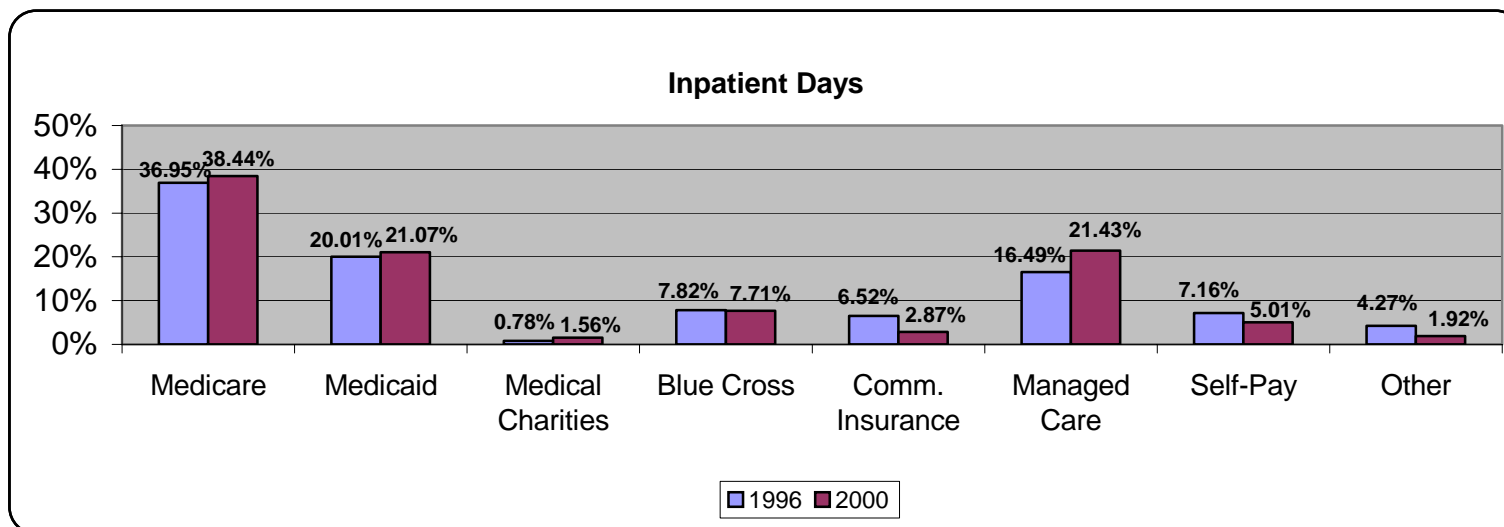
Inpatient Days by Payor Class

Five-Year Comparison: 1996 v. 2000

District of Columbia Hospitals

Several trends can be seen in the charts on pages 7 and 8. They include:

- ◆ Although Medicare revenue has increased only slightly since 1996, Medicare inpatient days and discharges have increased significantly. As the baby boomers live longer with more chronic illness, length of hospital stays and discharges among the elderly have escalated.
- ◆ As managed care continues to penetrate the District of Columbia health care market, managed care revenues, inpatient days, and discharges are increasing, and commercial/indemnity coverage revenues, inpatient days and discharges are decreasing.
- ◆ The dramatic drop in commercial insurance demonstrates the significant change in insurance products.
- ◆ The decrease in Medicaid revenues and discharges reflects the move of some of these patients to managed care, where care is often provided on an outpatient basis.



Note: Calculation excludes federal and psychiatric hospitals.

Source: 2000 DCHA Financial Indicators Survey.

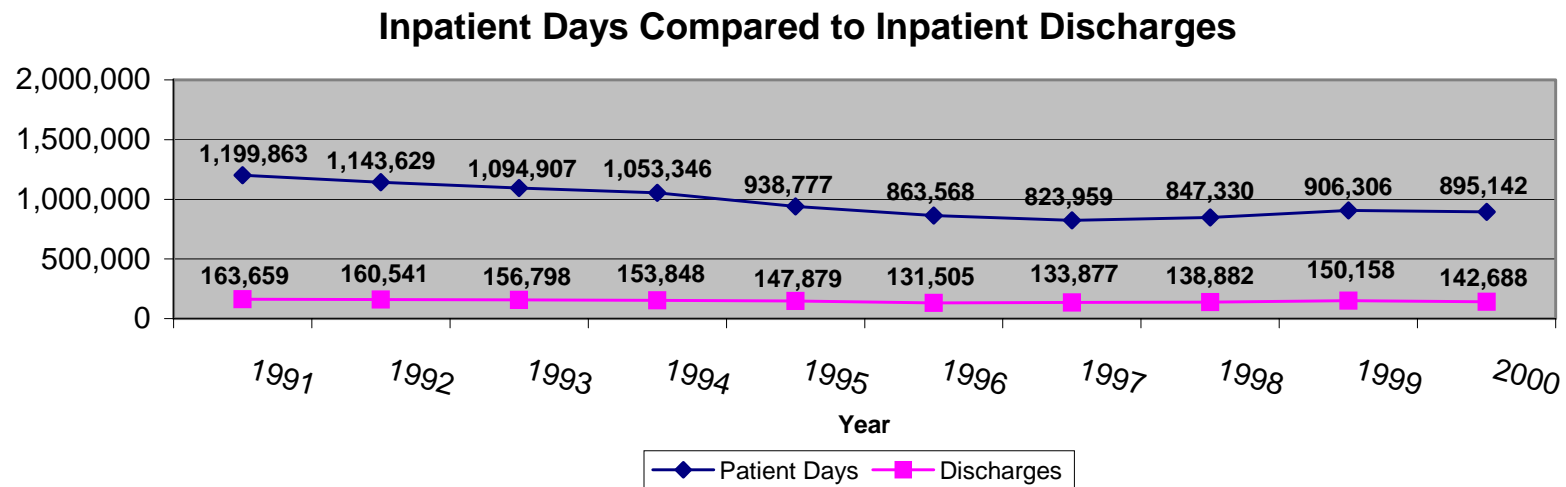
Inpatient Days Compared to Inpatient Discharges

Ten-Year Comparison: 1991 v. 2000

District of Columbia Hospitals

The chart below illustrates a number of influences that are affecting patient days and discharges. In 1991, District hospitals reported just under 1.2 million inpatient days. By 2000, however, inpatient days fell to 895,142 days, a drop of 25.4 percent over 10 years. Patient discharges have declined by 14.7 percent over this ten-year period, from 163,659 discharges in 1991 to 142,688 discharges in 2000. Major strides in medical technology have made outpatient treatment more available, thus reducing inpatient admissions and discharges.

Managed care has been successful in maximizing efficiency in hospitals by targeting clinical and non-clinical areas for process improvement, which, in turn, reduces patient length of stay. Managed care has also moved several clinical procedures and treatment plans to the outpatient setting, reducing need for hospital beds as well as the number of hospital inpatient admissions. The chart below reflects that the number of discharges as well as the number of patient days has leveled off in the past few years as the number of patients requiring inpatient care remains somewhat constant.



Note: Calculation excludes federal and psychiatric hospitals.

Source: 2000 DCHA Financial Indicators Survey.

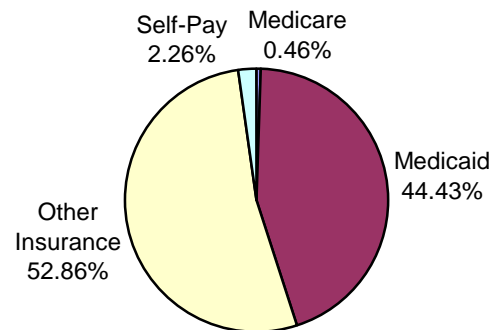
Payor Mix by Gross Patient Revenue - 2000

District of Columbia Hospitals

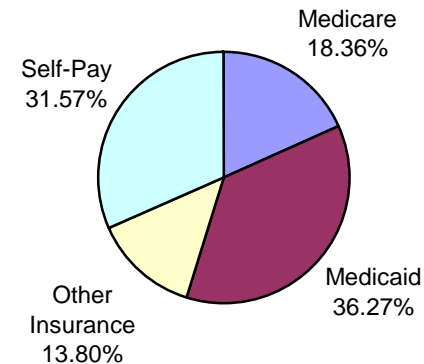
Payor mix is an important characteristic that defines hospital financial stability. A hospital's balance between public and private payors is often reflected in its overall financial health. The charts below indicate that financially troubled hospitals often have a higher percentage of public payors.

In the District, both Medicare and Medicaid patients generally have longer lengths of stay, more severe acuity, frequent comorbidities, as well as complications resulting from intermittent insurance coverage. In all graphs below "Medicaid" includes all Medicaid and medical charity payors, regardless of state. "Other Insurance" includes Blue Cross, commercial managed care, commercial fee-for-service and other insurers.

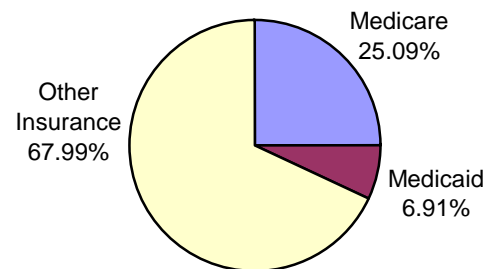
Children's National Medical Center



D.C. General Hospital



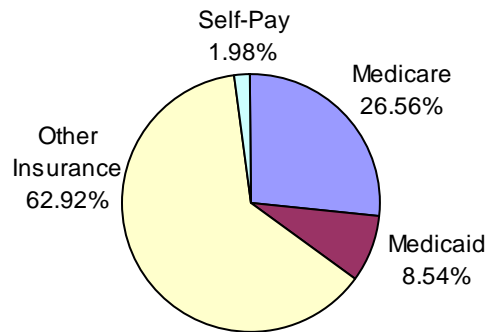
George Washington University Hospital



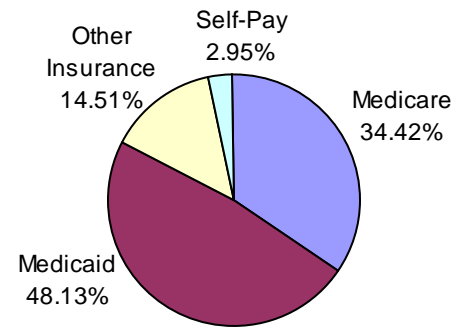
Payor Mix by Gross Patient Revenue - 2000

District of Columbia Hospitals (continued)

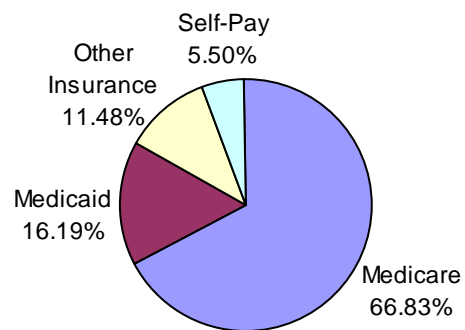
Georgetown University Hospital



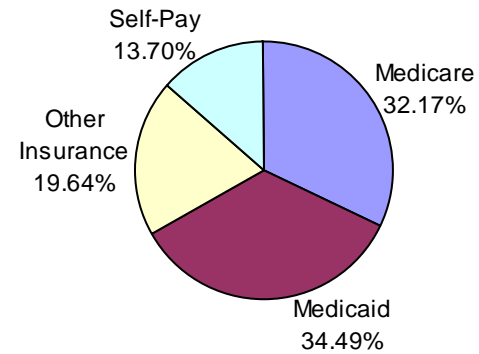
Hadley Memorial Hospital



Greater Southeast Community Hospital



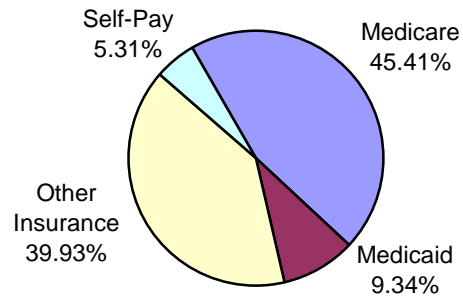
Howard University Hospital



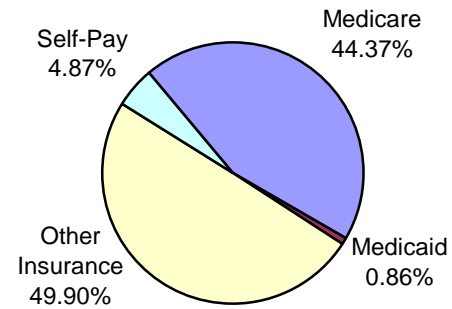
Payor Mix by Gross Patient Revenue - 2000

District of Columbia Hospitals (continued)

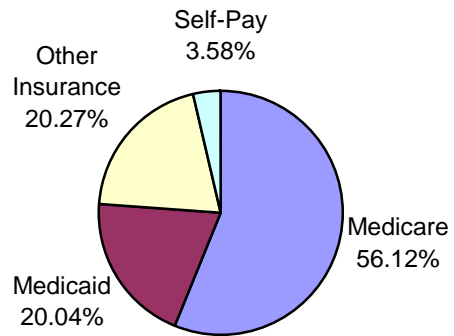
National Rehabilitation Hospital



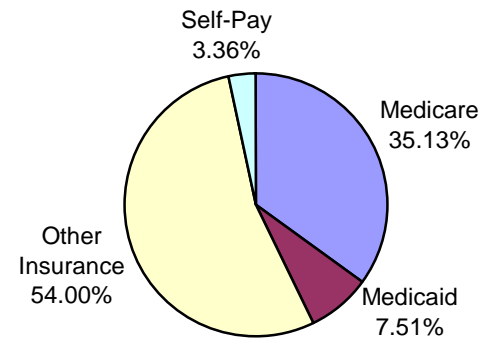
Sibley Memorial Hospital



Providence Hospital



Washington Hospital Center

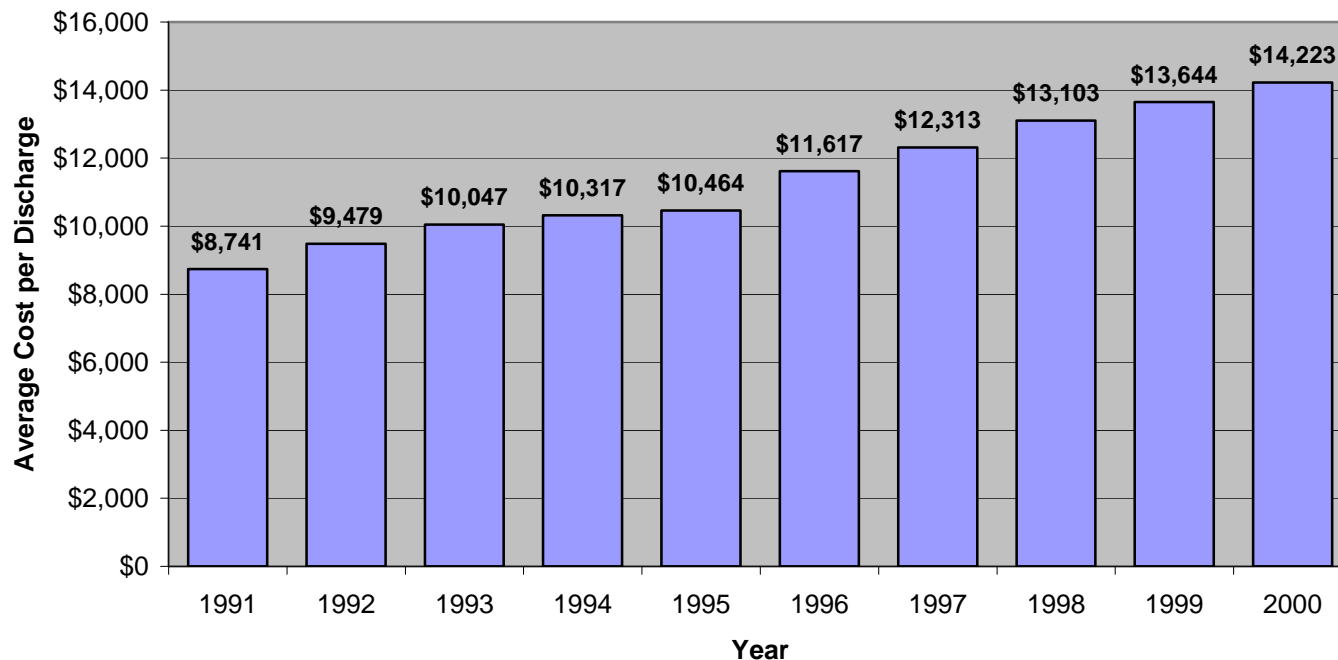


Average Cost per Discharge

Ten-Year Trend: 1991 - 2000

District of Columbia Acute Care Hospitals

The average cost per inpatient discharge includes a number of components: nursing, medical education, pharmaceuticals, dietary, housekeeping, laundry services, payroll, plant operations, maintenance, supplies, malpractice insurance, and other patient care costs. The chart below indicates that cost per patient discharge has increased each year. Over the past ten years, cost per patient discharge at District hospitals has increased by 62.72 percent, an increase consistent with national trends. Between 1990 and 2000, the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) reported that national health care expenditures increased by 88.19 percent, with total hospital care expenditures increasing by 65.37 percent during this same eleven-year period.



Note: Calculation excludes rehabilitation, psychiatric and federal hospitals.

Source: 2000 DCHA Financial Indicators Survey.

Operating Beds By Service

District of Columbia Hospitals

A variety of general factors influence bed-need in D.C. and the nation:

- ◆ technology will continue to advance, making more care available in an outpatient setting;
- ◆ baby-boomers will begin to reach age 65, with the concomitant increases in health care needs, some of which will require hospitalization; and
- ◆ managed care will continue to grow, but with moderating effects of legislation (such as the 48-hour rule for deliveries).

Factors unique to D.C. and its hospitals that influence bed-need are:

- ◆ District hospitals will remain the tertiary referral center for a population of over 3.5 million people;
- ◆ the District will remain an international center of activity, drawing dignitaries from throughout the world for major events, requiring effective and accessible premiere acute health care services; and
- ◆ the potential for terrorism in the nation's capital will require hospitals to maintain "surge capacity" for beds and services in the event of an attack.

	MED/ SURG	OB/ GYN	PEDS	ICU	NICU	PSYCH	SUBST ABUSE	OTHER	TOTAL
Non-Federal Acute Care Hospitals:									
Children's National Medical Center			120	16	30	22			188
Columbia Hospital for Women	29	51		4	35		12		131
District of Columbia General Hospital	75	7	4	14	8		10	4	122
George Washington University Hospital	109	43	9	27	9	34			231
Georgetown University Hospital	153	38	29	50	44	13			327
Greater Southeast Community Hospital	164	22	10	36	16	20		22	290
Howard University Hospital	190	20	23	28	9	24			294
Providence Hospital	236	32		12	9	41			330
Sibley Memorial Hospital	177	21		14		20		8	240
Washington Hospital Center	664	35		66	20	36	22		843
Non-Federal Acute Subtotal	1,797	269	195	267	180	210	44	34	2,996
Federal Acute Care Hospitals:									
Veterans Affairs Medical Center	123			20		28			171
Walter Reed Army Medical Center	116	22	20	41		35		19	253
Malcolm Grow Medical Center/Andrews AFB	36	17		15					68
Federal Acute Subtotal	275	39	20	76		63		19	492
Other Specialty and Psychiatric Hospitals:									
Hadley Memorial Hospital – Long Term Acute Care								45	45
National Rehabilitation Hospital								150	150
Psychiatric Institute of Washington						104			104
Saint Elizabeths Hospital						585			585
Specialty and Psychiatric Subtotal						689		195	884
GRAND TOTAL	2,072	308	215	343	180	962	44	248	4,372

Note: Columbia Hospital for Women's operating bed breakdown is an average for 1999.

Source: DCHA Bed Capacity and Occupancy Report, Second Quarter 2001.

Health Care Employee Information

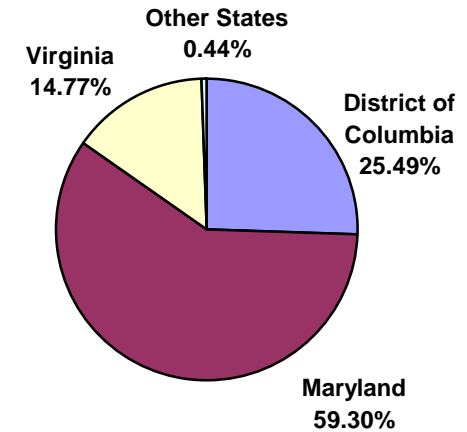
District of Columbia Hospitals

Hospitals in the District of Columbia consistently employ over 22,000 people from around the region. As the second largest non-government employer in the District of Columbia, hospitals are an economic force that provides stability to the Washington, D.C. metropolitan area.

However, with the critical health professions shortage across the U.S., District hospitals are experiencing extreme hardships due vacancies in key health professions. As a result, District hospitals are seeking new ways to attract and retain valued employees. The current vacancy rates for three of these essential job categories are:

- ◆ Nurses – 22.45 percent (includes all Registered Nurses, Licensed Practical Nurses and Nursing Aides)
- ◆ Pharmacists – 23.55 percent
- ◆ Radiology Technicians – 15.57 percent

D.C. Hospital Employee State of Residence



Percentage of District Hospital Employees Residing in D.C., Maryland and Virginia				
	District of Columbia	Maryland	Virginia	Other
Children's National Medical Center	23.09%	61.56%	14.84%	0.51%
D.C. General Hospital	45.01%	45.01%	9.98%	0.00%
George Washington University Hospital	25.49%	44.58%	29.86%	0.07%
Georgetown University Hospital	24.45%	43.02%	31.80%	0.73%
Greater Southeast Community Hospital	18.29%	73.79%	7.92%	0.00%
Hadley Memorial Hospital	27.00%	64.26%	8.75%	0.00%
Howard University Hospital	26.24%	66.43%	7.24%	0.09%
Providence Hospital	26.09%	68.08%	5.71%	0.13%
Sibley Memorial Hospital	22.33%	53.89%	23.20%	0.58%
Washington Hospital Center	22.28%	66.03%	10.81%	0.88%

Note: D.C. General Hospital and Howard University Hospital residency breakdowns are based on 1999 data.

Note: Calculation excludes psychiatric, federal and rehabilitation hospitals.

Source: 2000 DCHA Financial Indicators Survey.

GLOSSARY OF FINANCIAL TERMS

BAD DEBT: *The unpaid obligation for care provided to patients who have been determined to be able to pay, but have not demonstrated a willingness to do so.* Bad debt includes any unpaid patient responsibility, which may include, but is not limited to: deductibles; co-insurance; co-payments; and, non-covered services. Patients are presumed to be able to pay until and unless information is obtained which indicates an inability on their part to do so.

CHARGES: *The dollar amount billed for a service by a health care provider, similar to the “retail” price.*

CHARITY CARE: *Health care services provided to people who are determined to be unable to pay for the cost of health care services. Charity care results from a provider’s policy to render health care services to those individuals who are unable to pay for some or all of their care.* Inability to pay is determined through examination of one or more of the following: individual and family income; assets; employment status; family size; or, availability of alternative sources of payment. Charity care may include patients who may qualify for a public assistance program and meet the hospital’s guidelines, but who do not complete the application process despite the hospital’s best efforts.

CONTRACTUAL ALLOWANCES: *The difference between gross charges and payments received under contractual arrangements with insurance companies, Medicare and Medicaid, and health plans.*

COSTS: *The actual dollar amount incurred in providing a health service.*

DISCHARGE: *The formal release of a patient from a health care facility.*

INPATIENT SERVICES: *Health care treatment rendered to a patient while residing in the hospital.*

MANAGED CARE: *An entity that “manages” or controls what it spends on health care by closely monitoring how health care providers render services to patients.*

MEDICAL CHARITIES: *State-only Medicaid program.*

OPERATING MARGIN: *The percent difference between operating expenses and operating revenue.*

OUTPATIENT SERVICES: *Health care treatment rendered to a patient without being admitted to stay overnight in the hospital.*

PAYOR MIX: *The percentage of patients from each category of payors. The major payor classes included in the payor mix are: Medicare, Medicaid, Blue Cross, commercial insurance, managed care contracts, and self-pay patients.*

UNSPONSORED CARE: *The actual cost of services rendered to patients for which the health care provider does not expect to receive payment.* According to accounting guidelines, unsponsored care is a combination of bad debt and charity care. Unsponsored care does not include contractual allowances.