

Fall 2002



Financial / Indicators

Fiscal Year **2001**

Edwin K. Zechman, Jr.
Chairman of the Board

Robert A. Malson
President



ABOUT THIS REPORT ON FINANCIAL INDICATORS

INTRODUCTION

The District of Columbia's health care delivery system endured an enormous transition in 2001 as the District privatized the city's public hospital and ambulatory clinics. The initial impact of this change can be seen in some of the charts and graphs in this *Financial Indicators Report*. However, the full effect on the system will not be known until 2002 and beyond.

In addition, the attack on the Pentagon and the anthrax attacks in 2001 placed hospitals in a new position at the forefront of emergency preparedness. Emergency departments experienced heavy use once anthrax was detected and the need for heightened vigilance has put further pressures on an already stressed system.

The closure of DCGH, the anthrax attacks and the severe nursing shortage that District health care facilities are experiencing, have added significant stress on the District's health care delivery system. District hospitals, already constrained financially by decreases in reimbursement from managed care organizations and public payors, are struggling to find ways to handle the changes that they have experienced as well as maintain the quality of patient care.

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 2001 fiscal year. The charts and graphs on the financial condition of hospitals provide collective (and some individual) information about ten of the seventeen DCHA member hospitals. The seven DCHA member hospitals excluded from the aggregate data are three facilities providing only psychiatric services as well as four federally-owned acute care hospitals.

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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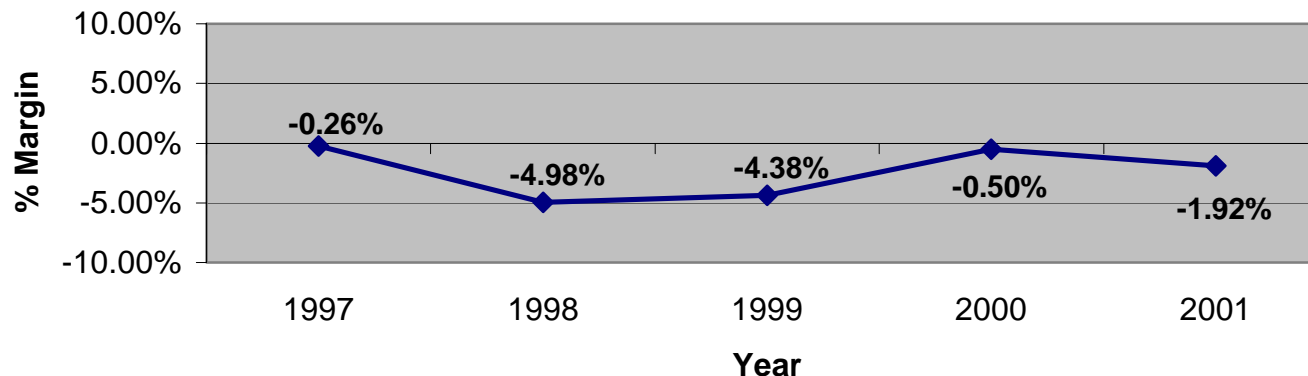
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Aggregate Operating Margin Percent

District of Columbia Hospitals

Massive changes to the District of Columbia health care system contributed to a significant downturn in the financial health of hospitals. The closure of D.C. General Hospital in June of 2001 will continue to impact hospitals over the next several fiscal years as the responsibility of providing a safety net to the uninsured falls to members of the D.C. Healthcare Alliance and other private hospitals. In addition to local changes, the aggregate D.C. hospital Medicare margin continued its downward trend to negative 19.72 percent (-19.72%) in 2001 from negative 6.78 percent (-6.78%) in 2000, most likely as a result of lingering effects of the Balanced Budget Act of 1997. Hospitals' ongoing attempts to reduce costs through budgetary and planning discretion may have prevented an even steeper decline in operating margins in 2001. However, hospitals continue to be concerned about the access, delivery and cost of health care services for District of Columbia Medicaid patients, as well as the uninsured and under-insured populations.

Aggregate Operating Margin Percent, 1997-2001



- 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 1997, 1998 and 1999 operating margin calculations.
- Note:** D.C. General Hospital's financial information was included in the 1997, 1998, 1999 and 2000 operating margin calculations.
- Note:** Calculations exclude Hadley Memorial Hospital, psychiatric and federal hospitals.
- Source:** 2001 DCHA Financial Indicators Survey.

Operating Margin Percent by Hospital

District of Columbia Hospitals

Six of the nine private hospitals in the District experienced significant declines in operating margins in 2001, compared to 2000. Very few of the District hospitals' margins approach the operating margin levels needed to invest in technology upgrades or infrastructure and capital improvements, which experts agree is above four percent. Locally, the public perception of the impending closure of D.C. General Hospital and its Emergency Department (ED) in spring 2001 began major shifts in where patients sought care. Subsequently, hospitals experienced significant increases in visits to the ED, where many patients continue to seek primary care and the treatment of ambulatory sensitive conditions.

	Operating Margin Percent		
	1999	2000	2001
Children's National Medical Center	-11.22%	0.04%	6.37%
District of Columbia General Hospital	-8.64%	-12.10%	CLOSED
George Washington University Hospital	-1.39%	-7.24%	-5.63%
Georgetown University Hospital	-14.77%	-6.52%	-12.42%
Greater Southeast Community Hospital	-28.63%	1.45%	-0.24%
Howard University Hospital	-0.52%	-1.26%	-0.77%
National Rehabilitation Hospital	2.36%	2.36%	0.76%
Providence Hospital	2.61%	2.71%	1.66%
Sibley Memorial Hospital	3.25%	3.75%	3.41%
Washington Hospital Center	4.14%	3.87%	-3.16%
Aggregate Percentage	-4.38%	-0.50%	-1.92%

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

Note: Columbia Hospital for Women Medical Center is now closed, but its financial information was included in the 1999 operating margin calculation.

Note: D.C. General Hospital is now closed, but its financial information was included in the 1999 and 2000 operating margin calculations.

Note: Calculations exclude Hadley Memorial Hospital, psychiatric and federal hospitals.

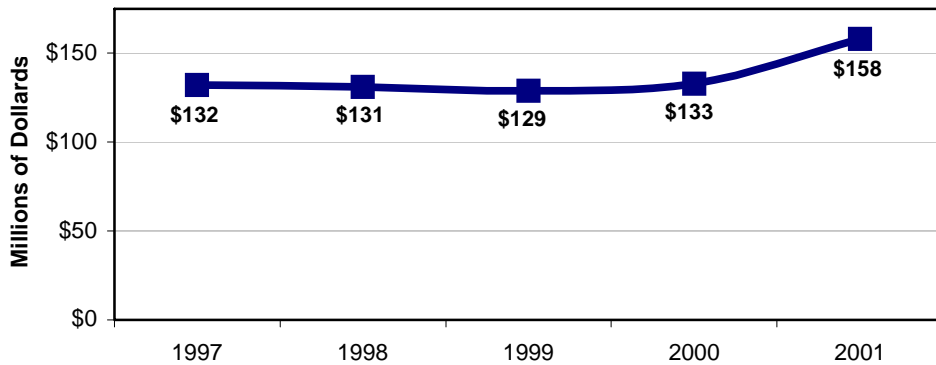
Source: 2001 DCHA Financial Indicators Survey.

Dollar Cost of Un-sponsored Care

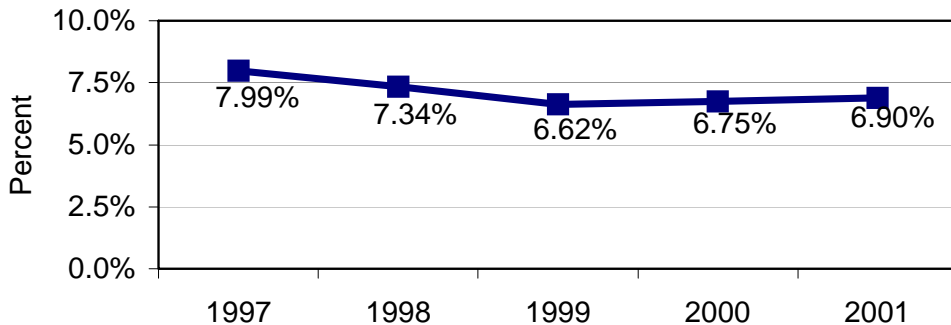
District of Columbia Hospitals

Five-Year Trend: 1997 – 2001

Dollar Cost of Un-sponsored Care, Private Hospitals



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



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

Note: Calculation excludes psychiatric and federal hospitals.

Source: 2001 DCHA Financial Indicators Survey.

Throughout the past decade, District hospitals have provided over \$200 million in care to the uninsured and underinsured each year, with D.C. General Hospital, the city's only public hospital, providing over \$75 million of that total. With the closure of D.C. General Hospital and the advent of the D.C. Healthcare Alliance, the District government's funding that had been allocated to D.C. General Hospital has been transferred to the Alliance for the provision of health care services to the uninsured and underinsured not eligible for Medicaid.

The charts on this page, therefore, reflect the un-sponsored care provided over the past five years by private hospitals only. The \$25 million increase in 2001 in un-sponsored care is most likely spurred by the increase in emergency department utilization, as public debate about the future of DCGH operations prompted patients to seek care elsewhere.

D.C. hospitals' collective dollar contribution to un-sponsored care has been consistent over the past five years, although it has declined as a percent of total hospital care provided. This is both the result of an increase in the value of total hospital care and the expansion of public coverage through Medicaid and D.C. Healthy Families programs.

Un-sponsored Care

Cost and Percentage of Individual Hospital Total Care

District of Columbia Hospitals

Private hospitals provided 18.8 percent (approximately \$25 million) more in un-sponsored care in 2001 than in 2000. With the closure of D.C. General Hospital (DCGH), private hospitals picked up a portion of the DCGH population base and consequently provided more unreimbursed care. However, 2002 will be the year when the true impact of the DCGH closure and the full implementation of the D.C. Healthcare Alliance can be measured with regards to the provision of health care services to those who have been uninsured.

	<u>2000</u>		<u>2001</u>	
	Cost of Un-sponsored Care	Percent Of Total Care	Cost of Un-sponsored Care	Percent Of Total Care
Children's National Medical Center	\$33,213,000	15.16%	\$30,971,000	13.27%
George Washington University Hospital	\$9,568,000	6.36%	\$9,272,000	5.37%
Georgetown University Hospital	\$9,169,000	3.95%	\$8,545,000	3.06%
Greater Southeast Community Hospital	\$6,528,000	5.93%	\$8,265,000	6.14%
Hadley Memorial Hospital	\$490,000	2.09%	\$155,000	0.33%
Howard University Hospital	\$24,891,000	12.10%	\$40,612,000	16.78%
National Rehabilitation Hospital	\$1,575,000	3.12%	\$1,025,000	1.89%
Providence Hospital	\$7,951,000	5.73%	\$8,192,000	5.77%
Sibley Memorial Hospital	\$3,636,000	2.88%	\$4,913,000	3.18%
Washington Hospital Center	\$35,868,000	5.99%	\$45,559,000	6.34%
District Total	\$132,889,000	6.75%	\$157,509,000	6.90%

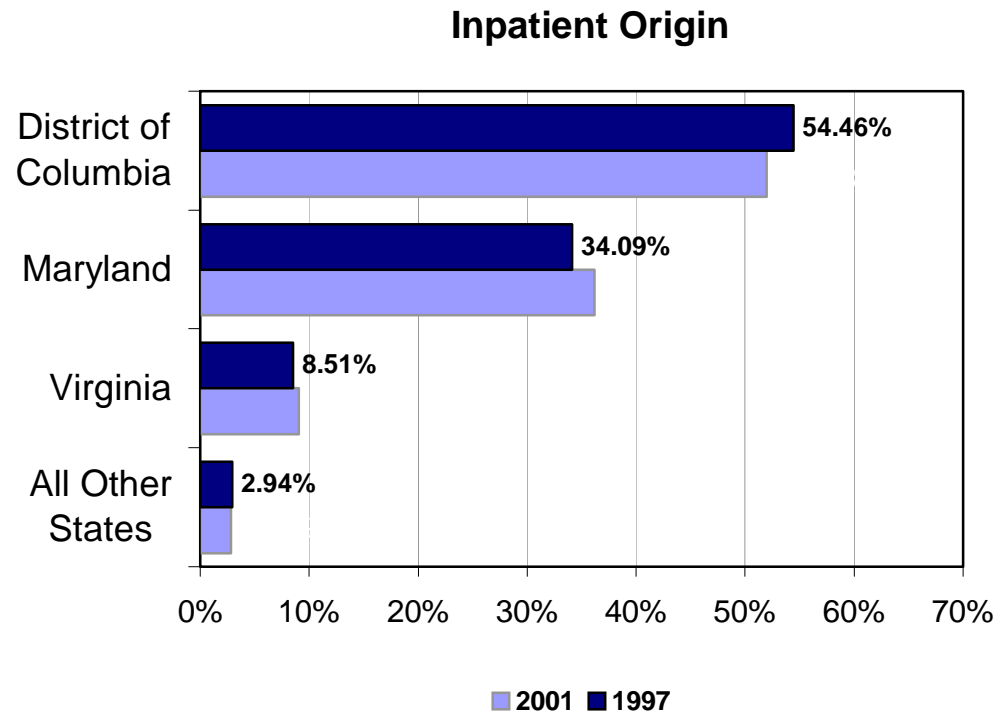
Note: Calculation excludes psychiatric and federal hospitals.

Source: 2001 DCHA Financial Indicators Survey.

Inpatient Origin: 1997 v. 2001

District of Columbia Hospitals

While the District of Columbia has a relatively small population (571,822 as of July 2001, according to the U.S. Census Bureau), District hospitals serve patients from throughout the region – over 3.6 million people. Only about half of the patients served in D.C. hospitals actually live in the city. Furthermore, compared to 1997 inpatient origin data, there is a decrease in inpatient service to District residents and an increase in inpatient service to Maryland and Virginia residents. Because many D.C. hospitals are Centers of Excellence for such services as cardiology, cancer, pediatrics, and organ transplantation, physicians throughout the Maryland-D.C.-Virginia region continue to refer their patients to these centers.

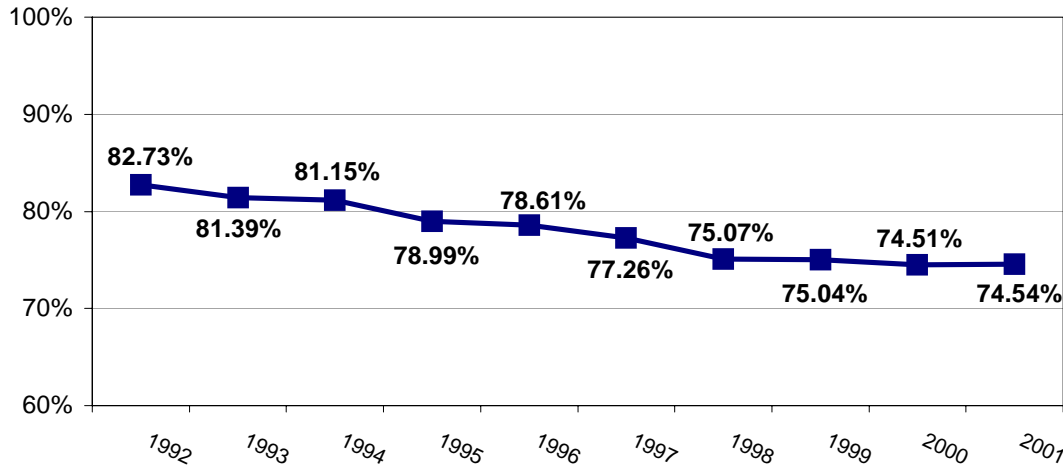


Source: DCHA Patient Data System, 1997 and 2001. Hospitals in this database include Children's National Medical Center, D.C. General Hospital (only first half of 2001 data included), George Washington University Hospital, Georgetown University Hospital, Greater Southeast Community Hospital, Hadley Memorial Hospital (only January and February 1997 data included), Howard University Hospital, National Rehabilitation Hospital, Providence Hospital, Sibley Memorial Hospital, Veterans Affairs Medical Center and Washington Hospital Center.

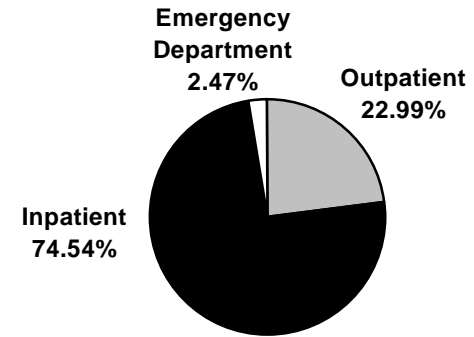
Inpatient, Outpatient and Emergency Department Revenue as a Percentage of Total Gross Patient Revenue

District of Columbia Acute Care Hospitals

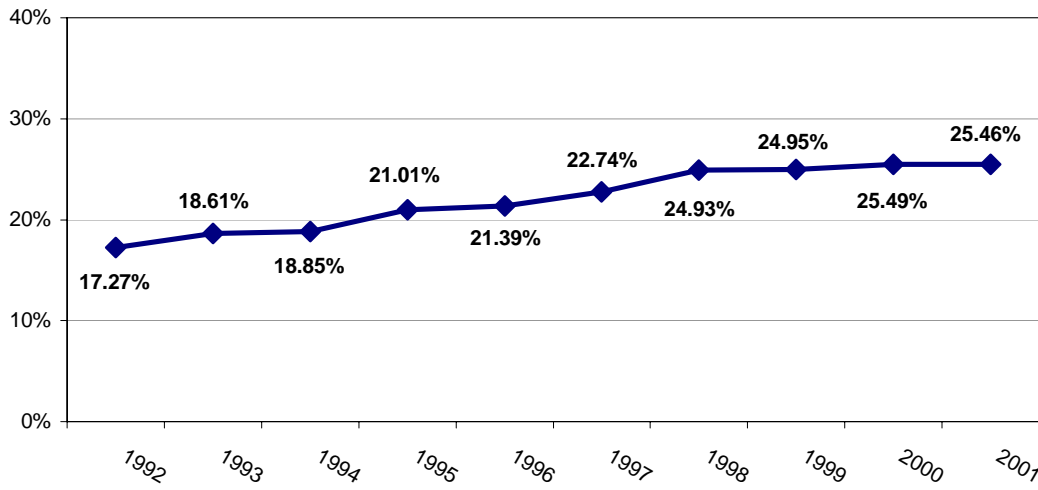
Inpatient Revenue



2001 Revenue Breakdown



Outpatient and Emergency Department Revenue



Source: 2001 DCHA Financial Indicators Survey.

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 department revenue from outpatient revenues. The pie chart shows the 2001 breakdown of District hospital revenues in these three categories.

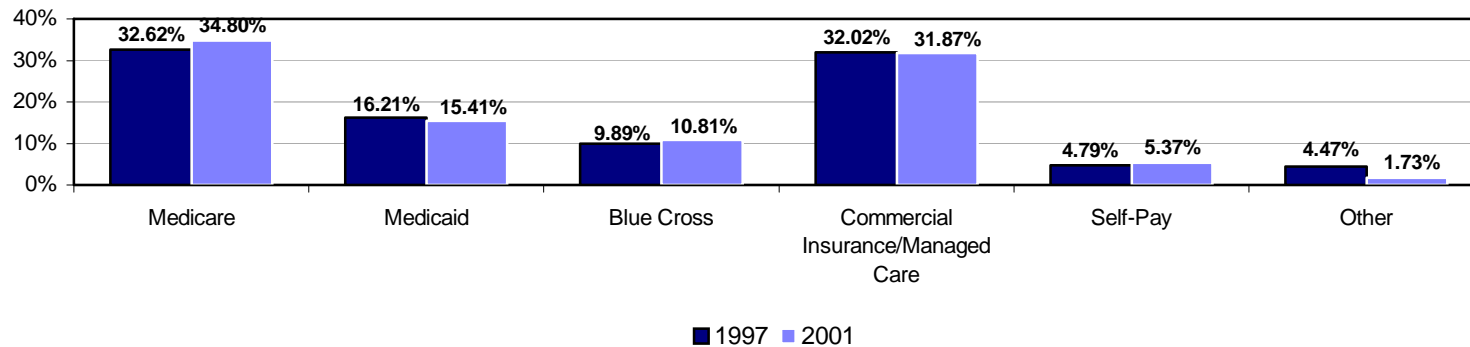
Over the past 10 years, the increased sophistication and technology of outpatient services has moved many services previously performed on an inpatient basis to the outpatient setting. However, 2001 inpatient, outpatient and emergency department revenues remained virtually unchanged from 2000 and appear to have stabilized over the past four years.

Total Patient Revenue & Inpatient Discharges by Payor Class

Five-Year Comparison: 1997 v. 2001

District of Columbia Hospitals

Total Revenue

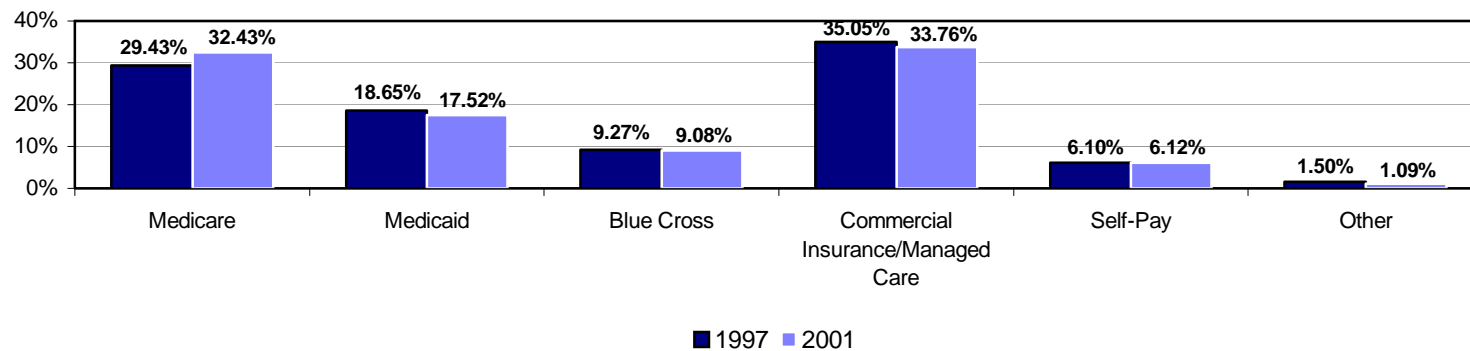


Note: "Medicaid" includes all Medicaid programs (regardless of state), including D.C. Healthy Families, all medical charities programs as well as the D.C. Healthcare Alliance program.

Note: Calculation excludes federal and psychiatric hospitals.

Source: 2001 DCHA Financial Indicators Survey.

Inpatient Discharges



Note: "Medicaid" includes all Medicaid programs (regardless of state), including D.C. Healthy Families, all medical charities programs as well as the D.C. Healthcare Alliance program.

Note: Calculation excludes federal and psychiatric hospitals.

Source: 2001 DCHA Financial Indicators Survey.

Inpatient Days by Payor Class

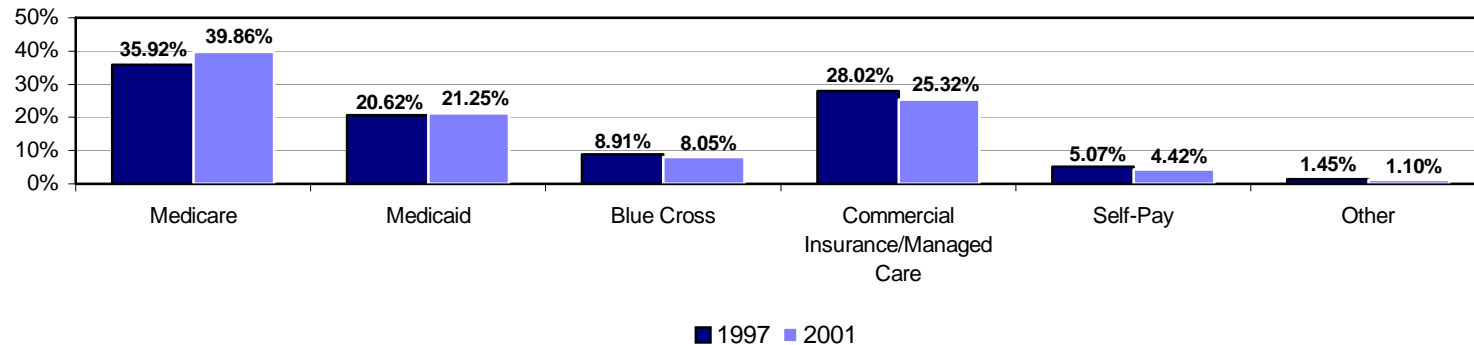
Five-Year Comparison: 1997 v. 2001

District of Columbia Hospitals

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

- ◆ Since 1997, Medicare revenue has increased at a much slower rate than Medicare discharges and inpatient days signifying that chronic illness, length of hospital stays and discharges among the elderly have escalated and that payments for Medicare services are not keeping pace. As hospitals treat more Medicare patients, the slower increase in Medicare revenue versus Medicare discharges and inpatient days explains the drastic decline in Medicare operating margins: negative 6.78 percent (-6.78%) in 2000 to negative 19.72 percent (-19.72%) in 2001.
- ◆ There has been a very slight increase in Medicaid inpatient days accompanied by very slight decreases in both Medicaid revenue and discharges. At this time it is difficult to determine whether these trends are significant.
- ◆ Managed care discharges and inpatient days continue to decline, indicating that managed care plans have continued their effectiveness in reducing inpatient lengths of stay and discharges through a focus on primary care and prevention, and the shift of many therapies and procedures to the outpatient setting.

Inpatient Days



Note: “Medicaid” includes all Medicaid programs (regardless of state), including D.C. Healthy Families, all medical charities programs as well as the D.C. Healthcare Alliance program.
Note: Calculation excludes federal and psychiatric hospitals.
Source: 2001 DCHA Financial Indicators Survey.

Inpatient Days Compared to Inpatient Discharges

Ten-Year Comparison: 1992 v. 2001

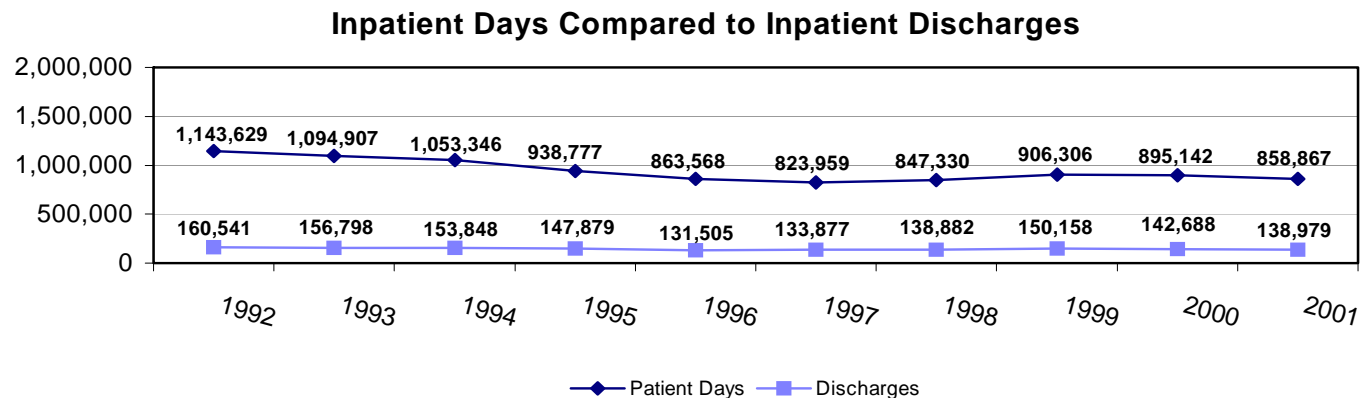
District of Columbia Hospitals

The chart below illustrates a number of influences that are affecting patient days and discharges. In 1992, District hospitals reported approximately 1.14 million inpatient days. By 2001, however, inpatient days had fallen to 858,867 days, a drop of 24.9 percent over 10 years. Patient discharges have declined by 13.4 percent over this same ten-year period, from 160,541 discharges in 1992 to 138,979 discharges in 2001, reflecting an overall reduction in average length of stay.

Since 2000, there has been a 4.1 percent reduction in inpatient days and a 2.6 percent reduction in inpatient discharges. These decreases may, in part, be reflective of the closure of D.C. General Hospital, which averaged 10,447 inpatient discharges and 66,561 inpatient days per year from 1996 to

Additionally, major strides in medical technology have made outpatient treatment more available, thus reducing inpatient discharges and patient days.

Finally, managed care plans have 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 encouraged the move of several clinical procedures and treatment plans to the outpatient setting, reducing need for hospital beds as well as the number of hospital inpatient admissions. DCHA will continue to monitor this data to note future trends.



2000.

Note: Calculation excludes federal and psychiatric hospitals.

Source: 2001 DCHA Financial Indicators Survey.

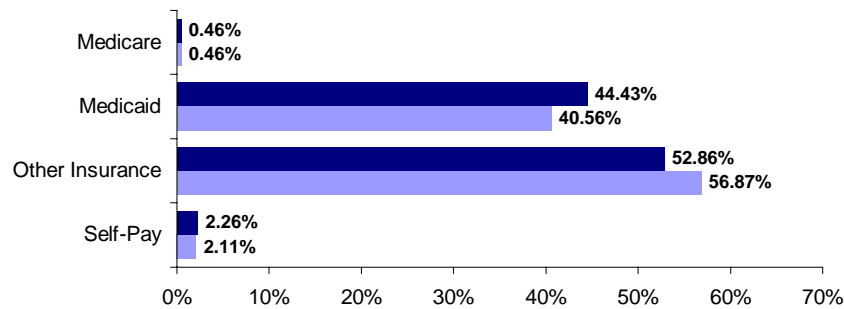
Payor Mix by Gross Patient Revenue – 2000 v. 2001

District of Columbia Hospitals

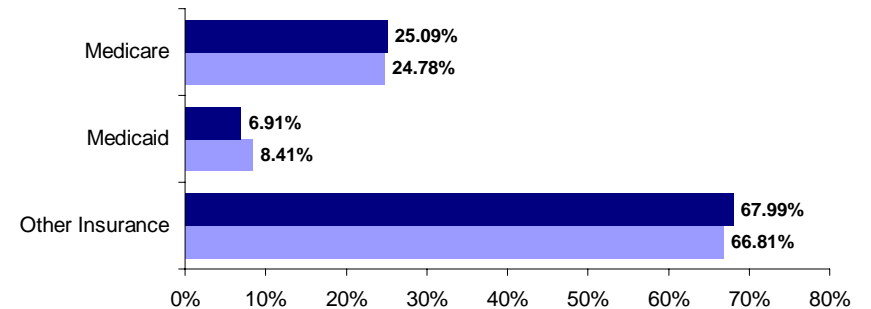
Payor mix is an important characteristic that defines hospital financial stability. A hospital’s balance between public and private payors is often reflected in its overall financial health. The charts below indicate that financially troubled hospitals often have a higher percentage of public payors.

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 charts below “Medicaid” includes all Medicaid payors, regardless of state, as well as revenues from D.C. Healthy Families and the D.C. Health Care Alliance, as described in the Introduction to this Report. “Other Insurance” includes Blue Cross, commercial managed care, commercial fee-for-service and other insurers.

Children’s National Medical Center

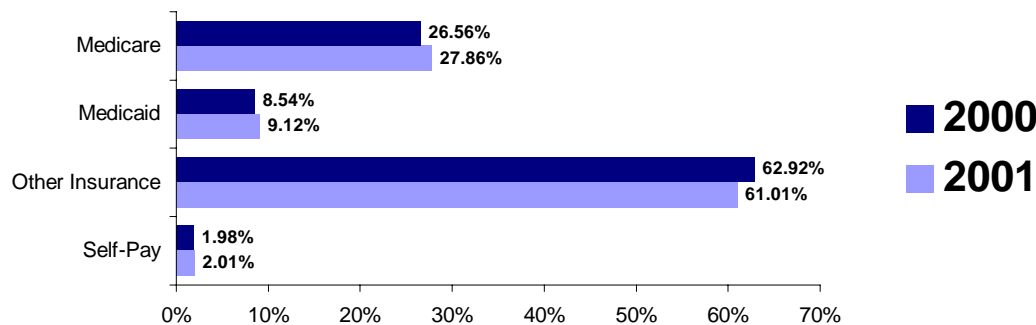


George Washington University Hospital



Note: “Self-Pay” is included in “Other Insurance” for George Washington University Hospital

Georgetown University Hospital

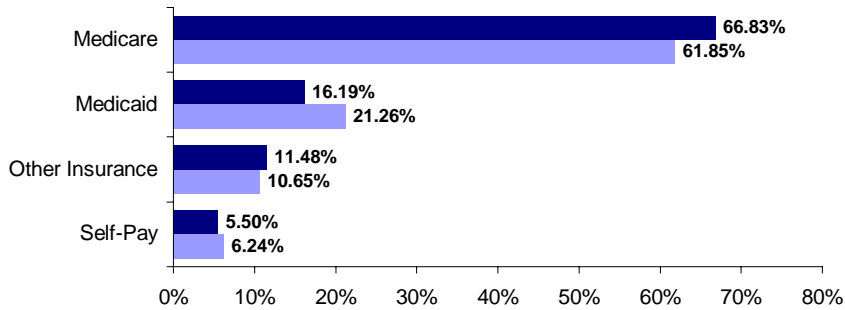


2000
2001

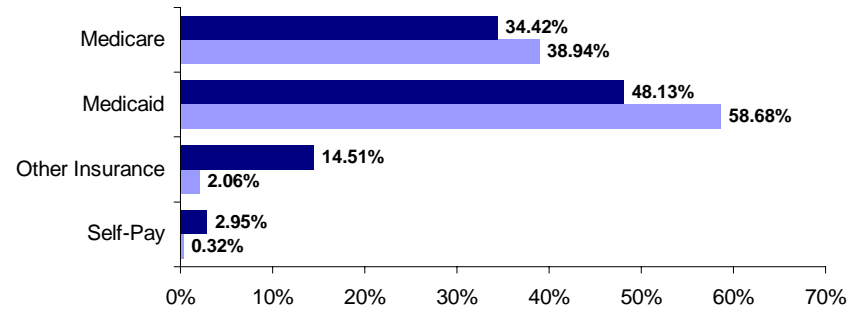
Payor Mix by Gross Patient Revenue – 2000 v. 2001

District of Columbia Hospitals (continued)

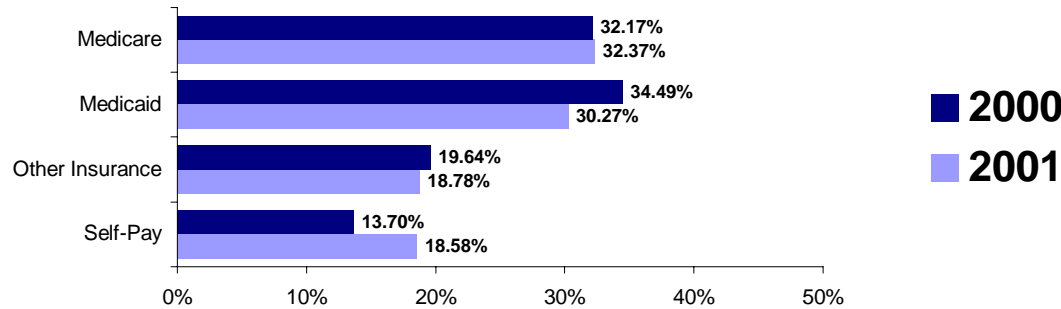
Greater Southeast Community Hospital



Hadley Memorial Hospital



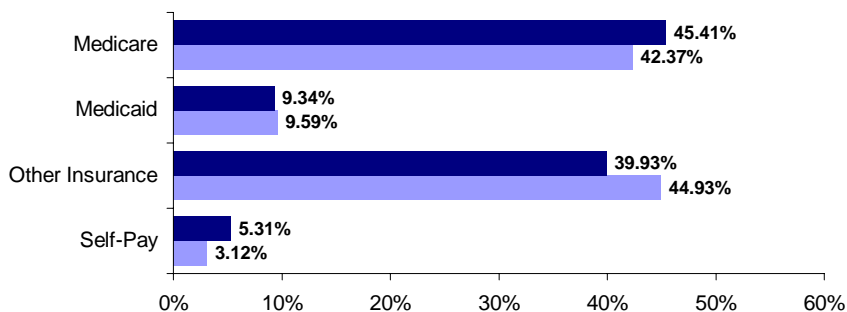
Howard University Hospital



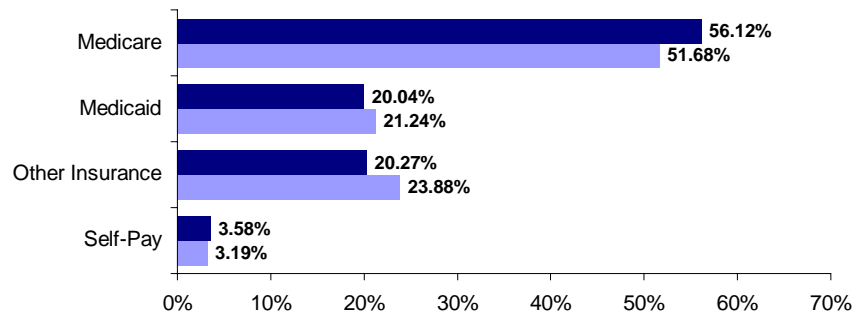
Payor Mix by Gross Patient Revenue – 2000 v. 2001

District of Columbia Hospitals (continued)

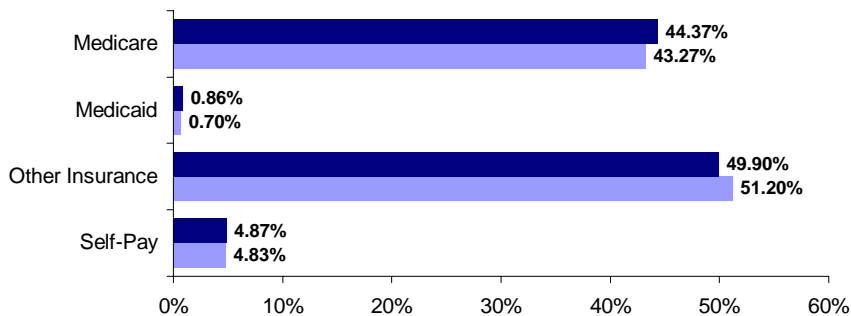
National Rehabilitation Hospital



Providence Hospital

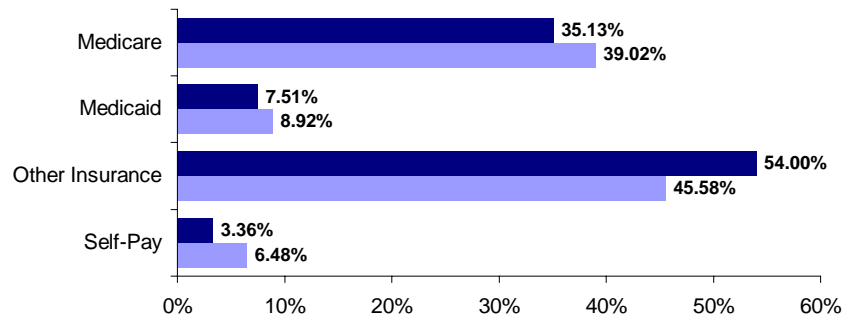


Sibley Memorial Hospital



■ 2000
■ 2001

Washington Hospital Center

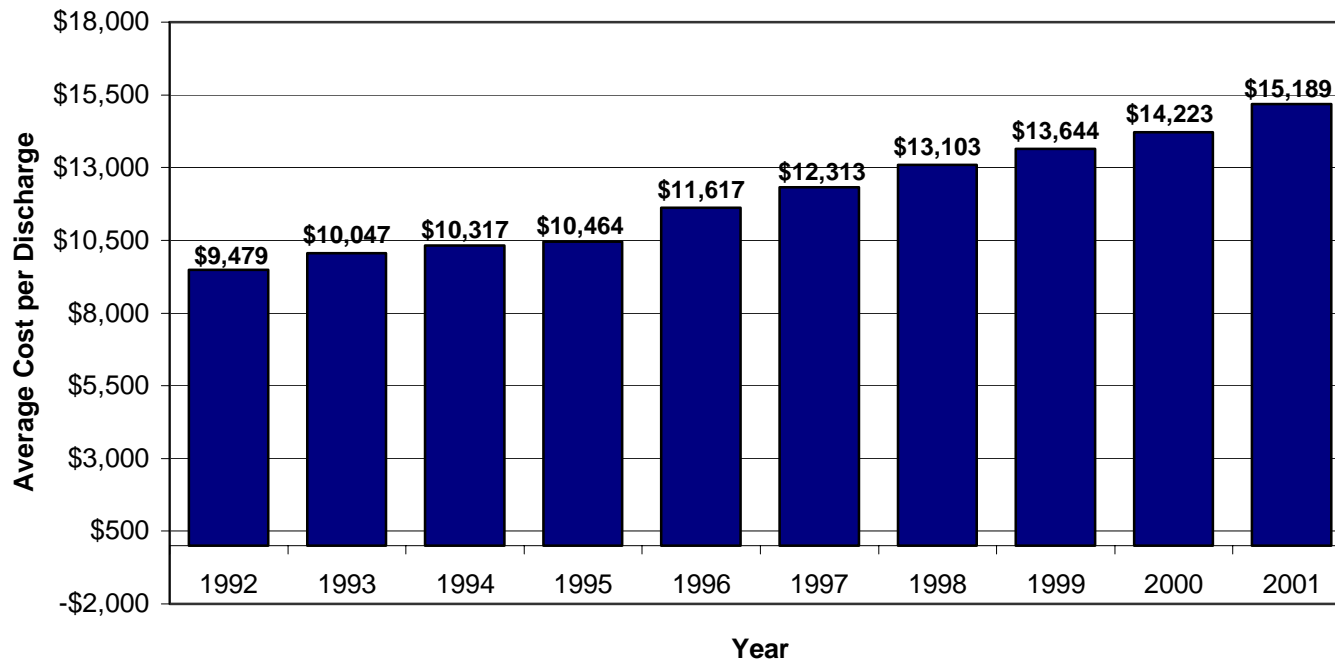


Average Cost per Discharge

Ten-Year Trend: 1992 - 2001

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. In fiscal year 2001, the average cost per discharge at District hospitals increased 6.8 percent over 2000, despite that fact that the Centers for Medicare and Medicaid Services (CMS) projected an 8.3 percent increase in hospital care expenditures from 2000 to 2001. Over the past ten years, cost per patient discharge at District hospitals has increased by 60.24 percent, an increase significantly lower than national trends. Between 1990 and 2001, CMS projects that national health care expenditures have increased by 104.57 percent, with total hospital care expenditures projected to have increased by 75.78 percent during this same eleven-year period.



Note: Calculation excludes rehabilitation, psychiatric and federal hospitals.

Source: 2001 DCHA Financial Indicators Survey.

Operating Beds By Service

District of Columbia Hospitals

In 2001, the District health care system experienced a 7.2 percent decrease in total operating beds, with a 5.4 percent combined reduction in med/surg and ICU beds alone. This reduction in beds reflects the closure of D.C. General Hospital. Coupled with a 21.85 percent nursing vacancy rate, the reduction in operating beds is forcing the closure of emergency departments (EDs) to ambulances across the city. The D.C. Fire and Emergency Medical Services Bureau reported that ambulances were rerouted an average of 1,300 hours per month in 2001 due to hospital ED closures and/or lack of bed availability.

Among the factors influencing bed-need in the District are: District hospitals continue to be the tertiary referral center for a population of over 3.6 million people; the District remains 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 very real threat of terrorism that requires 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	0	0	120	16	30	22	0	0	188
George Washington University Hospital	158	39	0	33	18	22	0	0	270
Georgetown University Hospital	178	32	30	38	46	14	0	0	338
Greater Southeast Community Hospital	194	22	10	40	16	20	0	32	334
Howard University Hospital	208	10	16	30	9	8	0	0	281
Providence Hospital	211	32	0	12	9	41	0	0	305
Sibley Memorial Hospital	160	29	0	14	0	20	0	8	231
Washington Hospital Center	578	35	0	66	20	36	22	0	757
Non-Federal Acute Subtotal	1,687	199	176	249	148	183	22	40	2,704
Federal Acute Care Hospitals:									
Veterans Affairs Medical Center	118	0	0	20	0	28	0	0	166
Walter Reed Army Medical Center	119	23	20	43	0	37	0	19	261
Malcolm Grow Medical Center/Andrews AFB	36	17	0	15	0	0	0	0	68
National Naval Medical Center/Bethesda	106	32	4	16	25	8	0	0	191
Federal Acute Subtotal	379	72	24	94	25	73	0	19	686
Other Specialty and Psychiatric Hospitals:									
Hadley Memorial Hospital – Long Term Acute Care	0	0	0	0	0	0	0	45	45
National Rehabilitation Hospital	0	0	0	0	0	0	0	148	148
Psychiatric Institute of Washington	0	0	0	0	0	104	0	0	104
Saint Elizabeths Hospital	0	0	0	0	0	565	0	0	565
Specialty and Psychiatric Subtotal	0	0	0	0	0	669	0	193	862
GRAND TOTAL	2,066	271	200	343	173	925	22	252	4,252

Source: DCHA Bed Capacity and Occupancy Report, Second Quarter 2002.

Note: Sibley Memorial Hospital reported changes to their bed allocation for 2001. Therefore, the total numbers do not exactly correspond to the DCHA Bed Capacity and Occupancy Report, Second Quarter 2002.

Health Care Employee Information

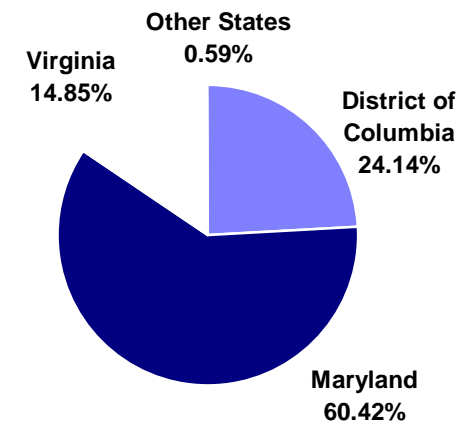
District of Columbia Hospitals

Hospitals in the District of Columbia consistently employ over 25,000 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.

The current critical health professions shortage across the U.S. has affected District hospitals as well. Vacancies in nursing, pharmacy, radiology technicians, medical technicians and others are major causes for concern. Additionally, the nursing shortage crisis has been identified by the American Hospital Association as their top priority going forward.

In 2001, District hospitals reported a 21.85 percent vacancy rate for nurses (includes all Registered Nurses, Licensed Practical Nurses and Nursing Aides), well above the national nursing vacancy rate of 13 percent. The nursing shortage is the primary reason why District hospitals are unable to staff additional beds, which can lead to overcrowding of emergency rooms and increased ambulance diversion hours.

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	24.53%	61.78%	13.17%	0.52%
George Washington University Hospital	23.73%	45.17%	31.10%	0.00%
Georgetown University Hospital	23.43%	42.61%	31.94%	2.02%
Greater Southeast Community Hospital	21.55%	71.11%	7.34%	0.00%
Hadley Memorial Hospital	26.09%	65.61%	8.30%	0.00%
Howard University Hospital	31.21%	64.21%	4.58%	0.00%
Providence Hospital	27.25%	66.82%	5.59%	0.34%
Sibley Memorial Hospital	22.99%	53.85%	22.88%	0.28%
Washington Hospital Center	21.49%	66.83%	10.94%	0.75%

Note: Calculation excludes National Rehabilitation Hospital and all psychiatric and federal hospitals.

Source: 2001 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, un-sponsored care is a combination of bad debt and charity care. Un-sponsored care does not include contractual allowances.