Fall 2004

Financial Indicators

Fiscal Year 2003

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ABOUT THIS REPORT ON FINANCIAL INDICATORS

INTRODUCTION

The District of Columbia's health care delivery system continues to undergo changes that began in 2001 when the District privatized the city's public hospital and ambulatory clinics and created the D.C. Healthcare Alliance. In addition, the health care community saw the conversion of Hadley Memorial Hospital from an acute to a long-term acute care facility in 2001 and the closure of Columbia Hospital for Women in 2002, as well as the conversion of D.C. General Hospital to an urgent care center. The impact of these changes can be seen in the charts and graphs in this Financial Indicators Report.

The closure and conversion of three hospitals, the potential for a terrorist event or major disease epidemic and the severe workforce 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, and the continuing challenges of caring for a large uninsured population, are struggling to find ways to handle these changes in a manner that maintains the highest 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 2003 fiscal year. The charts and graphs on the financial condition of hospitals provide collective (and some individual) information about ten of the eighteen DCHA member hospitals. The eight DCHA member hospitals excluded from the aggregate data are a long-term, acute care hospital, 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 in 1995. For analysis purposes, DCHA has classified bad debt as a separate line item.

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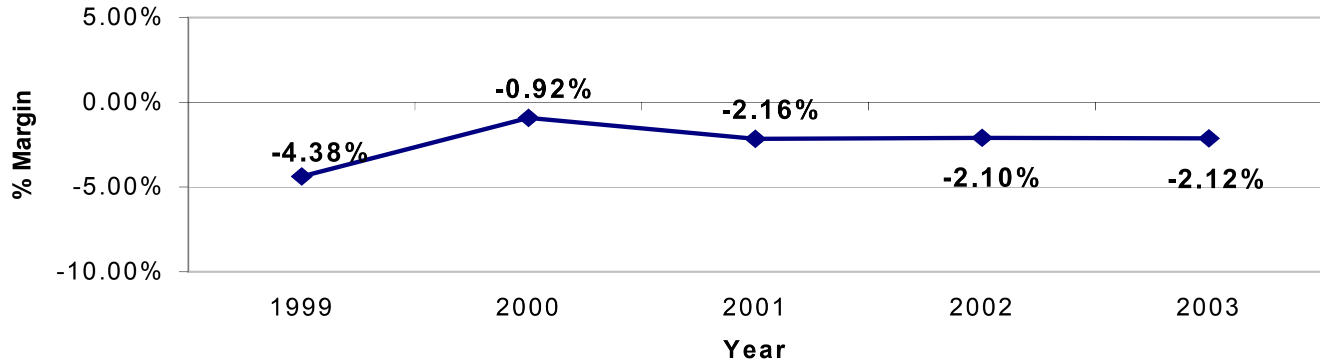
Operating Margin Percent
District of Columbia Hospitals

Massive changes to the District of Columbia health care system beginning in 2001 contributed to a significant downturn in the financial health of hospitals. The closure of D.C. General Hospital in June of 2001 continues to impact hospitals as the responsibility of providing a safety net to the uninsured falls to members of the D.C. Healthcare Alliance and other private hospitals. 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.



Note: Columbia Hospital for Women's financial information was included in the 1999 operating margin calculations.
Note: D.C. General Hospital's financial information was included in the 1999 and 2000 operating margin calculations.

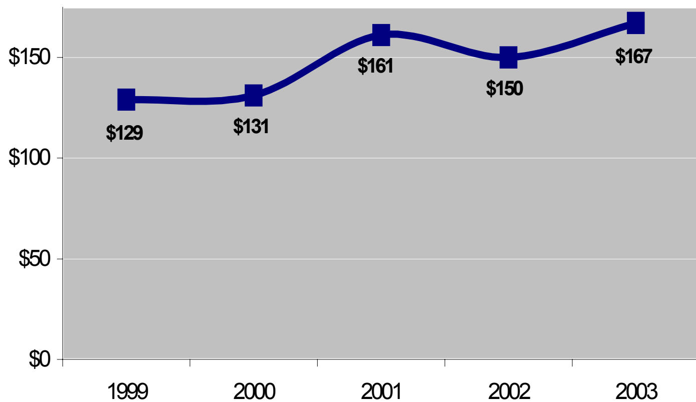
In 2003, nearly two-thirds of the private hospitals in the District had an operating margin less than one percent. None of the District hospitals' margins approached the operating margin levels needed to invest in technology upgrades or infrastructure and capital improvements, which experts agree is at least four percent. Since the closure of D.C. General Hospital, hospitals have experienced significant increases in visits to the emergency department where many patients continue to seek primary care and the treatment of ambulatory sensitive conditions.

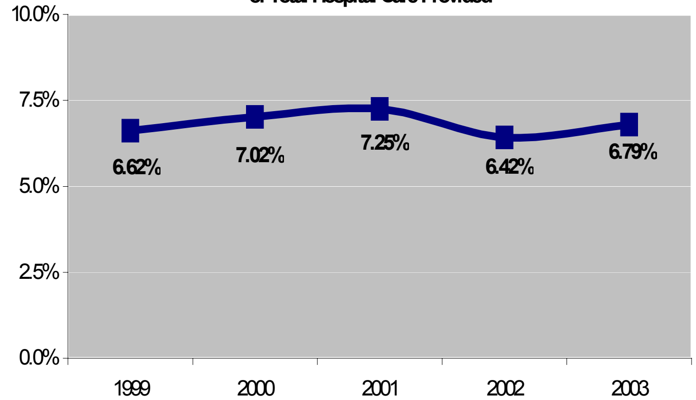
Operating Margin Percent	2001	2002	2003
Children's National Medical Center	2.69%	0.36%	-3.28%
George Washington University Hospital	-5.63%	-2.50%	1.73%
Georgetown University Hospital	-12.42%	-5.78%	-7.62%
Greater Southeast Community Hospital	-0.24%	-9.27%	-24.98%
Howard University Hospital	0.19%	0.29%	1.20%
National Rehabilitation Hospital	1.82%	2.81%	2.91%
Providence Hospital	1.66%	1.18%	0.33%
Sibley Memorial Hospital	3.41%	2.28%	2.79%
Washington Hospital Center	-3.16%	-2.86%	-2.73%
Aggregate Percentage	**-2.16%**	**-2.10%**	**-2.12%**

Note: New 2001 financial figures became available for Children's National Medical Center and operating margins were recalculated. Thus, the aggregate operating margins differ from the 2001 DCHA Financial Indicators Reports.
Note: New financial figures became available for Howard University Hospital and operating margins were recalculated. Thus, the aggregate operating margins differ from previous DCHA Financial Indicators Reports.
Note: Aggregate Operating Margin Percent is computed by calculating the percentage difference between aggregate operating expenses and aggregate operating revenues.
Note: Calculations exclude Hadley Memorial Hospital, MedLINK Hospital, psychiatric and federal hospitals.
Source: 2003 DCHA Financial Indicators Survey.

Unsponsored Care
District of Columbia Hospitals

Before its closure in June 2001, D.C. General Hospital provided over one-third, or about $75 million, of the $200 million in unsponsored care provided to the uninsured and under-insured by District hospitals annually. Since the establishment of the D.C. Healthcare Alliance, the District government's funding that had previously been allocated to D.C. General has now been transferred to the Alliance, which utilizes six private hospitals to serve those individuals who are eligible. For those individuals who are not eligible for the Alliance and are still uninsured, the private hospitals have picked up the burden that had been carried by D.C. General.



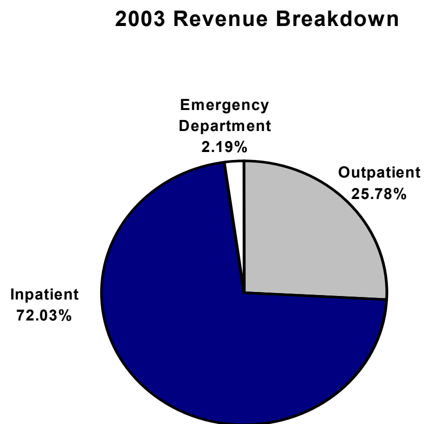


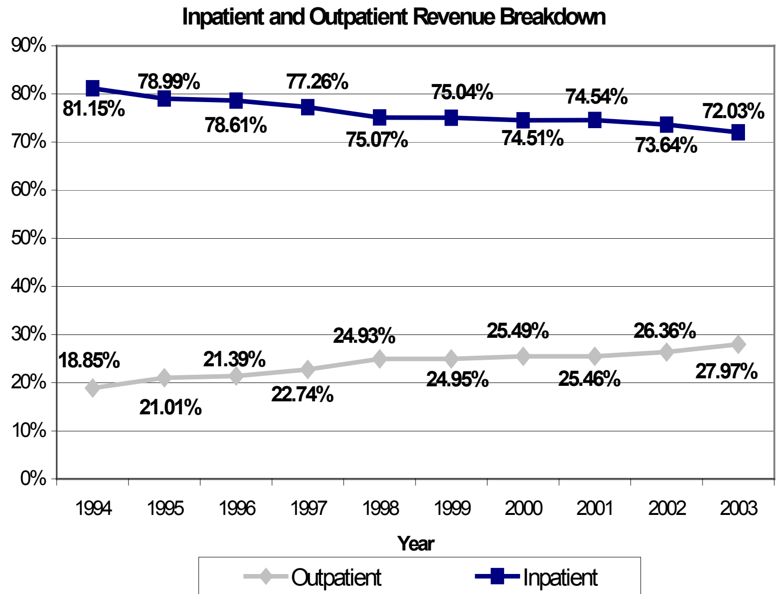
	2001		2002		2003	
	Cost of Unsponsored Care	Percent Of Total Care	Cost of Unsponsored Care	Percent Of Total Care	Cost of Unsponsored Care	Percent Of Care
Children's National Medical Center	$34,921,000	12.33%	$34,550,000	10.57%	$28,132,000	7.82%
George Washington University Hospital	$9,272,000	5.37%	$7,286,000	3.54%	$9,058,000	3.71%
Georgetown University Hospital	$8,545,000	3.06%	$9,742,000	2.94%	$10,938,000	2.92%
Greater Southeast Community Hospital	$8,265,000	6.14%	$11,285,000	6.66%	$25,333,000	20.52%
Hadley Memorial Hospital	$155,000	0.33%	N/A	N/A	N/A	N/A
Howard University Hospital	$40,612,000	16.78%	$33,021,000	13.10%	$38,326,000	15.28%
National Rehabilitation Hospital	$1,017,000	1.89%	$773,000	1.41%	$773,000	1.30%
Providence Hospital	$8,192,000	5.77%	$8,302,000	5.44%	$10,252,000	6.17%
Sibley Memorial Hospital	$4,913,000	3.18%	$3,772,000	2.42%	$4,427,000	2.76%
Washington Hospital Center	$45,559,000	6.34%	$43,059,000	6.02%	$41,174,000	5.55%
District Total	**$161,451,000**	**7.25%**	**$150,286,000**	**6.42%**	**$167,473,000**	**6.79%**

Note: Children's National Medical Center's uncompensated care cost does not reflect any amounts associated with bad debt.
Note: New 2001 financial figures became available for Children's National Medical Center and uncompensated care costs were recalculated. Thus, the costs differ from the 2001 and 2002 DCHA Financial Indicators Reports.
Note: Hadley Memorial Hospital is included 1999, 2000 and 2001.
Note: Calculations excludes MedLINK Hospital, psychiatric and federal hospitals.
Source: 2003 DCHA Financial Indicators Survey.

Inpatient, Outpatient and Emergency Department Revenue as a Percentage of Total Gross Patient 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 department revenue from outpatient revenues. The pie chart shows the 2003 breakdown of District hospital revenues in these three categories.



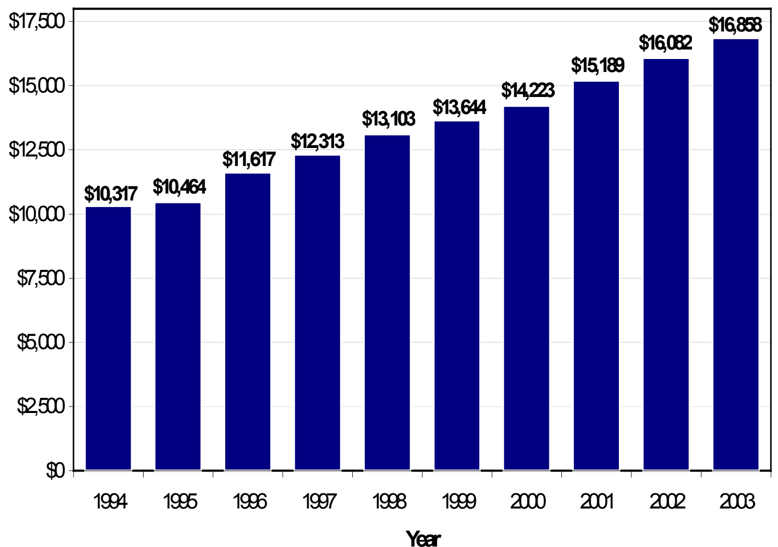


Over the past 10 years, the increased sophistication and technology of outpatient services has moved many services previously performed on an inpatient basis to the outpatient setting. After stabilizing over several years, the past two years' data indicate that outpatient and emergency department revenues appear to be on the rise again.

Source: 2003 DCHA Financial Indicators Survey.

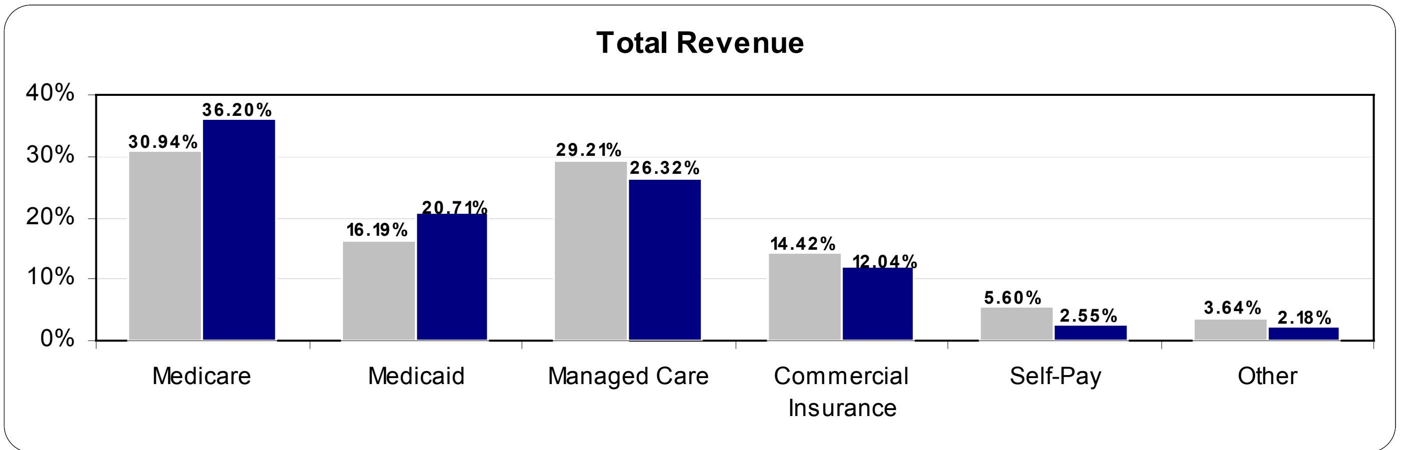
Average Cost Per Discharge – *Ten-Year Trend: 1994 - 2003*

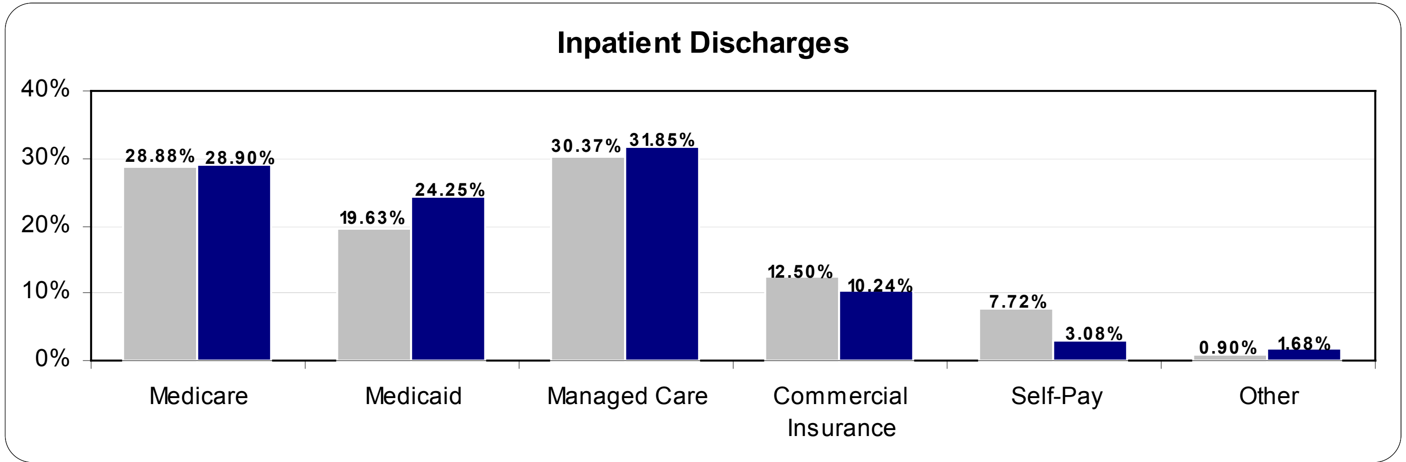
The average cost per inpatient discharge includes a number of components: nursing, medical education, pharmaceuticals, dietary, housekeeping, laundry services, payroll, plant operations, maintenance, supplies, malpractice insurance, and other patient care costs. The chart indicates that cost per patient discharge has increased each year. In fiscal year 2003, the average cost per discharge at District hospitals increased 4.83 percent over 2002, while the Centers for Medicare and Medicaid Services projected hospital spending growth to increase 6.5 percent for the time period.

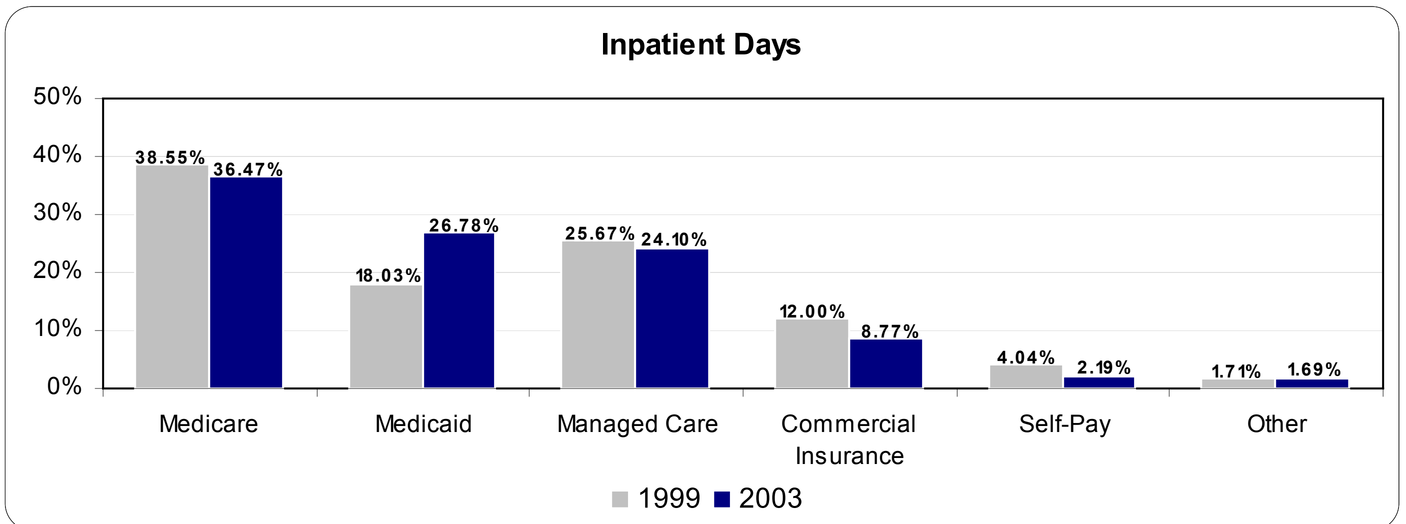


Note: Calculations excludes MedLINK Hospital, rehabilitation, psychiatric and federal hospitals.
Source: 2003 DCHA Financial Indicators Survey.

Total Inpatient Revenue, Discharges & Patient Days by Payor Class
Five-Year Comparison: 1999 v. 2003





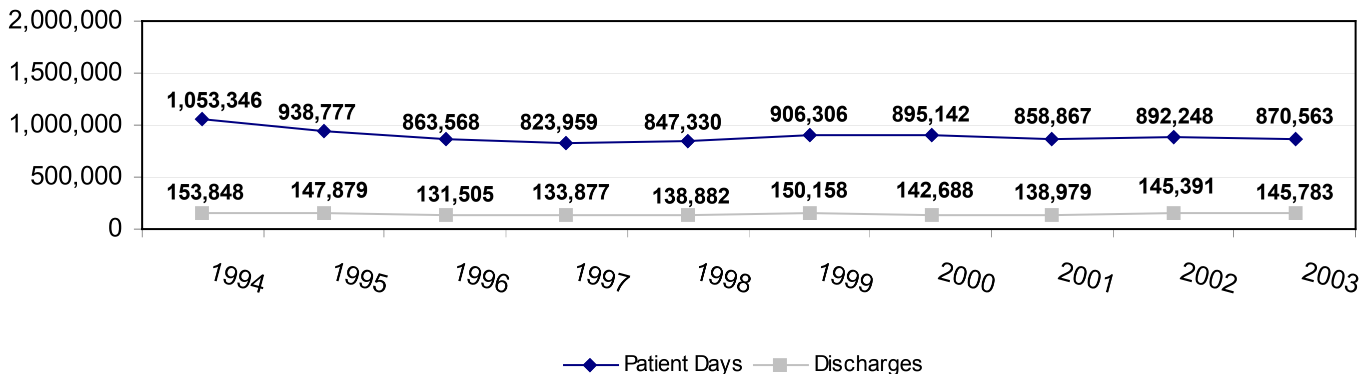


Note: "Medicaid" includes all Medicaid programs (regardless of state), including D.C. Healthy Families, all medical charities programs as well as the D.C. Healthcare Alliance program.
Note: Calculations excludes MedLINK Hospital, federal and psychiatric hospitals.
Source: 2003 DCHA Financial Indicators Survey.

Inpatient Days Compared to Inpatient Discharges
Ten-Year Comparison: 1994 v. 2003

In 1994, District hospitals reported over one million inpatient days. By 2003, however, inpatient days had fallen to 870,563 days, a drop of 17.35 percent over 10 years. Patient discharges have declined by 5.24 percent over this same ten-year period, from 153,848 discharges in 1994 to 145,783 discharges in 2003, reflecting an overall reduction in average length of stay.

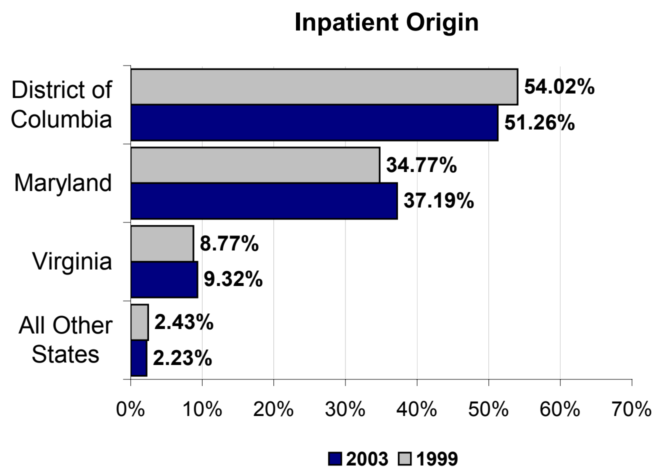
While inpatient days and discharges have leveled off or decreased over the last several years, since the closure or conversion of three District hospitals in 2001 and 2002, the remaining hospitals' discharges and patient days have increased an average of 4.76 percent and 2.62 percent, respectively, over the last two years.



Note: Calculation excludes MedLINK Hospital, federal and psychiatric hospitals.
Source: 2003 DCHA Financial Indicators Survey.

Inpatient Origin: 1999 v. 2003
District of Columbia Hospitals

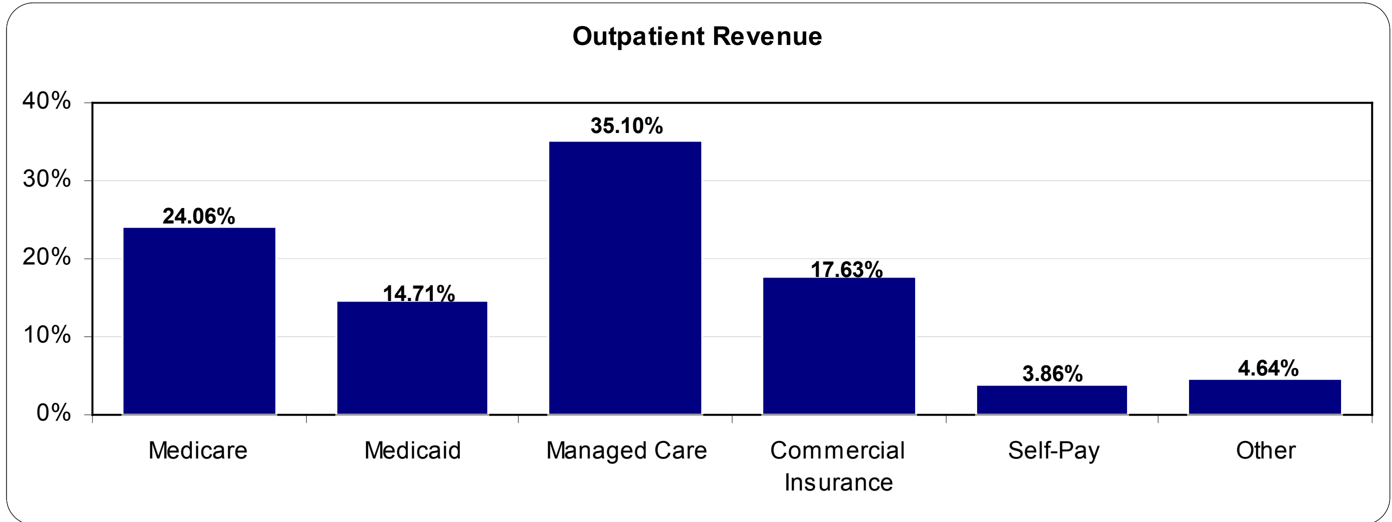
While the District of Columbia has a relatively small population (563,384 in 2003, as estimated by the U.S. Census Bureau), District hospitals serve patients from throughout the region. In fact, only about half of the patients served in D.C. hospitals actually live in the city. Furthermore, compared to 1999 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.

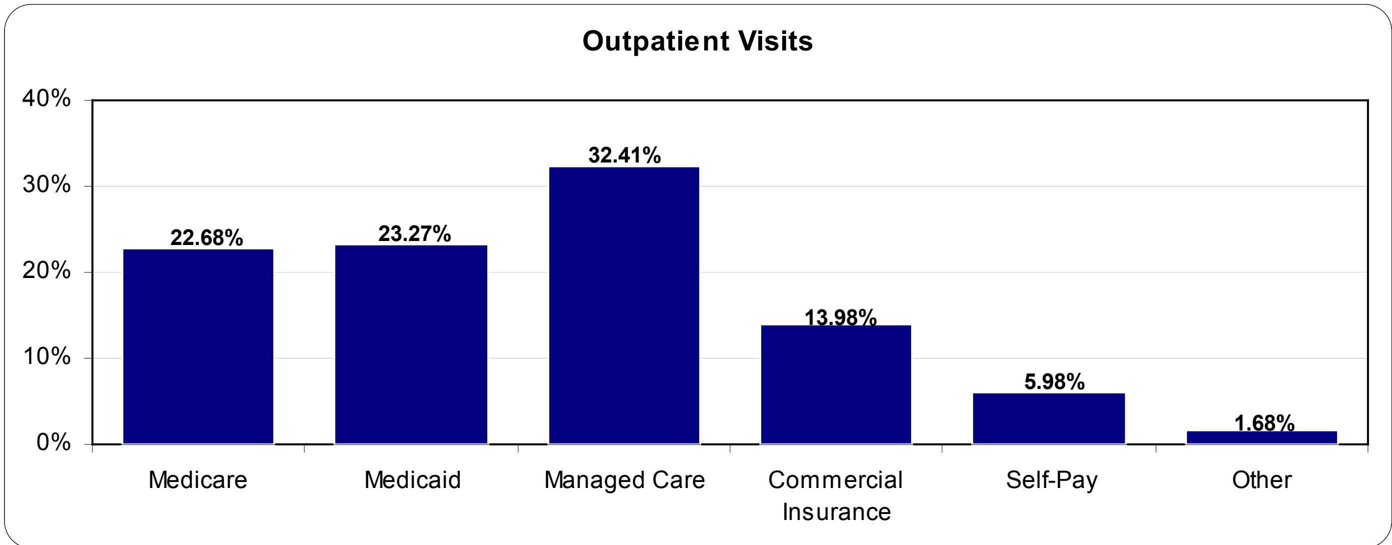


Source: DCHA Patient Data System, 1999 and 2003. Hospitals in this database include Children's National Medical Center, D.C. General Hospital (only in 1999), George Washington University Hospital, Georgetown University Hospital, Greater Southeast Community Hospital, Hadley Memorial Hospital (only in 1999), Howard University Hospital, National Rehabilitation Hospital, Providence Hospital, Sibley Memorial Hospital, Veterans Affairs Medical Center and Washington Hospital Center.

Total Outpatient Revenue and Visits by Payor Class
Fiscal Year 2003

Previously, 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 began to extract their emergency department revenue from outpatient revenues. The correlation between outpatient revenues and outpatient visits is consistent among all of the payors except Medicaid, where the percentage of revenue is significantly less than the percentage of visits.

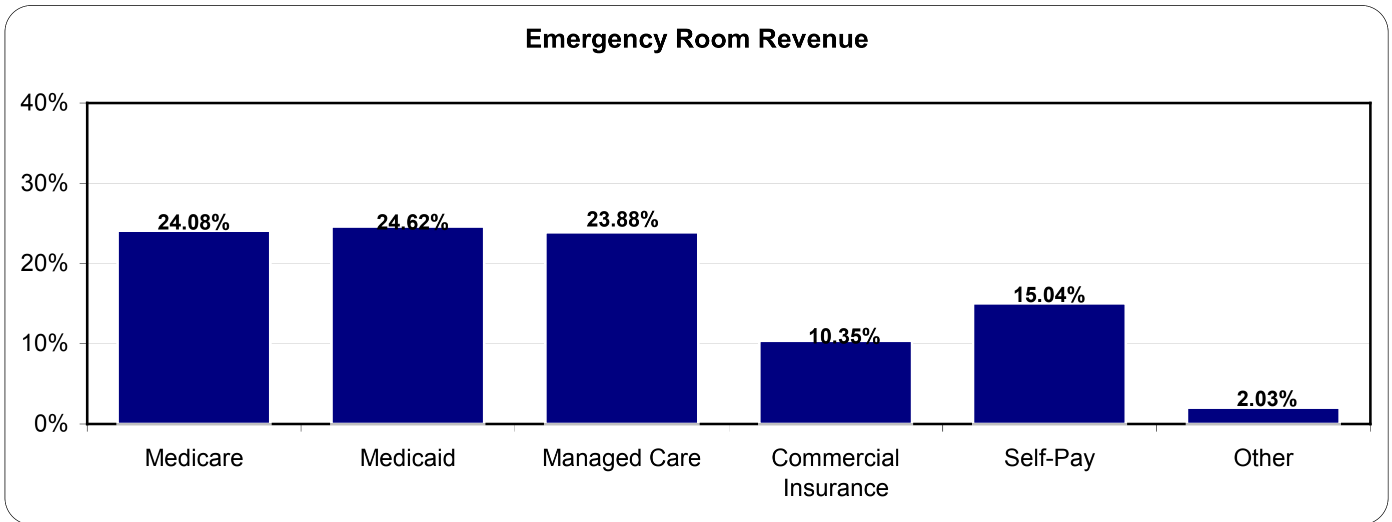


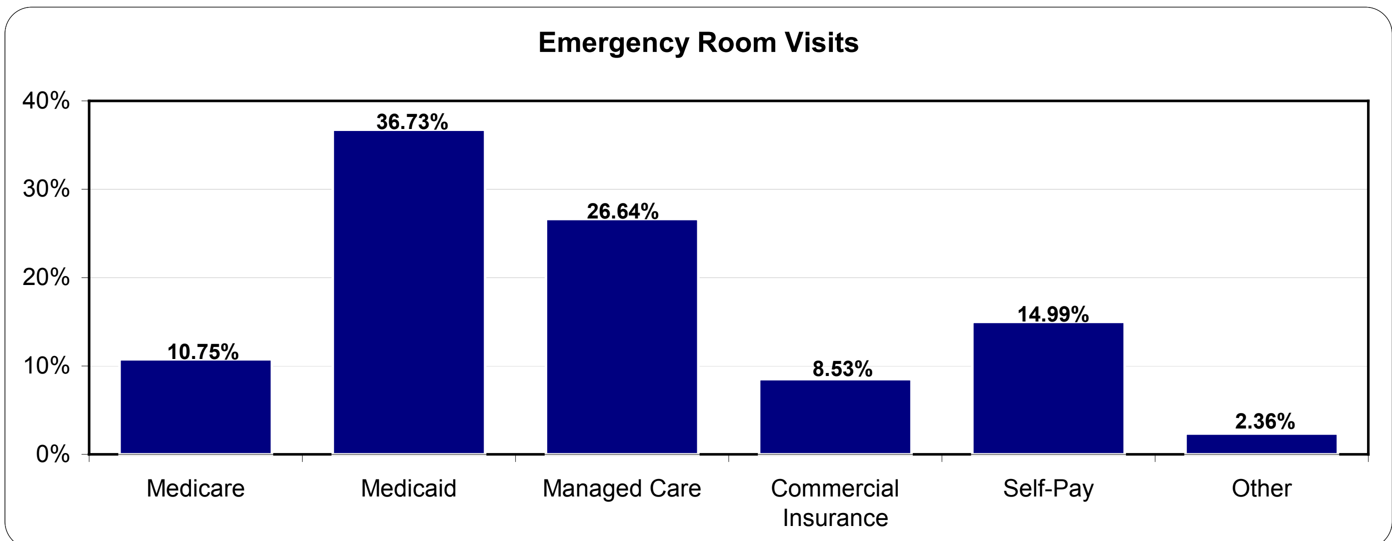


Note: "Medicaid" includes all Medicaid programs (regardless of state), including D.C. Healthy Families, all medical charities programs as well as the D.C. Healthcare Alliance program.
Note: Calculation excludes Hadley Memorial Hospital, MedLINK Hospital, National Rehabilitation Hospital, federal and psychiatric hospitals.
Note: Data was unavailable by payor class for George Washington University Hospital.
Source: 2003 DCHA Financial Indicators Survey.

Total Emergency Room Revenue and Visits by Payor Class
Fiscal Year 2003

Previously, 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 began to extract their emergency department revenue from outpatient revenues. As seen in the outpatient revenue/visits data, the correlation between emergency room revenues and emergency room visits is consistent among most of the payors. However, once again the percentage of Medicaid revenue is significantly less than the percentage of visits. In addition, the percentage of Medicare revenue is significantly greater than the percentage of Medicare emergency room visits.





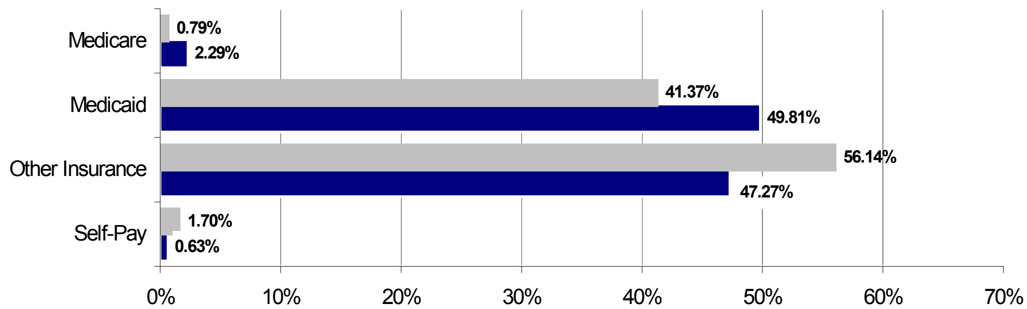
Note: "Medicaid" includes all Medicaid programs (regardless of state), including D.C. Healthy Families, all medical charities programs as well as the D.C. Healthcare Alliance program.
Note: Calculation excludes Hadley Memorial Hospital, MedLINK Hospital, National Rehabilitation Hospital, federal and psychiatric hospitals.
Note: Data was unavailable by payor class for George Washington University Hospital.
Source: 2003 DCHA Financial Indicators Survey.

Payor Mix by Gross Patient Revenue – 2002 v. 2003
District of Columbia Hospitals

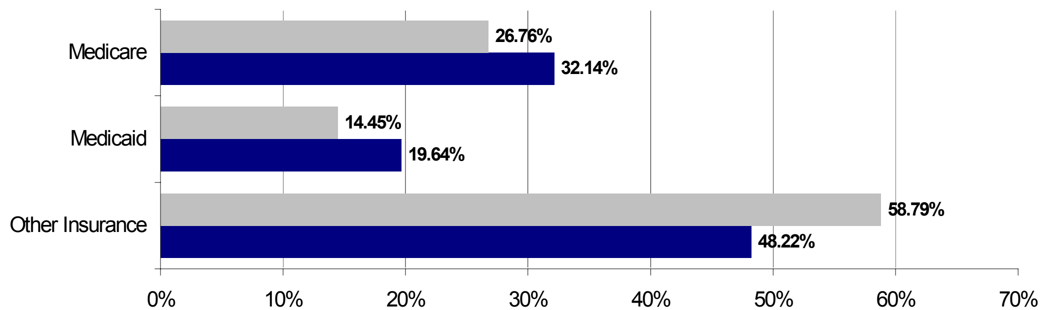
Payor mix is an important characteristic that defines hospital financial stability. A hospital's balance between public and private payors is often reflected in its overall financial health. In the District, both Medicare and Medicaid patients generally have longer lengths of stay, more severe acuity, frequent co-morbidities, as well as complications resulting from intermittent insurance coverage.

NOTE: 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. Healthcare Alliance, as described in the Introduction to this Report. "Other Insurance" includes Blue Cross, commercial managed care, commercial fee-for-service and other insurers. D.C. Healthcare Alliance hospital providers include: Children's National Medical Center, George Washington University Hospital, Greater Southeast Community Hospital, Howard University Hospital, Providence Hospital and Washington Hospital Center.

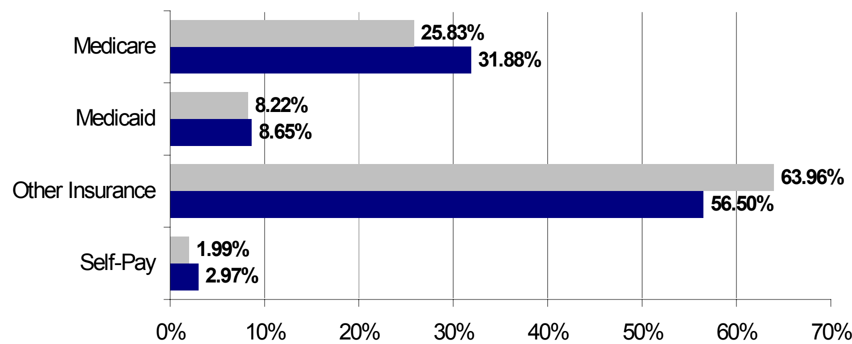
Children's National Medical Center



George Washington University Hospital



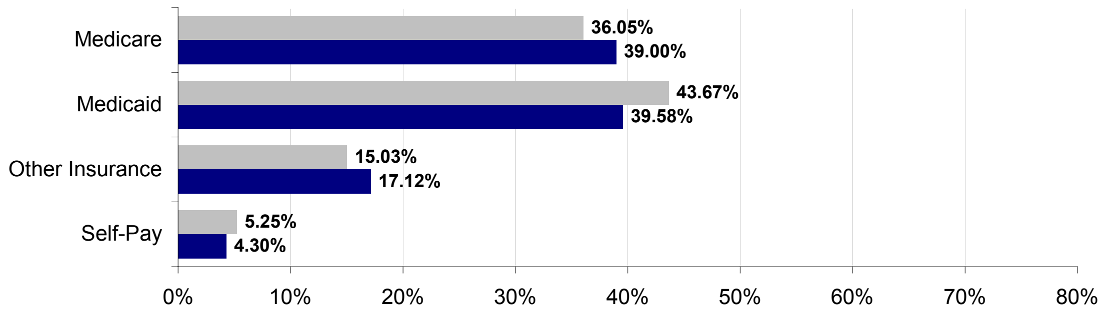
Georgetown University Hospital

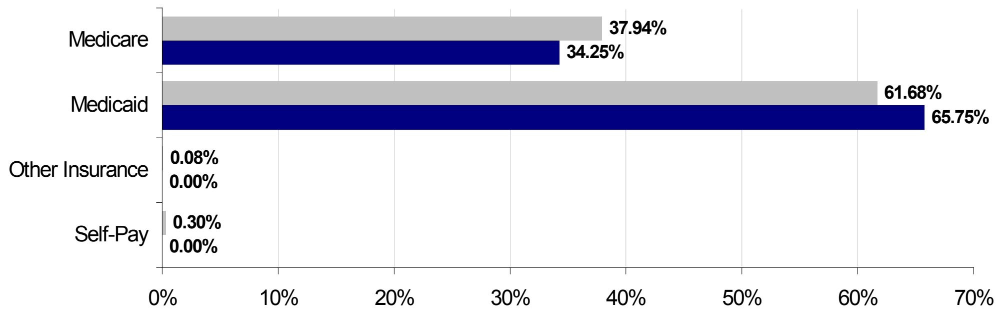


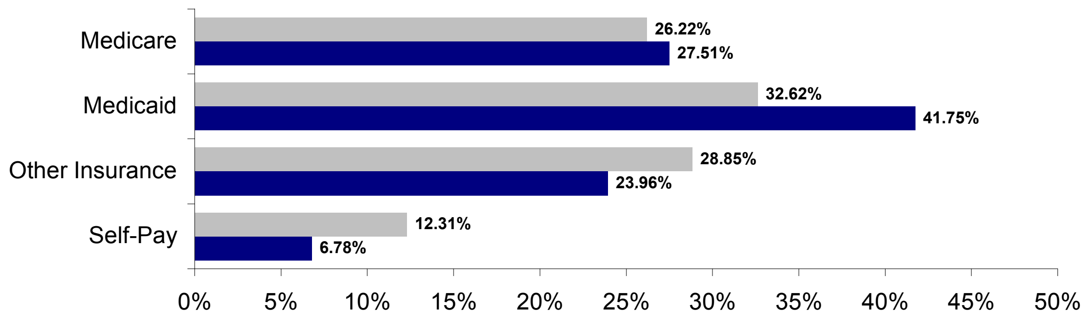
■ 2003 ■ 2002

Payor Mix by Gross Patient Revenue – 2002 v. 2003
District of Columbia Hospitals (continued)

NOTE: 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. Healthcare Alliance, as described in the Introduction to this Report. "Other Insurance" includes Blue Cross, commercial managed care, commercial fee-for-service and other insurers. D.C. Healthcare Alliance hospital providers include: Children's National Medical Center, George Washington University Hospital, Greater Southeast Community Hospital, Howard University Hospital, Providence Hospital and Washington Hospital Center.





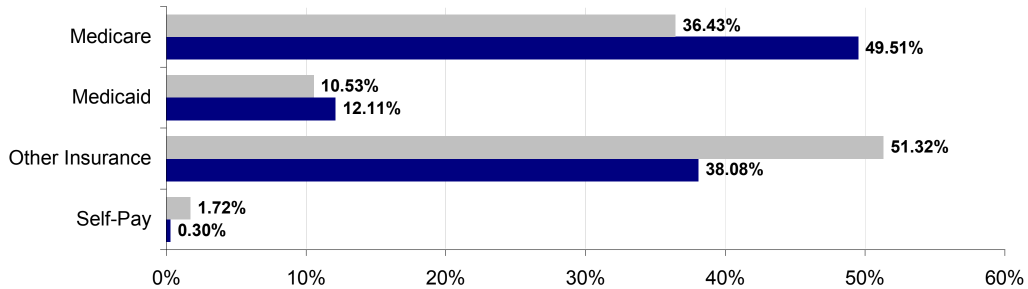


■ 2003 ■ 2002

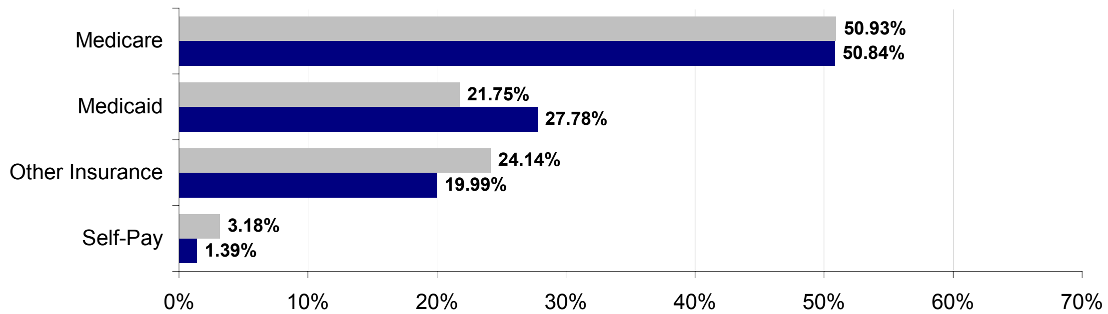
Payor Mix by Gross Patient Revenue – 2002 v. 2003
District of Columbia Hospitals (continued)

NOTE: 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. Healthcare Alliance, as described in the Introduction to this Report. "Other Insurance" includes Blue Cross, commercial managed care, commercial fee-for-service and other insurers. D.C. Healthcare Alliance hospital providers include: Children's National Medical Center, George Washington University Hospital, Greater Southeast Community Hospital, Howard University Hospital, Providence Hospital and Washington Hospital Center.

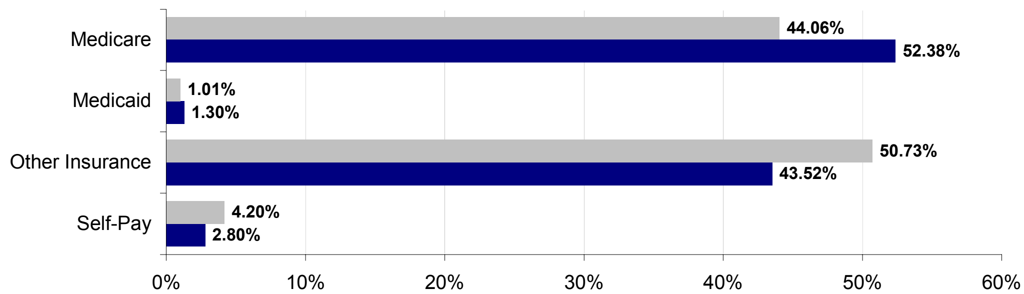
National Rehabilitation Hospital



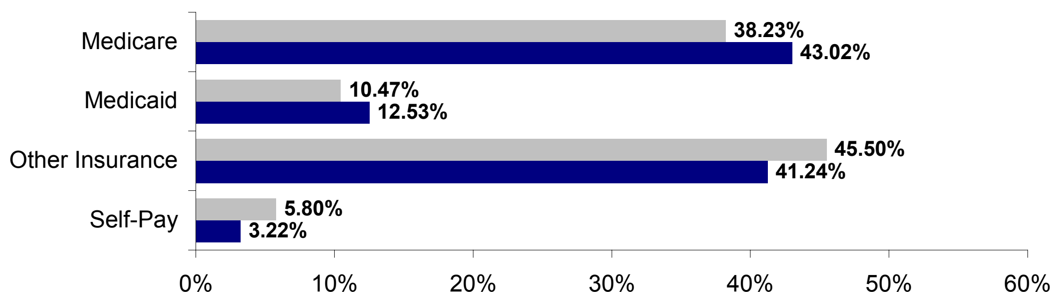
Providence Hospital



Sibley Memorial Hospital



Washington Hospital Center



■ 2003 ■ 2002

Operating Beds By Service

Second Quarter 2004

Following the loss of D.C. General Hospital and Columbia Hospital for Women, the District's non-federal acute care hospitals experienced a decrease 12.38 percent in total operating beds. Coupled with an estimated 14.6 percent nursing vacancy rate, the reduction in operating beds often causes diversion and re-routing ambulances to other emergency departments across the city.

Non-Federal Acute Care Hospitals:	MED/ SURG	OB/ GYN	PEDS	ICU	NICU	PSYCH	SUBST ABUSE	OTHER	TOTAL
Children's National Medical Center	0	0	115	18	35	20	0	0	188
George Washington University Hospital	185	45	0	48	18	20	0	16	332
Georgetown University Hospital	179	22	30	38	46	14	0	0	329
Greater Southeast Community Hospital	116	14	0	28	15	20	0	25	218
Howard University Hospital	208	10	16	30	9	18	0	0	291
Providence Hospital	169	32	0	12	9	29	12	0	263
Sibley Memorial Hospital	167	20	0	14	0	16	0	16	233
Washington Hospital Center	592	35	0	66	20	36	22	0	771
Non-Federal Acute Subtotal	**1,616**	**178**	**161**	**254**	**152**	**173**	**34**	**57**	**2,625**
Federal Acute Care Hospitals:									
Veterans Affairs Medical Center	98	0	0	20	0	28	0	0	146
Walter Reed Army Medical Center	153	0	22	54	0	32	0	0	261
Malcolm Grow Medical Center/Andrews AFB	36	17	0	15	0	0	0	0	68
National Naval Medical Center/Bethesda	107	32	0	13	24	9	0	23	208
Federal Acute Subtotal	**394**	**49**	**22**	**102**	**24**	**69**	**0**	**23**	**683**
Other Specialty and Psychiatric Hospitals:									
Hadley Memorial Hospital	0	0	0	0	0	0	0	71	71
National Rehabilitation Hospital	0	0	0	0	0	0	0	173	173
Psychiatric Institute of Washington	0	0	0	0	0	104	0	0	104
Riverside Hospital	0	0	0	0	0	126	16	0	142
Saint Elizabeths Hospital	0	0	0	0	0	548	0	0	548
Specialty and Psychiatric Subtotal	**0**	**0**	**0**	**0**	**0**	**778**	**16**	**244**	**1,038**
GRAND TOTAL	**2,010**	**227**	**183**	**356**	**176**	**1020**	**50**	**324**	**4,346**

Source: DCHA Bed Capacity and Occupancy Report, Second Quarter 2004.

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.

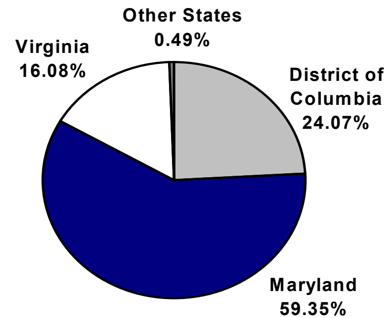
Health Care Employee Information
Fiscal Year 2003

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.

While hospitals' efforts to attract and retain these employees are underway, District hospitals reported an estimated 14.6 percent vacancy rate for nurses (includes all Registered Nurses, Licensed Practical Nurses and Nursing Aides) in 2003. 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	24.02%	60.05%	15.44%	0.49%
George Washington University Hospital	21.23%	45.63%	33.14%	0.00%
Georgetown University Hospital	25.15%	42.46%	31.53%	0.86%
Greater Southeast Community Hospital	18.66%	73.92%	7.42%	0.00%
Hadley Memorial Hospital	29.10%	63.47%	7.43%	0.00%
Howard University Hospital	29.95%	60.88%	8.00%	1.17%
Providence Hospital	25.88%	68.12%	5.68%	0.32%
Sibley Memorial Hospital	23.56%	53.13%	23.31%	0.00%
Washington Hospital Center	21.63%	66.57%	11.31%	0.49%

Note: Calculation excludes rehabilitation, psychiatric and federal hospitals.
Source: 2003 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 third party payors, including insurance companies, Medicare, Medicaid, D.C. Healthcare Alliance 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.***

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.*** Medicaid includes all Medicaid payors regardless of state, as well as revenues from D.C. Healthy Families and the D.C. Healthcare Alliance, as described in the Introduction to this Report. "Other Insurance" includes Blue Cross, commercial managed care, commercial fee-for-service and other insurers. D.C. Healthcare Alliance hospital providers include: Children's National Medical Center, George Washington University Hospital, Greater Southeast Community Hospital, Howard University Hospital, Providence Hospital and Washington Hospital Center.

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.