

*Fall 2000*



# Financial Indicators

## Fiscal Year 1999

Kenneth A. Samet  
Chairman of the Board

Robert A. Malson  
President



# ABOUT THIS REPORT ON FINANCIAL INDICATORS

## *INTRODUCTION*

Health care is both an essential human service and a key component of the District's economy. Over the last 15-20 years, hospitals and health care providers have been coping with changes in federal and local government policies, private sector market forces, growth of managed care, and advances in medical technology and practice. As hospital leaders work with government officials, other health care providers and community-based organizations for improved health care delivery, they must ensure that market forces and public policies result in a health care system that meets the needs of the community and improves the health status of District residents.

The charts in this report are intended to provide a financial picture of the hospital community in the District of Columbia for fiscal year 1999. The source of each chart is noted. Some of the financial changes depicted by the graphs in this report are a reflection of an industry-wide movement towards restructuring the delivery of health care services. Increased outpatient utilization, managed care penetration, changes in Medicare payment policies, and stagnant reimbursement from some government payors have all had an impact on the financial status of District hospitals.

## *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 1999 fiscal year, which does vary. The charts and graphs on the financial condition of hospitals provide collective (and some individual) information about twelve of the seventeen DCHA member hospitals. The five 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.

For more information about this report, please contact the District of Columbia Hospital Association at (202) 682-1581.

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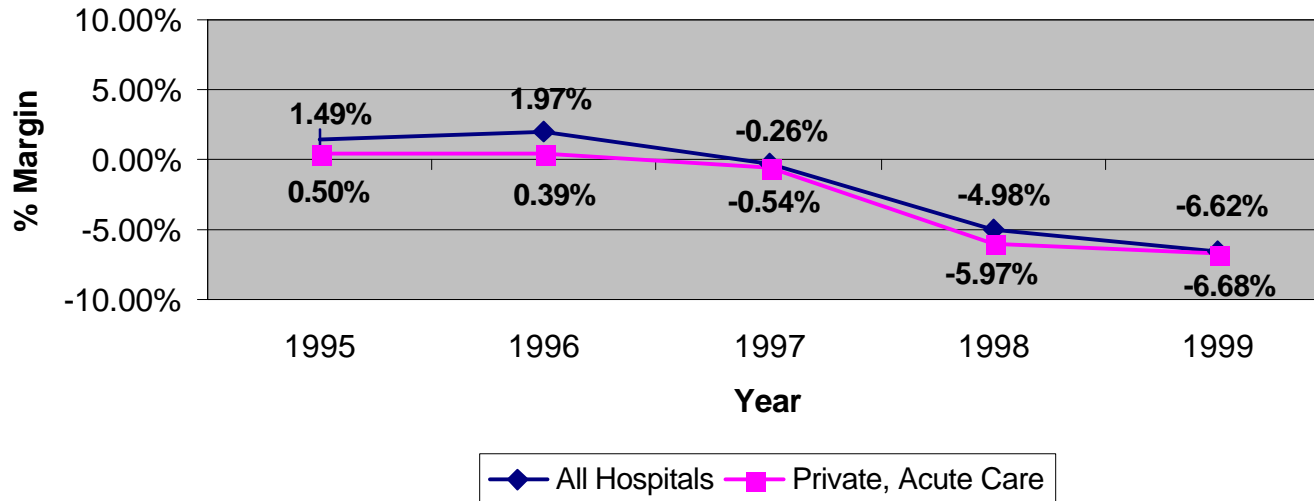
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# Aggregate Operating Margin Percent

## District of Columbia Hospitals

The District's aggregate decline in operating revenue over the last five years parallels the national trend. In addition to the fact that a negative operating margin threatens a hospital's existence, it also prevents the hospital from reinvesting in the physical facility and in key clinical programs. Health care experts recommend hospitals maintain a four percent operating margin for necessary reinvestment.

Among the influences driving hospital operating margins are the District of Columbia's uninsured and Medicaid populations which have always had limited access to primary and preventive care that many take for granted. Over one-quarter of the city's population receives health coverage through the Medicaid program, and another 17-18 percent (approximately 85,000 individuals) of the population has no health insurance at all. Data demonstrate that these populations have difficulty accessing primary care. Unfortunately, this means that there remains a consistent reliance, however inappropriate, on hospital emergency rooms for care, and that these individuals must be hospitalized for ambulatory sensitive conditions, such as diabetes, hypertension, pneumonia, asthma and bronchitis. Since these conditions respond well to primary and preventive care, an improved system of primary care could reduce hospital emergency room expenses for this significant portion of the population.



**Note:** "Private, Acute Care" hospitals include Children's National Medical Center, Columbia Hospital for Women Medical Center, George Washington University Hospital, Georgetown University Hospital, Greater Southeast Community Hospital, Hadley Memorial Hospital, Howard University Hospital, Providence Hospital, Sibley Memorial Hospital and Washington Hospital Center.

**Note:** Calculations exclude psychiatric and federal hospitals.

**Note:** New 1998 financial figures became available for Howard University Hospital. Its 1998 operating margin was recalculated, and thus the aggregate operating margin differs from the 1998 DCHA Financial Indicators Report.

**Source:** 1999 DCHA Annual Hospital Survey.

# Operating Margin Percent by Hospital

## District of Columbia Hospitals

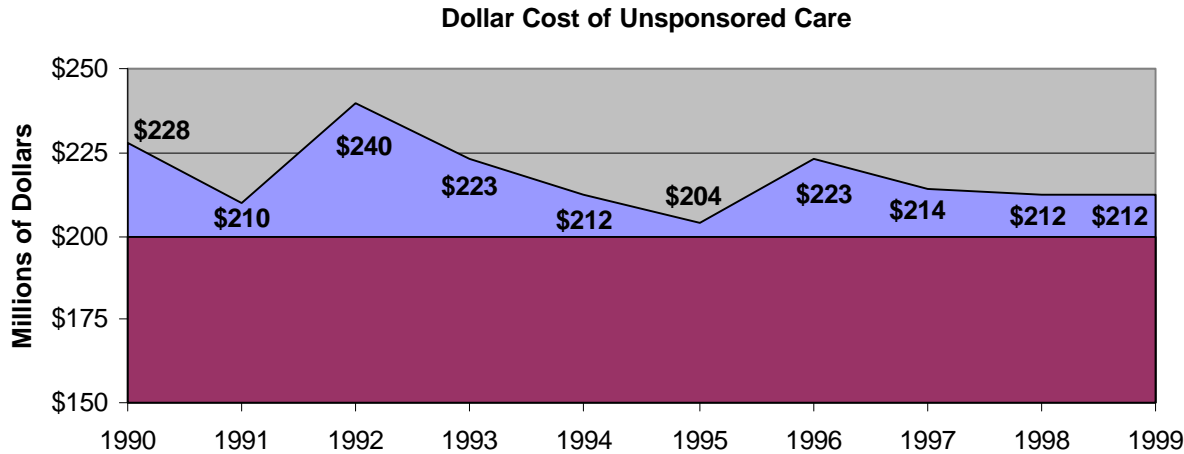
1999 proved to be another difficult year for District hospitals. Only four District hospitals reported positive operating margins. The strain on hospital finances has created a visibly demonstrated downward trend in operating margins. Those hospitals that serve a higher percentage of Medicaid and uninsured patients are the most financially troubled. Because of the medical complexity and the critical social needs of these patients, hospitals' costs for providing services far exceed the limited Medicaid reimbursement and impose heavy burdens on hospitals' charity and financial assistance programs.

	Operating Margin Percent		
	1999	1998	1997
Children's National Medical Center	-11.22%	-1.86%	3.13%
Columbia Hospital for Women Medical Center	-30.20%	-15.28%	-55.43%
District of Columbia General Hospital	-8.64%	5.81%	1.58%
George Washington University Hospital	-1.39%	-2.54%	1.07%
Georgetown University Hospital	-14.77%	-14.15%	-14.62%
Greater Southeast Community Hospital	-28.63%	-51.94%	1.69%
Hadley Memorial Hospital	-41.73%	NA	-5.33%
Howard University Hospital	-23.43%	-23.17%	-3.15%
National Rehabilitation Hospital	2.36%	5.18%	0.81%
Providence Hospital	2.61%	3.28%	3.53%
Sibley Memorial Hospital	3.25%	5.05%	5.35%
Washington Hospital Center	4.14%	3.02%	5.10%
<b>Aggregate Percentage</b>	-6.62%	-4.98%	-0.26%
<p><b>Note:</b> Aggregate Operating Margin Percent is computed by calculating the percentage difference between aggregate operating expenses and aggregate operating revenues.</p> <p><b>Note:</b> New 1998 financial figures became available for Howard University Hospital. Its 1998 operating margin was recalculated, and thus the individual operating margin and the aggregate operating margin differ from the 1998 DCHA Financial Indicators Report.</p> <p><b>Note:</b> Calculations exclude psychiatric and federal hospitals.</p> <p><b>Source:</b> 1999 DCHA Annual Hospital Survey.</p>			

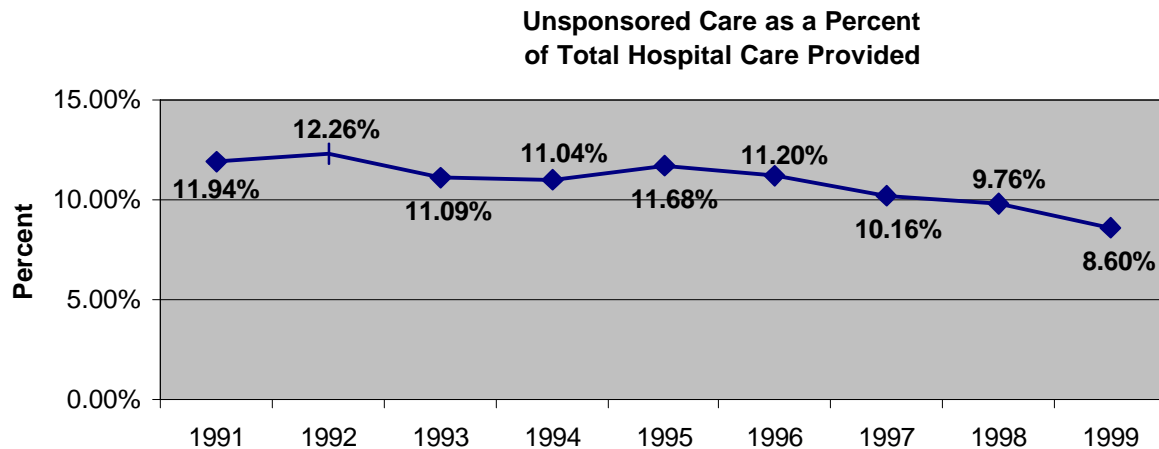
# Dollar Cost of Un-sponsored Care

## District of Columbia Hospitals

### Ten Year Trend: 1990 - 1999



In 1999, District of Columbia hospitals provided approximately \$212 million dollars in un-sponsored care. As demonstrated by the chart to the left, District hospitals have continually provided over \$200 million dollars each year in un-sponsored care over the past 10 years. But as hospital operating margins continue to decline, hospitals are finding it more challenging to provide un-sponsored care.



While the chart above indicates that D.C. hospitals have been consistent in their un-sponsored care contribution over the past 10 years, there has been a decline in un-sponsored care as a percent of total hospital care provided. This is the result of an increase in total hospital care, thus reducing the proportion of un-sponsored care as a percent of the total hospital care rendered.

**Note:** Hadley Memorial Hospital did not report in 1995 or 1998.

Columbia Hospital for Women did not report in 1998.

**Note:** Calculation excludes psychiatric and federal hospitals.

**Source:** 1999 DCHA Annual Hospital Survey.

# Un-sponsored Care

## *Cost and Percentage of Individual Hospital Total Care*

### District of Columbia Hospitals

Historically, one-third of all un-sponsored care has been provided by D.C. General Hospital, the only public, acute care hospital in the District of Columbia. In 1999, private hospitals in the District continued to demonstrate their commitment to the uninsured by providing over \$137 million, or sixty-five percent, of the un-sponsored care provided to under- and uninsured patients. As hospitals improve their efforts to enroll patients in the Medicaid and D.C. Healthy Families programs, un-sponsored care costs may decline for hospitals as these patients move into the insured population.

	<u>1999</u>		<u>1998</u>	
	Cost of Un-sponsored Care	Percent of Total Care	Cost of Un-sponsored Care	Percent of Total Care
Children's National Medical Center	\$27,069,000	13.32%	\$31,331,000	14.23%
Columbia Hospital for Women Medical Center	\$1,642,000	2.80%	NA	NA
District of Columbia General Hospital	\$73,834,000	43.96%	\$80,316,000	55.30%
George Washington University Hospital	\$7,527,000	5.08%	\$7,872,000	5.48%
Georgetown University Hospital	\$6,220,000	2.64%	\$6,321,000	2.81%
Greater Southeast Community Hospital	\$12,250,000	10.10%	\$12,883,000	9.20%
Hadley Memorial Hospital	\$1,069,000	2.99%	NA	NA
Howard University Hospital	\$37,191,000	15.84%	\$27,461,000	16.09%
National Rehabilitation Hospital	\$1,349,000	2.97%	\$1,481,000	2.97%
Providence Hospital	\$7,044,000	5.26%	\$8,456,000	6.55%
Sibley Memorial Hospital	\$4,197,000	3.75%	\$4,905,000	4.65%
Washington Hospital Center	\$32,346,000	5.63%	\$30,423,000	5.69%
<b>District Total</b>	<b>\$211,738,000</b>	<b>8.60%</b>	<b>\$211,449,000</b>	<b>9.82%</b>

**Note:** Columbia Hospital for Women and Hadley Memorial Hospital did not report for 1998.

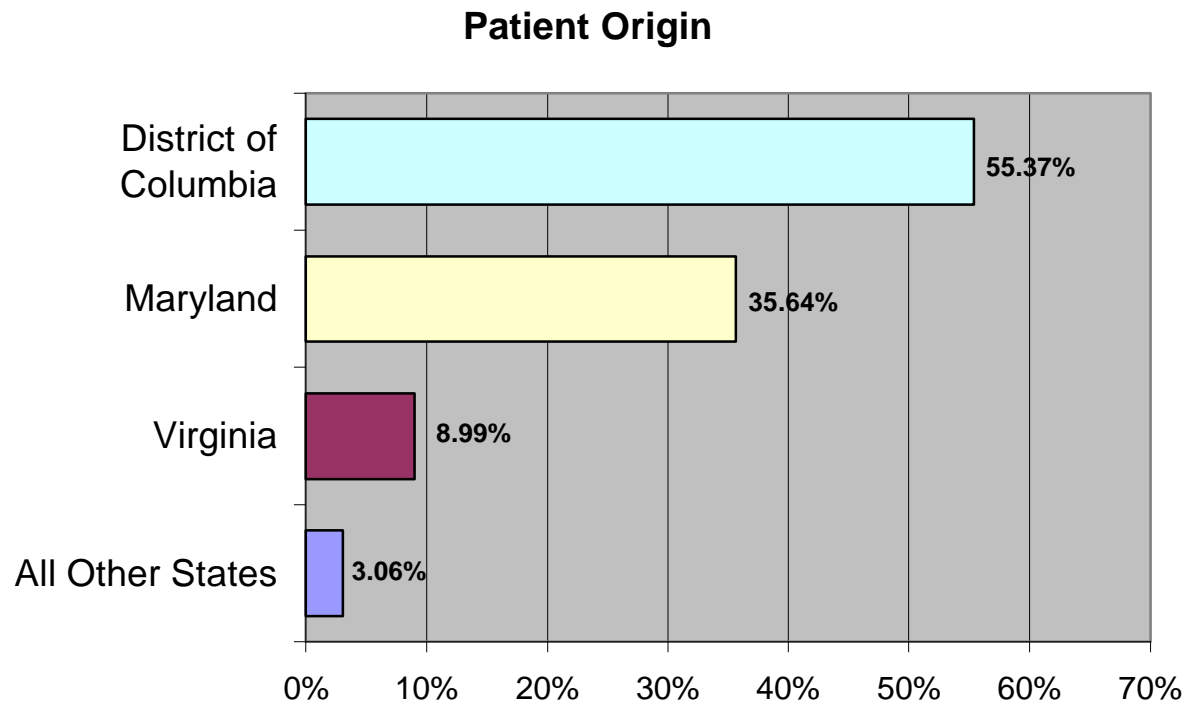
**Note:** Calculation excludes psychiatric and federal hospitals.

**Source:** 1999 DCHA Annual Hospital Survey.

# Patient Origin

## District of Columbia Acute Care Hospitals

While the District of Columbia has a relatively small population (519,000 as of July 1, 1999, according to the U.S. Census Bureau) the hospitals serve patients from throughout the region – over 3.4 million people. Many D.C. hospitals are Centers of Excellence for such services as cardiology, cancer and organ transplantation, and physicians throughout the Maryland-D.C.-Virginia region refer their patients to these centers.



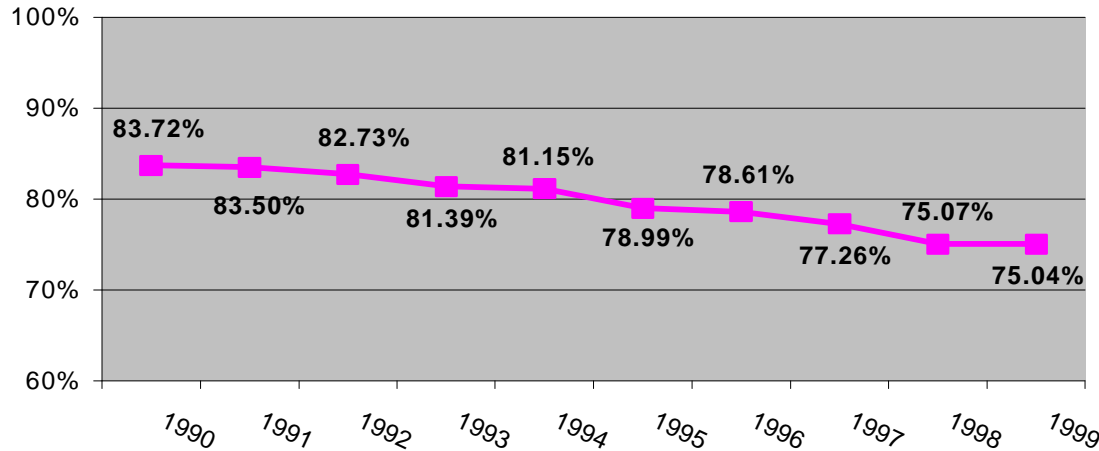
Source: 1999 DCHA Inpatient Database.

Note: DCHA has defined this hospital service area to include the District of Columbia, Prince George's County and Montgomery County in Maryland and Arlington County, Fairfax County, Alexandria City, Falls Church City and Fairfax City in Virginia. The source for each of the 1999 population estimates is the U.S. Census Bureau.

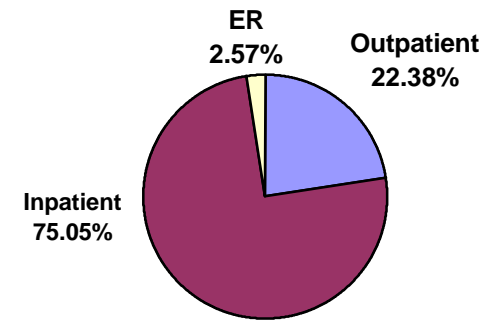
# Inpatient, Outpatient and Emergency Room Revenue as a Percentage of Total Gross Patient Revenue

## District of Columbia Acute Care Hospitals

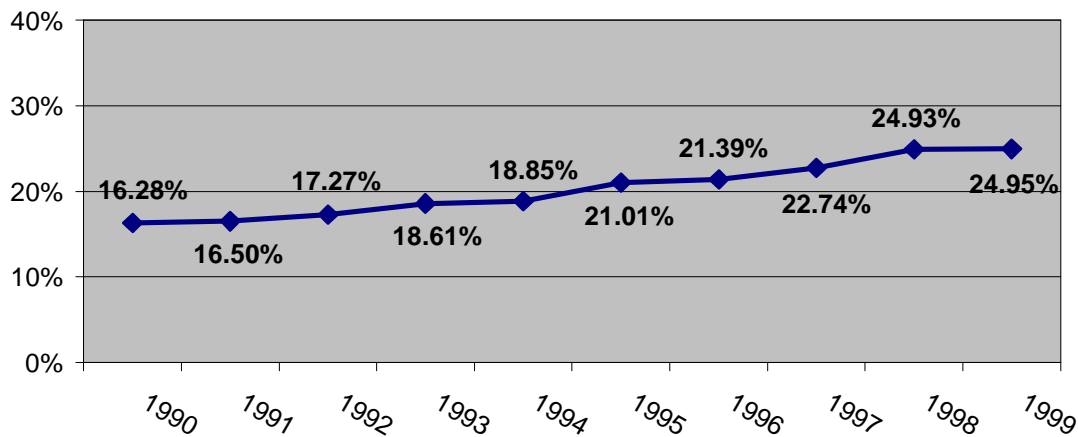
**Inpatient Revenue**



**1999 Revenue Breakdown**



**Outpatient and Emergency Room Revenue**



Until 1999, District hospitals reported only inpatient and outpatient revenues. Emergency Room revenue was generally included in each hospital's outpatient revenues. For fiscal year 1999, however, DCHA asked each hospital to extract and report their Emergency Room revenue from Outpatient revenues. The pie chart shows the 1999 breakdown of District hospital revenues in these three categories.

Since 1990, 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.

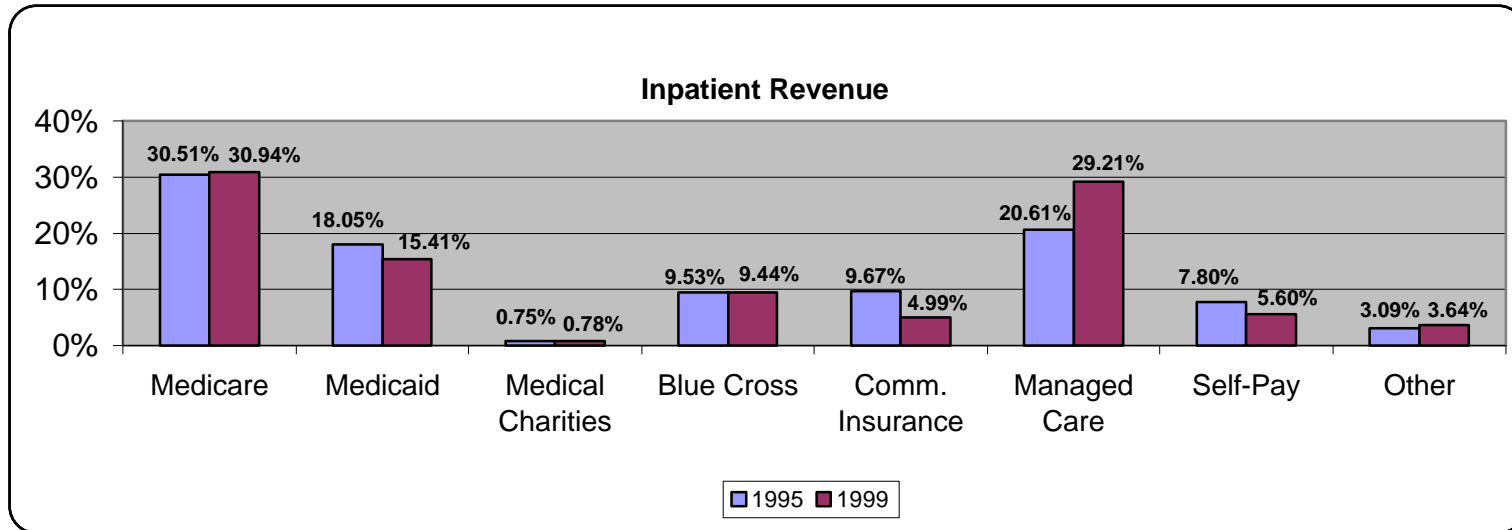
**Note:** Calculations excludes rehabilitation, psychiatric and federal hospitals.

**Source:** DCHA Annual Hospital Survey.

# Inpatient Revenue & Discharges by Payor Class

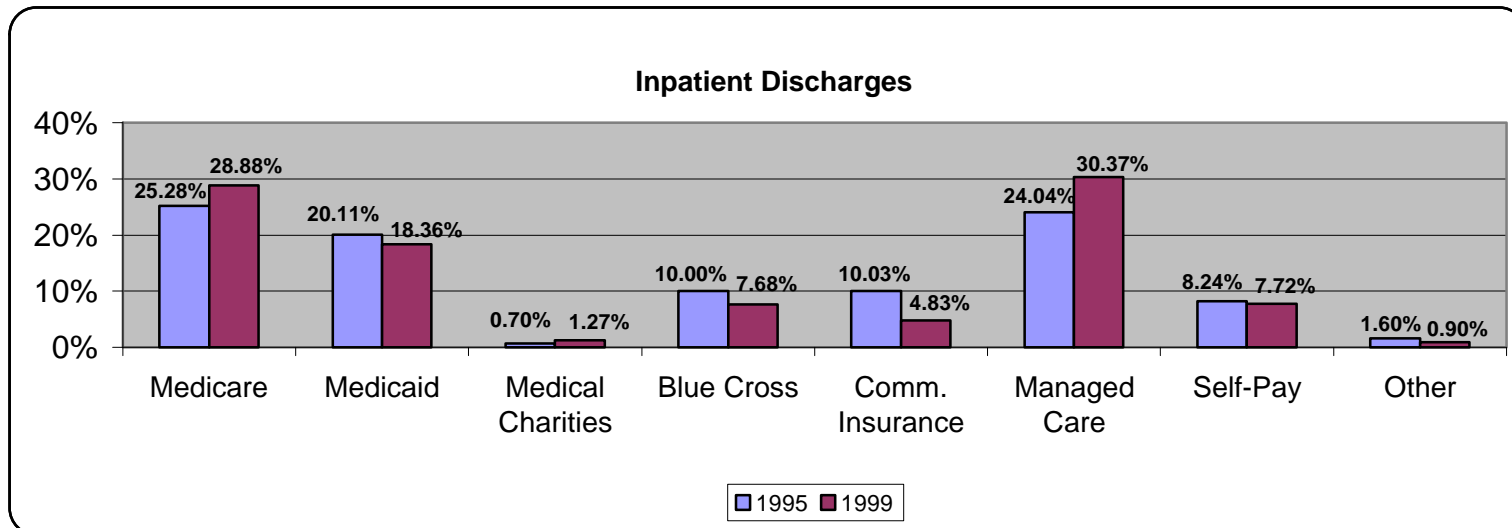
## *Five-Year Comparison: 1995 v. 1999*

### District of Columbia Hospitals



**Note:** Calculation excludes federal and psychiatric hospitals.

**Source:** DCHA Annual Hospital Survey.



**Note:** Calculation excludes federal and psychiatric hospitals.

**Source:** DCHA Annual Hospital Survey.

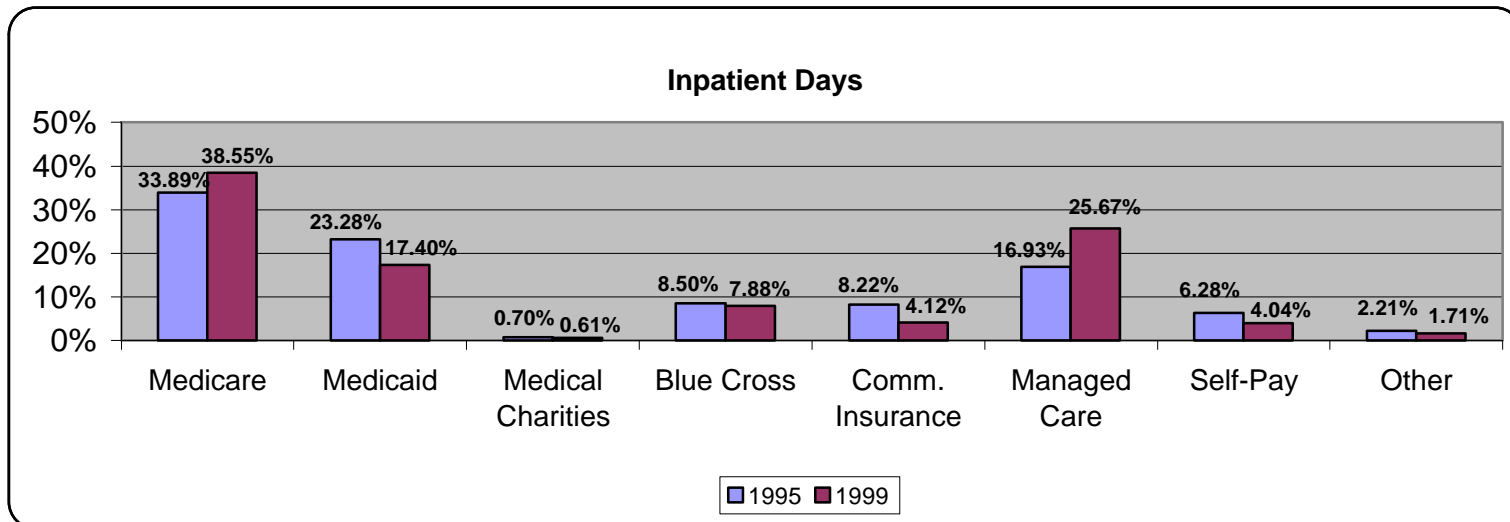
# Inpatient Days by Payor Class

## *Five-Year Comparison: 1995 v. 1999*

### 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 1995, 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 decrease in Medicaid revenues, inpatient days and discharges reflects the move of some of these patients to managed care.



**Note:** Calculation excludes federal and psychiatric hospitals.

**Source:** DCHA Annual Hospital Survey.

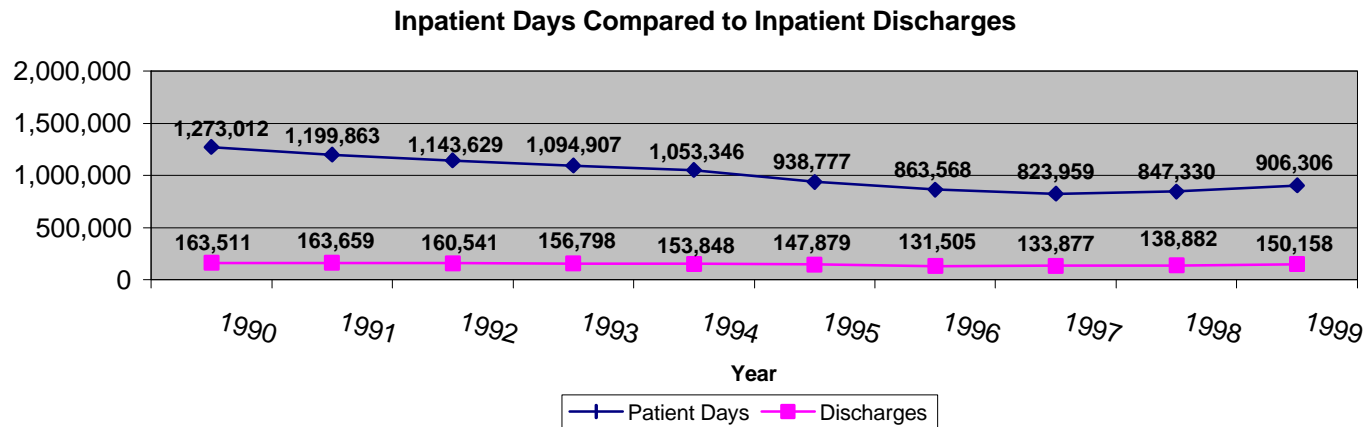
# Inpatient Days Compared to Inpatient Discharges

## *Ten-Year Comparison: 1990 v. 1999*

### District of Columbia Hospitals

The chart below illustrates a number of influences that are affecting patient days and discharges. In 1990, District hospitals reported just under 1.3 million inpatient days. By 1999, however, inpatient days fell to 906,306 days, a drop of 28.8 percent over 10 years. Patient discharges have declined by a little over eight percent over this ten-year period, from 163,511 discharges in 1990 to 150,158 discharges in 1999. 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 constant. Although there has been an increase in inpatient days and discharges since 1997, it is premature to suggest that an upward trend has developed. As DCHA collects data from hospitals for 2000 and beyond, it will be interesting to see if an upward trend has started.



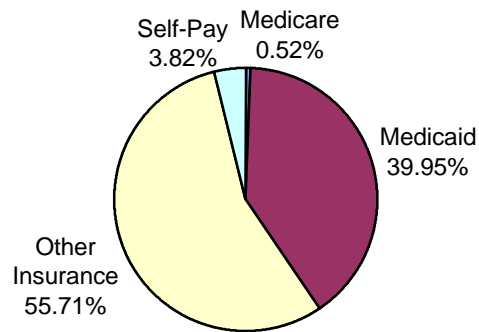
**Note:** Calculation excludes federal and psychiatric hospitals.  
**Source:** DCHA Annual Hospital Survey.

# Payor Mix by Gross Patient Revenue - 1999

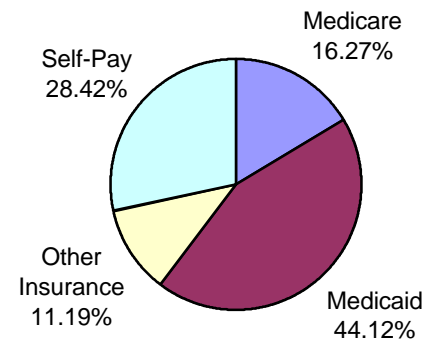
## District of Columbia Hospitals

Payor mix is an important characteristic that defines hospital financial stability. A hospital's ability to balance reimbursement between public and private payors is becoming more difficult as Medicare and Medicaid reimbursement continues to be pushed downward. In addition, District residents insured by public payors, particularly the Medicaid population, generally have a longer length of stay, more severe acuity and co-morbidities, and intermittent insurance coverage, which has a profound effect on hospital financial well-being, as demonstrated by the decline in District hospital operating margins. The charts below indicate that financially troubled hospitals often have a higher percentage of public payors. 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.

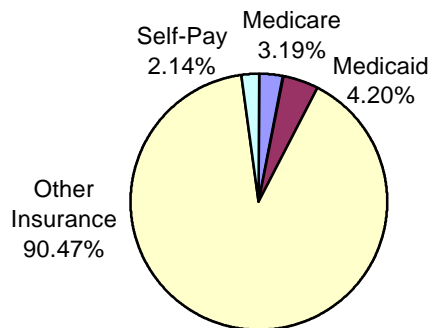
**Children's National Medical Center**



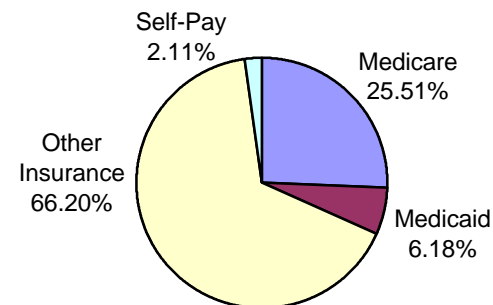
**D.C. General Hospital**



**Columbia Hospital for Women**



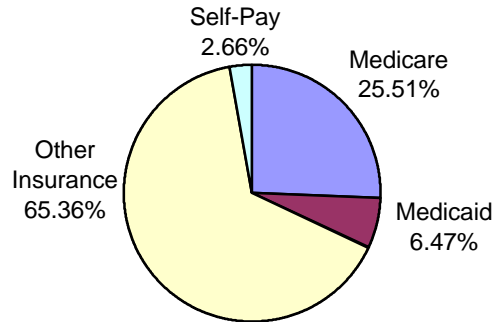
**George Washington University Hospital**



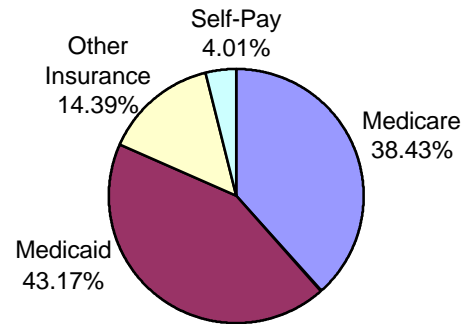
# Payor Mix by Gross Patient Revenue - 1999

## District of Columbia Hospitals (continued)

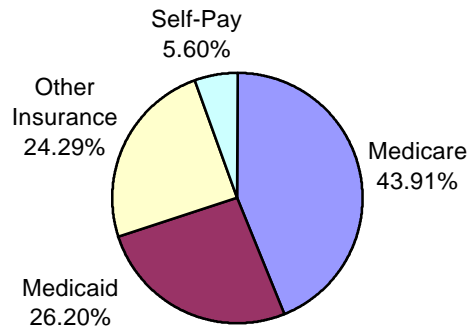
**Georgetown University Hospital**



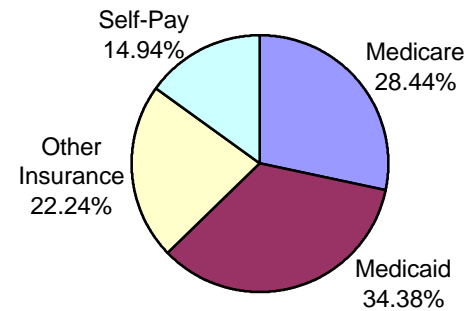
**Hadley Memorial Hospital**



**Greater Southeast Community Hospital**



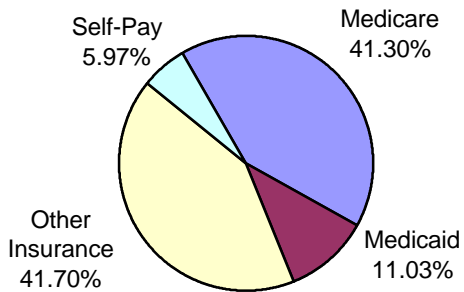
**Howard University Hospital**



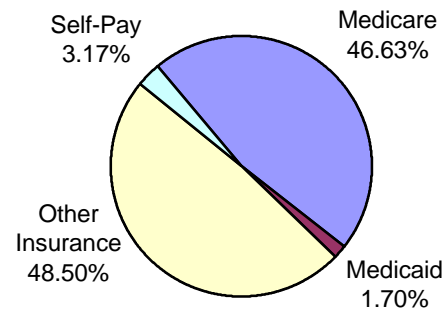
# Payor Mix by Gross Patient Revenue - 1999

## District of Columbia Hospitals (continued)

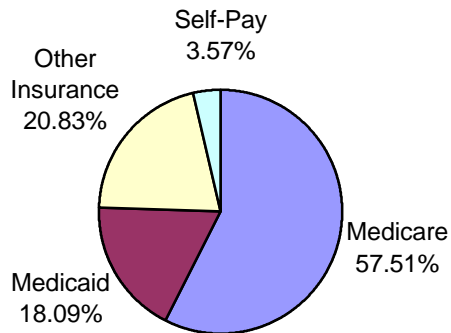
**National Rehabilitation Hospital**



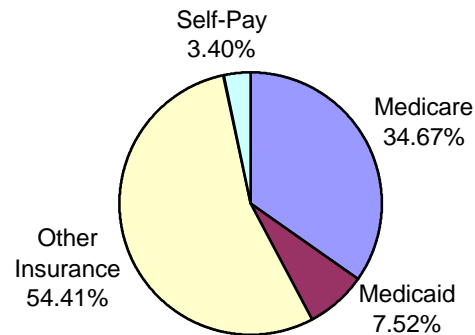
**Sibley Memorial Hospital**



**Providence Hospital**



**Washington Hospital Center**

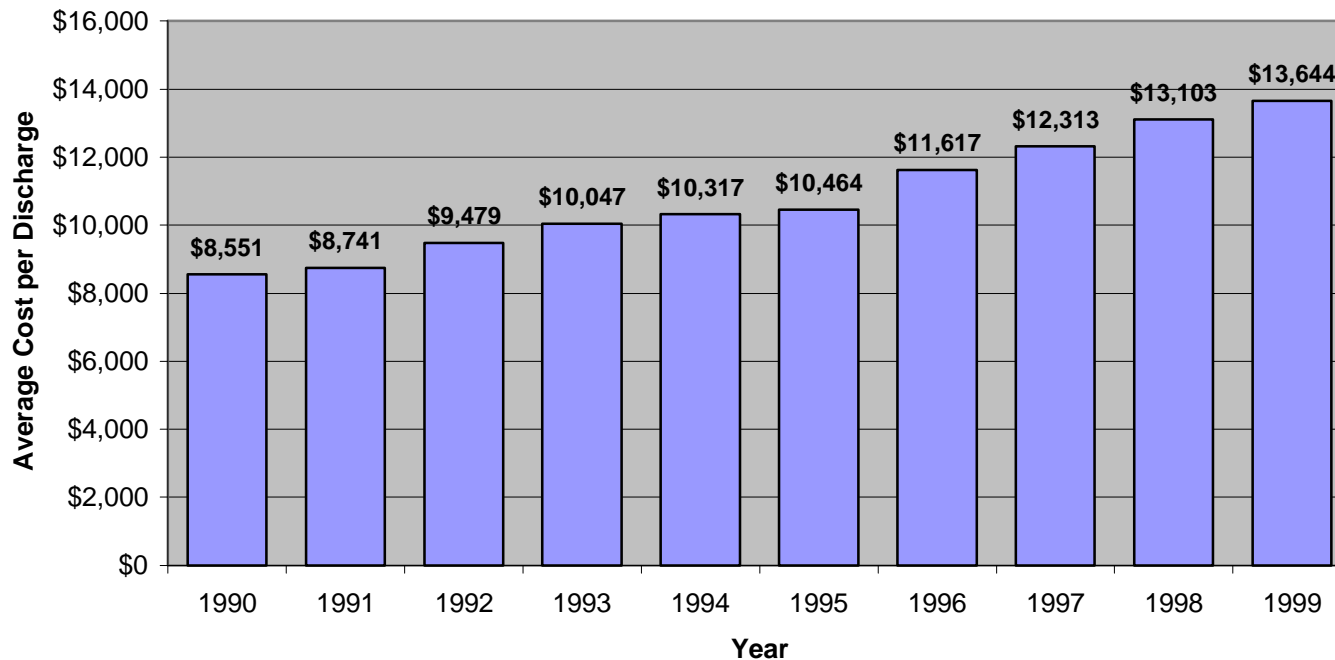


# Average Cost per Discharge

## *Ten-Year Trend: 1990 - 1999*

District of Columbia Acute Care Hospitals

The average cost per inpatient discharge includes a number of components: nursing, 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 59.56 percent, a yearly average increase of 6.62 percent, an increase consistent with national trends. Between 1990 and 1999, the Health Care Financing Administration reported that national health care expenditures increased by 75.65 percent, with total hospital care expenditures increasing by 56.51 percent during this same ten-year period.



**Note:** Calculation excludes rehabilitation, psychiatric and federal hospitals.

**Source:** DCHA Annual Hospital Survey.

# Acute Operating Beds By Service

## *District of Columbia Hospitals*

A variety of general factors influence bed-need in the District of Columbia 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;
- ▶ managed care will continue to grow, but with moderating effects of legislation (such as the 48-hour rule for deliveries);
- ▶ seasonal variations in hospital use will continue, with higher utilization during the winter months because of higher incidence of flu and pneumonia.

Factors unique to the District of Columbia and its hospitals that influence bed-need are:

- ▶ District hospitals will remain the tertiary referral center for a population of over 3.4 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;
- ▶ the size of the uninsured and Medicaid population will, on average, continue to be higher than the rest of the nation and suburbs.

	MED/ SURG	OB/ GYN	PEDS	ICU	NICU	PSYCH	SUBST ABUSE	OTHER	TOTAL
Children's National Medical Center			122	16	30	20			188
Columbia Hospital for Women	29	51		4	35		12		131
District of Columbia General Hospital	81	12	8	27	6		15	35	184
George Washington University Hospital	186	16		27	18	34			281
Georgetown University Hospital	195	18	36	38	50	14			351
Greater Southeast Community Hospital	180					20		36	236
Hadley Memorial Hospital	63								63
Howard University Hospital	178	32	23	28	9	24			294
Providence Hospital	201	48		17	9	29	12		316
Sibley Memorial Hospital	162	22		14		20			218
Washington Hospital Center	616	41		71	23	28		33	812
<b>TOTAL</b>	<b>1,891</b>	<b>240</b>	<b>189</b>	<b>242</b>	<b>180</b>	<b>189</b>	<b>39</b>	<b>104</b>	<b>3,074</b>

**Note:** The number of beds reported reflects an average for the entire fiscal year 1999.

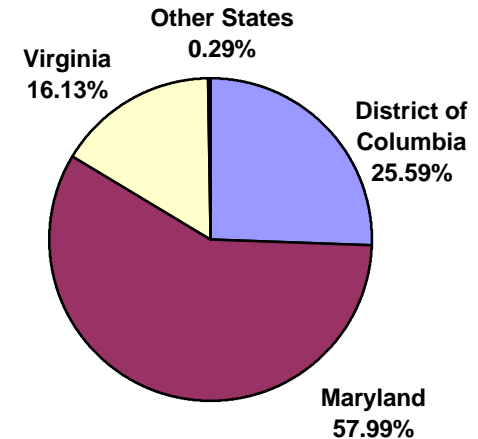
**Note:** The calculation excludes rehabilitation, psychiatric and federal hospitals.

**Source:** DCHA Annual Hospital Survey.

## Employees By State of Residence 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.

All D.C. Hospital Employees



	District of Columbia	Maryland	Virginia	Other
Children's National Medical Center	21.91%	61.76%	14.37%	1.95%
Columbia Hospital for Women	19.46%	52.95%	26.48%	1.12%
D.C. General Hospital	45.01%	45.01%	9.98%	0.00%
George Washington University Hospital	25.30%	44.50%	30.19%	0.00%
Georgetown University Hospital	25.47%	41.28%	33.25%	0.00%
Greater Southeast Community Hospital	19.29%	73.15%	7.56%	0.00%
Hadley Memorial Hospital	25.32%	67.70%	6.98%	0.00%
Howard University Hospital	26.24%	66.43%	7.24%	0.09%
Providence Hospital	25.78%	67.75%	6.24%	0.24%
Sibley Memorial Hospital	20.10%	54.24%	25.34%	0.32%
Washington Hospital Center	23.67%	63.96%	12.37%	0.00%

**Note:** D.C. General Hospital Department of Human Resources estimated their employee residency breakdown.

**Note:** Calculation excludes psychiatric, federal and rehabilitation hospitals.

**Source:** DCHA Annual Hospital Survey.

# GLOSSARY OF FINANCIAL TERMS

**BAD-DEBT:** The amounts from patient accounts which are “written off” because they are unpaid despite attempts to collect payment from either the patient and/or the insurance company. In many cases, bad debt is the result of patients who lack health insurance or have health insurance that does not cover all hospital services.

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

**CHARITY CARE:** The amount from patient accounts which are “written off” because a patient cannot pay for services rendered by the health care provider. These are services for which the provider never expected payment.

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

**DISCHARGE:** The formal release of a patient from a hospital after an acute episode of illness.

**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.

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



**District of Columbia Hospital Association**  
**1250 Eye Street, N.W., Suite 700**  
**Washington, D.C. 20005-3930**  
**Tel: 202/682-1581 • Fax: 202/371-8151**  
*Web: [www.dcha.org](http://www.dcha.org) • E-mail: [info@dcha.org](mailto:info@dcha.org)*