The Health of New Hampshire's Community Hospital System

A Financial and Economic Analysis

Section II – Analysis of Health Care Charitable Trusts In the State of New Hampshire: The Hospital Sector




Office of Planning and Research
New Hampshire Department of Health and Human Services
129 Pleasant Street • Concord, New Hampshire 03301
www.dhhs.state.nh.us

Section II

Analysis of Health Care Charitable Trusts in the State of New Hampshire

The Hospital Sector

Nancy M. Kane, DBA

Harvard School of Public Health

December 2000

Project Funded by Robert Wood Johnson Foundation under the Auspices of

The Access Project, Grant Number 031275

Done in Cooperation with

New Hampshire Department of Health and Human Services

New Hampshire Department of Insurance

New Hampshire Office of the Attorney General

Spitz Consulting Group, LLC

Contents

Introduction

In March 1999, a financial analysis of the health care charitable trusts of New Hampshire was undertaken to develop an understanding of the general financial condition of nonprofit healthcare organizations in the state[1]. In addition, the original charge was to identify, through publicly available and existing information sources, the quantifiable community benefits provided by these organizations. The information developed in this analysis had been intended for use as background to policy discussions on community benefits with New Hampshire Health District Councils[2] and other parties interested in the design and implementation of new legislation "to ensure that health care charitable trusts provide the communities they serve with benefits in keeping with the charitable purposes for which the trusts were established..."[3] The New Hampshire State Legislature passed a "charitable activities" bill roughly five months subsequent to the undertaking of this project; that law reinforces the need for the state to provide accurate factual information to communities about their health care charities as they become involved in the development of community benefit plans that are responsive to the true needs of the community. However, the legislation adopted a broad definition of community benefit for all health care charitable trusts that goes beyond the three measures analyzed here.

This report focuses on the 24 nonprofit hospitals in New Hampshire, due to the fact that they are the largest health care charitable organizations in the state, and that there is more publicly available financial information about them than about other health care charities in the state. We have also identified the size and nature of many of the organizations affiliated with hospital charitable organizations, such as parent holding companies, foundations, physician management organizations, and home care agencies.

The first report released in this series focused on the financial analysis of community health centers in New Hampshire, of which there are roughly 10 freestanding entities. A third major sector of health care in New Hampshire, the health insurance sector, has become dominated by noncharitable organizations; the sector is also in a state of flux given the conversion of the largest health plan (Blue Cross Blue Shield of New Hampshire) and the liquidation of another (Tufts

[1] Results of this analysis were also used in an economic analysis of the NH health care market.
[2] Seven District Councils were established in 1996 to develop the State Health Plan; they continue to meet on a regular basis to provide a "community voice" in the development and evaluation of state health policy.
[3] SB0069: An Act Relative to health care charitable trusts and community benefits, approved July 16, 1999, effective January 1, 2000, for trusts with assets of $1 million or more, and January 1, 2001 for trusts with assets greater than $100,000.

New England). A third report - the financial status of health plans – will also be released in order to provide information on the private health insurance context within which hospitals and plans operate in New Hampshire.

Our mandate was to review and analyze the audited financial statements and available IRS Form 990 reports of charitable hospitals and their affiliates, and to make preliminary recommendations for benchmarks to monitor their charitable activities. [4] Our benchmark recommendations must rely upon data that can be routinely collected from existing data sources.

Overview of Benchmarks

We divided our analysis into two types of benchmarks: those associated with financial position, and those associated with the level of quantifiable community benefit provided.[5]

Financial Benchmarks

Financial benchmarks include the traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined briefly below; additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992), and by reviewing the glossary of The Almanac (CHIPS, 1999), from which our national and regional comparative ratios are drawn. The financial benchmarks are derived from audited financial statements except where noted. For these ratios, it can be helpful to understand how a hospital's balance sheet and income statement elements are generally portrayed (**see APPENDIX A**).

[4] Copies of the IRS 990 filings for 650,000 charitable trusts in the US can now be viewed online at: www.guidestar.org. At this point, however, the financial data available is not consistent across organizations and only includes 1998.

[5] Two of the indicators chosen under "quantifiable community benefit" are not allowable under SB 69; the broad definition of community benefit adopted under the statute will allow for quantifiable community benefits that might not show up in audited financials.

	Purpose	Calculation
Profitability:		
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[6]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense

[6] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998.

Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense
Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[7]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Cash flow analysis uses the hospital's cash flow statement to identify, over a period of a year or more, the hospital's sources and uses of cash after all operating expenses have been met. The cash flows in our analysis are aggregated over all hospitals for the years 1993 through 1998 to show total sources and uses of cash statewide. 1999 is aggregated separately and analyzed for changes from the 1993-1998 period.

[7] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

There are three basic sources of cash: operating activities (cash profits), investing activities – the selling of assets, and financing activities (obtaining outside capital, including long-term debt, donations, and transfers of cash into the hospital from related organizations). The "healthiest" way to generate cash is through operating activities. A hospital that has to resort to selling off its assets to any substantial degree is not in a sustainable mode. Finally, while a limited amount of borrowing, particularly for working capital or fixed assets, is appropriate, over-reliance on outside sources of capital can become problematic, particularly if the capital has to be repaid or, in the case of transfers from related entities, there is a limit to the amount of cash available.

Similarly, there are three basic ways to use cash: operating activities (cash deficits from operations or nonoperating activities), investing activities (acquiring buildings, equipment, marketable securities, other businesses), and financing activities (paying off debts, transferring cash to related entities). The healthiest use of cash is generally investing activities – adding long-term assets that will produce future economic benefits for the hospital. As long as investing needs are met (particularly fixed asset needs), then it is a healthy sign if financing activities such as the repaying of debt is a use of cash. It is unhealthy for operating activities, particularly operating and nonoperating deficits, to be a use of cash for a period of several years. Generally, organizations cannot survive long if operating activities do not generate cash. The table below provides a guide, at a gross level, of the healthy vs. unhealthy pattern of sources and uses of cash.

	Source of Cash	**Use of Cash**
Operating Activities (operating income, nonoperating revenues, and working capital)	Healthy – best source of cash, especially if from operating income	Not Healthy over Sustained Period
Investing Activities (investments in property, plant, and equipment, acquisitions, marketable securities, affiliates)	Not Healthy	Healthy
Financing Activities (borrowing, capital transfers from related entities, capital donations)	Healthy in Short Term as a way to finance fixed assets, within ability to service debt Unhealthy if needed to cover operating deficits or borrowing exceeds ability to repay	Healthy if organization can afford to repay debt and still meet investing needs Unhealthy if all available cash flow is going to debt repayment or entity transfers at the expense of needed fixed asset investments

Community Benefit Benchmarks

Quantifiable community benefit benchmarks are less well established than financial performance benchmarks, and even those that can be quantified are less standardized than the traditional elements found on balance sheets, income statements, and statements of cash flow. Several states have developed community benefit reporting formats with detailed instructions on how to quantify and report the various types of community benefits that might be important to a particular community (Noble, Hyams and Kane, 1999). New Hampshire also has a formal community benefit reporting format. [8]

Our community benefits analysis was more exploratory than is the financial analysis. It sought to identify the elements of community benefits that are currently reported and publicly available, and to relate those elements to various denominators used to calibrate the relative adequacy of those benefits (e.g., the value of tax benefits and the level of gross patient revenues). The intent was to identify potential benchmarks and show how hospitals measure up against those benchmarks with historical data, much of which is based on estimates. However, the state decided (in SB 69) to define and collect a broader array of measures of community benefits. Two of the elements examined – bad debt and Medicaid shortfalls – may not be counted as community benefits. They are presented here as examples.

We were able to directly obtain only one measure of community benefit across all hospitals – the provision of free care. Values for bad debt (in charges) are also directly available. However, the new Community Benefits statute is clear that "charity care" should not include bad debts, which are amounts the hospital initially classifies as revenues owed to them, and which it is subsequently unable to collect (generally after multiple efforts to collect have failed). We do not intend to imply that this distinction is not appropriate. We acknowledge that it is likely, based on the literature on this topic, that at least some of the bad debts shown on historical financial statements are likely to have been considered free care if certain conditions had been present (i.e., a free care policy was publicly posted and patients were aware of its existence; or a hospital was willing to devote the resources to actively identify reluctant recipients of charity and help them fill out the necessary forms for eligibility, which could also require the availability of translation

[8] The first community benefit plan filings, together with the results of the (statutorily required) community needs assessments, were received in the Office of the Attorney General, Charitable Trusts Unit, in the fall of 2000. The list of filings received to date and information on how to obtain copies is available on the Unit's website: http://webster.state.nh.us/nhdoj/CHARITABLE/char.html.

services). In recognition of the likelihood that some bad debt may be free care, we considered the impact on our benchmarks if 50% of bad debts were considered to be charitable, as one benchmark possibility. If free care designations receive heightened scrutiny in the future, we think it is likely that some patients who would historically have been classified as bad debtors will instead be classified as free care recipients. Thus, our historical benchmark analysis adjusts for that possibility.

From our early presentations to hospitals, some hospital representatives felt that Medicaid shortfalls (the shortfall between Medicaid payment and Medicaid costs) should be considered as part of the community benefits hospitals provide. Only a handful of hospitals quantified the Medicaid shortfall in the footnotes to their audited financial statements. To at least begin the policy debate on the role of Medicaid shortfalls, we undertook an estimation of Medicaid shortfalls for each hospital for 1998 only, based on a study done by the New Hampshire Department of Health and Human Services, Office of Planning and Research. If Medicaid shortfalls are to be considered quantifiable community benefits in the future, it is recommended that the state develop a standardized method for calculating and reporting this value.

Another element of community benefits that we considered is the provision of what is considered in the literature to be "essential community services" that nearly always incur operating deficits. These services include neonatal intensive care units, trauma services, burn units, and HIV/AIDS services. Although we do not have the information to quantify losses incurred on such services, we did identify which hospitals had them.

The value of tax benefits is based on the following measures:

Property Tax	Equalized Tax Rate * Hospital Building and Land Assessments	For missing values, property tax was estimated using the equation: Operating Expense * .010 – 21 (based on regression analysis)
Business Enterprise Tax	Interest, payroll and fringe benefit expense * .0025	Included interest, payroll and fringe expenses as reported in audited financial statements; missing values were derived from payroll and fringe amounts reported in AHA guide, or, if fringes not available there, were estimated by multiplying payroll times 22%, the average fringe/payroll ratio for the period 1993 to 1998.
Business Profit Tax	Net Income * .07	For values below 0, value = 0
Federal Income Tax	(Net Income – Property Tax – Business Enterprise Tax – Business Profit Tax) * .35	For values below 0, value = 0.

Our charitable benchmarks are summarized in the table below.

Benchmark	**Purpose**	**Calculation**
Free Care/Gross Patient Service Revenue	Quantifies the percentage of total services that are provided to charity patients	Free Care (valued at charges)/Gross Patient Service Revenue (Both sides of equation valued at charges to measure "apples to apples")
Bad Debt/Gross Patient Service Revenue	Quantifies the percentage of total services that are provided to people who are charged but do not pay their bill	Bad Debt (valued at charges)/ Gross Patient Service Revenue
Free Care at Cost/Value of Tax Exemptions	Compares the level of free care, valued at average cost, to the benefits of tax exemption	(Free Care Valued at Charges/Markup Ratio)/Total Tax Value
50% of Bad Debt At Cost/Value of Tax Exemptions	Compares how 50% of bad debt relates to the benefits of tax exemption	((.5* Bad Debt Valued at Charges)/Markup Ratio)/Total Tax Value
Medicaid Shortfall/Value of Tax Exemption	Compares estimated Medicaid Shortfall, to the value of Tax Exemption	Estimated Medicaid Shortfall/Total Tax Value
Other Quantifiable Benefits	Identifies existence of essential community services that might be classified as community benefits	No quantification made

Findings

Financial Benchmarks

Profitability

Figure 1 shows the distribution of values for **total margin** for the 24 New Hampshire hospitals through 1998, and for 22 hospitals for 1999. For comparative purposes, the median (50th percentile) values for the Northeast Region (NE) and for the nation (NAT) are also provided. The Northeast Region includes hospitals in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, and Pennsylvania. National and regional medians for 1998 will not be available until December 2000.

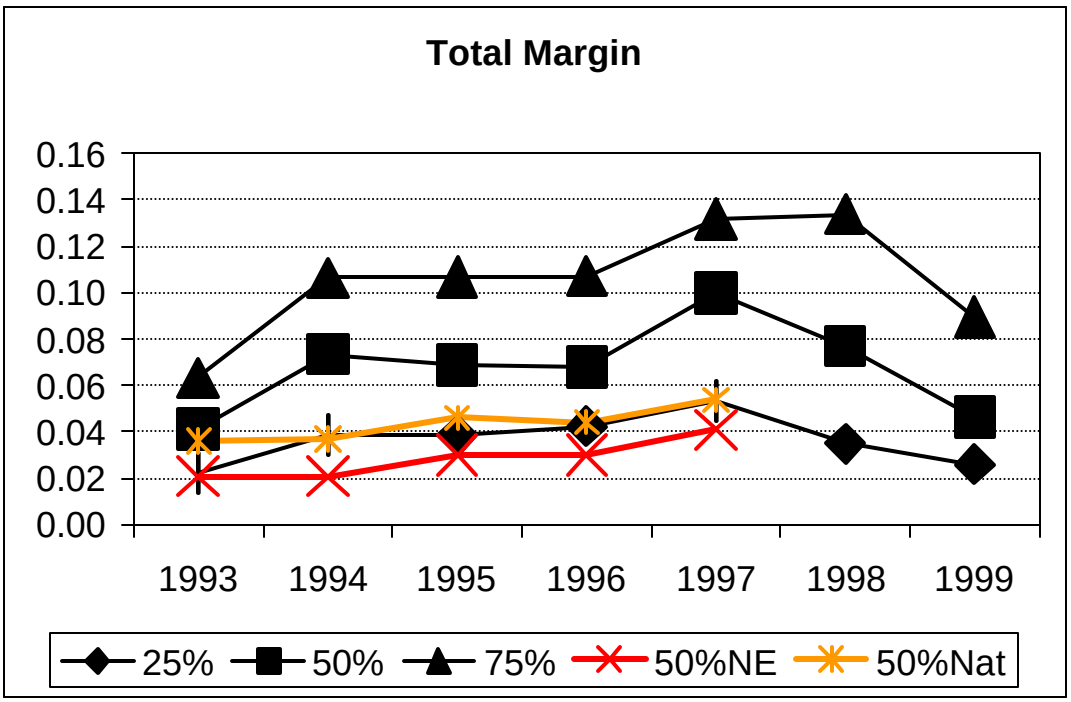


Figure 1

It is apparent from Figure 1 that between 1993 – 1997, New Hampshire hospitals outperform their regional and national counterparts on total margins: the national median is roughly at the level of the bottom quartile of New Hampshire hospitals, while the regional median falls below the New Hampshire bottom quartile. In other words, 50% of hospitals nationally had total margins at or below 3.6% in 1993, rising up to 5.4% in 1997. In New Hampshire, the lowest performing 25%

of hospitals had total margins at or below 2.3% in 1993, rising to 5.3 % in 1997. New Hampshire medians went from 4% in 1993 to a peak of 10% in 1997, falling back to 7.7% in 1998. In 1999, the total margin falls back to the 1993 levels, with a median of 4.4%.

Figure 2 represents the distribution of values for operating margins, which are a good indication of how well hospitals are doing in terms of keeping their patient care costs within the limits of their third party reimbursements. Relative to national and regional medians, New Hampshire hospitals again outperform. Only in 1993 did the median for New Hampshire hospitals fall below the national median (1% vs. 1.8% respectively); in all other years, the New Hampshire median stayed at or above the national median, with operating profit margins ranging from 3 – 5%, until 1998. Regional medians were at or below the bottom quartile of New Hampshire hospitals between 1994 and 1997. In 1998, median operating margins fell to 2% (no comparative data available), and in 1999, they dropped to 1%. The 1999 values approximate the 1993 values for the 50th and 75th percentiles, but are well below 1993 levels (25th percentile of -.03, compared to 1993 of -.01) for the bottom quartile of hospitals.

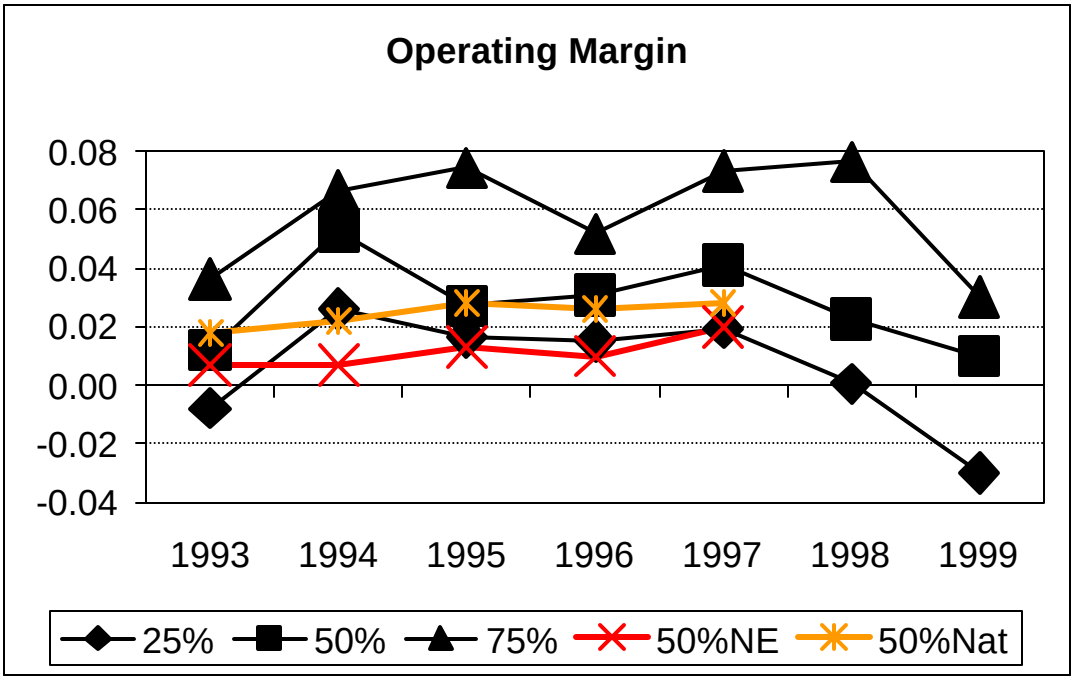


Figure 2

Figure 3 is the ratio of Medicare PPS Payment to PPS cost for the period 1994 – 1997 (the period for which the Medicare Cost Report data were available). This figure indicates that, for 75% of New Hampshire hospitals, the Medicare PPS payment to cost ratio was at or below 1 for the period 1994 – 1997. For the bottom quartile of hospitals, the PPS payment to cost ratio was at or below 80%. In other words, most New Hampshire hospitals have been losing money on Medicare inpatient care throughout the period of our analysis. As of 1997, the aggregate loss on the Medicare PPS was roughly $11 million.[9] In 1998, given the changes in the Medicare PPS made by the Balanced Budget Act of 1997, we estimated that the aggregate loss doubled to roughly $20 million (depending on how costs behave).

[9] PPS losses estimated based on the following formula (numbers in parens refer to field number on Medicare Minimum Data Set):
DRG Payment (f470) plus Outlier Payments (f471) plus Indirect Medical Education Adjustment (f477) plus Disproportionate Share Adjustment (f479) plus ESRD Payments (f480) = PPS Payments
Total Medicare Inpatient Operating Cost (f458) minus Capital Pass Through Costs (f376-f349-f350) minus Direct Medical Education Pass-through Costs (f440-f413-f414) = PPS Costs
Payments minus Costs = PPS Gains (Losses).

PPS Payment to Cost Ratios
1994 - 1997

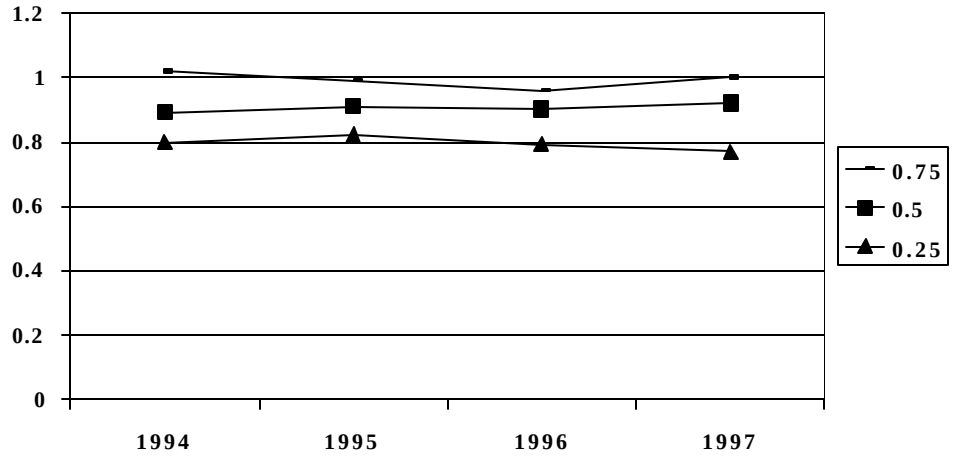


Figure 3

Non-PPS Payment to Cost Ratios
1994 - 1997

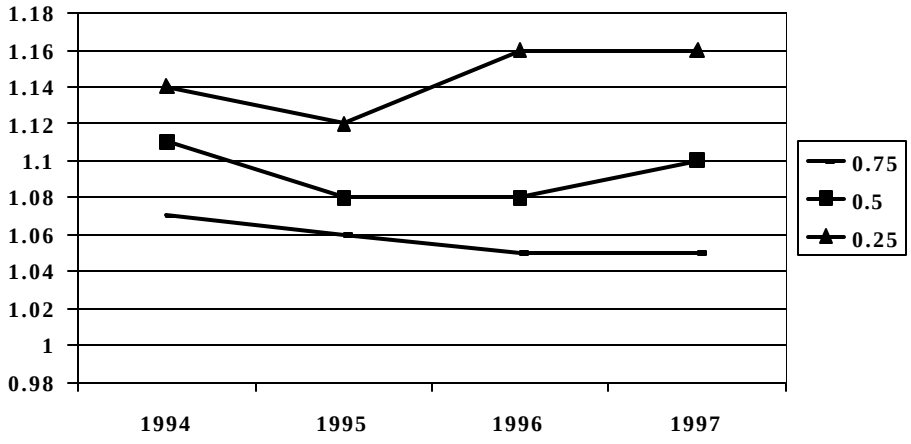


Figure 4

Given the positive operating margins of most New Hampshire hospitals, they are obviously making money on the other payers, which Figure 4 shows. The ratio of payments to costs for non-PPS payers (which includes outpatient care for Medicare patients) is well above 1. Thus in 1997, for 50% of hospitals, non-PPS payers pay above 110% of cost; for only 25% of New Hampshire hospitals do non-PPS payers pay at or below 105% of cost.

Figure 5 shows the markup of hospital charges above costs. New Hampshire markups are generally below regional and national markups. The median markups of hospitals' charges over costs in New Hampshire are roughly 1 – 4% lower than their regional and national counterparts, and the gap is narrowing over time. This does not say anything about absolute price levels; relative cost information is necessary for that. The distribution of markup ratios does not change significantly in 1999 over 1998.

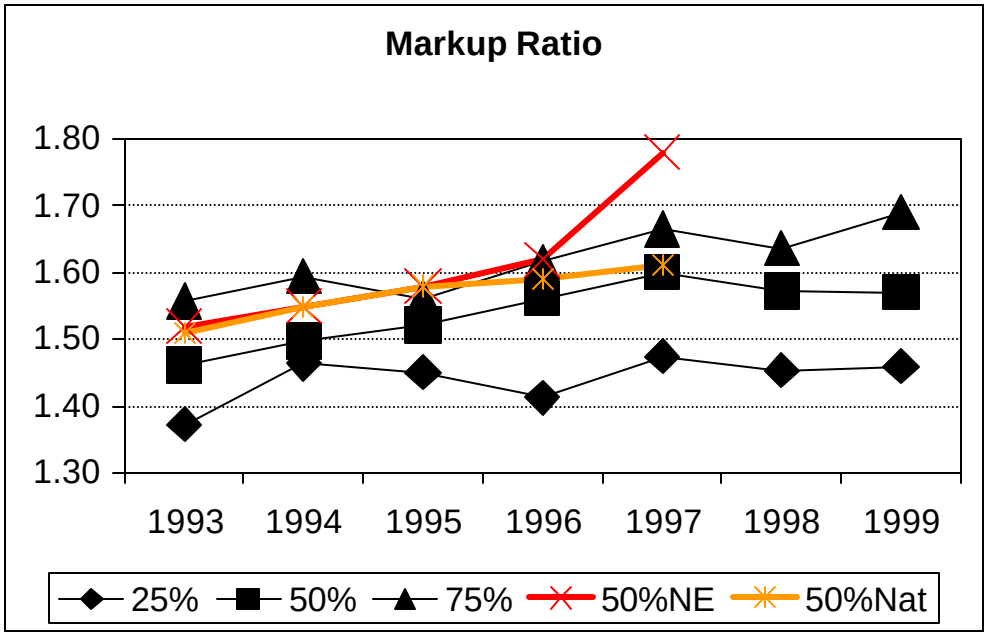


Figure 5

However, it appears that New Hampshire hospitals tend to discount much less than do hospitals nationally. Median discounts off charges under contractual agreements with third parties are between 30% and 38% less in New Hampshire than nationally (see Figure 6). The table below Figure 6 compares the national median markups and deductibles to those of New Hampshire. While New Hampshire hospitals do not appear to discount as steeply as hospitals elsewhere, the

trend in the deductible ratio is gradually rising, and in 1999 the deductible rises a few percentage points in all quartiles, while the markup remains unchanged. This 1999 trend in the deductible and markup is an indication that third parties are starting to squeeze hospitals more than they have in the past, which contributes to the drop in operating margins seen in 1999.

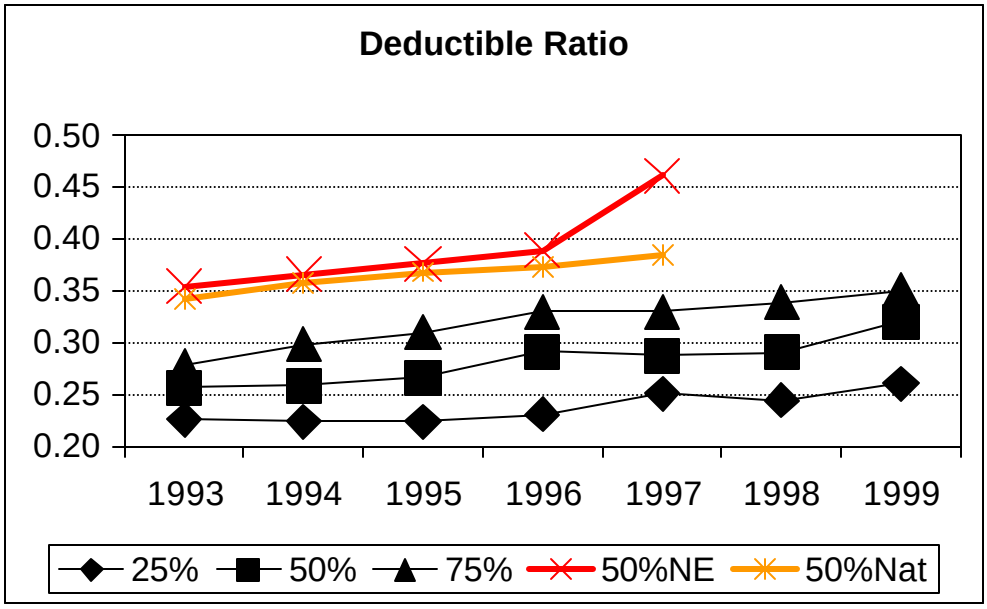


Figure 6

	1993	**1994**	**1995**	**1996**	**1997**
Markup:					
National 50% (% above NH)	1.51 3.4%	1.55 3.3%	1.58 3.9%	1.59 1.9%	1.61 .6%
New Hampshire 50%	1.46	1.50	1.52	1.56	1.60
Deductible:					
National 50% (% above NH)	.34 30.7%	.36 38.5%	.37 37%	.37 27.5%	.39 34.5%
New Hampshire 50%	.26	.26	.27	.29	.29

Figure 7 shows the proportion of total surplus (deficit) that comes from nonoperating revenues, which includes investment income, realized gains, and unrestricted donations (noncapital). New Hampshire hospitals realize a significant proportion of their total net income from nonoperating revenues, with median values ranging between 40% - 70%. The New Hampshire median for this ratio is just below the national median, which ranges between 50%-70% over time; and it is well below the regional median, which ranges between 70% – 160%. When this ratio rises above 100% it generally means that the hospital has operating losses, which are offset to some extent by nonoperating revenue. In 1999, roughly 25% of New Hampshire hospitals had nonoperating revenue ratios in excess of 100%. Lower values of nonoperating revenue to total profit generally indicate a more sustainable profit performance, in that more profit is generated by operating income. This ratio complements the information provided earlier in Figures 1 (total margin) and 2 (operating margin). One can conclude that, relative to hospitals regionally and nationally, New Hampshire hospitals rely more on operating profits and have higher operating and total profits over the period of our analysis, although in 1999, reliance on nonoperating profits increases significantly (no national comparison available).

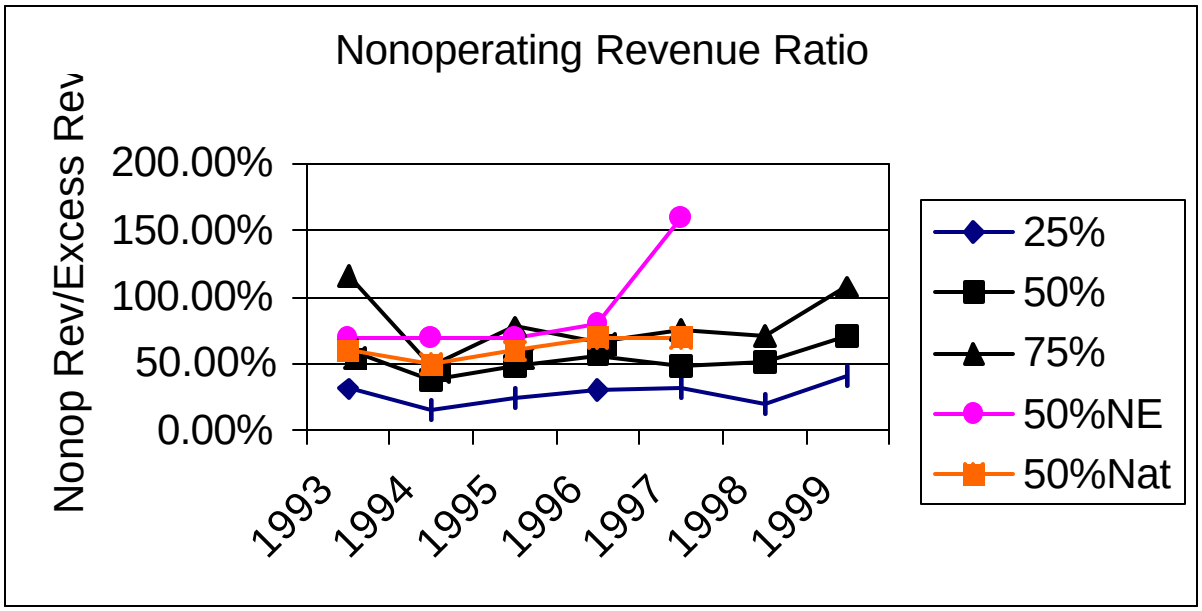


Figure 7

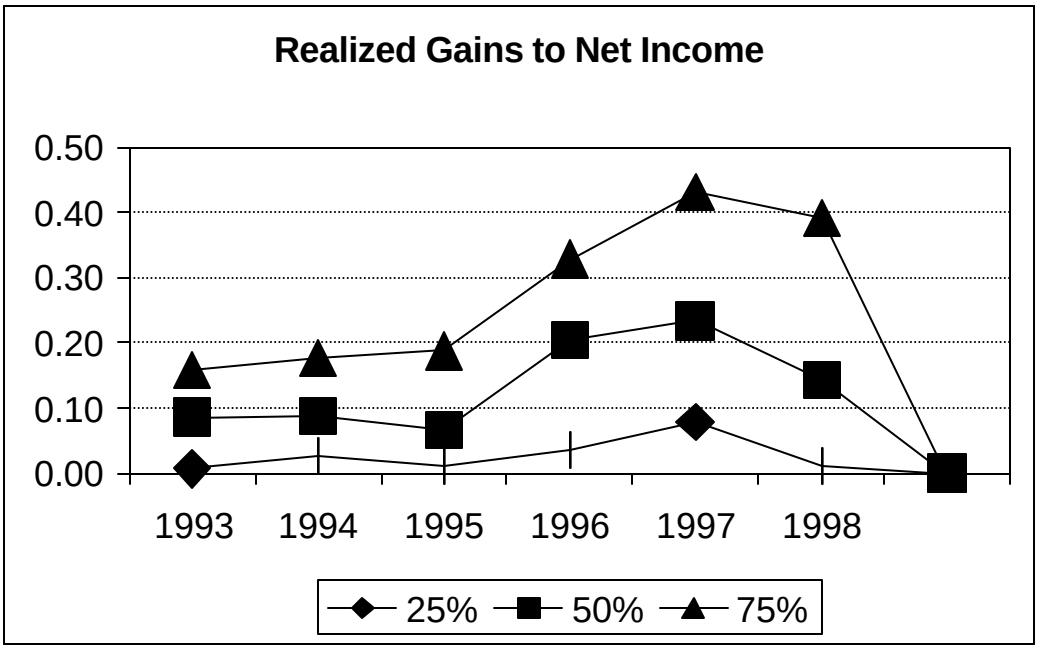


Figure 8

Figure 8 elaborates on the concept of nonoperating contribution to net income; it shows the proportion of net income that came from one element of investment income – realized gains. Realized gains (losses) represent the difference between the purchase value of marketable securities (stocks and bonds) and their selling price (when actually sold). This figure shows that realized gains contribute significantly to net income, especially in 1996 and 1997; for 50% of New Hampshire hospitals, realized gains represented 15 – 20% or more of their net income between 1996 – 1998. This source of income reflects the performance of capital markets and of the hospital's investment strategy, rather than how well the hospital is doing in its central mission of providing patient care. It cannot be expected to be maintained in a downturn affecting capital markets. A drop-off in realized gains, or incurring realized losses, could contribute to a drop in the future profitability of the hospitals, regardless of how the hospital is doing in providing patient care.

Table 1

	1993	1994	1995	1996	1997	1998	1999
Gross Patient Service Revenue	1331883	1400353	1523224	1574977	1665449	1776052	.
Less Revenue Deductions:							
Free Care	30651	30687	32134	31907	31751	28062	29135
Bad Debt	50909	55981	57197	58505	62860	66875	67482
Contractual Adjustments	339131	358985	402124	433765	480570	514647	.
Net Patient Service Revenue	911192	954700	1031769	1050800	1090268	1166468	1101249
Other Operating Revenue	21353	26026	31260	38887	40021	46958	47642
Total Operating Revenue	932545	980726	1063029	1089687	1130289	1213426	1148891
Operating Expenses:							
Depreciation & Amortization	58035	61907	68216	70313	68918	73839	70217
Interest	24580	24626	26429	25726	25439	25321	23014
Other Operating Expenses	827244	840785	923573	956540	994358	1098287	1044745
Total Operating Expenses	909859	927318	1018218	1052579	1088715	1197447	1137976
Operating Income*	22686	53408	44811	37108	41574	15979	10915
Nonoperating Revenue:							
Investment Income	22105	19555	27422	46403	70338	53962	.
Gains/Losses	-1476	-2727	3847	-439	-1059	7552	.
Other	4142	6260	8200	3128	3424	3816	.
Total Nonoperating Revenue	24771	23088	39469	49092	72703	65330	63688
Excess Revenue Over Expense	47457	76496	84280	86200	114277	81309	74603
	*Estimated sources of Op Income:						
Medicare PPS		-23417	-15976	-14323	-10932	-21345	
Non Medicare PPS		76825	60787	51431	52506	37324	
Percentage Changes:		**1994**	**1995**	**1996**	**1997**	**1998**	
Gross Patient Service Revenue		0.05	0.09	0.03	0.06	0.07	
Less Revenue Deductions:							
Free Care		0.00	0.05	-0.01	0.00	-0.12	
Bad Debt		0.10	0.02	0.02	0.07	0.06	
Contractual Adjustments		0.06	0.12	0.08	0.11	0.07	
Net Patient Service Revenue		0.05	0.08	0.02	0.04	0.07	
Other Operating Revenue		0.22	0.20	0.24	0.03	0.17	
Total Operating Revenue		0.05	0.08	0.03	0.04	0.07	
Operating Expenses:							
Depreciation & Amortization		0.07	0.10	0.03	-0.02	0.07	
Interest		0.00	0.07	-0.03	-0.01	0.00	
Other Operating Expenses		0.02	0.10	0.04	0.04	0.10	
Total Operating Expenses		0.02	0.10	0.03	0.03	0.10	

Table 1 (continued next page)

Operating Income*	1.35	-0.16	-0.17	0.12	-0.62
Nonoperating Revenue:					
Investment Income	-0.12	0.40	0.69	0.52	-0.23
Gains/Losses	0.85	-2.41	-1.11	1.41	-8.13
Other	0.51	0.31	-0.62	0.09	0.11
Total Nonoperating Revenue	-0.07	0.71	0.24	0.48	-0.10
Excess Revenue Over Expense	0.61	0.10	0.02	0.33	-0.29
*Estimated sources of Op Income:					
Medicare PPS		0.32	0.10	0.24	-0.95
Non Medicare PPS		-0.21	-0.15	0.02	-0.29

Table 1, continued

Table 1 shows the aggregate income statement of the 24 hospitals in New Hampshire by year through 1998, and for 22 hospitals in 1999 (1 of which did not report gross patient service revenue, and 2 did not report the details of nonoperating revenues). The bottom half of the table shows annual percentage changes of each income statement element through 1998 (1999 year is missing 2 hospitals, so changes were not calculated). Total operating revenues have grown as fast or faster than total operating expenses in 3 of the six years; operating income peaked in 1994, and has since shrunk for three out of the past four years. The primary contributor to the shrinking of operating revenues has been a reduction in non-Medicare-PPS profits, which peaked at $76.8 million in 1994, falling to an estimated $37.3 million by 1998. Medicare PPS losses peaked in 1994, and steadily improved until 1998 (the 1998 figures are estimates; we did not have a full set of 1998 Medicare cost reports). Then in 1998, Medicare PPS losses jump by roughly $10 million, by our estimates which are based on 1997 data and take into account the 1997 Balanced Budget Act effects on 1998 Medicare revenues.

Excess Revenue over Expenses grew every year except 1998; growth in nonoperating revenue was very high over the period 1995 – 1997.

The level of free care (valued at charges) provided did not change very much throughout the period, and actually dropped by 12% in 1998 over 1997.

In sum, for the period 1994 – 1997, New Hampshire hospitals enjoyed a very prosperous period, deriving largely from strong operating profits, but benefiting as well in more recent years from

nonoperating revenues driven primarily by investment income which includes realized gains. Non-PPS payers are providing the profits, which are more than offsetting aggregate PPS losses. However, in 1998, operating margins dropped for at least 50% of the hospitals, and in 1999, the operating margins drop in all quartiles. While the top 25% of hospitals continue to enjoy strong operating performance, starting in 1998 and continuing on in 1999, the bottom 25% appeared to be losing money on operations for the first time since 1993. As mentioned in the discussion about Table 1, the Medicare Balanced Budget Act contributes to this drop in operating profit in 1998, but non-PPS profits have been steadily eroding since 1994, contributing to the downturn in margins to a greater extent than have Medicare PPS losses.

Liquidity

Figure 9 represents the distribution of values of the current ratio (current assets/current liabilities), a measure of how well the hospitals can meet their current obligations with available and relatively liquid assets (cash, short term investments, accounts receivable, inventory). The New Hampshire hospitals do much better than the region (regional median is roughly equal to the New Hampshire bottom quartile of 1.5), and the state median is slightly better than the national median current ratio.

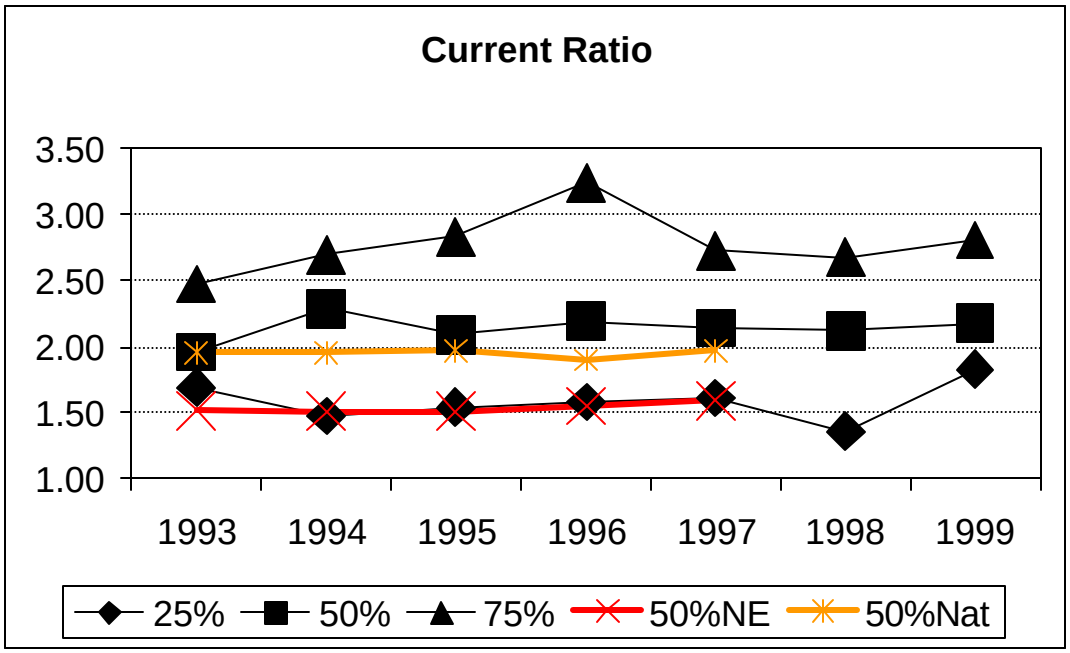


Figure 9

A high current ratio is generally considered good, although if it is high because of slow collection of receivables, this is unfavorable. Figure 10 shows the days of net patient service revenue that remain in accounts receivable; lower days are a positive sign. New Hampshire hospitals appear to be collecting revenues as fast as their regional counterparts, and faster than do hospitals nationally – a favorable sign through 1997. However in 1998 and more so in 1999, days in accounts receivables jump significantly. The cash implications of the slowdown become apparent in 1999, discussed further in the section, *Sources and Uses of Cash.*

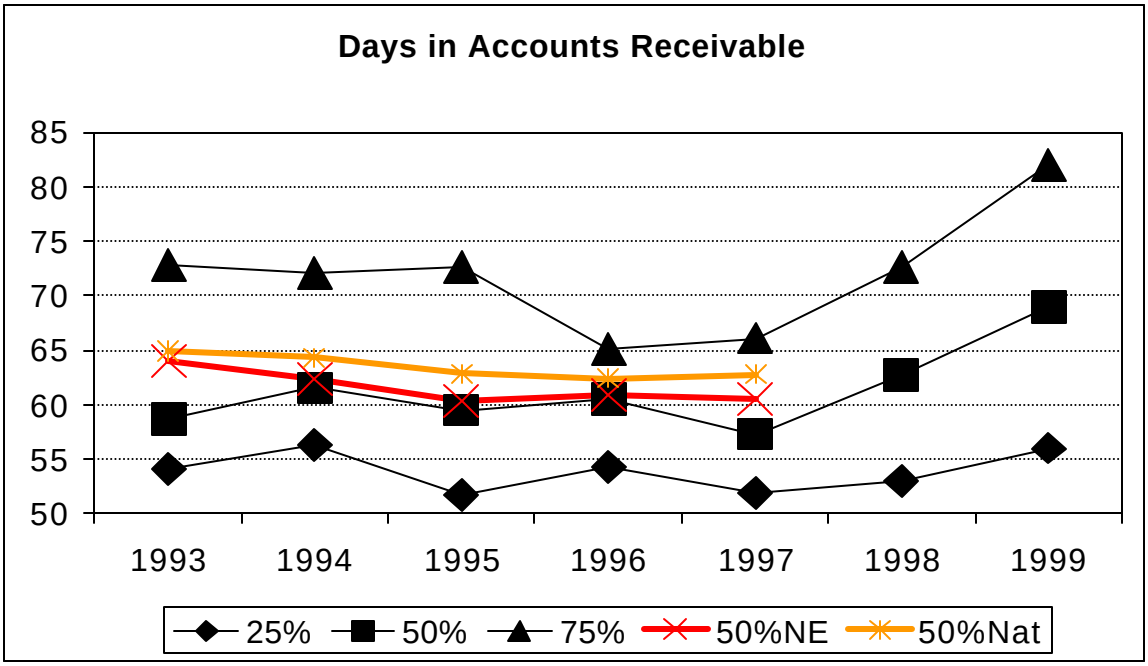


Figure 10

Figure 11 indicates how fast hospitals are paying their employees and vendors. 50% of hospitals are paying within 40 days or less of incurring the obligation to pay. While there is no comparable regional or national statistic, 40 days is a fairly reasonable payables cycle, and was steady from

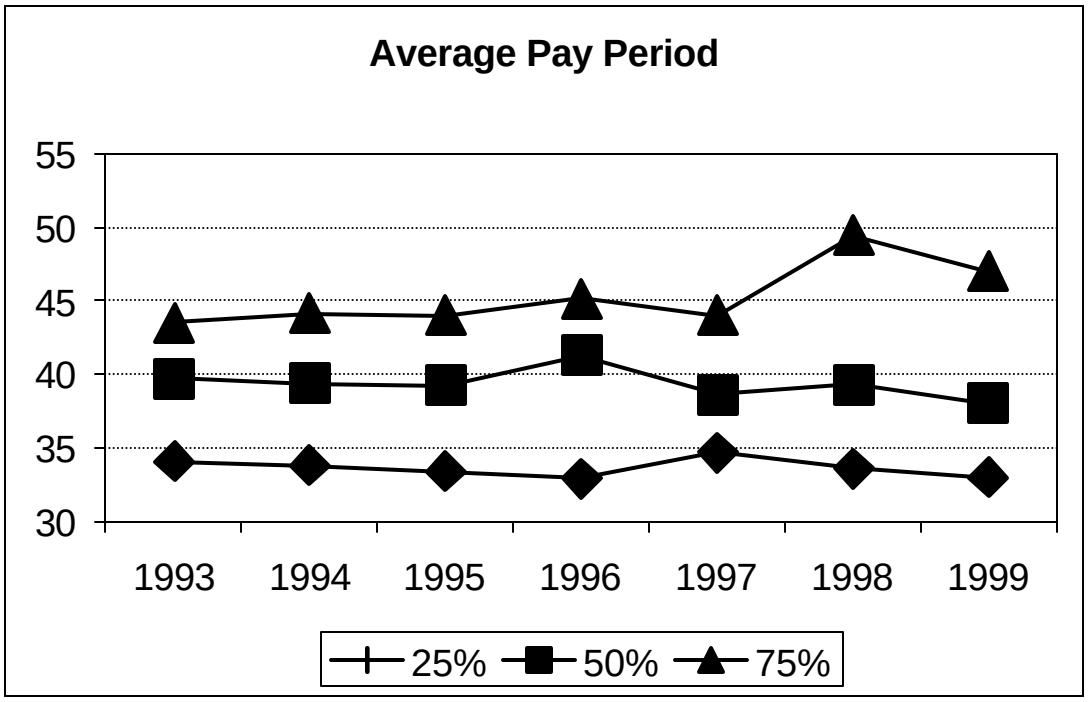


Figure 11

1993 – 1997. In 1998, the slowest quartile jumps to 50 days or higher; only one of the hospitals with days payable over 50 has a days cash on hand below 100, so the slowdown does not appear to be driven by a cash shortage. Despite the slowdown in collection of receivables in 1999, the average pay period does not change in 1999.

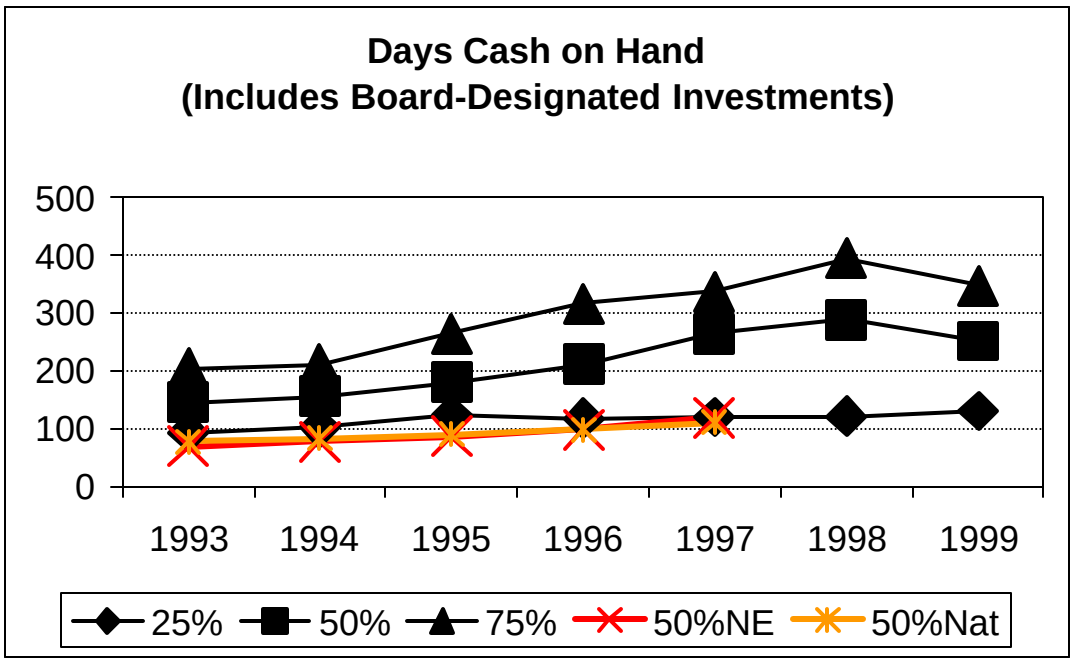


Figure 12

Figure 12 represents days of operating expenses available in cash on hand. New Hampshire hospitals have significantly higher days of cash on hand than do hospitals regionally or nationally. While the regional and national median trends upward from around 70 days in 1993 to almost 100 days in 1997, the median in New Hampshire is more than twice that, and rising much faster over time. By 1998, 50% of New Hampshire hospitals had cash balances of 300 days or more. 25% of hospitals in New Hampshire could continue to operate for over a year without any additional cash coming in. However, those in the bottom quartile have days cash on hand of 125 days or less; still very liquid. Only two hospitals have days cash on hand below 100 in 1998 (the lowest was 40). In 1999, average days cash decreases slightly for the 50th and 75th quartiles, but actually improves for the bottom 25% to 130 days cash on hand. The hospitals' cash position remains very strong in 1999.

In sum, hospitals in New Hampshire accumulated unusually high cash balances over the period 1993 – 1999, giving them very solid current ratios and days cash on hand that were well above regional and national values. Much of the cash on hand is in short- and longer-term investments, which contributes to the significant rise in investment income earned by the hospitals between 1994 and 1999.[10] However, an increase in the amount of time to collect accounts receivable becomes evident in 1998 and 1999, and this begins to affect the ability of the hospitals to generate additional cash in 1999.

Solvency

Figure 13 represents the equity financing ratio, or the amount of equity relative to total capital on the balance sheet. The New Hampshire median value, which ranges between 55% - 65%, is above both the regional and national medians. New Hampshire hospitals are less reliant on debt than most other hospitals in the country. However, the trend for the bottom quartile is downward in 1998 and 1999, due to losses eroding their equity base.

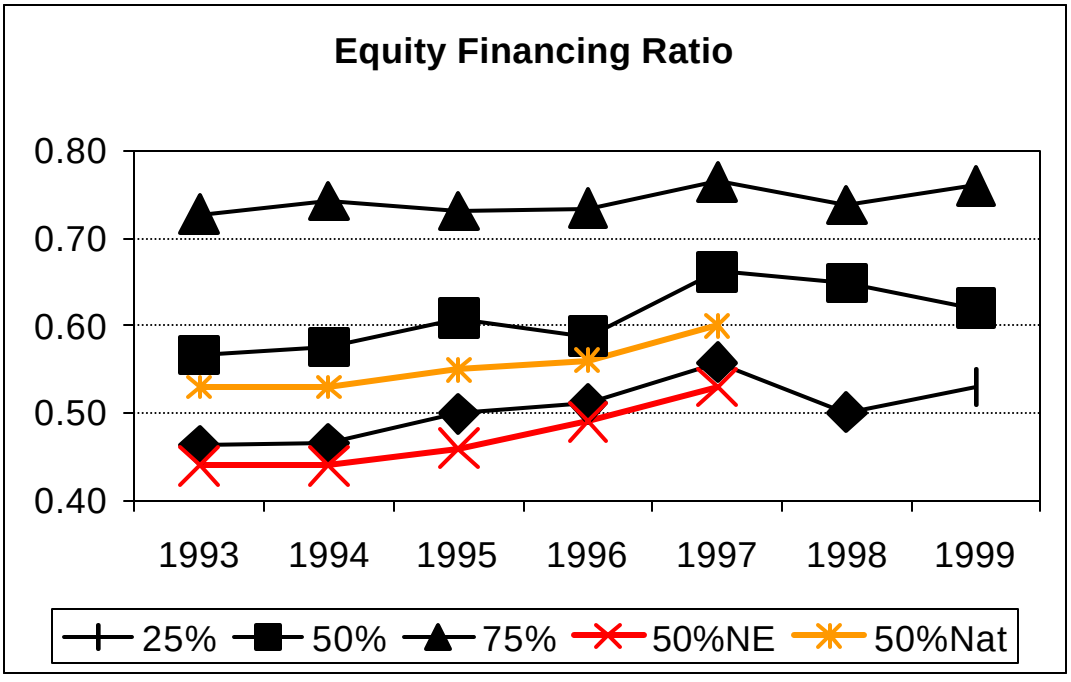


Figure 13

[10] The cash balances as of 1998 include very little Medicaid Enhancement Fund dollars; these are not the source of growth in cash balances over the period.

Coupling the relatively low debt with the relatively high profitability gives the New Hampshire hospitals very favorable cash flow to total debt ratios. As can be seen in Figure 14, since 1995 the median cash flow to total debt ratio has hovered around 30%, while the national median stayed below 20% for the entire period. The regional median stayed below 20% as well. Thus, New Hampshire hospitals have relatively low financing risk, given their lower borrowing and higher debt servicing capabilities. However, declining margins in 1999 push the trend downward; the bottom quartile of hospitals had cash flow to total debt ratios below 14%. Three of those hospitals have cash flow to total debt ratios below 10%, and one of those is negative. While this is certainly a red flag, the hospital with the negative ratio has twice as much cash as it owes in long-term debt, so insolvency is not an immediate concern.

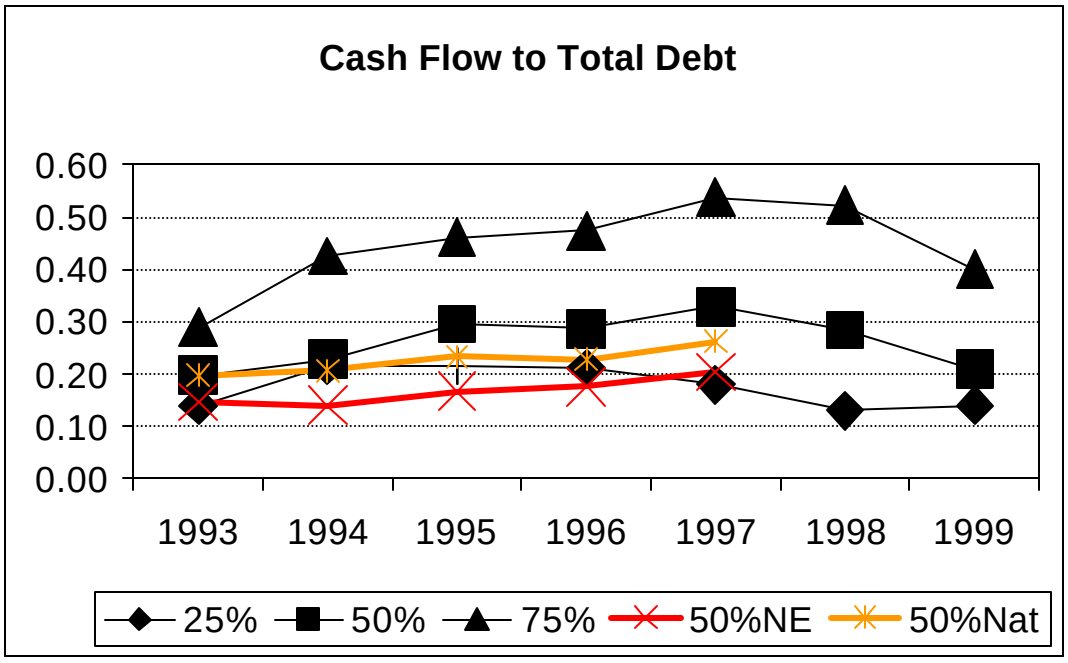


Figure 14

The higher liquidity and lower debt experience of New Hampshire hospitals has not been achieved at the expense of investment of property plant and equipment for the most part, as Figure 15 illustrates. The median average age of plant in New Hampshire is well below national and regional medians. The oldest quartile in New Hampshire approximates the oldest 50th percentile in value in the region; however, since 1996, the oldest quartile is a half year older than the national median. In 1999, plant age improves slightly for the older hospitals, while the youngest hospitals age only slightly, which are positive trends.

The solvency and plant age ratios are further evidence that the period 1993 – 1999 has been one of relative prosperity with less financial risk than hospitals regionally and nationally have had to undertake. However, the financial peak was in 1997; the bottom quartiles of hospitals in particular, are trending downward in key solvency indicators. The cash flow pattern reinforces these conclusions.

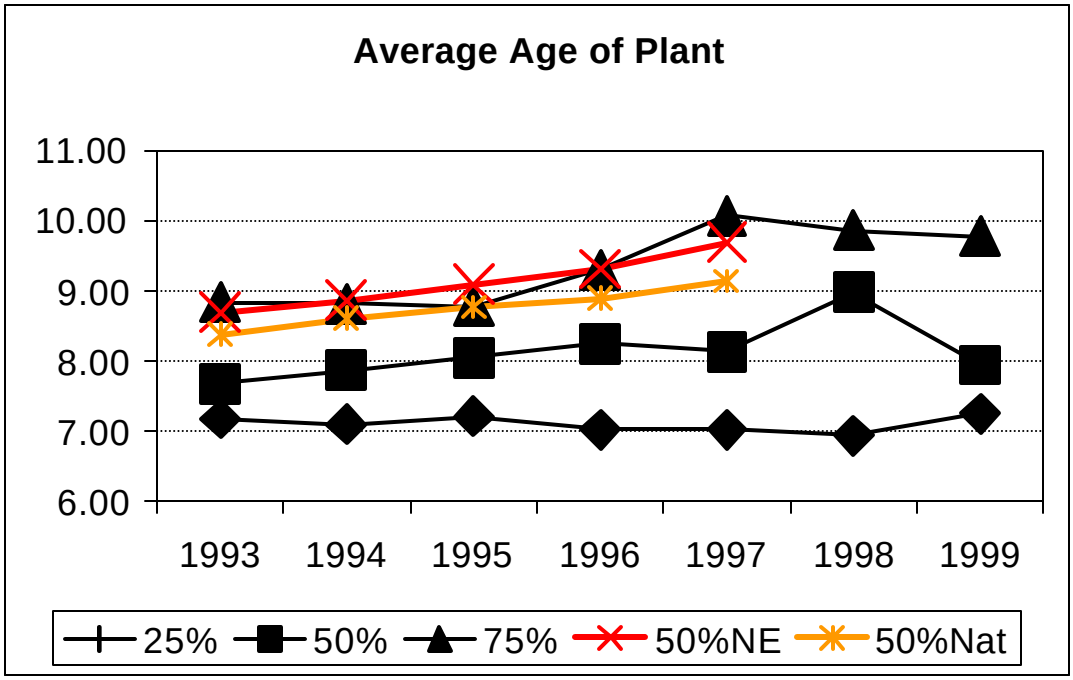


Figure 15

Sources and Uses of Cash, 1993 –1998

Table 2 provides the 6 year cumulative and aggregated cash flows for the 24 nonprofit hospitals in New Hampshire over the period 1993 – 1998. *Sources* of cash support the conclusion from the ratios that the hospitals are generally very healthy; and the number one *use* of cash is increasing cash and marketable securities, indicating that the hospitals have enjoyed a period of prosperity that has given them significant cash reserves against future adversity.

Table 2 Cash Sources and Uses, 1993-1998

Sources	$ 000	%	Uses	$000	%
Operating Income	215,566	20	Increase Cash and Marketable Securities (unrestricted)	508,835	46
Nonoperating Revenue	274,453	25	Investment in PP&E	455,715	41
Depreciation and Amortization	422,349	38	Affiliate Investments, Receivables and Equity Transfers	124,764	11
Net Working Capital	24,683	2	Other Uses	13,448	1
Net Long Term Debt	91,601	8			
Restricted Fund Transfers	39,535	4			
Sale of Assets and Other Noncurrent Assets	34,575	3			
Total Sources	1,102,762		Total Uses	1,102,762	

Cash from operating activities includes cash from operating income, nonoperating revenue, depreciation and amortization (expenses that lower operating income but do not require the use of cash), and working capital (primarily changes in receivables, inventory, accounts payable, estimated third party liabilities). Cumulatively over the six years, 85% of total cash generated by the hospitals was from operating activities. Only 12% was from outside capital sources (long term debt – 8%- and restricted funds (capital donations) - 4%). Only 3% was from the sale of assets (e.g., the sale of marketable securities in excess of the purchase of new securities).

The number one use of cash was investing in additional unrestricted cash and marketable securities. Forty-six percent of the cash generated over the six years was kept in cash or marketable securities, raising cash balances statewide by over $500 million. Another 41% was invested in property, plant, and equipment. This capital investment was only 8% above the amount written off as depreciation and amortization over 6 years. The level of capital spending suggests that some hospitals are not maintaining historical levels of investment in property, plant and equipment, given that depreciation is on an historical cost basis, while new property and equipment acquisition is on a market level or replacement cost basis (generally higher than historical cost basis). Clearly the restraint in capital investment is not because hospitals do not have the cash or debt capacity to invest more. It is more likely to be a sign that hospitals have excess capacity (i.e., there may be lower demand for inpatient care, so maintaining that level of investment is not wise), and/or that hospitals are choosing to maintain their liquidity in the face of future uncertainty, rather than increase their fixed costs and their financial risk.

Over the six years, hospitals have invested roughly $125 million in their affiliates, through a variety of instruments (notes, transfers, and investments). These affiliates consist of parent organizations, foundations, physician practices, physician-hospital organizations, physician joint ventures (lab, imaging, ambulatory surgery centers), sports medicine, home care, long-term care, life care, senior housing, pharmacy management, real estate ownership and management, and athletic clubs. They also involve multiple hospitals as affiliates within a larger system organization. Most of the hospitals in New Hampshire have at least one affiliate organization.

The cash flow picture is one of considerable strategic flexibility, and again supports the view that the industry is quite healthy financially over this period. However, the picture emerging from the 22 hospitals with data available in 1999 indicate some slowdown in additions to the cash prosperity. As the table below indicates, 1999 operating income is a significantly smaller contributor to cash, while nonoperating revenues contribute much more as a percentage of total sources. Working capital shifts from being a small *source* of cash to becoming a major *use* (25%) of cash, driven primarily by the increase in accounts receivables. This reduces the ability of the hospitals to increase cash and marketable securities, which shrink significantly as a use of cash to only 8%. Meanwhile, investments in property, plant, and equipment increase to 51% of uses, up from 41%, and consistent with the steady to improving trends in plant age for most hospitals. While the 1999 cash flow is still one of strategic flexibility, some strains are beginning to show.

Sources of Cash, 1999	**$000**	**% Total**	**Uses of Cash, 1999**	**$000**	**% Total**
Operating Income	10,915	6%	Investment in PP&E	92,783	55%
Nonoperating Revenue	63,688	38%	Working Capital	41,743	25%
Depreciation and Amortization	70,699	43%	Affiliate Transactions	19,621	12%
Longterm Debt, Net	12,496	7%	Increase cash & Marketable Securities	12,971	8%
Restricted Fund Transfers	10,070	6%	Other Noncurrent Assets & Liabilities	750	LT 1%

Community Benefit Benchmarks

Findings

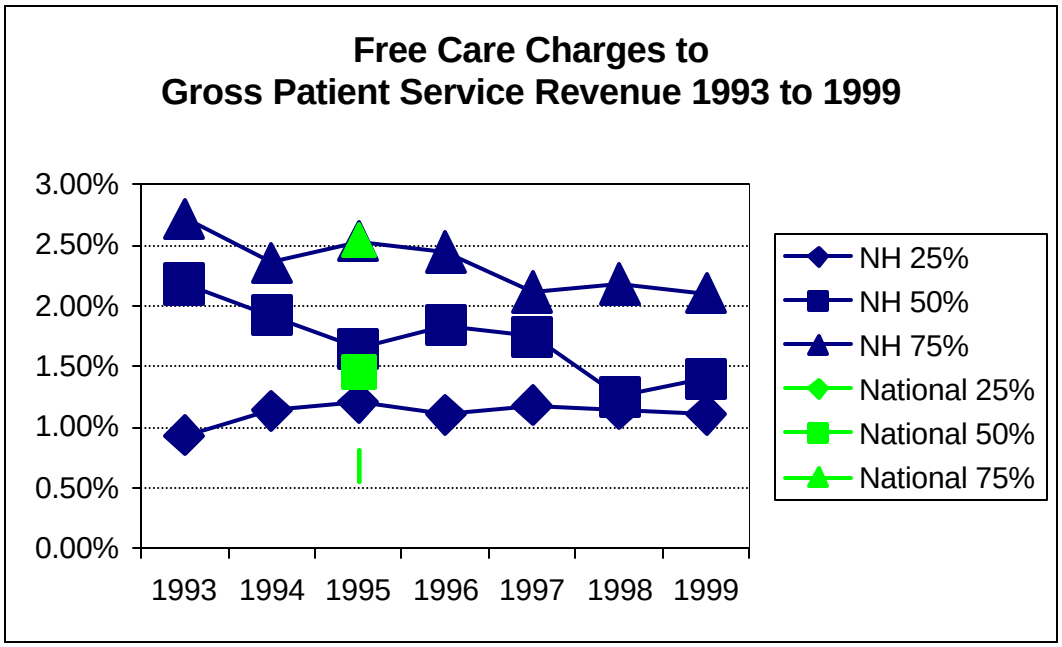


Figure 16

Figure 16 shows the ratio of free care, valued at charges, to gross patient service revenue. This is compared to a 1995 national database of 500 hospitals (Kane, 2000) for which free care data were collected as part of a previous research project. Two observations can be made about this value in New Hampshire; one, it is declining over time for between 50-75% of hospitals; and two, the the values in 1995 are similar to or slightly above the national sample. 1999 values do not change significantly from those of 1998.

Figure 17 shows total bad debt, valued at charges, to gross patient service revenue, and makes the comparison again to the 1995 data base mentioned above. The observations here are: one, the ratio appears to be fairly steady over time, with the 25th and 75th percentiles hovering in the 3% and 4.5% range over the period; and two, that the distribution of values is quite a bit higher than the national distribution. In 1995, the bottom 25% of hospitals in New Hampshire had bad debts of around 3% or less of gross revenue, while nationally, 50% of hospitals were below roughly 2.5 percent. Bad debts as a percentage of charges rise in all quartiles in 1999.

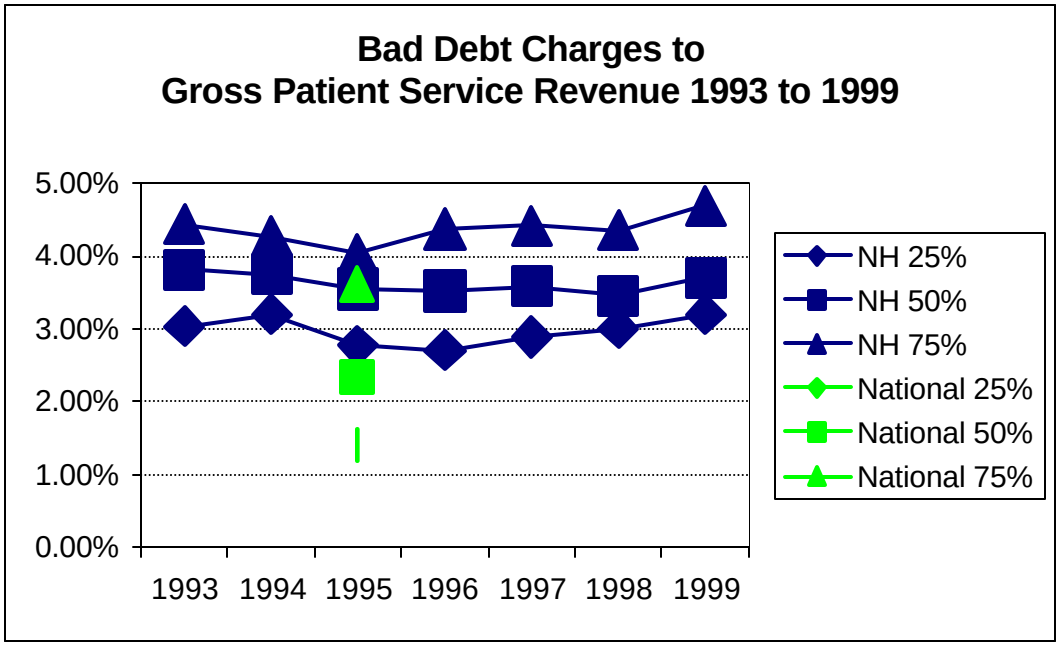


Figure 17

Figure 18 represents the ratio of free care, valued at cost, over the value of the tax benefit (summing the four taxes identified earlier). A number of observations can be made from this chart: first, that for most hospitals the ratio has been declining until 1998; second, that for more than 75% of hospitals in New Hampshire, the amount of free care, valued at cost, is below the value of tax exemptions. However, for a few hospitals (5 in 1998), the value of free care exceeds the value of tax exemptions, by substantial amounts (1.32 to 2.69 times). The median value (50 % are above and 50% are below) is roughly .5, that is, the cost of free care is roughly 50% of the value of the tax exemption.

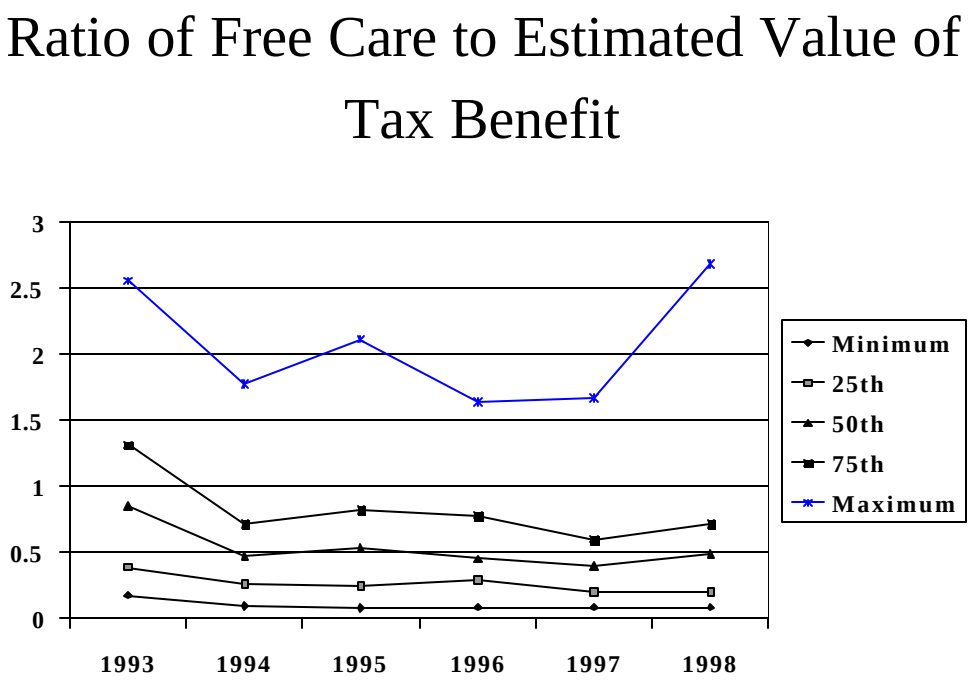
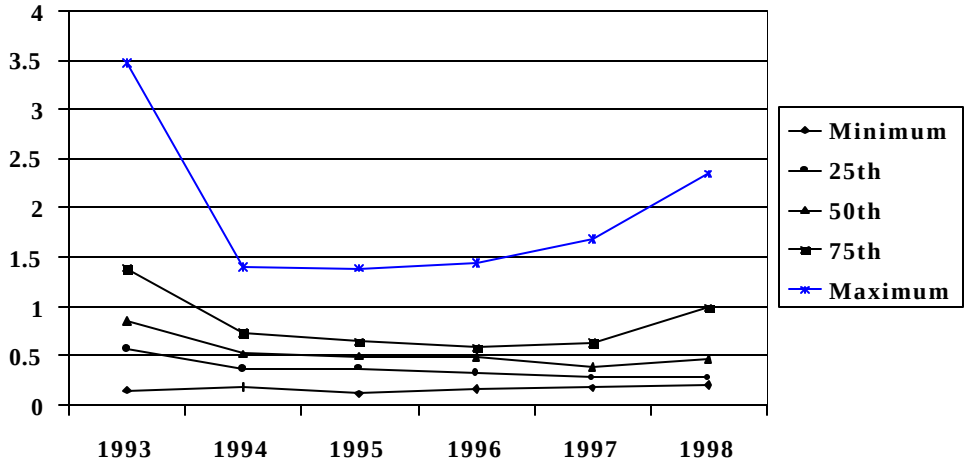


Figure 18

Figure 19 shows the ratio of bad debt, valued at cost and recognizing the 50% that might convert to free care status in the future if policies change. This value shows similar trends to the free care ratio: slightly declining until 1998, a 50% value for the median most years, and a few hospitals (the same five with high free care ratios in 1998) with ratios well above one.

Ratio of 50% of Bad Debt Cost to Estimated Value of Tax Benefit



24 observations 1994 - 1997, 23 in 1993, 22 in 1998

Figure 19

The estimated Medicaid shortfalls [11] are compared to the value of tax exemption for 1998 only. For roughly 83% of hospitals, Medicaid shortfalls were less than the value of tax exemptions; the median value of the Medicaid shortfall/tax value was 32%. Four hospitals had shortfalls that exceeded the estimated value of tax exemptions. Whether Medicaid shortfalls should or should not be considered part of a hospital's "community benefit" is a policy issue that has several pros and cons. "Pro's" include the fact that Medicaid payment policy has historically been set to cover less than a hospital's full cost to cover Medicaid patients; and that the beneficiaries are low income people. The "con" is that Medicaid is not a service uniquely provided by nonprofit hospitals; in many states, for-profit hospitals serve as high or higher a proportion of Medicaid patients as nonprofit hospitals (Kane, 1999). This is not generally true of free care; nonprofits generally provide more free care than do investor-owned hospitals.

[11] The Office of Planning and Research calculated an estimate of Medicaid shortfall for 1998 using actual Medicaid inpatient and outpatient charges and a Medicare Cost Report-derived cost-to-charge ratio. The results suggest that hospitals in NH are paid – on average – somewhere between 62-66% of costs for inpatient charges for a total shortfall of approximately $30 million or an unweighted average of $1.2 million per hospital. (NOTE: all hospitals receive 91.3% of costs-to-charges for outpatient services.)

All three of the values of free care, 50% bad debt, and Medicaid shortfall, are compared to tax benefits for 1998 only. Summing all three measures, 29% (7) hospitals have ratios below one (fail to provide community benefits equal to or greater than the value of tax exemption) in 1998.

In terms of essential community services, we found that no hospitals reported that they provided inpatient burn units, two hospitals were classified as teaching hospitals, three hospitals offer neonatal intensive care services, 12 provide trauma services, and 14 provide HIV services. Of the seven hospitals with total community benefit/tax benefit ratios below 1 in 1998, one reported HIV and trauma, one other trauma, and two HIV. Three had none of these services.

In sum, the community benefit benchmarks provide a perspective, in that they emphasize the need for state policymakers and communities to identify what they consider to be their communities' highest priority needs. To the extent that providing free care to the uninsured is a high priority, it appears New Hampshire hospitals provide about as much free care as is provided nationally as a percentage of gross revenue, but that the level of free care has fallen during a period of relative prosperity in the industry. For 75% of hospitals, the level of free care is well below the value of the benefits of tax exemptions. However, to the extent that bad debt and Medicaid shortfalls are considered high community need priorities, 17 (roughly 70 %) of hospitals provided levels of these benefits in excess of the value of their tax exemptions in 1998 (including free care). Bad debts/charges is high relative to available national levels. There is no comparable national comparison for Medicaid shortfalls.

Urban/Rural Performance Comparisons

The financial and some free care benchmarks were compared (using t tests) for significant differences between urban and rural hospitals. The following table summarizes the benchmark findings:

Ratio:	Difference between Urban and Rural:	Direction if Significantly Different:
Total Margin	Not significantly different	
Operating Margin	Not significantly different	
Markup Ratio	Significantly different	Rurals have lower markups
Deductible Ratio	Significantly different	Rurals have lower deductibles
Nonoperating Revenue Ratio	Not significantly different	
Current Ratio	Not significantly different	
Days in Accts Receivable	Significantly different	Rurals collect more slowly
Days in Accts Payable	Significantly different	Rurals pay more quickly
Days Cash on Hand, Including Board Designated Cash	Not significantly different	
Equity Financing Ratio	Significantly different	Rurals have relatively more equity
Cash flow/total Debt	Significantly different	Rurals have higher cash flow to total debt ratios
Average Age of Plant	Significantly different	Rurals have older plant
Free Care/Gross Revenue	Significantly different	Rurals provide less free care as a % of gross revenue

The benchmark ratios indicate that rural hospitals are generally just as profitable as the urban hospitals. They have just as much cash on hand, even though they collect their receivables more slowly and pay their bills more quickly, and they borrow less (particularly long-term debt). They also have older plants, which is the trade-off they face for having less long-term debt as a proportion of their capital structure. Finally, the rural hospitals provide a lower proportion of gross revenue as free care.

Conclusion

The financial and community benchmarks presented here present an historical analysis of New Hampshire hospitals over a period of relative prosperity – the mid-1990's. It will be important to link this analysis up with others being undertaken as part of the Department of Health and Human Services' larger project, looking at the competitive marketplace within which New Hampshire

charitable health care organizations operate. This study raises a number of questions that can be better answered once the results of the other research projects are complete:

- How were hospitals able to be so profitable over this period? Is it due to highly efficient operations (low costs) or to an ability to maintain high prices relative to costs?
- How can hospitals justify the accumulation of so much cash on their balance sheets, constituting 46% of all cash generated over a 6 year period? What do they plan to do with these resources?
- Why was the level and relative amount of free care provided level or declining over this period? Are there fewer uninsureds and, therefore, less need for free care? Are there obstacles facing the uninsured to receiving free care? It is hard to argue, based on the results of this analysis, that hospitals have been unable to provide more free care due to financial hardship.
- Finally, there are 3 – 5 hospitals whose financial performance has not been so prosperous; and they are consistently among the hospitals providing the highest levels, relative to their tax benefits, of quantifiable community benefits. Should these hospitals be in some way assisted financially? If they were to fail to survive, what would be impact be upon the "safety net" for New Hampshire's most vulnerable citizens?

Appendix A

	A	B	C	D	E	F	G	H
1	HOSPNAME							
2	FYEND							
3	YEAR							
4	**BALANCE SHEET, UNRESTRICTED FUND ($000s)**							
5	CURRENT ASSETS							
6	Cash and Investment							
7	Cash and Investment-Board Designated							
8	Cash and Investment-Trustee Held							
9	Current Assets Whose Use Is Limited							
10	Receivables:							
11	Net Patient Accounts Rec							
12	Due from Affiliates							
13	Third Party Settlemt Rec							
14	Other Accounts Rec							
15	Inventory							
16	Other Current Assets							
17	Total Current Assets							
18	NONCURRENT ASSETS							
19	Assets Whose Use Is Limited:							
20	Trustee-held Investments							
21	Board-Designated & Undesignated Investments							
22	Due From Affiliates							
23	Investment in Affiliates							
24	Land & Bldgs held for investmnt							
25	Other Noncurrent Assets							
26	Gross PP&E							
27	Accum. Depreciation							
28	Net PP&E							
29	Total Noncurrent Assets							
30	TOTAL UNRESTRICTED ASSETS							
31	LIABILITIES AND EQUITY							
32	CURRENT LIABILITIES							
33	Current Long Term Debt							
34	Accounts Payable + Accrued Expenses							
35	Estimated Third-Party Settlements							
36	Due to Affiliate							
37	Other Current Liabilities							
38	Total Current Liabilities							
39	NONCURRENT LIABILITIES							
40	Long term debt							
41	Estimated Third Party Settlements							
42	Due to Affiliate							
43	Self-Insurance Fund							
44	Accrued Pension & Post-Retiree Health Bens							
45	Other noncurrent liabilities							
46	Total Noncurrent Liabilities							

	A	B	C	D	E	F	G	H
47	Fund Balance-Unrestricted							
48	TOTAL LIABILITIES AND EQUITY							
49	**RESTRICTED FUNDS ($000s)**							
50	Cash and Investments							
51	Receivables							
52	Other Assets							
53	Total Restricted Assets							
54	LIABILITIES AND EQUITY							
55	Total liabilities							
57	Temporarily restricted							
58	Permanently Restricted							
59	Total Restricted Fund Bal							
60	Total Restr Liab and Equit							

	A	B	C	D	E	F	G	H
61	**INCOME STATEMENT ($000s)**							
62	Gross Patient Service Revenue							
63	Free Care							
64	Bad Debt							
65	Contractuals							
66	Net Patient Serv Revenue							
67	Other Operating Revenue							
68	Total Operating Revenue							
69	OPERATING EXPENSES							
70	Depreciation							
71	Interest							
72	Other operating expenses							
73	Total operating expenses							
74	Net Operating Income							
75	NONOPERATING REVENUE							
76	Investment Income							
77	Gains/Losses-other							
78	Other inc (exp)							
79	Total nonoperating revenue							
80	Excess of revenue over expenses							
81	OTHER GAINS (LOSSES) DUE TO:							
82	Extraordinary Gains (Losses)							
83	Total Surplus/Deficit							

	A	B	C	D	E	F	G	H
84	**STATEMENT OF CASH FLOWS ($000s)**							
85	CASH GENERATED FROM OPERATING ACTIVITIES							
86	Total Surplus/Deficit							
87	Noncash expenses (revenues)							
88	Funds from Operations							
89	Decr (incr) Bd. Desig Cash							
90	Decr (incr) Trustee-Held Cash							
91	Decr (incr) Current Assets Limited Use							
92	Decr (incr) Accounts Rec							
93	Decr(incr) Affil Rec							
94	Decr (incr) 3rd Party Rec							
95	Decr (incr) inventory							
96	Decr (incr) other current assets							
97	Incr (decr) accts pay/accd exp							
98	Incr (decr) 3rd Party Settlement							
99	Incr (decr) Due to Afffiliates							
100	Incr (decr) Other Curr Liab except LTD							
101	CASH FROM WORKING CAPITAL							
102	Cash from operating activities							
103	CASH FROM INVESTING ACTIVITIES							
104	Decr (incr) Bd Designted Invstmt							
105	Decr (incr) TrusteeHeld Invstmt							
106	Decr (incr) Due From Affiliates							
107	Decr (Incr) Affiliate Investments							
108	Decr (Incr) PP&E Invstmt							
109	Decr (incr) Other Noncurrent Assets							
110	Decr (incr) PP&E gross							
111	Sale of Fixed Assets							
112	Cash provided (used) in investing activities							
113	Cash Position before Outside Financing Activities							
114	CASH FROM FINANCING ACTIVITIES							
115	Issue Long Term Debt							
116	Repay Long Term Debt (incl Current LTD)							
117	Incr (decr) Third Party Settlmt							
118	Incr(decr) Due to Affiliates							
119	Incr(decr) Pension, Self Insur							
120	Incr(decr) other Noncurrent Liabl							
121	Transfers from (to) restricted funds							
122	Transfers from (to) other entities							
123	Cash Provided (Used) Financing Activities							
124	Net Change in Cash							
125	rec							
126	dif							
127								

	A	B	C	D	E	F	G	H
128	**RATIOS**							
129	TotMargin							
130	OpMargin							
131	Markup							
132	Deductible							
133	Markup Adj for Deductible							
134	TotalOpExpense Growth							
135	TotalOpRev Growth							
136	NonopRev							
137	RealizedGains/NonOpRev							
138	RealizedGains/NetIncome							
139	ROA							
140	ROE							
141	CurrentRatio w/ Bd & Undesig Assts							
142	CurrentRatio w/o Bd & Undesig Assts							
143	Acid Test							
144	Days A/R							
145	Average Pay Period, AP&AE							
146	Average Pay Period, CL							
147	Days Cash on Hand, Current							
148	Days Cash on Hand, Incl BD							
149	Equity Financing Ratio							
150	CashFlow/TotDebt							
151	CashFlow/TotDebt w/OpIncOnly							
152	LongtermDebt/Equity							
153	Fixed Asset Fin							
154	DebtSvcCovTot							
155	DebtSvcCovTot w/ OpIncOnly							
156	TotAssetTurn							
157	FixedAssetTurn							
158	AvgAgePlant-Depr. only							
159	Reported Income Index							

	A	B	C	D	E	F	G	H
160	**CHARITY CARE**							
161	Bad Debt Charges/GPSR							
162	Free Care Charges/GPSR							
163	Free Care at Cost (000s)							
164	Bad Debt at Cost (000s)							
165	Property Assessment							
166	Mill rate							
167	Property Tax ($000s)							
168	Business Enterprise Tax ($000s)							
169	Business Profits Tax ($000s)							
170	Sales Tax ($000s)							
171	State Income Tax ($000s)							
172	Federal Income Tax ($000s)							
173	Tax Value ($000s)							
174	Free Care/Tax Value							
175	Free Care & 50% Bad Debt / Tax Value							
176	Free Care & 100% Bad Debt / Tax Value							
177	Free Care & Bad Debt & Medicaid / Tax Value							
178	All Quant. Charity & Bad Debt / Tax Value							
179	Additional Charity/Community Benefits Reported:							
180	Medicaid costs exceeding payments (000s)							
181	community svc programs (000s)							
182	Burn Care Services							
183	HIV/AIDS Services							
184	NICU							
185	Trauma Center							
186	Teaching							
187	COUNTY							
188	MEDIAN INCOME							
189	PAYER MIX:							
190	MEDICARE							
191	PRIVATE							
192	MEDICAID							
193	SELF							
194	OTHER							
195								