

**Mission Critical:
The Essential Role of
Not-For-Profit
Community Hospitals
To California's Health Care
Delivery System**

Revised to Include Final 1999 Audited Reports

**Penny Stroud
Cattaneo & Stroud, Inc.**

Consultants to the Health Care Industry
1601 Old Bayshore Highway, Suite 107
Burlingame, California 94010-1506
Phone 650/692-8884, Fax 650/692-5923
www.cattaneostroud.com

May 2002

Mission Critical: The Essential Role of Not-For-Profit Community Hospitals To California's Health Care Delivery System

INTRODUCTION

Not-for-profit hospitals are the foundation of the American health care system. Representing 51% of all hospitals in the United States and 54% in California, and more than 70% of California's acute hospital discharges, 68% of emergency visits, and 70% of births, their legacies of excellence, innovation, research, and community service personify this country's commitment to the best and most accessible health care in the world.^a This report describes the essential role of not-for-profit organizations in the stewardship of community-based health care. Its focus is on California hospitals, although hospitals throughout the country face these same issues. The report documents the challenges facing our health care system, the pivotal role of not-for-profit providers in maintaining access and quality, and the not-for-profit sector's vital investments in research, innovation and infrastructure.

California's not-for-profit community hospitals, exclusive of Kaiser facilities, comprise 48% of all hospitals and discharged 59% of all hospitalized patients, 54% of Medi-Cal patients and 26% of county indigent patients.^{b, c} Not-for-profit community hospitals reported expenditures in excess of \$1.1 billion for charity care, research and education in 1999. For each patient day of care, they provided \$63 of charity care, and for each discharge, they provided \$338 of charity care.^d Yet, the future of these invaluable assets and their ability to preserve and enhance their legacy of leadership in American health care is questionable. Rising costs, inadequate reimbursement and heavy regulatory burdens threaten to stifle investments in leadership, research, education, and innovation while eroding their capacity to provide a health care safety net for the poor and uninsured. Some question whether these facilities earn their tax exemption, yet an analysis of the resources committed to charitable purposes and disadvantaged populations leaves no question that mission makes a profound difference to access and resource allocation.

The past three decades have seen unprecedented change in our system of health care: new financing mechanisms, accelerating technology innovations, and new paradigms for care. Experts predict these changes will pale in comparison to the investments providers must make

^a Not-for-profit hospitals refer to private, tax exempt hospitals that serve the general community. Other types of hospitals referred to in this report are investor-controlled, district and government. Kaiser hospitals are not-for-profit tax exempt organizations because they primarily serve enrollees of the Kaiser Foundation Health Plan, which reports data at a statewide rather than individual facility level. This report generally separates their data from other community not-for-profit hospitals in the state. Data used in this report includes hospitals reporting financial data to the Office of Statewide Health Planning and Development (OSHPD) in the years 1995-1999. State and federal hospitals, psychiatric health facilities, Shriners Hospitals and chemical dependency recovery hospitals are excluded from the analysis. Statistics are 1999 unless otherwise noted. A complete list of excluded hospitals is contained in Appendix A.

^b This report uses the term "not-for-profit community hospitals" to refer to non-Kaiser, non-governmental tax exempt hospitals.

^c Governmental hospitals discharged 67% of indigent patients and 19% of Medi-Cal patients.

^d Charity care is used in this report to refer to the value of services reported by hospitals that were provided to patients who were determined to be unable to pay for all or part of their care prior to receiving services. It does not include bad debt, charitable services provided to offset Hill-Burton obligations or services provided to county indigent patients for whom counties have financial responsibility.

to adapt to the challenges and opportunities of the 21st century. The Institute of Medicine's March 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century*, states in its introduction:

The performance of the health care system varies considerably. It may be exemplary, but often is not, and millions of Americans fail to receive effective care. If the health system cannot consistently deliver today's science and technology, we may conclude that it is even less prepared to respond to the extraordinary scientific advances that will surely emerge during the first half of the 21st century.¹

Not-for-profit community hospitals are integral to providing the leadership, research, and capital investment that will enable the health care system to respond to the changing demographic, regulatory and technology environment. They are essential to ensuring access and availability to the full spectrum of basic and specialty care needs to all segments of society. Understanding the environment and organizations that comprise our health care system, and the particular demands faced by California health care providers, underscores the resources required to maintain the complex infrastructure of health care, and the necessity to preserve institutions with a charitable purpose. Identifying operating statistics and levels of care across patient payer groups highlights the essential role of not-for-profit community health care organizations in maintaining access, providing dynamic leadership, disseminating information, contributing research and education, and maintaining a steadfast commitment to community-based, quality health care. This report describes the essential role of not-for-profit organizations in the stewardship of community-based health care. Several examples are presented to illustrate a few of the ways not-for-profit health care systems invest their resources to advance health status while fulfilling their missions of community service. Specific objectives of this report include:

- 1) To describe the current and future environment that challenges providers of health care in the 21st century;
- 2) To define the nature and role of not-for-profit community hospitals and health care systems, and to differentiate them from other types of organizations;
- 3) To provide statewide hospital utilization, financial and service line data by type of control to illustrate the pivotal role of not-for-profit community hospitals as providers of essential health care services and as critical access points for all segments of society;[°]
- 4) To illustrate not-for-profit health care organizations' commitment to quality, innovation, research, charity care and community-based programs.

[°] Type of control refers to the type of organization with management control over a hospital. There are a number of organizations owned by one type of organization that is operated by another type due to base or management agreements.

EXECUTIVE SUMMARY

Not-for-profit hospitals are the foundation of American health care. Their legacies of excellence, innovation, research, and community service personify this country's commitment to the best and most accessible health care in the world. California's not-for-profit community hospitals support a broad spectrum of health care services while maintaining a vital infrastructure and access to all segments of society. Representing only 48% of facilities, more than 60% of California's pediatric, obstetrics, neonatal, surgery and critical care services are provided in these hospitals. 69% of all unfunded charity care, research and education expenditures was provided by not-for-profit community hospitals in 1999,^f Not-for-profit community hospitals discharged 54% of Medi-Cal cases and 26% of county indigent patients who required acute hospitalization in 1999, and they delivered 58% of the babies born and treated 53% of all emergency patients. The community benefits flowing from not-for-profits are extensive: direct patient care, community and professional health education, research, leadership in health policy and advocacy and the basic infrastructure of California's health care delivery system. Protecting and nurturing these assets should be a priority commitment of the governments, businesses and communities that rely on the missions and services of these invaluable assets.

A Commitment to Community Service

California not-for-profit community hospitals provide the majority of health care to Californians, and are particularly vital to the most vulnerable populations: children, Medi-Cal, indigent, the critically ill, and emergency patients. Although they control only 48% of facilities, they are the principal providers of essential health services as shown below:

**CALIFORNIA HOSPITAL SERVICES
PERCENT OF VOLUME BY TYPE OF CONTROL**

SERVICE	NOT-FOR-PROFIT COMMUNITY	KAISER NOT-FOR-PROFIT	DISTRICT	INVESTOR	GOVERNMENT
Hospitals	48%	6%	10%	30%	6%
Average Daily Census	58%	7%	7%	19%	9%
Emergency Visits	53%	15%	7%	14%	11%
Births	58%	12%	6%	18%	6%
Pediatric Cases	64%	12%	4%	11%	9%
Critical Care Cases	60%	10%	5%	19%	7%

Source: OSHPD Annual Financial Disclosure Reports for California hospitals excluding state and federal facilities

Of the 47 designated trauma centers in the state, 32 (68%) are in not-for-profit community hospitals versus only 5 (11%) in investor-controlled facilities.

^f Charity care is used in this report to refer to the value of services reported by hospitals that were provided to patients who were determined to be unable to pay for all or part of their care prior to receiving services. It does not include bad debt, charitable services provided to offset Hill-Burton obligations or services provided to county indigent patients for whom counties have financial responsibility.

Not-for-profit community hospitals reported more than \$1.1 billion in charity care, research, and education in 1999. Their charity care deductions *exclusive* of bad debt, indigent care, and Hill-Burton charity obligations, were \$63 per patient day of care and \$338 per discharge. Research and education expenditures resulted in another \$45 per day of care and \$241 per discharge in community benefit services funded by not-for-profit community hospitals. Their role as safety net providers to the disadvantaged is illustrated by service to the county indigent and Medi-Cal population:

- q Not-for-profit, community facilities discharged 54% of California's Medi-Cal cases;
- q 26% of the state's county indigent discharges were seen in not-for-profit community hospitals;
- q 18% of county indigent outpatient visits were provided by not-for-profit community hospitals.

Payment for these patients falls far below costs, when reimbursed at all, yet policies of open access regardless of payment are fundamental to the mission of most not-for-profit providers. With California ranking between 48th and 51st in the U.S. and District of Columbia in Medi-Cal payments per eligible over the past few years, and payments per eligible only 53% of payments in New York, the burden on not-for-profit health care providers is formidable.

Not-For-Profit Charity Care: Economic Value in California

Nationally, it is estimated that in 2000 not-for-profit hospitals devoted more than 6% of their operating expenses to uncompensated care and care reimbursed at less than cost, a 50% increase from 1990.² In California in 1999, not-for-profit community hospitals reported more than \$646 million in deductions for Charity Care-Other. \$63 was expended by not-for-profits on a per day of care basis. On a *per facility* basis, charity care expenditures were \$2.9 million at the state's not-for-profit hospitals.

FINANCIAL MEASURES OF COMMUNITY BENEFIT BY TYPE OF CONTROL

CATEGORY OF EXPENSE	NOT-FOR-PROFIT COMMUNITY	KAISER NOT-FOR-PROFIT	DISTRICT	INVESTOR	GOVERNMENT
TOTAL AMOUNTS PAID					
Taxes and License Fees (1)	\$ 680,146	\$ 0	\$ 0	\$ 29,518,847	\$ 0
Charity Care-Other (2)	\$ 645,900,622	None reported	\$ 25,138,225	\$ 207,310,753	\$ 62,659,611
Research & Education	\$ 460,263,340	\$ 10,585,805	\$ 9,559	\$ 14,999,944	\$ 180,248,706
County Indigent (3)	\$ 795,867,851	None reported	\$ 27,773,806	\$ 143,912,752	\$1,885,360,107
DEDUCTIONS PER PATIENT DAY					
Taxes and License Fees	\$ 0.07	\$ 0	\$ 0	\$ 9	\$ 0
Charity Care-Other	\$ 63	\$ 0	\$ 20	\$ 61	\$ 40
Research & Education	\$ 45	\$ 8	\$.01	\$ 4	\$ 116
County Indigent	\$ 78	\$ 0	\$ 23	\$ 42	\$ 1,209

Source: OSHPD Annual Financial Disclosure Reports for California hospitals excluding CDRH, PHF, Shriners, state and federal facilities; charity care (other) excludes county indigent, Hill Burton and bad debt deductions.

(1) Taxes paid include reported income taxes, property taxes, and license fees.

(2) Charity Care-Other refers to care provided to patients who are unable to pay for all or part of their services.

(3) County indigent care services are provided to patients for whom a county is financially responsible.

Economic Challenges of Health Care Providers

The ability to fulfill a not-for-profit mission and ensure open access depends on maintaining adequate financial resources derived from operations, endowments and philanthropy. In an industry characterized by perpetual change and unfunded mandates, meeting the challenge of financial stability is daunting. Advances in technology and the need to invest in infrastructure to ensure safe and high quality facilities, staff and equipment must be addressed if health care providers are to deliver the promise of contemporary medicine and meet the health care needs of their communities.

Unprecedented change has characterized the past several decades of American health care. Between 1975 and 1995 the number of hospital beds per capita declined 40% and occupancy rates declined to only 52%, as demand for outpatient services grew exponentially.³ While for-profit sponsorship of community hospital beds increased from 9% to 15% nationally between 1990 and 1999, it declined from 34% to 31% in California, tangible evidence of the difficult California market.⁴ Between 1990 and 1999 the total number of hospital sites in California declined from 607 to 560, with 46 fewer for-profit, 8 fewer district, 1 fewer Kaiser, 7 fewer public hospitals, and nine *more* non-profit community hospitals. In 1999, 59% of California hospitals reported operating deficits, a percentage that rose to 64% in 2000.

Managed care became the predominant payment method, with large national HMOs increasing their dominance from 61% to 77% of all HMO enrollees between 1995 and 1999. In California in 2001 managed care plans represented more than 90% of the privately insured population and over 50% of the government-sponsored population.⁵ Of these managed care plans, the ten largest accounted for almost 86% of the managed care enrollment with *all but two plans* being for-profit entities. Not-for-profit community hospitals are becoming the only major not-for-profit, non-public advocate for health care in the mainstream of California health medicine. The public's dependence on these providers is profound.

Demographic and socioeconomic changes also influence health care needs and operations. The aging of the population will continue to increase the percentage of services paid for by the government. Large influxes of immigrants and other economic forces have increased the proportion of population working for employers with little or no employer-based insurance. Despite economic good times, last year more than one in five California non-elderly residents had no health insurance, and nearly 1.85 million California children were uninsured.⁶ Recent economic events are increasing the number of government-dependent insureds after several years of decline, and the number of uninsured has grown with the weakening economy. Yet, government programs have effectively decreased payments through budget-reduction initiatives and failure to increase payments apace with inflation.

Workforce changes impact health care organizations in particular: more than 55% of hospital expenses are labor-related, and the need for technically-savvy employees is high in the increasingly complex medical system. The tight labor market has driven wages up as the supply of skilled health care workers declines and as opportunities outside of health care expand. California has the lowest ratio of registered nurses per capita in the nation (566 versus 798 per 100,000 population) and, until recently, one of the lowest rates of unemployment. The average age of the health care workforce is also high, as fewer people enter the field. The physician workforce faces the same challenges: aging, difficulty recruiting and retaining new physicians and maintaining practices and families with low reimbursement rates and a high cost of living.

Regulatory and technology demands further stress the operation of health care organizations. Despite decreases in government reimbursement rates, a constant stream of major initiatives have been thrust upon providers without additional funding: seismic upgrades in California are forecast to cost \$24 billion for construction of new facilities and retrofits over the next 30 years; information technology and privacy regulations are forecast to exceed Y2K expenditures; emergency services (EMTALA) regulations impose new standards for physician on-call coverage that require hospital subsidies; new benefits have been mandated for managed care organizations, and minimum staffing ratios are being discussed.

The Challenge of the 21st Century

These forces require not just access to capital but aggressive leadership and innovation. Taking advantage of and incorporating the technology available to enhance health care and to meet rising expectations of both consumers and providers, will require investments in systems and innovations unprecedented in the history of health care. The Institute of Medicine's report states:

Between the health care we have and the care we could have lies not just a gap, but a chasm...The need for leadership in health care has never been greater. Transforming the health care system will not be an easy process. But the potential benefits are large as well. Narrowing the quality chasm will make it possible to bring the benefits of science and technology to all Americans in every community, and this in turn will mean less pain and suffering, less disability, greater longevity, and a more productive workforce.⁷

Not-for-profit hospitals, and in particular, not-for-profit, multi-hospital systems and integrated delivery systems have a long history of leading the research and investment in innovative systems and infrastructure that are necessary to address change, disseminate change into communities and integrate it into mainstream medical care. With more than 60% of California hospitals operating at a deficit from operations in 2000, it is critical to support and strengthen the organizations that will preserve community hospitals and enable them to lead the transformations required to meet the challenges ahead. Not-for-profit providers are guided by missions and values directed toward benefiting their communities rather than rewarding private investors. This commitment has been demonstrated throughout history by their support of unprofitable services, community education programs, academic training programs, and research. These organizations must *survive* to fulfill their commitments and preserve the legacies that are critical to the foundations of American health care. As economic and regulatory forces threaten the level of resources available for infrastructure and technology, organizations with resources focused on creative and efficient systems are crucial to meeting the challenges that lie ahead. This report documents the challenges health care organizations face in maintaining an effective health care system in the 21st century and some of the ways not-for-profit organizations are working to preserve the legacy of community hospitals in California.

THE HEALTH CARE ENVIRONMENT IN CALIFORNIA

Few days go by without reports of change and crisis among California health care providers: medical group insolvency, major hospital deficits, worker shortages, and failed health plan negotiations. Understanding the context of these reports provides the foundation for understanding the importance of preserving those organizations committed to maintaining high quality, community-based health care.

Profile of California Hospitals

The organizations involved in health care have changed considerably in the past two decades. Nationally, the number of acute hospitals declined 15% between 1975 and 1998, with the number of beds per capita falling 40% between 1975 and 1995.⁸ In California there has been a 7% decline in the number of hospitals since 1995. However, hospital utilization per capita has fallen even faster, with days per thousand decreasing 19% from 672 to 544 over that same period of time. In California, 86 hospital sites were closed between 1991 and 2000, compared to only 65 in the preceding decade. In 1995, 531 hospitals reported information to the Office of Statewide Hospital Planning and Development (OSHPD) compared to 473 in 1999. A comparison by type of control shows reductions in the number of facilities as follows:

CALIFORNIA HOSPITALS BY TYPE OF CONTROL

TYPE OF CONTROL	1995	1996	1997	1998	1999	% CHANGE
Not-For-Profit Community	232	227	227	230	225	-3%
Kaiser Not-For-Profit	29	28	27	27	28	-3%
District	57	58	56	51	47	-18%
Investor	174	175	171	164	144	-17%
Government	39	37	33	30	29	-26%
TOTAL	531	525	514	502	473	- 7%

Note: Hospitals are mandated to file annual financial disclosure reports to OSHPD; Kaiser hospitals are tax exempt organizations operated for the benefit of Kaiser health insurance enrollees. Excludes State, Shriners, Psychiatric Health Facilities & Chemical Dependency Recovery Hospitals.

A review of essential hospital services reveals the importance of not-for-profit community hospitals to meeting California's basic health care needs and ensuring access:

**CALIFORNIA HOSPITAL SERVICES
PERCENT OF VOLUME BY TYPE OF CONTROL**

SERVICE	NOT-FOR-PROFIT COMMUNITY	KAISER NOT-FOR-PROFIT	DISTRICT	INVESTOR	GOVERNMENT
Hospitals	48%	6%	10%	30%	6%
Total Discharges	59%	10%	6%	18%	8%
Acute Discharges	59%	11%	6%	17%	7%
Total Patient Days	58%	7%	7%	19%	9%
Emergency Visits	53%	15%	7%	14%	11%
Outpatient Visits-County Indigents	18%	0%	1%	2%	79%
Outpatient Visits-Medi-Cal	57%	0%	8%	9%	26%
Inpatient Surgery Cases	64%	9%	5%	15%	6%
Medi-Cal Discharges	54%	0.3%	6%	21%	19%
Co. Indigent Programs Discharges	26%	0.1%	1%	5%	67%
Long-term Care Discharges	71%	0%	8%	19%	1%
Psychiatric Discharges	46%	1%	3%	34%	16%
Chem. Dependency Discharges	63%	0%	0%	37%	0%
Rehabilitation Discharges	57%	3%	2%	30%	8%

Source: OSHPD Annual Financial Disclosure Reports for California hospitals excluding state and federal facilities, PHFs, CDRHs, and Shriners Hospitals. Emergency Visits, Long-term care discharges, psychiatric discharges, Chem. Dependency Discharges, and Rehabilitation Discharges are from 1999 OSHPD Annual Reports of Hospitals.

Financial Condition of California Hospitals

Surviving the California health care environment challenges all health care providers. In 1999, 57% of California hospitals reported operating deficits, a figure that rose to more than 64% in 2000. Only investment income from reserves, endowments and philanthropy enabled many institutions to operate with a positive margin from all sources of income.⁹

Philanthropy remains a crucial component in the ability of not-for-profit hospitals to maintain quality, scope of services, and access in addition to allowing timely replacement of aging facilities. Gifts, bequests, and donations support the research and community service that enables not-for-profit community hospitals to fulfill their missions and continue efforts to improve community health. Volunteerism and charitable giving are the heart of most not-for-profit hospitals, inspiring new leaders to protect and enhance the missions of these vital community resources.

The management profile of California's hospitals in 1999 demonstrates the prominence of private not-for-profit community hospitals in the health care delivery system. With 48% of facilities, not-for-profit community hospitals provided 59% of discharges, 58% of all hospital days and 60% of all acute care days. Total operating revenues failed to cover expenses for any control group *except* the investor-controlled and Kaiser hospitals. The following table summarizes a few key operating statistics for California hospitals in 1999:

**CALIFORNIA HOSPITAL PROFILE BY TYPE OF CONTROL
AND KEY OPERATING STATISTICS – 1999**

TYPE OF CONTROL	FACILITIES		BEDS		DISCHARGES		AVERAGE DAILY CENSUS		NET OPERATING MARGIN* (000s)
	No.	%	No.	%	No.	%	No.	%	
Not-For-Profit Community	225	48%	51,817	57%	1,909,858	59%	28,088	58%	(\$324,426)
Kaiser Not-For-Profit	28	6%	7,022	8%	325,003	10%	3,443	7%	\$217,781
District	47	10%	5,462	6%	184,812	6%	3,362	7%	(\$ 32,994)
Investor	144	30%	19,124	21%	598,507	18%	9,383	19%	\$282,214
Government	29	6%	8,265	9%	245,227	6%	4,274	9%	(\$369,115)
TOTAL	473	100%	91,690	100%	3,263,407	100%	48,550	100%	(\$226,540)

Source: OSHPD Annual Financial Disclosure Reports for California hospitals excluding state and federal facilities, PHFs, CDRHs, and Shriners Hospitals.

*Net margin before disproportionate share payments

The California Healthcare Association reports that more than 60% of California hospitals had negative patient care margins in 2000, with an *aggregate statewide margin of negative 5.2%*.¹⁰

Ownership of Other Segments of the Health Care Industry

Hospital ownership, with its dominance by not-for-profit organizations, contrasts starkly with ownership of health plans, insurers, suppliers and other segments of the health care industry. Between 1981 and 1997, for-profit HMOs across the country grew from representing 12% to 63% of all HMO enrollees and from 18% to 75% of all plans, with 65% of enrollees represented by the ten largest health plans. Contrast this to *only 16% of hospital beds* contained in the ten largest hospital systems. Of the 57 Blue Cross and Blue Shield plans across the country, 47 own one or more for-profit subsidiaries, 3 have become wholly for-profit (including Blue Cross of California), and 2 more are in the process of converting.¹¹ With the loss of not-for-profit insurance coverage, not-for-profit hospitals and health systems are in a particularly important position as guardians of access, holding the responsibility to allocate scarce resources to serve communities and the underserved. While more than 64% of California's hospitals operated at a deficit at least one year between 1997-2000, average profit margins for the 6 largest HMOs nearly tripled in 1999, and the percentage of insurance premiums spent on medical care actually *declined* from 87% to 86%.¹² The following table compares operating margin and financial statistics for major providers and insurers in the California and national market:

**SELECTED KEY FINANCIAL STATISTICS
AMONG HEALTH CARE INDUSTRY SEGMENTS**

COMPANY NAME	MARKET CAP/NET ASSETS(1) (000'S)	P/E (TTM)	PROFIT/ OPERATING MARGIN (%) (3)	ROE (TTM)	DEBT TO EQUITY	EPS GROWTH (5 YR.)
Industry Average-Hospitals (For profit)	\$ 602	47	4.37%	10.40%	1.02	0.96%
Industry Average-Insurance Cos.	\$ 3,173	20	5.94%	19.08%	NM	21.81%
Industry Average-Pharmaceutical Cos.	\$93,340	36	17.25%	33.30%	0.34	13.47%
Sutter Health, Inc. (Not-For-Profit)	\$ 1,611	NA	1.00%			NA
Kaiser Health Plan/Hosps (Not-For-Profit)(2)	\$ 5,601	NA	3.80%	8.00%		NA
HCA-Health care Co. (For-Profit Hosp)	\$21,246	86	1.47%	4.91%	1.48	(24.01%)
Magellan Health Svcs (For-Profit Hosp)	\$ 356	17	1.35%	13.68%	5.44	NM
Tenet Health care Corp. (For-Profit Hosp)	\$14,402	26	4.82%	12.87%	0.99	(0.73%)
Aetna (New) (For-Profit Insuror & HMO)	\$ 4,077	NM	(0.48%)	(1.19%)	0.16	NM
WellPoint Health Networks (For-Profit HMO)	\$ 6,199	18	3.70%	23.71%	0.51	14.29%
CIGNA Corp. (For-Profit HMO)	\$16,278	18	4.94%	17.47%	0.24	44.67%
United Health Group (For-Profit Insuror & HMO)	\$21,005	28	3.57%	20.92%	0.29	22.65%
Health Net, Inc. (For-Profit HMO)	\$ 2,606	16	1.80%	16.85%	0.72	(2.82%)

Source: Charles Schwab

(1) Net Assets reported for Non-for-Profits; (2) First quarter of 2001; (3) After tax operating margin
TTM-Trailing 12 months to 3/2001; NM – Not meaningful

More than 35% of California hospitals' credit ratings carried a negative outlook in 2001. Since January 2000, the rating agency Fitch lowered 24 hospital credit ratings during the 18 months ending June 2001 and issued only one upgrade.¹³

Payment Rates and Insurance Coverage

Insurance coverage of the population has changed markedly over the past decade, with California experiencing the most radical transitions. Managed care plans insured 80% of the California population in 2000 (90% of the insured population), compared to 70% in the rest of the country, with HMOs the dominant type of plan (69% of managed care members in California compared to 41% nationally).¹⁴ California cities consistently represent 8 of the 10 top metropolitan areas in the nation for HMO penetration. Although national HMO membership declined in 1999 for the first time in 30 years, California HMO enrollment grew 1.8% between 1999 and 2000, to an estimated 50.3% of the total population and continued to increase another 4.7% in 2001, more than double the state's population growth rate.¹⁵ Yet, as enrollment grew, premiums *in real dollars* have declined. As stated by a California Health Policy Roundtable:

Managed care had a stabilizing effect on health care costs for purchasers, with relatively little increase in HMO premiums from 1992-97 in California, translating into relatively stable revenues for plans. *However the costs of providing care over this same period were continuing to rise*, in part due to increased pharmaceutical utilization and prices. The combination of stable premium revenues and rising costs created financial problems in the health care system, and medical groups have not been the only organizations to feel these effects. All types of medical care providers in California have experienced financial problems, including physician practice management firms, HMOs, hospitals systems, and medical groups... *Capitation rates have fallen from an average of \$45 pmpm during 1990-93 to \$29 pmpm during 97-99, a 35% decrease – while the cost of living has increased by 25.2%.*¹⁶

Despite a cost of living second only to New York City, and the most expensive labor market in the country, health insurance premiums were on average 10% lower in California and HMO premiums actually declined between 1997 and 1999, though 2000 rates finally rose above 1997 rates.

**ANNUAL MONTHLY PREMIUMS FOR SINGLE COVERAGE
CALIFORNIA AND THE UNITED STATES
1997 – 2000**

PLAN TYPE	1997		2000		CA % of U.S.	
	CA	U.S.	CA	U.S.	1997	2000
All Plan Types	NA	NA	\$192	\$202		95%
HMO	\$147	\$160	\$166	\$181	92%	92%
PPO	\$186	\$169	\$241	\$210	110%	115%
POS	\$171	\$168	\$196	\$202	102%	97%

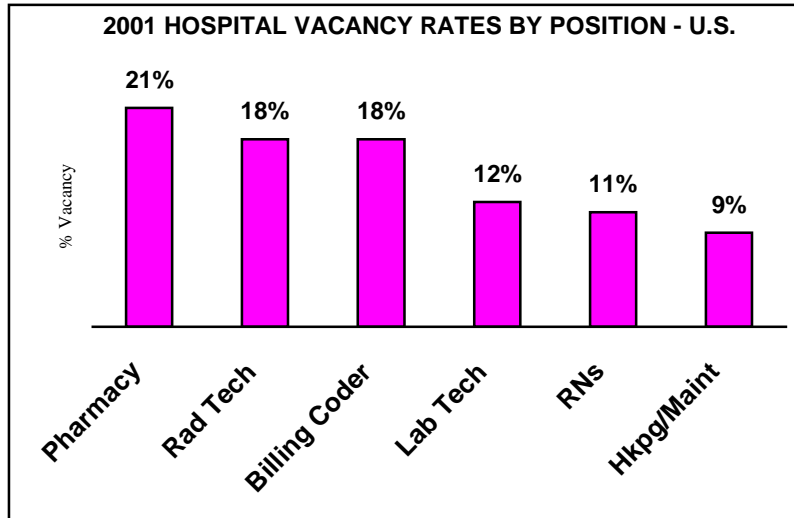
Source: Kaiser/HRET/UC Berkeley 2000 California Survey of Employer-Sponsored Health Benefits; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000.

Both the percentage of premium paid by workers as well as co-payments for office visits and prescription drugs have been lower in California than the rest of the country, factors that further contribute to reduced provider revenues. California businesses pay less for insurance than any other state. Robert Pearl, CEO and Executive Director of The Permanente Medical Group at Kaiser Permanente stated early in 2001 that California purchasers pay only 77¢ for health care compared to \$1 in the rest of the nation.¹⁷

Another major difference is the percentage of firms that offer retiree health benefits: only 5% in California versus 9% in the U.S. Even among large firms, the difference is major: 29% in California versus 37% in the U.S.¹⁸ It is factors such as these that increase rates of uninsured and increase Medi-Cal enrollments.

The Crisis in Labor

A severe shortage of the skilled workers and nurses needed to staff hospitals is perhaps the largest issue facing health care providers in the next two decades. Turnover is extremely high and supply is diminishing as fewer students enroll in training programs and more leave the profession.¹⁹ William M. Mercer, Incorporated reported that nationally there is a 32% turnover in nurses. California ranks 50th in terms of nurse-to-population ratio (566 vs. 798 RNs per 100,000 nationally, almost 30% below the national supply). The *shortage* of nurses is forecast to grow to 25,000 by 2006 and to 43,000 by 2010.^{20,21} Many hospitals report RN vacancies in excess of 10%, which have the effect of raising costs by increasing reliance on more expensive per diem and registry staff.²² Shortages are also being felt in technical areas such as radiology, laboratory, pharmacy and respiratory care.^{23,24} Between 1998 and 2000 there was a 15% decline in the actual *number* of certified nursing assistants in California, representing a reduction of more than 18,000 CNAs.²⁵



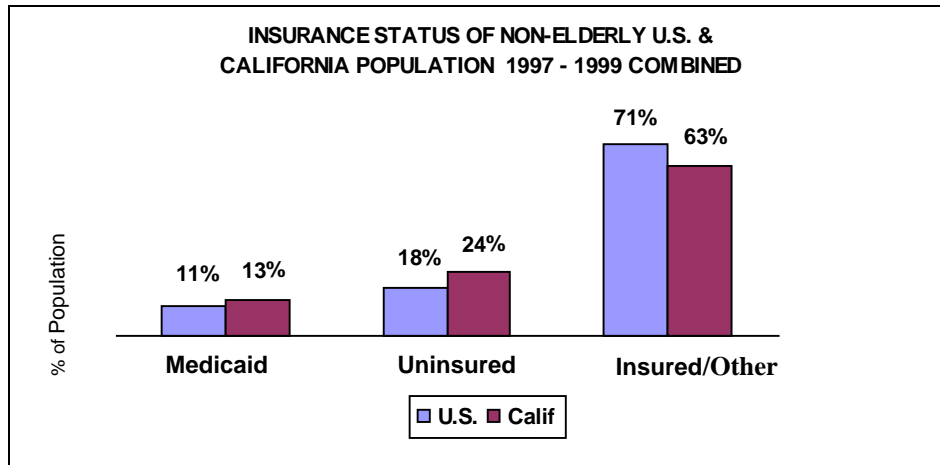
Source: William Mercer

The proposed minimum nurse-to-patient ratios set for implementation in 2002 will cost each hospital in California between \$200,000 to \$2.3 million each year according to the Public Policy Institute in California, yet additional reimbursement for the increases is not forthcoming, and the ability to recruit new staff is questionable with already high vacancy rates.²⁶

The need for creative and effective recruitment and retention policies will only increase, and the cost of labor will continue to rise. In 2000 an administrative assistant in San Francisco was paid 19% more than the national average, with workers in information technology commanding a 29% *premium* to the national average, a cost differential that contrasts sharply with the lower than average reimbursement rates from health plans.^{27,28} Physician recruitment and retention is also growing increasingly difficult and costly to medical groups, medical schools, and communities throughout California.

The Uninsured and Under-Insured Burden

The number of uninsured Californians is far above, and those provided with employment-based and other non-Medi-Cal insurance falls far below, the nation. In 1999 6.8 million or 22.4% of Californians were uninsured, compared to 17% nationally.²⁹ There is concern that recent increases in insurance rates and the weakening economy will further increase these numbers.



Source: Kaiser Family Foundation State Health Facts

Uncompensated care costs at the nation's hospitals increased from \$12.2 billion to \$20.7 billion between 1990 and 1999, representing 6% of overall hospital expenses.³⁰ In California, uncompensated care rose from \$1.9 billion to almost \$2.5 billion, a staggering 28.8% increase from 1998 to 1999.³¹ Not-for-profit, community hospitals in California shouldered an estimated 69% of this burden statewide despite representing only 48% of licensed providers. Of the predetermined charity care provided in 1999 by California hospitals, not-for-profit community hospitals incurred 69% of all reported services. On a per facility basis, community not-for-profit hospitals incurred \$2.9 million in predetermined charity care services. In addition, not-for-profit community hospitals provided 57% of the state's Medi-Cal outpatient visits 54% of Medi-Cal inpatient discharges. Not-for-profit community hospitals provided 26% of all county indigent patient discharges and 18% of county indigent outpatient hospital visits statewide, despite low or no payments to many facilities. Not-for-profit community hospitals saw 53% of the state's emergency patient visits, the primary access point for many of the state's uninsured, underinsured, and vulnerable populations.

Costs Of Supplies, Pharmaceuticals, Equipment, and Utilities

Other economic forces compound the challenges hospitals and health care providers face. The California Healthcare Foundation reports that prescription drug costs have risen more than 19% over the past year, following more than a decade of double digit increases.³² Prices, as well as both the quantity and variety of durable medical equipment and other technology such as catheters, stents, implants and both major and minor equipment continue to increase at rates faster than the prices paid by the government and insurers for care.³³ Equipment and procedures such as PET scans, DNA testing, chemotherapies, and faster CT scanners promise improved diagnosis and treatment, yet stress the capital and operating budgets of hospitals. Fixed capitation and per diem payments rarely are modified when new technology is introduced, yet consumer and physician expectations as well as quality assurance and new standards of care require continuous investment. One California hospital found that its acquisition cost of cardiac stents alone exceeded the total per diem reimbursements received from their largest payer for patients undergoing these procedures.

The California energy crisis further contributes to the economic crisis of its health care providers. Sharp Healthcare in San Diego saw a 50% jump in its electricity bills in 2000,

\$570,000 over budget, seriously cutting into its 1% operating margin. Lassen Community Hospital in Susanville, which struggles to break even, had electricity bills in 2001 that were 75% over budget, contributing to the need to reduce and eliminate services such as its adult and child day care programs.³⁴ With tight budgets and predetermined reimbursement rates, there is little room for major variances in infrastructure expenses such as electricity, gas, and water.

Government Funding

Revenue and funding challenges are endemic in health care. Federal, state and private insurers are exerting increasing pressure on the ability of hospitals to operate in the black. The Balanced Budget Act of 1997 and amendments passed in 1999 dramatically altered payments for most health care organizations, producing a \$224 billion reduction in the government's estimated Medicare expenditures through its first five years (1998 through 2002).³⁵ Hospital inflation rates rose 8.2% between 1998-2000 whereas Medicare payment updates rose only 1.6%.³⁶ The Urban Institute analyzed these changes in a report published in 2000 and concluded that these legislative acts converted Medicare from a program that *contributed a surplus* of \$4.2 billion to the nation's hospitals to one that *cost* them \$2.1 billion. Furthermore, the report stated that:

Medicare payments did not keep up with the rapid rise in costs.... In the period between 1992 and 1997, hospitals were experiencing considerable pressure from private payers: payments per case for these patients actually fell by 0.7% per year, compared with the 10.9% annual increase they provided in the previous period.³⁷

Additional funding cuts impact the most vulnerable hospitals, the "disproportionate share" providers who care for larger than average percentages of low and no income patients. Federal funds to augment payments for these safety net facilities have fallen 20% in real dollars from \$1.1 billion in California in 1997-1998 to \$877 million in 2001-2002.³⁸

In California, Medi-Cal has not increased payments to many hospitals for years, and HMO premiums have declined in many markets. Medi-Cal expenditures per capita in California ranked between 48th and 51st in the United States (including the District of Columbia) over the past few years, falling *33% below the national average in 1998*, at \$2,573 annually versus \$3,822 nationally and \$7,180 in New York, the market with the most comparable cost of living.³⁹ In an analysis of payment rates to its physicians, UCSF Medical Center calculated that payment rates in 2000 were *lower in real dollars* than a decade earlier. The ability of institutions and physicians to maintain quality operations in this environment is precarious, and particularly challenges their ability to maintain or enhance services to below cost Medi-Cal and uncompensated patients. A report from Price Waterhouse Coopers, commissioned by the California Medical Association (CMA) in 1999 found that at least 34, or almost 10% of the state's medical groups or IPAs, were near bankruptcy.⁴⁰ A new report issued by the Department of Managed Care found that only 44% of California's medical groups that held HMO contracts met all of the financial solvency standards that had been set by an expert commission.⁴¹ The Urban Institute notes in its policy recommendations that:

The health care system has been characterized by cross-subsidies among its components and missions. Even in the early 1980s private payers paid hospitals more than the costs of their patients, presumably to offset payment shortfalls from Medicare and Medicaid and losses on patients who did not pay for care, as well as to underwrite other social and academic missions that hospitals might undertake despite the lack of explicit revenue sources to support them. The pattern and magnitude of these cross-subsidies has changed

over time, as both the missions and the willingness and ability of different payers to provide them has shifted.

Despite the deteriorating financial environment, and the increase in spending on charity care, there has been discussion to mandate a minimum expenditure by not-for-profits for charity care. It is clear from the data reported to the state, that not-for-profits fund significant charity care without such a mandate. Regarding a set percentage in concert with all of the other unfunded mandates and diminishing margins from insured products will drive greater increases in premiums and further compromise the financial stability of not-for-profit providers.⁴²

Unfunded Mandates and Compliance Costs

In addition to reimbursement that has failed to keep pace with inflation, the health care market has been burdened with expensive legislative/public policy initiatives that are largely unfunded. The impact of these is compounded by government budget initiatives that have reduced payments to providers. Among the unfunded mandates providers must implement:

HIPAA, the privacy regulations imposed as part of the Health Insurance Portability and Accountability Act, are estimated to cost the nation's health care system \$18 billion over the next 10 years, \$1.2 billion of which will be in the first year of implementation.^{43,44} The California Hospital Association estimates California hospitals' costs at \$2.5 billion through 2005, compared to the more than \$1 billion in unplanned and unfunded expenses they had to shoulder to address Y2K concerns.⁴⁵ The national Blue Cross and Blue Shield Association estimates HIPAA will cost hospitals an average of \$775,000 to \$3.5 million each.⁴⁶ The regulations will limit the use and exchange of information by health care professionals, employers and insurers while giving patients the right to review and enforce corrections to their records. New information technology, encryption systems, personnel and bureaucracy will be required throughout the health care delivery system to meet these standards.

EMTALA, the Emergency Medical Treatment and Labor Act passed in 1986, requires hospitals to provide a broad range of physician and hospital services and systems to respond to patient emergencies. Recent court interpretations and federal enforcement efforts have increased the standards for on-call physician coverage.⁴⁷ Increasingly, physicians are demanding payment for the coverage required to meet the regulations, with some hospitals having to choose between eliminating services or incurring tens of thousands of dollars in on-call stipends to ensure physician availability. Some hospitals are considering reductions in services to deal with the conflicts between EMTALA and inadequate reimbursement. Not-for-profit community hospitals bear the brunt of these costs because their sponsorship of facilities with emergency rooms and tertiary services, open access to Medi-Cal, and uninsured patients is disproportionately high compared to their share of facilities. In fact, of the 47 designated trauma centers in the state, 32 (68%) are not-for-profit community hospitals and only 5 (11%) are investor-controlled facilities.

Benefit mandates, such as length of stay for maternity care, expanded mental health services and specialty physician access, all of which address important public policy issues and legitimate qualitative concerns, have been passed without incremental funding. These costs have generally been absorbed by health care providers *not* insurers, under the prepaid capitation system that is funding much of California health care.

Seismic upgrades, unique to California, have been mandated to ensure the seismic safety of hospitals. The state estimates that more than a third of California's inpatient hospital buildings will have to be significantly remodeled, replaced or converted to other uses by 2008 to meet the standards of SB1953. Hospitals reported that 966 (39%) of 2,467 California's acute care structures are in danger of collapse during a major earthquake.⁴⁸ The California Hospital Association has estimated the 2008 seismic upgrades will cost more than \$10 billion, with an additional \$14 billion required to meet the 2030 standards.⁴⁹ Sacramento area providers alone estimate costs of at least \$180 million to meet 2008 requirements.⁵⁰ Investments may exceed \$1 billion in San Francisco and San Mateo Counties alone. The State reports that only 13% of all California acute care hospital buildings currently meet the 2030 full compliance requirements.⁵¹

Implementation of this mandate underscores the need for financially stable organizations, as well as the value of not-for-profit organizations in continuing services. The legislation will call into question the survival of many hospitals, and will certainly change the capacity of the industry as hospitals seek to "right size" their replacements.

The Health Care Association of Southern California estimates a 26% reduction in hospital capacity in Los Angeles County alone as a result of SB1953. Access to tax exempt financing as well as fundraising and philanthropy will be essential to rebuild and retrofit hospitals and maintain access, particularly in facilities seeing large numbers of vulnerable patients. Not-for-profit providers will be especially important in overseeing the impact such restructuring will have on the health care industry in California, because of their number and their missions. At least one example of this is the community of Merced in which Sutter Health and Catholic Healthcare West have sponsored hospitals, each operating at low occupancy levels. When seismic studies determined a need for full replacement of both facilities at an estimated cost of \$200 million each, the two systems negotiated a merger so that only one hospital will be rebuilt with a commitment to continue the same level of community service and benefit previously provided by the two institutions.

Other Initiatives also threaten to increase operating costs. The proposed OSHA ergonomic standards may cost \$150 - \$900 per affected job, with many health care workers subject to the proposed rules.⁵² The Mayo Foundation estimates that Medicare and Medicaid alone have over 132,720 pages of regulations, three times the size of the entire IRS code and its federal tax regulations. In its first 25 years, Medicare implemented a single prospective payment system (PPS) whereas during the five years beginning in 1998, a total of *eight* PPS systems for hospital outpatient departments, home health agencies, skilled nursing, rehabilitation, long term care hospitals, psychiatric facilities and ambulatory surgery centers are scheduled for implementation.⁵³ In addition, there are Occupational Safety and Health Administration (OSHA), Environmental Protection Agency (EPA), Food and Drug Administration (FDA), Federal Aviation Administration (FAA), Federal Communications Commission (FCC), Internal Revenue Service (IRS), Securities and Exchange Commission (SEC), Department of Commerce (DOC), Office of Inspector General (OIG), Department of Labor (DOL), and other state, federal and even local agencies issuing regulations with which hospitals must comply. These regulations are expensive to implement, but they also take a toll on the morale and job satisfaction of employees and physicians working in health care. One study recently found that for every hour of patient care, nurses spend 1.5 hours in paperwork and documentation.⁵⁴ A hospital's first priority is to provide high quality health care to patients, and many regulations contribute to that

effort. However, in today's tight job market and challenging financial environment, efforts to reform the flow of work and improve the system of health care delivery are sorely needed.

The forces shaping and assaulting the American health care system require leadership, vision and investment beyond the scope of many individual hospitals and providers, and are often at odds with the investment objectives of shareholder-based organizations. Not-for-profit hospitals, with their long histories and community ties, are in the health care business for the long haul. Multi-hospital health care systems are in a unique position to leverage resources across communities and facilities to enable each member of the system to survive, and thrive, in good and bad times. Only depth and access to resources will enable the health care system to reinvest and restructure to meet the challenges ahead and continue to be effective agents of change to educate physicians and communities so they can embrace the opportunities modern medicine presents. The next section of this report describes some of the fundamental differences between not-for-profit and for-profit health care organizations and how those differences impact the communities they serve.

RETURN ON INVESTMENT vs. RETURN TO COMMUNITY

The factors that differentiate non-profit community health care organizations are vast. The importance of those factors to Californian's health care is immeasurable. Mission, motive, and ownership molds every aspect of an organization, from scope of services to access and community service. The most obvious major difference is ownership: not-for-profit organizations do not own their assets. Rather they, and their boards of directors, hold assets "in trust" on behalf of the public, for the purposes set forth in their articles of incorporation.⁵⁵ Revenues generated by not-for-profit organizations, and the programs they operate, must support a stated charitable purpose and mission. For-profit organizations are free to return profits to shareholders, whether they are private individuals or corporations. For-profit companies are founded and owned by investors who buy stock in that corporation as a means of making money. Such a hospital is accountable to owners and has as a primary purpose to return investments to the stockholder owners. Both investor-controlled and not-for-profit organizations strive to earn more than they spend in order to fulfill their missions, and all successful hospitals have money left over after expenses are paid to maintain adequate reserves and to finance needed capital expenditures. The difference is that not-for-profits invest excess revenues in the facilities and services that further their mission, improving facilities and programs, offering new programs to meet community need, paying off debts and caring for people with limited health care coverage or no means. As stated by the National Center for Not-For-Profit Boards,

The idea of the not-for-profit sector may be abstract and poorly understood, but the sector's role in our society is tangible and easily recognized. Freed from the profit motive that dominates business and from the constraints of government, the not-for-profit sector serves as a forum for the creation and dissemination of new ideas, an efficient vehicle for delivering social services, and a guardian of our environment, values and heritage.⁵⁶

In health care, the role of the not-for-profit is even more critical than in most other sectors of the economy. It is in community not-for-profits that many essential services are provided and in not-for-profits where many of the most important innovations in health care arose: refinement of the prepaid health care system; the Mayo Clinic's model of comprehensive, leading edge clinical care, the City of Hope's contributions to genetic engineering, and more recently, the emergence of evidence-based clinical care and quality initiatives. The need for aggressive innovation to fully realize the potential of new technology and medical care and to meet the demands of an aging population is perhaps stronger than it has been in the history of modern medicine.

This section of the report describes some of the rules, operations and impacts of not-for-profit community-based health care organizations. A review of these factors clearly illustrates the importance of preserving and protecting these organizations as vital stewards of an accessible and high quality health care delivery system.

The Tax Exemption Guidelines

The promotion of health is considered a charitable purpose, and the IRS has issued specific standards for hospital tax exemption that include:

- 1) Meeting the criteria applicable to all tax exempt 501(c)(3) organizations; these criteria include broad statements such as "operated exclusively for the promotion of social

welfare” and “to demonstrate by objective means that its activities can reasonably be expected to provide some benefit for the community as a whole”,⁵⁷

- 2) A board of directors composed of community representatives;
- 3) Medical staff privileges available to all qualified physicians in the area, consistent with the size and nature of the facility;
- 4) A 24-hour emergency room from which no one requiring emergency care is denied treatment (exceptions recognized for specialty hospitals);
- 5) Provision of charity care to the extent of its financial ability (adjusted for capital replacement and expansion, debt repayment, improvements in patient care and medical training, education and research) and/or participates in or accepts payment from the Medicare and Medicaid programs on a nondiscriminatory basis.

Not-for-profit community hospitals provide a wide range of community benefits, including charity care, payments that fall below cost, plus ensuring the availability of vital services such as emergency, standby physicians, outreach, research, education and other services to serve and improve their communities’ health, and advance health care knowledge.⁹ Furthermore, not-for-profit community hospitals provide numerous social benefits, health improvement and education initiatives, and quality of life benefits to residents of their communities. In 1994 California passed Senate Bill 697 that requires most not-for-profit hospitals to report community benefit activities. In the legislation, the Senate stated:

Private not-for-profit hospitals meet certain needs of their communities through the provision of essential health care and other services. Public recognition of their unique status has lead to favorable tax treatment by the government. In exchange, not-for-profit hospitals assume a social obligation to provide community benefits in the public interest.⁵⁸

Community benefit activities span a broad range of direct medical care as well as services and initiatives focused on education, research and health improvement. Dozens of health vans, such as Lucile Packard Children’s Hospital’s Mommy Van and Hanford Community Medical Center’s mobile clinics, plus other school-based and hospital-based programs provide thousands of vaccines, screenings, and other health services to migrant workers, poor and uninsured children, and other vulnerable populations. The 1998 OSHPD Report to the Legislature on Community Benefit identified more than \$823 million in charity care and government program shortfalls in 1995-1996, a figure that rose to more than \$1 billion in 1999-2000. The estimates do not include any of the other community benefits provided by the 205 reporting hospitals nor the services provided by the 60 other not-for-profit hospitals that were not required to submit reports.

SB679, the California Community Benefit reporting legislation, defined community benefit categories as:

- 1) Medical care services;
- 2) Benefits for vulnerable populations;

⁹ Kaiser hospitals are tax exempt entities operated for the primary benefit of members of Kaiser Foundation Health Plan. Their role in providing access to underinsured and uninsured Californians has been limited since they do not provide open access to all services to non-members. Kaiser has undertaken a number of targeted initiatives to meet their community benefit obligations.

- 3) Benefits to the broader community;
- 4) Health research, education and training; and
- 5) Non-quantifiable benefits, including sole community provider status; training for allied health personnel; major employer and participant in community development programs; and hospitals that provide assistance and back-up to community-based health care organizations.⁵⁹

OSHPD reports the following number of citations by type of benefit provided from the first set of SB679 reports submitted in 1998:

COMMUNITY BENEFITS MOST FREQUENTLY CITED IN HOSPITAL SB697 PLANS

BENEFITS	# HOSPITALS	BENEFITS	# HOSPITALS
<u>Community Health Education</u> Classes such as parenting education, labor and delivery, smoking cessation, fitness, CPR and other educational programs.	135	<u>Clinical Service Training</u> Nursing programs, graduate medical education & continuing professional education.	74
<u>Charity Care</u>	128	<u>Volunteers</u>	50
<u>Counseling & Support Groups</u> Support groups for cancer patients and various other individuals.	117	<u>Day Care</u>	50
<u>Health Information Resources</u> Health fairs, community resource directories and helplines.	116	<u>Medical Research</u>	44
<u>Access to Care</u> Transportation and home health services.	114	<u>Medicare Shortfalls</u>	44
<u>Health Screenings</u> Mammogram, blood pressure & other health screenings.	114	<u>Community Building Activities</u>	39
<u>Hospital Donations</u> Donations of money, food, clothing, employee expertise and other contributions.	108	<u>Skills Training Programs</u>	34
<u>Medi-Cal Shortfalls</u>	104	<u>Prenatal Care</u>	32
<u>Link to Schools</u> Mentoring and career development and other support.	101	<u>Social Activities</u>	27
<u>Immunizations</u>	87	<u>Dental Care</u>	23

Source: Report to the Legislature Not-for-Profit Hospital Community Benefit Legislation (Senate Bill 697) 1/98

Most economists and health policy organizations define hospitals' unreimbursed care provided to the medically indigent and uninsured to be a combination of bad debt and charity care. From an accounting perspective, bad debt consists of services for which hospitals anticipated but did not receive payment. There is no formal definition of charity care, however, charity care is commonly referred to as services for which the provider does not expect, and does not receive payment because the patient's inability to pay has been pre-determined. Many hospitals use a formal process to determine who can pay. Some *uncompensated* care as used by the state is

comprised of both charity care and bad debts, whereas *underpayments* are governmental payer shortfalls, private payer discounts, other services for which partial or no payment is received. Uncompensated care and underpayment losses as a percentage of hospitals' total operating expenses nationally have risen from less than 4% in 1990 to nearly 6% in 2000, a 50% increase.⁶⁰ OSHPD estimates that in 1995-96 the total value of *charity care* and *government program shortfalls* in California, only two of the defined community benefit programs, was \$823 million for reporting hospitals. This estimate does not include any of the other benefits provided by the 205 hospitals subject to the reporting legislation nor does it include bad debts.⁶¹ We believe there is a practical if not symbolic difference in charity care and bad debt since there are financial reporting and performance implications to aggressive classification of bad debts. The pre-determined nature of charity care and one's inability to pay assumes a definitive process to facilitate access to charitable services.

A review of 1999 OSHPD data on the charity care and community benefit contributions of not-for-profit community illustrates the scope of their charitable benefits. These indicators of direct community benefit services illustrate the commitment of the state's not-for-profit community hospitals to their missions and communities, as well as their central role in providing access to underserved populations:

**SELECTED FINANCIAL MEASURES OF COMMUNITY BENEFIT
BY TYPE OF HOSPITAL CONTROL-1999**

INDICATOR	TYPE OF CONTROL				
	NOT-FOR-PROFIT COMMUNITY	KAISER NOT-FOR-PROFIT	DISTRICT	INVESTOR	GOVERNMENT
Taxes and Fees					
Total	\$680,146	\$ 0	\$ 0	\$29,518,847	\$ 0
Per Facility (total)	\$3,050	\$ 0	\$ 0	\$206,426	\$ 0
Per Licensed Bed (total)	\$13	\$ 0	\$ 0	\$1,544	\$ 0
Per Patient Day (total)	\$ 0.07	\$ 0	\$ 0	\$9	\$ 0
Per Discharge (total)	\$0.36	\$ 0	\$ 0	\$ 49	\$ 0
Charity Care Charges					
Total	\$645,900,622	\$ 0	\$25,138,225	\$ 207,310,753	\$ 62,659,611
Per Facility	\$2,896,415	\$ 0	\$534,856	\$1,449,726	\$2,160,676
Per Bed	\$12,465	\$ 0	\$4,602	\$10,840	\$7,581
Per Patient Day	\$63	\$ 0	\$20	\$61	\$40
Per Discharge	\$338	\$ 0	\$136	\$346	\$256
Research and Education					
Total	\$460,263,340	\$10,585,805	\$9,559	\$14,999,944	\$180,248,706
Per Facility (total)	\$2,063,961	\$378,064	\$203	\$104,895	\$6,215,473
Per Licensed Bed (total)	\$8,882	\$1,508	\$2	\$784	\$21,809
Per Patient Day (total)	\$45	\$8	\$0	\$4	\$116
Per Discharge (total)	\$241	\$33	\$0	\$25	\$735
County Indigent Deductions					
Total	\$795,867,851	\$ 0	\$27,773,806	\$143,912,752	\$1,885,360,107
Per Facility	\$3,568,914	\$ 0	\$590,932	\$1,006,383	\$65,012,417
Per Bed	\$15,359	\$ 0	\$5,085	\$7,525	\$228,114
Per Patient Day	\$78	\$ 0	\$23	\$42	\$1,209
Per Discharge	\$417	\$ 0	\$150	\$240	\$7,688

Source: OSHPD Annual Financial Disclosure Reports for California hospitals excluding PHF, Shriners, CDRH, and state and federal facilities, PHFs, CDRHs, and Shriners Hospitals. "Value" refers to the un-reimbursed charges in services rendered. Charity care is defined by OSHPD as the difference between gross patient revenue and the amount paid for patients who are unable to pay for all or part of their services. County indigent refers to indigent patients covered under Welfare Institution Code 17000, i.e.; all patients for whom a county is financially responsible.

Note: Charity care gross revenue is defined by OSHPD as the difference between gross charges and amount paid.

In addition to these expense categories, the following statistics show the importance of not-for-profit community hospitals as a provider to the poor and underserved:

**SELECTED COMMUNITY BENEFIT SERVICES
BY TYPE OF HOSPITAL CONTROL-1999
PERCENT OF CALIFORNIA TOTALS**

INDICATOR	TYPE OF CONTROL				
	NOT-FOR-PROFIT COMMUNITY	KAISER NOT-FOR-PROFIT	DISTRICT	INVESTOR	GOVERNMENT
Facilities	48%	6%	10%	30%	6%
Beds	57%	8%	6%	21%	9%
Medi-Cal Discharges	54%	.03%	6%	21%	19%
Medi-Cal Outpatient Visits	57%	0%	8%	9%	26%
County Indigent Discharges	26%	.2%	1%	5%	67%
County Indigent Outpatient Visits	18%	0%	1%	2%	79%

Excludes PHF, Shriners, CDRH, state and federal hospitals.

Not-for-profit community hospitals provide significantly more services to the low income and indigent population than any other type of hospital, including more than twice the number of Medi-Cal discharges and outpatient visits than publicly-owned facilities. These data demonstrate their commitment to access for their communities and their vital role in California's health care infrastructure.

Scope Of Services: Not-For-Profits Carry The Burden

The crisis in health care impacts services fundamental to the infrastructure of the health care system and basic needs of the population. In California, 12% (50) of hospital emergency departments have closed since 1990. Hospitals lost an estimated \$46 per emergency visit, or \$317 million in 1999.⁶² While not-for-profit hospitals represent 48% of the state's facilities, they cared for 53% of emergency visits. More than 40% of California's emergency patients are either uninsured or Medi-Cal, and emergency departments are often the only providers willing to treat them in a timely basis. Not-for-profit community hospitals are not only *required* by law to maintain emergency departments, statistics demonstrate their pivotal role in assuring availability of care throughout California. Many not-for-profit community hospitals have developed programs to complement their emergency departments to further address access issues and enable indigent persons to receive more appropriate and timely primary care services. Hospital-supported programs such as the Marin Community Clinic and Sutter Davis Community Clinic provide basic primary and urgent care to uninsured and Medi-Cal patients in areas where access to primary and preventive health services is limited in the private sector.

An analysis of major hospital services by type of control illustrates the crucial role of not-for-profits in the basic fiber of the California health care system. Many of these services generate revenues at or even far below cost levels, yet few not-for-profit systems would consider elimination or reductions in levels of care.

**SELECTED HOSPITAL SERVICES BY TYPE OF CONTROL-1999
PERCENT OF STATEWIDE VOLUME**

INDICATOR	TYPE OF CONTROL				
	NOT-FOR-PROFIT COMMUNITY	KAISER NOT- FOR-PROFIT	DISTRICT	INVESTOR	GOVERNMENT
ALL HOSPITALS	48%	6%	10%	30%	6%
Emergency Visits	53%	15%	7%	14%	11%
Basic Emergency Departments	59%	8%	8%	21%	5%
Designated Trauma Centers	69%	0%	2%	10%	19%
Births	58%	12%	6%	18%	6%
Low Birthweight Infants	61%	11%	5%	15%	8%
Neonatal Intensive Care Days	67%	10%	2%	12%	10%
All Pediatric Cases	64%	12%	4%	11%	9%
Pediatric Heart Surgery	99%	1%	0%	0%	0%
ICU/CCU Days	63%	8%	4%	17%	8%
Burn Days	65%	0%	0%	6%	29%
Surgery Cases	62%	11%	5%	17%	5%
Adult Heart Surgery	72%	10%	4%	13%	2%
Adult Caths	73%	6%	6%	14%	2%
Rehabilitation Days	52%	3%	1%	30%	14%
Psychiatric Days	45%	1%	2%	35%	17%
AIDS/HIV Patients	73%	0%	2%	18%	7%
Alzheimer's Patients	75%	0%	7%	17%	0%

Source: 1999 OSHPD Annual Report of Hospitals. Excludes PHFs, CDRHs, and Shriners Hospitals.

These data, combined with previously cited financial data, provide strong evidence that the commitments of community not-for-profit hospitals to community benefit far outweigh the cost of their favorable tax treatment. Furthermore, research has shown that charity care often declines when not-for-profit hospitals convert to investor-controlled status.⁶³ Struggling hospitals often need partners to remain viable, and not-for-profit hospital systems provide that opportunity. Studies have found that "system membership is positively and significantly associated with the provision of charitable care, suggesting that multi-hospital systems do cross-subsidize among member hospitals. Larger hospitals and those in better financial condition, also provide more charitable care".⁶⁴ The structure of a multi-hospital system enables at least a portion of the system's assets and revenues to be directed throughout the system according to need, which frequently fluctuates from year to year. Sutter Health facilities provide an example of one system's ability to support its affiliates through good times and bad, and illustrate the size and regional diversity that a large system can support. Over the five-year period from 1995-1999, 11 of Sutter Health's 24 California hospitals had at least one unprofitable year, yet all have maintained vital community services and continued to invest in their facilities and programs. Not-for-profit systems also can deliver cost savings and operating efficiencies to their individual hospital members through joint purchasing, lower financing costs, and shared services. However, their greatest value may be their ability to disseminate best clinical practices and standards of care across multiple communities and facilities. The last section of this report highlights several examples of programs supported by not-for-profit community hospitals that are changing standards of care and improving clinical practice through comprehensive efforts across multiple providers.

Leveraging a system's resources has enabled many hospitals to provide free and low cost health screenings and vaccination programs as well as education and direct services to their communities and providers as part of their charitable purpose. Not-for-profit health systems are California's leaders in assuring high quality, accessible services to all segments of society.

Value of Tax Exemption to Community Hospitals

In an exceptionally challenging financial environment, perhaps the most significant *advantage* of the not-for-profit model for health care to hospital and health care systems is access to tax exempt financing. Interest rates for tax exempt bonds are often half that of taxable bonds, a factor that can make the difference in a low margin hospital's ability to rebuild itself and meet regulatory and quality standards. Larger health care organizations can access even lower rates of interest than independent facilities due to their ability to leverage more assets and pool resources. Kaiser recently announced a major refinancing following a half percent cut in interest rates that will result in annual savings of millions of dollars. The Kaiser system, which has introduced some of the most innovative systems for managing care plans to spend more than \$1 billion for information technology over the next few years, an illustration of the massive investments needed to incorporate technology into health care in the next decade.⁶⁵

Only for-profit hospitals have access to the equity market, a financing source unavailable to the not-for-profit sector. The availability of tax-exempt financing for not-for-profit entities is crucial for access to needed capital at reasonable rates. Standard & Poor's has stated, "Access to capital for California hospitals will continue to be difficult. Those hospitals which can access the market will likely do so, on an un-enhanced basis, as the majority of bond insurers have chosen to severely limit their insurance of California hospital bonds."⁶⁶

Tax exemption provides many not-for-profit hospitals access to debt financing that would not be available in the commercial market. The value of community benefits provided by California's not-for-profit community hospitals demonstrates the value to the state of their commitment to a not-for-profit mission. There should be little question of the value of not-for-profit health care organizations in assuring Californian's access to quality health care and the importance of maintaining access to tax exempt financing so that not-for-profits continue to maintain the state's health care delivery system infrastructure.

Access to tax exempt capital will be crucial to meeting many of the regulatory and technology challenges of the coming decades. The troubled health care environment is impacting interest rates charged to all health care organizations, especially not-for-profits. Both Moody's and Standard and Poor's report continuing deterioration of credit ratings among not-for-profit hospitals due to the financial uncertainties introduced by the Balanced Budget Act, the nursing shortage, rising supply and pharmaceutical costs and managed care revenue pressures.⁶⁷ These threats make it difficult for not-for-profits to go to the bond market without strong credit ratings, which require financial stability. As stated in a recent Standard & Poor's report on California's hospitals:

California's hospitals and health systems are suffering from the same financial woes affecting the rest of the health care sector, resulting in deteriorating credit quality and more limited access to capital. In addition, the nation's most populous state has some unique features affecting the health care sector, which compound an already extremely challenging health care environment.

Credit deterioration of California hospitals and health systems is linked not only to reimbursement pressures, staffing shortages, and problems with integrated delivery systems that plague the industry as a whole, but also to state-specific issues, such as pronounced labor union activity and very high managed care penetration. In addition, more than 100 California-based physician groups have declared bankruptcy over the past three years. Further, significant capital needs associated with seismic regulations – estimated as high as \$10 billion over the next 8 to 13 years – will most likely strain the balance sheets of most California hospitals and health systems.

While some positive factors, such as recent rate increases in managed care contracts and the shift from capitated to fee-for-service reimbursement, may contribute to stabilization over the medium term, capital needs will likely pose longer term credit pressure in the California market for all but the strongest organizations. As a result of these negative factors, credit deterioration, and weakened income statement performance for hospital and health care systems in California has been pervasive and more extreme than for the industry as a whole. Recently, rating downgrades of California hospitals have outpaced rating upgrades at a higher level than the national ratio. Nationally, downgrades exceeded upgrades by 5 to 1 in 1999. In 1999, there were eight California hospital and health system downgrades with no upgrades. This year, the trend has continued in California, with 10 downgrades to date and no upgrades. Some of the more notable downgrades in California in the last two years have included Catholic Healthcare West, Kaiser, St. Joseph Health System, and Memorial Health Services. In addition, 30% of ratings in California currently carry a negative outlook or are on Credit Watch with negative implications, whereas nationwide only 16% of credits have a negative outlook or are on Credit Watch.⁶⁸

California hospitals face major challenges just to maintain adequate care in conforming facilities, much less continue their role as leaders of innovation and stewards of access. The role of not-for-profit systems as an effective model for meeting these challenges is particularly crucial in times such as these.

How A Not-For-Profit System Allocates Resources

Not-for-profit community hospital systems provide an effective means to enhance the stability and quality of multiple hospitals and health care programs. The governance, policies and procedures of Sutter Health serve as an example of the commitment not-for-profit hospitals and health systems have for their communities, as well as the process whereby resources are directed to ensure the survival of hospitals in each of their communities. During the past two decades, the growth of managed care drove many hospitals to join together to seek efficiencies in operations and to meet the challenges of a rapidly consolidating and highly competitive health insurance market. In the 1980s the Sacramento Sutter system began to seek affiliated hospitals, with a focus on "smaller, floundering facilities that, save the support of a larger system, might go under, leaving their communities bereft of needed medical services".⁶⁹ A number of community and even government hospitals survive today, many with new or expanded facilities, due to affiliations with larger systems such as Sutter, Adventist Health System West, Sharp Healthcare, and the various Catholic health care systems. Over the past ten years Sutter Health, like many of its not-for-profit health system counterparts in California, has replaced seven of its hospitals and invested hundreds of millions of dollars to upgrade emergency and other vital hospital facilities, and to maintain community resources. In an era with few health plans and high costs, developing systems across which assets and negotiations with vendors and health plans can be leveraged is crucial to survival for many health care providers. Van Johnson, CEO of Sutter Health, noted in a 1999 interview with *California*

Medicine, "There was never a grand design for Sutter to become Northern California's major system. The metamorphosis wasn't for power; it wasn't for ego; it was to fund our mission of helping preserve health care organizations in their communities."⁷⁰

Not-For-Profit Structure and Governance

Not-for-profit systems do not "own" hospitals: the community does. Affiliates become integral parts of a system legal structure and part of an organization that shares mission, values and culture. Most not-for-profit systems have a central board as well as local and regional boards or advisory groups, all comprised of volunteer members representing the communities served. Individual hospital affiliates usually are primarily responsible for their own local organizations, overseeing quality of care, ensuring the hospital is operated for the benefit of the community and developing the operating and capital budgets. Decisions made locally often include: identifying and planning for local health care needs, making patient care staffing decisions, medical staff issues, and negotiating labor contracts with unions representing the hospital's employees. Revenues of local entities first are used to cover expenses and meet on-going commitments. Centralized operations include finance, legal, insurance, contracting, risk management and numerous quality and clinical improvement initiatives.

Income in excess of the cost of operations is needed to keep pace with increasingly expensive advances in health care, to create new patient care services, to rebuild, replace and improve facilities, and to maintain community benefit programs. For the past three years, few of the state's hospitals and major health systems had combined positive net incomes and those that did were well below levels required to enable full funding of the investments needed to fully address seismic, technology and replacement needs. For many systems, recent earnings in excess of expenses have derived largely from endowment and reserves, not operations. Expenditures for community benefit activities are frequently a major component of a system's expenses. At Sutter Health in 2000, community benefit expenditures were \$305 million or 9% of operating expenses, a 40% increase over 1999.

Not-for-profit systems provide many community hospitals with a mechanism to reduce costs of operations and the cost of capital financing. The "obligated group" is a legal structure that allows affiliated organizations to act as a single entity for borrowing and credit purposes, and to operate with a shared balance sheet. This enables the cost of debt to be spread across multiple facilities at rates much more favorable than those available to individual institutions. Furthermore, group purchasing programs enable small facilities with fewer than 100 beds to purchase equipment and supplies at costs similar to those of 500-bed affiliates. In summary, the benefits of not-for-profit multi-hospital systems are multi-dimensional, enabling efficient operations, timely and less costly investments in facilities and equipment, and maintenance of comprehensive programs that support each hospital's ability to address local needs. In addition, not-for-profit health systems are at the forefront of advancing and disseminating knowledge and technology to physicians and communities, serving as leaders and change agents for health care innovation.

Not-For-Profits as Innovators

The American health care system has the opportunity to advance health status through investments in delivery system innovations and outcomes research, some of the hallmarks of not-for-profit community hospitals. Despite the highest per capita costs of care, morbidity and mortality in the U.S. fall far behind much of the developed world. Ensuring access to advanced care and disseminating proven standards of care and clinical innovations are critical to the future health status of Americans. The Institute of Medicine's report on quality states:

Yet there remains a dearth of clinical programs with the infrastructure required to provide the full complement of services needed by people with heart disease, diabetes, asthma, and other common chronic conditions (Wagner, et al., 1996). The fact that more than 40 percent of people with chronic conditions have more than one such condition argues strongly for more sophisticated mechanisms to communicate and coordinate care (The Robert Wood Johnson Foundation, 1996). Yet physician groups, hospitals, and other health care organizations operate as silos, often providing care without the benefit of complete information about the patient's condition, medical history, services provided in other settings, or medications prescribed by other clinicians.⁷¹

California's not-for-profit community hospitals spent more than \$460 million on research and education in 1999, 69% of all California hospitals. Even when the eight university not-for-profit hospitals are excluded, this sector spent \$309 million. The importance of these research and education investments to past and future generations can not be underestimated.

Most of the leading not-for-profit health systems invest substantial resources in quality initiatives and outcomes research. Sharp Healthcare's work on clinical protocols for hip replacements, Catholic Healthcare West's and Sutter Health's heart programs, and projects such as those highlighted below are improving clinical care and disseminating best practices across multiple communities.

The missions of commitment and the ability of not-for-profit health care systems to invest in the development of a more effective health care system, is illustrated by the following initiatives of several organizations.

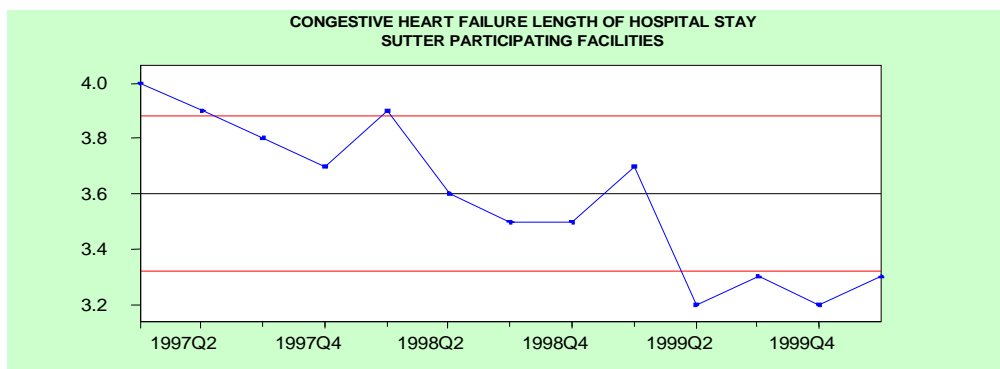
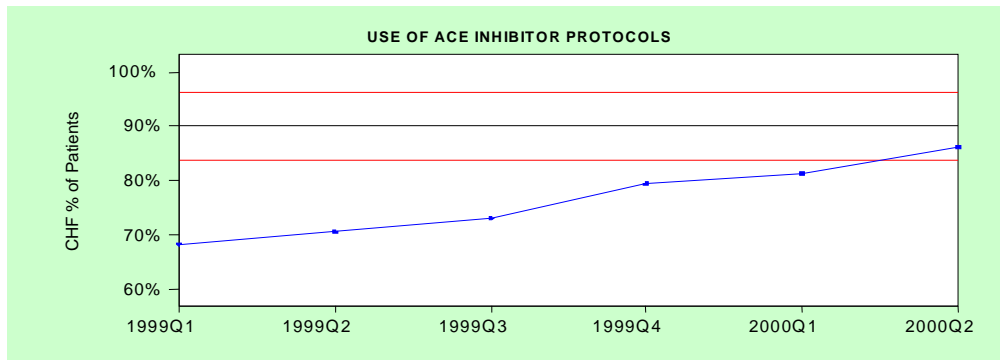
Advancing Quality and Outcomes

Congestive heart failure is a significant problem nationwide accounting for more hospitalizations than any other single disease process. Appropriate care for these patients requires the integration of inpatient and outpatient services, the correct use of medications, and effective patient education. The Sutter Health Congestive Heart Failure (CHF) initiative began in 1998, with the goal to focus resources on improvements in CHF patient management through the implementation of proven guidelines, standard processes, and the use of accurate, clinically relevant data and management to drive change. Dissemination of the program throughout the Sutter Health network of facilities and more than 5,000 affiliated physicians began in 1999.

Work on the CHF initiative began with a task force of physicians and health care experts from throughout the system who analyzed research and defined care maps to improve the consistency and quality of medical care outcomes. Medication dosages, timing and follow up protocols were developed, based on research that showed reduced costs and improved health. Based on the principles of evidence-based medicine, the initiative focuses on improving the

quality of care and outcomes for CHF patients in the communities served by affiliated hospitals and physicians.

Best practice guidelines were disseminated throughout the system, with continuing medical education sessions and local physician organizations and individuals designated to assist in implementation. Specific guidelines for use of ACE inhibitors and the implementation of preprinted order sets were used, with goals of increasing their use and producing measurable outcomes of use, lower length of stay for CHF and lower readmission rates. The results indicate the powerful impact a system can have on influencing medical practice. These impacts save lives and money by advancing the use of proven medical protocols.



Adventist Health System West is another system leveraging its resources to raise the standards of care in multiple communities through its Clinical Improvement Projects (CIP). Since 1995, Adventist Health System West hospitals and affiliated physicians studied surgical wounds throughout the system with a goal of reducing the number and severity of wound infections. Outcomes of various techniques were analyzed to determine best practices and define care maps that were then disseminated throughout the system. Positive reductions in infections have been demonstrated across the hospitals and communities served by this system. Additional CIP studies have been conducted for falls, diabetes, and administration of intravenous medications.

Clinical initiatives such as these take sustained investment of resources as well as an infrastructure for dissemination, monitoring and refinement. They also raise the awareness and expectations of communities to levels that reflect the best available knowledge and use of health care resources. With the stresses hospitals and physicians face in today's environment,

the ability of any one hospital or group of physicians to effect change is limited. Not-for-profit health care systems are taking the lead to ensure such efforts continue.

Technology Innovation

The Institute of Medicine report on quality highlighted the need to integrate information technology with health care if the promise of 21st century medicine is to be realized. Many not-for-profit providers are focusing on the development of systems that employ internet technology to increase knowledge and improve access to health care providers. One such example is E-Health On-Line, a system being piloted by Palo Alto Medical Foundation (PAMF), to improve patient care and access to health information. Patients will have the ability to remotely view their personal health records, including information on medications, allergies, immunizations and reminder notices after signing up for the service and establishing a unique ID and password. Appointments, refill requests and administrative services can be accessed on-line, as can medical advice.

PAMF is also implementing a comprehensive electronic medical records (EMR) system that promises patient access and more efficient documentation and follow-up. Dr. Paul Tang, director of the project states, "The EMR provides physicians with instant access to patient information from the Clinic, hospital or home. Built-in decision support helps physicians make optimal decisions and reduces the risk of medication errors. It also facilitates consultations between primary care physicians and specialists." In the future, some clinical encounters that currently occur face-to-face may be conducted remotely. Innovations such as these are beyond the reach of most physician groups or individual hospitals, and many technology initiatives have been abandoned by for-profit companies as too costly or with too limited a potential for return-on-investment. Not-for-profit systems can provide the resources for development, research, and investment that will help to realize the promise of information technology to improve health care.

Basic and Clinical Research

Not-for-profit health care organizations' contributions to basic research provide further evidence of the value of their mission to society. Over the five year period (1995 – 1999), these hospitals reported expenditures of more than \$672 million for research, including \$163 million in 1999 alone. Research institutes at California's not-for-profit medical centers, such as Scripps, City of Hope, California Pacific, Cedars-Sinai, and Memorial of Long Beach have contributed knowledge and discoveries that advanced the treatment of bone marrow transplantation, breast cancer, heart surgery, and other severe and chronic diseases. Philanthropic and organizational support for these initiatives is strong endorsement for the role of mission and the not-for-profit sector's commitment to advancing health status and delivering community benefit.

Research efforts of not-for-profits have parlayed grants, philanthropy, and community service commitments into major discoveries that have served communities, influenced national policy, advanced best practices in medicine and developed systems for improved dissemination of information and management of disease. Protecting and enhancing the financial health of these institutions protects a vital part of the country's health care infrastructure and ensures the survival of a major resource to advance knowledge and disseminate best practices throughout the health care delivery system.

SUMMARY

Not-for-profit hospitals and health care organizations are held to a higher standard of community accountability than other types of organizations. California's not-for-profit community hospitals and health systems demonstrate the vital importance of mission to the maintenance and improvement of the health care delivery system. Their commitment to caring, improving, and protecting health care is demonstrated in innumerable ways, from caring for disproportionate numbers of children, premature infants, and victims of tragedies that require trauma centers, burn centers and intensive care, and to providing long-term rehabilitation and treatment for devastating diseases such as HIV and Alzheimer's. Their research efforts to discover better systems and therapies for treating and curing disease, and continual initiatives to improve the delivery system directly flow from enduring commitment to their not-for-profit missions.

These critical health care providers face unprecedented threats to continue their legacies and maintain the services so vital to California's health care infrastructure. Keeping community hospitals financially stable is a responsibility shared by government, communities and the businesses that benefit from the services they offer. Maintaining access to tax exempt financing, working toward adequate reimbursement rates and addressing regulatory burdens are critical to the survival of these essential providers of care. At a time of constant economic and regulatory turbulence, providing leadership and direction to invest the necessary resources and capital for facilities, equipment, and personnel, and to continue advancing research and innovation is invaluable to a society that expects the best from its health care system.

Rising to the challenge of the Institute of Medicine's report on quality will require intense and sustained efforts. Those efforts will depend on the stability and financial health of the not-for-profit community hospitals and health care systems whose missions support our communities and whose research and innovation will advance quality and ensure access. The financial investments of not-for-profit hospitals in community services and California's health care delivery system infrastructure serve as tangible evidence of the importance of mission. Protecting the financial health and survival of not-for-profit hospitals is essential to ensuring Californians' access to the quality of health care the 21st century promises.

-
- ¹ “Crossing the Quality Chasm: A New Health System for the 21st Century”, *Institute of Medicine*, March 1, 2001
- ² *aha.org/resource*
- ³ “Trends and Indicators in the Changing Health Care Marketplace”, L. Levitt, J. Lundy, *The Henry J. Kaiser Family Foundation*, 8/98
- ⁴ *ibid*
- ⁵ “2000 HMO Survey” and “2001 HMO Survey”, *Cattaneo & Stroud, Inc.*
- ⁶ “The State of Health Insurance in California: Recent Trends, Future Prospects” *UCLA: Center for Policy Research*, March 2001
- ⁷ “Crossing the Quality Chasm: A New Health System for the 21st Century”, *Institute of Medicine*, March 1, 2001
- ⁸ “Natural Selection. Weaker Hospitals Find Today’s Climate a Jungle”, Deanna Bellandi, *Modern Healthcare* 2/7/00
- ⁹ *ibid*
- ¹⁰ “CHA Special Report: California Hospitals Continue to Face Financial Pressures”, *California Health Association*, 2001
- ¹¹ “California Employers Health Benefits Survey – 2000” *Kaiser/HRET 2000 California Employer Health Benefits Survey*, 3/01
- ¹² “Bay Area HMOs Increase Profit Margins, CMA Study Finds”, *California Healthline*, 04/19/2001
- ¹³ “Weighed down by debt” At Fitch, analyst Jordan Melick says about a quarter of the downgrades issued by his agency since January 2000 have been primarily because of increasing debt. Fitch lowered ratings on 24 hospital credits during the 18 months ended in June, vs. just one upgrade, *Modern Healthcare*, 9/3/01
- ¹⁴ “Trends and Indicators in the Changing Health Care Marketplace”, L. Levitt, J. Lundy, *The Henry J. Kaiser Family Foundation*, 8/98
- ¹⁵ “Survey 2001”, *Cattaneo & Stroud, Inc.*
- ¹⁶ “A Risky Proposition?: Risk-Bearing and Solvency in California’s Medical Groups”, *California Health Policy Roundtable-Policy Brief*, 2/00
- ¹⁷ “Robert Pearl’s Thoughts on “Who Will Pay for Healthcare?”, *The Society of Professionals In Healthcare*, Vol. 6, Issue 2, 2001
- ¹⁸ “California Employers Health Benefits Survey – 2000” *Kaiser/HRET 2000 California Employer Health Benefits Survey*, 3/01
- ¹⁹ “Health Care Employers Continue to Struggle to Attract and Detain Registered Nurses”, *Mercer US Resources Center, News Release*, 1/3/01
- ²⁰ “Nurse Shortage-2000-2001 State Budget – Proposed Appropriation: Nurse Education Funding”, *California Healthcare Association*, 4/4/01
- ²¹ “Critical Nurse Shortage-California Hospitals Facing New Nurse-Staffing Ratios”, D. Harms, *Spectrum-Society for Healthcare Strategy and Market Development*, Jan/Feb 2000
- ²² “Nursing Shortage-A Critical Hospital Issue”, K. Robertson, *Sacramento Business Journal* 8/25/00
- ²³ “Demand for respiratory therapists exceeds supply at nation’s hospitals”, *AHA News*, 3/5/01
- ²⁴ *AHA News*, 3/12/01
- ²⁵ “Cain Brothers Hospitals to Housing”, Oct. 6, 2000
- ²⁶ “Minimum nurse staffing requirements could cost California hospitals between \$200,000 to \$2.3 million annually”, *Public Policy Institute in California*, July 27, 2001
- ²⁷ “U.S. Salaries Continue to Vary Significantly by Geography”, *Mercer US Resources Center: News Release*, 2/4/00
- ²⁸ “Geographical Pay Patterns Continue in the US”, *Mercer US Resources Center: News Release*, 3/21/01
- ²⁹ “The State of Health Insurance in California: Recent Trends, Future Prospects”, E. Browning, PhD, N. Ponce, PhD, T. Rice, PhD, *UCLA Center for Health Policy Research*, 3/10
- ³⁰ “Uncompensated Care Cost , Percentage Grow”, *AHA News*, January 29, 2001
- ³¹ “California Healthcare Association Statement on the Analysis of Charity Care Provided by San Francisco’s Non-Profit and Public Hospitals”, 8/00
- ³² “Prescription Drug Use and Expenditures in California”, *California HealthCare Foundation*, April 2001
- ³³ “Towers Perrin Health Care Cost Survey”, *Towers Perrin*, New York, NY, January 29, 2001
- ³⁴ “Not so golden now”, *Modern Healthcare*, August 6, 2001

-
- ³⁵ “Putting Medicare in Context: How Does the Balanced Budget Act Affect Hospitals?”, S. Guterman, *Health Policy Center-The Urban Institute*, July 2001
- ³⁶ “Statement of the American Hospital Association Before the Department of Health and Human Services Blood Safety and Availability Advisory Committee”, A.J. Marenzo-Rowe, M.D., 4/26/00
- ³⁷ “Putting Medicare in Context: How Does the Balanced Budget Act Affect Hospitals?”, S. Guterman, *Health Policy Center-The Urban Institute*, July 2001
- ³⁸ “California Healthcare Association Statement on the Analysis of Charity Care Provided by San Francisco’s Non-Profit and Public Hospitals”, 8/00
- ³⁹ “Health Care Trends and Indicators in California and the United States”, *Kaiser Family Foundation*, June 2000
- ⁴⁰ “California Healthcare Association Statement on the Health Care Scene in California; California Business Roundtable”, *California HealthCare Association*, May 23, 2001
- ⁴¹ “Risk-Bearing Organizations First Quarter of 2001 Financial Reporting Results”, *Department of Managed Care*, October 4, 2001
- ⁴² “Putting Medicare in Context: How Does the Balanced Budget Act Affect Hospitals?”, S. Guterman, *Health Policy Center-The Urban Institute*, July 2001
- ⁴³ “Bush to Put Medical-Data Privacy Rules Into Effect-With Changes”, T. Pugh, *San Jose Mercury News*, 4/13/01
- ⁴⁴ “HIPPA Standards Offer More Accuracy & Eventual Cost Savings”, P. H. Hamby, M. McLaughlin, *Healthcare Financial Management*, 4/01
- ⁴⁵ “California Healthcare Association Statement on the Health Care Scene in California; California Business Roundtable”, *California HealthCare Association*, May 23, 2001
- ⁴⁶ “Democrats Back New Privacy Rules”, E. Lovern, *Modern Healthcare*, 3/26/01
- ⁴⁷ “EMTALA: Reaching Beyond the Emergency Room to Expand Hospital Liability”, B.E. Kamoie, *Journal of Health Law*, Winter 2000
- ⁴⁸ Regional News-West, *Modern Healthcare*, 4/16/01
- ⁴⁹ “OSHPD Releases Summary of Building Evaluations”, *CHA News*, 3/30/01
- ⁵⁰ “Sacramento Hospitals Question Need for Costly Seismic Upgrades”, *California Healthline*, 3/22/01
- ⁵¹ “Summary of Hospital Seismic Performance Ratings”, *OSHPD*, March 2001
- ⁵² “Statement of the American Hospital Association Before the Department of Health and Human Services Blood Safety and Availability Advisory Committee”, A.J. Marenzo-Rowe, M.D., 4/26/00
- ⁵³ “Testimony of the American Hospital Association Before US House of Representatives Ways and Means Subcommittee of Health on Bringing Regulatory Relief to Beneficiaries and Providers”, 3/15/01
- ⁵⁴ *ibid*
- ⁵⁵ “Health Care Alliances and Conversions: A Handbook for Nonprofit Trustees”, J. Schwartz & H. C. Horn, 1999
- ⁵⁶ “What you should know about non-profits”, National Center for Nonprofit Boards, March 28, 2001
- ⁵⁷ “IRS Exempt Organizations CPE Technical Instruction Program for FY1996”, C.F. & T.J. Sullivan
- ⁵⁸ “Not-for-Profit Hospital Community Benefit Legislation”, OSHPD, January 1998
- ⁵⁹ *ibid*
- ⁶⁰ “Annual uncompensated Care Survey”, AHA
- ⁶¹ “Not-for-Profit Hospital Community Benefit Legislation”, OSHPD, January 1998
- ⁶² “California’s Emergency Services: A System In Crisis”, *California Medical Association*, January 2001
- ⁶³ “The For-Profit Conversion of Nonprofit Hospitals in the U.S. Health Care System: Eight Case Studies”, Sara R. Collins; Bradford H. Gray; and Jack Hadley, *The Commonwealth Fund*, May 2001
- ⁶⁴ “The Effect of Chain Membership on Hospital Costs”, Terri J. Menke, June 1997
- ⁶⁵ “Kaiser to refinance after Fed’s rate cut”, *S.F. Chronicle*, April 19, 2001
- ⁶⁶ “California Health Care Facing Near-Term Credit Volatility”, Terry Goode and Lisa Zuckerman, December 7, 2000
- ⁶⁷ “Down in the ratings”, *Modern Healthcare*, April 16, 2001
- ⁶⁸ “California Health Care Facing Near-Term Credit Volatility”, Terry Goode and Lisa Zuckerman, December 7, 2000
- ⁶⁹ “Sizing up Sutter”, *California Medicine*, June/July 1999
- ⁷⁰ *ibid*
- ⁷¹ “Crossing the Quality Chasm: A New Health System for the 21st Century”, *Institute of Medicine*, March 1, 2001

APPENDIX A
NOTES ON HOSPITALS INCLUDED AND EXCLUDED FROM DATA

- 1) Excluded hospitals:
 - § Chemical Dependency Recovery Hospitals
 - § Psychiatric Health Facilities
 - § State and Federal hospitals
 - § Shriners' Hospitals

- 2) Hospitals reported as closed with no reported data include:
 - § Bloss Memorial District
 - § Del Puerto
 - § Friendly Hills Regional
 - § Long Beach Doctors
 - § North Hollywood
 - § Pacifica Hospital
 - § South Bay
 - § Washington – Culver City
 - § Capistrano by the Sea

- 3) A new Watsonville Community Hospital was opened in 1999, and that facility was included in the dataset. The old Watsonville Community Hospital closed, reported no data and was therefore excluded from the dataset.

- 4) OSHPD excluded Crystal Springs Rehabilitation Center from the updated 1999 dataset because it is no longer a licensed hospital.

- 5) The following hospitals were listed twice as partial years in the original dataset from OSHPD. The two listings were added to create a complete year record, which was then included in the dataset.
 - § East Los Angeles Doctor's
 - § Palm Drive
 - § U S Family Care – Montclair

- 6) The following hospitals were listed multiple times in the original dataset from OSHPD. The most complete listing was included in the analysis, and the other listing(s) were excluded when the additions resulted in more than 365 days of operation.
 - § Canyon Ridge
 - § Charter BHS – San Jose
 - § Columbia San Leandro
 - § Good Samaritan – SC
 - § Little Company of Mary
 - § Ross Hospital
 - § San Jose
 - § San Luis Rey
 - § San Pedro Peninsula
 - § Selma District
 - § Summit
 - § UCSF
 - § Villa View Community

- 7) The following hospitals were excluded because of their size and the large number of skilled nursing beds and days reported in proportion to acute beds and days:
 - § Hebrew Home for the Aged Disabled
 - § Laguna Honda & Rehab Center
 - § San Diego County Psychiatric