ADVISORY COMMISSION ON HOSPITALS

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NEW JERSEY DEPARTMENT of HEALTH and SENIOR SERVICES

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REPORT OF THE ADVISORY COMMISSION ON HOSPITALS

EXECUTIVE SUMMARY

On any given day, one out of every three staffed acute care hospital beds in New Jersey is empty. The health care system's success in creating alternative preventive and ambulatory care services is a major reason for empty beds. If current trends continue through 2002, that figure could rise to one out of every two beds. The cost of this excess capacity, which could be as much as $1 billion annually, puts New Jersey hospitals at a staggering competitive disadvantage in today's healthcare marketplace. High length of stay and staffing levels, among other factors, have contributed to the inability of New Jersey hospitals to cover costs with available revenues.

In addition to having eliminated the need for many acute care beds as well as changing hospital missions, a number of external factors are also reducing revenues available to New Jersey hospitals for remaining capacity. Reductions in Medicare reimbursement, some already in effect, others yet to be implemented, will reduce annual revenues by an estimated $515 million by 2002 to this $10.5 billion industry. Managed care, which is an increasingly popular insurance option for New Jersey employers, is also exerting downward pressure on revenues by seeking to eliminate unnecessary hospital days and services through utilization review. The insolvencies of two managed care organizations further reduced revenues to hospitals during 1998. The state's Medicaid

program has turned to managed care as well, in an attempt to provide quality care at reasonable prices.

Further exacerbating the situation is the increasing number of New Jersey residents without health care insurance. As a result, the amount of charity care provided by New Jersey hospitals and physicians has also increased. Although state subsidies have helped offset these rising costs, the growth of care for the indigent has put more financial pressure on the state's hospitals.

The cumulative effect of these trends is a hospital industry with rapidly deteriorating financial performance. By 1998, the median profit margin in the state fell to .55% and 42 out of 84 hospitals had negative profit margins. Other financial indicators, notably cash reserves, had declined as well.

After studying the issues since April 1999, the Advisory Commission on Hospitals has concluded that significant structural changes to the hospital industry in New Jersey are necessary to put the state's hospitals on a sound financial footing. The recommended changes are organized into three areas:

- assistance to hospitals and communities in the transition of hospitals to more efficient organizations providing services in the appropriate physical setting;
- modifications to the state's financial, regulatory, and leadership responsibilities to ensure access to and the quality of health care services in the state; and

– actions to ensure a climate of fair business practices between payers and hospitals.

Those responsible for implementing these changes will include hospital management, boards of trustee, physicians and other health care professionals, the state, payers, managed care companies and the general public.

Assistance to hospitals and communities to appropriately configure the state's health care system should include:

- creation of a Hospital Asset Transformation Program to assist facilities that that are no longer needed nor financially viable as acute care hospitals in transitioning to other uses that the market can support;
- creation of a Hospital Transition Group within the Department of Health and Senior Services (DHSS) that will coordinate state actions to facilitate hospital changes;
- establishment by the DHSS of a quarterly financial monitoring system to identify fiscal problems before they become unmanageable;
- creation of a Post-acute Care Study Group to assess how availability of services and financial incentives hinder efforts to reduce acute care length of stay; and
- education of boards of trustees, health care professionals, and the public of the changing realities of the health care marketplace.

The state's financial, regulatory, and leadership practices should include:

- establishment of a supplemental charity care fund to ensure that all hospitals receive some funding for charity care services provided in excess of a minimum standard;
- more flexible charity care documentation requirements to ensure that eligible patients are appropriately identified;
- establishment of affordable health insurance programs that will reduce the burden of charity care;
- consideration of changes to Medicaid reimbursement, including rebasing to a more current year, establishing a new peer group to recognize facilities serving a disproportionate share of low-income patients, and implementing a periodic interim payment system for Medicaid managed care plans;
- uniting with industry groups to: advocate for changes to Medicare reimbursement cuts where they are excessive (the Balanced Budget Act); maximize revenues to New Jersey hospitals from the federal government (e.g., disproportionate share payments); and align payment incentives between physicians and hospitals;
- adoption of measures to reduce the likelihood of insolvencies by managed care companies and adoption of a plan to pay hospitals money due to them as a result of insolvencies by managed care organizations in 1998; and
- attaining favorable rulings from the Health Care Financing Administration (the federal agency that administers Medicare) regarding the close to $400 million in disproportionate share payments for which New Jersey hospitals may be eligible.

Actions to ensure a climate of fair business practices between hospitals and payers should include:

- completing a study of claims processing and billing processes to accurately assess where problems exist;
- enforcement of existing prompt payment regulations; and
- strengthening of regulations where needed.
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I. INTRODUCTION

Early in 1999, the system-wide deterioration in the fiscal condition of New Jersey's acute care hospitals was becoming apparent. The state had already seen an overall decline in the profitability of its hospitals in 1997 and 1998 mid-year financial statements suggested a rapid worsening of the situation. Hospital executives cited the numerous pressures on their hospitals, including revenue cuts by Medicare, the growing burden of charity care, and the effects of managed care.

In response, at the direction of Governor Whitman, the Department of Health and Senior Services (DHSS) reconvened an existing health care commission to determine the seriousness and breadth of the financial problems and how they could be addressed. The 33-member panel, which had previously studied the problem of financing and organizing New Jersey's charity care program, included cabinet members, representatives from hospitals, employers, consumers, government, unions, physicians, nurses, and others involved in health care (a complete list of members and affiliations is provided in Appendix A). Because of its expertise and established working relationships, this Advisory Commission on Hospitals was able to adhere to a quick-turnaround schedule and to work effectively to evaluate hospitals' financial issues. Governor Whitman charged the Advisory Commission on Hospitals to:

- Assess the overall health of New Jersey hospitals;
- Identify the warning signs that might indicate a facility is in jeopardy; and
- Recommend options for hospitals that want to merge or convert to other uses

In carrying out this charge, the commission examined the effects on New Jersey hospitals of significant developments over the past several years. Based on its assessment of the causes for the financial deterioration, the commission is recommending corrective actions and identifying the parties responsible for each action. This report highlights recommendations for actions to be taken by state regulators, hospital management and boards, physicians, and third-party payers.

Chapter II describes the activities of the commission. Chapter III details the deterioration of the financial condition of New Jersey hospitals and the factors driving the decline. Proposals developed by the commission to address the fiscal problems are outlined in Chapter IV.

II. ADVISORY COMMISSION ON HOSPITALS

Due to concern that the potential severity of the financial decline of New Jersey hospitals could adversely affect access to health care, it was clear that any committee studying this issue would have to form its recommendations as quickly as possible. Therefore, Governor Whitman turned to an existing panel of health care experts that could be reconvened quickly to tackle the issues at hand. Chaired by the Commissioner of Health and Senior Services Christine Grant and staffed by various state agencies, the Advisory Commission on Hospitals convened in April 1999. Appendix A lists the members of the commission.

The commission met monthly to review research materials prepared or collected for the commission, hear presentations from outside experts, discuss and debate issues, and develop and refine proposals to improve the situation. To explore issues in greater detail, the commission formed several subcommittees that met between commission meetings and presented their findings at full commission meetings. Subcommittees included:

- Hospital Financial Status, which reviewed different analyses of New Jersey hospitals' financial condition to identify areas of agreement or disagreement in interpreting the information;
- Market Response, which arranged for presentations to discuss responses to similar problems across the nation;

- State Role, which explored those initiatives which the state could realistically and appropriately be expected to do to address hospitals' financial problems as well as those actions that other groups could do to help;
- Prompt Payment, which attempted to sort out the controversial issue of how providers and payers each contributed to claims processing and service denial payment problems; and
- Post-acute Care, which will assess how the structure and financing of the broader health care system hinders efforts to reduce length of stay and what steps might be taken to address the problem.

The commission benefited from resources that members or other organizations brought to meetings. Presentations or documents distributed to members are listed in Appendix B.

III. TRENDS IN NEW JERSEY HOSPITAL FINANCIAL STATUS SINCE 1995

The commission was convened during a period when hospitals faced multiple challenges that, according to widespread reports, were severely affecting financial performance. Information presented to the commission confirmed that there has been a significant decline in the financial condition of New Jersey's 84 not-for-profit acute care hospitals since 1995. The depth and breadth of the decline convinced commission members that systemic factors, in addition to hospital-specific performance issues, were contributing to the financial deterioration. Over the course of its meetings, the commission identified many internal and external factors contributing to the trend.

A. EVIDENCE OF FINANCIAL DECLINE

The commission was provided with three studies that documented the financial deterioration. These included:

- a study by PricewaterhouseCoopers ("PwC") commissioned by the New Jersey Health Care Facilities Financing Authority ("NJHCFFA") entitled "Assessment of the Fiscal Condition of New Jersey's Acute Care Hospitals;"
- a report prepared by the New Jersey Hospital Association entitled "Financial Status of New Jersey Hospitals, 1998 Edition;" and
- data regarding the financial status of urban hospitals prepared by the New Jersey Hospital Alliance.

Copies of the reports or their executive summaries are provided in Appendices C, D and E.

The different reports provided essentially the same picture. According to the PwC study, profit margins dropped from 4.40% in 1995 to 1.76% in 1997 and .55% in 1998. Declines were consistent across all categories of hospitals regardless of teaching status, size, or geographic location. In 1997, 26 hospitals reported net losses from operations. This number increased to 42 in 1998. Other measures of financial performance such as days in accounts receivable, long-term debt to capitalization, and debt service coverage ratio have also deteriorated, although not to the same extent as profitability. And, while all hospitals have been affected, the declines have created a more precarious situation for inner city and urban hospitals, because they were in a weaker financial position.

After reviewing available financial information, the commission concluded that the declines are becoming more widespread and are likely to persist for the foreseeable future. The commission therefore turned its attention to identifying the causes and possible solutions.

B. EXTERNAL AND INTERNAL FACTORS AFFECTING HOSPITAL PERFORMANCE

The state's hospitals face numerous external challenges. The growth of managed care enrollment, reduction in Federal Medicare inpatient and outpatient reimbursement, changes in Medicaid reimbursement, and a large uninsured population are all contributing

to the decline in financial performance and are likely to persist into the next decade. Advances in technology and pharmaceuticals allow for more outpatient and non-hospital-based treatments, contributing to the downward pressure on utilization. Lack of alignment between physician and hospital payment incentives makes changing physician practice patterns difficult.

Additionally, internal factors hamper needed change. These include:

- slower than needed reductions in length of stay, particularly for Medicare patients;
- persistent excess and misdirected hospital capacity;
- higher staffing levels than hospitals in other states;
- lack of alignment between physician and hospital payment incentives, making changes in physician practice patterns difficult to implement;
- board ambivalence about transitioning a hospital's services or closing facilities to appropriately meet the community's needs while ensuring adequate reimbursement to cover costs; and
- inadequate education of the general public about changes in health care delivery and reimbursement.

Together these factors have contributed to higher operating costs at New Jersey hospitals when compared to their counterparts nationwide.

C. EXTERNAL FACTORS

1. GROWTH OF MANAGED CARE

Enrollment in managed care plans increased dramatically after the Legislature repealed New Jersey's Hospital Rate Setting system in 1993. Managed care has grown dramatically as New Jersey employers have found it a viable way to rein in the costs of employees' health benefits. The state's Medicaid program has also turned to managed care as a way to improve access and the quality of services and to control costs. By 1998, approximately 30 percent of the state's population had enrolled in health maintenance organizations, up from just 5 percent in 1993. This percentage would be higher if it included many thousand of others enrolled in preferred provider organizations and other forms of managed care for which data is unavailable.

The growth of managed care has reduced hospitals' revenues in several ways. First, hospitals typically must have a contract with a managed care company to be included in a provider network. Physicians are generally prohibited from admitting patients to hospitals without contracts, except on an emergency basis. The threat of this lost volume creates pressure for hospitals to sign contracts at less than optimum rates.

Most managed care companies pay per diem rather than per admission rates. The rate is negotiated and may not cover the hospital's actual cost for the patient. This situation is exacerbated by the hospitals' general lack of cost accounting systems, without which they cannot determine whether per diem payments cover costs. In addition, managed care companies employ utilization review techniques to eliminate unnecessary services. The threat of payment denial for excess days creates an incentive for hospitals to quickly move patients out of acute care beds. The drop in length of stay in New Jersey

hospitals from 7.3 days in 1993 to 5.8 days in 1997 (PwC report) is in large part attributable to these incentives. Since hospitals are often paid on a per diem basis, this decline in length of stay has further reduced hospital revenues. Even with this decline in days, third party payers are expected to press for additional reductions.

Managed care has affected hospital financial performance in less obvious ways too. Without rate setting regulations, hospitals now compete with each other for managed care business by offering lower prices or more comprehensive services; either strategy can hurt financial performance. In addition, managed care companies review hospital bills more closely as part of their efforts to eliminate unnecessary services. This scrutiny puts added pressure on the hospitals to document the services provided, generate error-free bills and to ensure that preauthorization is obtained before services are provided. The result has been higher administrative costs, slower payments as bills are reviewed, and denied claims in situations where payers believe the services were not properly documented or were deemed unnecessary.

While New Jersey has legislation and regulations requiring prompt payment of bills, the commission heard conflicting opinions as to whether insurers are adhering to these requirements. A sub-committee, convened to study the issue, concluded that hospitals and payers may misunderstand the rules and that many factors contribute to the slowdown in payments.

Managed care organizations, under pressure from employers to keep premiums as low as possible, themselves face financial problems, which in turn can affect the hospitals. A managed care trade organization reported that New Jersey HMOs lost $250 million since mid-1996. In late 1998 and early 1999, the insolvency of two health

maintenance organizations left hospitals with significant unpaid claims. In a presentation to the commission, Randi Reichel, Executive Director of the American Association of Health Plans, predicted continued pressure on hospitals to lower prices as managed care companies work to stabilize their own declining margins. She also suggested that smaller managed care organizations will be merging with larger ones, giving them more leverage in negotiating rates with hospitals.

All the information provided to the commission suggests that the effects of managed care will continue to challenge hospitals in the future. The state's Medicaid program, which has already converted most of the TANF population (mothers and children) from fee-for-service to managed care, expects to move a significant portion of its disabled population into managed care plans in the next two years. Analysis provided in the PwC report from Milliman & Robertson (an actuarial and consulting firm) predicted that utilization will continue to decline and medical denials will increase as New Jersey's use rates fall into line with those of other states with moderate levels of managed care. Managed care companies are expected to broaden their focus from just unnecessary days to unnecessary admissions as well. Therefore, the downward pressure on hospital revenues is expected to worsen.

Estimating the likely dollar impact of continued growth in managed care is difficult. However, the projections provided by PwC using the Milliman & Robertson rates, which assumed only moderate managed care activity, suggest that the state could expect to see a drop of approximately 150,000 non-Medicare patient days per year. The revenue impact of such a decline could be as much as $150 million to $200 million based

on average net revenue per day. To the extent that managed care penetration reaches higher levels, the impact could be larger.

2. FEDERAL BALANCED BUDGET ACT OF 1997 (BBA)

The federal government, in response to budget pressures and reports of double digit positive hospital Medicare margins nationally, moved to restrict the growth of Medicare payments with the passage of the Balanced Budget Act of 1997. The BBA affects Medicare reimbursement in several ways, including:

- limiting increases in Medicare reimbursement rates to less than the measured level of inflation;
- reducing capital reimbursement by 17.8% from current levels;
- reducing Medicare payments to teaching hospitals for graduate medical education
- reducing Medicare payments to hospitals that provide high levels of care to indigent patients;
- reducing reimbursement for certain Medicare patients who receive post-acute care services after a hospital stay; and
- reducing reimbursement to managed care organizations participating in Medicare risk contracting.

The BBA has had, and will continue to have, a dramatic effect on all hospitals.

Unlike the rest of the country, New Jersey's Medicare margins prior to the BBA were barely above break-even (1.9%, the fifth lowest in the country in 1996). The PwC report suggests that an excessive Medicare average length of stay (1.5 days higher than the national average in 1997) and high staffing levels contributed to these relatively low margins. Hospital representatives suggested that another reason for the low margins is that while New Jersey hospitals must pay health care professionals at New York City or Philadelphia wage rates, Medicare reimbursement assumes that state's hospitals compete

for personnel in New Jersey's lower cost labor markets. The result is that New Jersey hospitals are being particularly hard hit by the BBA. According to analysis from several sources, by the time the BBA is fully implemented in 2002, the $10.5 billion a year New Jersey hospital industry can expect to see $515 million less in Medicare reimbursement annually than if BBA had not been enacted. The cumulative effect over the five years of the BBA is expected to be nearly $2 billion less in Medicare revenue for New Jersey hospitals.

Through 1998, hospitals have already absorbed about $160 million of the impact and the BBA is, in part, responsible for the breadth of the financial decline in New Jersey hospitals. Like managed care, the impact is expected to be felt for several more years. Unless reversed in whole or in part, by 2002, the BBA will take another $355 million a year out of Medicare reimbursement on top of the amounts already eliminated.

3. UNINSURED POPULATION

Health care for New Jersey's substantial uninsured population, approximately 16 percent in 1998 according to the federal Census Bureau imposes considerable costs on hospitals. A subset of the uninsured population is eligible for charity care. As the cost of health care has continued to rise (albeit at lower rates than in the early 1990s), the cost of charity to New Jersey hospitals has also risen, from $337 million in 1993 to $483 million in 1999. The committee also heard anecdotal information regarding the impact that a growing undocumented population is having on charity care costs.

Fortunately, New Jersey remains one of relatively few states which provides some reimbursement to private hospitals for charity care. The state has two subsidy funds that, in 1998, provided $320 million in payments for charity care and another $203 million in hospital relief funds to facilities that treat a high proportion of special needs patients (e.g. AIDS, low birth weight babies, tuberculosis).

In spite of the fact that $80 million was added to these two funds in 1998 charity care presents a continuing problem to hospitals. First, funding is not keeping pace with increases in charity care. For hospitals with high levels of charity care, the combination of the two subsidies helps offset the costs of bad debt (which hospitals suggest is often really undocumentable charity care, much of which comes from admissions through emergency rooms). As the burden of charity care increases, however, more bad debt is left uncovered. Second, because the subsidies are funneled to high charity care hospitals, 18 hospitals receive no subsidies for charity care. Although the levels of charity care are not rising as quickly at these hospitals, they are still experiencing an increasing charity care burden in addition to the other financial pressures.

4. CERTIFICATE OF NEED

Traditionally, New Jersey had a comprehensive Certificate of Need program that regulated the addition of beds and services. Throughout the 1990s, the state has been incrementally exempting certain services from certificate of need requirements. In its current form, the Certificate of Need program may exacerbate the financial pressures on some hospitals, although in other cases it has worked to strengthen financially vulnerable

hospitals. Eliminating certificate of need requirements for certain services has exposed hospitals to more market pressures as they compete with other hospitals and health care providers for patients. On the other hand, the remaining certificate of need regulations prevent hospitals from competing for certain services which they believe will strengthen their financial position. The commission also heard evidence that profitable outpatient services that once were provided by hospitals are now rendered in physician offices and other outpatient settings. Regulatory barriers may exist which constrain hospitals from developing timely and cost-effective ambulatory care services. In 1998, the Legislature created a Certificate of Need commission to determine which services, if any, should remain subject to certificate of need regulations. This commission, which is looking at the implications for quality as well as finances, will conclude its deliberations by year-end.

5. ADVANCES IN MEDICAL TECHNOLOGY AND PHARMACEUTICALS

Hospitals have also been affected by changes in medical technology that make it possible to perform many profitable surgical procedures on an outpatient basis. For example, the ambulatory surgery centers in New Jersey grew from 16 in 1996 to 40 in 1999, an increase of 250 percent. Drug therapies for conditions such as diabetes and cardiovascular diseases have also reduced the need for hospitalization. These improvements in technology and pharmaceuticals have also increased costs for hospitals, and they are growing at a significantly faster rate than other costs.

D. INTERNAL FACTORS

1. LENGTH OF STAY

The PwC report indicated that while New Jersey's average length of stay for non-Medicare patients was consistent with national averages, the length of stay for Medicare patients was 1.5 days higher than the national average. This longer length of stay results in approximately 600,000 extra patient days for which the hospitals receive no revenue under Medicare's fixed payment per admission reimbursement system. Estimates of the added cost of these days range from $200 million to $600 million. The magnitude of these added costs suggests that reducing length of stay for Medicare patients could be a way for hospitals to cope with continuing reductions to Medicare revenues resulting from the BBA.

The commission heard many reasons for the state's high length of stay. Some suggested that New Jersey's Medicare population may be older and sicker than in other states and that a higher length of stay is inevitable, although many disputed this claim. A New Jersey Hospital Association study concluded that New Jersey patients are not older or sicker than patients in other states. Others note that physicians are paid by Medicare for each day a Medicare patient remains hospitalized and that this fee-for-service payment system works against hospital efforts to reduce lengths of stay. Many suggested a lack (as well as regulatory obstacles to the utilization) of post-acute care placement alternatives as the primary reason. Clearly, reducing Medicare length of stay will be a

difficult task for hospital management to address without help from other players in the health care delivery system.

2. EXCESS CAPACITY

On any given day, as many as 50% of New Jersey's 30,000 licensed acute care beds are unoccupied and that percentage is likely to increase as managed care and pressure to reduce Medicare length of stay continue to bring down the state's hospital use rates. Counting only staffed beds (hospitals set staffing levels based on the number of beds expected to be in use, not the number of licensed beds), the occupancy rate statewide is just 67%. This oversupply of beds is the root cause of many of the problems that contribute to the weak financial condition of the New Jersey hospital industry. For example, pressure to fill empty beds puts hospitals at a disadvantage in negotiating rates with payers and the widespread availability of beds means that physicians have no incentives to shorten the length of stay of their patients. Most importantly, the oversupply means that the industry is not generating enough revenue to adequately cover its fixed costs.

The financial benefits of eliminating the excess beds will depend on how the supply of beds is reduced. Reducing the inpatient capacity of all facilities by 30 percent to 50 percent might improve the hospitals' bargaining position with payers and put pressure on physicians to reduce lengths of stay. However, that approach would leave fixed costs relatively unchanged and would not dramatically improve the financial condition of hospitals. In fact, the steady decrease in the number of staffed beds in the

state since deregulation (approximately 5,000 beds, a 17% decline) does not seem to have helped financial performance to date.

Closing entire hospitals, as opposed to across-the-board downsizing, offers much more potential for improving the financial condition of the state's hospitals as a whole. Remaining hospitals will gain additional patients and will likely be able to treat them without significantly increasing their fixed costs. For example, many hospitals will treat these new patients in previously vacant beds. Therefore, the cost of treating new patients at these hospitals will be less than the new revenues they will receive. As outlined in the chart in Appendix F, the industry could handle the expected demand for services with as much as $1 billion less in fixed costs. Put another way, eliminating the excess capacity by closing hospitals rather than across the board downsizing could increase revenues to remaining hospitals by as much as $1 billion without any aggregate increase in payments. While the commission believed that the underlying assumptions of this analysis were reasonable, some members cautioned that this figure may be overstated.

When a facility needs to close, the hospital and its community face a new set of obstacles, including enormous political and community pressures to remain open. Hospital trustees worry about the welfare of the community the hospital serves, the people it employs, and the debts for which it is obligated. The host community and its leaders worry about the health care needs of their residents and the economic impact on their region. Physicians worry about where they will practice their profession. In addition, nurses and other health care professionals worry about the loss of employment and adequate staffing to ensure quality of care. These issues are very difficult to deal with even when there is an orderly, planned closure process. When a hospital closes

suddenly, as in the case of a bankruptcy, they become almost impossible to address in a constructive way. Without assistance in addressing the broad range of issues, hospital management may not be able to bring about a managed downsizing of the system.

3. MERGERS AND ACQUISITIONS

In anticipation of, and in reaction to, the impending changes in the health care market, some hospitals have merged or consolidated with other hospitals or have entered into affiliation agreements, hoping to capture a larger market share, reduce costs and improve their bargaining position with payers. Many of these mergers are still relatively new, but results to date have been mixed. Some hospitals reported they were able to reduce administrative costs through mergers and consolidations. Others reported little savings due to differences in business and clinical protocols, incompatible computer systems, and community and physician opposition to change in the delivery system. Perhaps most telling is, despite the merger activity since deregulation and the reduction in staffed beds, the number of hospital physical plants in operation has only decreased by three. Reducing staffed beds, consolidating clinical services, and eliminating duplicative administrative functions appear to be necessary but insufficient to accomplish system-wide savings that the anticipated reductions in utilization will require. Many agreed that significant savings from mergers may come only when entire facilities are actually closed or converted to other uses. Commission members also noted that clinical consolidation is difficult unless the facilities are geographically close. Outside experts presented similar

information about the impact of mergers and acquisitions in other parts of the country to date.

4. HIGH COSTS

New Jersey hospitals cost more to treat patients than their regional and national counterparts. PwC found that New Jersey's average cost per admission (adjusted for the types of cases seen and wage differences) was $6,214 in 1997 compared with $5,257 for hospitals in the region and $5,892 for urban hospitals nationwide. Much of the variance results from higher staffing levels for the volume of patients seen. In 1997, New Jersey hospitals used 4.73 full time staff per occupied bed compared to 4.56 nationwide and 4.2 for the region. PwC estimated that New Jersey hospitals could save $50 million in salary and fringe benefits for each one- percent reduction in staffing per occupied bed.

5. EDUCATION

Educated boards and competent management are also important in ensuring that essential services will be available. The commission was dismayed to learn that some hospitals cannot identify profitability by payer or product line. Ability to track costs varies greatly among hospitals and can contribute to difficulties in negotiating adequate managed care rates. In addition, many hospitals are unable to track the differences between hospital charges and contract rates and therefore cannot accurately value accounts receivable and expected revenue from these receivables. Further, some hospital

boards and physicians underestimate the critical need to reduce length of stay to maintain financial viability.

Education of key policy makers is also needed. Understandably, local officials get very involved when there is an initiative to close or convert hospitals in their communities. Better and earlier dialogue to discuss the gravity of the situation and to identify realistic options open to the key stakeholders is of paramount importance. Lastly, resistance on the part of hospital boards to face the realities of the changing health care environment is hampering efforts to improve the financial condition of hospitals. Declining utilization means that closure of some acute care facilities is inevitable and attempts to keep unneeded hospitals open weakens all hospitals and jeopardizes the quality of health care provided in the state.

IV. RECOMMENDATIONS

As described above, there are numerous and complex internal and external factors driving the current financial downturn. No single approach will lift the industry out of this downturn. However, the commission did identify several promising approaches that in aggregate can strengthen the financial condition of hospitals without jeopardizing the quality of care provided to patients. Just as there is no one solution, those responsible for making these changes will include hospital management, boards of trustees, physicians and other health professionals, the state, payers, managed care companies and the general public. All have responsibilities to ensure that hospitals maintain financial viability in this dramatically changed health care environment. This section outlines several recommendations for the current financial situation and the relevant role that each party can play.

The recommendations are organized into three major areas, including:

- assistance to hospitals and communities in the transition of hospitals to more efficient organizations providing services in the appropriate physical setting;
- modifications to the state's financial, regulatory, and leadership responsibilities to ensure access to and the quality of health care services in the state; and
- actions to ensure a climate of fair business practices between payers and hospitals.

While some of the proposals call for funding new programs, the main emphasis is on helping hospitals to restructure and reduce costs in response to the changing health care environment. The commission believes that these structural changes provide a longer-term solution to the financial problems of the state's hospitals than temporary infusions of cash that do nothing to change the fundamental realities of the health care market.

A. ASSISTANCE TO HOSPITALS AND COMMUNITIES IN THE TRANSITION OF HOSPITALS TO MORE EFFICIENT ORGANIZATIONS PROVIDING SERVICES IN THE APPROPRIATE PHYSICAL SETTING

1. CREATE HOSPITAL ASSET TRANSFORMATION PROGRAM TO ASSIST IN REDUCTION OF EXCESS CAPACITY

As the evolving health care environment continues to put pressure on the finances of many hospitals, all stakeholders would benefit from a process that would help hospitals address the issues of closures or transition to other uses in a proactive manner. The following Hospital Asset Transformation Program ("HATP") proposal is an attempt to develop a mechanism through which hospitals that are destined to close or transition to non-acute services could receive assistance to transition out of the acute care market in an orderly fashion.

The Commissioner of Health and Senior Services, acting through the Health Care Facilities Financing Authority, with approval from the Director of the Division of Budget and Accounting in the Treasury Department, should be authorized to refinance the debt of the hospital terminating acute care services and pay up to the full amount of the annual debt service. This financial assistance should be conditioned upon the receipt of a plan from the new business partner (whether hospital or other entity) that:

- ensures continued patient access to urgent care services through urgent care centers or other appropriate means;
- includes appropriate employee protection commitments, such as job placement assistance, or job training grants. For example, the New Jersey State Nurses Association could assist in the orderly transfer of nurses from one facility to another;
- provides for limited or temporary credentialing for physicians at remaining facilities;
- takes responsibility for the remaining liabilities of the hospital;
- provides for the re-use of the property whenever feasible ;
- provides an opportunity for input and ongoing involvement by some existing Trustees;
- ensures that assets will not be transferred across state borders;
- provides technical assistance upon request to develop an acceptable plan for transforming the hospital from acute care services to financially viable services.

Clearly, this is a sweeping proposal that will require the cooperation of many participants in the health care industry. Further, the issues will be particularly difficult at inner city hospitals that are often critical economic and social institutions and may be the only source of access to health care in the community. However, the commission believes that the HATP will enable New Jersey's hospital industry to radically restructure so that it will face future challenges from a position of strength. The DHSS should be an active participant in this process, assuring a fair and open process and the appropriate use of both the facility and state funds.

2. CONTINUE THE HOSPITAL ASSISTANCE UNIT

Earlier this year, the Department of Health and Senior Services established a Hospital Assistance Unit to coordinate state resources and to bring in outside resources, as needed, to aid distressed hospitals. The commission recommends that this concept continue in the form of a Hospital Transition Group. Such a group would help by developing a list of qualified consultants who could quickly identify the cause of financial problems at a particular institution. In addition, the group would be responsible for coordinating state actions to ensure that inappropriate regulatory hurdles do not stymie solutions.

The Department of Health and Senior Services should also continue to retain a merger/consolidation specialist. There will be some situations in which the demand for services requires continued operation of an acute care hospital, but not in its current form. A merger/consolidation specialist would serve as a "broker" to identify potential partners

that would offer the appropriate fixes such as economies of scale, broader services, or access to capital.

3. INSTITUTE HOSPITAL QUARTERLY FINANCIAL REPORTING AND MANAGEMENT PLAN

The Department of Health and Senior Services should establish, through regulation, a mandatory quarterly financial monitoring system to identify potential problems before they become unmanageable. The commission favored quarterly over annual monitoring because the annual audited financial statements are typically issued four to six months after the end of the year. A problem starting in the first quarter of one year might not be detected for another 15 months. Financial data provided must be of sufficient detail to allow the DHSS to calculate a broad range of financial indicators, including liquidity (days cash on hand and average payment period), profitability (total margin), and utilization (occupancy rate). (Although the New Jersey Health Care Facilities Financing Authority collects data of this type, it cannot release hospital-specific information without the written permission of the facility.)

The commission discussed selecting specific levels of financial performance that would qualify a facility as "distressed". However, it decided that financial distress should not be defined as failure to meet a specified number of ratio targets, but should instead be based on expert judgments made after reviewing those indicators in combination with other information about the facility.

4. ELIMINATE OBSTACLES TO REDUCING MEDICARE LENGTH OF STAY

The commission has formed a post-acute care study group that will continue working after the commission disbands. This group has been charged with analyzing how factors such as physician practice patterns and preferences; availability of post-acute care alternatives such as sub-acute and home health care; and common ownership of acute and post-acute facilities affect discharge planning and post-acute care treatment. Alternatives this group might consider include:

- assessing statutory and regulatory impediments to developing and using post-acute care services such as certificate of need and reimbursement restrictions;
- developing programs for state government and trade associations to assist hospital boards and management in educating physicians about the consequences of excessive length of stay; these could include using consultants or management firms, developing clinical protocols, and improved management information systems; and
- ensuring that payers align the payment incentives of hospitals and physicians so that physicians are not paid if the hospital is not paid.

Reducing excess capacity can also indirectly help the length of stay issue. With fewer acute care beds available, providers (hospitals and physicians) will find that length of stay will have to be reduced to accommodate the flow of new patients into the hospitals. In other words, a reduced supply of beds forces physicians to discharge patients in a timely manner to make room for new patients. As with the Hospital Asset Transformation Program, successful resolution of this issue will require all parties to participate in the solution.

5. EDUCATE BOARDS OF TRUSTEES AND PUBLIC ABOUT CHANGES IN THE HEALTH CARE DELIVERY SYSTEM

The Hospital Transition Group should partner with other established entities to develop and present information and education in various formats to trustees, the public and employers. This is currently done throughout the state and through the New Jersey Hospital Association, but not in a coordinated or collaborative fashion and would benefit from a more proactive and consistent approach.

6. PHYSICIAN LEADERSHIP

Physicians are indispensable leaders in determining the financial health of New Jersey hospitals. They have many responsibilities; to their own practices, their patients as well as hospitals and increasing contractual obligations to managed care companies. Physicians need to be leaders in transitioning hospital missions and leaders in explaining to the public why and how New Jersey can better design acute and ambulatory care.

The hospital financial and patient care incentives are not always going to be aligned with physician financial incentives when hospitals must change.

Physician-originated solutions are needed to balance competing interests, in partnership with the hospitals which serve them and their patients.

Also patients trust physicians, and physicians can help ensure that patients enroll in available insurance programs such as KidCare.

B. FINANCIAL, REGULATORY, AND LEADERSHIP RESPONSIBILITIES OF THE STATE IN ENSURING ACCESS TO QUALITY HEALTH CARE

1. BRING STATE AND PRIVATE PARTIES TOGETHER TO ADVOCATE FOR IMPROVED FEDERAL REIMBURSEMENT

While some of the factors affecting the financial condition of New Jersey hospitals are largely outside the control of players in the state, initial advocacy efforts to improve Medicare reimbursement have met with some success. For example, the commission heard presentations that suggested that the effect of the BBA has exceeded original projections. Several parties represented in the commission (e.g. trade associations in conjunction with the Department of Health and Senior Services) have already begun to forward this information to federal officials in an attempt to have certain provisions of the BBA repealed or softened. Also, based on recent rulings by the Health Care Financing Administration (the federal agency that administers Medicare) on similar issues, the state may be eligible for up to $100 million in additional Medicare disproportionate share payments. The state is also assisting hospitals in seeking a ruling on Medicare disproportionate share payments that could add close to $300 million in retroactive reimbursement, and, assuming favorable Federal policies remain unchanged, up to $70 million a year going forward. Again, the trade associations, the state, and other

players in the health care field can play a role by advocating for correction of this oversight. And, there may be other opportunities for advocacy efforts to improve the financial position of the state's hospitals.

2. ENSURE APPROPRIATE REIMBURSEMENT OF CHARITY CARE AND ESTABLISH A SUPPLEMENTAL CHARITY CARE FUND

In general, New Jersey does not rely on public hospitals to treat indigent patients. The charity care subsidies are the state's way of addressing the reality that private, not-for-profit hospitals fill this role. The current method of distributing existing charity care funds appropriately concentrates those dollars at facilities that provide high levels of charity care, have low levels of privately insured patients, and whose profitability is below the statewide median. However, all facilities in the state do provide some level of charity care, which the commission believes is an inherent part of a hospital's mission. But this "unrecognized cost" has been growing along with the uninsured population and the wherewithal to absorb these costs is diminishing. To prevent further erosion of the financial condition of New Jersey's acute care hospitals, the commission recommends the establishment of a supplemental charity care fund to provide some reimbursement for all hospitals that exceed some threshold level of charity care. This would not change the eligibility requirements for individuals applying for charity care. While specific details may need to be addressed later, the principles for distributing funding would be:

- hospitals receiving no funding from the existing charity care fund will be required to provide some level of charity care annually (expressed as a percent of total revenues or expenses);
- hospitals exceeding this threshold would receive some minimum payment (for example, 50 cents on the dollar) for charity care costs in excess of the required level; and
- since payment from this fund is based on charity care as a percent of revenues or expenses, the fund would therefore automatically keep pace with changes in the volume of charity care and inflation.

The supplemental fund would not reduce or change the distribution of existing subsidy funds. The state would need to identify a funding source for these new payments as well as administer the supplemental uncompensated care funding. Combined with the existing subsidy funds, this supplemental fund will ensure that all hospitals providing a threshold level of charity care will receive some level of funding for charity care.

3. EASE DOCUMENTATION REQUIREMENTS FOR CHARITY CARE SUBSIDIES

The state needs to re-examine the documentation requirements for emergency room patients to qualify for charity care. Currently hospitals must obtain the patient's identity, verify New Jersey residence, and determine family income and assets. Acceptable documentation ranges from a driver's license to a signed statement from the

patient (hospitals can document no more than 10 percent of their charity care cases with signed statements). But language barriers, fear of authorities, mental conditions and other factors often prevent hospitals from obtaining the necessary documentation to qualify an emergency room patient for charity care. Even post-discharge follow-up by social workers rarely yields the required information because the patients may be homeless, living in temporary housing, or housing with no telephone.

Allowing hospitals to provide a "Best Efforts Attestation" in lieu of the information currently required would permit more emergency room cases to be appropriately classified as charity care. Such an attestation would verify that:

- the patient is not enrolled in or eligible for Medicaid;
- at least two attempts were made to contact the patient by telephone;
- a visit was made to determine whether the patient lives at the address given to the hospital; and
- an attempt was made to determine that the patient's income and assets conform to the standards for charity care cases by visiting the address given and speaking with relatives or neighbors.

Measures like these would ensure that medically destitute emergency room patients qualify for charity care reimbursement without overburdening hospitals or patients. In return, hospitals would, if the statute allows, receive a slightly reduced charity care

payment (90 percent of the Medicaid rate) to maintain the incentive for hospitals to fully document charity care patients and receive full charity care payments.

4. ASSURE CERTIFICATE OF NEED AND LICENSING REGULATIONS FACILITATE NEEDED CHANGES

The Hospital Asset Transformation Program, described earlier, will assist hospitals that want to transition from acute care services to other services through the regulatory process. The commission recommends that similar resources be made available to hospitals that want to consolidate campuses to ensure that emergency and ambulatory services are maintained appropriately. DHSS regulations should also be reviewed to clarify and strengthen the procedures that apply in the event of closures and bankruptcies.

5. EXPAND ACCESS TO AFFORDABLE HEALTH INSURANCE TO REDUCE CHARITY CARE BURDEN

As noted earlier, the burden of charity care continues to rise in New Jersey despite the state's unique subsidy programs. Revisions to that subsidy program are discussed earlier in the report, but the commission felt that another way to attack the problem is to improve access to affordable health insurance. The state has already seen some success in this area with the NJ KidCare program that makes low-cost insurance available for uninsured children in families with incomes up to 350 percent of the federal poverty level.

The commission recommends that the state investigate other affordable insurance programs for the remaining uninsured population. Implementing other affordable insurance programs would provide a more sustainable approach to providing and paying for patient care. The commission applauds Governor Whitman's creation of a Task Force on the Affordability and Accessibility of Health Insurance. The importance and magnitude of this task require representatives of all key stakeholders to work together to recommend actions that the state can take to make health insurance more affordable. The commission also recommends that the state consider withholding state contracts from employers that do not provide reasonably comprehensive health insurance for their employees. Hospitals should consider a similar approach. For these ideas to have an effect there would need to be an array of insurance options for small employers.

For existing and new state insurance programs, hospitals play a vital role in enrolling eligible patients into these plans. Sister Jane Frances Brady, past Chief Executive Officer of St. Joseph's Hospital in Paterson, described for commission members the steps that St. Joseph's has used to significantly increase enrollment in the KidCare insurance program in its market area. These included:

- creating marketing materials in a variety of languages;
- working with community-based groups to identify potential families;
- distributing token gifts, such as key rings and t-shirts with promotional literature; and
- dedicating staff to the task of enrolling families in the program.

One potential concern with new insurance programs is that providers believe that they won't relief until subscribers are enrolled. It may be possible to significantly accelerate enrollment of large numbers of uninsured given the state's knowledge of identities and incomes of parents of children already enrolled in KidCare, Medicaid, and general assistance. The Task Force on Affordability and Accessibility of Health Insurance should also investigate how to provide health insurance for health care professionals, including hospital, nursing home, and home health workers.

6. EXPLORE ADDITIONAL FINANCING APPROACHES THAT THE NEW JERSEY HEALTH CARE FACILITIES FINANCING AUTHORITY SHOULD CONSIDER

The New Jersey Health Care Facilities Financing Authority (Authority) plays an important role in the area of the state's acute care hospital debt. As the primary issuer of tax-exempt debt on behalf of the state's hospitals, the Authority should continue to explore ways to lessen the impact of indebtedness, both bonded and commercial. This should include identifying opportunities to refinance for savings and/or cash flow relief. The Authority should also take every opportunity to educate various constituencies such as the rating agencies and bond insurance companies with regard to the strengths of New Jersey's health care institutions and the environment in which they operate. Last, the Authority should take every opportunity to advocate on behalf of the state's acute care hospitals on issues that relate to their cost of borrowing.

7. EXPLORE MODIFICATIONS TO STATE MEDICAID PAYMENT RULES

Financial distress at necessary and efficiently run hospitals providing needed services presented a different problem for the commission. Put differently, if necessary and efficiently run facilities are still struggling financially, then the state must re-examine existing policies to assist those hospitals. As these hospitals often provide the only access to acute services or specialty services for area residents, closure of these facilities is not an option. Although it considered developing criteria to explicitly identify such "anchor hospitals," the commission opted to support recommendations that would help those hospitals through improved public program reimbursement, closer monitoring, and technical support.

First of all, improvements in the three key areas discussed above -- reducing excess capacity and Medicare length of stay and increasing access to health insurance - will work to ensure that needed facilities remain financially viable. As noted earlier in the report, the added revenue of patients coming from closed facilities will improve the bottom line of surviving hospitals without any change in total reimbursement from payers. Similarly, reducing length of stay for Medicare patients lowers costs without affecting revenues. And, with more people insured, the burden of charity care can be lightened. But there are also many other ways that the various players in the health care sector can ensure access to needed facilities.

The state should explore several changes to the Medicaid reimbursement system. These include:

- considering basing the Medicaid rates (fixed rate per admission) on more recent cost data to reflect current hospital operations and changes in medical practices. Currently, the system uses cost data from 1988, updated for inflation.
- exploring the possibility of creating a new peer group in the Medicaid rate structure to recognize that hospitals serving a disproportionate share of charity care and Medicaid patients tend to have higher costs. Since Medicaid is moving more and more enrollees to managed care, these changes might seem of little consequence. However, even with the movement to managed care, hospitals will likely be reimbursed on a fixed rate per admission for some Medicaid patients. More importantly, because charity care and hospital relief fund cases are priced at the Medicaid fixed rate per admission, changes in the Medicaid rates would redistribute these subsidies more equitably.
- considering some type of Periodic Interim Payment (PIP) system for Medicaid managed care for hospitals that meet explicit financial and utilization criteria. A PIP system for Medicaid would advance, under limited conditions, reimbursement to facilities with low cash reserves to ensure that delays in payment did not jeopardize the operations of these hospitals.

Given the current financial condition of some hospitals, these options should be considered as quickly as possible. The commission also discussed the fact that payments for graduate medical education (GME) included in the Medicaid managed care rates do not go directly to the hospitals for the TANF population. However, Medicaid plans to

make GME payments directly to hospitals for the SSI population about to move into managed care. While many hospital representatives urged that all GME payments should go directly to hospitals, the commission did not reach a consensus on this issue. Another unresolved issue was the adequacy of Medicaid rates. Some commission members contended that New Jersey's rates were low in comparison to many other states. Medicaid officials noted that courts have found that the state's Medicaid rates meet statutory and regulatory requirements.

C. RESOLVE BILLING AND CLAIMS PROCESSING ISSUES

Hospitals face two major challenges that few other industries face when attempting to collect revenues for services they render. First, hospitals must document that the services they rendered complied with whatever criteria third-party insurers deem necessary. This, in itself, can be a cumbersome and time-consuming process. And, since documentation is partially dependent on physician cooperation, this burden is not entirely under the control of the hospitals. Second, even after documentation is complete, payment may not be forthcoming if the insurer questions some aspect of the treatment. Both steps can add many days between the time of service provision and payment and increase the cost of collecting patient revenues. These and other factors have led to uncertainty of hospitals' accounts receivable and problems in managing this aspect of their finances.

1. ENFORCE EXISTING PAYMENT AND CLAIMS DENIAL REGULATIONS AND STRENGTHEN REGULATIONS AS NEEDED

The state issued regulations requiring managed care plans to provide notice of denials or to make payment to providers within 60 days. Also, the state legislature recently passed laws requiring prompt payment or notice of deficiencies in a claim; regulations will be issued to implement these laws. The commission heard differing reports as to whether the earlier regulations have been effective. The commission supported enforcement of existing regulations.

Another area for the state to consider is the insolvency of managed care companies. Hospitals and other providers are still owed large sums from outstanding claims resulting from two previous insolvencies. New regulations strengthening the solvency requirements for HMOs were recently adopted.

2. INSTITUTE STUDY OF CLAIMS PROCESSING AND BILLING PROBLEMS BETWEEN MANAGED CARE ORGANIZATIONS AND HOSPITALS

The commission has created a work group to investigate the validity of hospital reports of delays and denials of claims submitted to third party insurers, especially managed care organizations. The work group determined that the information available was anecdotal and that there is currently no satisfactory data upon which to make informed decisions. After speaking with representatives of the University Health System and Ernst & Young, the group determined that the system was incredibly complex and susceptible to major delays in payments. For example, hospitals and payers often use

third-party vendors, which greatly increases the chances of system incompatibility and miscommunication.

Therefore, the work group will commission a study of the claims generated by five hospitals during a three-month period with two managed care organizations to track claims processing and payment to accurately determine where problems exist. The objective of the study will be to identify the points at which a claim can be rejected, the reasons for the rejections, the dollar value of these claims and the time lags involved at each level of processing, including preparation of the initial bill.

V. CONCLUSION

As noted earlier in the report, the financial problems cut across all hospitals with varying degrees of severity. The commission believes that the recommendations outlined in the preceding chapter offer some financial relief in the short term with prospects for significant improvement in the longer term. Also, while hospitals may benefit differently (or not at all) from various pieces of the proposal, the package taken together is a comprehensive plan to put the state's hospitals on more sound financial footing.

All hospitals stand to benefit from a reduction in excess capacity, length of stay and costs, which is the primary focus of the Hospital Asset Transformation Program, the Hospital Transition Group, and work of the post-acute care study group. In addition, affordable health insurance programs, improvements in payment practices and protection from insolvencies of managed care companies will help hospitals deal with the financial pressures of today's health care environment. High Medicaid/charity care hospitals will benefit from changes to Medicaid reimbursement and charity care documentation requirements. Other hospitals will benefit from a supplemental minimum charity care funding plan and advocacy efforts to mitigate the effects of the BBA.

Programs that require new funding (affordable insurance programs, minimum charity care, Hospital Asset Transformation Program, etc) probably cannot be implemented until the next state fiscal year which begins July 1, 2000. Since periodic interim payments do not involve new funding, these might be put in place as early as the second quarter of calendar 2000. Other efforts aimed at reducing cost or restructuring the

acute care hospital sector can probably begin earlier but their impact may not be felt immediately.

ACKNOWLEDGEMENTS

Although everyone on the Advisory Commission on Hospitals worked intensively to produce this report, the Commission would like to thank the following staff for their significant contributions. In particular:

Margaret Murray and John Guhl, of the New Jersey Department of Human Services;

Edith Behr, Stephen Fillebrown and Jeanette Bergeron, of the New Jersey Health Care Facilities Financing Authority; and

Anne Weiss, Maura Johnston, Jill Wellman and Andrea Mahon, of the New Jersey Department of Health and Senior Services.

Their efforts were crucial in carrying out the Commission's charge and are much appreciated.

APPENDIX A

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Name	Organization
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Bob Peden	Office of Management & Budget (Treasury)
R. Gregory Sachs	Medical Society of NJ
Joesph Gonzalez	NJ Business & Industry Association
Brian Baxter	Office of the Governor

APPENDIX B

List of Presentations and Documents Distributed to Commission Members

- Findings from the June 1, 1999 report, "Assessment of the Fiscal Condition of New Jersey's Acute Care Hospitals" by PricewaterhouseCoopers, commissioned by the New Jersey Health Care Facilities Financing Authority (See Appendix C for the executive summary);
- Findings from the 1998 edition of the "Financial Status of New Jersey Hospitals" by the New Jersey Hospital Association (See Appendix D);
- The February 1999 "Report on the Financial Status of Urban Hospitals" by the Hospital Alliance of New Jersey (See Appendix E);
- The March 1999 report, "A New Framework for Physician Workforce Policy in New Jersey", by the New Jersey Commission on the Physician Workforce, sponsored by the Medical Society of New Jersey;
- Summary of the March 1999 "Early Impact Balanced Budget Act of 1997 Survey Report" by the Hospital and Healthsystem Association of Pennsylvania;
- "The Northern New Jersey Health Care Market: How Does It Compare to Other Communities?" July 1999 by the Center for Studying Health System Change;
- "What Do We Know About Hospital Total Margins?" by The Lewin Group;
- Spending and utilization trends presented by the American Association of Health Plans;

- Overview of Medicaid Reimbursement and Reasonableness, Overview of Hospital Relief Subsidy Fund Payment Methodology, and Implications of Federal Policies on Medicaid Rates; and
- Published articles describing similar situations around the country.

APPENDIX C

Assessment of the Fiscal Condition of New Jersey's Acute Care Hospitals

June 1, 1999

PricewaterhouseCoopers

I. EXECUTIVE SUMMARY

A. Purpose and introduction

The following report provides an analysis of the financial condition of New Jersey's acute care hospitals. This analysis was performed in light of the changing competitive forces, modifications of the certificate of need law, experience with and exposure to third party payers, the Balanced Budget Act and other federal legislative changes, potential costs related to year 2000 issues and state funding for Medicaid and subsidies for uncompensated care. The following procedures were performed to complete this report:

- Analyzed changes in financial results from 1993 through 1998.
- Identified the characteristics associated with differing financial performance among the hospitals within the state.
- Compared the financial, operational and utilization results of New Jersey hospitals with those hospitals in the Northeast region and the rest of the country.
- Compared New Jersey's admissions and patient days per population, utilization rates, to the Mid-Atlantic region and the rest of the country.
- Identified the factors that have had a material impact on the financial results of New Jersey's acute care hospitals.
- Analyzed the financial impact of the Balanced Budget Act (BBA), year 2000 compliance costs, and the continued conversion of Medicare and Medicaid populations to managed care.

In addition, this report identifies cost saving measures that could result in stronger financial performance.

The report is organized into seven sections and one appendix:

I. Executive Summary

II. Methodology for Financial, Operational and Utilization Analyses

III. Results and Findings for Financial, Operational and Utilization Indicators

IV. Additional Findings

V. Observations

VI. Future Risks

VII. Conclusion

Appendix A – Net transfers of hospital funds for the five-year period, 1993-1997.

B. Key findings

- In 1993, the New Jersey acute care hospitals entered into the competitive market place environment from an all-payer regulatory reimbursement system with a relatively high level of debt and low levels of cash and low operating margins as compared to that of national benchmarks.

- The first three years' financial performance under the marketplace environment was strong. Statewide means for many of the selected financial benchmarks compared favorably to national benchmarks and usually exceeded the lowest 25th percentile regional benchmark. Statewide subsidies for uncompensated care were relatively high and managed care penetration was still low. Further, newly negotiated managed care payment rates, which were mostly percent of charges or per diem payment arrangements, reflected the hospitals' current cost and length of stay patterns.

- Beginning in 1996, New Jersey hospitals started to experience decreases in financial performance, while hospitals across the country strengthened. These declines continued into 1997 and 1998. By year-end 1997, New Jersey's statewide means had slipped in comparison to both national and regional benchmarks.

- Total margins, for New Jersey hospitals, dropped to a critically low rate in 1998. This occurred in spite of an increase in statewide subsidies for uncompensated care from $442 million in 1997 to $523 million in 1998 and stable admissions, between 1997 and 1998.

- The total margin is made up of operating and non-operating revenue. The proportion of the total margin generated by operations for New Jersey hospitals decreased significantly from 83.4% in 1993 to 26.7% in 1997, while the proportion of revenue generated by other services or gifts and investment returns has increased as a percent of the total margin.

- Although the reasons may be different, the decrease in financial performance is across all categories of hospitals, from teaching to non-teaching categories, from inner city to suburban for 1993 through 1998. The contributing factors varied among hospitals based on cost structure and payer mix.

- While the decline in financial performance has been across-the-board, inner city hospitals have the lowest total margins and the lowest levels of cash reserves. However, hospitals with the most admissions in any given county have been less affected by the declines. The better-than-average performance of these hospitals is not correlated with lower costs, which may indicate that they have been able to negotiate more favorable rates with managed care payers due to their strong market share position.

- Hospitals that are part of a multi-hospital system did not significantly outperform stand-alone hospitals in New Jersey. Although affiliations and system formations have the potential to reduce costs and enhance total margins, systems may not have been in place for a long enough period of time for this to happen. In addition, some newly formed systems focused on increasing their market share rather than containing costs and increasing profitability.

C. Contributing factors

Our analysis revealed several interrelated and overlapping factors, that contributed to the deterioration in the financial condition of New Jersey hospitals from 1993 to 1998. These factors are: high average length of stay for the over 65 population, high staffing levels, reduced levels of revenue from payers, and delays in developing outpatient services to replace lost inpatient revenues.

- The current New Jersey average length of stay for Medicare patients exceeds the national average by 1.6 days. This equates to approximately 600,000 excess patient days, per year, for which hospitals, under Medicare's fixed price per admission reimbursement, receive no additional reimbursement (except for cases that qualify as cost outliers for Medicare) but incur approximately $600 million in additional costs (based on 1997's average statewide cost per adjusted admissions divided by the average statewide length of stay). Saving the full $600 million from reducing the length of stay would require reducing variable cost as well as fixed cost, which is difficult to accomplish without conversion or consolidation of services or introduction of new services and/or closure of facilities.

- Cost per adjusted admission increased from 1993 to 1997, for all categories of New Jersey hospitals. The percent increase in cost per adjusted admission from 1993 to 1997 for New Jersey teaching and non-teaching hospitals was 3.5% and 11.2% respectively, in contrast to the teaching and non-teaching hospital national benchmarks of 6.0% and 2.2% respectively.

- New Jersey's full time equivalent (FTE) staff per occupied bed, adjusted for outpatient activity and case mix, increased faster than national and regional benchmarks during the period 1993 through 1997. Further, New Jersey teaching hospitals had more than half an FTE more per occupied bed than the national benchmark. Although the actual savings would depend on many factors, such as the number of physicians employed by the hospitals and outsourcing of contractual services, we estimate that each 1% reduction in the statewide salary cost related to reductions in FTEs, would generate savings of approximately $45 million in salary and $9 million of fringe benefit cost.

- New Jersey hospitals compared unfavorably to national and regional benchmarks for the growth of outpatient revenues as a percent of total revenues. As a result, unlike hospitals in other parts of the country, New Jersey hospitals have not been able to offset losses in inpatient revenue through growth in outpatient services. Given the changing nature of outpatient reimbursement (e.g. Medicare's expected move to prospective payment), New Jersey's hospitals may be challenged to find profitable outpatient services.

- Increases in the statewide mean for hospital cost per case are not being offset by increases in revenue per case. On the cost side, length of stay and staffing did not come down as fast as revenues were dropping. Factors affecting the revenue side included implementation of the Balanced Budget Act, low rates for per diem contracts from managed care companies, growth in uncompensated care, the failure of two managed care plans, and increasing number of denied claims.

D. Potential Savings

A further analysis was performed of New Jersey hospitals which have cost in excess of the peer group median, for New Jersey-specific teaching and non-teaching hospitals, for the following indicators: cost per adjusted admission, full-time equivalents per adjusted occupied bed and the average length of stays adjusted for case mix. An estimate of the potential 1997 cost savings was determined, for hospitals that compared unfavorably to the applicable peer group medians.

- If hospitals were to reduce cost per adjusted admission to the peer group median, the potential savings would be approximately $778 million. Approximately $553 million of salary cost and related fringe benefits could be saved, if hospitals that exceeded the full-time equivalents per occupied bed, peer group median, reduced their number of full-time equivalents to the median. Approximately $662 million could be saved, if hospitals that exceeded the median average length of stay, peer group median, reduced their averaged length of stay to the median.

- These savings are duplicative in nature and should not be added together. The findings do indicate that reducing the length of stay will generate a significant opportunity to reduce cost per case. Saving the full amounts of the excess of cost over the median for all of the above categories would require hospitals to reduce variable cost as well as fixed cost. Reduction to fixed cost is difficult to accomplish, without conversion or consolidation of services or introduction of new services and/or closure of facilities.

E. Future risks

Several other important factors could significantly affect the financial performance of New Jersey hospitals. How these factors are addressed will be critical to restoring the financial health of the New Jersey hospitals.

- New Jersey hospitals have already experienced 13.2%, or $199 million, of the five-year impact of the Balanced Budget Act as of year-end 1998. Because of the Balanced Budget Act's planned payment reductions that directly affect Medicare reimbursement, it is imperative that New Jersey's hospitals reduce their Medicare length of stay. Without such action New Jersey hospitals should expect to see increased negative effects from the BBA of $252 million in 1999, $323 million in 2000, $381 million in 2001, and an additional $351 million in 2002. A portion of these amounts are reductions from current levels of reimbursement, and a portion reflects revenue increases at levels less than the measured rate of inflation.

  Without adjusting their cost New Jersey hospitals could expect to incur a cumulative 3.9% reductions in total margins, by year 2002, due solely to the Balanced Budget Act's planned reductions in Medicare payments. New Jersey hospitals have already incurred an 1.9% reduction in total margins due to the impact of the Balanced Budget Act and could expected further annual reductions in their total margins of an additional .5% in 1999, an additional .7% in 2000, an additional .5% in 2001 and an additional .3% in 2002 cumulating in a reduction of total margins of 3.9% by 2002. In addition, any further freezes on the Medicare inflation adjustment will increase the projected negative impact on hospitals.

- Expected increases in managed care penetration for Medicare and commercial patients, as well as expansion of Medicaid managed care coverage, will likely further reduce patient days and admissions. In addition, reducing Medicare length of stay to national levels, which is critical to restoring the financial health of the state's hospitals, could result in additional excess capacity of as many as 2,050 of the state's 30,000 beds. Hospitals will either need to find profitable uses for the excess space or explore consolidation and closure strategies. Failure to do so will saddle the hospitals with fixed costs for which there is no reimbursement.

APPENDIX D

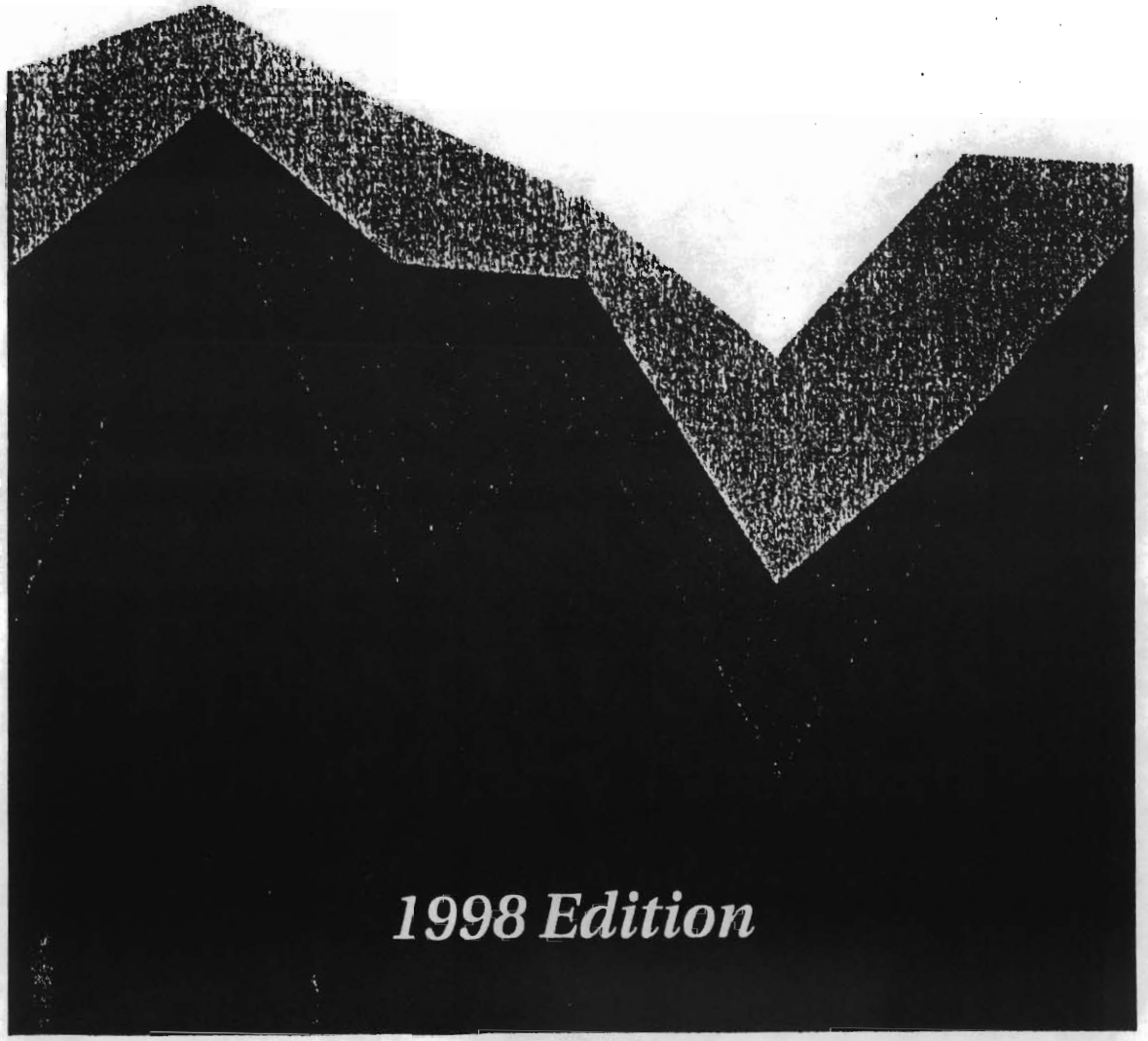
Financial Status of New Jersey Hospitals

1997 Audited Financial Statements

New Jersey Hospital Association

FINANCIAL STATUS
of New Jersey Hospitals

1997 Audited Financial Statements



NJHA
NEW JERSEY HOSPITAL ASSOCIATION

Foreword

The comparative financial data contained in this 1998 edition "Financial Status of New Jersey Hospitals" report has been condensed from hospital audited financial statements. The reports are trended over two- and five- year periods, which has proven useful in the past to member hospitals and others for performing comparative analysis in management planning or for making financing decisions.

This "Financial Status" report can be used to assess and evaluate the current financial health of New Jersey hospitals, for both acute care hospitals and non-acute specialized hospitals and rehabilitation hospitals. The specific information contained in this report provides authoritative and reliable information to legislators, regulators, healthcare industry analysts and others who require a thorough understanding of the current financial status of New Jersey hospitals.

A great deal of care has gone into the abstracting, controlling and reporting of the hospital audited financial information contained in this report in order to encourage and facilitate the industry's reliance on, and use of, the findings of this publication.

If you would like further information about this report, please contact Roger D. Sarao, director, Health Economics at 609-275-4026.

We hope that the New Jersey Hospital Association's report, "Financial Status of New Jersey Hospitals," is helpful to you and your organization.

Gary S. Carter
President and Chief Executive Officer

Financial Status of New Jersey Hospitals
Table of Contents

Introduction

This 21st annual *Financial Status of New Jersey Hospitals* report continues the New Jersey Hospital Association's long-standing practice of publishing an annual summary of the financial health of New Jersey hospitals based on audited financial statements. The data reported in this publication is accurate and reliable since it has been compiled from audited financial statements which have undergone rigorous accounting and reporting controls.

This 1998 edition *Financial Status* report contains condensed balance sheets, condensed statement of operations and financial ratio comparisons essential to a meaningful analysis of the New Jersey hospital industry. The comparative condensed statements of operations have been revised to be consistent with the American Institute of Certified Public Accounts Audit and Accounting Guide – Audits of Providers of Health Care Services, which became effective for periods beginning on or after July 15, 1990.

The condensed financial statements presented in this report have been derived and consolidated from the 1997 audited financial statements of 68 acute care hospitals and hospital systems and six specialized or rehabilitation hospitals. We have reclassified selected financial statement information to conform to a common condensed format for both the balance sheet and statement of operations. The 1997 financial statements were prepared on the accrual basis of accounting. Effective Jan 1, 1995, most hospitals adopted Statement of Financial Standards (SFAS) No. 116, No. 117, and No. 124. These reporting changes are reflected in this version of the *Financial Status* report.

There are several reasons for the variance in the number of participants from 1996 to 1997. First, several acute care hospitals still had not submitted their audited financial statements as of the time of publication. In addition, more hospital systems are reporting consolidated financials, rather than separate statements for each hospital in the system. This last fact may cause minor fluctuations in ratios from one year to the next when viewed across categories such as Local Advisory Board or teaching classification, as individual hospitals within the system may fall into different categories. In such cases, the largest hospital in the system was the driving factor in placing the system into a particular category.

University Hospital (UMDNJ) is excluded from this report because of an inconsistent financial reporting basis. Additionally, the financial information for Columbus Hospital reflects unaudited data.

The 13 individual ratios and one comprehensive ratio found in this report reflect hospital financial performance in the four major comparative ratio categories: Profitability, Liquidity, Capital Structure and Activity. The Financial Flexibility Index (FFI) was developed by William O. Cleverley, Ph.D., CPA, Ohio State University, for the Healthcare Financial Management Association. The FFI is a composite of seven financial ratios and provides a comprehensive measure of the overall financial health of the hospitals by measuring a hospital's ability to control the flow of funds. All ratio values reported were derived using the arithmetic mean measure of central tendency.

Northeast (NE) regional and United States (US) national mean comparative data reported for each ratio was obtained and reprinted with permission from The Center for Healthcare Industry Performance Studies (CHIPS). Adjusted admission data is derived from the 1997 N.J. Acute Care Hospitals Cost Reports. Where 1997 data was unavailable, the 1996 N.J. Acute Care Hospitals Cost Reports were utilized. Adjusted admission information is not available for non-acute care hospitals.

Hospital financial ratios are compared across four categories: Local Advisory Boards (LABs), hospital classification, catchment area and bed size. According to Public Law 1992, Chapter 187, LABs were established to replace Health System Areas. Although the six LABs were recently replaced with three Regional Boards, this edition of *Financial Status of New Jersey Hospitals* will compare hospitals across LABs due to the industry's familiarity with them. Next year's edition will utilize the three Regional Boards. A map of the six Local Advisory Boards is included as Appendix A. Acute care hospitals are further classified according to degree of teaching (major teaching, minor teaching or non-teaching), specifically defined in section 8:31B - 3.22 (standard costs per case) of the Chapter 83 Procedural and Methodological Regulations. In addition, hospitals are assigned a catchment area designation (inner city, urban, suburban, rural) by the Department of Health based on the hospital's site location. Finally, bed size categories are based on the hospital's maintained beds as reported in the 1997 N.J. Acute Care Hospitals Cost Reports.

The Health Care Reform Act ended 12 years of state hospital rate regulation by repealing the Chapter 83 acute care hospital payment system on Dec 31, 1992. The statutory end of state rate regulation left many hospitals with substantial reserves of uncollected approved revenue. Future collection of these reserves is uncertain. In accordance with general accepted accounting principles, most of the affected hospitals wrote off these reserves as extraordinary items on their 1992 income statements. Several of the ratios for 1993 may reflect the financial impact of this significant event.

Acknowledgments

Financial Status of New Jersey Hospitals is produced and published annually by the New Jersey Hospital Association's Health Economics department.

Roger D. Sarao, director, Health Economics

The audited financial statements of the following hospitals and hospital systems are included in this 1998 edition *Financial Status of New Jersey Hospitals* report:

Atlantic City Medical Center
Atlantic Health System [1]
Bacharach Institute for Rehabilitation
Barnert Hospital
Bayonne Hospital
Bayshore Community Hospital
Bergen Pines County Hospital
Beth Israel Hospital (Passaic)
Burdette Tomlin Memorial Hospital
Capital Health System [2]
Carrier Foundation
Cathedral HealthCare System
CentraState Medical Center
Children's Specialized Hospital
Chilton Memorial Hospital
Christ Hospital
Christian Health Care Center
Clara Maass Medical Center
Columbus Hospital [3]
Community Medical Center
Cooper Hospital/University Medical Center
Deborah Heart and Lung Center
East Orange General Hospital
Elizabeth General Medical Center
Englewood Hospital & Medical Center
Greenville Hospital
Hackensack University Medical Center
Hackettstown Community Hospital
Holy Name Hospital
Hospital Center at Orange
Hunterdon Medical Center
Irvington General Hospital
Jersey City Medical Center
John F. Kennedy Medical Center (Edison)
Kennedy Memorial Hospital-UMC
Kimball Medical Center
Medical Center at Princeton
Memorial Hospital of Burlington County
Memorial Hospital of Salem County
Memorial Medical Center at South Amboy
Meridian Health System [4]
Monmouth Medical Center
Muhlenberg Regional Medical Center
Newark Beth Israel Medical Center
Newton Memorial Hospital
Northwest Covenant Medical Center [5]
Our Lady of Lourdes Medical Center
Palisades General Hospital
R.W.J. University Hospital
R.W.J. University Hospital at Hamilton
Rahway Hospital
Raritan Bay Medical Center
Saint Barnabas Medical Center
Shore Memorial Hospital
Shoreline Behavioral Health Center
Somerset Medical Center
South Jersey Hospital System [6]
Southern Ocean County Hospital
St. Elizabeth Hospital
St. Francis Hospital (Jersey City)
St. Francis Medical Center (Trenton)
St. Joseph's Hospital & Medical Center
St. Lawrence Rehabilitation Center
St. Mary Hospital (Hoboken)
St. Mary's Hospital (Passaic)
St. Peter's Medical Center
Underwood-Memorial Hospital
Union Hospital
Valley Hospital
Warren Hospital
Wayne General Hospital
West Hudson Hospital
West Jersey Health System
William B. Kessler Memorial Hospital

[1] Atlantic Health System is comprised of Morristown Memorial Hospital, Mountainside Hospital, and Overlook Hospital.
[2] Capital Health System is comprised of Helene Fuld Medical Center and Mercer Medical Center.
[3] Columbus Hospital represents unaudited financial information.
[4] Meridian Health System is comprised og Jersey Shore Medical Center, Medical Center of Ocean County and Riverview Medical Center.
[5] Northwest Covenant Medical Center is comprised of St. Clare's - Riverside, Denville Campus; St. Clare's - Riverside, Sussex Campus; Dover Campus; and St. Clare's - Riverside, Boonton Township Campus. Northwest Covenant closes its fiscal year on September 30.
[6] South Jersey Hospital System includes Elmer Community Hospital.

New Jersey Hospitals

Financial Highlights - A Five Year Comparison

(dollars in thousands except per adjusted admission data)

	1997[a]	1996[b]	1995[c]	1994[c]	1993[c]
Cash	$ 640,197	$ 512,471	$ 542,583	$ 556,931	$ 496,185
Accounts receivable - net	1,780,929	1,812,341	1,734,266	1,668,756	1,616,050
Notes payable	14,978	8,449	38,883	63	12,603
Accounts payable	787,137	810,622	748,105	673,872	663,190
Long-term debt	3,267,356	3,203,598	3,247,300	3,339,569	3,120,528
Total revenue	10,070,819	10,070,640	10,288,686	9,981,013	9,747,183
Total expenses	9,991,915	9,862,796	9,969,840	9,653,263	9,317,992
Income from operations	$ 78,904	$ 207,844	$ 318,846	$ 327,750	$ 429,191
Income from operations (per adjusted admission - acute care only)	$ 57.16	$ 151.16	$ 222.35	$ 229.04	$ 216.79
Operating Margin Ratio	0.8%	2.1%	3.1%	3.3%	4.4%
Days in Patient Accounts Receivable Ratio	69.22	69.93	65.90	64.40	63.31
Days Cash on Hand Ratio	39.78	36.95	37.50	40.90	37.45
Long-term Debt to Equity Ratio	0.66	0.68	0.74	0.84	0.88
Hospitals with :					
Loss from operation[d]	22	26	14	10	4
Deficiency of revenue over expenses[e]	25	20	9	10	2
Adjusted admissions (All Hospitals)[f]	N/A	N/A	N/A	N/A	1,397,379
Adjusted admissions (Acute Care)[g]	1,398,826	1,419,500	1,405,207	1,371,583	1,385,487
Adjusted admissions (Non-acute Care)[f]	N/A	N/A	N/A	N/A	11,892

a. 74 hospitals/systems

b. 83 hospitals/systems

c. 88 hospitals/systems

d. Hospitals' total expenses are greater than total revenue.

e. Hospitals' total expenses are greater than the sum of total revenue, nonoperating gains, and extraordinary items.

f. Adjusted admission data is not available for non-acute care hospitals from the N.J. Cost Reports (Shares), but NJHA is researching alternative data sources for future use.

g. Adjusted admissions include inpatient plus equivalent amount for outpatients.

New Jersey Hospitals
Condensed Balance Sheet - All Hospitals
(in thousands of dollars)

Assets	December 31, 1997	1996	Liabilities and Net Assets	December 31, 1997	1996
General Funds					
Current assets			Current liabilities		
Cash (including certificates of deposit)	$ 640,197	$ 512,471	Notes payable	$ 14,978	$ 8,449
Accounts receivable, less contractual allowances and uncollectibles (1997 - $947,550 ; 1996 - $890,567)	1,780,929	1,812,341	Current installment on long-term debt	155,848	168,139
			Accounts payable	787,137	810,622
Assets whose use is limited - current portion	394,925	437,513	Accrued expenses and other current liabilities	794,217	790,715
Inventories	78,000	79,039	Retroactive rate adjustment - net	0	0
Prepaid expenses and other current assets	471,972	378,425			
Total current assets	$ 3,366,023	$ 3,219,789	Total current liabilities	$ 1,752,180	$ 1,777,925
Assets whose use is limited			Other liabilities	528,257	526,248
By board of trustees	1,742,937	1,603,172	Long-term debt	3,267,356	3,203,598
By agreement with third party regulatory agencies	296	8,357	Retroactive rate adjustment - net	0	0
Held by trustee	539,082	559,643			
Others	148,626	406,363			
Less: current portion	(393,015)	(437,513)			
Assets whose use is limited - non-current portion	2,037,925	2,140,023	Total liabilities	$ 5,547,792	$ 5,507,771
Property, plant and equipment, net of accumulated depreciation	4,629,319	4,523,571	Net assets	4,930,349	4,745,212
Deferred charges and other non-current assets	444,874	369,600			
Total assets	$ 10,478,142	$ 10,252,983	Total liabilities and net assets	$ 10,478,142	$ 10,252,983

New Jersey Hospitals

Condensed Balance Sheet - Acute Care Hospitals

(In thousands of dollars)

Assets	December 31, 1997	December 31, 1996
General Funds		
Current assets		
Cash (including certificates of deposit)	$ 619,112	$ 497,246
Accounts receivable, less contractual allowances and uncollectibles (1997 - $939,212 ; 1996 - $884,009)	1,755,920	1,791,446
Assets whose use is limited - current portion	393,346	435,747
Inventories	77,383	78,435
Prepaid expenses and other current assets	462,559	361,458
Total current assets	$ 3,308,321	$ 3,164,332
Assets whose use is limited		
By board of trustees	1,732,399	1,593,917
By agreement with third party regulatory agencies	296	8,357
Held by trustee	522,706	538,383
Others	145,486	400,755
Less: current portion	(391,437)	(435,747)
Assets whose use is limited - non-current portion	2,009,450	2,105,665
Property, plant and equipment, net of accumulated depreciation	4,541,538	4,445,279
Deferred charges and other non-current assets	413,632	339,240
Total assets	$ 10,272,940	$ 10,054,515

Liabilities and Net Assets	December 31, 1997	December 31, 1996
Current liabilities		
Notes payable	$ 14,978	$ 8,449
Current installment on long-term debt	154,085	166,610
Accounts payable	783,697	804,847
Accrued expenses and other current liabilities	773,349	773,729
Retroactive rate adjustment - net	0	0
Total current liabilities	$ 1,726,109	$ 1,753,636
Other liabilities	520,195	515,689
Long-term debt	3,206,511	3,143,332
Retroactive rate adjustment - net	0	0
Total liabilities	$ 5,452,815	$ 5,412,656
Net assets	4,820,125	4,641,859
Total liabilities and net assets	$ 10,272,940	$ 10,054,515

New Jersey Hospitals
Condensed Balance Sheet - Non-Acute Care Hospitals
(In thousands of dollars)

Assets	December 31, 1997	1996	Liabilities and Net Assets	December 31, 1997	1996
			General Funds		
Current assets			Current liabilities		
Cash (including certificates of deposit)	$ 21,085	$ 15,225	Notes payable	$ 0	$ 0
Accounts receivable, less contractual allowances and uncollectibles (1997 - $8,338 ; 1996 - $6,559)	25,009	20,895	Current installment on long-term debt	1,763	1,529
			Accounts payable	3,439	5,775
			Accrued expenses and other current liabilities	20,868	16,986
Assets whose use is limited - current portion	1,578	1,765			
Inventories	617	604			
Prepaid expenses and other current assets	9,413	16,967			
Retroactive rate adjustment - net	0	0			
Total current assets	$ 57,702	$ 55,457	Total current liabilities	$ 26,070	$ 24,289
Assets whose use is limited			Other liabilities	8,062	10,559
By board of trustees	10,538	9,255	Long-term debt	60,845	60,266
By agreement with third party regulatory agencies	0	0			
Held by trustee	16,376	21,260			
Others	3,140	5,608			
Less: current portion	(1,578)	(1,765)			
Assets whose use is limited - non-current portion	28,475	34,358	Total liabilities	$ 94,977	$ 95,115
Property, plant and equipment, net of accumulated depreciation	87,782	78,292	Net assets	110,224	103,353
Deferred charges and other non-current assets	31,242	30,361			
Retroactive rate adjustment - net	0	0			
Total assets	$ 205,201	$ 198,468	Total liabilities and net assets	$ 205,201	$ 198,468

New Jersey Hospitals
Condensed Statement of Operations
(in thousands of dollars)

	Year Ending December 31, 1997			Year Ending December 31, 1996		
	All Hospitals	Acute Care Hospitals	Non-Acute Care Hospitals	All Hospitals	Acute Care Hospitals	Non-Acute Care Hospitals
Net patient service revenue	$ 9,391,183	$ 9,256,862	$ 134,321	$ 9,459,525	$ 9,331,494	$ 128,030
Other revenue	679,636	663,827	15,809	611,116	601,845	9,271
Total revenue	10,070,819	9,920,689	150,130	10,070,640	9,933,339	137,301
Expenses						
Expenses other than depreciation and amortization and provision for bad debts	8,849,933	8,710,776	139,157	8,850,178	8,714,795	135,382
Depreciation and amortization	495,164	489,157	6,007	477,573	472,105	5,468
Provision for bad debts	646,818	640,804	6,013	535,046	531,867	3,179
Total expenses	9,991,915	9,840,738	151,177	9,862,796	9,718,767	144,029
Income from operations	78,904	79,952	(1,047)	207,844	214,572	(6,728)
Nonoperating gains	178,825	170,213	8,612	159,539	149,833	9,706
Excess revenue and gains over expenses before extraordinary items	257,730	250,165	7,565	367,383	364,405	2,979
Extraordinary gain (loss)	(29,120)	(28,271)	(848)	(2,966)	(2,966)	0
Excess revenue and gains over expenses including extraordinary items	$ 228,610	$ 221,893	$ 6,717	$ 364,418	$ 361,439	$ 2,979

New Jersey Hospitals
Condensed Statement of Operations
Per Adjusted Admission

	Year Ending December 31, 1997 Acute Care Hospitals	Year Ending December 31, 1996 Acute Care Hospitals
Net patient service revenue	$ 6,617.59	$ 6,573.79
Other revenue	474.56	423.98
Total revenue	7,092.15	6,997.77
Expenses		
Expenses other than depreciation and amortization and provision for bad debts	6,227.20	6,139.34
Depreciation and amortization	349.69	332.59
Provision for bad debts	458.10	374.69
Total expenses	7,035.00	6,846.61
Income from operations	57.16	151.16
Nonoperating gains	121.68	105.55
Excess revenue and gains over expenses before extraordinary items	178.84	256.71
Extraordinary gain (loss)	(20.21)	(2.09)
Excess revenue and gains over expenses including extraordinary items	$ 158.63	$ 254.62

New Jersey Hospitals
Condensed Statement of Operations
Hospitals with Loss from Operations
(In thousands of dollars)

	Year Ending December 31, 1997			Year Ending December 31, 1996		
	All Hospitals	Acute Care Hospitals	Non-acute Care Hospitals	All Hospitals	Acute Care Hospitals	Non-acute Care Hospitals
Net patient service revenue	$ 2,151,473	$ 2,092,945	$ 58,529	$ 2,188,205	$ 2,106,019	$ 82,185
Other revenue	151,352	144,082	7,269	152,045	147,397	4,647
Total revenue	2,302,825	2,237,027	65,798	2,340,249	2,253,417	86,833
Expenses						
Expenses other than depreciation and amortization and provision for bad debts	2,128,950	2,065,366	63,584	2,193,937	2,105,082	88,855
Depreciation and amortization	118,071	115,015	3,056	115,856	111,945	3,911
Provision for bad debts	203,238	199,097	4,141	133,900	131,594	2,306
Total expenses	2,450,259	2,379,477	70,781	2,443,692	2,348,621	95,071
Income from operations	(147,434)	(142,450)	(4,984)	(103,443)	(95,204)	(8,238)
Nonoperating gains	(14,159)	(20,537)	6,378	54,783	46,243	8,541
Excess revenue and gains over expenses before extraordinary items	(161,593)	(162,987)	1,394	(48,659)	(48,962)	302
Extraordinary gain (loss)	(2,434)	(2,434)	-	0	0	0
Excess revenue and gains over expenses including extraordinary items	$ (164,027)	$ (165,421)	$ 1,394	$ (48,659)	$ (48,962)	$ 302
Adjusted Admissions	N/A	314,983	N/A	N/A	346,105	N/A

Per Adjusted Admission	Year Ending December 31, 1997			Year Ending December 31, 1996		
Net patient service revenue	$ N/A	$ 6,644.62	$ N/A	$ N/A	$ 6,084.92	$ N/A
Other revenue	N/A	457.43	N/A	N/A	425.88	N/A
Total revenue	N/A	7,102.05	N/A	N/A	6,510.80	N/A
Expenses						
Expenses other than depreciation and amortization and provision for bad debts	N/A	6,557.06	N/A	N/A	6,082.21	N/A
Depreciation and amortization	N/A	365.15	N/A	N/A	323.44	N/A
Provision for bad debts	N/A	632.09	N/A	N/A	380.21	N/A
Total expenses	N/A	7,554.29	N/A	N/A	6,785.87	N/A
Income from operations	N/A	(452.25)	N/A	N/A	(275.07)	N/A
Nonoperating gains	N/A	(65.20)	N/A	N/A	133.61	N/A
Excess revenue and gains over expenses before extraordinary items	N/A	(517.45)	N/A	N/A	(141.46)	N/A
Extraordinary gain (loss)	N/A	(7.73)	N/A	N/A	0.00	N/A
Excess revenue and gains over expenses including extraordinary items	$ N/A	$ (525.17)	$ N/A	$ N/A	$ (141.46)	$ N/A

New Jersey Hospitals
Condensed Statement of Operations
Hospitals with Income from Operations
(In thousands of dollars)

	Year Ending December 31, 1997			Year Ending December 31, 1996		
	All Hospitals	Acute Care Hospitals	Non-acute Care Hospitals	All Hospitals	Acute Care Hospitals	Non-acute Care Hospitals
Net patient service revenue	$ 7,239,710	$ 7,163,918	$ 75,792	$ 7,271,320	$ 7,225,475	$ 45,845
Other revenue	528,284	519,744	8,540	459,071	454,447	4,623
Total revenue	7,767,994	7,683,662	84,332	7,730,391	7,679,922	50,468
Expenses						
Expenses other than depreciation and amortization and provision for bad debts	6,720,984	6,645,411	75,573	6,656,241	6,609,713	46,528
Depreciation and amortization	377,093	374,142	2,951	361,717	360,160	1,557
Provision for bad debts	443,579	441,707	1,872	401,146	400,272	873
Total expenses	7,541,656	7,461,260	80,396	7,419,104	7,370,146	48,958
Income from operations	226,338	222,402	3,936	311,287	309,776	1,511
Nonoperating gains	192,984	190,750	2,235	104,756	103,590	1,166
Excess revenue and gains over expenses before extraordinary items	419,322	413,151	6,171	416,043	413,366	2,676
Extraordinary gain (loss)	(26,686)	(25,837)	(848)	(2,966)	(2,966)	0
Excess revenue and gains over expenses including extraordinary items	$ 392,637	$ 387,314	$ 5,323	$ 413,077	$ 410,401	$ 2,676
Adjusted Admissions	N/A	1,083,843	N/A	N/A	1,073,396	N/A

Per Adjusted Admission	Year Ending December 31, 1997			Year Ending December 31, 1996		
Net patient service revenue	$ N/A	$ 6,609.74	$ N/A	$ N/A	$ 6,731.42	$ N/A
Other revenue	N/A	479.54	N/A	N/A	423.37	N/A
Total revenue	N/A	7,089.28	N/A	N/A	7,154.79	N/A
Expenses						
Expenses other than depreciation and amortization and provision for bad debts	N/A	6,131.34	N/A	N/A	6,157.76	N/A
Depreciation and amortization	N/A	345.20	N/A	N/A	335.53	N/A
Provision for bad debts	N/A	407.54	N/A	N/A	372.90	N/A
Total expenses	N/A	6,884.08	N/A	N/A	6,866.20	N/A
Income from operations	N/A	205.20	N/A	N/A	288.59	N/A
Nonoperating gains	N/A	175.99	N/A	N/A	96.51	N/A
Excess revenue and gains over expenses before extraordinary items	N/A	381.19	N/A	N/A	385.10	N/A
Extraordinary gain (loss)	N/A	(23.84)	N/A	N/A	(2.76)	N/A
Excess revenue and gains over expenses including extraordinary items	$ N/A	$ 357.35	$ N/A	$ N/A	$ 382.34	$ N/A

New Jersey Hospitals
Condensed Statement of Operations
Percentage to Net Patient Service Revenue
(In thousands of dollars)

Year Ending December 31, 1997

	All Hospitals		Acute Care Hospitals		Non-acute Care Hospitals	
Net patient service revenue	$ 9,391,183	100.0 %	$ 9,256,862	100.0 %	$ 134,321	100.0 %
Other revenue	679,636	7.2	663,827	7.2	15,809	11.8
Total revenue	10,070,819	107.2	9,920,689	107.2	150,130	111.8
Expenses						
Expenses other than depreciation and amortization and provision for bad debts	8,849,933	94.2	8,710,776	94.1	139,157	103.6
Depreciation and amortization	495,164	5.3	489,157	5.3	6,007	4.5
Provision for bad debts	646,818	6.9	640,804	6.9	6,013	4.5
Total expenses	9,991,915	106.4	9,840,738	106.3	151,177	112.5
Income from operations	78,904	0.8	79,952	0.9	(1,047)	(0.8)
Nonoperating gains	178,825	1.9	170,213	1.8	8,612	6.4
Excess revenue and gains over expenses before extraordinary items	257,730	2.7	250,165	2.7	7,565	5.6
Extraordinary gain (loss)	(29,120)	(0.3)	(28,271)	(0.3)	(848)	(0.6)
Excess revenue and gains over expenses including extraordinary items	$ 228,610	2.4 %	$ 221,893	2.4 %	$ 6,717	5.0 %

Year Ending December 31, 1996

	All Hospitals		Acute Care Hospitals		Non-acute Care Hospitals	
Net patient service revenue	$ 9,459,525	100.0 %	$ 9,331,494	100.0 %	$ 128,030	100.0 %
Other revenue	611,116	6.5	601,845	6.4	9,271	7.2
Total revenue	10,070,640	106.5	9,933,339	106.4	137,301	107.2
Expenses						
Expenses other than depreciation and amortization and provision for bad debts	8,850,178	93.6	8,714,795	93.4	135,382	105.7
Depreciation and amortization	477,573	5.0	472,105	5.1	5,468	4.3
Provision for bad debts	535,046	5.7	531,867	5.7	3,179	2.5
Total expenses	9,862,796	104.3	9,718,767	104.2	144,029	112.5
Income from operations	207,844	2.2	214,572	2.3	(6,728)	(5.3)
Nonoperating gains	159,539	1.7	149,833	1.6	9,706	7.6
Excess revenue and gains over expenses before extraordinary items	367,383	3.9	364,405	3.9	2,979	2.3
Extraordinary gain (loss)	(2,966)	(0.0)	(2,966)	(0.0)	0	0.0
Excess revenue and gains over expenses including extraordinary items	$ 364,418	3.9 %	$ 361,439	3.9 %	$ 2,979	2.3 %

New Jersey Hospitals
Comparisons of Income (Loss) from Operations

	Total Number of Hospitals*		Income (Loss) from Operations Millions of Dollars					Income (Loss) from Operations (Percentage to total operating revenue)				
	Acute Care	Non-acute Care	1997	1996	1995	1994	1993	1997	1996	1995	1994	1993
Statewide	68	6	$78.9	$207.8	$318.8	$327.7	$429.1	0.8%	1.4%	3.1%	3.3%	4.4%
Local Advisory Boards:												
LAB I	10	0	(3.0)	13.3	57.6	50.7	77.8	-0.3	1.07	4.03	3.7	5.54
LAB II	13	1	33.0	29.9	47.1	61.2	60.3	1.9	1.18	2.64	3.51	3.52
LAB III	14	0	(9.5)	10.7	49.3	48.6	84.3	-0.4	0.1	2.22	2.18	3.8
LAB IV	11	2	16.6	91.1	70.2	63.3	66.0	1.0	5.31	4.57	4.3	4.59
LAB V	9	0	22.8	23.8	38.4	44.3	59.0	1.5	-1.52	2.06	2.45	3.97
LAB VI	11	3	19.0	39.0	56.0	59.4	81.8	1.1	2.31	3.94	4.38	5.5
Classifications:												
Major Teaching	16	0	51.4	158.5	183.1	143.7	170.8	1.1	2.5	4.39	3.63	4.75
Minor Teaching	15	0	10.4	33.3	50.1	69.3	87.3	0.5	1.56	2.82	3.96	4.52
Non-Teaching	37	0	18.2	33.4	88.4	107.2	173.9	0.6	0.68	2.21	2.73	4.44
Rehabilitation	0	3	(0.4)	(2.4)	7.6	8.8	8.7	-0.5	-4.4	4.84	5.76	5.84
Specialized	0	3	(0.6)	(14.9)	(10.5)	(1.5)	(11.5)	-0.8	-8.47	-6.03	-0.85	-7.36
Catchment Areas:												
Inner City	16	0	(10.0)	6.0	54.2	34.8	105.4	-0.4	-2.05	1.81	1.18	3.92
Urban	17	0	(29.1)	27.4	95.1	88.0	104.0	-1.3	0.82	3.95	3.85	4.31
Suburban	24	6	119.0	159.6	156.7	175.3	184.9	2.6	3.41	3.8	4.38	4.72
Rural	11	0	(1.0)	14.9	12.7	29.4	34.9	-0.1	1.91	1.65	3.95	4.79
Bed Size Ranges:												
Under 100	1	2	(0.8)	(2.5)	3.9	2.3	7.3	-1.1	-4.43	3.33	2.04	6.95
100 to 199	10	2	(12.1)	(14.0)	3.9	14.1	13.6	-2.1	-2.53	0.63	2.33	2.31
200 to 299	14	1	0.2	(7.1)	23.5	35.2	33.1	0.0	-0.7	1.96	3	2.82
300 to 399	12	0	1.0	(3.9)	18.3	29.5	84.6	0.1	-0.36	1.29	2.1	5.64
400 to 499	8	1	54.4	102.1	76.8	78.6	80.3	4.2	7.55	3.55	3.75	4.06
500 to 1000	23	0	36.3	133.3	192.3	167.7	210.3	0.6	1.36	4.04	3.67	4.78
Acute Care Hospitals	68	0	$80.0	$214.6	$300.2	$420.5	$420.5	0.8%	1.5%	3.1%	3.2%	4.4%
Non-acute Care Hospitals	0	6	($1.0)	($6.7)	$14.2	$8.7	$8.7	-0.7%	-5.5%	2.8%	6.0%	4.2%

* Indicates number of hospitals or hospital systems in their designated groupings for 1997

New Jersey Hospitals
Number of Hospitals with Loss from Operations

	Total Number of Hospitals						
	Acute Care	Non-acute Care	1997	1996[a]	1995[b]	1994[b]	1993[b]
Statewide	**68**	**6**	**22**	**26**	**14**	**10**	**4**
Local Advisory Boards:							
LAB I	10	0	4	5	2	0	0
LAB II	13	1	3	6	1	0	0
LAB III	14	0	7	6	6	6	1
LAB IV	11	2	4	4	3	0	1
LAB V	9	0	2	3	2	1	1
LAB VI	11	3	2	2	0	3	1
Classifications:							
Major Teaching	16	0	5	3	3	2	0
Minor Teaching	15	0	4	2	2	1	0
Non-Teaching	37	0	11	17	6	5	1
Rehabilitation	0	3	1	1	1	0	1
Specialized	0	3	1	3	2	2	2
Catchment Areas:							
Inner City	16	0	5	9	5	3	0
Urban	17	0	7	5	3	2	0
Suburban	24	6	7	10	5	4	3
Rural	11	0	3	2	1	1	1
Bed Size Ranges:							
Under 100	1	2	1	1	1	1	1
100 to 199	10	2	5	4	2	2	2
200 to 299	14	1	4	6	3	1	1
300 to 399	12	0	4	8	3	3	0
400 to 499	8	1	1	3	3	0	0
500 to 1000	23	0	7	4	2	3	0
Acute Care Hospitals	68	0	20	23	12	9	2
Non-acute Care Hospitals	0	6	2	3	2	1	2

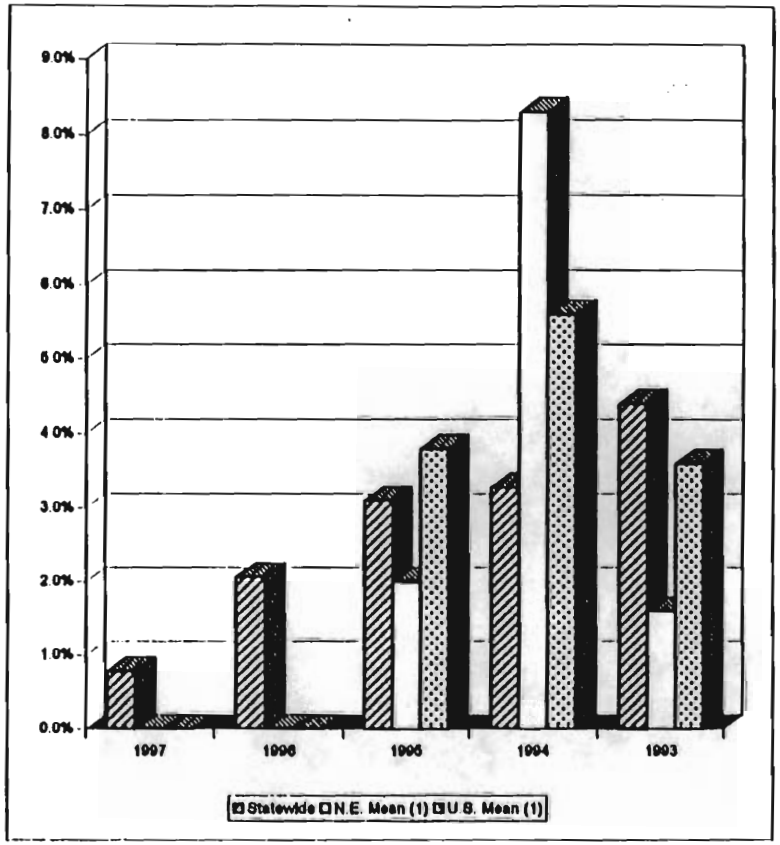
Number of hospitals in groupings:

a. 83 hospitals/systems

b. 88 hospitals/systems

Operating Margin Ratio

	1997	1996	1995	1994	1993
Statewide	0.8%	2.1%	3.1%	3.3%	4.4%
Local Advisory Boards:					
LAB I	-0.3%	1.2%	4.0%	3.7%	5.5%
LAB II	1.9%	1.6%	2.6%	3.5%	3.5%
LAB III	-0.4%	0.5%	2.2%	2.2%	3.8%
LAB IV	1.0%	5.6%	4.6%	4.3%	4.6%
LAB V	1.5%	1.5%	2.1%	2.5%	4.0%
LAB VI	1.1%	2.4%	3.9%	4.4%	5.5%
Classifications :					
Major Teaching	1.1%	4.0%	4.4%	3.6%	4.8%
Minor Teaching	0.5%	1.8%	2.8%	4.0%	4.5%
Non-Teaching	0.6%	0.8%	2.2%	2.7%	4.4%
Rehabilitation	-0.5%	-3.4%	4.8%	5.8%	5.8%
Specialized	-0.8%	-8.4%	-6.0%	-0.9%	-7.4%
Catchment Areas:					
Inner City	-0.4%	0.2%	1.8%	1.2%	3.9%
Urban	-1.3%	1.1%	4.0%	3.9%	4.3%
Suburban	2.6%	3.6%	3.8%	4.4%	4.7%
Rural	-0.1%	1.9%	1.7%	4.0%	4.8%
Bed Size Ranges:					
Under 100	-1.1%	-3.4%	3.3%	2.0%	7.0%
100 to 199	-2.1%	-2.5%	0.6%	2.3%	2.3%
200 to 299	0.0%	-0.7%	2.0%	3.0%	2.8%
300 to 399	0.1%	-0.2%	1.3%	2.1%	5.6%
400 to 499	4.2%	8.0%	3.6%	3.8%	4.1%
500 to 1000	0.6%	2.5%	4.0%	3.7%	4.8%
Acute Care Hospitals	0.8%	2.2%	3.1%	3.2%	4.4%
Non-acute Hospitals	-0.7%	-4.9%	2.8%	6.0%	4.2%
N.E. Mean (1)	N/A	N/A	2.0%	8.3%	1.6%
U.S. Mean (1)	N/A	N/A	3.8%	5.6%	3.6%



This profitability ratio defines the proportion of operating revenue (net of reduction) retained as income. The higher the ratio, the better the hospital's financial condition.

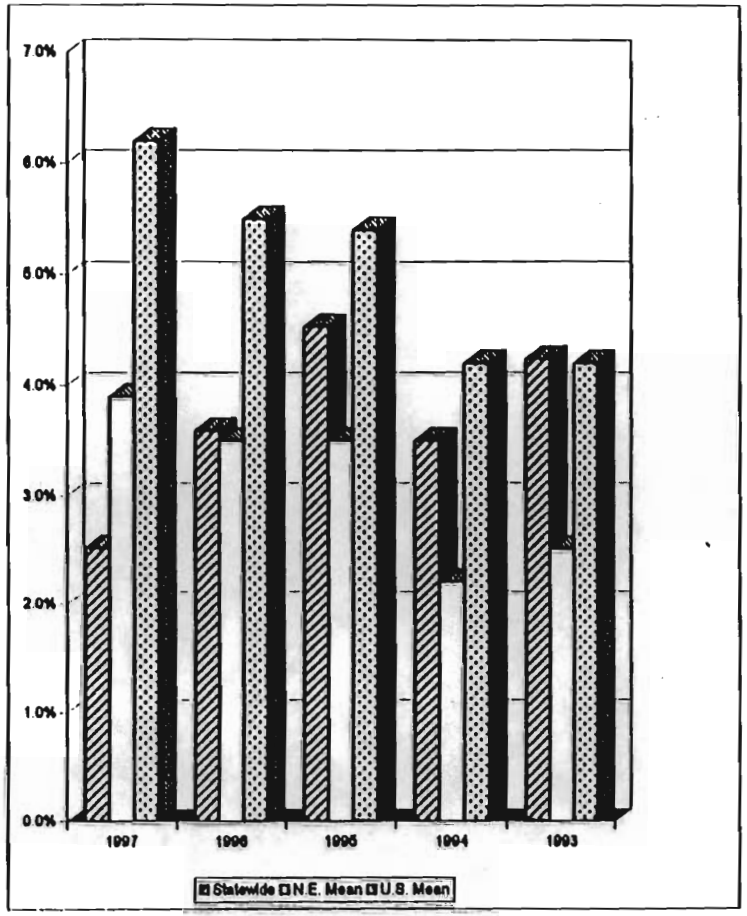
$$\text{Formula:} \quad \frac{\text{Total revenue - Total expenses}}{\text{Total revenue}}$$

Desired Trend: Increasing values are favorable

(1) Operating Margin being phased out - per new accounting principles.

Total Margin Ratio

	1997	1996	1995	1994	1993
Statewide	2.5%	3.6%	4.5%	3.5%	4.2%
Local Advisory Boards:					
LAB I	0.8%	3.7%	5.4%	3.8%	2.5%
LAB II	2.5%	2.4%	3.3%	3.9%	4.2%
LAB III	1.8%	2.2%	4.0%	2.5%	3.8%
LAB IV	2.9%	5.5%	6.1%	5.1%	4.2%
LAB V	4.0%	4.3%	3.4%	3.0%	4.8%
LAB VI	2.9%	4.3%	5.9%	3.3%	6.1%
Classifications :					
Major Teaching	2.4%	5.5%	5.0%	3.6%	4.7%
Minor Teaching	2.8%	1.8%	4.4%	4.6%	4.5%
Non-Teaching	2.5%	2.8%	4.1%	2.7%	3.8%
Rehabilitation	4.5%	3.1%	7.5%	8.1%	7.5%
Specialized	5.0%	-0.6%	2.8%	3.2%	-1.2%
Catchment Areas:					
Inner City	0.0%	0.4%	2.7%	1.3%	4.2%
Urban	0.5%	2.7%	5.1%	3.6%	4.1%
Suburban	4.4%	5.7%	5.4%	5.0%	4.0%
Rural	5.0%	4.4%	5.2%	3.9%	6.3%
Bed Size Ranges:					
Under 100	2.8%	2.0%	7.3%	2.9%	7.2%
100 to 199	-0.3%	1.1%	3.2%	4.1%	4.6%
200 to 299	2.7%	1.8%	4.0%	3.7%	3.1%
300 to 399	2.5%	1.2%	3.8%	1.8%	5.9%
400 to 499	6.6%	7.2%	5.3%	3.8%	1.9%
500 to 1000	1.9%	4.2%	4.7%	3.8%	4.9%
Acute Care Hospitals	2.5%	3.6%	4.5%	3.4%	4.2%
Non-acute Hospitals	4.8%	2.0%	7.9%	8.1%	5.5%
N.E. Mean	3.9%	3.5%	3.5%	2.2%	2.5%
U.S. Mean	6.2%	5.5%	5.4%	4.2%	4.2%



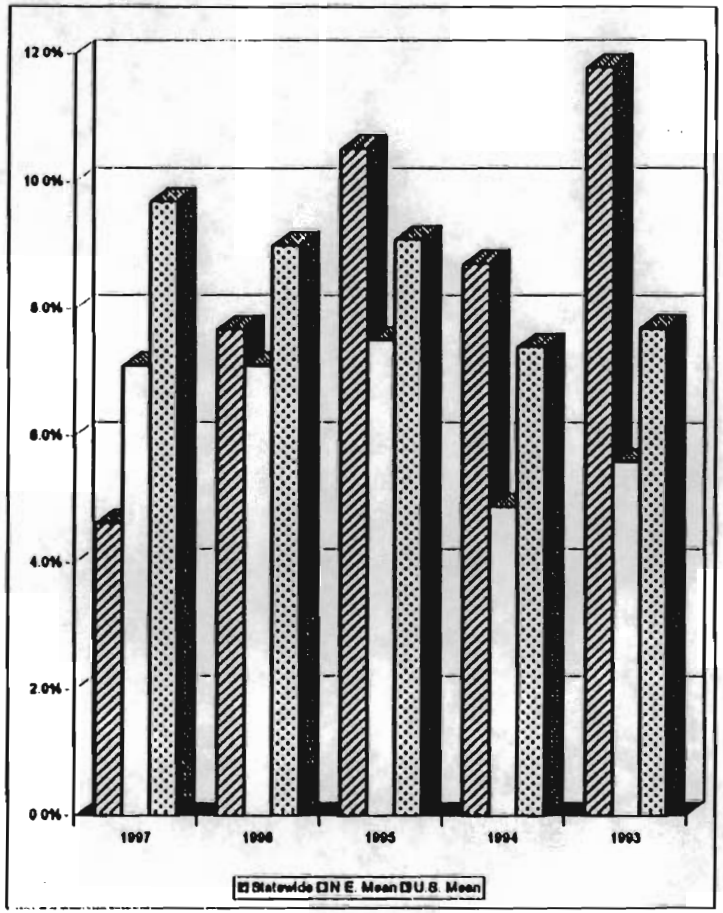
The total margin ratio is a measure of the overall profitability of a hospital. It reflects profits from both operations and nonoperations.

Formula: $\frac{\text{Excess revenue and gains over expenses}}{\text{Total revenue + nonoperating gains}}$

Desired Trend: Increasing values are favorable

Return on Equity Ratio

	1997	1996	1995	1994	1993
Statewide	4.6%	7.7%	10.5%	8.7%	11.8%
Local Advisory Boards:					
LAB I	1.6%	8.4%	12.0%	9.3%	7.3%
LAB II	5.1%	5.6%	7.9%	9.9%	12.2%
LAB III	2.2%	4.2%	8.5%	5.8%	9.5%
LAB IV	5.2%	10.6%	13.0%	11.9%	11.1%
LAB V	8.0%	10.1%	9.2%	8.1%	14.7%
LAB VI	5.9%	9.5%	14.7%	8.9%	17.1%
Classifications :					
Major Teaching	4.3%	10.9%	11.8%	9.2%	13.2%
Minor Teaching	5.4%	4.3%	10.0%	11.2%	12.0%
Non-Teaching	4.7%	6.1%	9.8%	7.1%	11.3%
Rehabilitation	6.2%	4.3%	9.1%	10.3%	11.1%
Specialized	6.0%	-1.3%	5.5%	6.7%	-2.3%
Catchment Areas:					
Inner City	-0.5%	0.9%	7.9%	3.9%	14.3%
Urban	0.5%	6.9%	13.4%	10.4%	12.7%
Suburban	7.0%	10.5%	10.8%	10.7%	9.7%
Rural	7.8%	7.4%	9.7%	7.6%	14.0%
Bed Size Ranges:					
Under 100	4.3%	3.1%	14.0%	6.2%	15.5%
100 to 199	-1.3%	2.3%	6.0%	8.0%	10.1%
200 to 299	5.8%	4.4%	10.2%	10.2%	9.5%
300 to 399	3.6%	2.8%	9.5%	4.8%	17.1%
400 to 499	10.8%	12.8%	11.4%	9.1%	5.3%
500 to 1000	3.5%	8.9%	11.2%	9.5%	13.7%
Acute Care Hospitals	4.6%	7.8%	10.5%	8.6%	11.9%
Non-acute Hospitals	6.1%	2.9%	10.4%	11.3%	8.4%
N.E. Mean	7.1%	7.1%	7.5%	4.9%	5.6%
U.S. Mean	9.7%	9.0%	9.1%	7.4%	7.7%



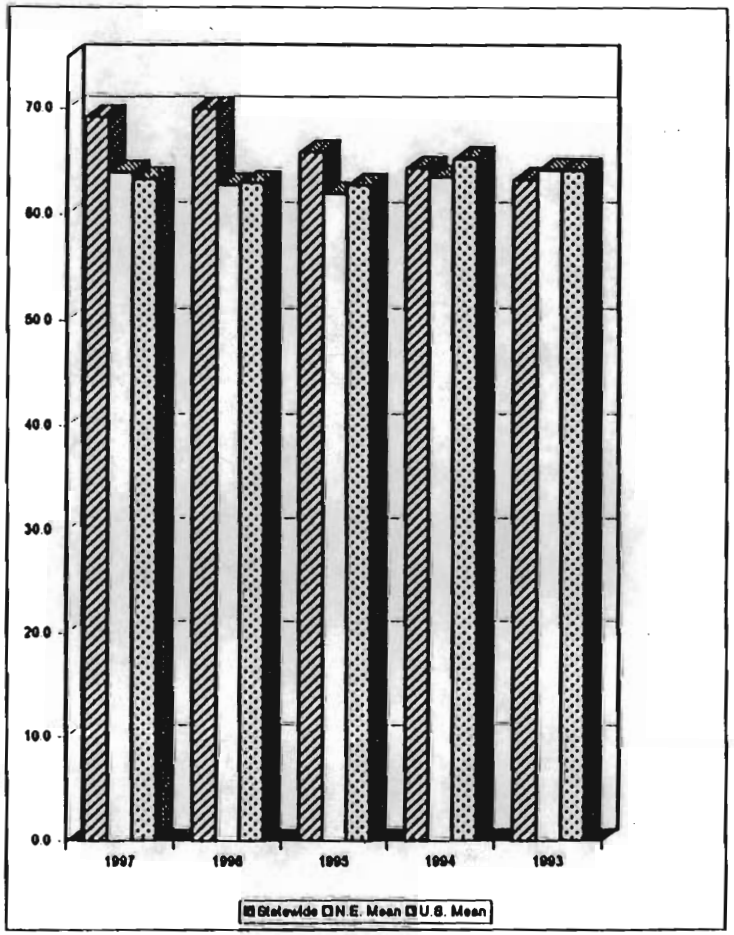
The return on equity ratio measures the amount of net income earned per dollar of equity investment (fund balance).

Formula: $\frac{\text{Excess revenue and gains over expenses}}{\text{Equity (net assets)}}$

Desired Trend: Increasing values are favorable.

Days in Patient Accounts Receivable Ratio

	1997	1996	1995	1994	1993
Statewide	69.2	69.9	65.9	64.4	63.3
Local Advisory Boards:					
LAB I	81.5	73.3	70.8	68.3	64.9
LAB II	63.6	71.3	66.4	70.8	72.1
LAB III	70.9	75.6	71.4	66.6	64.7
LAB IV	70.4	68.5	63.0	62.3	63.5
LAB V	74.0	65.9	60.4	57.8	58.5
LAB VI	60.4	64.1	62.1	59.7	54.3
Classifications :					
Major Teaching	73.8	77.0	70.5	64.9	62.7
Minor Teaching	66.1	66.4	63.6	65.9	61.8
Non-Teaching	65.0	65.1	62.4	63.7	64.6
Rehabilitation	75.0	64.1	55.5	49.9	54.1
Specialized	60.0	67.3	72.1	67.1	72.0
Catchment Areas:					
Inner City	73.4	72.8	63.9	62.2	63.5
Urban	71.6	74.1	69.6	70.6	66.4
Suburban	66.1	66.2	65.7	62.8	61.3
Rural	68.4	69.4	63.0	62.6	63.3
Bed Size Ranges:					
Under 100	82.5	75.7	58.4	46.2	66.3
100 to 199	65.2	72.3	64.0	65.3	62.9
200 to 299	60.7	63.7	65.0	70.7	67.9
300 to 399	67.8	66.5	66.2	68.7	68.1
400 to 499	64.6	61.5	61.2	60.5	61.0
500 to 1000	72.2	74.2	68.7	63.6	61.5
Acute Care Hospitals	69.2	70.1	66.1	64.7	63.5
Non-acute Hospitals	68.0	59.6	57.9	50.9	55.0
N.E. Mean	64.0	62.8	62.0	63.6	64.2
U.S. Mean	63.4	63.0	62.8	65.3	64.2



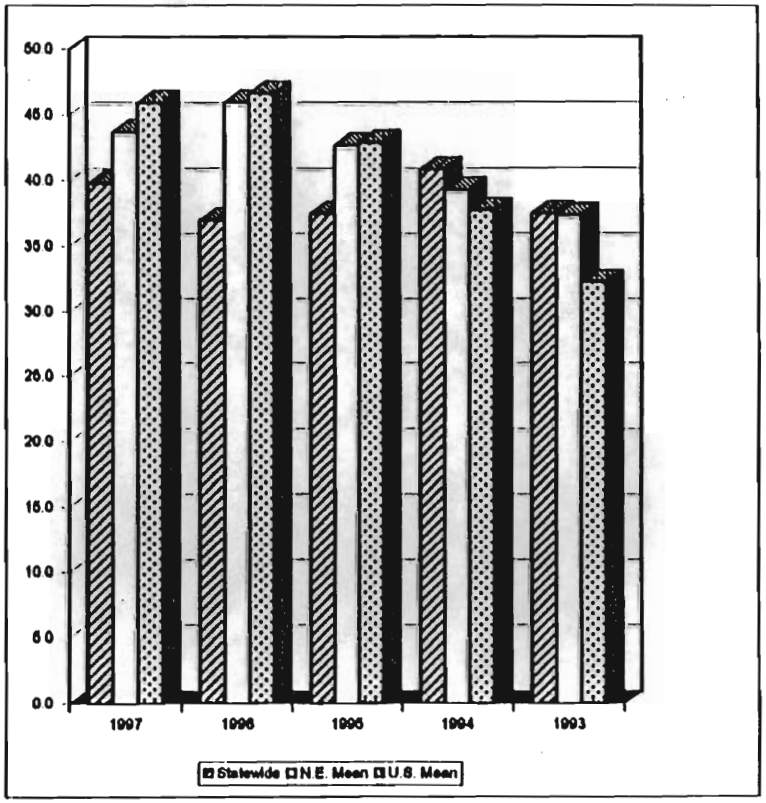
The days in patient accounts receivable ratio measures the average time that receivables are outstanding, commonly referred to as the average collection period.

$$\text{Formula: } \frac{\text{Net accounts receivable}}{\text{Net patient service revenue}} \times \text{Number of Days in the period}$$

Desired Trend: Decreasing values are favorable.

Days Cash on Hand Ratio

	1997	1996	1995	1994	1993
Statewide	39.8	36.9	37.5	40.9	37.4
Local Advisory Boards:					
LAB I	48.0	43.3	47.6	48.8	38.3
LAB II	28.1	23.8	32.6	34.8	30.9
LAB III	26.7	30.0	32.0	36.4	40.7
LAB IV	60.1	55.7	66.8	79.5	60.1
LAB V	20.7	21.1	15.3	16.4	17.0
LAB VI	63.1	55.1	40.7	39.8	38.2
Classifications :					
Major Teaching	37.2	32.3	31.5	34.3	38.0
Minor Teaching	46.6	44.0	52.8	64.9	42.1
Non-Teaching	38.2	38.7	31.5	34.3	38.0
Rehabilitation	54.3	34.5	39.7	39.3	33.6
Specialized	59.7	26.2	29.5	24.1	31.9
Catchment Areas:					
Inner City	37.2	34.8	34.9	40.4	34.1
Urban	33.1	38.1	43.4	43.7	36.0
Suburban	45.9	39.6	38.2	42.1	43.1
Rural	32.0	25.2	25.8	28.0	24.3
Bed Size Ranges:					
Under 100	30.1	20.4	40.2	43.1	38.7
100 to 199	34.7	28.8	35.5	41.7	35.1
200 to 299	46.0	34.1	46.2	44.5	44.7
300 to 399	43.7	44.1	42.5	47.5	32.0
400 to 499	38.3	31.2	45.9	48.7	44.4
500 to 1000	38.9	37.6	30.2	34.3	34.5
Acute Care Hospitals	39.5	36.8	37.2	40.8	37.3
Non-acute Hospitals	57.0	44.8	47.6	42.7	42.5
N.E. Mean	43.7	45.9	42.7	39.3	37.3
U.S. Mean	45.9	46.6	42.9	37.7	32.2



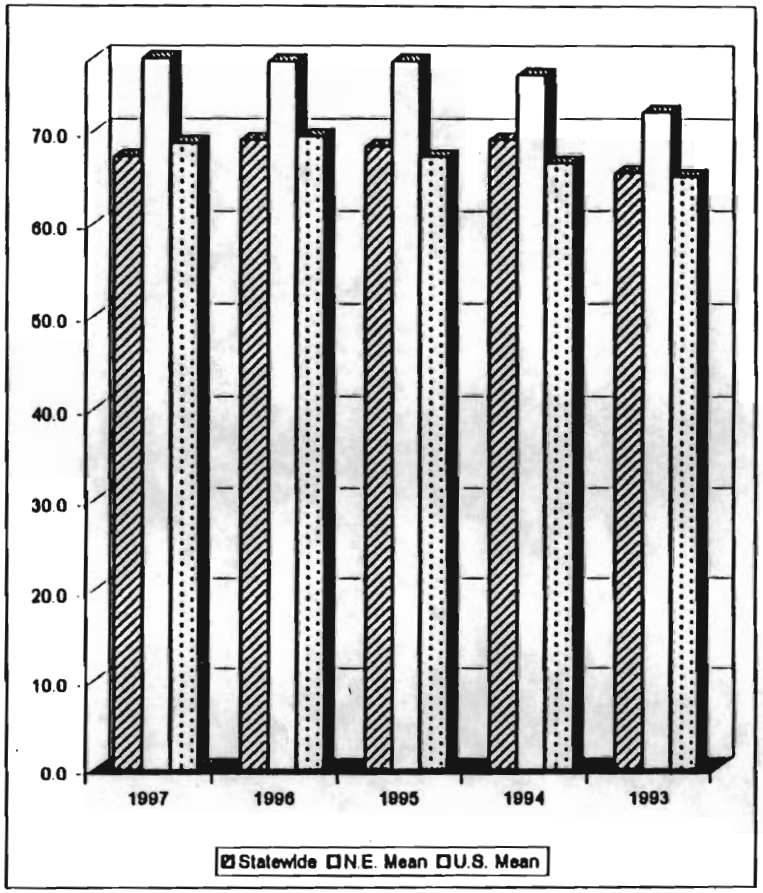
The days cash on hand ratio indicates the number of days that a hospital would be able to operate at a current level with available cash and temporary investments if no additional income were received and no additional expenses were incurred. Non-cash items include depreciation and amortization.

$$\text{Formula: } \frac{\text{Cash + Short Term Investments + Funds whose use is limited - current portion}}{\text{Total Expenses - Non-cash items}} \times \text{Number of Days in the period}$$

Desired Trend: Increasing values are favorable.

Average Payment Period Ratio

	1997	1996	1995	1994	1993
Statewide	67.3	69.2	68.4	69.1	65.5
Local Advisory Boards:					
LAB I	72.3	70.9	65.3	64.8	63.5
LAB II	69.4	70.5	70.7	72.9	68.5
LAB III	68.1	71.0	72.0	68.9	65.5
LAB IV	61.6	64.2	108.1	106.6	101.8
LAB V	64.8	66.8	62.7	65.4	60.8
LAB VI	68.8	70.8	69.0	72.3	69.7
Classifications:					
Major Teaching	67.0	69.0	69.5	66.8	64.8
Minor Teaching	61.3	61.6	65.0	69.3	63.8
Non-Teaching	71.9	72.9	70.7	74.2	69.5
Rehabilitation	69.0	65.7	40.6	39.1	42.1
Specialized	62.1	68.1	63.0	60.3	56.2
Catchment Areas:					
Inner City	74.1	73.2	66.8	67.5	65.4
Urban	68.1	66.7	68.2	74.3	68.1
Suburban	62.4	67.1	69.5	66.6	64.2
Rural	72.9	75.6	69.5	73.5	65.3
Bed Size Ranges:					
Under 100	57.5	60.5	47.6	55.5	50.7
100 to 199	75.2	81.6	67.7	77.7	67.8
200 to 299	77.6	81.9	77.6	76.9	75.2
300 to 399	68.8	71.1	62.8	68.3	64.9
400 to 499	67.4	62.0	74.5	69.7	66.2
500 to 1000	64.7	66.2	66.0	66.8	63.6
Acute Care Hospitals	67.4	69.2	69.1	70.3	66.5
Non-acute Hospitals	65.5	64.0	45.0	47.8	45.4
N.E. Mean	77.9	77.6	77.6	76.1	72.1
U.S. Mean	68.8	69.5	67.3	66.6	65.1



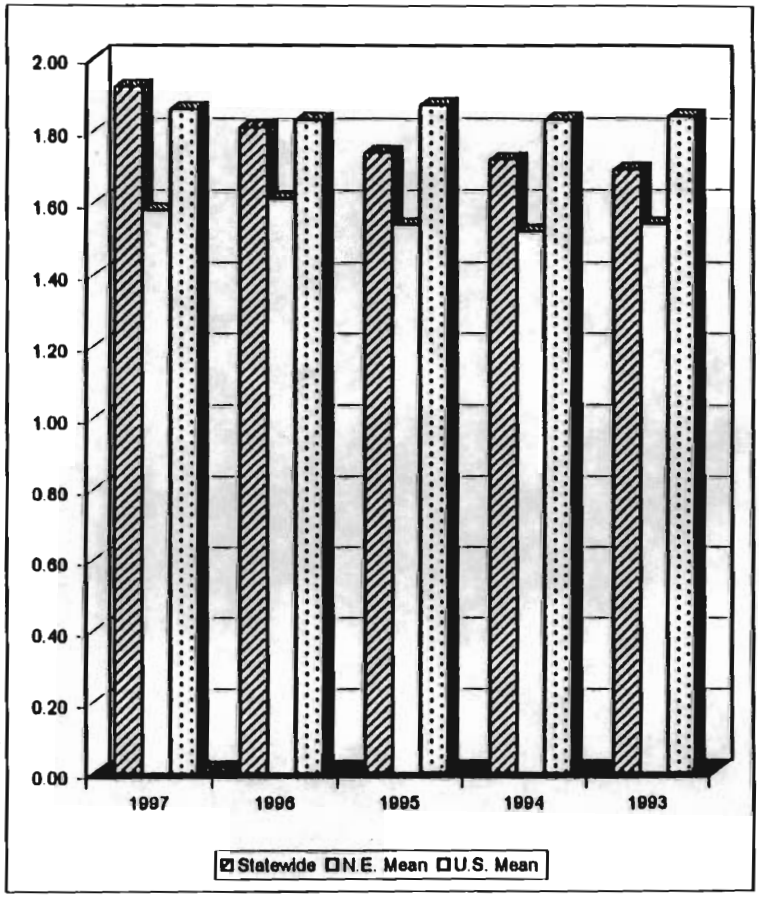
The average payment period ratio provides a measure of the average time that elapses before current liabilities are paid. High values may indicate potential liquidity problems.

$$\text{Formula: } \frac{\text{Current liabilities}}{\text{Total expenses - Depreciation}} \times \text{Number of Days in the period}$$

Desired Trend: Decreasing values are favorable.

Current Ratio

	1997	1996	1995	1994	1993
Statewide	1.92	1.81	1.74	1.72	1.69
Local Advisory Boards:					
LAB I	2.01	1.87	2.00	2.02	1.80
LAB II	1.65	1.73	1.67	1.64	1.67
LAB III	1.89	1.71	1.79	1.76	1.71
LAB IV	2.34	2.25	1.79	1.76	1.71
LAB V	1.69	1.51	1.39	1.32	1.43
LAB VI	2.01	1.91	1.65	1.54	1.53
Classifications :					
Major Teaching	2.03	1.84	1.75	1.73	1.70
Minor Teaching	2.09	2.13	1.99	2.00	1.75
Non-Teaching	1.67	1.66	1.58	1.53	1.59
Rehabilitation	2.40	2.51	3.48	3.60	3.32
Specialized	2.00	1.59	1.80	2.19	2.04
Catchment Areas:					
Inner City	1.71	1.64	1.64	1.64	1.62
Urban	1.68	1.93	1.82	1.67	1.64
Suburban	2.25	1.92	1.82	1.87	1.80
Rural	1.59	1.47	1.45	1.45	1.56
Bed Size Ranges:					
Under 100	2.66	2.81	3.05	2.55	3.15
100 to 199	1.52	1.40	1.66	1.62	1.63
200 to 299	1.51	1.40	1.54	1.60	1.58
300 to 399	1.89	1.84	2.01	1.86	1.72
400 to 499	1.87	1.97	1.59	1.73	1.75
500 to 1000	2.06	1.91	1.78	1.70	1.66
Acute Care Hospitals	1.92	1.80	1.72	1.69	1.66
Non-acute Hospitals	2.21	2.28	3.06	3.15	3.07
N.E. Mean	1.58	1.61	1.54	1.52	1.54
U.S. Mean	1.86	1.83	1.87	1.83	1.84



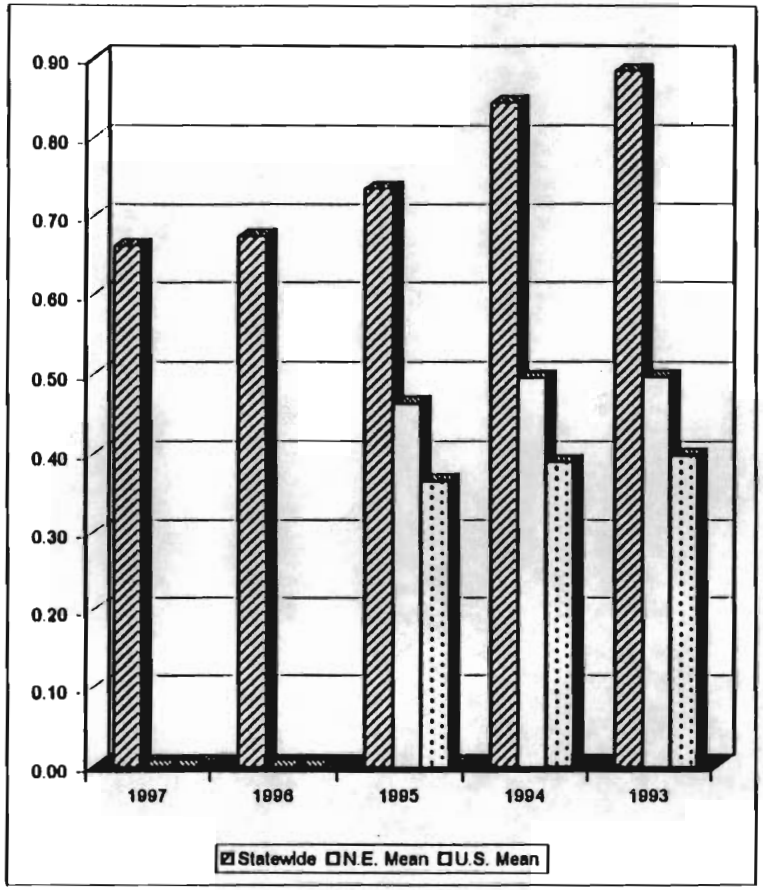
The current ratio indicates the number of dollars of current assets for each dollar of current liabilities; it shows the number of times that current assets will "pay off" the current debts of the hospitals, and relates to a safety margin.

Formula: $\frac{\text{Current assets}}{\text{Current liabilities}}$

Desired Trend: Increasing values are favorable.

Long-Term Debt to Equity Ratio

	1997	1996	1995	1994	1993
Statewide	0.66	0.68	0.74	0.84	0.88
Local Advisory Boards:					
LAB I	0.73	0.86	0.64	0.80	0.91
LAB II	0.52	0.60	0.64	0.72	0.77
LAB III	0.76	0.61	0.68	0.77	0.79
LAB IV	0.62	0.65	0.73	0.84	0.85
LAB V	0.51	0.57	0.81	0.88	0.87
LAB VI	0.79	0.87	1.00	1.17	1.20
Classifications :					
Major Teaching	0.62	0.54	0.67	0.79	0.75
Minor Teaching	0.78	0.80	0.77	0.83	0.88
Non-Teaching	0.66	0.77	0.84	0.97	1.08
Rehabilitation	0.41	0.46	0.13	0.13	0.19
Specialized	0.71	0.73	0.73	0.86	0.78
Catchment Areas:					
Inner City	0.84	0.84	0.89	1.00	0.91
Urban	0.96	0.98	0.95	1.14	1.17
Suburban	0.56	0.54	0.61	0.70	0.77
Rural	0.42	0.42	0.51	0.59	0.70
Bed Size Ranges:					
Under 100	0.17	0.20	0.41	0.47	0.37
100 to 199	0.67	0.57	0.47	0.51	0.58
200 to 299	0.68	0.81	0.88	1.03	1.19
300 to 399	0.78	0.90	0.87	0.99	1.06
400 to 499	0.39	0.47	0.68	0.78	0.85
500 to 1000	0.72	0.66	0.75	0.86	0.84
Acute Care Hospitals	0.67	0.68	0.76	0.87	0.91
Non-acute Hospitals	0.55	0.58	0.29	0.32	0.30
N.E. Mean	N/A	N/A	0.46	0.50	0.50
U.S. Mean	N/A	N/A	0.37	0.39	0.40



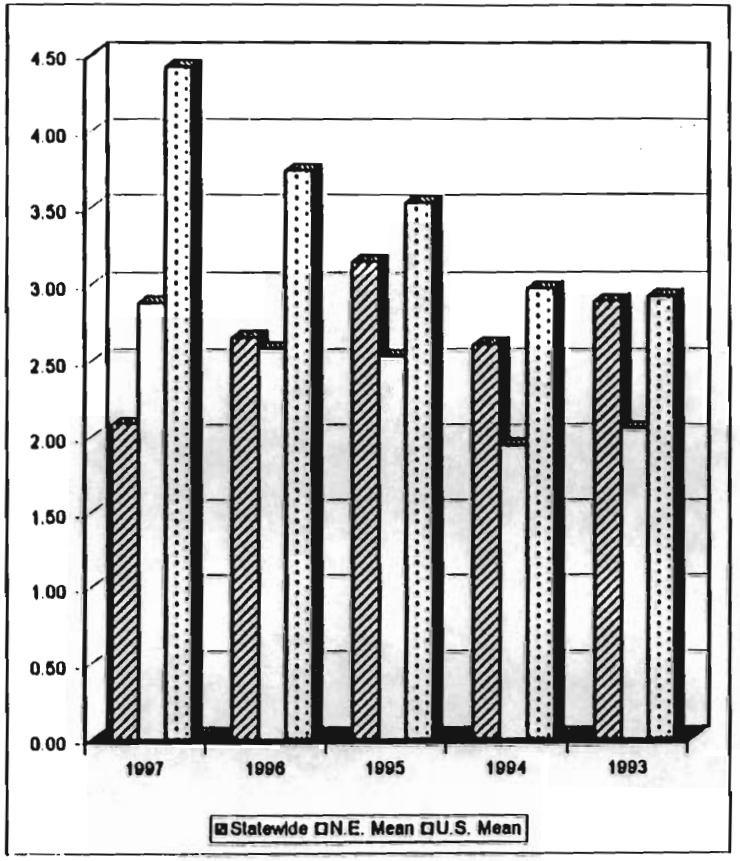
This ratio reflects the relationship between debt and non-debt sources of asset financing, thereby serving as an indicator of the soundness of the hospital's capital structure. This ratio could also indicate the ability to borrow additional long-term funds, sometimes referred to as financial leverage.

Formula: $\frac{\text{Long-term debt}}{\text{Equity (net assets)}}$

Desired Trend: Decreasing values are favorable.

Times Interest Earned Ratio

	1997	1996	1995	1994	1993
Statewide	2.08	2.65	3.15	2.61	2.89
Local Advisory Boards:					
LAB I	1.34	2.48	3.43	2.48	1.88
LAB II	2.32	2.26	2.70	3.16	3.34
LAB III	1.47	1.95	2.73	2.10	2.71
LAB IV	2.46	3.82	4.10	3.53	3.34
LAB V	3.60	3.49	3.06	2.74	3.52
LAB VI	2.05	2.57	3.21	2.14	2.99
Classifications :					
Major Teaching	2.09	3.89	3.79	3.08	3.71
Minor Teaching	2.15	1.86	3.29	3.32	3.06
Non-Teaching	2.00	2.12	2.63	2.00	2.35
Rehabilitation	4.92	3.43	8.00	8.59	7.47
Specialized	2.16	0.76	1.96	2.27	0.22
Catchment Areas:					
Inner City	0.91	1.15	2.41	1.65	3.05
Urban	1.07	2.08	3.17	2.51	2.68
Suburban	3.02	3.78	3.51	3.21	2.70
Rural	4.06	3.53	3.82	3.07	4.35
Bed Size Ranges:					
Under 100	3.69	2.70	4.08	2.16	5.85
100 to 199	0.65	1.60	2.85	3.57	4.12
200 to 299	2.12	1.73	2.52	2.34	2.12
300 to 399	1.66	1.42	2.50	1.65	3.04
400 to 499	4.83	4.92	3.58	2.76	1.90
500 to 1000	1.78	3.07	3.43	2.96	3.38
Acute Care Hospitals	2.07	2.67	3.12	2.56	2.87
Non-acute Hospitals	2.86	1.75	4.62	4.56	3.92
N.E. Mean	2.88	2.58	2.53	1.94	2.05
U.S. Mean	4.42	3.74	3.53	2.97	2.92



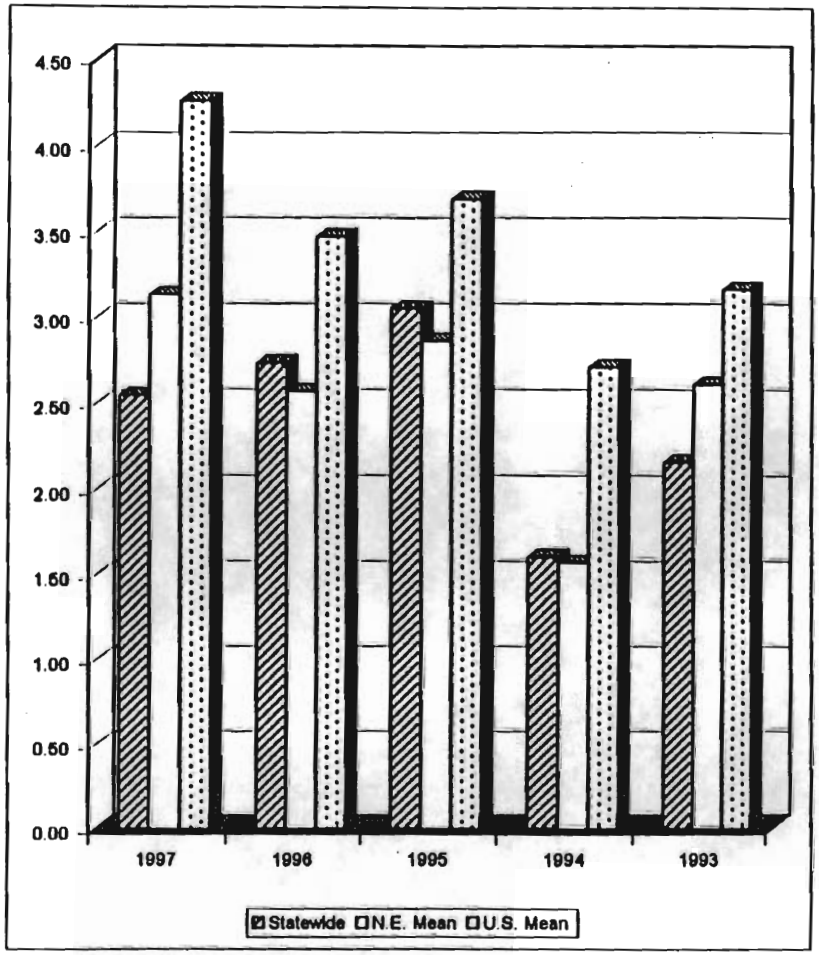
This ratio measures the ability of a hospital to meet its interest payments. It shows the extent to which earnings could drop and still allow a hospital to meet existing interest obligations, and it measures the extent to which a hospital can assume additional debt based on current profitability.

$$\text{Formula:} \quad \frac{\text{Excess of revenue and gains over expenses + Interest expense}}{\text{Interest expense}}$$

Desired Trend: Increasing values are favorable.

Debt Service Coverage Ratio

	1997	1996	1995	1994	1993
Statewide	2.55	2.73	3.05	1.60	2.16
Local Advisory Boards:					
LAB I	2.17	2.40	3.06	1.86	2.12
LAB II	2.57	2.52	2.79	1.10	1.84
LAB III	2.29	2.49	2.86	1.94	2.50
LAB IV	2.87	3.61	3.01	2.88	2.57
LAB V	2.99	2.88	3.51	3.22	1.56
LAB VI	2.50	2.67	3.24	0.87	2.59
Classifications :					
Major Teaching	2.80	3.70	4.08	1.48	2.73
Minor Teaching	2.61	2.34	2.88	2.14	1.79
Non-Teaching	2.25	2.25	2.56	1.48	2.18
Rehabilitation	3.75	2.91	6.45	2.83	3.83
Specialized	2.63	1.78	1.30	2.80	0.26
Catchment Areas:					
Inner City	1.75	1.84	2.83	1.23	2.19
Urban	1.85	2.40	2.92	1.00	1.99
Suburban	3.17	3.47	3.20	2.45	2.18
Rural	3.71	2.55	3.29	3.01	2.49
Bed Size Ranges:					
Under 100	3.00	2.52	2.42	1.16	2.72
100 to 199	2.07	1.74	2.61	2.57	1.36
200 to 299	2.20	1.91	2.22	1.31	1.93
300 to 399	2.18	1.94	2.53	1.21	1.75
400 to 499	3.54	4.02	3.41	2.10	2.21
500 to 1000	2.53	3.18	3.51	1.59	2.62
Acute Care Hospitals	2.54	2.74	3.09	1.58	2.22
Non-acute Hospitals	3.04	2.26	2.18	2.79	0.92
N.E. Mean	3.13	2.57	2.86	1.57	2.61
U.S. Mean	4.26	3.47	3.69	2.71	3.16



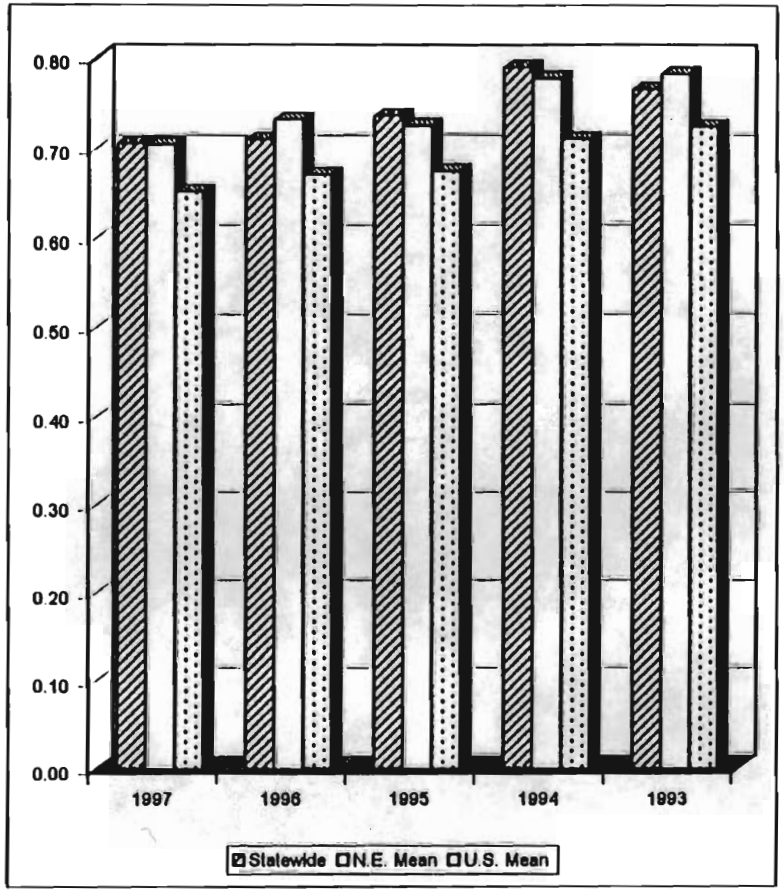
The debt service coverage ratio measures the number of times cash flow would pay debt service (principal + interest).

$$\text{Formula:} \quad \frac{\text{Cash flow + Interest expense}}{\text{Principal payment + Interest expense}}$$

Desired Trend: Increasing values are favorable.

Fixed Asset Financing Ratio

	1997	1996	1995	1994	1993
Statewide	0.71	0.71	0.74	0.79	0.77
Local Advisory Boards:					
LAB I	0.76	0.85	0.71	0.80	0.78
LAB II	0.53	0.57	0.61	0.65	0.64
LAB III	0.78	0.69	0.70	0.75	0.73
LAB IV	0.66	0.70	0.73	0.79	0.71
LAB V	0.72	0.70	0.84	0.87	0.85
LAB VI	0.77	0.81	0.86	0.93	0.92
Classifications :					
Major Teaching	0.69	0.62	0.66	0.73	0.66
Minor Teaching	0.68	0.73	0.76	0.79	0.78
Non-Teaching	0.75	0.79	0.82	0.87	0.87
Rehabilitation	0.56	0.75	0.25	0.28	0.38
Specialized	0.82	0.65	0.66	0.76	0.79
Catchment Areas:					
Inner City	0.79	0.78	0.80	0.89	0.80
Urban	0.73	0.79	0.79	0.86	0.83
Suburban	0.68	0.65	0.68	0.72	0.71
Rural	0.59	0.55	0.61	0.65	0.73
Bed Size Ranges:					
Under 100	0.27	0.32	0.52	0.56	0.53
100 to 199	0.67	0.58	0.53	0.58	0.63
200 to 299	0.73	0.76	0.77	0.82	0.86
300 to 399	0.71	0.77	0.90	0.94	0.92
400 to 499	0.63	0.70	0.72	0.75	0.73
500 to 1000	0.72	0.70	0.73	0.79	0.73
Acute Care Hospitals	0.71	0.71	0.73	0.78	0.77
Non-acute Hospitals	0.69	0.77	0.47	0.57	0.58
N.E. Mean	0.70	0.73	0.73	0.78	0.78
U.S. Mean	0.65	0.67	0.68	0.71	0.72



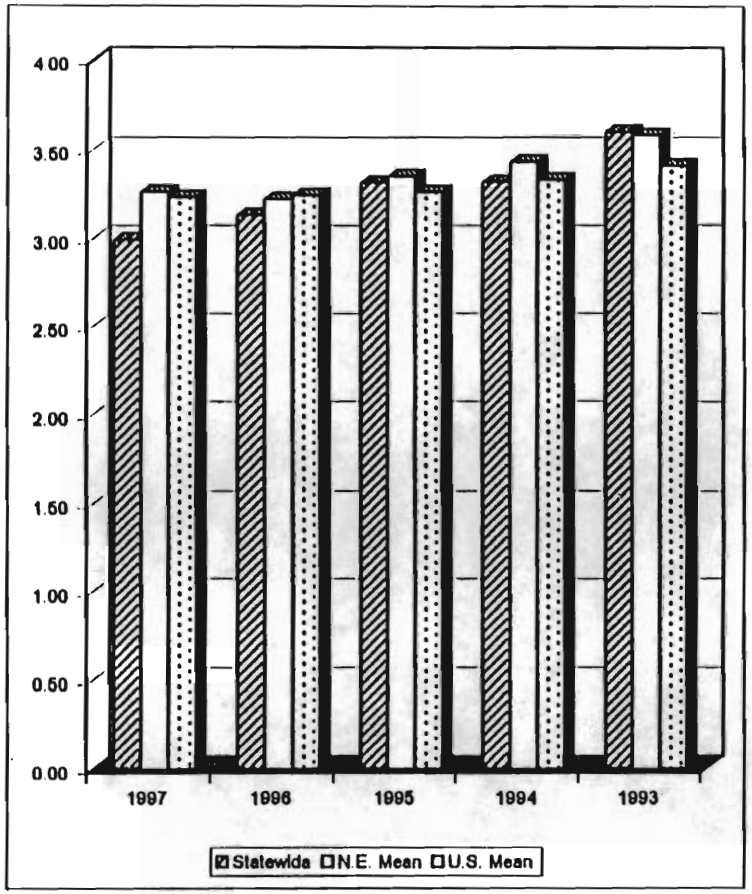
This ratio defines the proportion of long-term debt to net fixed assets. It expresses a relationship between the use of funds (debt principal) and a source of funds (depreciation on fixed assets).

$$\text{Formula:} \quad \frac{\text{Long-term debt}}{\text{Net fixed assets}}$$

Desired Trend: Decreasing values are favorable.

Current Asset Turnover Ratio

	1997	1996	1995	1994	1993
Statewide	2.99	3.13	3.32	3.32	3.60
Local Advisory Boards:					
LAB I	2.63	2.93	3.05	3.02	3.52
LAB II	3.41	3.20	3.33	3.30	3.46
LAB III	2.96	3.17	3.04	3.21	3.54
LAB IV	2.70	2.82	2.08	2.12	2.30
LAB V	3.54	3.84	4.47	4.50	4.55
LAB VI	2.82	2.93	3.52	3.62	3.83
Classifications :					
Major Teaching	2.85	3.14	3.28	3.42	3.62
Minor Teaching	3.01	2.98	3.04	2.86	3.57
Non-Teaching	3.23	3.21	3.50	3.47	3.61
Rehabilitation	2.28	2.22	2.83	2.86	2.87
Specialized	3.04	3.26	3.18	2.87	3.07
Catchment Areas:					
Inner City	3.01	3.18	3.53	3.48	3.73
Urban	3.30	3.01	3.20	3.19	3.56
Suburban	2.81	3.11	3.15	3.22	3.48
Rural	3.32	3.54	3.89	3.74	3.93
Bed Size Ranges:					
Under 100	2.46	2.16	2.70	2.74	2.55
100 to 199	3.30	3.28	3.43	3.10	3.54
200 to 299	3.27	3.31	2.26	3.20	3.30
300 to 399	2.97	2.93	3.07	3.06	3.61
400 to 499	3.18	3.42	3.37	3.32	3.44
500 to 1000	2.90	3.10	3.38	3.48	3.78
Acute Care Hospitals	3.00	3.14	3.32	3.32	3.60
Non-acute Hospitals	2.60	2.48	2.84	2.69	2.83
N.E. Mean	3.26	3.22	3.35	3.43	3.58
U.S. Mean	3.23	3.24	3.26	3.33	3.41



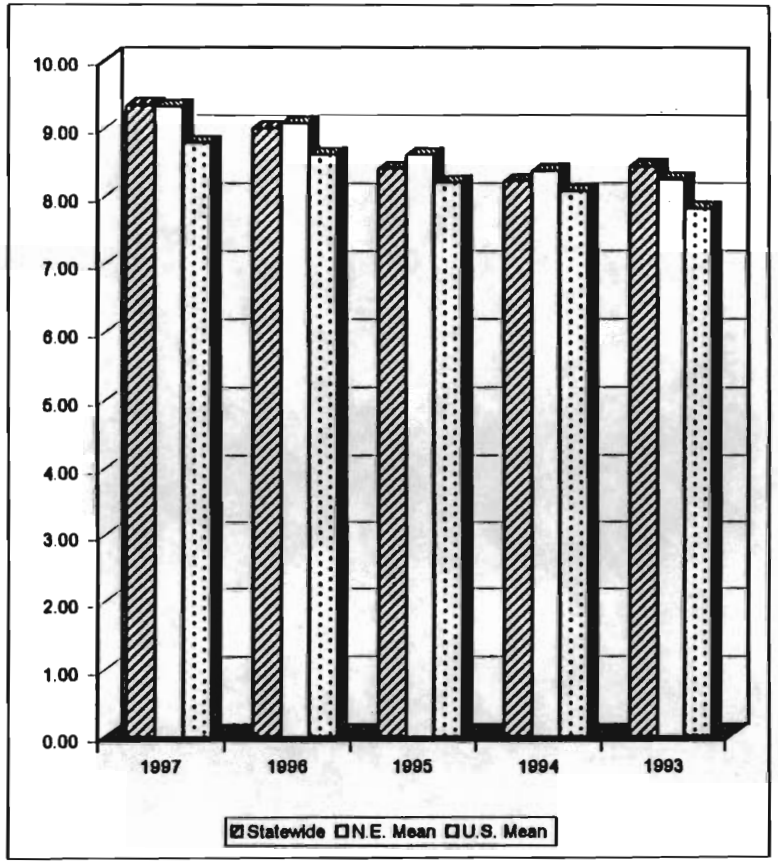
The current asset turnover ratio measures the number of total revenue dollars earned per dollar in current assets. Higher values indicate a more effective utilization of current assets.

Formula: $\frac{\text{Total revenue}}{\text{Current assets}}$

Desired Trend: Increasing values are favorable.

Average Age of Plant Ratio

	1997	1996	1995	1994	1993
Statewide	9.33	8.99	8.41	8.22	8.43
Local Advisory Boards:					
LAB I	9.74	9.94	7.46	7.49	8.95
LAB II	10.47	9.28	8.86	8.71	8.62
LAB III	9.39	8.80	9.36	8.75	8.02
LAB IV	8.52	8.48	8.09	7.96	8.67
LAB V	9.46	9.31	8.88	9.18	9.17
LAB VI	8.78	8.62	7.21	6.81	7.68
Classifications :					
Major Teaching	8.85	8.41	8.34	8.25	7.90
Minor Teaching	9.45	8.74	8.53	8.52	8.81
Non-Teaching	9.89	9.59	8.36	8.00	8.65
Rehabilitation	9.62	10.30	11.30	11.56	9.19
Specialized	8.77	8.83	8.08	7.68	9.03
Catchment Areas:					
Inner City	8.82	8.56	9.53	9.42	9.12
Urban	9.23	8.74	8.61	8.54	8.25
Suburban	9.60	9.26	7.55	7.22	8.04
Rural	9.39	9.37	8.95	9.05	9.17
Bed Size Ranges:					
Under 100	10.17	9.81	9.12	7.88	9.25
100 to 199	9.57	9.78	10.19	10.57	9.75
200 to 299	10.30	9.78	9.50	9.34	9.13
300 to 399	9.53	9.01	9.54	9.02	8.75
400 to 499	9.23	8.56	7.08	6.85	8.06
500 to 1000	9.12	8.82	8.23	8.11	8.14
Acute Care Hospitals	9.33	8.98	8.37	8.19	8.43
Non-acute Hospitals	9.18	9.76	10.38	9.62	8.89
N.E. Mean	9.31	9.06	8.61	8.37	8.24
U.S. Mean	8.78	8.61	8.20	8.07	7.81



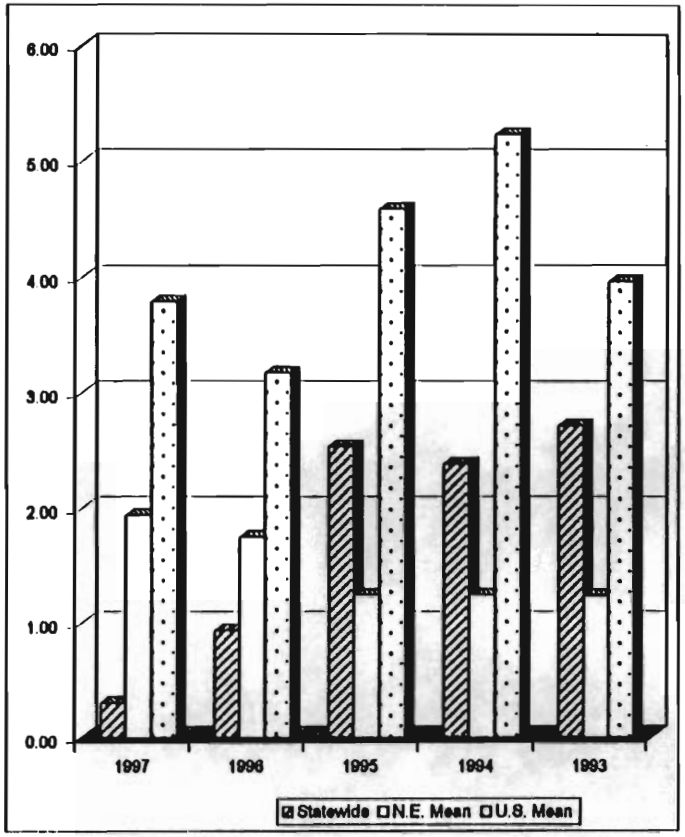
The average age of plant ratio measures the average age in years of all fixed assets. Lower values indicate a newer fixed assets base and less of a need for short-term replacement.

Formula: $\frac{\text{Accumulated depreciation}}{\text{Depreciation}}$

Desired Trend: Decreasing values are favorable.

Financial Flexibility Index

	1997	1996	1995	1994	1993
Statewide	0.30	0.93	2.53	2.37	2.71
Local Advisory Boards:					
LAB I	0.27	1.26	4.29	3.35	2.76
LAB II	(0.51)	(0.49)	0.78	1.52	1.52
LAB III	(1.40)	(0.63)	1.02	0.69	2.32
LAB IV	2.46	3.57	4.62	4.77	3.01
LAB V	(0.18)	0.01	1.37	1.33	2.30
LAB VI	1.99	2.72	4.68	4.02	4.49
Classifications :					
Major Teaching	0.13	1.74	2.34	1.90	2.45
Minor Teaching	0.56	0.61	2.79	3.76	3.34
Non-Teaching	0.58	0.54	2.60	2.18	2.66
Rehabilitation	1.01	(0.87)	7.07	7.73	7.27
Specialized	1.50	(2.35)	(1.21)	(0.63)	(2.86)
Catchment Areas:					
Inner City	(0.43)	(0.24)	0.48	(0.06)	1.58
Urban	(0.07)	0.59	2.50	2.06	1.99
Suburban	1.42	1.96	3.83	4.08	3.60
Rural	(0.46)	0.19	3.34	3.48	4.17
Bed Size Ranges:					
Under 100	(1.40)	(1.50)	4.68	1.55	5.18
100 to 199	(0.66)	(1.02)	0.88	2.21	2.36
200 to 299	0.45	(0.13)	1.79	1.74	1.36
300 to 399	1.75	1.86	1.99	1.16	3.40
400 to 499	1.01	1.65	4.26	4.00	2.89
500 to 1000	0.34	0.32	2.31	2.27	2.76
Acute Care Hospitals	0.28	0.95	2.46	2.29	2.67
Non-acute Hospitals	1.23	(0.58)	5.78	6.02	4.48
N.E. Mean	1.94	1.75	1.24	1.24	1.23
U.S. Mean	3.79	3.17	4.58	5.23	3.96



The financial flexibility index is derived from seven financial ratios that measure the ability to control the flow of funds and indicates the overall financial health of the hospital.

Ratios used to compute the financial flexibility index are:

- Operating margin ratio
- Nonoperating gain ratio
- Replacement viability ratio
- Equity financing ratio
- Days Cash on Hand ratio
- Cash flow to total debt ratio
- Average age of plant ratio

Desired Trend: Increasing values are favorable.

The Center for Healthcare Industry Performance Studies (CHIPS) modified the formula for financial flexibility index for 1996. New Jersey, N.E. mean and U.S. mean ratios for 1996 and 1997 reflect this change. All ratios for 1993 - 1995 were calculated under the original methodology.

Appendix A
State Health Plan
Local Advisory Board Map

LAB I Morris, Passaic, Sussex, and Warren

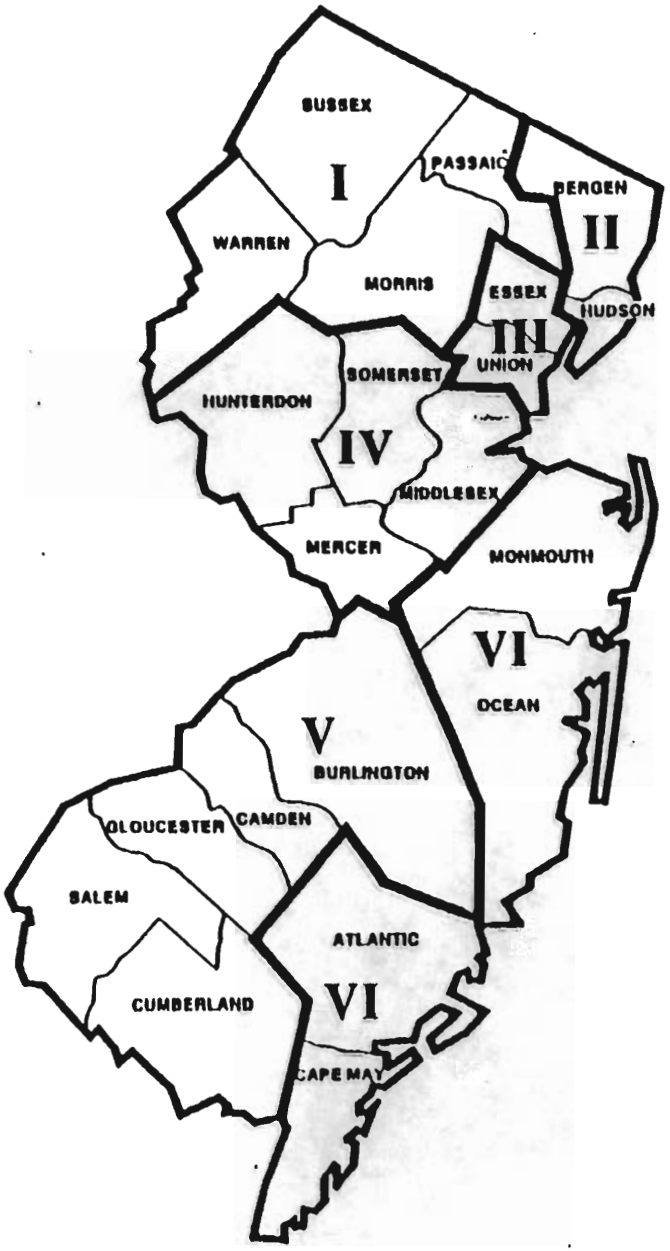
LAB II Bergen and Hudson

LAB III Essex and Union

LAB IV Hunterdon, Mercer, Middlesex, and Somerset

LAB V Burlington, Camden, Cumberland, Gloucester, and Salem

LAB VI Atlantic, Cape May, Monmouth, and Ocean



APPENDIX E

Report on the Financial Status of Urban Hospitals

Hospital Alliance of New Jersey

REPORT ON THE FINANCIAL STATUS OF URBAN HOSPITALS

REPORT ON THE FINANCIAL STATUS OF URBAN HOSPITALS

Hospital Alliance of New Jersey
February 1999

The Hospital Alliance of New Jersey is a coalition of safety-net providers that serve a significant portion of the State's indigent patients. Its goal is to improve and advance healthcare for New Jersey's most vulnerable populations. Members of the Alliance continue to be alarmed by a financial erosion taking place within the State's urban hospitals which will jeopardize their ability to continue to provide needed services.

This report includes data on the 27 designated urban hospitals listed below. Collectively, these hospitals have over 11,600 beds representing 40% of the total beds available in New Jersey. For the purposes of this report, these hospitals are referred to as "Alliance" hospitals.

Barnert Hospital (Paterson)
Bergen Regional Med. Ctr. (Paramus)
Beth Israel Hospital (Passaic)
Capital Health System (Trenton)
Cathedral Healthcare System (Newark)
Christ Hospital (Jersey City)
Cooper Health System (Camden)
East Orange General Hospital (E. Orange)
Elizabeth General Med. Ctr. (Elizabeth)
Greenville Hospital (Jersey City)
Hospital Center at Orange (Orange)
Irvington General Hospital (Irvington)
Jersey City Medical Center (Jersey City)
Meadowlands Hospital (Secaucus)
Meridian Hospital System (Mon./Ocean counties)
Muhlenberg Regional Med. Ctr. (Plainfield)
Newark Beth Israel Med. Ctr. (Newark)
Our Lady of Lourdes Med. Ctr. (Camden)
Palisades General Hospital (North Bergen)
St. Clare's Health Services (Morris/Sussex counties)
St. Elizabeth Hospital (Elizabeth)
St. Francis Medical Center (Trenton)
St. Francis Medical Center (Jersey City)
St. Joseph's Hospital & Med. Ctr. (Paterson)
St. Mary's Hospital (Hoboken)
St. Mary's Hospital (Passaic)
University Hospital (Newark)

The data reflected in this report was provided by the New Jersey Health Care Facilities Financing Authority's Apollo program, with the exception of the charity care and Hospital Relief Fund information which was obtained from the Department of Health and Senior Services and the Department of Human Services.

KEY INDICATORS

General Information

1) Alliance hospitals provide a disproportionate share of care to the poor.

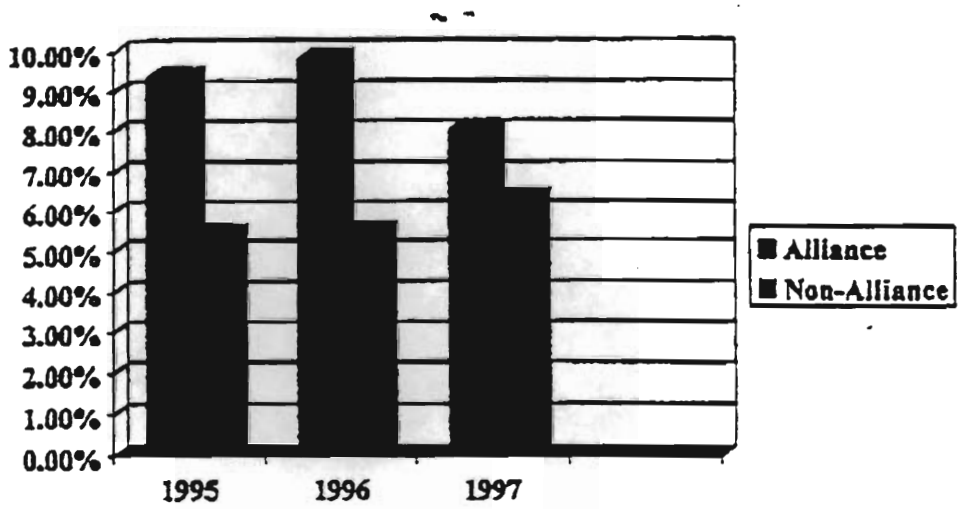
A. Alliance hospitals are responsible for 65% of all documented charity care services provided in New Jersey hospitals:

Alliance Hospitals	$311.5 million
Non-Alliance Hospitals	171.5 million
Total Charity Care	$483.0 million

Charity care documented for 1997 at Medicaid rates totals $483 million while the appropriation for SFY 1999 is only $320 million.

B. Alliance hospitals incur bad debt at a greater rate than Non-Alliance hospitals. Bad debt as a percent of total expenses:

	1995	1996	1997
Alliance Hospitals	9.36%	9.82%	8.04%
Non-Alliance Hospitals	5.42%	5.50%	6.32%



Bad debt expense at Alliance hospitals in 1997 was $333 million or 46% of all bad debts incurred by New Jersey hospitals. A significant portion of bad debt is charity care where patients do not comply in providing the documentation necessary to meet the State's criteria.

2) Alliance hospitals employ approximately 40,000 workers:

	1995	1996	1997
Alliance Employees (Full-Time Equivalent Basis)	45,688	44,138	43,285

The job security of over 40,000 people depends upon the solvency of these urban institutions. Loss of these jobs will have a significant negative impact upon the State's economy in the following areas: unemployment insurance, medically uninsured, welfare and loss of tax revenue.

3) Alliance hospitals have a significant amount of outstanding debt:

	1995	1996	1997
Alliance Debt	$1.16 billion	$1.15 billion	$1.19 billion

The majority of this debt has been financed by tax-exempt bonds issued through the New Jersey Health Care Facilities Financing Authority.

4) Alliance hospitals provide a high volume of needed services:

	1995	1996	1997
Admissions	363,069	356,616	356,537
Patient Days	2,811,833	2,402,950	2,257,959
Same Day Surgeries	87,783	88,927	95,312
Emergency Room Visits	773,342	745,432	680,048

Financial Indicators

5) Days cash on hand:

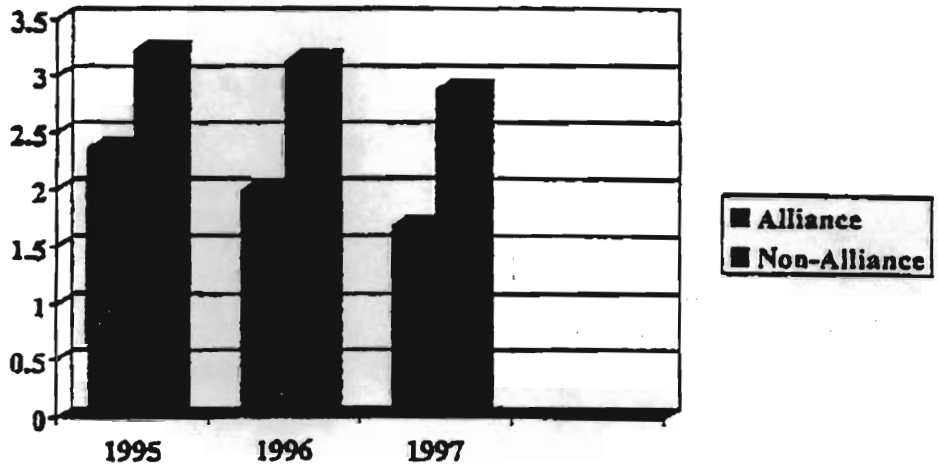
This indicator definitely shows that Alliance hospitals are less able to sustain losses. While Non-Alliance hospitals' days cash on hand has increased, Alliance Hospitals days cash on hand has decreased, thereby widening the gap between these hospitals.

	1995	1996	1997
Alliance Hospitals	80 days	80 days	68 days
Non-Alliance Hospitals	105 days	110 days	114 days

6) Debt service coverage ratio:

This indicator measures the ability of an organization to pay its debt. While the Non-Alliance hospitals debt service coverage ratio has decreased slightly since 1995, the Alliance number has seen a larger decrease. Many bond documents consider a hospital to have a covenant violation once its debt service coverage ratio reaches 1.10.

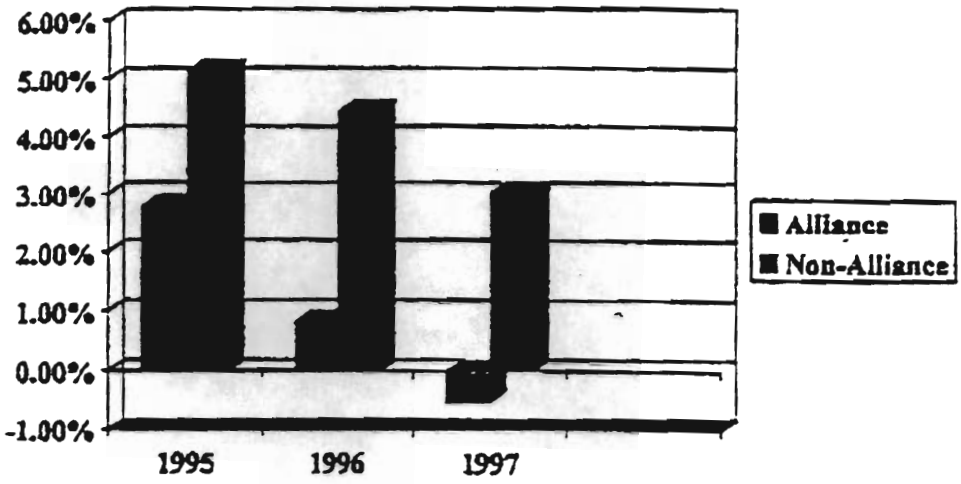
	1995	1996	1997
Alliance Hospitals	2.37	2.00	1.68
Non-Alliance Hospitals	3.23	3.14	2.88



7) Profit margin:

Declining subsidies and reduced Medicaid rates have had a negative effect on Alliance hospitals. While the trend has been the same for Non-Alliance hospitals, it has not been as drastic.

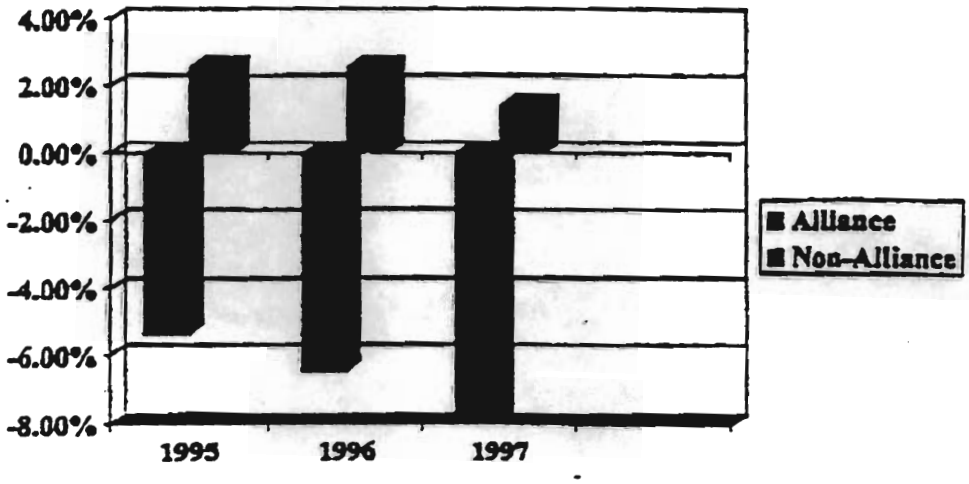
	1995	1996	1997
Alliance Hospitals	2.80%	0.84%	-0.51%
Non-Alliance Hospitals	5.15%	4.45%	3.04%



8) Profit margins if Charity Care and Hospital Relief Funds were removed:

This indicator demonstrates that the current distribution formulas properly target subsidies to those hospitals with the largest burden of uninsured care. Even without any subsidies the Non-Alliance hospitals have positive profit margins, while Alliance hospitals' viability would be seriously threatened.

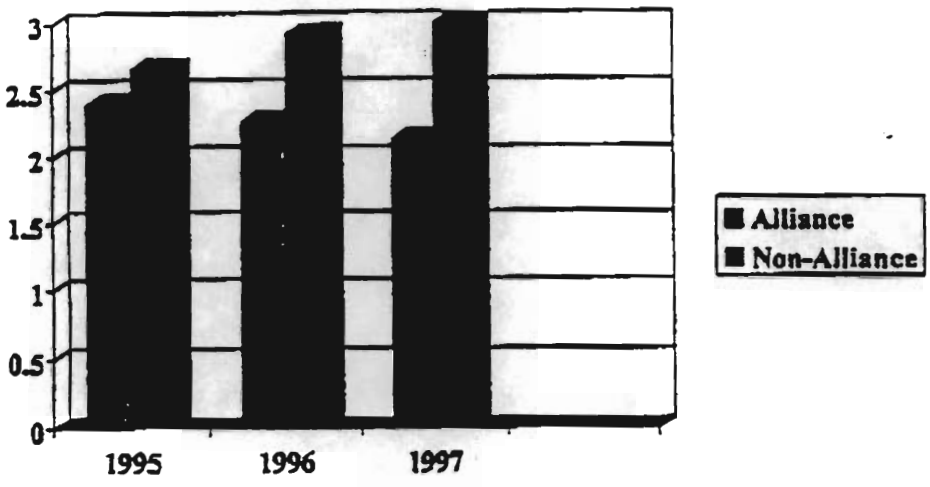
	1995	1996	1997
Alliance hospitals	-5.38%	-6.44%	-7.93%
Non-Alliance hospitals	2.56%	2.57%	1.42%



9) Current ratio:

Alliance hospitals are in a weaker position than Non-Alliance hospitals in their ability to pay current obligations. While the Alliance ratio has declined, the Non-Alliance ratio has improved.

	1995	1996	1997
Alliance Hospitals	2.40	2.27	2.13
Non-Alliance Hospitals	2.66	2.92	3.00



Summary

Alliance hospitals provide the majority of vital health care services to New Jersey's most vulnerable populations. As the numbers and statistics indicate, the Alliance facilities are experiencing increasing financial pressures. Due to their historical mission of serving the indigent, most have lower levels of cash, high levels of debt and an overall financial position which is far more vulnerable to downward financial trends.

The Alliance hospitals recognize that the marketplace demands greater value at lower cost. We are not requesting a "blank check" to maintain the status quo, but rather reasonable payment for services that we are obligated to provide. As the marketplace evolves, recognition must be given to the unique role the Alliance hospitals play in protecting the public health in our cities. Funding for charity care and the safety-net services provided by these institutions must be a priority of this Administration.

APPENDIX F

Example of Costs Eliminated from New Jersey Hospitals by Closing Hospitals to Reduce Excess Acute Care Beds

1997 Excess Calculation

1997 patient days (from cost reports)	5,647,045
Required bed days (patient days/365)	15,471
Required beds @ 85% target occupancy	18,202
1997 staffed beds (from cost reports)	23,051
1997 excess beds	4,849

2002 Excess Calculation

Projected days (from PwC study)	5,113,640
Required bed days	14,010
Required beds @ 85% target occupancy	16,482
1999 staffed beds (from 1st quarter B-2 forms)	22,798
Projected excess beds	6,316

A Percent reduction through closure	B Number of beds downsized	C Number of beds closed	D Admissions Redistributed	E Net improvement to bottom line
0	6,316	0	0	0
10	5,684	632	25,118	101,377,878
20	5,053	1,263	50,237	202,755,756
30	4,421	1,895	75,355	304,133,634
40	3,789	2,526	100,474	405,511,512
50	3,158	3,158	125,592	506,889,391
60	2,526	3,789	150,710	608,267,269
70	1,895	4,421	175,829	709,645,147
80	1,263	5,053	200,947	811,023,025
90	632	5,684	226,066	912,400,903
100	0	6,316	251,184	1,013,778,781

A – Percentage of bed reduction that will be at facilities that will close as opposed to downsize

B – The number of beds eliminated at facilities that are assumed to continue as acute care facilities; calculated as (100-Column A) multiplied by the projected excess for 2002

C - The number of beds eliminated at facilities that are assumed to close as acute care facilities; calculated as Column A times projected excess for 2002

D – Number of admissions projected to go from closed facilities to other facilities; calculated as beds (Column C) times statewide average admissions per staffed bed (46.79) times the percentage of admissions that are assumed to stay in the system (85%)

E – Net gain to remaining hospitals; calculated as admissions (Column D) times average revenue per admission ($10,090) times the percentage not needed to cover variable costs (40%)