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How Denver Health Compares to Peer Public Safety Net Hospitals

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CPEC Center for Tax Policy Director's Note

We are pleased to present this latest in the series of publications initiated by CPEC Center for Tax Policy, and undertaken by graduating MBA students in the Integrative Challenge course at the University of Denver's Daniels College of Business. This ambitious report is the result of only one academic quarter's (10 weeks) worth of work. Under that time constraint, the students collected and analyzed the relevant data, synthesized it and presented it in the report that follows. In this time of increasing pressure on health care providers, analyses such as the one here are increasingly important in the constant search for efficiencies in service provision.

As with any comparative research, there is a natural time lag between the available data and the current situation. For this report, the research team used the latest available comparative data for public safety net hospitals, the year 2000 comparisons published by the National Association of Public Hospitals and Health Systems. As such, the comparisons and analysis contained herein are for operating year 2000. In the intervening time, economic changes at all levels, national, state, and local have served to alter the environment in which hospitals, particularly public safety net hospitals, are operating. Hospitals, Denver Health included, that prior to the economic downturn were able to sustain slim profits, are now suffering operating deficits as they cope with additional pressures from the sluggish economy. However, current conditions in no way render the following analysis irrelevant. In contrast, the identification of efficiencies such as Denver Health's integrated service delivery system is increasingly important and relevant as public safety net hospitals nation-wide attempt to continue delivering comprehensive medical services under current economic conditions.

Introduction

This study was conducted to determine why Denver Health has been successful in maintaining a profit and exceeding the operational efficiency averages of other public safety net hospitals around the country. Given that all public safety net hospitals share common sources of funding, specifically Medicare, Medicaid, Disproportionate Share Hospital (DSH), and commercial, this study evaluates whether Denver Health's integrated system is the differentiating factor that has made the organization financially successful while maintaining a high quality of care.

The purpose of this report is to provide facts about the current state of the healthcare industry, to define the sources of funding that these public safety net hospitals share, and to evaluate benchmark and demographic comparisons of a sample group of members in the National Association of Public Hospitals (NAPH), an organization representing many public safety net hospitals in the country. It is not intended to provide definitive conclusions or recommended courses of action.

Analysis Design

Despite the current turmoil of the healthcare industry and the inability of Medicare, Medicaid, and DSH payments to keep up with changes in medical trends and populations served, Denver Health has continued to maintain an annual profit. For 2000 and 2001, Denver Health had an operating profit margin of 1.1% and 0.5%¹ compared to the industry average of 2.6% to -1.0%² respectively. These statistics demonstrate the difficulty that many other public safety net hospitals have maintaining the same level of success, despite primary reliance on the same sources of funding. The NAPH reports on the issues that its members are facing in its annual survey for 2000.

Public safety net hospitals are the medical treatment systems of last resort for many citizens who are unable to access medical care elsewhere due to lack of insurance, inability to pay, or other limitations. Denver Health serves as the public safety net hospital in the Denver metro area. Its operating procedures are studied and followed by institutions across the nation. Many believe that Denver Health's success is due to its integrated medical service delivery system. This system is thought to better serve patients by providing efficient and accessible facilities available across the organization's entire structure, enabling patients to receive care at the appropriate treatment facility. All of Denver Health's components are connected through a unified mission, a single information technology system linking patient records, a coordinated staff of physicians, and a common pool of financial resources. According to Dan Hawkins, policy director of the National Association of Community Health Centers in Washington, this delivery system is "the very best in the country."³

Many other hospitals across the country also claim to be using an integrated delivery system. However, it is difficult to determine how truly integrated these hospital systems are, as each facility defines integrated differently. Therefore, this analysis is not a direct comparison of integrated systems. Rather, it is a means for determining possible reasons for Denver Health's success in maintaining a profit using the hypothesis

¹ Denver Health 2001 Annual Report.

² Ingrid Singer, James Kuzner, and Lynne Fagnani, "America's Safety Net Hospitals and Health Systems, 2000: Results of the 2000 Annual NAPH Member Survey" National Association of Public Hospitals and Health Systems July 2002.

³ Jeff Tieman, "A Community Solution," Modern Healthcare January 13, 2003.

that it is due to its integrated system. To accomplish this analysis, ten other members of the NAPH were selected for comparison purposes. The facilities chosen are single-location hospitals, operating in medium to large metropolitan areas across the three safety net hospital categories: separate public entities, non-profit corporations, and local or state government operated facilities. The distribution of categories selected adequately represents the ratio of NAPH members. The following chart illustrates the hospitals used for comparison in this analysis:

Hospital	Location	Category
Alameda County Medical Center	Oakland, CA	Separate Public Entity
Boston Medical Center	Boston, MA	Non-Profit Corporation
Grady Health System	Atlanta, GA	Separate Public Entity
Harborview Medical Center	Seattle, WA	Separate Public Entity
Hennepin County Medical Center	Minneapolis, MN	Direct Operation by Local Government
Jackson Memorial Hospital	Miami, FL	Separate Public Entity
Parkland Health & Hospital System	Dallas, TX	Separate Public Entity
The MetroHealth System	Cleveland, OH	Direct Operation by Local Government
University Hospital of Brooklyn	Brooklyn, NY	Direct Operation by State Government
University Medical Center of Southern NV	Las Vegas, NV	Direct Operation by Local Government

State of the Healthcare Industry

As the American population continues to age and healthcare expenses further increase, the funding of Medicare and Medicaid programs remains a contentious debate. The percentage of the population qualifying for Medicare coverage alone will grow from 9.5% in 1970 to close to 22% in 2030.⁴ The national healthcare spending per capita is projected to increase by approximately 83% over the next decade.⁵ Personal healthcare expenditures by Medicare increased from 11.5% in 1970 to 19.2% in 2000.⁶ These expenditures by Medicaid increased from 8.0% in 1970 to 16.8% in 2000.⁷

Public safety net hospitals, traditionally treating a higher percentage of uninsured, Medicaid, and Medicare funded patients than other hospitals, have been the most financially impacted by these healthcare trends. These facilities have always had low margins, approximately one-third to one-half the level of other hospitals in 2000.⁸ As Figures 1 and 2 show, the industry average operating margins decreased from 2.6% in 1996 to -1.0% in 2000.⁹ In those same years, the number of NAPH members reporting negative earnings grew to 49%.¹⁰

⁴ The CMS Chart Series “An Overview of the U.S. Healthcare System: Two Decades of Change”, 1980-2000.

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

⁸ America’s Safety Net Hospitals and Health Systems, 2000.

⁹ Ingrid Singer, James Kuzner, and Lynne Fagnani, “America’s Safety Net Hospitals and Health Systems, 2000: Results of the 2000 Annual NAPH Member Survey” National Association of Public Hospitals and Health Systems July 2002.

¹⁰ Ibid.

Figure 1 - Total Margins for NAPH Members, 1996-2000

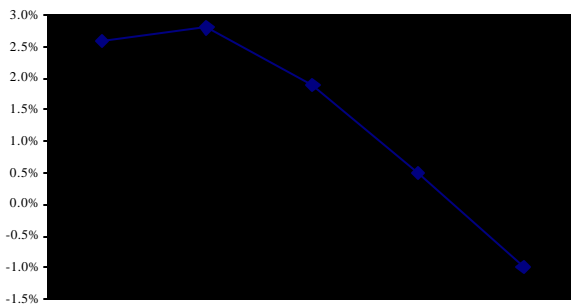
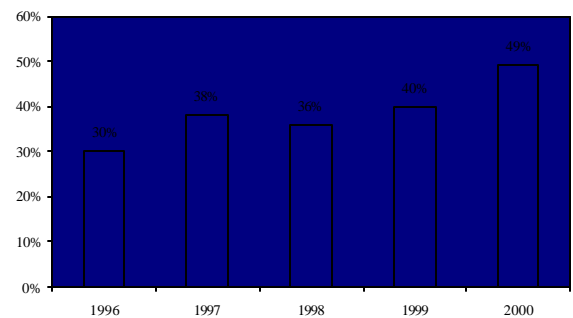


Figure 2 - Percentage of NAPH Members with Negative Margins, 1996-2000



Denver Health has been successful in maintaining positive earnings, with an operating profit of 1.1% in 2000 and 0.5% in 2001, despite numerous cuts to funding programs nation-wide. Although the hospital is a not-for-profit entity, it cannot properly serve its population without adequate funding.

Major Sources of Funding for Public Safety Net Hospitals

Medicare

The Medicare program, funded by taxpayers, was originally established in 1965 to provide all senior citizens with affordable, comprehensive healthcare. This program expanded in 1973 to include disabled and end-stage renal disease patients, and in 1988 to add medical catastrophes. After the passing of the Balanced Budget Act of 1997, changes in Medicare spending became negligible. However, with the Budget Refinement Act of 1999, Medicare spending has once again followed an increasing trend.³ In the last several decades, the public sector share of healthcare spending has increased, while out-of-pocket spending has declined. In 1998, the state of Colorado had an average ranking (15.6% - 21.8%) for the share of state health spending financed by Medicare.¹¹ In 2001, Denver Health received 8% of its revenues from Medicare payments.¹²

Medicaid

Medicaid provides essential medicine and medically related services to the most vulnerable populations in society. This government program serves low-income families with children, low-income elderly, and persons with disabilities. The Medicaid program became law in 1965 as a jointly funded cooperative venture between federal and state governments to assist states in providing adequate medical care to eligible needy persons. According to the NAPH, in 1998 Medicaid covered 40.4 million Americans or 12% of the total U.S. population.¹³ This makes Medicaid one of the largest health insurance providers in the United States and a major source of funding for public safety net hospitals. A similar form of funding available is Medicaid HMO, which is typically run by not-for-profit organizations offering HMO plans to this

¹¹ An Overview of U.S Healthcare Systems.

¹² Denver Health 2001 Annual Report

¹³ www.naph.com

population. In 1998, Colorado ranked low (9.1% - 16.6%) for the share of state health spending financed by Medicaid.¹⁴ In 2001, Denver Health received 22% of its revenue from Medicaid and Medicaid HMO.¹⁵

Disproportionate Share Hospital Payments

Disproportionate Share Hospital (DSH) payments are given to hospitals in proportion to the number of uninsured patients served.¹⁶ DSH payments are provided as a part of both Medicaid and Medicare. The program was created in the 1980's by Congress to help cover the costs accrued by public safety net hospitals and to ensure that Medicare and Medicaid patients are able to receive quality care from those facilities. The current law places caps on the DSH payments received by hospitals, both in the total amount of DSH payments a hospital is allowed to receive, as well as on the total DSH payments made in any given state. There is much variance in the DSH payment systems between states. In 2001, Denver Health received 14% of its total revenue from DSH payments.¹⁷

Commercial Revenue

Commercial revenue encompasses all other sources of funding not provided by the government or uninsured patients. Denver Health has taken advantage of several unique programs to increase revenue. In 2001, Denver Health received 39% of its revenue from the following commercial sources: 21% from private insurance, 6% from other operating sources such as Rocky Mountain Poison and Drug Center, 6% from restricted grants/contracts mainly from pharmaceutical companies, 4% from city services such as prison care, and 2% from non-operating services such as the cafeteria.¹⁸

Comparison Results

In order to gain some understanding of the potential impact of Denver Health's integrated system, this analysis explored various benchmarks set by the NAPH survey. Although somewhat limited (i.e., no cost breakdown was available), the comparisons revealed potential areas of success, as well as opportunity, for Denver Health. The analysis also laid a foundation for the potential problems faced by public safety net hospitals without sufficient funding. The following section includes an analysis of financial and industry data for Denver Health and other comparable public safety net hospitals. The benchmarks used to determine these findings are: net revenues by payer source, revenue as a percentage of patient charges, emergency department and outpatient visits, occupancy rate, total uncompensated care costs, and revenue per patient.¹⁹ In addition, environmental factors were examined to determine effects on the baseline comparison results.

Net Revenues by Payer Source

Denver Health receives a lower percentage of its total funding from state and local subsidies as seen in Figure 3. Additionally, uninsured patients, represented by the self pay/other category, comprise a lower percentage of treated patients than other selected NAPH members. It is possible that Denver Health receives less state and local subsidies as a result of having fewer uninsured patients. Denver Health is

¹⁴ An Overview of U.S. Healthcare Systems.

¹⁵ Denver Health 2001 Annual Report

¹⁶ <http://cms.hhs.gov/dsh/codsh.asp>

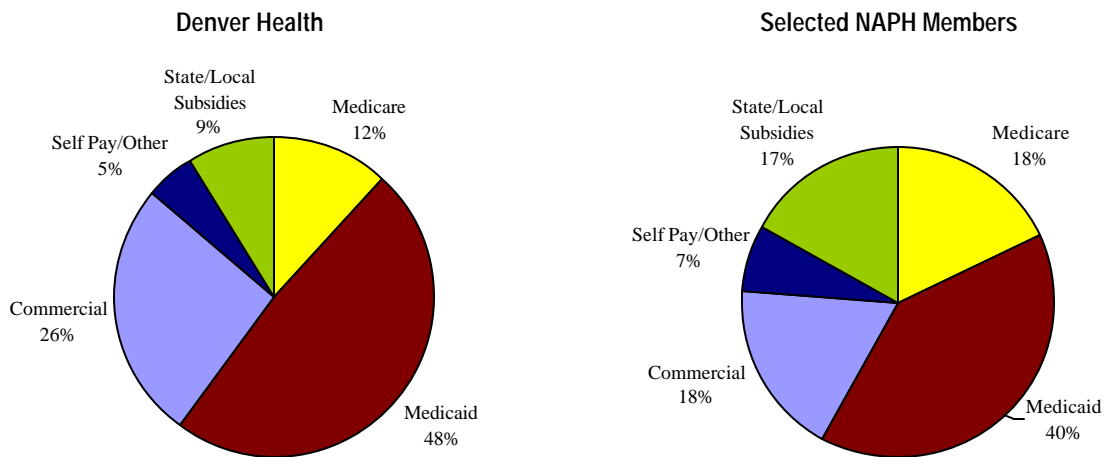
¹⁷ Denver Health 2001 Annual Report

¹⁸ Ibid.

¹⁹ America's Safety Net Hospitals and Health Systems, 2000

also receiving a slightly lower percentage of revenue from Medicare sources than the industry standard, which may be a result of a different demographic base. Denver Health receives a higher percentage of its funding from commercial and Medicaid sources than other industry players. Typically, commercial income results in higher profit margins than government funded revenue. It is important to note that Figure 3 only outlines net revenues by payer source, but does not indicate the costs associated with each source. For example, uncompensated care costs account for 40% of Denver Health's total expenses but only brings in five percent of revenues. Consequently, it is important to also understand cost/charges before coming to final conclusions.

Figure 3 - Net Revenues by Payer Source, 2000



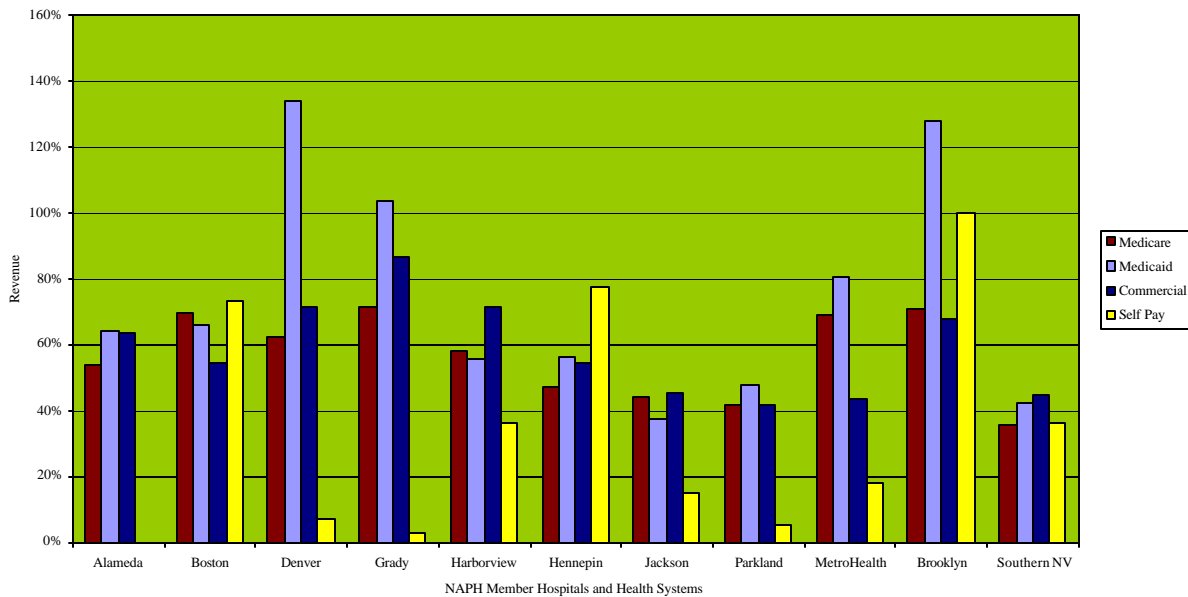
Revenue as a Percentage of Patient Charges

Although the data analyzed for this study did not contain specific information about costs associated with each payer source, information related to charges was explored. This is an important distinction. Charges are defined as the fee amounts that the patients are billed for certain services. Costs, on the other hand, represent the expense amount the hospital incurs to deliver these services.

As can be seen in Figure 4 (details of this chart are located in Appendix A), Denver Health receives an above average percentage of revenue compared to charges from Medicare and commercial sources, but below average on uninsured patients. Of particular note, Denver Health leads its comparison group in receiving Medicaid payments at 134%, while the group average is 82%, with the majority of the hospitals being less than 70%. It may seem surprising for a hospital to collect more than 100% of Medicaid charges; however, Denver Health is not the only facility with these high figures. Grady Health System and University Hospital of Brooklyn also collect more revenue from this source than they charge. One reason for Denver Health's success in this area may be the nature of Medicaid payments. These payments are directly related to the diagnosis of each patient without regard to the expense the hospital incurs for the treatment. Consequently, a hospital that is able to keep its costs and patient charges below Medicaid's established diagnosis allocation could appear to be making a profit on these payments. However, a further investigation into the diagnosis costs would be necessary before reaching this conclusion.

A second reason that Denver Health may appear to be receiving over 100% on Medicaid payments is because of their participation in the Medicaid HMO plan. In this plan, hospitals receive a set amount per participant monthly. Not treating a patient, or charging the patient below the monthly rate during that timeframe, may increase the hospital's net revenue.

Figure 4 – Revenue as a Percentage of Patient Charges, 2000

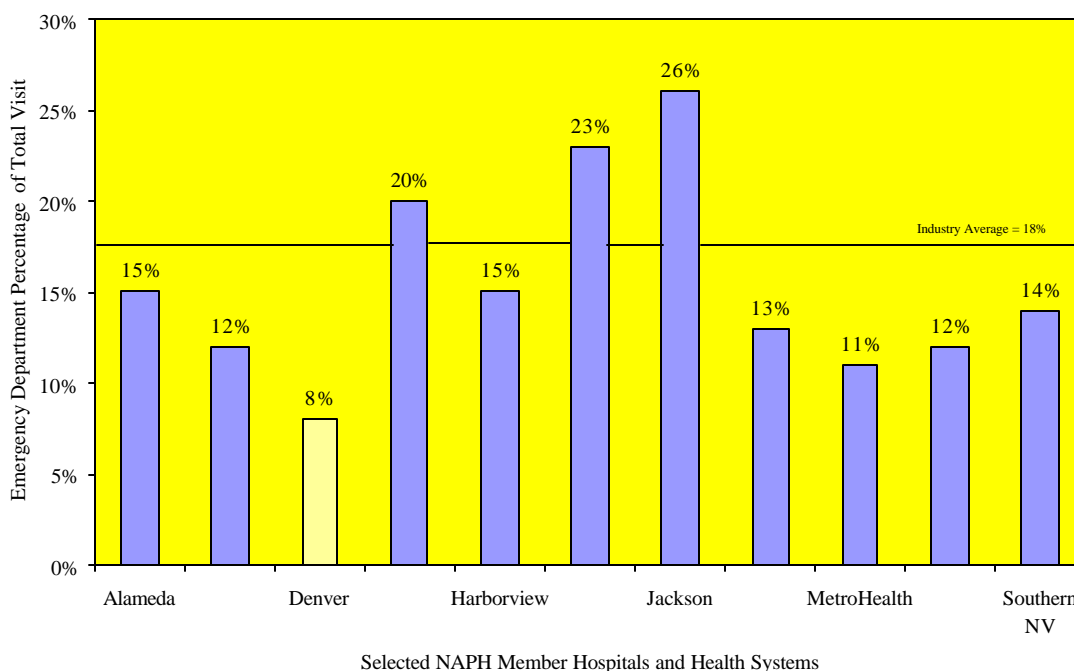


Emergency Department and Outpatient Visits

Emergency departments are typically the most expensive treatment facilities. Hospitals that are able to divert patients to outside locations (i.e., community centers) can decrease overall treatment costs for those individuals. This is particularly important for public safety net hospitals that treat a significant number of patients who are unable to pay for these services. Although Denver Health's costs for emergency versus outpatient visits are unavailable, the average amount Denver Health charges patients for an emergency room visit is \$950 compared to \$185 for a clinic visit.

As seen in Figure 5, Denver Health has a lower percentage of emergency department visits than all other facilities in this comparable group. Denver Health's figure of 8% is well below the average value of 18% for the other NAPH members. This lower value may indicate that Denver Health's integrated system is helping to shift patients from the emergency room to its other facilities. The move toward alternate facilities is important in order to reduce the total cost the hospital incurs from treating patients in the emergency room. The magnitude of this favorable difference for Denver Health may be a significant reason for their relative profitability.

Figure 5 - Emergency Department and Outpatient Visits, 2000

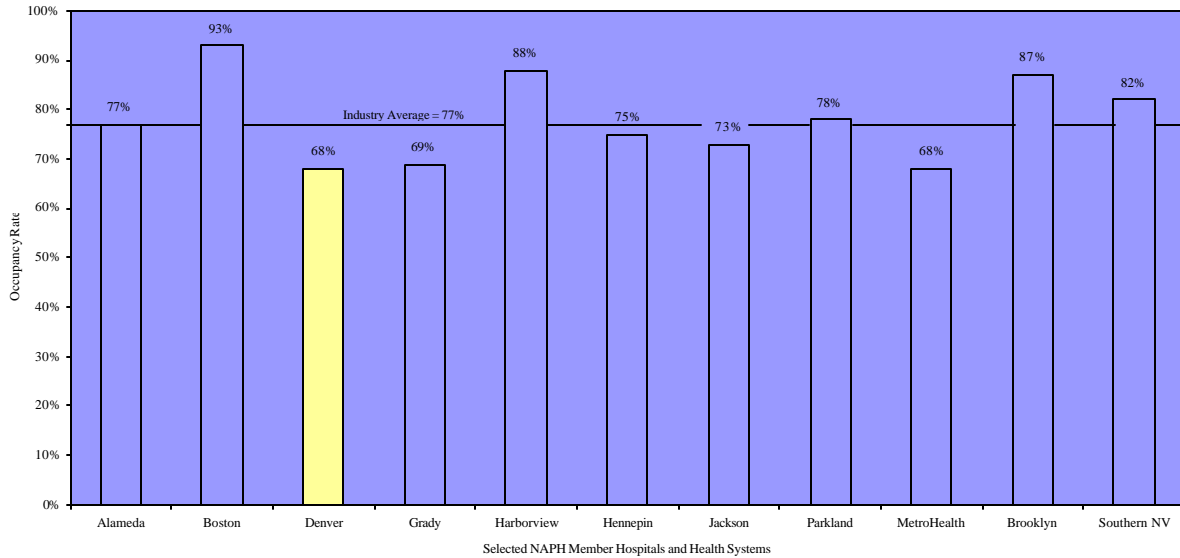


Occupancy Rate

Occupancy rates are especially important because the surrounding hospitals are required to accept the overflow of patients should these public safety net hospitals become unable to handle demand. If overflow occurs on a continual basis, treatment at other hospitals may become less effective because of the increased demand to those facilities. Treatment may also become more expensive to paying patients due to the higher expenses those hospitals incur from uninsured patients.

Denver Health appears to be in a good position to handle additional patient demand, which is apparent from the lower occupancy rate of their 309 staffed beds compared to the industry (see Figure 6). Although the NAPH average is at 77%, a number of facilities in the NAPH survey showed an occupancy rate of 100%. Denver Health's occupancy rate suggests that that the organization is able to effectively transfer care to its other facilities. This ability is a benefit to Denver citizens, tax payers, and other constituent groups because it facilitates a more cost-effective environment.

Figure 6 - Occupancy Rate, 2000

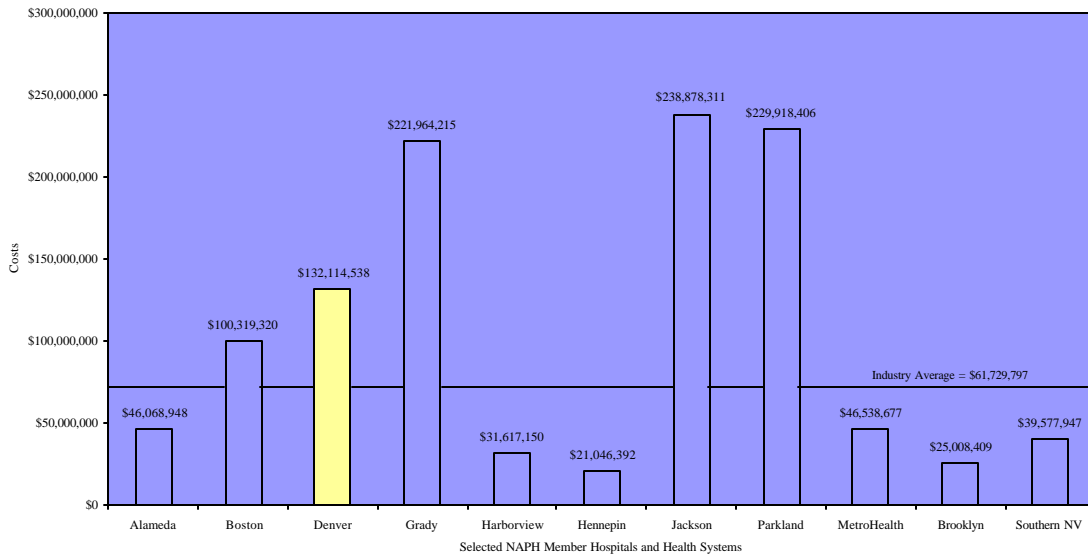


Total Uncompensated Care Costs

Uncompensated care costs are defined by the NAPH survey as the combination of a hospital's total bad debt and charity care costs. These costs represent the amount of care provided with no compensation for the service. The higher this total, the more difficult it is for hospitals to achieve profitability. Therefore, keeping the total uncompensated care costs minimized is critical to the financial well-being of these facilities. Without profitability, public safety net hospitals cannot adequately provide the necessary quality of patient care.

As seen in Figure 7, over \$132 million of Denver Health's costs are uncompensated. This figure represents 40% of total costs the organization incurs. Although this analysis does not report on the financial positions of the comparison group's health systems, it is evident that Denver Health is able to maintain a profit despite the uncompensated care costs. A public safety net hospital must cover the costs of treating patients whose care is uncompensated through the revenue that it earns on other patients.

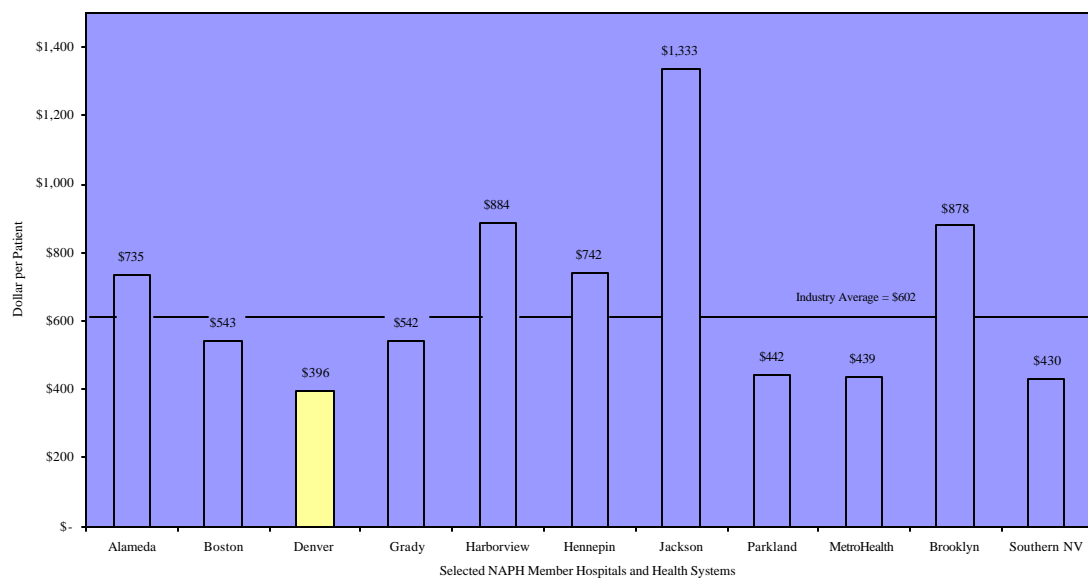
Figure 7 - Total Uncompensated Care Costs, 2000



Revenue per Patient

Denver Health receives the lowest amount of revenue per patient as compared to the selected group as seen in Figure 8. This disparity may be the result of a successful integrated system. If Denver Health is able to treat less critical patients at surrounding facilities, rather than the emergency room, which has the highest costs, it may be able to operate more efficiently, even while receiving less revenue from the facility visits.

Figure 8 - Revenue per Patient, 2000



Environmental Factors

Another influencing factor that may attribute to Denver Health's success is the environment in which the organization operates. In reviewing the demographics of Denver and the cities where the comparison hospitals are located, it can be seen that Denver has a slightly higher per capita income than the average, while its household income is lower (See Appendix B). In addition, Denver's poverty rate is consistent with the average. These factors do not appear to have any anecdotal impact on the results of this analysis.

Conclusion

Denver Health has continued to maintain an annual operating profit between 1.1% and 0.5% in 2000 and 2001 respectively, despite the current environment of the healthcare industry and the relative decreasing funding provided by Medicare, Medicaid, and DSH. In order to further analyze how Denver Health compares to other public safety net hospitals, this study explored net revenues by payer source, revenue as a percentage of patient charges, emergency department and outpatient visits, occupancy rates, total uncompensated care costs, and revenue per patient. In addition, environmental factors were taken into consideration in an attempt to explain some of these findings. Overall, the data support the hypothesis that Denver Health's integrated medical service delivery system could be a positive factor in its ability to maintain profitability. Whether this is the case or not, it is clear that Denver Health has been able to remain financially stable, while many of the other hospitals have not.

CPEC Center for Tax Policy, formerly the Colorado Public Expenditure Council, was formed in 1946. It is the state's oldest non-profit organization with a mission of disseminating non-partisan information and research on Colorado tax and expenditure policy and providing contract based research studies for industry, government, and individuals.

Acknowledgements and Bios

We would like to thank all of the individuals who were instrumental in providing the data we needed for this study. We would specifically like to mention Dr. Patricia Gabow, Ms. Bobbie Barrow, Mr. Frank Barrett, and their staff members at Denver Health. From the National Association of Public Hospitals, we are grateful for the help that we received from Ms. Lynne Fagnani with the NAPH membership information. This project could not have been possible without the backing of CPEC Center for Tax Policy, including Ms. Phyllis Resnick and Mr. Bud Hover. Last but not least, we would like to thank our faculty advisor, Dr. Mac Clouse, for his support in our final quarter of graduate business school.

Patricia Barnard received her Bachelor of Business Administration and Bachelor of Arts in Spanish from Southern Methodist University. She spent three years at Coca-Cola in sales and internal consulting; she then worked as a strategic account manager for Faison Office Products Company and Corporate Express, managing a multi-million dollar joint venture contract with the State of Colorado. Currently, Patty is pursuing a Master of Business Administration at the Daniels College of Business, University of Denver. Her strengths lie in communication and organization, with experience training and managing employees, as well as building strong relationships with customers.

Brett Hoopes received a Bachelor of Science in Engineering with a Mechanical Specialty from the Colorado School of Mines. Over the past 10-years, he participated in the engineering and construction of several diverse projects including luxury trains, ski chair lifts, and high tech facilities. Brett most recently worked in the design and construction of high-tech facilities with Inflow, a web-hosting company, as Senior

Engineering Manager. Currently, he is pursuing a Master of Business Administration and a Master of Finance at the Daniels College of Business, University of Denver. Brett's strengths in problem solving and financial analysis include business valuation, financial modeling, and rate of return analysis.

Kristie Moore received a Bachelor of Business Administration in Finance and International Business from Ohio University. After graduation she worked for four years in Information Technology Consulting, primarily as a Business Analyst. Currently, Kristie is pursuing a Master of Business Administration and a Master of Science in Information Technology at the Daniels College of Business, University of Denver. Following graduation, she will be working for Focus Logic, a multimedia marketing and technical development company, running the Project Management Department. In addition to strong project planning capabilities, Kristie's experience has also provided her with a strong knowledge of various information systems.

Christina Von Stroh received a Bachelor of Science in Psychology from the University of Denver. She is currently pursuing two graduate degrees at the University of Denver, a Master of Business Administration from the Daniels College of Business and a Master of Arts in Digital Media Studies, an interdisciplinary degree. She is currently employed by Colorado Economic and Management Associates, performing strategic planning and creating web application solutions. Christina's strengths are in data analysis, organization, digital solutions, and strategic management.

Dr. Maclyn Clouse, faculty advisor, is a Professor of Finance and the Director of the Reiman School of Finance at the Daniels College of Business, University of Denver. He has a Bachelor of Arts in Mathematics and Economics from Willamette University and a Master of Business Administration in Operations and Systems Analysis and a PhD in Finance from the University of Washington. Dr. Clouse has been at the University of Denver since 1977, and teaches primarily in the area of corporate finance.

Appendix A – Revenues and Charges by Payer Source Figures

Medicare			
	Revenues	Charges	Percentage
Alameda	\$23,855,007	\$44,498,274	53.61%
Boston	\$116,539,945	\$167,181,007	69.71%
Denver	\$33,173,000	\$53,351,000	62.18%
Grady	\$78,200,970	\$109,842,890	71.19%
Harborview	\$69,943,191	\$120,475,201	58.06%
Hennepin	\$70,505,346	\$149,978,576	47.01%
Jackson	\$126,662,676	\$286,710,139	44.18%
Parkland	\$52,250,974	\$124,207,154	42.07%
MetroHealth	\$76,783,000	\$111,039,000	69.15%
Brooklyn	\$51,089,565	\$72,198,095	70.76%
Southern NV	\$63,876,004	\$180,441,053	35.40%
Group Avg	\$69,352,698	\$129,083,854	53.73%
Ind Avg	\$42,403,961	\$83,118,186	51.02%

Medicaid			
	Revenues	Charges	Percentage
Alameda	\$109,851,361	\$170,554,047	64.41%
Boston	\$92,701,445	\$140,093,157	66.17%
Denver	\$132,402,000	\$98,866,000	133.92%
Grady	\$194,017,213	\$187,189,591	103.65%
Harborview	\$97,759,998	\$174,429,089	56.05%
Hennepin	\$127,612,464	\$226,183,856	56.42%
Jackson	\$200,866,952	\$532,954,137	37.69%
Parkland	\$115,100,042	\$241,253,906	47.71%
MetroHealth	\$120,850,000	\$149,580,000	80.79%
Brooklyn	\$110,789,436	\$86,443,625	128.16%
Southern NV	\$65,801,173	\$155,193,486	42.40%
Group Avg	\$124,341,099	\$196,612,809	63.24%
Ind Avg	\$90,584,235	\$134,256,334	67.47%

Commercial			
	Revenues	Charges	Percentage
Alameda	\$13,975,584	\$21,836,849	64.00%
Boston	\$78,944,098	\$144,491,567	54.64%
Denver	\$71,118,549	\$99,348,000	71.59%
Grady	\$50,019,601	\$57,462,425	87.05%
Harborview	\$116,510,611	\$163,645,248	71.20%
Hennepin	\$80,962,520	\$149,530,261	54.14%
Jackson	\$164,199,327	\$359,207,282	45.71%
Parkland	\$40,561,221	\$97,187,901	41.73%
MetroHealth	\$75,966,000	\$174,011,000	43.66%
Brooklyn	\$58,741,253	\$86,898,818	67.60%
Southern NV	\$117,979,448	\$262,469,602	44.95%
Group Avg	\$78,998,019	\$146,917,178	53.77%
Ind Avg	\$42,202,115	\$78,386,096	53.84%

Self Pay/Other			
	Revenues	Charges	Percentage
Alameda	\$0	\$126,963,540	0.00%
Boston	\$109,284,733	\$148,912,377	73.39%
Denver	\$14,005,391	\$191,061,563	7.33%
Grady	\$7,482,817	\$261,358,357	2.86%
Harborview	\$24,891,895	\$68,288,335	36.45%
Hennepin	\$30,393,893	\$39,004,935	77.92%
Jackson	\$70,000,092	\$457,366,522	15.31%
Parkland	\$20,090,298	\$363,273,482	5.53%
MetroHealth	\$13,170,000	\$73,608,000	17.89%
Brooklyn	\$18,822,907	\$18,822,907	100.00%
Southern NV	\$67,211,454	\$186,788,797	35.98%
Group Avg	\$34,123,044	\$175,949,892	33.88%
Ind Avg	\$16,129,178	\$113,906,986	14.16%

Appendix B – Demographic Information

	Population 2000	Under 5 yrs.	Under 18 yrs.	Over 65 yrs.	# of Households 2000	Medium Household Income 1999	Per Capita Income 1999	% Below Poverty
Alameda County Medical Center Alameda County	1,443,741	6.8%	24.6%	10.2%	523,366	\$55,946	\$26,680	11.0%
Boston Medical Center Suffolk County	689,807	5.6%	20.2%	11.0%	278,722	\$39,355	\$22,766	19.0%
Grady Health System Fulton County	816,006	7.0%	24.4%	8.5%	321,242	\$47,321	\$30,003	15.7%
DeKalb County	665,865	7.1%	24.6%	8.0%	249,339	\$49,117	\$23,968	10.8%
Harborview Medical Center King County	1,737,034	6.1%	22.5%	10.5%	710,916	\$53,157	\$29,521	8.4%
Jackson Memorial Hospital Miami-Dade County	2,253,362	6.5%	24.8%	13.3%	776,774	\$35,966	\$18,497	18.0%
Parkland Health & Hospital System Dallas County	2,218,899	8.2%	27.9%	8.1%	807,621	\$43,324	\$22,603	13.4%
Hennepin County Medical Center Hennepin County	1,116,200	6.6%	24.0%	11.0%	456,129	\$51,711	\$28,789	8.3%
University of Southern Nevada Clark County	1,375,765	7.5%	25.6%	10.7%	512,253	\$44,616	\$21,785	10.8%
The Metro Health System Cuyahoga County	1,393,978	6.5%	25.0%	15.6%	571,457	\$39,168	\$22,272	13.1%
Denver Health Denver County	554,636	6.8%	22.0%	11.3%	239,235	\$39,500	\$24,101	14.3%
University of Brooklyn Kings County	2,465,326	7.4%	26.9%	11.5%	880,727	\$32,135	\$16,775	25.1%
Queens County	2,229,379	6.4%	22.8%	12.7%	782,664	\$42,439	\$19,222	14.6%

In consideration of Denver Health's request, included in this mailing are comments by Mr. Frank Barrett, CFO (303) 436-6619

In 1996, Denver Health entered into an agreement with Colorado Access, a Colorado health maintenance organization (HMO), to be a provider in its Medicaid prepaid health plan. In 2000, the Denver Health entered into a similar agreement with Rocky Mountain Health Plan. At December 31, 2002, there were approximately 20,000 Colorado Access members and 2,490 Rocky Mountain Health Plan members for whom Denver Health was at risk for all covered benefits, including outpatient pharmacy and authorized care provided at non-Denver Health care sites. (*Comments on page 5*)

The Denver Health Medicaid charges shown above are understated because they do not include Medicaid charges for services rendered by non-Denver Health providers to designated members of Colorado Access and Rocky Mountain Health Plan. Denver Health makes payments to providers in accordance with the HMO's agreements at discounted rate, which approximates typical Medicaid reimbursement rates. Also not included in the above Medicaid charges are administrative fees, reinsurance, pharmacy claims, and incurred but not reported accruals (IBNR). (*Chart on page 12*)