AGENDA

TASK FORCE TO ANALYZE
THE HIGHER COSTS OF TEACHING HOSPITALS

AAMC Headquarters
One Dupont Circle
Thursday, May 27, 1971

I. Call to Order: 10:00 a.m.

II. Introduction of Task Force Members — TAB A

III. Review of Background Events Leading to the Establishment of the Committee — TAB B & C

IV. Current Activities of the AAMC and Other Organizations Relating to the Issue:

a) AAMC Committee on Financing Medical Education (Dr. Chase) — TAB D

b) Activities of the American Hospital Association

1) Hospital Administrative Services — TAB E & F

2) Kellogg Foundation Grant, Dr. James Cooney

c) New York City Study of Teaching Hospitals, Martin Steinberg, M.D.

d) AAMC Cost Allocation Study

e) University of Kansas Study of Teaching Hospitals

V. Determination of Future Course of Action by the Committee

VI. Date of Next Meeting and Adjournment

TASK FORCE TO ANALYZE THE HIGHER COSTS OF TEACHING HOSPITALS

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THE NEW YORK HOSPITAL

Chartered 1771

525 EAST 68th STREET, NEW YORK, N. Y. 10021

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OFFICE OF THE DIRECTOR

December 23, 1970

John M. Danielson, Director
Council of Teaching Hospitals
& Health Services
One Dupont Circle, N. W.
Washington, D. C. 20036

Dear John:

At the annual meeting of the Council of Teaching Hospitals (Eastern Contingent) on December 4th and 5th the matter of grouping of hospitals was discussed.

The effect of the change in the grouping of teaching hospitals in New York State for calculating Medicaid reimbursement was cited. As you know, the group of hospitals in metropolitan New York was expanded from six "primary" teaching hospitals to twenty-eight. The effect was to lower the average per diem cost and the reimbursement ceilings calculated from the average. Six hospitals were penalized by the new ceilings of which three were in the former "primary" teaching hospital group, or 50 per cent of the previous group.

The State Health Department justifies the change on two scores:

1. All of the twenty-eight hospitals are teaching hospitals as defined by AAMC-COTH.

2. Ceilings were calculated on "routine" hospital costs which should be comparable in all hospitals.

The basis for defining certain costs as "routine" is open to serious question, but it is not the matter of concern discussed at the COTH meeting. However, the first item, grouping of hospitals, was discussed at length and there was a concensus that this is a matter of national concern, one which needs urgently the attention of the national AAMC-COTH organization. We were asked to write to you on this matter in behalf of the group of institutions.

It is suggested that the AAMC-COTH review the membership with the objective of developing groups or categories within the membership. Clearly, not all of the member hospitals are involved to the same degree in undergraduate and graduate education nor are the hospitals comparable in size, complexity and expense of operation.

It would be helpful, we believe, if upon review, the section of the By-Laws relating to Teaching Hospital Members could be revised to delineate the differences and to subdivide the membership appropriately, grouping hospitals of comparable complexity and educational commitment.

Sincerely,

Stanley A. Ferguson
Executive Director
University Hospitals of Cleveland

David D. Thompson, M.D.
Director
The New York Hospital

Excerpted from State of New York Department of Health Hospital Memorandum, Series 70-56, Date Dec 23, 1970.
Subject: Part 86, Reporting and Rate Certification for Facilities, Administrative Rules and Regulations.

86.13 Groupings. (a) For the purpose of establishing ceilings, medical facilities will be grouped as follows:

(1) Type of medical facility:

(i) hospitals part of or affiliated with teaching centers or maintaining a substantial program of graduate education;
(ii) general hospitals;
(iii) special hospitals by type;
(iv) nursing homes;
(v) health related facilities;
(vi) independent out-of-hospital health facilities.

(2) Geographic areas:

(i) Western New York Hospital Service Region;
(ii) Rochester Hospital Service Region;
(iii) Central New York Hospital Service Region;
(iv) Northeastern New York Hospital Service Region;
(v) Long Island Hospital Service Region;
(vi) Northern Metropolitan Hospital Service Region;
(vii) New York City Hospital Service Region.

(3) Size of medical facility:

(i) For hospitals:

(a) under 100 beds;
(b) 100 - 199 beds;
(c) 200 - 299 beds;
(d) 300 - 499 beds;
(e) over 500 beds.

(ii) For nursing homes:

(a) under 40 beds;
(b) 40 - 99 beds;
(c) 100 - 199 beds;
(d) 200 - 299 beds;
(e) 300 and over.

(4) Sponsor:

(i) voluntary hospitals;
(ii) public hospitals;
(iii) proprietary hospitals;
(iv) voluntary nursing homes;
(v) public nursing homes
(vi) proprietary nursing homes

Excerpted from State of New York Department of Health Hospital Memorandum, Series 69-33, Date Dec. 5, 1969.
Subject: Part 86, Reporting and Rate Certification for Medical Facilities, Administrative Rules and Regulations.

86.13 Groupings. (a) For the purpose of establishing ceilings, medical facilities will be grouped as follows:

(1) Type of medical facility:

(i) hospitals part of teaching centers;

(ii) hospitals affiliated with teaching centers or maintaining a substantial program of graduate education;

(iii) general hospitals;

(iv) special hospitals by type;

(v) nursing homes, grouped by average length of stay;

(vi) health related facilities;

(vii) independent out-of-hospital health facilities.

(2) Geographic areas:

(i) Western New York Hospital Service Region;

(ii) Rochester Hospital Service Region;

(iii) Central New York Hospital Service Region;

(iv) Northeastern New York Hospital Service Region;

(v) Long Island Hospital Service Region;

(vi) Northern Metropolitan Hospital Service Region;

(vii) New York City Hospital Service Region.

(3) Size of medical facility:

(i) For hospitals:

(a) under 100 beds;

(b) 100 - 199 beds;

(c) 200 - 299 beds;

(d) 300 - 499 beds;

(e) over 500 beds.

TEACHING GROUP

UPSTATE:

Sub Group A
- Albany Medical Center
- Buffalo General
- * E. J. Meyer
- Sisters of Charity - Buffalo

Sub Group R
- Genesee
- Highland
- Rochester General
- Strong Memorial
- St. Mary's - Rochester
- State University - Upstate Medical Center -- Was held to Group R Ceiling, but not included in group.

* Because this hospital did not use the UFR, it was not possible to include their data in this group.

DOWNSTATE:

		AMS Group
*	Beth Israel	556	2
	Brookdale	417	2
	Bronx-Lebanon	564	3
	Flower & Fifth Avenue	388	2
	Flushing	371	3
*	French Polyclinic	571	2
*	Grasslands		
	Jamaica	285	3
	Jewish Hospital & Medical Center	636	2
	Lenox Hill	587	2
	Long Island College	575	2
	Long Island Jewish	516	3
	Lutheran Medical Center	288	3
	Maimonides	613	2
	Meadowbrook		
	Methodist of Brooklyn	467	3
	Montefiore	1088	1
	Mount Sinai	1300	1
	Nassau	—	3
	New York Hospital	1442	1
*	New York University	635	1
	Presbyterian	1578	1
	Roosevelt	571	2
	St. John's Episcopal	288	3
	St. Luke's	729	1
	St. Vincent's - NYC	818	1
	St. Vincent's - Richmond	340	3
	North Shore	307	3

(Data not included in group) State University - Downstate

* Indicates hospitals whose data was not included because it was not available at time of grouping.

Excerpted from AHS Publication Entitled
MEMBER HOSPITAL REIMBURSEMENT FORMULA
Effective January 1, 1970

AHS

CHAPTER TEN - GROUPING OF MEMBER HOSPITALS

Section 1001 - Requirement for Grouping

Member hospitals will be segregated into groups similar in size, location and scope of services rendered in accordance with Section 1004 following.

Section 1002 - Rules for Classifying Hospitals by Groups

In classifying hospitals by groups in accordance with the criteria outlined in Section 1001, the following rules shall apply:

a. when the total of adult and children patient days of care annually for two of the three most recent years, including the year under review, is such as to indicate a change in grouping, such change shall automatically be made.

b. when the total of adult and children patient days of care annually for the year under review indicates a change in grouping but the adult and children patient day total of each of the two years immediately preceding does not, the question of whether a change in grouping will be effected shall be decided by AHS on the basis of evidence satisfactory to it as to whether the patient day total for the year subsequent to the year under review will or will not require such group change.

c. with the exception of the patient day total, the determination of the facts governing the classification of the hospital by groups, such as accreditation status, licensure of outpatient department, existence of approved internships and residencies, etc. shall be made in accordance with the status of the hospital as of December 31 of the year under review.

d. a hospital not fully meeting the requirements of a particular group of hospitals but which is considered to be in substantial compliance with the requirements may be included in the group subject to approval by the Review Committee.

Section 1003 - Special and Unclassified Voluntary Hospitals

The provision of the reimbursement formula with respect to the determination of group maximum payment rates in accordance with Section 204 is not applicable to accredited special and unclassified voluntary hospitals classified in Group 10 by Section 1004.

Section 1004 - Grouping of Member Hospitals

Group 1

Accredited voluntary general hospitals rendering at least 200,000 patient days annually (exclusive of newborn days) that meet the following requirements:

(i) full time physicians serving as residents under an American Medical Association approved residency training program covering at least thirteen different specialties of which ten must be clinical specialties including internal medicine and surgery.

(ii) a professional nursing school or an affiliation which requires the regular training of professional nursing students on at least two clinical services under an agreement with a college or university offering a degree course in nursing.

(iii) full time physicians serving as interns under an A.M.A. approved internship program.

(iv) a licensed outpatient department and an emergency service.

Group 2

Accredited voluntary general hospitals not included in Group 1, rendering at least 125,000 patient days annually (exclusive of newborn days) that meet the following requirements:

(i) full time physicians serving as residents under an American Medical Association approved residency training program covering at least eight different specialties of which five are

clinical specialties which include internal medicine and surgery.

(ii) a professional nursing school or an affiliation which requires the regular training of professional nursing students on at least two clinical services under an agreement with a college or university offering a degree course in nursing,

or

in the absence of the above, full time physicians serving as interns under an A.M.A. approved internship program.

(iii) a licensed outpatient department and an emergency service.

Group 3

Accredited voluntary general hospitals not included in Groups 1 and 2, rendering at least 75,000 patient days annually (exclusive of newborn days) that meet the following requirements:

(i) full time physicians serving as residents under an American Medical Association approved residency training program covering at least four different clinical specialties including internal medicine and surgery.

(ii) a professional nursing school or an affiliation which requires the regular training of

professional nursing students on at least the clinical services under an agreement with a college or university offering a degree course in nursing,

or

in the absence of the above, full time physicians serving as interns under an A.M.A. approved internship program.

(iii) a licensed outpatient department and an emergency service.

Group 4

Accredited voluntary general hospitals located in New York City not included in Groups 1 through 3, rendering at least 50,000 patient days of care annually (exclusive of newborn days).

Group 5

Accredited voluntary general hospitals located in New York City rendering less than 50,000 patient days of care annually (exclusive of newborn days).

Group 6

Accredited voluntary general hospitals outside New York City not included in Groups 1, 2 and 3, rendering at least 50,000 patient days of care annually (exclusive of newborn days) that meet the following requirements:

(i) full time physicians serving as residents under an American Medical Association approved

residency training program covering at least four specialties two of which must be internal medicine and surgery,

or

full time physicians serving as interns under an A.M.A. approved internship program.

(ii) a licensed outpatient department and an emergency service.

Group 7

Accredited voluntary general hospitals outside New York City not included in Groups 1, 2, 3 and 6 that render more than 25,000 patient days of care annually (exclusive of newborn days).

Group 8

Accredited voluntary general hospitals outside New York City rendering less than 25,000 patient days of care annually (exclusive of newborn days).

Group 9

Accredited voluntary general hospitals in Connecticut.

Group 10

Accredited special and unclassified voluntary hospitals.

Group 11

Accredited proprietary hospitals rendering less than 25,000 patient days of care annually (exclusive of newborn days).

Group 12

Accredited proprietary hospitals rendering at least 25,000 patient days of care annually (exclusive of newborn days) located in the counties of Queens, Nassau and Suffolk.

Group 13

Accredited proprietary hospitals rendering at least 25,000 patient days of care annually (exclusive of newborn days) not included in Group 12.

Group 14

Non-accredited hospitals.

MEMBERSHIP GROUPING BY NUMBER OF RESIDENCY PROGRAMS OFFERED

# of Spec	Aff	Region	Control	Bed Size	Hospital Name	# of Clerkships	Total Expense per Patient Day
0	-	4	-	1	University Hospital, Tucson		$ --
	-	2	5	1	National Children's Cardiac Hospital, University of Miami-School of Medicine		126.40
	4	2	8	2	U.S. Public Health Service Hospital, Carville, La.		36.33
	1	1	1	-	University Hospital, State University of New York at Stony Brook		--
	2	1	5	2	Crouse-Irving Memorial Hospital of Syracuse		--
	2	2	6	2	Veterans Administration Hospital, Charleston, S.C.		62.56
	2	4	2	2	Martin Luther King, Jr. General Hospital		--

Total Hospitals	Average Cost per Patient Day
7	$ 75.10

1	2	3	5	1	Schwab Rehabilitation Hospital		76.07
	4	1	8	3	Clinical Center, National Institutes of Health		152.07
	3	1	5	1	Hospital for Special Surgery		130.19
	2	3	5	1	Milwaukee Psychiatric Hospital		46.94
	4	2	5	1	Cedars of Lebanon Hospital		90.15

Total Hospitals	Average Cost per Patient Day
5	$ 99.08

2	2	1	6	4	Veterans Administration Hospital, D.C.		74.14
	2	3	2	4	Marion County General Hospital		72.13
	3	2	5	1	Jewish Hospital, Louisville		72.64
	2	1	5	1	Massachusetts Eye and Ear Infirmary		109.50

	2	1	1	1	Massachusetts Mental Health Center	30.82
	2	1	5	1	Robert B. Brigham Hospital	99.22
	1	1	6	3	Veterans Administration Hospital, Philadelphia	57.81
	2	1	5	1	University of Pittsburgh-Western Psychiatric Institute and Clinic	102.76
	2	2	6	1	Veterans Administration Hospital, Clarksburgh, West Virginia	45.72
	3	1	5	2	Northwestern Hospital	72.56
	2	1	5	1	The Miriam Hospital	96.06
	2	1	5	1	Providence Lying In Hospital	108.90
	2	1	5	1	The Good Samaritan Hospital, Maryland	--
	2	4	5	2	Veterans Administration Hospital, Albuquerque	60.01

Total Hospitals	Average Cost per Patient Day
14	$ 77.10

3	3	3	4	3	St. Joseph Hospital, Chicago	85.48
	3	1	5	1	Church Home and Hospital of the City of Baltimore	82.22
	2	3	5	2	Edward W. Sparrow Hospital	66.16
	2	1	5	4	Harrisburg Polyclinic Hospital	50.50
	3	1	6	2	Veterans Administration Hospital, Providence	67.15
	2	2	5	1	The Fairfax Hospital Association	100.47
	3	3	4	3	St. Mary's Hospital	65.79
	3	2	4	1	Appalachian Regional Hospital	64.68

Total Hospitals	Average Cost per Patient Day
8	$ 72.81

4	3	3	4	3	Little Company of Mary Hospital, Inc.	73.19
	3	1	5	2	The Union Memorial Hospital	86.57
	3	1	2	2	Prince George's General Hospital	77.51
	2	1	5	1	Boston Hospital for Women	132.29
	3	1	5	3	St. Vincent Hospital, Worcester	60.87
	4	3	4	3	Saint John's Mercy Hospital	70.88
	4	1	4	1	Booth Memorial Hospital	104.16
	3	1	5	3	Conemaugh Valley Memorial Hospital	53.11
	4	2	4	1	St. Thomas Hospital	74.49
	3	3	4	1	Fairview Hospital	60.27
	4	3	5	2	Crawford W. Long Memorial Hospital of Emory University	63.73
		2	5	4	Bayfront Medical Center, Inc.	58.04
		1	6	1	Veterans Administration Hospital, Newington	100.20
		3	4	3	Iowa Methodist Hospital	59.68
	4	3	5	2	Saint John Hospital	87.40
	4	3	4	2	Fairview General Hospital	80.35
		2	5	4	Greenville General Hospital (Division-Greenville Hospital System)	56.20
		4	6	1	Veterans Administration Hospital, Tucson	57.11
0	3	1	5	2	St. Luke's Hospital, Bethlehem, Pa.	59.22

Total Hospitals	Average Cost per Patient Day
19	$ 72.03

5	3	4	4	2	Presbyterian Medical Center, Denver	74.02
	4	1	5	3	Bridgeport Hospital	84.89
	4	1	4	2	St. Vincent's Hospital	--
	3	1	5	2	New Britain General Hospital	88.78
	3	1	4	1	The Carney Hospital	85.51
	4	1	5	2	The Springfield Hospital Medical Center	77.00
	3	1	6	1	Veterans Administration Hospital, West Roxbury	58.24
	4	1	3	2	Worcester City Hospital	56.14
	2	3	5	2	Hutzel Hospital	85.84
	4	3	5	2	The Charles T. Miller Hospital, Inc.	75.96
	4	1	5	1	Jersey Shore Medical Center-Fitkin Hospital	63.49
	2	1	5	1	Highland Hospital of Rochester	90.00
	3	3	6	4	Veterans Administration Hospital, Dayton	59.48
	3	1	5	3	Harrisburg Hospital	63.95
	3	1	5	3	York Hospital	64.70
	4	2	5	1	Memorial Hospital, Charleston, W.Va.	63.80
	4	4	5	2	Tucson Medical Center	81.16
	4	2	4	3	St. Joseph's Infirmary	69.67
	2	1	5	1	Roger Williams General Hospital	99.85
	2	1	5	1	The Memorial Hospital	79.74
	4	3	3	2	Pontiac General Hospital	98.79
	4	1	4	2	Sisters of Charity Hospital	66.05

		3	5	2	Oakwood Hospital	68.87
		3	5	2	Mac Neal Memorial Hospital	79.63
		1	5	1	The Jamaica Hospital	96.26
		2	6	2	Veterans Administration Hospital, Shreveport, La.	43.49
		1	5	2	Hamot Hospital	59.87

Total Hospitals	Average Cost per Patient Day
27	$ 74.43

6	3	1	4	2	Providence Hospital	69.64
	2	4	5	2	The Queen's Hospital	68.56
	4	1	4	2	St. Agnes Hospital of the City of Baltimore	82.03
	4	3	4	3	Mount Carmel Mercy Hospital	83.41
	4	3	4	1	St. Joseph Mercy Hospital	89.81
	2	3	5	1	Saint Louis Children's Hospital	85.24
	2	3	4	3	Creighton Memorial St. Joseph Hospital	70.13
	2	1	5	3	The Cooper Hospital	55.46
	4	1	5	3	Monmouth Medical Center	--
	4	1	4	1	St. John's Episcopal Hospital	69.69
	2	1	5	1	Mary Imogene Bassett Hospital	92.94
	4	1	4	2	St. Clare's Hospital	87.26
	3	1	4	1	St. Mary's Hospital of the Sisters of Charity	89.87
	4	3	5	4	State University Hospital	67.83
	2	1	4	2	Fitzgerald Division	67.94
	2	1	5	1	St. Christopher's Hospital for Children	108.48
	2	1	5	3	Montefiore Hospital	86.76

	4	3	5	2	Mount Sinai Hospital, Inc.	--
	4	1	5	3	Saint Barnabas Medical Center	--
	3	1	5	3	Allentown Hospital Association	55.40
		3	5	4	Youngstown Hospital Association	72.64
		4	6	4	Veterans Administration Hospital, Martinez	49.80
		2	4	2	Baptist Memorial Hospital, Oklahoma City	64.07
		1	4	4	Catholic Medical Center of Brooklyn & Queens, Inc.	
		2	4	2	Methodist Hospital of Dallas	80.13

Total Hospitals	Average Cost per Patient Day
24	$ 76.05

7	4	4	2	1	San Joaquin General Hospital	--
	2	4	5	3	Memorial Hospital of Long Beach	88.28
	3	4	4	2	The Hospital of the Good Samaritan	125.95
	1	1	1	1	University of Connecticut Hospital-McCook Division	85.55
	2	2	6	4	Veterans Administration Hospital, Augusta	29.26
	3	3	5	3	Illinois Masonic Hospital Association	93.86
	3	1	5	2	Maryland General Hospital	62.22
	3	1	5	2	Berkshire Medical Center	93.77
	2	3	4	3	St. Joseph Mercy Hospital	95.52
	4	3	4	2	Providence Hospital	93.43
	4	1	4	2	St. Michael's Medical Center	73.89

	4	1	4	1	Misericordia Hospital	99.60
	4	1	3	2	Fordham Hospital	139.21
	4	1	4	1	Lutheran Medical Center	96.74
	3	1	5	2	Nassau Hospital	79.94
	2	3	4	2	Mount Carmel Hospital	67.45
	3	3	2	1	Maumee Valley Hospital	35.89
	4	3	4	3	Saint Elizabeth Hospital	67.25
	2	1	5	1	Eye and Ear Hospital of Pittsburgh	74.28
	3	2	4	3	St. Paul Hospital	76.27
	4	1	5	1	North Shore Hospital	106.81
	3	3	4	2	St. Luke's Hospital of Kansas City	67.99
	3	4	5	1	Kaiser Foundation Hospitals, San Francisco	86.32
	4	2	7	4	William Beaumont General Hospital	--
	3	3	3	4	Hurley Hospital	80.98
		3	4	4	Wesley Medical Center	71.55
		2	1	1	University of Texas M.D. Anderson Hospital & Tumor Institute at Houston	--
		4	2	2	Maricopa County General Hospital, Phoenix	76.36

Total Hospitals	Average Cost per Patient Day
28	$ 82.73

8	4	4	4	2	St. Joseph's Hospital and Medical Center	97.70
	4	2	5	3	Mount Sinai Hospital of Greater Miami	87.04
	3	3	4	3	Mercy Medical Center	93.88
	3	1	5	2	Maine Medical Center	86.58
	2	1	4	2	Saint Elizabeths Hospital	

2	1	4	2	Saint Elizabeths Hospital Of Boston	99.44
2	3	5	4	The Grace Hospital	88.62
3	3	5	2	Blodgettt Memorial Hospital	79.17
4	1	5	3	Bronx-Lebanon Hospital Center	101.61
3	1	5	2	The Brookdale Hospital Center	136.25
3	1	4	2	Methodist Hospital of Brooklyn	88.83
3	1	6	4	Veterans Administration Hospital, Buffalo	40.73
2	1	5	2	The Genessee Hospital	102.52
4	3	5	2	Akron General Hospital	75.76
3	4	4	3	Emanuel Hospital	81.27
1	1	5	1	Hospital of the Medical College of Pennsylvania	93.18
2	2	4	4	Baptist Memorial Hospital	62.90
1	2	4	1	George W. Hubbard Hospital	65.53
4	2	7	2	Gorgas Hospital	94.98
3	4	4	3	Mercy Hospital and Medical Center	92.75
3	1	5	2	Greater Baltimore Medical Center	97.41
3	3	5	2	The Butterworth Hospital	71.15
	4	8	2	Public Health Service Hospital, San Francisco	81.08
	2	5	1	The Henrietta Egleston Hospital for Children, Inc.	93.96

Total Hospitals	Average Cost per Patient Day
23	$ 87.49

9	4	4	5	4	Good Samaritan Hospital, Phoenix	102.24
	1	4	2	3	University Hospital of San Diego County	112.35
	3	4	4	1	Presbyterian Hospital of the Pacific Medical Center	124.72
	3	1	4	3	St. Francis Hospital	90.46
	2	1	5	4	Brooklyn Cumberland Medical Center	95.57
	2	1	6	4	Veterans Administration Hospital, Brooklyn	41.44
	3	1	5	3	Millard Fillmore Hospital	57.02
	3	1	2	2	Grasslands Hospital	119.46
	3	2	5	4	Charlotte Memorial Hospital	71.64
	3	3	4	4	Good Samaritan Hospital	69.76
	2	3	6	2	Veterans Administration Hospital, Cincinnati	67.39
	2	1	5	2	Pennsylvania Hospital	54.79
	3	1	5	4	St. Francis Hospital	57.69
	4	1	X	1	American University Hospital	--
		3	4	4	St. Francis Hospital	65.35
		1	4	1	St. Vincent's Medical Center of Richmond	93.13

Total Hospitals	Average Cost per Patient Day
16	$ 81.53

10	3	4	5	4	Cedars Sinai Medical Center, L.A.	160.69
	3	4	5	2	Mount Zion Hospital and Medical Center	115.93
	3	3	4	4	St. Francis Hospital, Wichita	57.88

2	2	6	4	Veterans Administration Hospital, Lexington	28.59
3	2	5	3	Touro Infirmary	93.80
2	1	6	4	Veterans Administration Hospital, East Orange	45.76
2	1	5	2	Newark Beth Israel Hospital	76.07
2	1	5	3	Maimonides Medical Center	116.72
4	1	5	3	Lenox Hill Hospital	118.20
4	3	5	3	The Mount Sinai Hospital Of Cleveland	96.38
4	3	4	3	St. Luke's Hospital Association of the Methodist Church	98.68
2	1	4	1	Presbyterian University of Pennsylvania Medical Center	108.22
3	1	4	3	Mercy Hospital of Pittsburgh	68.22
2	1	5	3	Presbyterian University Hospital	82.83
3	1	5	3	The Western Pennsylvania Hospital	73.49
3	2	4	4	Baylor University Medical Center	--
2	2	5	1	Texas Children's Hospital	116.42
2	4	8	1	U.S. Public Health Service Hospital	55.79
4	2	5	3	Norfolk General Hospital	63.74
2	4	2	1	Bernalillo County Medical Center	74.13
	1	5	2	Deaconness Hospital of Buffalo	65.02
	4	4	2	Latter Day Saints Hospital	70.52

Total Hospitals	Average Cost per Patient Day
22	$ 85.10

11	4	1	4	2	The Hospital of St. Raphael	93.85
	2	1	5	4	Washington Hospital Center	101.64
	3	3	4	3	St. Francis Hospital	81.81
	1	3	4	2	Loyola University Hospital	--
	3	2	8	2	U.S. Public Health Service Hospital	56.56
	3	1	5	3	Sinai Hospital of Baltimore, Inc.	105.12
	2	1	5	1	Children's Hospital Medical Center	202.91
	2	3	5	1	Children's Hospital of Michigan	102.22
	3	3	5	3	Kansas City General Hospital and Medical Center	116.18
	2	3	5	3	The Jewish Hospital of St. Louis	90.36
	4	1	2	3	Meadowbrook Hospital	127.66
	3	1	5	4	Beth Israel Medical Center	116.67
	4	1	5	2	Geisinger Medical Center	139.96
	2	1	5	2	Magee Womens Hospital	92.73
	2	1	6	4	Veterans Administration Hospital, Pittsburgh	57.73
	2	4	5	1	Children's Orthopedic Hospital and Medical Center	125.88
	2	3	5	2	Madison General Hospital	69.24
		2	6	2	Veterans Administration Hospital, San Juan	95.70

Total Hospitals	Average Cost per Patient Day
18	$ 98.47

12	1	4	4	1	Loma Linda University Hospital	125.04
	2	4	5	1	Children's Hospital of San Francisco	114.30

3	1	5	4	Hartford Hospital	93.77
4	1	5	4	Wilmington Medical Center	84.96
3	2	2	1	Duval Medical Center	81.88
3	2	6	2	Veterans Administration Hospital, Atlanta	84.54
2	3	5	2	Passavant Memorial Hospital	87.52
2	3	6	3	Veterans Administration Hospital, West Side	85.63
4	3	4	4	Methodist Hospital of Indiana, INc.	82.86
2	1	5	4	Massachusetts General Hospital	201.17
2	3	6	2	Veterans Administration Hospital, Kansas City	60.60
1	3	4	1	St. Louis University Hospitals	84.88
2	3	6	3	Veterans Administration Hospital, Omaha	53.83
2	1	5	1	Mary Hitchcock Memorial Hospital	83.35
2	1	5	3	The Jewish Hospital and Medical Center of Brooklyn	92.45
3	1	5	4	Harlem Hospital	131.15
2	1	5	1	The Children's Hospital of Philadelphia	133.26
2	1	5	2	Episcopal Hospital	61.67
3	1	5	3	Allegheny General Hospital	80.92
3	2	5	3	Hermann Hospital	76.15
2	3	6	2	Veterans Administration Hospital, Madison	51.99
3	4	7	4	Fitzsimons General Hospital	--

Total Hospitals	Average Cost per Patient Day
22	$ 88.98

13	2	4	6	1	Veterans Administration Hospital, San Francisco	109.57
	2	3	5	2	Mount Sinai Hospital and Medical Center	121.48
	2	3	5	3	Evanston Hospital	95.22
	2	1	5	1	Peter Bent Brigham Hospital	186.80
	1	1	5	1	University Hospital, Inc. - Boston	168.45
	2	3	6	4	Veterans Administration Hospital, Allen Park	68.71
	1	3	1	1	University of Nebraska Hospital	106.60
	2	1	5	3	The Long Island College Hospital	96.44
	2	1	5	1	Children's Hospital of Buffalo	--
	2	1	5	1	The Long Island Jewish Hospital	119.69
	2	1	5	3	The Roosevelt Hospital	129.97
	2	2	6	4	Veterans Administration Hospital, Memphis	48.03
	2	4	6	3	Veterans Administration Hospital, Salt Lake City	55.47
	4	2	7	4	Brooke General Hospital	--
	2	1	1	4	Harrison S. Marltand Hospital of the New Jersey College of Medicine and Dentistry	69.16
		4	2	2	Riverside General Hospital	73.92
		3	6	2	Veterans Administration Hospital, Iowa City	54.16

Total Hospitals	Average Cost per Patient Day
17	$ 100.25

14	2	4	2	3	Sacramento Medical Center	110.53
	2	1	4	2	Georgetown University Hospital	73.84
	2	2	6	3	Veterans Administration Hospital, Gainesville	66.90
	2	3	6	4	Veterans Administration Hospital, Indianapolis	54.98
	3	2	6	3	Veterans Administration Hospital, New Orleans	55.14
	2	2	6	3	Veterans Administration Hospital, Jackson	49.93
	4	1	3	4	Queens Hospital Center	95.52
	3	1	4	4	St. Vincent's Hospital & Medical Center of New York	107.07
	4	3	5	3	Akron City Hospital	63.35
	2	2	6	3	Veterans Administration Hospital, Oklahoma	63.07
	2	4	6	3	Veterans Administration Hospital, Portland	55.71
	2	1	5	4	Albert Einstein Medical Center	68.85
	2	2	6	4	Veterans Administration Hospital, Richmond, Va.	48.57
	2	4	6	1	Veterans Administration Hospital, Seattle	94.00
				3	St. Boniface General Hospital	--
		3	6	4	Veterans Administration Hospital, St. Louis	33.76

Total Hospitals	Average Cost per Patient Day
16	$ 69.42

15	4	2	5	1	Children's Hospital of L.A.	143.21
	2	4	2	3	Orange County Medical Center	122.03
	2	1	5	3	George Washington University Hospital	91.76
	1	2	5	1	Emory University Hospital	84.89
	3	2	5	1	Oschner Foundation Hospital	77.00
	2	1	6	4	Veterans Administration Hospital, Albany	40.66
	2	1	5	4	The Buffalo General Hospital	75.59
	2	1	2	4	Edward J. Meyer Memorial Hospital	--
	2	1	5	4	St. Luke's Hospital Center	120.74
	2	1	5	4	Rhode Island Hospital	126.42
	2	2	6	4	Veterans Administration Hospital, Texas	47.77
	3	2	3	3	San Juan Memorial Hospital, Lopez Nussa Memorial	66.91

Total Hospitals	Average Cost per Patient Day
12	$ 90.63

16	2	1	5	4	Yale-New Haven Hospital	119.74
	2	1	5	1	Children's Hospital Center of the District of Columbia	--
	2	2	6	4	Veterans Administration Hospital, Miami	108.87
	2	3	5	1	The Childrens Memorial Hospital, Chicago	163.10
	3	3	5	4	Michael Reese Hospital & Medical Center	115.64
	1	3	1	4	University of Iowa Hospitals	65.05
	2	1	6	4	Veterans Administration Hospital, Boston	47.99

	2	3	5	4	Harper Hospital	90.79
	2	3	2	2	Hennepin County General Hospital	103.62
	2	3	6	4	Veterans Administration Hospital, Minneapolis	77.27
	2	1	5	2	The Rochester General Hospital	95.65
	2	3	2	3	Cleveland Metropolitan General Hospital	135.44
	1	1	5	1	The Graduate Hospital of the University of Pennsylvania	83.17
	1	2	1	2	West Virginia University Hospital	--
	2	3	5	1	Milwaukee Childrens Hospital	92.62
	2	3	6	4	Veterans Administration Hospital, Wood	82.36
	4	4	X	3	University Hospital, Saskatoon	--
		2	6	4	Veterans Administration Hospital, Little Rock	37.06
		1	5	1	Children's Hospital of Pittsburgh	103.79

Total Hospitals	Average Cost per Patient Day
19	$ 95.14

17	2	2	6	2	Veterans Administration Hospital, Birmingham	57.74
	2	1	6	4	Veterans Administration Hospital, West Haven	48.23
	2	3	5	3	Chicago Wesley Memorial Hospital	118.60
	2	3	6	3	Veterans Administration Hospital, Research	52.98
	2	2	2	2	Louisville General Hospital	72.23
	2	1	3	4	Baltimore City Hospitals	64.00

	2	1	5	2	Beth Israel Hospital, Boston	146.81
	2	3	2	2	Wayne County General Hospital & Infirmary	92.85
	1	2	1	2	University Hospital, Jackson	72.58
	2	2	6	3	Veterans Administration Hospital, Durham	56.20
	2	2	4	2	North Carolina Baptist Hospitals, Inc.	95.82
	1	1	5	4	Hospital of the University of Pennsylvania	105.18
	1	2	1	2	Medical College Hospital	103.13
	2	2	9	4	Dallas County Hospital District	99.89
	3	2	7	4	Wilford Hall U.S. Air Force Hospital	--
	2	1	5	3	Medical Center Hospital of Vermont	100.78
	4	4	1	1	University of Alberta Hospital	--
		4	6	4	Veterans Administration Hospital, Long Beach	43.47

Total Hospitals	Average Cost per Patient Day
18	$ 83.16

18	2	4	6	4	Wadsworth Hospital, L.A.	71.41
	2	4	6	4	Veterans Administration Hospital, Palo Alto	35.46
	1	2	1	2	Eugene Talmadge Memorial Hospital	78.57
	2	3	6	4	Veterans Administration Hospital, Hines	56.65
	1	2	1	2	University of Kentucky Hospitals	65.05
	3	2	6	2	Veterans Administration Hospital, Louisville	59.36

2	1	5	4	The Johns Hopkins Hospital	111.42
2	1	5	2	New England Medical Center Hospitals	148.47
2	3	2	3	St. Paul-Ramsey Hospital	97.26
2	3	5	4	Barnes Hospital	91.85
2	1	5	4	Albany Medical Center Hospital	79.15
2	1	3	4	City Hospital Center Of Elmhurst	107.04
3	1	5	2	Memorial Hospital for Cancer and Allied Diseases	214.97
2	1	5	4	New York Hospital	111.78
3	1	6	4	Veterans Administration Hospital, New York	60.24
2	3	6	4	Veterans Administration Hospital, Cleveland	66.41
1	3	1	4	Ohio State University Hospitals	--
2	1	5	3	Hahnemann Medical College & Hospitals	99.79
2	1	2	4	Philadelphia General Hospital	69.36
2	2	6	3	Veterans Administration Hospital, Nashville	61.40
4	2	9	4	Harris County Hospital District	111.08
2	2	6	4	Veterans Administration Hospital, Houston	42.34
2	2	1	2	University District Hospital	73.03
4	3	X	4	Winnepeg General Hospital	--
3	1	6	4	Veterans Administration Hospital, Bronx	52.69
2	4	2	2	Harborview Medical Center	99.91
	1	6	2	Veterans Administration Hospital, Sryacuse	66.47

Total Hospitals	Average Cost per Patient Day
27	$ 85.25

19	1	2	1	4	University of Alabama Hospital and Clinics	93.17
	1	2	1	1	University Hospital, Little Rock	75.58
	2	4	2	4	L.A. County Harbor General Hospital	141.87
	2	2	2	4	Grady Memorial Hospital	72.20
	1	3	1	3	Indiana University Hospitals	100.53
	1	3	1	4	University Hospital, Ann Arbor	121.31
	2	3	6	2	Veterans Administration Hospital, Ann Arbor	57.83
	2	3	3	3	Detroit General Hospital	100.15
	1	1	5	2	New York Medical College Flower & Fifth Avenue Hospitals	117.74
	2	3	5	4	University Hospitals of Cleveland	104.38
	1	2	5	3	Vanderbilt University Hospital	100.15
	2	2	4	4	Methodist Hospital	--
	1	3	1	4	University of Wisconsin Hospitals	80.54
	2	1	3	4	Bronx Municipal Hospital Center	124.61

Total Hospitals	Average Cost per Patient Day
14	$ 99.24

20	2	3	2	4	Cook County Hospital	63.90
	1	3	1	3	University of Illinois Research & Educational Hospitals	95.75
	2	1	5	4	Presbyterian Hospital in the City of New York	116.58
	1	1	1	1	State University Hospital	146.69
	1	3	3	4	Cincinnati General Hospital	88.20
	4	3	5	3	Cleveland Clinic Hospital	92.92

	1	4	1	3	University of Oregon Medical School Hospitals & Clinics	71.81
	1	1	5	4	Thomas Jefferson Medical College Hospital	90.69
	2	2	3	4	City of Memphis Hospitals	86.30
	1	2	5	3	University of Virginia Hospital	78.50

Total Hospitals	Average Cost per Patient Day
10	$ 93.13

21	2	4	2	4	L.A. County, University of Southern California Medical Center	--
	1	4	5	3	Stanford University Hospital	119.60
	1	4	1	2	University of Colorado Medical Center	99.69
	1	2	1	2	Shands Teaching Hospital & Clinics	63.01
	1	3	5	3	University of Chicago Hospital & Clinics	118.16
	2	2	1	4	Charity Hospital of La.	37.47
	2	1	5	4	Montefiore Hospital and Medical Center	150.06
	1	1	1	4	Downstate, Kings County Medical Center	88.82
	2	1	5	4	Mount Sinai Hospital, N.Y.	125.41
	1	1	5	3	University Hospital of NY.U. Medical Center	128.54
	1	1	5	3	Strong Memorial Hospital	121.23
	1	2	1	2	North Carolina Memorial Hospital	107.85
	2	3	2	4	Milwaukee County General Hospital	108.15

Total Hospitals	Average Cost per Patient Day
13	$ 105.67

22	1	4	5	2	U.C.L.A. Hospital	181.11
	1	4	5	3	University of California Hospitals	140.80
	2	3	5	4	Presbyterian-St. Luke's Hospital	182.65
	1	3	1	4	University of Minnesota Hospitals	107.78
	1	2	5	4	Duke University Hospital	98.84
	1	1	5	4	Temple University Hospital	114.24
	2	4	1	1	University of Utah Hospitals	100.25

Total Hospitals	Average Cost per Patient Day
7	$ 132.24

23	2	1	5	2	Freedmens Hospital	104.33
	2	2	2	4	Jackson Memorial Hospital	96.01
	1	1	1	4	University of Maryland Hospital	117.36
	4	3	5	4	Henry Ford Hospital	--
	1	4	1	1	University Hospital, Seattle	136.55

Total Hospitals	Average Cost per Patient Day
5	$ 113.56

24	1	3	1	3	University of Kansas Medical Center	96.40
	1	2	1	4	Virginia Commonwealth University Hospitals	92.47
	3	3	4	4	St. Mary's Hospital	47.02

Total Hospitals	Average Cost per Patient Day
3	$ 78.63

25	1	2	1	2	University of Oklahoma Hospitals	87.54

Total Hospitals	Average Cost per Patient Day
1	$ 87.54

26	2	2	9	1	Bexar County District Hospital	100.45

Total Hospitals	Average Cost per Patient Day
1	$ 100.45

27	1	3	1	3	University of Missouri Medical Center	103.82

Total Hospitals	Average Cost per Patient Day
1	$ 103.82

28	1	2	1	4	University of Texas Medical Branch Hospitals	56.53

Total Hospitals	Average Cost per Patient Day
1	$ 56.53

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HIGHLIGHTS FROM AND COMMENTS ON PUBLIC HEARINGS ON FILING OF PHILADELPHIA BLUE CROSS FOR SUBSCRIBER RATE INCREASE

March 17 to 20 and 22, 1971

by

Leon A. Korin, Assistant Director

With kudos from his admirers and unflattering barbs from his adversaries - and sometimes both from each of these groups - Pennsylvania Insurance Commissioner, Dr. Herbert S. Denenberg, ended 5 days of gruelling public hearings on the premium rate increase of 50% requested by Philadelphia Blue Cross.

The hearings started on Wednesday, March 17, 1971 at 9:00 a.m. and ran for 4 consecutive days - (including Saturday) and were completed on the fifth day, Monday evening, March 22, 1971 at 7:30 p.m. - but not until more than 40 hours of actual testimony had been presented and 132 witnesses had appeared, spoke and were interrogated, to fill more than 2,000 pages for the record! Klieg lights, television and movie cameras were the order of the day. One TV station carried the full proceedings for the first 3 days - live and in color. Philadelphia newspaper, radio and TV reporters were evident throughout the five days and the "New York Times" sent a reporter to cover the story.

"Flamboyant," "brilliant," indefatiguable," "dynamic," "consumer-protector," "clever," "expert," "challenging," and "witty" - and the like, are adjectives which his admirers and supporters might use in describing Dr. Denenberg. His opponents might call him "caustic," "naive," "abraisive," "disruptive," "impetuous," "superficial," "bombastic," "clowning," and the like. But no one will deny that his words and actions are meant to shake up the hospitals, Blue Cross, physicians and the consuming public, as well - for Dr. Denenberg used all communications media to invite the consumers to come to the hearings for their "days in court" - to tell their experiences - good and bad - with doctors, hospitals, Blue Cross, and commercial health and hospital insurance carriers.

In prior public hearings before Insurance Department Commissioners some consumers were "ruled out of order" if they started to tell their complaints about Blue Cross, hospitals and doctors. Not so before Dr. Denenberg. Although this was purported to be a public hearing on the applications by Philadelphia Blue Cross for a $37 million hike in premiums to be effective on April 1, 1971 and another boost of $37 million - a total of $74 million - to become efrective August 1, 1971 - "all was fair game" and the presentations at times were not only about the rate increase - but more significantly - the entire health delivery system was under scrutiny and attack for "betraying the public trust."

To put the hearings in proper perspective, one should realize that in addition to Blue Cross Plan representatives, individual hospital administrators, organized hospital regional and state associations, physicians - individually - regional and state organizations, providers of health care services such as multiphasic screening corporations, labor groups, consumers - individually and through organizations - representatives of government, local and State and national were much in evidence. In fact, for the first time in the 13 year history of public hearings on Blue Cross Plans' applications for rate adjustments, the Governor of the Commonwealth appeared in person for a 13 minute presentation on the first day of the hearing. In addition to the Governor, other government personages appeared, including cabinet level State officials - the Auditor General, the Secretary of Community Affairs and the Secretary of the Commonwealth, plus representatives of the Secretaries of Public Welfare and Health. Not to be forgotten were appearances of the Mayor of Philadelphia, U.S. Representative Joshua Eilberg, the State Director of the Consumer Protection Bureau, Bette J. Clemens (in the Attorney General's Office), State Representatives Eugene Gelfand and John Renninger, both interested in health affairs and consumer protection, plus a city councilman (Bellis) and a city mayorality candidate (Cohen).

Commissioner Denenberg, flanked on his right by chief counsel for the Insurance Department Robert A. Miller (although the Commissioner himself holds a Masters of Law degree from Harvard Law School) and his special assistant for long range planning Rodney Pyfer, and on his left by John Sheehy, Bureau Director, Regulation of Rates and Policies and Actuary Paul H. Henning, conducted the 5-days of hearings, asking almost all the questions himself and commenting again on his own. He started each day's hearings with a synopsis of the previous day's activities including his orders to the Plan, hospitals and doctors. He announced on the second day of the hearings that he had approved a Blue Shield proposal for paying participating physicians for treatment of patients in nursing homes and E.C.F.'s. This was seen as a measure to induce physicians to keep their patients from remaining longer than medically necessary in expensive, acute care hospital beds, if they could be treated in E.C.F.'s.

The official statements for Blue Cross of Philadelphia were made by its Board Chairman, Donaldson Creswell, and Bruce Taylor, Executive Vice President, with the latter carrying almost all of "the ball" during the 5 days. Many Blue Cross officials and Board members were present throughout the hearings, and President Thomas Manley also participated.

Blue Cross stated that unless it received "sufficient money to continue its operation" it faced bankruptcy and would run out of ready cash by April 1. It attributed the drain to increased benefits forced on it by the previous Insurance Commissioner who mandated a co-pay preferred comprehensive contract for Blue Cross and its subscribers. Secondly, the Blue Cross subscribers have used these "substantially expanded benefits" so that the request for "emergency relief rests exclusively in this rise in incidence" of use of services during 1970, according to Bruce Taylor. The Plan also called for involuntary (governmental) control of hospital costs, because, alleged Blue Cross, it had taken "all steps to ....encourage voluntary control of hospital costs...."

The Commissioner dropped his first bombshell three hours after the hearings started by ordering Philadelphia Blue Cross to cancel its contracts with member participating hospitals and to renegotiate the contract. This edict came after nine months of hassling between Blue Cross and the Delaware Valley Hospital Council, representing member hospitals to negotiate the current contract, which was made retroactive to July 1, 1970. Either party may cancel the contract 90

days after written notice of intent to do so is given, and the Commissioner gave his verbal directive and then, upon request for the order "in writing" a hand written order (a piece of note pad paper saying: "3-17-71, Blue Cross of Greater Philadelphia - Please move to renegotiate in writing - signed, H. S. Denenberg").

Blue Cross had also recommended legislation or other controls which would (1) eliminate educational costs (of physicians) from Blue Cross reimbursable items; (2) eliminate unsuitable hospital beds which it felt would decrease stays; and (3) establish norms for numbers of hospital employees for staffing purposes in patient care and research, (4) refuse to reimburse hospitals on an accelerated depreciation basis.

Dr. Denenberg hit hard against reimbursing hospitals for patients placed in what he called "unsafe" beds - meaning "non-conforming" according to Hill-Burton standards. He also expressed his astonishment that hospitals in the Philadelphia area moved so slowly to take advantage of what he called "free management and industrial engineering services" offered by Blue Cross. It was noted that these services have only been available a brief period of time.

As in most governmental hearings of this type someone brings up "unreasonable" charges or "expenditures beyond prudence" - such as "50 cent aspirin charge." The hearings produced a witness who said she could buy stainless steel surgical scissors in a department store for $2.50, whereas a hospital she knew paid a surgical supply house $7.50 for comparable scissors! She alleged that medical equipment was marked up in price between 400-2,500%! The Commissioner also referred to $10 tape measures which could be bought for 50 cents in the 5 and 10 cent stores.

One of the facts that became evident to this observer in the hearings was that each witness did not have to be qualified as to his expertise - statements could be made without authority, reasonableness or validity - and they most frequently went unchallenged. /"Don't confuse me with facts; my mind is made up" - could be an apt description/.

Owner-operators of proprietary extended care facilities - with economic motives that could be questioned - urged patients be assigned to their facilities costing"$23.50 per day compared with $103 per day at a university hospital." Approving the Blue Shield payment for physicians' services at E.C.F's, the Commissioner felt, should ease this situation.

Governor Milton J. Shapp's appearance the first afternoon was highlighted by his announcement of the appointment of a cabinet level TASK FORCE ON HEALTH CARE including the Secretaries of: Community Affairs, Health, Public Welfare and the Insurance Commissioner "plus top level staff men." He also indicated the consumer advisory health care groups would be appointed. The Governor supported Certificate of Need legislation and hoped that use could be made of his branch offices for consumer health programs.

Later, at a press conference in Harrisburg, Governor Shapp warned of possible governmental action to reduce physician and hospital costs. Said he, "If a way can't be found to get the cost of medical care within reasonable boundaries, then the State will have to find a way to set priorities, eliminate duplication and hold costs down."

(Reliable sources in the Governor's office reported to HAP staff on March 25 that Insurance Commissioner Denenberg will be Chairman of the Governor's Task Force aforementioned, and that a meeting of the Task Force is scheduled for the week of March 29, 1971.)

Describing the financial plight of the southeastern Pennsylvania area hospitals was Daniel E. Gay, President of the Delaware Valley Hospital Council. He stressed: (1) need for all purchasers of hospital care - including government - to pay reasonable costs for in-and out-patients; (2) higher costs are due, in a great part, to increases in salaries which account for about 2/3 of total costs; (3) he called for an indemnity insurance program and a uniform benefits package for all insurance underwriters; (4) reasonable cost reimbursement for E.C.F. care; (5) rejection of Blue Shield payments to doctors if a Blue Cross case is rejected for hospital payment; (6) protection from excessive costs of malpractice and liability insurance; (7) adequate State reimbursement for educating student nurses; (8) discourage further licensing or certification of paramedical personnel; (9) prompt payments to hospitals for services rendered (to preclude borrowing for operating needs at high interest rates); (10) single audits annually for all hospital jurisdictional agencies; (11) accelerated depreciation and (12) a "no-fault" insurance program.

The Commissioner was caustic in his questioning of Mr. Gay, alleging hospitals want to tell everyone else what to do - Blue Cross, government and the public - but he felt hospitals were slow moving or reluctant "to do things themselves to set their houses in order."

After Jay E. Helme, Executive Director of the Hospital Survey Committee, the facilities (only) planning agency for the area, testified about how their group has saved the community millions of dollars which might have been expended for unneeded new beds and other facilities (replacements or expansions), Commissioner Denenberg asked the Survey Committee to make determination which the hospitals and Blue Cross would abide by in deciding which beds are to be removed from the "suitable" list or to decide which facilities and services - such as open heart surgery, cobalt and other expensive procedures are to be curtailed or established - and at what institutions in accordance with "proven need."

Dropping his second bombshell - after hearing about varying hospital costs, Commissioner Denenberg ordered Blue Cross to furnish him with the per diem costs at each Blue Cross member hospital so that he could publish a "shopper's guide" for consumers, listing all the hospitals and their costs. Realizing subsequently that even with this "guide" consumers could only be admitted to the hospitals where their physicians have staff privileges, the Commissioner hit the "country club like" procedures hospitals use in appointing medical staffs and directed that hospitals examine staff appointment procedures and extend staff privileges to more doctors which "would be one way of introducing a more competitive aspect into the hospital operation."

The position statement of the Hospital Association of Pennsylvania was presented by Executive Vice President John F. Worman. The statement, a copy of which was sent to each member hospital, included, among other items: (1) disallowing physicians' Blue Shield payments when hospital payments are disallowed under Medicare, Medical Assistance or Blue Cross; (2) a suggestion to merge the five Pennsylvania Blue Cross Plans and Blue Shield into one statewide, single plan; (3) better communications and disclosure to Blue Cross subscribers so they will know exactly what Blue Cross pays the hospital for care rendered - not the vague statement appearing on some hospital bills - that the Blue Cross "allowance" is equivalent to billed charges and hence the subscriber may think Blue Cross pays billings.

Alleging that there were problems in our health delivery system, Mr. Worman took the Commissioner to task for referring to our health care delivery

system as "a Frankenstein monster built on Rube Goldberg principles." Mr. Worman reminded the Commissioner of the health strides made by the system. Subsequently, the Commissioner apologized for referring to the system as a "Frankenstein monster."

Mr. Worman also felt that: (1) research and educational costs - now generally added on to the patient's cost - should be borne by the entire community; (2) costs will rise under the pressure of employee unionization; (3) Unemployment Compensation coverage for employees could increase operating costs by as much as $12.5 million; (4) malpractice insurance could increase a hospital's cost by as much as $1.00 per patient day - or more - and the practice of "defensive medicine" by physicians also contributes to higher costs.

He indicated what hospitals are doing to strive for economies and hopefully to "contain" costs and reduce the acceleration of the rate of increases, such as, shared laundries, group purchasing, shared computers, shared industrial engineering, group insurance, educational and training sessions and manpower recruitment campaigns.

Stressing the essentiality for Certificate of Need State legislation and the creation of a new qualified Pennsylvania Health Care Commission, Mr. Worman also asked the Commissioner's help and support in obtaining reasonable cost reimbursement for outpatient and extended care facility services from the State.

One State official (Dr. Alfred Kraft, Commissioner of the Office of Medical Services and Facilities) ended his remarks, after he had indicated that the system needed revamping, but that hospitals were doing a good job under the circumstances, with "there is no problem which we are unable to solve, except the one of the pocketbook." But the whole subject of the hearings was a question of money for Blue Cross to continue to operate - if at all!

Even though only Philadelphia Blue Cross' filing was the reason for the public hearings, Pennsylvania Blue Shield, Inter-County Hospitalization Plan and the other four Blue Cross Plans in Pennsylvania were "invited" ("directed" might be more accurate) to appear and make statements or to respond to 54 questions enunciated by the Commissioner when he announced the public hearings through a press release. He advised the Blue Cross Plans' (outside of Philadelphia) chief executives they would have their public hearings, too, when they next filed for rate adjustments.

Floods of consumer complaints about their bills, their inability to get through to Blue Cross when they tried to phone their offices, alleged cancellation of coverage after 20 years of coverage and getting little consideration concerning representation on the Blue Cross Board brought expressions of concern from the Commissioner.

He opened the third day of the hearings by saying, "We are not anti-hospitals; not anti-Blue Cross; not anti-doctors. We are pro-comsumer and pro-Blue Cross subscriber!"

He continued, "this is the beginning, not the end of our investigations." He cited the on-the-spot agreement of Blue Shield to stop paying doctors, if their patients' hospital stay is not a reimbursable Blue Cross hospital stay; Blue Shield to research how physicians could be paid for home visits; he wanted to have hospitals move about 30% of the patients "who don't belong there" to less costly E.C.F.'s. He wanted more definitive consideration for health maintenance organizations and multiphasic screening outpatient work done as preventive health

care measures. He cautioned against misleading advertising of prepayment hospitalization plans and said he was disappointed that some hospital and physician "establishment" representatives were "intellectually sterile" for not coming up with "a single new idea" - and that the Medical Care Foundation described by Pennsylvania Medical Society representatives was something "long in the future." He continued his concern for poor communications between Blue Cross and its subscribers.

He directed the Delaware Valley Hospital Council to furnish him with data relating to their member institutions as to:

(1) Composition and frequency of meetings of Budget Committees.

(2) Amounts spent for non-patient care activities such as education and research.

(3) Amounts spent on dues to the Delaware Valley Hospital Council, HAP and AHA and "other organizations engaged in lobbying, collective bargaining and public relations activities."

(4) Travel expenses of hospital personnel to attend meetings of aforementioned groups.

(5) Salaries paid to hospital executive employees.

(6) Extent of and expenditures for public relations activities.

(7) Copies of hospital annual budgets.

The Commissioner indicated he may also want similar data for the rest of the hospitals in Pennsylvania in the near future.

Organized labor had several persons testify for it, but its prime spokesman was Harry Boyer, President, Pennsylvania AFL-CIO speaking for more than 1.5 million members in the Commonwealth. He also was offering his testimony on behalf of the Pennsylvania League for Consumer Protection, of which he is a Board member.

He opposed educational and research costs and all non-patient care related costs being part of Blue Cross and hospital charges - suggesting that "Blue Cross and other carriers of hospitalization insurance refuse to pay such charges." Secondly, he felt Blue Cross should not be permitted to recognize charges for "inadequately utilized services" such as costly and complicated radiological therapeutic services or underutilized obstetrical beds. Next, he called for full services being available at hospitals on a seven-day week basis. He called for Blue Shield to pay physicians for other than hospital inpatient physician services, and the greater use of outpatient diagnostic and therapeutic services and extended care facilities.

Mr. Boyer supported legislation introduced by Representative Gelfand last year to form a Hospital Control Commission (H-2183 of the 1970 session)!

He, too, called for a merger of Blue Cross with Blue Shield into one Plan. He wanted private insurance carriers which write hospitalization coverage on a highly selective basis to be compelled...."to have to cover all groups if they are permitted to cover any."

Also, Mr. Boyer called for consumer representation on the Blue Cross Board of Directors.

(Labor representatives consistently and uniformly oppose deductibles and co-insurance features and have supported the service type subscriber contracts with Blue Cross.) But opposing this viewpoint was the former chief actuary for the Social Security Administration, Robert J. Myers, now a Professor of Actuarial Science at Temple University. Mr. Myers called for "cost-sharing by the consumer"- a euphemism for deductibles and co-insurance. How to reconcile labor's opposition to deductibles with the actuarial expert's suggestions (which the Commissioner also seemed to look favorably upon - as in auto insurance, despite criticisms of comparing human lives with automobiles!), are opposite viewpoints which must ultimately be decided upon by the Commissioner.

National health legislation also came in for its fair share of references, but its imminence was not expected and all agreed in this Blue Cross hearing, no one dared wait for a national program - if it should come at all! Some felt a more inclusive national health program (for the under 65 years of age group) might be two or more years away - and Blue Cross, the hospitals and the consumer needed action and relief now!

Philadelphia Blue Cross was asked to give the Commissioner details on its refusal to reimburse six member hospitals for certain elements of cost. He wanted to know in what way the charges made by these hospitals were "excessive."

U.S. Representative Joshua Eilberg (D-Phila.) called for a consumer's ombudsman whose authority should "originate outside the power structures of the health and medical professions" and who, "most importantly, should have the authority to say no. If a proposed contract is too expensive, he should be able to veto it."

The Commissioner was urged to "flex his legal muscle" to provide consumer protection. This from an attorney, previously with State government in the Consumer Protection Bureau.

The Assistant City Solicitor for the City of Pittsburgh, Mrs. Marion Finkelhor, reminded the Commissioner that he "inherited" a suit against the Insurance Department (now in Commonwealth Court) brought by the City of Pittsburgh, for failure by the former Insurance Commissioner George F. Reed to allow Mrs. Finkelhor to cross-examine witnesses at the public hearings of a rate adjustment requested last year by Blue Cross of Western Pennsylvania (Pittsburgh based Plan).

The Commissioner indicated he wished to keep the hearings informal and expressed fear that cross-examinations might mean the hearings would bog down on technical and legal matters and drag on for months like some public utilities' rate hearings before the PUC.

The poor, the blacks and the senior citizen consumers were adequately represented even though the Blue Cross filing did not involve its "over 65" coverage. The Young Great Society, the Germantown Community Council for Improved Health Care, the Senior Citizens Action Council, and representatives of the Health Information Project - a student centered group - among others, made lengthy presentations on their suggested remedies to change the health care delivery system. Commissioner Denenberg always manifested courtesy to these persons, with a "thanks a lot; thanks a million for coming in to give us your ideas" at the end of their presentations.

Dr. H. Newton Spencer, President of the Health Service Plan of Pennsylvania (HSP), sometimes referred to as the "Kaiser - Permanente Plan of the East" testified for that health maintenance organization - which has a long way to go before it is really operational as a capitation payment plan for comprehensive health care services.

Paul Guest, Esq., President of Methodist Hospital, the last witness in one long day of the hearing's proceedings, ran out of time (the City Hall Court Room had to be vacated by 6:00 p.m.) in his question and answer period with the Commissioner. His suggestions of why the elements of cost have increased in the past several years and the discount given to Blue Cross by hospitals ("If all hospital patients were Blue Cross subscribers, hospitals would not be able to continue in operation") and his proposals for remedying the situation were precise analyses of the problem. The Commissioner asked Mr. Guest to give him detailed proposals in writing for his study and consideration.

On the fourth day (Saturday, March 20, 1971) of the hearings, several hospital administrators came forward to present their testimony, including Edwin L. Taylor, Director, Graduate Hospital (and President of HAP), who presented a statement on behalf of the Graduate Hospital and as representative of Dr. Luther L. Terry, Vice President for Medical Affairs for the University of Pennsylvania and its hospitals. Mr. Taylor's excellent presentation and the way in which he fielded the questions put to him by the Insurance Commissioner were most masterful. He pointed out that the full financial requirements of provider health institutions must be met, if they are to remain available to the consumer to provide the health care he desires. Indicating that at Graduate Hospital very few doctors have not had their applications for staff appointments approved and that there was "no country club atmosphere, to his knowledge" at the Graduate Hospital medical staff. Other questions put before Mr. Taylor by the Insurance Commissioner pertained to statistical and financial data, occupancy figures, budget committee composition, and the like.

Mr. H. Robert Cathcart, President of Pennsylvania Hospital, spoke on behalf of the Group Health Planning Association of Greater Philadelphia, of which he is Vice President. This organization might be referred to as a health maintenance organization for a geographic unit in the center-city core area of Philadelphia.

Executive Vice President of Hahnemann Medical College and Hospital, Charles S. Paxson, presented his statement as to the methods of determining reimbursable costs for health care providers and the questionable proposals to disallow such items as depreciation, the cost of education for physicians, nurses and related hospital technical personnel. He also recommended coordination or merger of Blue Cross and Blue Shield. He referred to the "shameful way in which the State of Pennsylvania is responsible for not reducing hospital stay dramatically" in that it allows only $11 a day for care of a DPA patient for skilled nursing services in an E.C.F., when the costs for same are much higher, running over $20 a day. He also reiterated the fact, as did Mr. Taylor before him, that the increased emergency adjustment of 20.25% requested by Blue Cross was due to the consumer utilization of new benefits, directed by the former Insurance Commissioner and not related to hospital operating cost estimates.

On the last day of the hearings Norman W. Skillman, Administrator, Chester County Hospital, gave his suggestions for reducing hospital expenditures, similar to the testimony he gave last year before the Senate Finance Committee when it was reviewing questions pertaining to extension or contraction of benefits under the Medicare and Medicaid Programs. One of his major thrusts was to reduce the average length of stay of patients and thus reduce the cost of medical care.

If the stay could be reduced by two days in the Philadelphia area it would save millions of dollars.

A representative of Employers Mutuals Insurance Company of Wausau, Wisconsin (the HAP endorsed carrier for Comprehensive General Malpractice and Professional Liability Insurance), presented information to the Insurance Commissioner on the safety education and loss prevention programs conducted by that company in Pennsylvania.

Accusing Blue Cross representatives, Board Chairman Donaldson Creswell, and Executive Vice President Bruce Taylor, of including "half truths, self serving conclusions, and even mis-statements" in their testimony was Barnet Lieberman, Esq., former Philadelphia Commissioner of Licenses and Inspections, who was recently appointed as an unpaid special consultant by Commissioner Denenberg. Supporting Mrs. Marion K. Finkelhor, Mr. Lieberman also called for Blue Cross representatives to be subjected to oath and cross-examination when they present their statements because "public money is at stake."

A most comprehensive, scholarly and balanced presentation was made by Charles P. Hall, Jr., Ph.D., Professor of Insurance and Chairman of the Department of Health Administration at Temple University. Dr. Hall wished to make it "clear at the outset that the public would be making a serious mistake to expect any reduction in the total expenditures for health care in the foreseeable future. At best, we can hope for a decline in the rate of increase in expenditures." He spoke of many problems at the root of the question of health care delivery and indicated that the problem was both complex and many faceted, requiring solutions to be coordinated on many fronts. He gave each element involved in the health care delivery service its fair share of both accolades and criticisms, calling for an end to looking for any one scapegoat to shoulder all of the blame.

The Philadelphia Chapter of the Hospital Financial Management Association, in its testimony, questioned Blue Cross' request for an immediate emergency increase of 20.25% and the additional 30% requested to become effective on August 1, 1971 (on top of the 25% received last year). It was noted that hospital costs did not increase 25% last year and certainly not 50% so far this year. "Approximately 14% to 15% would be more like it." Furthermore, they questioned the Blue Cross Annual Financial Report which does not include the certification of an independent certified public accountant, suggesting that the Commissioner request the Auditor General to perform an audit of Blue Cross. In the area of recommendations, they suggested a method of prospective reimbursement be authorized and pledged their availability to develop a workable solution in this budgeted prospective reimbursement method. They also recommended that "Blue Cross not be permitted to extend benefits to subscribers unless included in the rate filings with the Insurance Department."

The last day of hearings saw three of the five Blue Cross Plan chief executives (Ralph Smith, President, Blue Cross of Northeastern Pennsylvania; Earl G. Wray, Jr., Executive Director, Blue Cross of Lehigh Valley; and Richard D. Rife, President of Capital Blue Cross) present their statements for the Commissioner's consideration. President of the Blue Cross Plan of Western Pennsylvania had testified on the previous Friday.

The Commissioner also listened to testimony about the American Hospital Association's "Ameriplan" presented by the Chairman of the AHA Committee, Mr. Earl Perloff, Chairman of the Boards of the Albert Einstein Medical Center and Philadelphia General Hospital. The HCC's (Health Care Corporations) as a means of restructuring the American health care delivery system were discussed in brief by Mr. Perloff, since a copy of the full Perloff Committee report had been presented to the Commissioner in advance.

Shining forth as the consumers' advocate (one might almost think that the Insurance Commissioner had organized his "Denenberg's Devils" to compete with Nader's Raiders) the Insurance Commissioner during the five days of hearings on the Blue Cross rate increase had the following seven major demands or recommendations to make:

(1) Reorganization - He ordered Blue Cross to reorganize its 36 member Board of Directors within two weeks to reflect greater consumer interest and employer representation. He asked for the elimination of hospital and physician members from the Board, and questioned affiliation of the Board's 21 "public representatives" with Blue Cross subscribers.

(2) Costs - Acknowledging that Blue Cross would probably get an increase or else be put out of business, he questioned and asked for explanations why Blue Cross rejected as "excessive" $5 million in claims from six Philadelphia area hospitals. He wanted information on non-patient care costs, such as education and research items.

(3) Cost Shoppers' Guide - He stated that his Department, after receiving information from Blue Cross and the Delaware Valley Hospital Council on the average cost per day of care in each of the Blue Cross member hospitals, would publish the per diem cost and also indicate the per diem cost of extended care facilities operating in the area. Also included would be a list of the multiphasic screening corporations in the Delaware Valley area. Along these lines he demanded more liberal policies for admitting doctors to staffs of hospitals to prevent patients from being turned away from hospitals of their choice, where costs might be lower, because their physicians are not staff members.

(4) Meetings - He called for widespread publicity of Blue Cross meetings and asked for the elimination of three year waiting periods before subscribers could get voting privileges.

(5) Costs of Intern and Resident Training - He indicated that the salaries of interns and residents should be paid by physicians who are on a fee-for-service basis since they benefit from the patient care activities of such student interns and residents. He did not feel this was a cost that should be loaded on to the cost of hospital care, to be paid for by the horizontal patients or Blue Cross subscribers.

(6) Nursing Homes - He approved Blue Shield payments of physicians' fees for care in nursing homes to encourage physicians to transfer patients from high cost acute hospital care facilities to E.C.F.'s.

(7) Beds - He ordered Blue Cross not to pay hospitals for unnecessary or "unsafe" beds, charging that some hospitals are "overbedded."

(The aforementioned seven demands are based on a Philadelphia newspaper account, since HAP has not had an opportunity to review the verbatim testimony transcript.)

After five full days of dramatic public hearings the "piece de resistance" came when Insurance Commissioner Denenberg conceded on Sunday, March 21, 1971, in a TV interview that the requested Blue Cross rate increase of up to 50% was probably inevitable. He indicated that everything would be done to minimize the amount of the increase. "But there is really no choice. You either have to give them the rate increase or put them out of business."

Commissioner Herbert S. Denenberg ended the f[illegible] days of public hearings at 7:30 p.m. on Monday, March 22, 1971 with a statement that his decision with reference to the rate adjustment filing presented by Philadelphia Blue Cross would be announced within a brief period of time, hopefully within the following two weeks.

Health care personnel in the Commonwealth of Pennsylvania have an interesting time ahead of them as long as this administration continues Dr. Denenberg in office as Insurance Commissioner. Significantly, Dr. Denenberg referred to "the next eight years of this administration" as its time span in which to affect major changes in the health care delivery system of the Commonwealth. It should also be pointed out that from the very beginning, when Dr. Denenberg held his first press conference on February 8, 1971, at 10:30 a.m. and announced the public hearings in Philadelphia for the Blue Cross rate increase, his news release "covered" the Commissioner for eventualities by stating the following: "Rate increases for Blue Cross may be inevitable," Dr. Denenberg said, "but a comprehensive effort must be exerted to contain costs." On that same day, he issued another press release stating that, "The Insurance Department of Pennsylvania will no longer grant rate increases without first reviewing the steps being taken by insurance companies to lower costs, to modernize contracts in order to meet changing consumer needs, to offer more adequate amount of coverage, to offer deductibles that can lower premiums, and to stop arbitrary cancellations and nonrenewals." Not only the health care insurance and prepayment industry is in for its "interesting" times, but the entire insurance industry in all its ramifications may find this Commissioner to be quite different from others with whom they dealt in the past.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

MEMORANDUM

March 17, 1971

TO: Committee on the Financing of Medical Education

FROM: Joseph S. Murtaugh

SUBJECT: Notes on the meeting of the Committee, March 15.

Dr. Charles C. Sprague, Chairman, convened the meeting at 10 a.m. Present were the following:

COMMITTEE:	AAMC STAFF:
Dr. Charles C. Sprague	Dr. John A. D. Cooper
Dr. Howard L. Bost	Mr. John M. Danielson
Dr. Robert A. Chase	Mr. Joseph S. Murtaugh
Dr. Robert G. Petersdorf	Mr. Armand Checker
	Mr. William C. Hilles
	Mr. Peyton Stapp

Dr. Sprague noted that this was the initial meeting of the new AAMC Committee on the Financing of Medical Education. He named the full membership as it now stands [Attachment 1] and remarked on the difficulties of finding a suitable meeting date to make it possible for all members to participate. Although it was only possible for four members of the Committee to be present, he and Dr. Cooper agreed that it was of the highest importance that the activities of the Committee be initiated; thus the convening of the meeting. (Although Dr. James W. Bartlett was unable to attend this meeting, he transmitted his general observations to Dr. Sprague; these comments were made available to the Committee.) [Attachment 2] The agenda for the day's meeting is appended to these notes. [Attachment 3]

Dr. Sprague indicated that the Committee's first task would be to identify the major problems and determine their priorities. He stated that it was his intention to conduct the Committee in a manner that would not presume the preparation of a final grand report setting forth the views and conclusions concerning the financing of medical education. Rather, the Committee will draw upon a series of task force examinations of major areas of the problem of financing. This approach might result in interim statements concerning particular aspects of the overall problem. The overall

Committee itself would be a continuing activity which would not have a given endpoint, but rather a charge to consider, on a continuing basis, the major issues involved in the financing of medical education.

Dr. Cooper stated that the Committee would be confronting the most important matters that make up the Association. He described the background of the Committee and spoke briefly to the many important issues with which the Committee will be concerned. The most challenging matter which he thought the Committee will be engaged in is the set of questions surrounding the cost of undergraduate medical education. This will be a key issue in the forthcoming legislative hearings on the extension of the Health Professions Educational Assistance Act, since the three pieces of legislation now before the Congress all propose different levels of capitation support for medical students. The resolution of these differences will almost certainly involve considerable inquiry into the existing data on medical educational costs. In the course of this discussion, the legislative proposals dealing with medical education were described. These included H.R. 4171 (S. 934) introduced by Congressman Staggers and supported by the AAMC; H.R. 5614, the Administration's proposal for the extension of the HPEA Act; and H.R. 4155, legislation introduced by Congressman Rogers of Florida to extend the HPEA Act. H.R. 4170 (S. 935), the second AAMC bill, was also discussed. [Attachments 4 - 7]

There was further discussion of the scope of the matters which might come before the Committee. These ranged from problems surrounding student assistance through the financing of construction; the manifold questions surrounding operating support and the problems of determining costs; the financing of graduate education through the relationship of and effect upon financing of patient services to medical education.

It was noted that there are in existence (either now or very shortly) other committees of the AAMC dealing with the aspects of these matters. Dr. Cooper suggested that these other committees could be viewed as a part of the framework for examining the financing of medical education and could serve in task force roles for the Committee on Financing. Among these other AAMC committees are the following:

1. A committee to consider the programmatic costs in teaching hospitals, which Mr. Danielson noted was being set up under the Council of Teaching Hospitals (COTH). The work of this committee would provide important information relevant to the overall question of financing medical education. The Chairman designated Dr. Robert Chase to serve on this committee as liaison member from the Committee on Financing.

2. The Committee on Biomedical Research Policy, chaired by Dr. Louis Welt, of the Council of Academic Societies (CAS), has also dealt with the matters relating to the support of research. This committee is in the final stages of submitting a report on its activities. It was agreed that further inquiry into the areas of financing of biomedical research might well be done as an extension of the Committee on Financing, assuming some agreeable arrangement could be worked out with the CAS. Dr. Robert Petersdorf agreed to serve as a liaison member with this CAS committee.

3. An advisory committee to the AAMC Division of Health Services of COTH is being established which will be concerned with the organization, delivery, and financing of health services. This committee, too, would relate in important ways to the work of the Committee on Financing. The Committee designated Dr. Bost and Dr. Stewart to work with the COTH committee.

In further discussion, it was agreed that it would be desirable to set up two additional task force groups:

1. The first task force to be established would be a task force on construction financing, chaired by Dr. Bost. Individuals for membership of this task force were suggested by those present.

2. The second group would study the problems which surround the cost of undergraduate medical education. The Chairman stated that he would ask Dr. William Mayer to serve as the chairman of this task force. The work of this group was considered to be particularly important, as it would deal with the fundamental question of undergraduate educational costs.

There were a variety of discussions relating to the manner in which the costs associated with medical education, particularly undergraduate medical education, should be measured. The current status of the AAMC Cost Allocation Study was reported to the group by Mr. William Hilles of the AAMC Division of Operational Studies. Dr. Cooper commented that this Study will produce data which will hopefully identify costs associated with the various functions involved in the conduct of an academic health center; (i.e., teaching, research, patient care, and public service.) The task of translating such functional costs into end-purpose program costs, (i.e. undergraduate medical education, graduate medical education, education of clinical specialists and other health professionals, improving health, and advancing knowledge,) from the inclusion of such functions in educational programs was yet to be engaged. At this point, Dr. Cooper presented

the following grid:

RELATIONSHIP OF FUNCTIONS TO END-PURPOSE PROGRAMS IN THE ACADEMIC HEALTH CENTER

FUNCTION:	END-PURPOSE PROGRAMS: M.D. EDUCATION	Ph. D. EDUCATION	CLINICAL SPECIALISTS	OTHER HEALTH PROFESSIONALS	IMPROVING HEALTH	ADVANCING KNOWLEDGE	TOTAL:
TEACHING	X	X	X	X			
RESEARCH	X	X	X	X	X	X	
PATIENT CARE	X	X	X	X	X	X	
PUBLIC SERVICE	X	X	X	X	X	X	
TOTAL							

He expressed his feeling that moving from functional costing to end-purpose costing might be the most difficult, yet the most important, problem confronting the Committee.

It was agreed that this task force, when formed, should make every effort to review the data that will emerge from the Cost Allocation Study. It is anticipated that this data will be available for 17 schools around April 1 and that an array of these data will be available for the Committee's review by April 15. An effort will be made to form this task force on the costs of undergraduate medical education as soon as possible, in order that the group will have an opportunity to study the data from the Cost Allocation Study prior to the next meeting of the full Committee.

The Committee discussed probable membership of such a task force, and it was agreed that Dr. Sprague would suggest to Dr. Mayer a list of names for consideration as members of the task force.

It was agreed that the task force groups would explore alternative solutions to the problems which they considered to be most important in their respective areas, setting forth both the pros and the cons bearing upon the choices among the alternatives.

Following the establishment of this task-force based approach, there was discussion of possible additional members for the full Committee. Names suggested for this purpose were:

Gerald Weber, Economist; (Co-author, Financing of Medical Education, with Rashi Fein)
University of California/Berkeley

2. Burt Seidman, Labor specialist
Director of Social Security
AFL-CIO
Washington, DC

3. Samuel Castleman, Treasurer, Washington Hospital Center
Senior Vice President
American Security and Trust Company
Washington, DC

Invitations to join the Committee on Financing will be transmitted to these three individuals immediately.

Because of the timeliness of the Committee's investigations, the importance of communicating the work of the Committee and its task forces to the AAMC membership was emphasized. It was agreed that interim reports being developed by the Committee might be sent out to the regional groups for discussion before final publication.

In addition to Dr. Bartlett's comments and the several ...es of legislation, the following were distributed to the Committee as information items:

1. Portions of a report by the National Advisory Committee on Health Research Facilities [Attachment 8]

2. An analysis of the three HPEA bills now before Congress [Attachment 9]

3. Financing Medical Education, Carnegie Commission report by Rashi Fein and Gerald Weber

4. The New Depression in Higher Education, also sponsored by the Carnegie Commission, by Earl Cheit.

The Committee was also informed that Dr. Charles Kidd, Association of American Universities, is studying the relationships between an academic health center and its surrounding community. It is hoped that this study will yield data for the Committee's consideration.

The Committee will hold its next meeting on April 29 at the AAMC in Washington. It is planned that during this meeting there will be a review of the Cost Allocation Study and, hopefully, a report from the task force on the cost of undergraduate medical education on its examination of these data.

Attachments

ADMINISTRATIVE PROFILES

Administrative and General Expenses

Frequent subjects for discussion are the amount of paperwork and number of administrative procedures required to operate a hospital today, and the financial burden of these activities is frequently cited as a not unimportant element in rising hospital costs. The administrative and general expense category in reports prepared by the Hospital Administrative Services program provides a rough index of this type of hospital activity. This category includes expenses incurred in administration and supervision above the departmental level, along with admitting, billing, insurance verification and collection, budgeting, accounting, and public relations. Reports from 1925 community hospitals participating in the HAS program during the last six months of 1967 provide details about the nature of this activity and how much it costs.

First, administrative and general expenses per patient day tend to be higher for larger hospitals than smaller ones (see Fig. 1). Although the magnitude of differences is not extreme, the median administrative expense ranges from $4.57 to $5.66 per patient day. Hospitals in all size groupings above 100 beds have a median administrative expense in excess of $5 per patient day, whereas no hospital smaller than 100 beds reaches that level.

Second, the aggregate level of effort shows little difference among the size categories (see Fig. 2). In terms of the median number of administrative and general man-hours per patient day, hospitals with fewer than 50 beds report 1.3 man-hours, whereas hospitals in other size groupings report 1.4 man-hours per patient day.

Finally, when viewed in terms of the total hospital operation, these reports show that administrative and general expense comprises a smaller proportion of the total expenditures of larger hospitals than smaller hospitals (see Fig. 3). Again, the differences are relatively small, but the trend is clear.

In summary, then, these data suggest that the absolute level of administrative expenses are higher in large hospitals than small ones, but that these expenses are *relatively* lower in larger hospitals, since they make up a smaller share of total hospital expenses in the larger size groupings. ■

*Median = the middle indicator, when the indicators for all hospitals are ranked from lowest to highest.

Figure 1—Administrative and general expenses per patient day

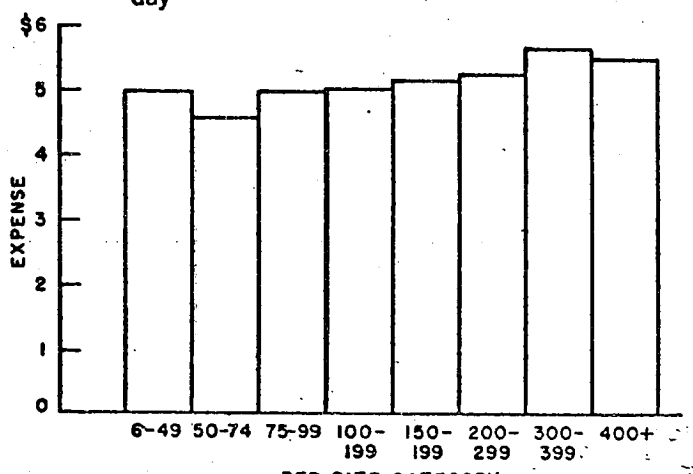


Figure 2—Administrative and general man-hours per patient day

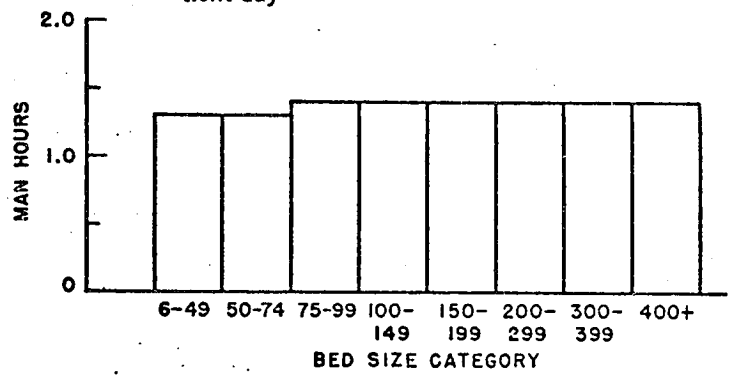
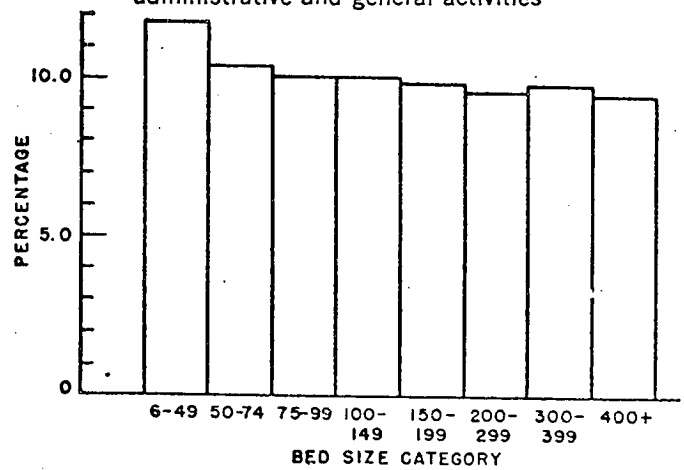


Figure 3—Percentage of total hospital expense allocated to administrative and general activities



The total number of hospitals reporting was 1925. By size groups the numbers were: 6-49—386; 50-74—283; 75-99—192; 100-149—336; 150-199—199; 200-299—271; 300-399—139; and 400+—119.

Range and complexity of hospital services

This series frequently has commented on the wider range and the more complex nature of services rendered in larger hospitals. Previous articles have pointed out that these services not only raise costs directly, but also complicate the provision of many of the more routine hospital services.

For examining the effect of hospital size on the range of services offered, an appropriate statistic is the percentage of all reporting hospitals that report nonzero costs for a particular department.

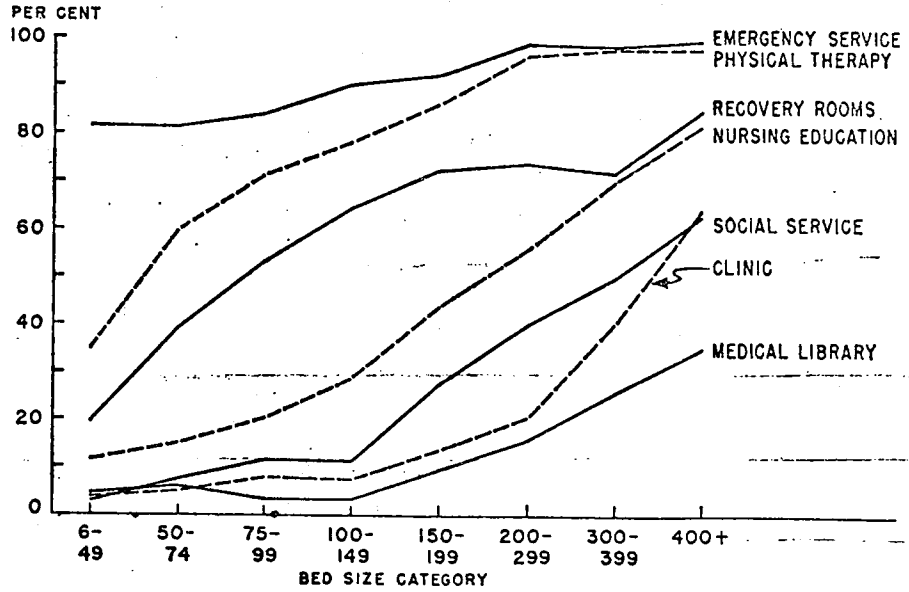
These data, based on reports from 2059 HAS participants for the three months ending June 30, 1970, indicate that a number of services become much more widely available as hospital size increases (Fig. right). Several services, such as emergency service, physical therapy, and recovery rooms, associated with the hospital's traditional role as a provider of services to the seriously ill or injured seem to increase rapidly in availability as hospital size increases up to about 150 to 200 beds. Above that size, the frequency with which these services are available appears to level off. Expenses for operating rooms, radiology, laboratory, and pharmacy were reported by virtually every hospital in every size category.

Services more closely associated with the hospital's roles in the social and educational areas, such as nursing education, social service, clinic, and medical library, display a quite different pattern. The availability of these services increases more rapidly with size among hospitals with 150 or more beds than among smaller hospitals. Such services seem to be added only after other services considered more basic are available. Expenses for home health care and for research were reported more often as hospital size increased, but these remained uncommon even in the largest hospitals, relative to the other services mentioned.

The complexity of hospital service is much more difficult to measure than is the range of services. Limited evidence on the complexity of service can be obtained, however, by examining utilization in some of the departments for which nearly all hospitals reported expenses. The median number of clinical laboratory inpatient procedures per admission in hospitals with 400 or more beds is more than twice as great as the number performed in hospitals with fewer than 50 beds (see Table, below). Operating room visits per 100 medical and surgical admissions and x-ray diagnostic procedures per admission were likewise substantially higher in larger hospitals. The increasing utilization of these services suggests rising complexity of care as hospital size increases.

In summary, these data confirm the belief that the range and the complexity of services tend to increase as hospital size increases. Services reflecting the hospital's roles in social and educational areas are added only after other services associated with the hospital's role as a provider of acute care are available. ■

PERCENTAGE OF HOSPITALS REPORTING EXPENSES FOR SELECTED DEPARTMENTS



MEDIAN UTILIZATION RATES FOR DEPARTMENTS

Hospital size	*Clinical laboratory inpatient tests/admissions*	*X-ray diagnostic procedures/ admissions*	*Operating room visits/100 medical and surgical admissions*
6- 49	10.09	1.30	25.83
50- 74	11.63	1.33	33.79
75- 99	12.69	1.40	41.52
100-149	14.05	1.45	45.79
150-199	16.15	1.54	53.10
200-299	18.07	1.55	57.71
300-399	19.61	1.60	58.38
400+	22.64	1.64	59.59

Outpatient services and per diem costs

By most criteria, outpatient activity increases with hospital size. For example, reports from some 2000 participants in the Hospital Administrative Services program for the three months ending August 1970 indicate that emergency department and clinic visits are higher—both in absolute and in relative terms—among larger hospitals.* The median number of emergency and clinic visits per bed per day ranged from 3.92 for hospitals with fewer than 50 beds to 6.69 for hospitals with 400 or more beds.

The growth of outpatient activity has led to attempts to adjust per diem expense figures to reflect these services. The best known method yields the "expense per adjusted patient day" figure reported in *Hospital Indicators.* Hospital Administrative Services reports a figure for "inpatient cost per day—ratio of charges to charges applied to costs (RCCAC)." The formula for the latter is equivalent to the formula for expense per adjusted patient day. The difference in terminology reflects the fact that the same measure can be viewed from different perspectives.

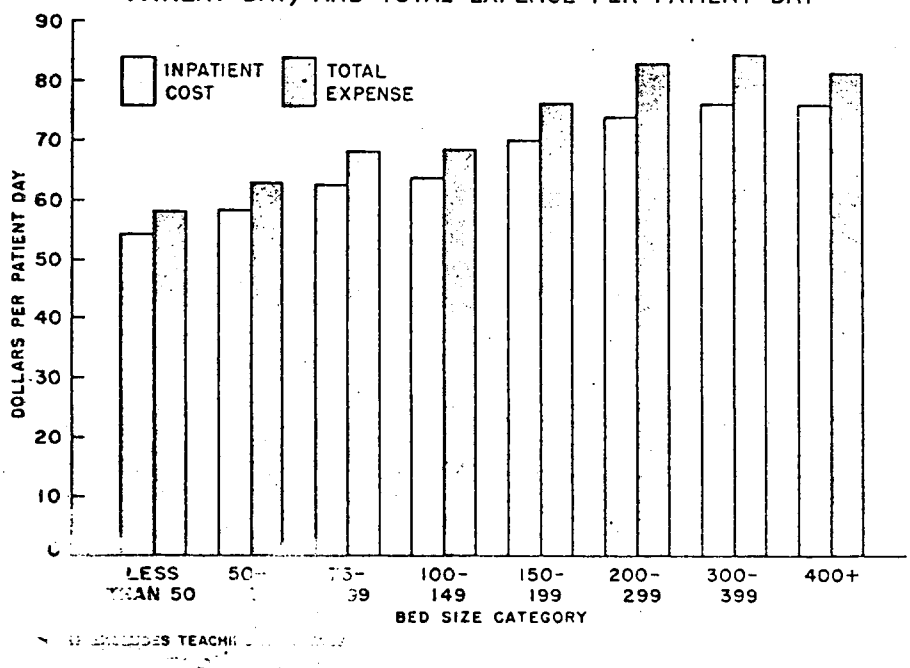
One way of interpreting the adjusted figure is to imagine that outpatient expenses first are deducted from total expense and then a per diem rate based on the residual is computed—hence the term "inpatient cost per day." It is difficult to determine outpatient costs directly, however, because many hospital departments serve both inpatients and outpatients. A simple way of getting around this difficulty is to assume that the ratio of inpatient charges to outpatient charges is the same as the ratio of inpatient costs to outpatient costs—hence the term "RCCAC." According to this procedure, then, inpatient cost is equal to total expense multiplied by the ratio of inpatient charges to total patient charges. "Inpatient cost per day" is then computed by dividing inpatient cost by inpatient days.

The second way of interpreting the adjusted figure is to imagine that outpatient services have been converted into units equivalent to inpatient days. Thus, the denominator in the ratio of cost to days of service is increased rather than the numerator being decreased. To convert outpatient services into equivalent patient days, the relative cost of inpatient and outpatient services, which is measured by relative charges of inpatients and outpatients (a detailed description of this adjustment procedure is provided in "The Nation's Hospitals: A Statistical Profile," *Hospitals, J.A.H.A.* 43:15 Part 2, August 1, 1969), is considered. The basic assumption that relative costs are measured by relative charges underlies both procedures.

The impact of this adjustment on per diem costs can be seen in the Figure on this page. Inpatient cost per patient day (or, equivalently, expense per adjusted patient day) is consistently lower than total expense per patient day. The relative size of the reduction is fairly stable with respect to hospital size — median inpatient cost per patient day is 93 per cent of median expense per patient day in both the smallest and largest size categories. Increased activity on the part of the larger hospitals in the area of outpatient care is apparently matched by the greater scope and complexity of inpatient services in these hospitals.

In summary outpatient care makes expense per patient day an overestimate of the average cost of a day of inpatient care. The most familiar method of adjusting per diem costs to take outpatient services into account can be interpreted in either of two ways. The adjustment results in a new per diem figure that is lower than expense per patient day by an amount fairly stable with respect to hospital size. ■

FIGURE—MEDIAN INPATIENT COST PER DAY (EXPENSE PER ADJUSTED PATIENT DAY) AND TOTAL EXPENSE PER PATIENT DAY*



*The participants do not include teaching hospitals.

Complexity of outpatient services

Reports from some 2000 nonteaching hospitals participating in the Hospital Administrative Services program for the three months ending August 1970, indicate that outpatients account for approximately 40 per cent of hospital x-ray diagnostic procedures (see Figure 1). Outpatient radiology charges, however, represent only about 30 to 35 per cent of total radiology charges. This difference results from higher average charges per procedure for inpatients than for outpatients. This, in turn, is partially a reflection of the greater complexity of the diagnostic procedure performed on the typical inpatient relative to the typical outpatient. The higher average charge for inpatients also is partially a reflection of the fact that some of the more complex and more expensive diagnostic procedures are performed only on inpatients. Such procedures might, for example, be associated with surgery or might require extensive control over the patient's activities prior to the procedure.

Because the data on charges, shown in Figure 1, reflect therapeutic as well as diagnostic procedures, it might be suspected that the gap between outpatient share of procedures and outpatient share of charges is related to therapeutic procedures. Because charges for therapeutic procedures generally represent only a small portion of total radiology charges, however, it seems unlikely that they could explain much of the effect. This is especially true because most therapeutic procedures, including such advanced procedures as cobalt therapy, can be performed as easily on outpatients as on inpatients. Furthermore, radiotherapy is more extensive in larger hospitals, while the gap in Figure 1 remains fairly stable across hospital size groups.

Slightly more than 10 per cent of clinical laboratory tests are performed on outpatients (see Figure 2). The outpatient share of total laboratory charges is generally within one or two per cent of the outpatient share of clinical tests, suggesting that the difference between average charges for inpatient and outpatient procedures may not be as large in the laboratory as in the radiology department.

The outpatient share of activity in the radiology and laboratory departments, however measured, varies little with hospital size. This is true in spite of the fact that larger hospitals generally treat more outpatients relative to inpatients than do smaller hospitals. The explanation lies in the point made earlier in this series that both inpatient x-ray diagnostic procedures per admission and inpatient clinical laboratory tests per admission increase with hospital size.

In summary, the average x-ray diagnostic procedure performed on an inpatient is more complex and more expensive than the average procedure performed on an outpatient. This implies that the outpatient share of activity in the radiology department is higher when measured by the outpatient proportion of procedures than when measured by the outpatient proportion of charges. Differences in charges for laboratory tests fail to produce similar differences when laboratory activity is allocated to inpatients and outpatients by the two methods. The outpatient share of activity in the two departments, regardless of how it is measured, varies little with hospital size. ■

FIGURE 1—PERCENTAGE OF RADIOLOGY ACTIVITY DEVOTED TO OUTPATIENTS

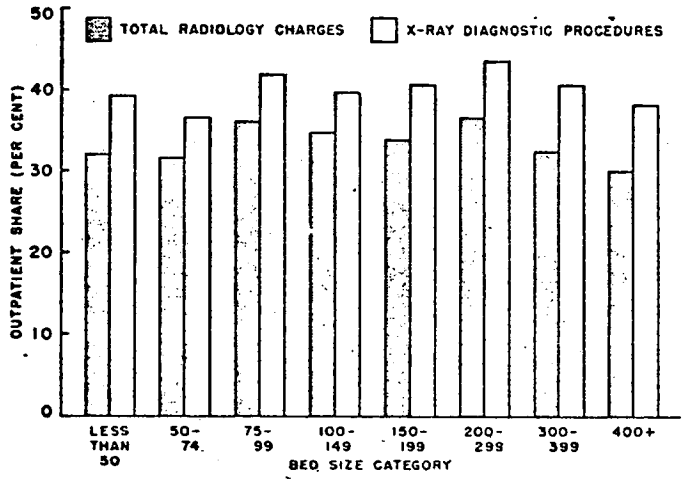
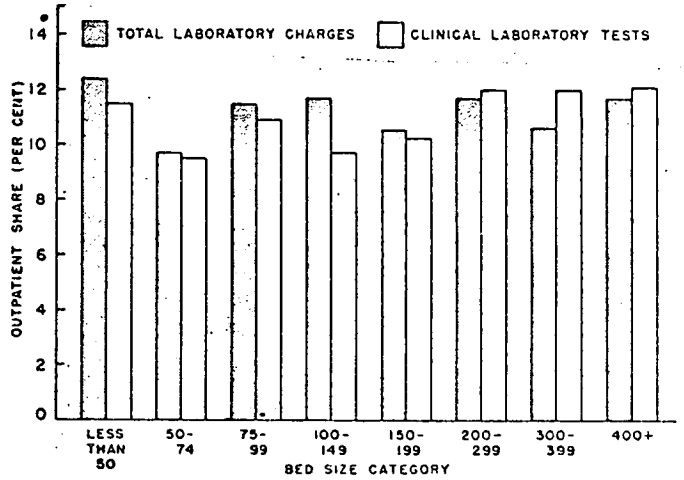


FIGURE 2—PERCENTAGE OF LABORATORY ACTIVITY DEVOTED TO OUTPATIENTS



Nursing expenses per discharge

A major component of the cost of hospitalization to the patient is the expense of nursing services, and this expense has been going up. Comparison of figures from the first half of 1966 with the same period in 1968 shows that nursing expense per discharge increased substantially in all hospital size classes (see Fig. 1). While the increase in nursing expenses per discharge stood at about 46 per cent for most hospital size groups, these expenses increased by 52 per cent in hospitals with 400 or more beds.

This report is based on monthly statistical submissions to Hospital Administrative Services from 621 community hospitals for the first half of the years 1966, 1967, and 1968. By focusing on this fixed group of hospitals, the effects of new additions to the hospital field and the closure of existing units are excluded and the data reflect the experience of ongoing hospitals.

The two major contributors to this sharp increase in nursing expense per discharge are increases in basic nursing expenses (especially salaries) and a longer average length of stay by patients. The expense for nursing services per patient day has been increasing during this three-year period, with the total increase approximating 35 to 40 per cent (see Fig. 2). At the same time, because the average length of stay is increasing, more days of nursing care are given to the average patient (see Fig. 3). The combined effect of these two forces is that nursing expense per discharge (or per hospital stay) has been increasing much more rapidly than most other hospital indicators. ■

FIGURE 1—NURSING EXPENSE PER DISCHARGE: 1966-68

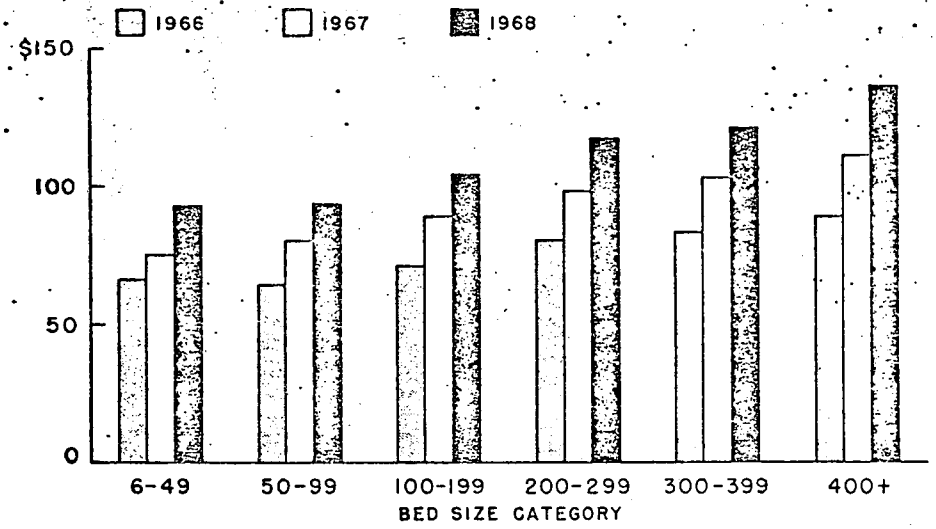


FIGURE 2—NURSING EXPENSE PER PATIENT DAY: 1966-68

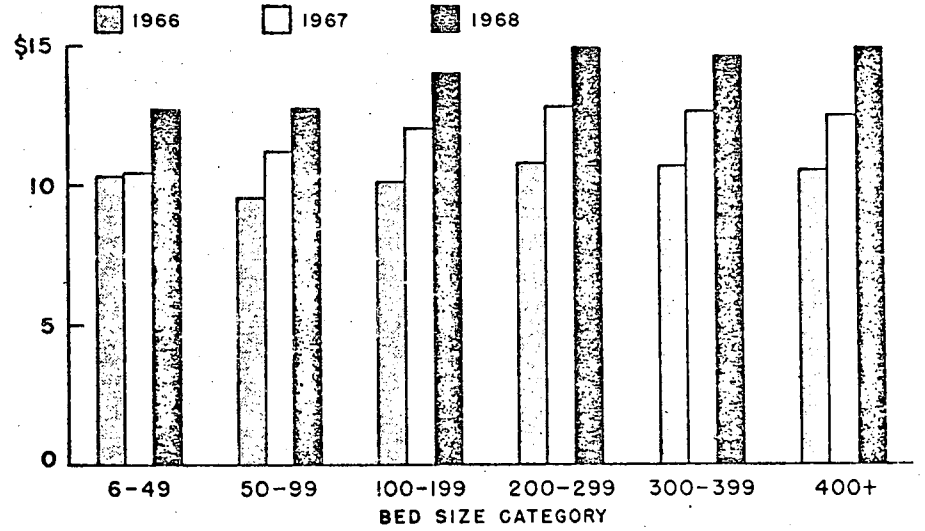
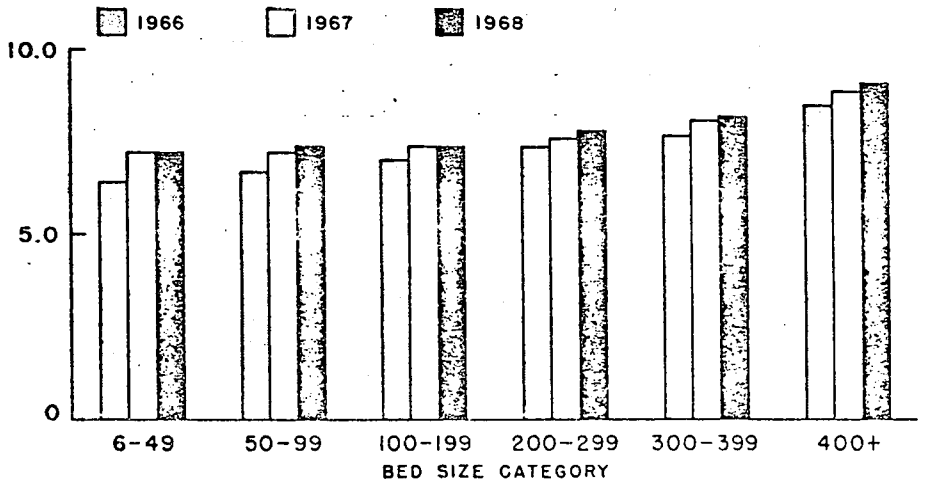


FIGURE 3—AVERAGE LENGTH OF STAY: 1966-68



The total number of hospitals reporting is 621. By size group the numbers are: 1-49—84; 50-99—143; 100-199—190; 200-299—80; 300-399—64; 400+ —70.

ADMINISTRATIVE PROFILES

Measuring ambulatory services

One of the most prominent trends of the last decade has been the expansion in responsibility of hospitals for the delivery of emergency and outpatient services. Measurement of outpatient services is difficult because composition of the services varies substantially from institution to institution. A useful summary measure is the expense in dollars incurred by the hospital in delivering this care, and a companion measure is the dollar revenue generated from this service.

Using these two yardsticks, reports of 1936 community hospitals to the Hospital Administrative Services during the first six months of 1968 provide a basis for examining the delivery of these services in terms of the hospital's inpatient capacity. These HAS data show that the median* monthly volume of emergency and outpatient services is substantially greater for hospitals with larger inpatient capacities than those with smaller inpatient units (see Fig. 1). While this might be expected to be true, the magnitude of the differences far surpasses the variation in inpatient capacity alone.

This greater magnitude of difference suggests that the concentration of personnel and facilities available in larger institutions may act as a magnet in drawing demands for outpatient services. Further, the fact that many of the larger institutions are located in urban areas leads to the speculation that density of population alone might serve to add to this difference.

Whereas the differences in the dollar volume of emergency and outpatient services are amplified substantially from smaller to larger hospitals, the median proportion of the total dollar expenditures or revenue of the hospital devoted to these services shows less variation among size groups (see Fig. 2). When the percentage of total patient revenue derived from emergency and outpatient services is studied by bed size category, it is clear that larger hospitals obtain a relatively higher proportion of their total revenue from this source than do smaller institutions. Similarly, the median percentage of total operating expense devoted to emergency and outpatient services increases with each hospital size category, but in both cases the magnitude of the differences is substantially smaller than those differences involving the dollar volume of outpatient services.

In summary, these data indicate that larger hospitals (in terms of inpatient bed capacity) provide a substantially higher dollar volume of emergency and outpatient services than their smaller counterparts. ■

*Median = the middle indicator, when the indicators for all hospitals are ranked from lowest to highest.

FIGURE 1—MEDIAN MONTHLY REVENUE AND EXPENSE FOR EMERGENCY AND OUTPATIENT SERVICES

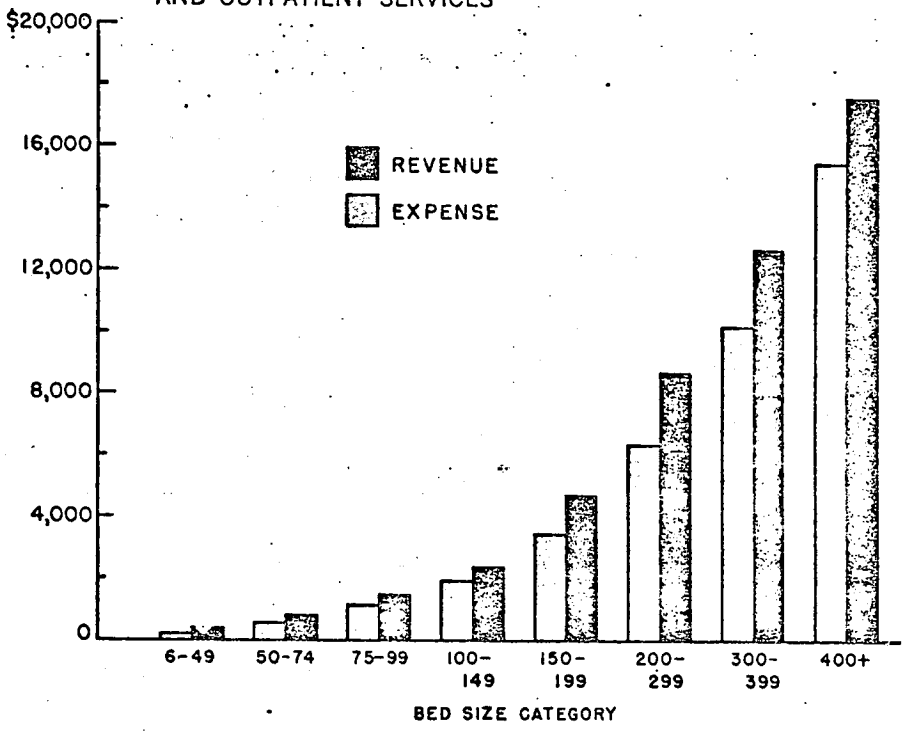
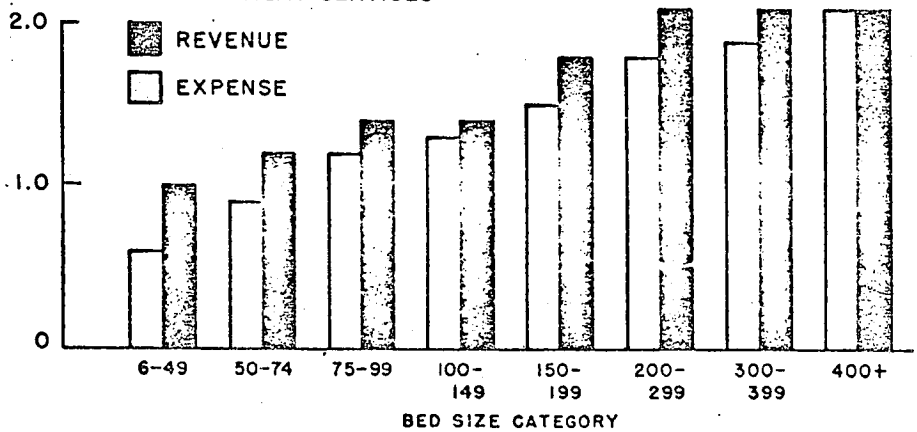


FIGURE 2—MEDIAN PERCENTAGE OF TOTAL OPERATING EXPENSE AND TOTAL PATIENT REVENUE DERIVED FROM EMERGENCY AND OUTPATIENT SERVICES



The total number of hospitals reporting is 1936. By size group the numbers are: 6-49—368; 50-74—292; 75-99—191; 100-149—349; 150-199—201; 200-299—268; 300-399—142; and 400+—125.

slightly, and as noted above, the per capita use of inpatient hospital services by this group continues to rise. There were 311.2 admissions of elderly persons per thousand population in 1969 compared with 283.9 for 1967. Despite the slowing rate of increase of inpatient days, the percentage of total days used by older patients increased from 31.9 per cent in 1967 to 34.5 per cent in 1969. ■

ADMINISTRATIVE PROFILES

Dietary Direct Costs

In the new reporting format of the Hospital Administrative Services, data are collected for the dietary department as a whole and for the patient food service separately. This new information allows more detailed analysis of the direct costs involved in the dietary department. The information used in this article is drawn from the reports of 1905 hospitals for the three-month period ending December 1969.

For the dietary department as a whole, the median direct cost per meal rises slightly for hospitals through 299 beds. In the larger hospitals, the median cost declines slightly (see table 1). Median direct cost per meal is $1.22 for hospitals with fewer than 50 beds, and it ranges between $1.30 and $1.36 for all larger hospitals.

The patient food service is the largest service of the dietary department and accounts for the largest part of the labor and supply cost of the department. When the patient food service is examined separately, a pattern of rising costs is observed. For hospitals with fewer than 50 beds, the median direct cost per meal for patient food service is $1.17 (see Table 2). Median direct cost increases gradually to $1.83 for hospitals with 300 to 399 beds. Hospitals with 400 beds or more present a slight deviation from this pattern. These hospitals have a median direct cost per meal of $1.69.

The two components of direct cost in the patient food service indicate that the cost of both supplies (including food) and labor tend to increase with hospital size. Larger hospitals spend more per meal on supplies and on labor in the patient food service than do smaller hospitals. Again, the largest hospitals deviate from this trend.

The productivity of workers in the patient food service does not vary substantially with hospital size (see Table 3). The number of meals served per manhour ranges between 2.2 and 2.6 for all reporting hospitals, but the pattern of variation is irregular. While the number of meals served per manhour is relatively stable across hospital size groupings, it was noted above that labor costs tend to increase with hospital size. This indicates that dietary workers in larger hospitals receive higher wages than workers in smaller hospitals. ■

TABLE 1—TOTAL DIETARY DIRECT COSTS PER MEAL

Hospital size (beds)	*Dietary direct costs per meal*
6-49 beds	$1.22
50-74	1.30
75-99	1.30
100-149	1.31
150-199	1.36
200-299	1.36
300-399	1.34
400+	1.32

TABLE 3—MEALS SERVED PER MANHOUR IN PATIENT FOOD SERVICE

Hospital size (beds)	*Meals served per manhour*
6-49 beds	2.6
50-74	2.2
75-99	2.4
100-149	2.3
150-199	2.4
200-299	2.3
300-399	2.4
400+	2.6

TABLE 2—COMPONENTS OF MEDIAN DIRECT COST PER MEAL FOR PATIENT FOOD SERVICE

Hospital size (beds)	*Food & supplies costs*	*Labor costs*	*Total direct cost per meal*
6-49 beds	$.49	$.68	$1.17
50-74	.68	.81	1.49
75-99	.65	.79	1.44
100-149	.68	.72	1.40
150-199	.72	.81	1.53
200-299	.83	.97	1.80
300-399	.87	.96	1.83
400+	.81	.88	1.69

Utilization and costs in the clinical laboratory

The clinical laboratory provides services in the areas of bacteriology, biochemistery, histology, serology, and hematology. The occasion of service for these fields is the number of tests provided, which are classified according to the nature of the test. Data from the Hospital Administrative Services report for December 1969 give some insight into utilization and costs in this important component of laboratory services.

In terms of the number of tests per inpatient admission, larger hospitals provide more clinical laboratory services than do smaller hospitals (Fig. 1). However, the direct cost per test is less for larger hospitals than for smaller hospitals (Fig. 2). The median direct cost per test declines from $1.45 for hospitals with fewer than 50 beds to $1.14 for hospitals with more than 400 beds.

The declining cost per test may be in part a function of the degree of automation in the clinical laboratory of larger hospitals, since automated equipment is most economical for hospitals with a large volume of inpatient admissions.*

If the lower cost per test in larger hospitals was exclusively a function of automation, the number of tests performed per man-hour could be expected to increase with hospital size. An examination of the median number of tests per man-hour for hospitals of various sizes indicates that this is not the case (Fig. 3). The number of tests per man-hour does increase with hospital size, but only for hospitals with fewer than 300 beds. The number of tests per man-hour decreases slightly for hospitals with more than 300 beds.

This pattern of productivity may indicate that only a standard core of tests is automated. Less routine tests may require sophisticated hand analysis and may be more labor-consuming. Those hospitals with a greater number of tests per admission are likely to provide a higher number of these less routine tests, and therefore experience a slight decrease in the number of tests per man-hour. ■

*Other factors that may contribute to the number of tests administered per inpatient admission are length of stay, number of interns, case load, and the presence of specialized clinics.

FIGURE 2—CLINICAL LABORATORY DIRECT COST PER TEST

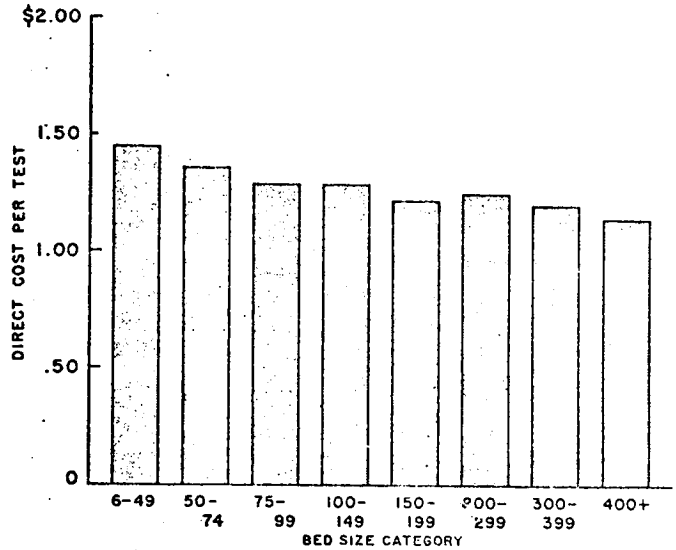


FIGURE 1—CLINICAL LABORATORY TESTS PER INPATIENT ADMISSION

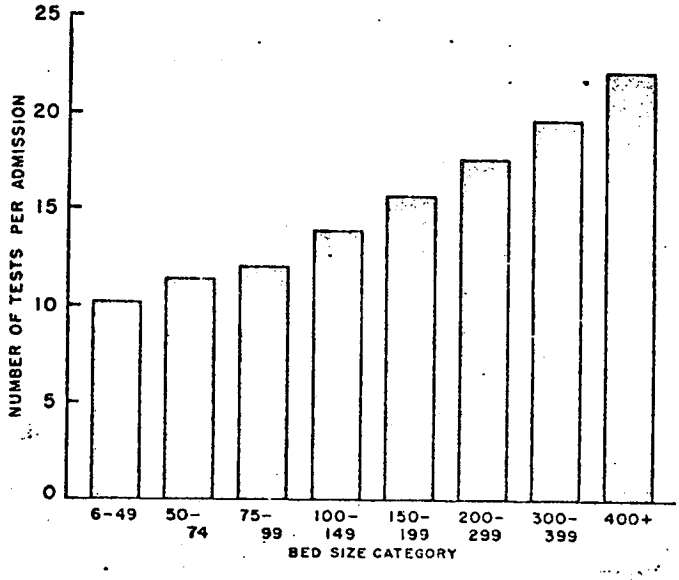
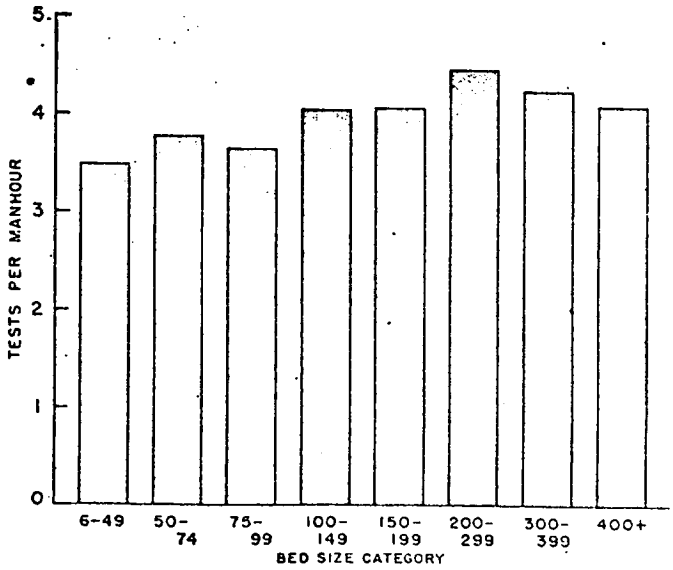


FIGURE 3—CLINICAL LABORATORY TESTS PER MANHOUR



Nursing man-hours, salaries, and expenses

This is the third of a series of Profiles exploring the factors contributing to the generally higher expense per patient day in larger hospitals.

The number of nursing man-hours for each patient day shows a very slight tendency to be higher in smaller hospitals (see Fig. 1). On the basis of monthly data from 1192 community hospitals, the proportion of hospitals using six or more nursing man-hours per patient day decreases from smaller to larger size classes. Over 45 per cent of hospitals with less than 100 beds use six or more hours of nursing services per patient day in contrast to approximately 25 per cent of hospitals with 300 or more beds.

The average hourly nursing salary shows a sharp increase from smaller to larger size classes (see Fig. 2). Over 50 per cent of hospitals under 100 beds report an average hourly nursing salary below $2, in contrast to 10 per cent of hospitals over 300 beds. Similarly, more than 45 per cent of the 300-bed hospital group report an average hourly nursing salary in excess of $2.50, while only 15 per cent of hospitals under 100 beds report a comparable salary.

The tendency for larger hospitals to pay higher nursing salaries more than offsets the lower number of nursing man-hours used in these institutions; thus, total nursing expense per patient day tends to be higher in larger hospitals than smaller ones (see Fig. 3). Over half of hospitals with less than 100 beds have total nursing expenses below $12.50 per patient day, while approximately 25 per cent of hospitals with 400 or more beds have nursing expenses below that level.

In last month's *Profile* it was stated that larger hospitals tend to have a longer average length of stay than smaller hospitals. It follows, then, that nursing expenses per discharge tend to be higher in larger hospitals than in smaller hospitals.

In summary, these data suggest that larger hospitals tend to have a higher nursing expense per patient day than their smaller counterparts and that this higher expense results from a higher average hourly nursing salary rather than the number of nursing man-hours employed per patient day. Since nursing expense is the largest single item in almost every hospital budget, this is an important factor in explaining expense differentials between larger and smaller hospitals. ■

FIGURE 1—NURSING MAN-HOURS PER PATIENT DAY

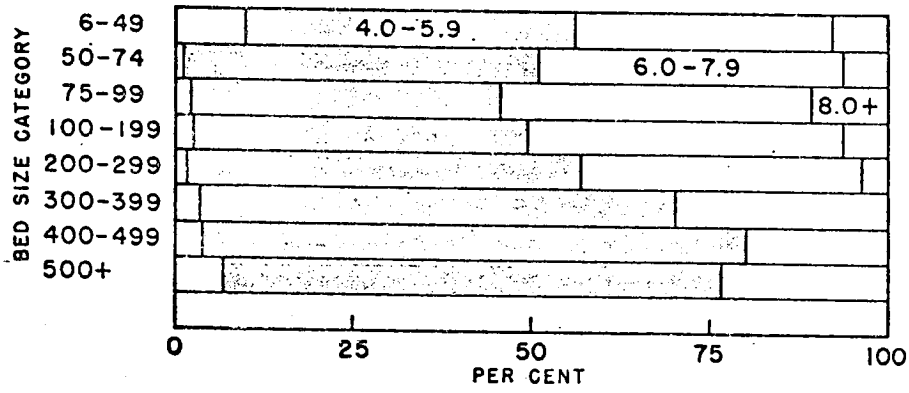


FIGURE 2—AVERAGE HOURLY NURSING SALARY

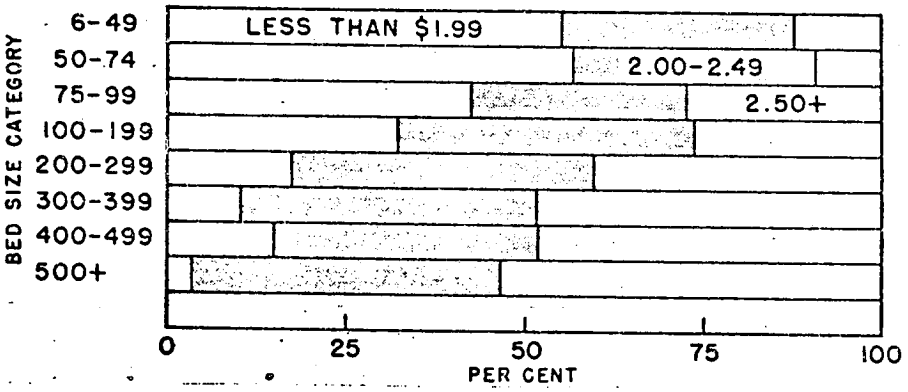
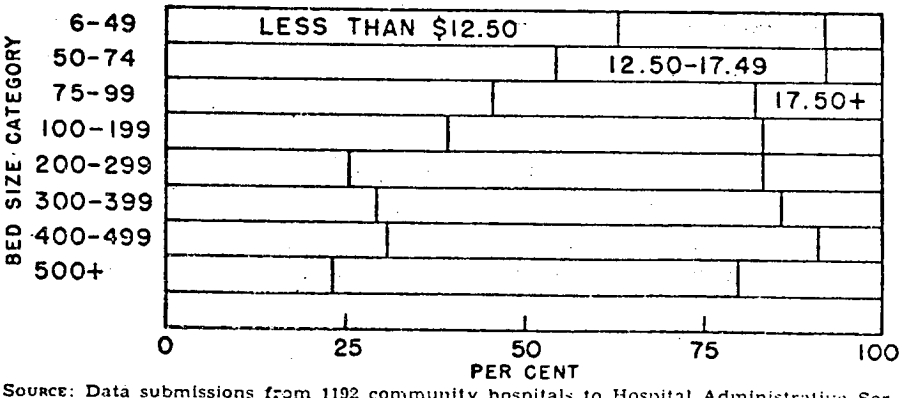


FIGURE 3—NURSING EXPENSE PER PATIENT DAY



SOURCE: Data submissions from 1192 community hospitals to Hospital Administrative Services for October 1957. The number of reporting hospitals in each size group was: 6-49, 103; 50-74, 132; 75-99, 102; 100-199, 359; 200-299, 237; 300-399, 119; 400-499, 81; 500 or over, 59.

ADMINISTRATIVE PROFILES

Laboratory Services and Expenditures

This is the fourth of a series of Profiles exploring the factors contributing to the generally higher expense per patient day and per discharge in larger hospitals.

The number of inpatient laboratory tests per patient day increases steadily from smaller to larger hospital size groups. Data from 1192 community hospitals show that over 75 per cent of hospitals with less than 100 beds perform fewer than two inpatient laboratory tests per patient day, while only 35 per cent of hospitals with 400 beds or more perform less than two tests per patient day (see Fig. 1). As the center shaded portion of Figure 1 demonstrates, the proportion of hospitals using a higher number of tests per patient day increases consistently with each larger hospital size class.

These same data indicate that the expense per laboratory test differs only slightly among the size groups (see Fig. 2). For hospitals with 100 or more beds, there is a slight tendency for each larger size class to have a slightly lower expense per test, suggesting an economy of volume. At the same time, a larger proportion of all hospital size groups under 100 beds report a lower level of expense per test than hospitals with 100 or more beds. This difference may reflect the type of tests being performed in the various institutions, but in any case the differences are slight.

To find the laboratory expense per patient day, the number of inpatient laboratory tests per patient day is multiplied by the expense per test; thus the trends in both are magnified in the summary figure of laboratory expense per patient day. Accordingly, laboratory expense per patient day tends to increase from smaller to larger hospital size classes (See Fig. 3). These data show that slightly over 20 per cent of hospitals with less than 100 beds have laboratory expenses in excess of $4 per patient day, whereas over 40 per cent of hospitals with 400 or more beds have laboratory expenses of over $4 per patient day. Since larger hospitals tend to have a longer average length of stay than smaller hospitals, laboratory expense per discharge shows a stronger increase from smaller to larger size groups. ■

FIGURE 1—INPATIENT LABORATORY TESTS PER PATIENT DAY

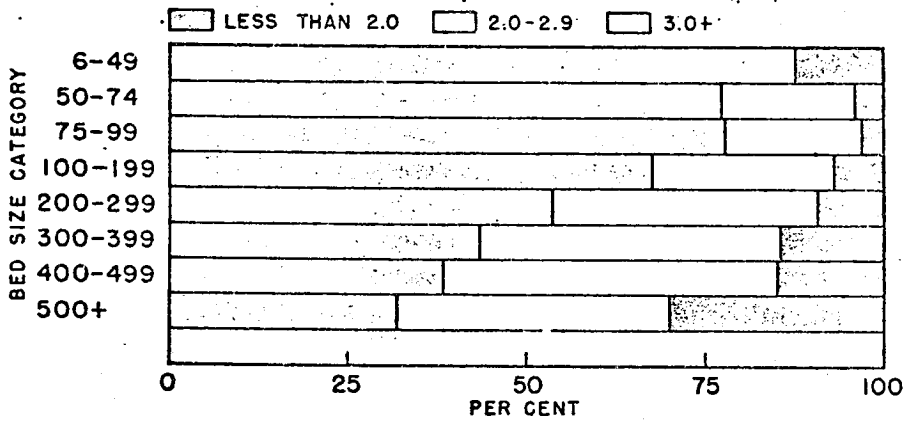


FIGURE 2—EXPENSE PER LABORATORY TEST

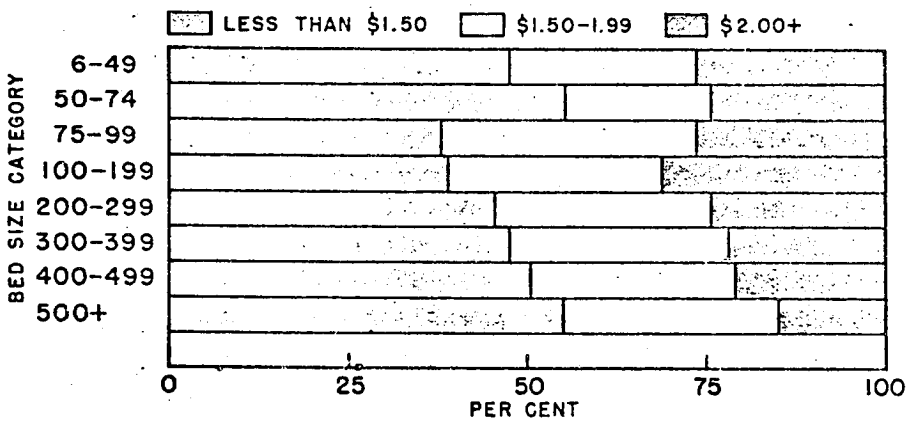
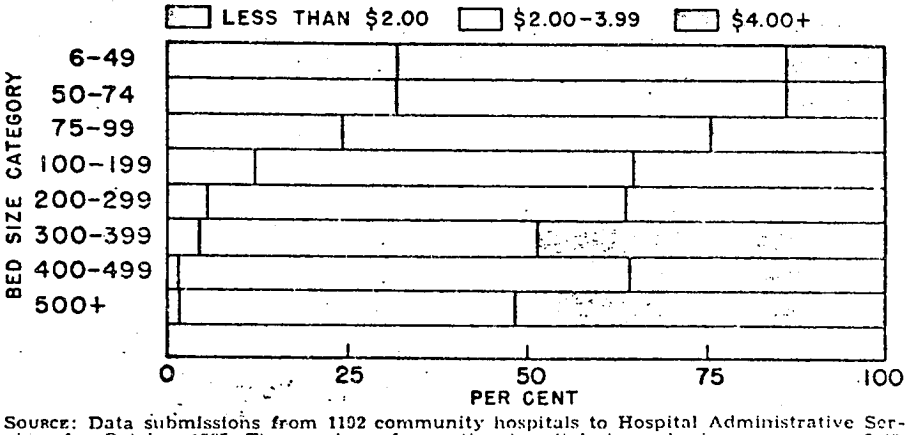


FIGURE 3—LABORATORY EXPENSE PER PATIENT DAY



Source: Data submissions from 1192 community hospitals to Hospital Administrative Services for October 1967. The number of reporting hospitals in each size group was: 6-49, 103; 50-74; 132; 75-99, 102; 100-199, 359; 200-299, 237; 300-399, 119; 400-499, 81; 500 or over, 59.

ADMINISTRATIVE PROFILES

Radiology Services and Expenses

This is the fifth of a series of Profiles *exploring the factors contributing to the generally higher expense per patient day and per discharge in larger hospitals.*

The number of inpatient radiology procedures performed per discharge is generally higher in larger hospitals than in smaller units (see Fig. 1). Data from 1192 community hospitals for October 1967 show that the number of radiology procedures per patient day also tends to be higher in larger hospitals, but the difference is somewhat smaller. Over 40 per cent of hospitals with less than 100 beds average less than one radiology procedure per admission, whereas less than five per cent of hospitals with 300 or more beds have a similar average.

Data from these same hospitals show that there is no significant difference among hospital size classes in the expense per radiology procedure (see Fig. 2). Apparently any variations in salary and productivity combine to produce relatively the same distribution of per unit expense in all hospital size groups.

Total radiology expense per discharge is a reflection of the number of procedures used and the expense per procedure; thus radiology expense per discharge tends to increase from smaller to larger hospital size groupings (see Fig. 3). Almost 60 per cent of hospitals with less than 100 beds report a total radiology expense per discharge of less than $20, while 30 per cent of the hospitals with 300 or more beds have radiology expenses below $20 per discharge. The radiology expense per patient day also tends to be higher in larger size groups than in smaller ones, but the magnitude of the differences is smaller.

Overall, the patterns of utilization and expense in radiology are very much like those for laboratory services (see Administrative Profiles, HOSPITALS, J.A.H.A., Aug. 16, 1968, p. 24). Larger hospital size groups tend to use more radiology services than the smaller size groupings, and there appears to be little in the way of productivity differences among the eight size classes. The result is that radiology expense per discharge tends to be higher in larger institutions. ■

FIGURE 1—RADIOLOGICAL PROCEDURES PER DISCHARGE

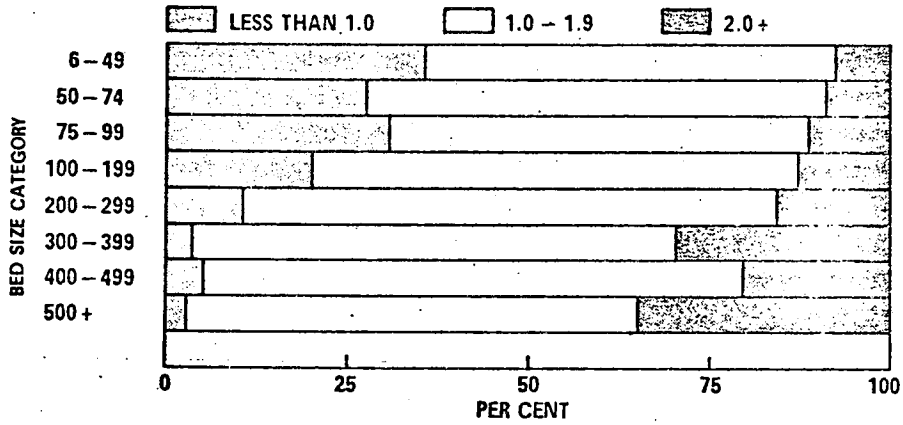


FIGURE 2—EXPENSE PER RADIOLOGICAL PROCEDURE

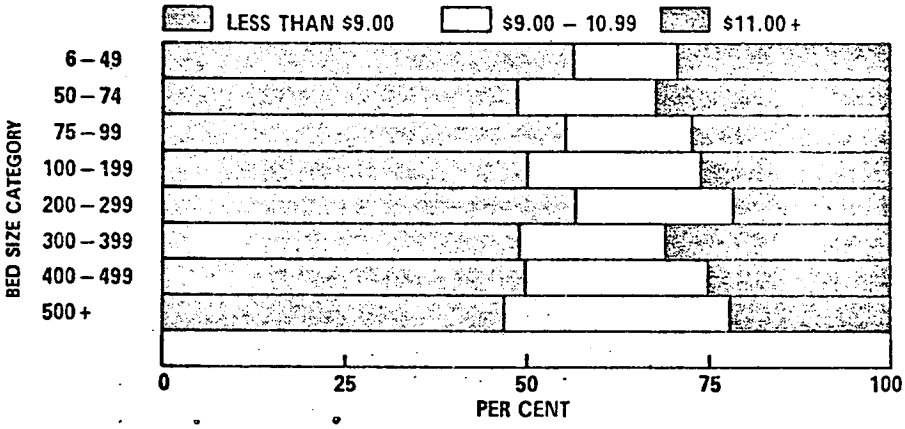
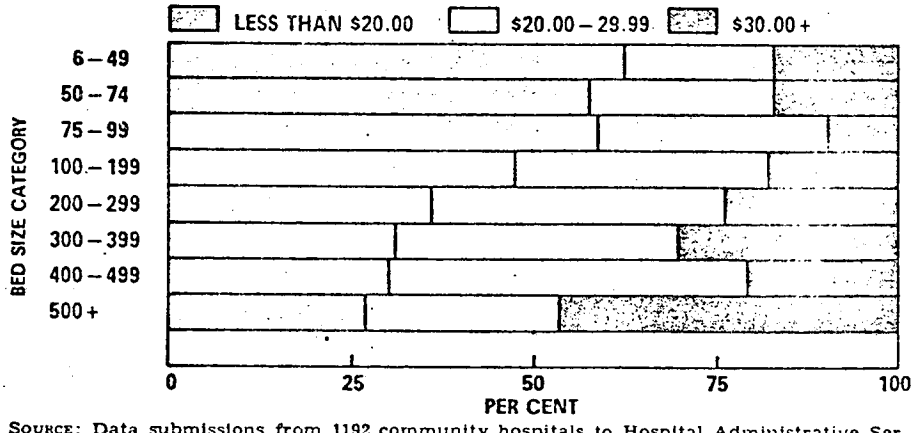


FIGURE 3—RADIOLOGICAL EXPENSES PER DISCHARGE



SOURCE: Data submissions from 1192 community hospitals to Hospital Administrative Services for October 1967. The number of reporting hospitals in each size group was: 6-49, 103; 50-74, 132; 75-99, 102; 100-199, 359; 200-299, 237; 300-399, 119; 400-499, 81; 500 or over, 59.

ADMINISTRATIVE PROFILES

Nonnursing Salaries and Expenses

This is the sixth of a series of Profiles exploring the factors contributing to the generally higher expense per patient day and per discharge in larger hospitals.

In the third Profile of this series, the data indicated that nursing expenses tend to be higher in large hospitals than in small ones. Subsequent Profiles showed that larger hospitals tend to have higher expenses per patient day and per discharge for laboratory and for radiology services. In addition to these specific services, hospitals also differ in the range and volume of other services offered. For example, some institutions may provide physical therapy and rehabilitation services, while others do not offer these services. A helpful summary measure of these special diagnostic and therapeutic services is the percentage of total hospital expenses devoted to nursing. Hospitals with a high proportion of expense for nursing services are more likely to spend less on other direct patient services or perform fewer of them. A closely related measure is the percentage of total salary expense devoted to nursing salaries; this percentage expresses the relative distribution of personnel.

On the basis of data from 1192 community hospitals, hospitals in the larger size classes tend to devote a lower percentage of their total expenses to nursing services than do hospitals in smaller size classes (see Fig. 1). A fourth of all hospitals with less than 100 beds use 30 per cent or more of their total expenditures for nursing services, while less than five per cent of hospitals with 300 or more beds spend that much for nursing services. Larger hospitals, then, tend to use more of their resources for nonnursing services.

These same data show that larger hospitals devote a smaller share of total salary expenses to nursing salary expense than do smaller units (see Fig. 2). Slightly over 60 per cent of hospitals with less than 100 beds allocate 40 per cent or more of their salary expenditures to nursing, while approximately 15 per cent of hospitals with 300 or more beds use that proportion of salary expenses for nursing. The tendency for larger hospitals to devote a larger share of their salary expenses to nonnursing salaries is even stronger than the trend noted above in total expense allocations.

Larger hospitals may use a smaller share of their total and salary expenses for nursing, but they devote a relatively larger proportion to laboratory, radiology, and other types of services. In some cases, this reflects a wider range of services; in other cases, it means a larger volume of a narrow range of special diagnostic and therapeutic services. In either case, these data suggest that larger hospitals tend to have relatively higher expenses for such services than do smaller hospitals, thus contributing to the differences in total expense per patient day and per discharge. ■

FIGURE 1—PERCENTAGE OF TOTAL EXPENSES DEVOTED TO NURSING*

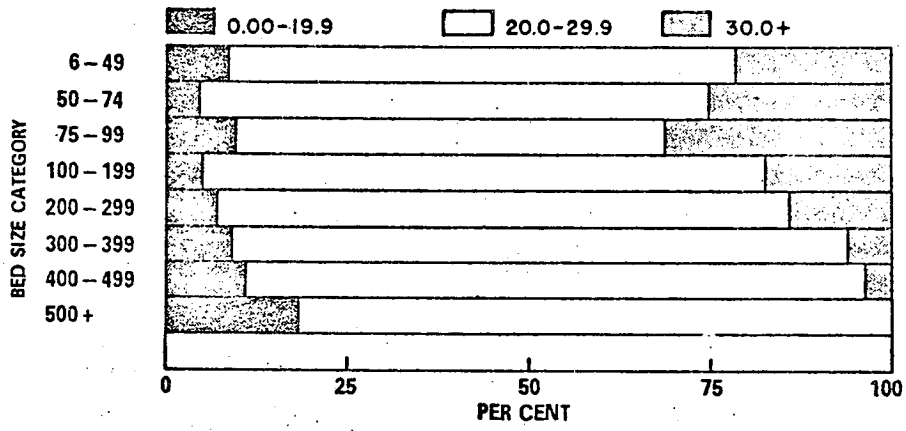
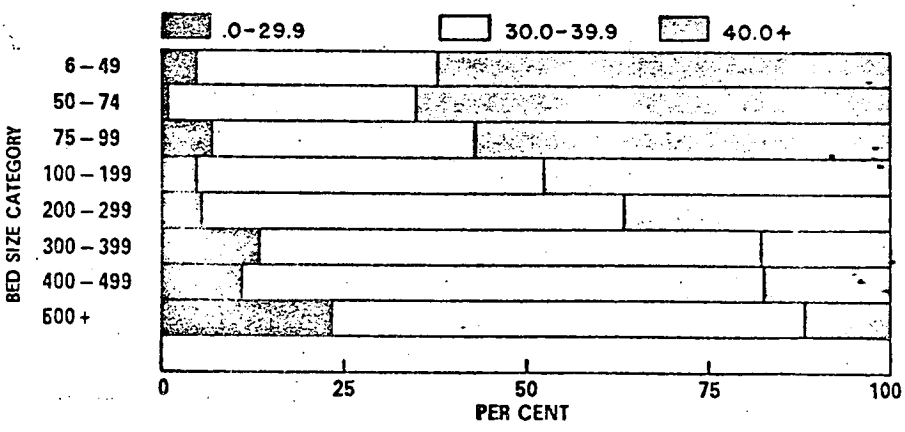


FIGURE 2—PERCENTAGE OF TOTAL SALARY EXPENSE DEVOTED TO NURSING SALARIES*



*The number of hospitals reporting in each size class is: 6 to 49 beds, 103; 50 to 74 beds, 132; 75 to 99 beds, 102; 100 to 199 beds, 359; 200 to 299 beds, 237; 300 to 399 beds, 119; 400 to 499 beds, 81; 500 beds and over, 59. The data reflect reports for the month of October 1967.

Summary: Two Factors in Expense Differentials

This is the seventh and last of a series of Profiles exploring the factors contributing to the generally higher expense per patient day and per discharge in larger hospitals.

In the first Profile of this series, it was noted that larger hospitals tend to have a higher expense per discharge and a higher expense per patient day than smaller hospitals. Since discharges and patient days are units of production in a broad sense, it was noted that this pattern of expense tended to run counter to the idea of an economy of scale. The question was raised as to why this pattern appears to exist. The next five Profiles addressed themselves to this problem; this Profile will summarize the findings.

It was first observed that larger hospitals tend to have a longer average length of stay than smaller institutions; this difference served to explain some of the variation in the expense per discharge. Since larger hospitals keep patients longer on the average, the total expense per discharge would be higher in larger hospitals, even if the expense per patient day were the same for all size classes. But the expense per patient day also is higher in larger hospitals than smaller ones; primary attention was focused on this difference.

It was observed that since larger hospitals have a higher rate of occupancy, they should have a lower expense for fixed costs (building and other standard items) than smaller hospitals. If any such saving does occur, it is more than offset by other factors that force larger institutions to have higher expenses per patient day than their smaller counterparts.

Since nursing service is the largest single item in the budgets of most hospitals, differences in this critical area were analyzed next. The number of nursing man-hours per patient day showed little difference among the size groups, with a slight tendency for smaller hospitals to use more nursing man-hours than larger institutions. The average hourly nursing salary was significantly higher for larger than smaller hospitals, reflecting the tendency of larger hospitals to be in predominantly urban areas and therefore in higher wage markets. The net effect of these two trends is that the nursing expense per patient day is higher in larger hospitals than smaller units.

While the basic hospital services represented by nursing showed little difference in the level of effort (as measured in man-hours), the use of various diagnostic and therapeutic services appears to vary significantly among the size classes. The use of laboratory procedures varies markedly across size groups, with larger hospitals using more laboratory tests per patient day than smaller hospitals. Larger hospitals also tend to use more radiology services per patient day than smaller institutions, but the magnitude of difference is smaller than in the case of laboratory services. The expense per procedure for these two services shows no significant variation among the size groups. Since it is to be expected that larger hospitals must pay higher salaries for these personnel as they do for nurses, the absence of differences in expense per procedure suggests a compensating offset from higher productivity or the greater use of automation in larger institutions. In this area, then, it appears that there may be some economy of scale in hospital operations.

Finally, in an effort to measure the range and volume of services other than basic nursing services, the analysts looked at the proportion of total hospital expenses devoted to nursing services. As the range and the volume of diagnostic and therapeutic services (including laboratory, radiology, physical therapy, inhalation therapy) expand, the proportion of hospital expenses going to nursing should decline. This analysis showed that smaller hospitals tend to devote a greater part of their total expense to nursing services than larger institutions, thus indicating that larger hospitals provide a wider range and/or a higher volume of these nonnursing services.

As a result of these findings, it appears that there are two major factors active in generating expense differentials among the hospital size classes.

First, higher nursing salaries lead to a higher expense per patient day for nursing services in larger hospitals. The small differences in the numbers of nursing service man-hours suggests that there is not much offset from productivity in this area—probably indicative of the personal nature of the services provided.

Second, larger hospitals tend to use more laboratory and radiology services per patient day than their smaller counterparts. The expense differential here can be attributed not to wages, but rather to the greater use of these special diagnostic and therapeutic services. The proportion of hospital expense devoted to nonnursing services confirms the general observation made relative to laboratory and radiology services.

In summary, two of the major factors contributing to expense differentials among hospitals appear to be higher nursing salaries in larger hospitals and more extensive use of therapeutic and diagnostic services outside the department of nursing in larger institutions. ■

HOSPITAL ADMINISTRATIVE SERVICES, AMERICAN HOSPITAL ASSOCIATION
Chicago, Illinois 60611

TO: State and Allied Associations

SUBJECT: HAS Median Data for National Bed Size Groups for Three Months Ending September 30, 1970

This report contains the following data concerning Laboratory:

	MEDIANS NATIONAL BED SIZE GROUPS								
	Under 50	50-74	75-99	100-149	150-199	200-299	300-399	400 & Over	Teaching
Laboratory:									
Inpatient Revenue a per cent of total Revenue	9.2	9.3	9.2	9.1	9.3	9.0	9.1	9.0	10.5
Outpatient Revenue a per cent of total Revenue	1.4	1.0	1.2	1.2	1.1	1.1	1.2	1.2	2.0
Expense a per cent of total Expenses	6.1	6.6	6.9	7.1	7.5	7.1	7.3	7.2	7.3
Clinical Lab Tests per Admission	9.7	11.5	13.1	14.0	16.1	18.4	19.8	24.4	31.1
Clinical Lab Test per Man-Hour	3.6	3.5	3.9	3.8	3.7	4.4	3.9	4.2	3.2

NATIONAL GROUP MEDIANS FOR THREE MONTHS PERIOD ENDING SEPT, 1970

	NATIONAL BED SIZE GROUPS								
	UNDER 50	50 74	75 99	100 149	150 199	200 299	300 399	OVER 400	TEACH-ING
REVENUE PERCENTAGES									
OBSTETRICAL NURSING UNITS	3.1	3.2	3.4	3.7	3.6	3.7	3.5	3.4	3.0
NURSERIES	1.1	1.2	1.4	1.6	1.7	1.9	1.8	1.8	2.0
DELIVERY AND LABOR ROOMS	0.9	0.9	1.0	1.1	1.0	1.2	1.1	1.2	0.8
TOTAL OBSTETRICAL SERVICE	3.6	4.0	5.2	5.7	5.7	6.5	6.1	5.7	5.6
MEDICAL + SURGICAL NURSING UNITS	48.2	47.4	47.5	46.6	46.8	47.2	47.9	47.2	45.2
OPERATING ROOMS	2.8	3.8	4.2	4.8	5.3	5.8	5.9	6.2	6.1
RECOVERY ROOMS	0.4	0.5	0.6	0.6	0.7	0.8	0.9	0.8	0.7
CENTRAL SERVICES + SUPPLY	4.2	3.8	3.6	3.3	2.9	2.7	2.4	2.3	1.7
INTRAVENOUS THERAPY	1.3	1.4	1.4	1.5	1.5	1.4	1.5	1.4	1.2
EMERGENCY SERVICES	1.4	1.7	2.0	2.1	2.4	2.8	2.5	2.3	2.0
LABORATORY--INPATIENT	9.2	9.3	9.2	9.1	9.3	9.0	9.1	9.0	10.5
--OUTPATIENT	1.4	1.0	1.2	1.2	1.1	1.1	1.2	1.2	2.0
BLOOD BANK	0.4	0.4	0.4	0.5	0.5	0.5	0.6	0.9	1.6
RADIOLOGY - INPATIENT	5.1	5.1	5.0	5.0	4.9	4.8	4.8	4.6	4.7
- OUTPATIENT	2.6	2.5	2.9	2.6	2.5	2.7	2.3	2.0	2.7
PHARMACY - INPATIENT	8.3	7.8	7.4	7.2	6.7	6.0	6.0	5.7	4.4
- OUTPATIENT	0.6	0.5	0.5	0.4	0.4	0.3	0.3	0.3	0.7
ANESTHESIOLOGY	2.5	2.7	2.7	2.6	2.0	1.7	1.7	1.5	1.6
INHALATION THERAPY	1.3	1.4	1.4	1.7	1.8	1.7	1.8	1.8	2.1
PHYSICAL THERAPY	0.8	1.2	1.2	1.0	0.9	1.0	1.0	0.9	0.6
OCCUPATIONAL + RECREATIONAL THERAPY	0.4	0.3	0.5	0.4	0.2	0.3	0.3	0.2	0.2
SOCIAL SERVICE	0.0	0.5	0.0	0.0	0.0	0.1	0.0	0.0	0.1
CLINICS	0.4	0.4	0.6	0.8	0.5	0.4	0.5	0.6	3.2
ALL OTHER PROFESSIONAL SERVICES	1.6	1.6	1.4	1.5	1.7	1.7	1.9	2.1	2.8
GROSS PATIENT REVENUE									
DEDUCTIONS FROM REVENUE									
CONTRACTUAL ADJUSTMENTS	-3.4	-4.7	-3.7	-4.5	-5.9	-5.4	-5.1	-4.6	-5.7
PROVISION FOR BAD DEBTS	-2.6	-2.3	-2.2	-2.4	-2.2	-1.9	-2.0	-2.2	-2.3
OTHER DEDUCTIONS	-0.4	-0.6	-0.4	-0.4	-0.5	-0.5	-0.6	-1.0	-2.0
TOTAL PATIENT REVENUE DEDUCTIONS	-6.9	-7.3	-6.7	-7.8	-9.4	-8.8	-7.5	-9.6	-13.2
OTHER REVENUES	1.6	1.7	1.7	1.9	2.2	2.3	2.5	2.6	3.4
MISCELLANEOUS NONOPERATING	0.8	0.6	0.7	0.5	0.6	0.7	0.8	0.8	1.2
TOTAL GROSS INPATIENT CHARGES	92.5	92.7	92.2	92.0	92.0	91.3	92.0	92.4	88.8
TOTAL GROSS OUTPATIENT CHARGES	7.6	7.3	7.7	7.9	7.9	8.6	7.9	7.6	11.1

AMERICAN HOSPITAL ASSOCIATION • 840 NORTH LAKE SHORE DRIVE • CHICAGO, ILL. 60611
HOSPITAL ADMINISTRATIVE SERVICES

HAS 200 - 200M - (REV. 11/68) - 20360

NATIONAL GROUP MEDIANS FOR THREE MONTHS PERIOD ENDING SEPT, 1970

	NATIONAL BED SIZE GROUPS								
	UNDER 50	50 74	75 99	100 149	150 199	200 299	300 399	OVER 400	TEACH-ING
EXPENSE PERCENTAGES									
NURSING SERVICE - ADM. OFFICE	1.3	1.2	1.3	2.1	1.9	1.8	1.6	1.5	1.6
NURSING SERVICE - OBSTETRICAL UNITS	0.9	1.9	2.1	2.2	2.0	1.8	1.5	1.3	1.1
NURSING SERVICE - NURSERY UNITS	0.7	1.0	1.2	1.2	1.3	1.4	1.4	1.4	1.3
MEDICAL + SURGICAL NURSING UNITS	25.5	24.5	24.2	23.1	21.9	21.7	21.8	21.2	18.2
TOTAL NURSING SERVICE	28.0	27.7	28.0	27.6	26.7	26.5	26.6	25.6	22.6
DELIVERY + LABOR ROOMS	0.4	0.6	0.6	1.0	1.1	1.3	1.2	1.2	1.0
OPERATING ROOMS	1.9	3.2	3.7	3.9	4.0	4.0	4.3	4.2	3.8
RECOVERY ROOMS	0.3	0.4	0.4	0.4	0.4	0.5	0.5	0.5	0.4
CENTRAL SERVICES + SUPPLY	2.9	2.7	2.5	2.5	2.4	2.2	2.1	2.1	1.9
INTRAVENOUS THERAPY	0.7	0.6	0.6	0.7	0.6	0.6	0.6	0.5	0.6
EMERGENCY SERVICE	0.6	0.9	1.4	1.4	1.8	2.1	2.0	1.8	1.3
LABORATORY	6.1	6.6	6.9	7.1	7.5	7.1	7.3	7.2	7.3
BLOOD BANK	0.3	0.4	0.4	0.5	0.5	0.6	0.6	0.9	1.3
RADIOLOGY	5.8	5.7	5.7	5.5	5.4	5.4	4.7	4.8	5.2
PHARMACY	3.7	4.0	3.8	3.8	3.6	3.3	3.4	3.6	3.2
ANESTHESIOLOGY	2.0	2.0	1.9	1.7	1.3	1.0	0.9	0.9	1.2
INHALATION THERAPY	0.5	0.5	0.5	0.8	0.9	1.0	0.9	0.9	0.8
PHYSICAL THERAPY	0.7	1.0	0.8	0.7	0.6	0.6	0.6	0.6	0.5
SOCIAL SERVICE	0.2	0.6	0.3	0.3	0.2	0.2	0.2	0.2	0.7
MEDICAL RECORDS	1.5	1.4	1.4	1.3	1.2	1.2	1.2	1.1	1.4
MEDICAL LIBRARY	0.4	0.1	0.2	0.2	0.1	0.1	0.1	0.1	0.1
ALL OTHER PROFESSIONAL SERVICES	0.6	0.7	0.8	0.8	1.0	1.0	1.1	1.5	2.7
DIETARY	9.1	8.7	8.6	8.2	8.1	8.0	8.0	7.9	6.8
PLANT ENGINEERING	5.4	5.1	4.8	4.8	4.7	4.8	4.8	4.8	5.3
HOUSEKEEPING	3.3	3.6	3.6	3.7	3.5	3.5	3.6	3.6	3.8
LAUNDRY + LINEN	2.4	2.2	2.1	2.1	1.9	1.9	1.9	1.7	1.7
ADMINISTRATION + FISCAL	11.9	10.5	10.2	10.2	10.2	10.4	10.5	10.3	11.2
EMPLOYEE HEALTH + WELFARE	3.8	4.0	4.1	4.2	4.7	4.9	4.7	5.1	5.7
DEPRECIATION	4.5	4.0	4.2	4.0	4.0	4.1	4.3	4.4	4.1
MISCELLANEOUS OPERATING	1.5	1.2	1.2	1.3	1.2	1.5	1.2	1.5	1.2
BASE TOTAL									
HOME HEALTH CARE	0.0	1.2	0.5	0.4	0.6	0.5	0.5	0.7	0.5
NURSING EDUCATION	0.4	0.5	0.6	0.4	0.6	1.5	1.7	1.7	1.2
MEDICAL STAFF	4.5	2.3	2.0	2.7	2.2	1.5	1.9	3.0	6.5
RESEARCH	0.0	0.0	0.0	0.0	1.3	0.7	0.2	0.3	0.5
CLINIC	0.7	1.4	1.3	0.5	0.8	0.5	0.5	0.5	2.7
PERSONNEL QUARTERS	0.3	0.3	0.2	0.2	0.4	0.4	0.3	0.3	0.4
MISCELLANEOUS NONOPERATING	0.6	0.9	0.5	0.7	0.6	1.0	0.8	1.0	1.1
SALARIES - % OF ALL EXPENSES	58.0	59.3	59.2	59.5	59.4	60.8	61.1	61.3	62.7
PROF. SUID	3.7	4.4	4.6	4.7	4.6	4.2	3.6	3.0	2.4
FRINGE EXPENSES									

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HAS 200 - 200M - (REV. 11/68) - 20360

NATIONAL GROUP MEDIANS FOR THREE MONTHS PERIOD ENDING SEPT, 1970

		NATIONAL BED SIZE GROUPS								
		UNDER 50	50 74	75 99	100 149	150 199	200 299	300 399	OVER 400	TEACH-ING
1										
2	NURSING ADMINISTRATION MH PER BED	3.64	3.26	4.11	7.76	7.70	7.65	7.02	6.16	9.61
3	OBSTETRICAL UNITS - % OCCUPANCY %	33.33	36.66	42.08	53.00	60.00	65.39	68.15	76.28	80.00
4	-% OF TOTAL ADMISSIONS %	11.84	12.76	12.74	14.20	14.54	14.76	14.17	14.43	15.85
5	-AVERAGE LENGTH OF STAY	3.50	3.55	3.61	3.73	3.83	3.88	3.98	3.96	4.20
6	-NURSING MH PER BED PER DAY	0.94	2.14	2.78	3.35	3.73	3.33	3.48	3.51	3.70
7	-DELIVERY + LABOR MH PER DELIVERY	4.33	5.77	6.11	9.22	10.70	14.45	15.45	15.02	17.42
8	-NURSERY MH PER BASSINET PER DAY	0.54	1.03	1.44	1.69	1.87	2.27	2.61	2.66	3.29
9	-DELIVERY + LABOR DC PER DELIVERY $	17.00	21.77	27.45	35.31	46.82	61.81	65.64	63.83	74.01
10	MED. + SURG. UNITS-% OCCUPANCY %	64.60	71.38	75.59	77.38	81.21	83.22	84.00	86.42	83.20
11	-O. R. VISITS PER 100 ADMISSIONS	26.78	34.01	40.89	46.95	52.63	57.61	58.40	60.10	60.76
12	-AVERAGE LENGTH OF STAY	6.73	6.96	7.26	7.25	7.80	8.09	8.26	9.02	10.28
13	-NURSING MH PER BED PER DAY	4.26	4.67	4.93	4.96	4.93	4.94	4.85	4.86	5.11
14	-NURSING MH PER PATIENT DAY	6.65	6.50	6.38	6.35	6.09	6.03	5.84	5.67	6.13
15	-% REGISTERED NURSES %	26.14	24.46	29.96	28.70	32.57	34.48	35.21	36.19	37.40
16	-% LICENSED PRACTICAL NURSES %	15.28	16.55	16.24	19.75	18.77	17.51	14.92	17.61	18.74
17	TOTAL NURS. SERV.- DC PER PT. DAY $	17.11	17.41	19.65	19.93	20.23	21.15	21.23	20.21	23.80
18	- MANHOURS PER BED PER DAY	4.09	4.74	4.99	5.24	5.31	5.38	5.34	5.33	5.68
19	OPERATING ROOM DC PER VISIT $	34.53	45.03	50.85	47.65	49.50	53.02	53.72	54.07	79.93
20	OPERATING ROOM MH PER VISIT	6.29	8.87	9.49	9.70	9.84	10.00	10.59	10.11	14.14
21	CENTRAL SERVICES DC PER LINE ITEM $	2.26	2.03	1.79	1.72	1.60	1.66	1.59	1.54	2.10
22	CENTRAL SERVICES LINE ITEM PER MH	2.80	3.11	3.39	4.02	3.70	3.44	3.85	3.56	2.70
23	EMERGENCY ROOM MH PER VISIT	0.58	0.69	0.87	1.12	1.22	1.33	1.42	1.46	1.43
24	CLINICAL LAB IP TESTS PER ADM.	9.71	11.48	13.10	13.93	16.13	18.39	19.75	24.37	31.13
25	CLINICAL LAB TOTAL TESTS PER MH	3.55	3.51	3.86	3.79	3.73	4.37	3.87	4.18	3.24
26	CLINICAL LAB DC PER TEST $	1.69	1.67	1.44	1.45	1.41	1.28	1.43	1.25	1.59
27	% OUTPATIENT CLINICAL LAB TESTS %	11.90	9.39	10.43	10.02	10.99	11.50	12.22	11.75	21.08
28	TOTAL LABORATORY TESTS PER MH	3.42	3.65	3.58	3.62	3.66	3.83	3.59	4.01	3.15
29	TOTAL LABORATORY DC PER TEST $	1.89	1.69	1.58	1.58	1.49	1.45	1.51	1.29	1.62
30	BLOOD BANK MH PER UNITS DRAWN	2.22	1.25	2.40	2.62	2.34	2.38	2.58	3.53	4.29
31	X-RAY DIAG. PROCEDURES PER ADM.	1.22	1.33	1.37	1.42	1.51	1.54	1.54	1.67	2.01
32	X-RAY DIAG. DC PER PROCEDURE $	6.21	6.12	6.11	6.11	6.76	6.75	7.44	7.75	10.46
33	X-RAY DIAG. MH PER PROCEDURE	1.05	1.02	0.98	1.07	1.12	1.20	1.31	1.34	1.68
34	% OF X-RAY DIAGNOSTIC PROCEDURES %	40.00	37.13	40.41	39.85	41.13	43.51	41.16	37.66	46.41
35	TOTAL X-RAY MH PER PROCEDURE	1.09	1.05	1.04	1.12	1.15	1.22	1.35	1.32	1.66
36	TOTAL X-RAY DC PER PROCEDURE $	6.79	6.51	6.55	6.33	6.95	6.89	7.40	7.69	10.00
37	PHARMACY LINE ITEMS PER MH	12.02	7.84	10.29	10.28	9.74	10.79	11.78	11.13	7.32
38	PHARMACY DC PER PATIENT DAY $	2.37	2.59	2.59	2.69	2.80	2.69	2.72	2.74	3.56
39	PHYSICAL THERAPY TREATMENTS PER MH	1.70	1.50	1.46	1.33	1.30	1.30	1.19	1.09	0.79
40	HOME CARE VISITS PER MH	0.0	0.28	0.26	0.31	0.43	0.34	0.30	0.25	0.33
41	SOCIAL SERVICE MH PER ACCEPTED CASE	0.0	4.57	8.00	5.54	4.26	4.82	5.63	6.15	7.70
42	IV THERAPY DC PER PATIENT DAY $	0.41	0.40	0.42	0.50	0.44	0.48	0.43	0.43	0.65

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HOSPITAL ADMINISTRATIVE SERVICES.

HAS 200 - 200M - (REV. 11 '68) - 20369

NATIONAL GROUP MEDIANS FOR THREE MONTHS PERIOD ENDING SEPT, 1970

		NATIONAL BED SIZE GROUPS								
		UNDER 50	50 74	75 99	100 149	150 199	200 299	300 399	OVER 400	TEACH-ING
1										
2	X-RAY REC. MH PER DISCHARGE UNIT	2.14	2.22	2.23	2.12	2.30	2.24	2.20	2.01	1.84
3	MEDICAL RECORDS MH PER BED	6.31	6.68	7.31	7.22	7.55	7.75	7.63	7.26	11.50
4	ER + CLINIC VISITS PER BED	3.71	4.79	5.50	5.43	5.91	6.48	6.22	6.70	17.09
5	CLINIC MH PER VISIT	0.61	0.50	0.67	0.87	1.06	1.59	1.76	1.23	1.39
6	-DIETARY FUNCTION-									
7	SALARY, FOOD + SUPPLY COST PER MEAL $	1.32	1.38	1.40	1.39	1.40	1.47	1.49	1.42	1.56
8	FOOD + SUPPLY COST PER MEAL $	0.56	0.60	0.62	0.66	0.67	0.68	0.66	0.65	0.67
9	TOTAL MEALS SERVED PER PATIENT DAY	4.12	4.06	4.16	4.14	4.24	4.31	4.38	4.44	5.10
10	TOTAL MEALS SERVED PER MANHOUR	2.48	2.54	2.54	2.75	2.85	2.89	2.99	3.14	2.87
11	AVERAGE HOURLY SALARY-PATIENT FOOD $	1.82	1.92	1.94	2.01	2.16	2.27	2.38	2.34	2.61
12	AVERAGE HOURLY SALARY-CAFETERIA $	1.77	1.91	1.87	1.95	2.00	2.28	2.29	2.26	2.47
13	CAFETERIA MEALS SERVED PER MANHOUR	2.51	3.55	5.03	4.88	6.22	6.43	6.84	7.57	5.63
14	CAFETERIA REVENUE PER MEAL $	0.44	0.48	0.54	0.61	0.64	0.68	0.69	0.65	0.71
15	CAFETERIA MEALS PER EMPLOYEE-FT	0.51	0.50	0.52	0.48	0.51	0.55	0.56	0.55	0.61
16	PLANT DC PER BED $	58.40	66.50	72.65	75.65	88.45	93.10	98.54	96.00	146.17
17	PLANT DC PER 1000 FEET $	111.91	120.39	130.30	125.47	138.25	137.99	138.92	127.45	138.85
18	PLANT MH PER 1000 FEET	14.64	16.48	16.65	17.86	19.54	18.51	19.02	17.89	18.52
19	HOUSEKEEPING DC PER BED $	37.38	48.25	55.08	60.19	65.50	68.25	73.21	72.34	103.79
20	HOUSEKEEPING DC PER 1000 FEET $	86.91	111.22	114.85	120.51	125.29	122.51	122.85	118.65	128.74
21	HOUSEKEEPING MH PER 1000 FEET	41.03	50.04	50.75	52.21	52.22	48.43	48.53	45.49	42.50
22	LAUNDRY DC PER 100 POUNDS $	10.79	10.04	9.27	9.20	8.99	8.30	7.80	6.75	8.99
23	LAUNDRY POUNDS PER MH	20.27	25.40	28.30	27.52	31.76	34.23	40.04	41.48	37.35
24	LAUNDRY POUNDS PER PATIENT DAY	11.86	12.08	12.47	13.14	14.26	15.50	15.89	15.81	16.50
25	LINEN DC PER BED $	4.27	5.88	6.34	7.16	7.60	8.92	8.99	9.91	11.13
26	ADMINISTRATIVE + FISCAL DC PER BED $	129.53	136.80	148.09	157.28	184.86	203.74	210.07	207.54	314.04
27	-SALARY DC PER BED $	80.18	87.88	97.29	99.64	113.52	126.91	126.47	126.32	190.37
28	-MH PER BED	27.66	31.05	34.43	34.27	37.90	40.37	39.67	38.57	54.30
29	-OTHER EXP. -% OF NONSALARY EXP. %	10.62	9.51	9.23	9.99	9.75	10.20	10.39	10.14	10.87
30	EMP. HEALTH + WELFARE-% OF SALARIES %	6.73	6.78	6.95	7.24	7.90	8.01	7.73	8.27	8.86
31	DAYS REVENUE IN ACCOUNTS RECEIVABLE	72.09	75.00	71.08	71.90	68.01	67.56	65.19	62.54	79.04
32	INPATIENT REVENUE PER PATIENT DAY $	55.73	62.59	66.20	70.02	78.06	80.60	84.04	85.03	109.57
33	INPATIENT COST PER DAY - RCCAC $	56.48	59.45	64.00	66.11	72.09	74.32	76.49	77.06	106.79
34	FULL TIME EMPLOYEES PER BED	1.50	1.71	1.89	2.00	2.20	2.28	2.35	2.31	2.98
35	TOTAL EXPENSE PER PATIENT DAY $	61.03	64.74	68.62	70.98	77.72	81.42	83.57	83.80	120.05
36	NET REVENUE PER PATIENT DAY $	57.96	64.33	70.21	72.87	78.50	84.18	87.52	85.81	114.89
37	RES. FOR BAD DEBTS-% ACCT. REC. %	15.05	14.72	14.34	15.39	16.05	14.48	13.72	14.83	15.54
38	VAC+HOLIDAY+SICK PAY % OF SALARIES %	7.89	8.54	8.58	8.81	9.68	9.72	9.78	9.68	11.19
39	DC PER PHSYICAL THERAPY TREATMENT $	3.29	3.12	3.11	3.19	3.02	2.97	3.36	3.17	4.62
40	FULL TIME EMPLOYEE PER OCCUPIED BED	2.48	2.53	2.63	2.68	2.78	2.84	2.85	2.73	3.65
41	MED.+SURG. TURNOVER RATE	2.91	3.03	3.09	3.15	3.19	3.05	2.99	2.81	2.34
42	OBSTETRICAL TURNOVER RATE	2.75	3.09	3.63	4.27	4.76	4.85	5.26	5.83	5.54

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HOSPITAL ADMINISTRATIVE SERVICES

HAS 200 - 200M - (REV. 11/68) - 20360

HOSPITAL ADMINISTRATIVE SERVICES, AMERICAN HOSPITAL ASSOCIATION
Chicago, Illinois 60611

TO: State and Allied Associations

SUBJECT: HAS Median Data for National Bed Size Groups for Three Months Ending August 31, 1970

This report contains the following data concerning Radiology:

	MEDIANS NATIONAL BED SIZE GROUPS								
	Under 50	50-74	75-99	100-149	150-199	200-299	300-399	400 & Over	Teaching
Radiology:									
Inpatient Revenue a per cent of total Revenue	5.3	5.2	4.8	4.9	4.9	4.7	4.8	4.9	4.9
Outpatient Revenue a per cent of total Revenue	2.5	2.4	2.7	2.6	2.5	2.7	2.3	2.1	2.8
Expense a per cent of total Expenses	5.6	5.6	5.6	5.4	5.2	5.4	4.9	4.8	5.4
X-Ray Diagnostic Procedures per Admission	1.2	1.3	1.3	1.4	1.5	1.5	1.5	1.6	2.0
X-Ray Diagnostic Man-Hours per Procedure	1.0	1.0	1.0	1.1	1.2	1.2	1.3	1.3	1.6

NATIONAL GROUP MEDIANS FOR THREE MONTHS PERIOD ENDING AUG, 1970

	NATIONAL BED SIZE GROUPS								
	UNDER 50	50 74	75 99	100 149	150 199	200 299	300 399	OVER 400	TEACH-ING
REVENUE PERCENTAGES									
OBSTETRICAL NURSING UNITS	2.8	3.1	3.2	3.6	3.6	3.6	2.4	3.3	3.1
NURSERIES	1.0	1.1	1.4	1.6	1.6	1.9	1.7	1.8	2.0
DELIVERY AND LABOR ROOMS	0.8	0.9	1.0	1.0	1.0	1.2	1.1	1.2	0.9
TOTAL OBSTETRICAL SERVICE	3.3	3.9	5.1	5.6	5.3	6.2	6.1	5.5	5.8
MEDICAL + SURGICAL NURSING UNITS	48.4	47.4	47.1	47.0	46.9	46.6	47.6	47.5	44.9
OPERATING ROOMS	2.3	4.0	4.4	5.0	5.6	6.0	6.0	6.4	6.1
RECOVERY ROOMS	0.4	0.5	0.7	0.7	0.7	0.8	0.8	0.8	0.8
CENTRAL SERVICES + SUPPLY	4.3	3.7	3.5	3.3	2.9	2.6	2.4	2.2	1.5
INTRAVENOUS THERAPY	1.3	1.3	1.4	1.5	1.5	1.4	1.5	1.4	1.1
EMERGENCY SERVICES	1.5	1.8	2.0	2.0	2.5	2.9	2.5	2.3	1.8
LABORATORY--INPATIENT	9.2	9.3	9.2	9.1	9.4	9.1	9.3	9.1	10.3
--OUTPATIENT	1.3	1.0	1.2	1.2	1.1	1.2	1.1	1.2	2.0
BLOOD BANK	0.4	0.4	0.5	0.4	0.5	0.5	0.7	0.8	1.6
RADIOLOGY - INPATIENT	5.3	5.2	4.8	4.9	4.9	4.7	4.8	4.9	4.9
- OUTPATIENT	2.5	2.4	2.7	2.6	2.5	2.7	2.3	2.1	2.8
PHARMACY - INPATIENT	8.4	7.8	7.2	7.3	6.6	6.0	6.0	5.6	4.2
- OUTPATIENT	0.7	0.5	0.5	0.4	0.3	0.3	0.3	0.3	0.7
ANESTHESIOLOGY	2.6	2.9	2.8	2.7	2.0	1.8	1.7	1.5	1.9
INHALATION THERAPY	1.3	1.3	1.3	1.7	1.8	1.8	1.9	1.8	1.9
PHYSICAL THERAPY	0.9	1.2	1.3	1.0	0.9	1.0	1.0	0.8	0.7
OCCUPATIONAL + RECREATIONAL THERAPY	0.2	0.5	0.5	0.4	0.1	0.2	0.2	0.2	0.2
SOCIAL SERVICE	0.0	0.3	0.0	0.0	0.0	0.1	0.0	0.0	0.1
CLINICS	0.5	0.3	0.6	0.7	0.4	0.5	0.5	0.5	3.1
ALL OTHER PROFESSIONAL SERVICES	1.6	1.6	1.5	1.5	1.7	1.7	1.8	2.1	2.8
GROSS PATIENT REVENUE									
DEDUCTIONS FROM REVENUE									
CONTRACTUAL ADJUSTMENTS	-4.6	-4.5	-3.7	-4.8	-6.1	-5.7	-4.7	-5.2	-5.9
PROVISION FOR BAD DEBTS	-2.5	-2.1	-2.0	-2.3	-2.1	-1.9	-1.8	-2.0	-2.3
OTHER DEDUCTIONS	-0.4	-0.5	-0.3	-0.4	-0.4	-0.5	-0.7	-1.1	-1.6
TOTAL PATIENT REVENUE DEDUCTIONS	-6.8	-6.7	-6.2	-7.4	-9.6	-8.6	-7.2	-9.2	-12.0
OTHER REVENUES	1.5	1.7	1.6	1.9	2.1	2.3	2.3	2.5	3.7
MISCELLANEOUS NONOPERATING	0.8	0.7	0.8	0.7	0.6	0.7	0.8	0.7	1.2
TOTAL GROSS INPATIENT CHARGES	92.5	93.0	92.0	92.2	92.0	91.2	92.3	92.3	88.4
TOTAL GROSS OUTPATIENT CHARGES	7.5	7.2	8.1	7.7	8.0	8.7	7.6	7.6	11.5

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HOSPITAL ADMINISTRATIVE SERVICES

HAS 200 - 200M - (REV. 11/68) - 20360

NATIONAL GROUP MEDIANS FOR THREE MONTHS PERIOD ENDING AUG, 1970

	NATIONAL BED SIZE GROUPS								
	UNDER 50	50 74	75 99	100 149	150 199	200 299	300 399	OVER 400	TEACH-ING
EXPENSE PERCENTAGES									
NURSING SERVICE - ADM. OFFICE	1.2	1.2	1.3	2.1	1.9	1.8	1.7	1.5	1.6
NURSING SERVICE - OBSTETRICAL UNITS	0.9	1.8	2.2	2.2	2.0	1.8	1.5	1.3	1.1
NURSING SERVICE - NURSERY UNITS	0.6	1.0	1.2	1.2	1.3	1.4	1.3	1.4	1.3
MEDICAL + SURGICAL NURSING UNITS	25.9	24.7	24.1	23.3	22.0	21.6	21.5	21.2	18.7
TOTAL NURSING SERVICE	28.2	28.2	28.1	28.0	26.6	26.4	26.4	25.4	22.6
DELIVERY + LABOR ROOMS	0.4	0.6	0.7	0.9	1.1	1.3	1.2	1.2	0.9
OPERATING ROOMS	1.9	3.2	3.6	4.0	4.1	4.1	4.4	4.3	3.9
RECOVERY ROOMS	0.3	0.4	0.4	0.4	0.4	0.5	0.5	0.5	0.4
CENTRAL SERVICES + SUPPLY	2.7	2.7	2.5	2.4	2.4	2.3	2.2	2.1	2.1
INTRAVENOUS THERAPY	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.5	0.5
EMERGENCY SERVICE	0.6	0.9	1.2	1.4	1.8	2.1	1.8	1.9	1.4
LABORATORY	6.1	6.5	6.8	7.1	7.3	7.1	7.3	7.2	7.1
BLOOD BANK	0.3	0.4	0.5	0.5	0.6	0.6	0.6	0.9	1.2
RADIOLOGY	5.6	5.6	5.6	5.4	5.2	5.4	4.9	4.8	5.4
PHARMACY	3.8	3.9	3.6	3.8	3.5	3.3	3.4	3.4	3.2
ANESTHESIOLOGY	2.0	2.1	1.9	1.7	1.2	1.0	1.0	0.9	1.3
INHALATION THERAPY	0.5	0.5	0.5	0.7	0.9	0.9	1.0	0.9	0.8
PHYSICAL THERAPY	1.0	0.9	0.8	0.6	0.6	0.6	0.6	0.6	0.6
SOCIAL SERVICE	0.2	0.6	0.3	0.3	0.2	0.2	0.2	0.2	0.8
MEDICAL RECORDS	1.4	1.5	1.4	1.3	1.2	1.2	1.2	1.1	1.3
MEDICAL LIBRARY	0.3	0.2	0.1	0.2	0.1	0.1	0.1	0.1	0.1
ALL OTHER PROFESSIONAL SERVICES	0.6	0.7	0.8	0.9	1.0	1.0	1.2	1.6	2.3
DIETARY	9.2	8.8	8.6	8.3	8.3	7.9	7.9	7.9	7.0
PLANT ENGINEERING	5.4	5.1	4.8	4.7	4.7	4.7	4.8	4.9	5.4
HOUSEKEEPING	3.4	3.7	3.6	3.8	3.6	3.5	3.6	3.5	3.8
LAUNDRY + LINEN	2.3	2.1	2.1	2.0	2.0	1.9	1.9	1.7	1.7
ADMINISTRATION + FISCAL	11.9	10.6	10.0	10.1	10.2	10.4	10.5	10.2	11.7
EMPLOYEE HEALTH + WELFARE	3.7	4.0	4.2	4.2	4.6	4.9	4.9	5.2	5.7
DEPRECIATION	4.3	4.1	4.2	3.9	3.9	4.1	4.2	4.4	4.0
MISCELLANEOUS OPERATING	1.6	1.2	1.1	1.3	1.3	1.6	1.4	1.5	1.0
BASE TOTAL									
HOME HEALTH CARE	0.0	1.1	0.6	0.7	0.9	0.5	0.4	0.4	0.5
NURSING EDUCATION	0.4	0.5	0.6	0.5	0.5	1.5	1.8	1.8	1.3
MEDICAL STAFF	3.8	2.1	2.0	2.5	2.2	1.5	1.8	3.0	6.0
RESEARCH	0.0	0.0	0.0	0.0	1.0	0.9	0.4	0.2	1.4
CLINIC	0.5	0.7	1.5	0.5	0.9	0.5	0.5	0.6	2.4
PERSONNEL QUARTERS	0.5	0.3	0.2	0.2	0.3	0.4	0.3	0.2	0.4
MISCELLANEOUS NONOPERATING	0.6	0.4	0.7	0.7	0.6	0.9	0.7	1.0	1.0
SALARIES - % OF ALL EXPENSES	58.0	60.0	59.1	59.8	59.8	60.3	60.8	61.[illegible]	62.2
PROFESSIONAL FEES - % OF ALL EXPENSES	3.8	4.3	4.7	4.7	4.5	4.3	3.6	3.[illegible]	2.4

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HOSPITAL ADMINISTRATIVE SERVICES
HAS 200 - 200M - (REV. 11/68) - 20360

NATIONAL GROUP MEDIANS FOR THREE MONTHS PERIOD ENDING AUG, 1970

			NATIONAL BED SIZE GROUPS							
		UNDER 50	50 74	75 99	100 149	150 199	200 299	300 399	OVER 400	TEACH-ING
1										
2	NURSING ADMINISTRATION MH PER BED	3.59	3.25	4.31	7.72	7.60	7.55	6.97	6.09	9.27
3	OBSTETRICAL UNITS - % OCCUPANCY %	30.00	36.00	40.74	51.33	59.47	63.77	67.50	74.53	77.54
4	-% OF TOTAL ADMISSIONS %	10.85	12.16	12.67	13.58	14.05	14.68	13.67	13.75	15.31
5	-AVERAGE LENGTH OF STAY	3.50	3.47	3.51	3.71	3.79	3.91	3.98	3.95	4.20
6	-NURSING MH PER BED PER DAY	0.89	2.19	2.92	3.48	3.65	3.24	3.47	3.59	3.72
7	-DELIVERY + LABOR MH PER DELIVERY	4.39	5.95	6.66	9.27	11.15	14.69	15.47	15.23	17.07
8	-NURSERY MH PER BASSINET PER DAY	0.51	1.07	1.44	1.67	1.89	2.21	2.53	2.69	3.00
9	-DELIVERY + LABOR DC PER DELIVERY $	17.11	22.92	27.27	35.64	47.73	63.08	66.55	67.02	74.46
10	MED. + SURG. UNITS-% OCCUPANCY %	66.96	71.56	76.41	78.05	81.61	83.84	84.62	87.65	83.89
11	-O. R. VISITS PER 100 ADMISSIONS	27.18	35.43	41.10	47.96	52.61	59.13	59.54	59.74	64.47
12	-AVERAGE LENGTH OF STAY	6.80	6.90	7.16	7.27	7.78	7.96	8.24	8.93	10.27
13	-NURSING MH PER BED PER DAY	4.31	4.71	4.93	5.01	5.00	5.03	4.93	4.84	5.08
14	-NURSING MH PER PATIENT DAY	6.62	6.58	6.44	6.33	6.09	6.07	5.88	5.61	6.20
15	-% REGISTERED NURSES %	25.50	24.78	29.52	28.55	31.54	33.46	34.22	35.57	36.79
16	-% LICENSED PRACTICAL NURSES %	14.62	16.94	17.90	19.70	19.63	17.30	16.13	18.75	17.77
17	TOTAL NURS. SERV.- DC PER PT. DAY $	16.73	17.66	19.78	19.49	19.71	21.30	21.14	20.00	24.45
18	- MANHOURS PER BED PER DAY	4.16	4.72	4.97	5.30	5.29	5.40	5.34	5.31	5.71
19	OPERATING ROOM DC PER VISIT $	32.57	41.92	48.16	46.32	48.07	51.82	51.79	52.62	80.24
20	OPERATING ROOM MH PER VISIT	6.00	8.72	9.12	9.46	9.60	9.84	10.40	9.85	13.72
21	CENTRAL SERVICES DC PER LINE ITEM $	2.05	1.92	1.68	1.57	1.68	1.64	1.66	1.55	2.27
22	CENTRAL SERVICES LINE ITEM PER MH	2.63	3.30	3.37	3.99	3.61	3.53	4.03	3.47	2.61
23	EMERGENCY ROOM MH PER VISIT	0.57	0.68	0.84	1.09	1.21	1.30	1.42	1.50	1.47
24	CLINICAL LAB IP TESTS PER ADM.	9.82	11.63	12.61	13.72	16.18	17.85	19.20	23.23	31.05
25	CLINICAL LAB TOTAL TESTS PER MH	3.63	3.56	3.90	3.82	3.79	4.12	3.81	4.04	3.30
26	CLINICAL LAB DC PER TEST $	1.64	1.56	1.37	1.43	1.42	1.28	1.54	1.28	1.47
27	% OUTPATIENT CLINICAL LAB TESTS %	11.48	9.46	10.90	9.65	10.15	12.03	11.97	12.12	20.32
28	TOTAL LABORATORY TESTS PER MH	3.56	3.68	3.55	3.62	3.64	3.82	3.57	3.83	3.20
29	TOTAL LABORATORY DC PER TEST $	1.83	1.68	1.54	1.50	1.52	1.44	1.50	1.36	1.55
30	BLOOD BANK MH PER UNITS DRAWN	1.75	1.23	2.68	2.77	2.36	2.65	2.96	3.57	3.52
31	X-RAY DIAG. PROCEDURES PER ADM.	1.19	1.30	1.31	1.39	1.49	1.51	1.55	1.64	2.00
32	X-RAY DIAG. DC PER PROCEDURE $	6.21	6.12	6.09	5.94	6.53	6.80	7.54	7.59	9.93
33	X-RAY DIAG. MH PER PROCEDURE	1.01	1.01	1.01	1.06	1.11	1.18	1.31	1.31	1.61
34	% OP X-RAY DIAGNOSTIC PROCEDURES %	39.27	36.61	41.88	39.69	40.62	43.39	40.46	38.19	43.05
35	TOTAL X-RAY MH PER PROCEDURE	1.07	1.07	1.06	1.09	1.16	1.20	1.32	1.29	1.64
36	TOTAL X-RAY DC PER PROCEDURE $	6.66	6.51	6.36	6.24	6.96	6.90	7.46	7.91	9.91
37	PHARMACY LINE ITEMS PER MH	8.94	8.83	10.25	10.32	9.75	10.97	10.97	10.60	7.23
38	PHARMACY DC PER PATIENT DAY $	2.40	2.52	2.62	2.69	2.73	2.66	2.76	2.68	3.64
39	PHYSICAL THERAPY TREATMENTS PER MH	1.83	1.53	1.34	1.30	1.34	1.27	1.23	1.10	0.76
40	HOME CARE VISITS PER MH	0.0	0.28	0.29	0.35	0.49	0.34	0.37	0.26	0.31
41	SOCIAL SERVICE MH PER ACCEPTED CASE	0.0	3.62	4.42	4.35	4.67	5.02	6.67	6.35	6.58
42	IV THERAPY DC PER PATIENT DAY $	0.36	0.	0.46	0.47	0.44	0.48	0.50	0.	0.58

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HAS 200 - 200M - (REV. 11/68) - 20360

NATIONAL GROUP MEDIANS FOR THREE MONTHS PERIOD ENDING AUG, 1970

		NATIONAL BED SIZE GROUPS									
		UNDER 50	50 74	75 99	100 149	150 199	200 299	300 399	OVER 400	TEACHING
1											
2	MED. REC. MH PER DISCHARGE UNIT	2.05	2.15	2.20	2.09	2.27	2.22	2.16	1.97	1.78
3	MEDICAL RECORDS MH PER BED	6.03	6.83	7.38	7.21	7.50	7.69	7.67	7.18	10.60
4	ER + CLINIC VISITS PER BED	3.92	4.71	5.61	5.44	5.92	6.47	6.26	8.69	17.24
5	CLINIC MH PER VISIT	0.57	0.50	1.13	0.88	1.11	1.73	1.76	1.27	1.43
6	-DIETARY FUNCTION-									
7	SALARY, FOOD + SUPPLY COST PER MEAL $	1.31	1.38	1.41	1.38	1.41	1.45	1.48	1.42	1.56
8	FOOD + SUPPLY COST PER MEAL $	0.56	0.61	0.63	0.64	0.67	0.67	0.66	0.65	0.67
9	TOTAL MEALS SERVED PER PATIENT DAY	4.07	4.03	4.18	4.15	4.17	4.32	4.37	4.45	4.58
10	TOTAL MEALS SERVED PER MANHOUR	2.51	2.54	2.52	2.76	2.82	2.94	2.95	3.19	2.87
11	AVERAGE HOURLY SALARY-PATIENT FOOD $	1.81	1.92	1.93	1.97	2.13	2.25	2.36	2.35	2.60
12	AVERAGE HOURLY SALARY-CAFETERIA $	1.77	1.95	2.00	1.99	1.97	2.23	2.25	2.27	2.46
13	CAFETERIA MEALS SERVED PER MANHOUR	2.86	3.61	5.27	5.39	5.69	6.74	6.84	7.43	5.22
14	CAFETERIA REVENUE PER MEAL $	0.44	0.48	0.54	0.61	0.64	0.67	0.66	0.65	0.75
15	CAFETERIA MEALS PER EMPLOYEE-FT	0.51	0.49	0.51	0.49	0.51	0.54	0.54	0.56	0.60
16	PLANT DC PER BED $	60.29	66.24	70.67	74.89	85.00	93.10	98.12	97.48	145.51
17	PLANT DC PER 1000 FEET $	114.85	125.41	126.96	124.25	138.69	137.19	139.54	127.07	145.34
18	PLANT MH PER 1000 FEET	15.51	16.75	17.30	18.02	19.08	18.49	18.66	18.24	20.33
19	HOUSEKEEPING DC PER BED $	37.85	47.82	54.35	58.00	65.47	69.23	74.61	72.38	102.40
20	HOUSEKEEPING DC PER 1000 FEET $	90.89	107.53	114.88	120.03	125.68	122.92	125.41	118.74	129.58
21	HOUSEKEEPING MH PER 1000 FEET	44.11	50.34	51.78	52.27	53.98	48.56	49.88	45.31	44.25
22	LAUNDRY DC PER 100 POUNDS $	10.65	9.79	9.66	8.95	8.72	8.11	7.87	6.66	8.97
23	LAUNDRY POUNDS PER MH	20.21	25.43	28.50	27.52	32.68	34.22	38.28	40.24	37.88
24	LAUNDRY POUNDS PER PATIENT DAY	11.71	12.21	12.83	13.26	14.31	15.47	15.85	15.64	16.06
25	LINEN DC PER BED $	4.65	5.65	6.55	6.36	7.50	8.90	9.15	10.34	12.95
26	ADMINISTRATIVE + FISCAL DC PER BED $	130.91	134.20	146.27	155.41	184.96	203.75	210.69	212.39	321.86
27	-SALARY DC PER BED $	78.58	88.43	98.56	98.18	117.60	126.91	131.06	126.16	198.40
28	-MH PER BED	27.06	31.17	34.31	34.27	37.86	40.21	41.19	39.66	55.63
29	-OTHER EXP. -% OF NONSALARY EXP. %	11.15	9.72	9.11	9.79	10.14	10.45	10.48	10.06	11.72
30	EMP. HEALTH + WELFARE-% OF SALARIES %	6.28	6.81	7.06	7.08	7.73	8.17	7.99	8.37	8.80
31	DAYS REVENUE IN ACCOUNTS RECEIVABLE	72.33	73.16	69.98	69.92	67.17	65.85	65.27	63.20	82.15
32	INPATIENT REVENUE PER PATIENT DAY $	54.82	61.88	66.18	69.39	77.20	80.71	83.66	84.03	110.58
33	INPATIENT COST PER DAY - RCCAC $	54.36	58.30	62.77	64.05	70.22	74.22	76.29	76.19	106.54
34	FULL TIME EMPLOYEES PER BED	1.53	1.73	1.90	1.99	2.19	2.31	2.38	2.34	2.96
35	TOTAL EXPENSE PER PATIENT DAY $	58.21	63.07	68.45	68.83	76.49	83.07	84.96	81.68	121.70
36	NET REVENUE PER PATIENT DAY $	57.30	64.34	70.00	71.84	77.59	83.75	85.30	85.26	123.98
37	RES. FOR BAD DEBTS-% ACCT. REC. %	14.51	14.53	13.72	16.02	15.78	14.78	15.85	14.19	15.72
38	VAC+HOLIDAY+SICK PAY % OF SALARIES %	8.02	8.50	8.42	8.47	9.07	9.21	9.39	9.22	10.13
39	DC PER PHSYICAL THERAPY TREATMENT $	3.36	3.20	3.38	3.25	2.95	3.01	3.14	3.26	5.17
40	FULL TIME EMPLOYEE PER OCCUPIED BED	2.48	2.57	2.66	2.65	2.76	2.86	2.86	2.76	3.68
41	MED.+SURG. TURNOVER RATE	2.94	3.09	3.15	3.22	3.18	3.12	3.02	2.91	2.35
42	OBSTETRICAL TURNOVER RATE	2.50	3.00	3.62	4.15	4.59	4.76	5.26	5.5[illegible]	5.76

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