

ST. LOUIS AREA HOSPITAL INDUSTRY OVERVIEW

2006

**Financial and
Quality Performance**



“Consumer choice creates incentives at all levels and motivates the entire system to provide better care for less money. Improvements will come as providers see how their practice compares to others.”

— HHS Secretary Michael Leavitt

Letter to America’s Business Leaders From HHS Secretary Michael O. Leavitt

Dear CEO:

I am writing to invite you to play a leadership role in the movement toward transparency and value-driven health care purchasing. We all celebrate the advances in medicine that help us live longer and healthier lives. At the same time, we also know the challenges that our health care sector faces and realize that our health care dollars could be spent more effectively.

In August of this year, President Bush signed an Executive Order committing Federal health programs to provide meaningful, consistent information on both the quality and price of health care services. Under this initiative, participants in Federal health programs will be able to access quality and price information about the health care they receive. By making this information available, all stakeholders in the health care system will have better tools and incentives to improve care and maximize the value of their health care purchases.

I am asking you to support the four "cornerstone" actions of the recent Executive Order—interoperable health IT; transparency of quality; transparency of price; and incentives for high-value health care, thus building upon the good work already underway by the private sector and by broad-based, public-private collaborations. The Federal government and America's employers, working with health insurance plans and health care providers can help bring about uniform, consensus-based approaches for measuring the quality and cost or price of care and provide this information to consumers to help them make informed and confident health care choices. This information is critical to the growing number of Americans who are enrolling in consumer-directed health plans and is essential for improving patient care and enhancing the effectiveness of our health care system.

I encourage you to support the transformation of our health care system through the four cornerstones of value-driven health care by signing the Purchaser Statement of Support. This Statement of Support and other useful information can be found in this packet or online at: www.hhs.gov/transparency. If you have further questions, please contact HHS Value-driven Health Care at (202) 205-5552 or valuedriven@hhs.gov.

Sincerely,

Michael O. Leavitt, *Secretary*
U.S. Department of Health and Human Services

Four Cornerstones for Improving Health Care Value

1. Quality Transparency
2. Price Transparency
3. Interoperable Information Systems
4. Incentives that Recognize and Reward Value

BHC Supports the Four Cornerstones

The BHC appreciates Secretary Leavitt’s focus on better health care value and pledges to support broader adoption of the four cornerstones of value-driven health care in St. Louis.

1. Quality Transparency

- BHC will work to achieve broader quality measurement and public reporting in the St. Louis region.
- BHC will encourage the use of national consensus-based measures and metrics.
- BHC will act to increase awareness and use of the information by consumers, physicians, nurses and other health care professionals.

2. Price Transparency

- BHC will work to accompany quality measures with cost comparisons so that consumers can focus on value.

3. Interoperable Information (IT) Systems

- BHC will work to hasten the adoption of interoperable health information systems across the region.
- BHC will continue its requests of St. Louis hospitals and other health care providers to publicly report their progress toward IT implementations so that St. Louis citizens can utilize this information in seeking optimal care.

4. Positive Incentives

- BHC will work to develop and promote approaches that recognize and encourage high quality, cost effective health care. ■



Employer-sponsored health benefit premiums rose 7.7% in 2006, and 87% since 2000, according to the Kaiser Family Foundation. McKinsey projects by 2008 the average Fortune 500 Company will spend as much on health benefits as it earns in profits; up from 58% of after tax profits in 2000. Each year health benefits represent a larger portion of employees' total compensation thus reducing real income for many Americans in significant ways.

Individuals pay the health care bill every day in lower wages, higher taxes, higher costs for other goods and services, health insurance premiums (if insured), and in direct health care expenditures. Despite this, [consumers still lack basic information on health care cost and quality from which to make more effective health care decisions for themselves and their families.](#)

St. Louis hospital profits remain strong in 2004

St. Louis hospitals' operating and profit margins again exceeded national averages. Total profit hit the second highest level in 10 years. National sources report continuing hospital profitability in 2005 and 2006 with the same expectations for 2007.

Efficiency Matters

Still early in its analysis, this report provides a second year comparison of case-mix adjusted operating costs for St. Louis area hospitals. Three out of four St. Louis hospital systems' average 2004 case-mix adjusted operating costs were significantly higher than in 2003 and the gap widened between the best and worst performance. When hospital merger activity accelerated in the mid-1990s, the promised community benefit was improved efficiency from economies of scale and centralized management.

BHC will continue to report changes in this metric over time and is eager to applaud St. Louis hospitals for their improvements in efficiency. With hospital efficiency improvement initiatives underway for some time now, results are expected soon.

Investment needed in IT, not bricks and mortar

St. Louis' non-profit hospitals realized profits in excess of \$800 million in 2003 and 2004. Yet, no St. Louis hospital has announced operational bar code medication administration, computerized systems for order entry, or an electronic medical record. These information technology (IT) investments are needed to improve quality, efficiency, and ensure safety. Absent these systems, care coordination and quality suffer. St. Louis citizens should be kept apprised of progress in implementation of these systems.

Capital spending plans reported by St. Louis hospitals in the local media in 2006 approach \$400 million. A substantial amount of these will duplicate services, particularly outpatient cardiac and radiology.

[Startling gains in improving patient safety, advancing quality, eliminating infections, and also reducing cost are beginning to be reported nationally by top performing organizations.](#) The leaders of these organizations report making patient safety and quality improvement priority number one because it is the right thing to do, and also because it is the basis of a sound business model. Other common threads are substantial investments in IT, embracing performance measurement and transparency, redesigning care processes to become truly patient centered, and use of incentives to reward improvements by employees and physicians.

Reporting on Adverse Events and Infections

Health care infections affect 2 million people annually, cause 90,000 deaths, and add \$5 billion to our nation's health care bill according to the CDC. Recent research suggests that hospital-acquired infections most often occur from a breakdown in hospital procedures and are generally an avoidable outcome, even for the sickest patients. Leading hospitals now target zero hospital-acquired infections; learn how patients can protect themselves and help achieve this goal on page 21.

Following 2004 legislation, Missouri hospitals began reporting certain infection information to the Department of Health and Senior Services (DHSS) in July 2006. Central line infection rates for Missouri hospitals were provided by the DHSS on December 29, 2006. BHC is pleased to be able to include this information in this report and appreciates the effort that went into making it available. Caution is advised in drawing strong conclusions from this first report and data from a single point in time.

Adverse or "never" events are preventable occurrences that health care professionals agree should never happen. 25 states require adverse event reporting. Missouri does not. Public reporting is an important quality improvement tool. [Mandatory adverse event reporting is needed in Missouri.](#)

Transparency in Community Benefit Reporting

Provision of charity care by St. Louis area hospitals in 2004 was relatively flat for the fourth straight year even though the number of insured and underinsured remains high. In May 2006, the Missouri Hospital Association (MHA) began publicly reporting the community benefits provided by Missouri hospitals on its website. BHC commends MHA and Missouri hospitals for providing this information and for separating bad debt, Medicare and Medicaid shortfalls, and other categories of community benefit from charity care. In the continuing debate on uncompensated care and the adequacy of payments from public programs, it is important to consider these components separately.

Creating a Value Driven Health Care Market

During October 2006, HHS Secretary Michael Leavitt visited St. Louis to meet with physician and business leaders. During these sessions, the Secretary shared both his concern and optimism for American health care and listened to local perspectives. He requested leadership and collaboration from St. Louis physician and business leaders in securing value-driven health care by adopting the four cornerstones (details provided at left).

BHC holds a vision of St. Louis as a value-driven health care community that responds to consumers' right to know, encourages improvements in value, and recognizes and rewards those truly distinguished by their excellence. BHC is pleased with the commitment made toward this goal by the multi-stakeholder collaboration that began in 2006, Gateway Health Information Partners (GHIP). But much remains to be accomplished.

Reshaping St. Louis' health care market will be a tremendous accomplishment for our community, and it will be a significant challenge. As with most great undertakings, success will be the result of the commitment and cooperation of many. All health care stakeholders, most importantly the public, have a role to play. We encourage you to use this and other information to inform your health care decisions and improve health care value. ■

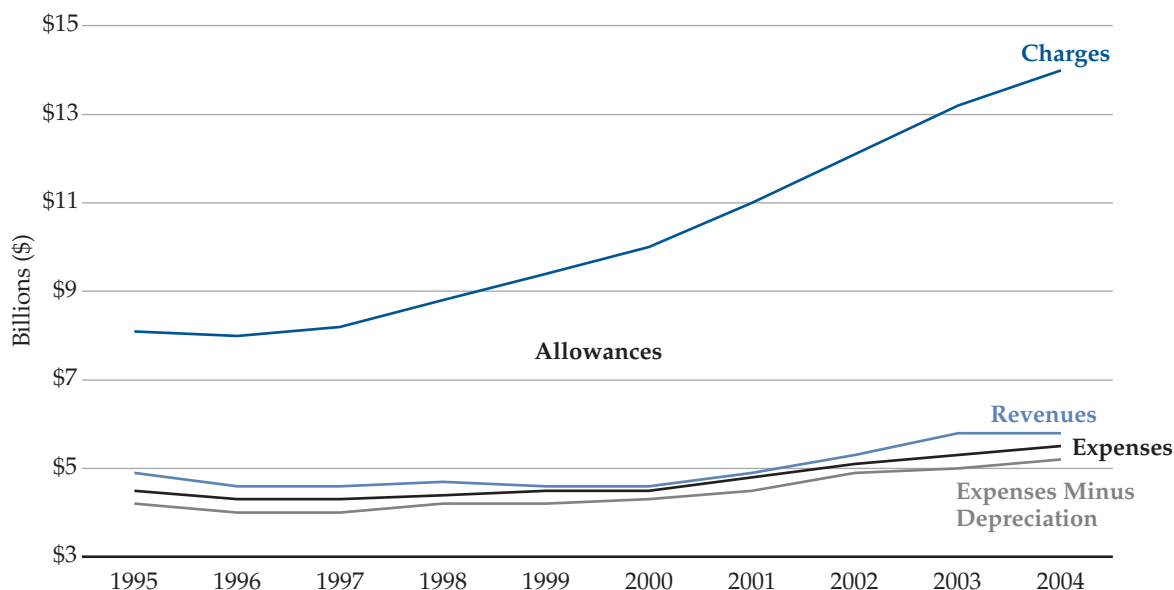


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As a result of limited access to information, this report largely focuses on hospitals, only one factor of the health care affordability crisis. BHC is committed to expanding its focus to provide a more complete picture of the St. Louis health care market. Public reporting is critical to improving the quality, safety, and affordability of our health care system. Consumers clearly want and deserve

comparative information on the cost and quality outcomes of health care treatments and providers. BHC calls upon the public and all sectors of the St. Louis health care community to work together to ensure access to this information to make health care work better for consumers and to secure the economic future of our community and nation.

Aggregate Charges, Revenues and Expenses St. Louis Area Hospital Industry Shown in 2004 Dollars



Revenues increased 1.2% in 2004.

Charges increased 6% in 2004.

Expenses increased 3.8% in 2004.

Source: Centers for Medicare and Medicaid Services Medicare Cost Reports and audited financial statements. Inflation adjustments are based on the St. Louis area CPI (including medical component), provided by the U.S. Labor Department. Hospitals that are part of consolidated organizations may not report all of their non-operating revenue and expenses by individual hospital and their cumulative effect may not be reflected in these results.

Revenue Growth leveled off in 2004, as hospital payment increases from all payers decelerated. Utilization of inpatient services grew at approximately the same rate as revenues. Despite the increasing amount of health care services being delivered by non-hospital owned providers, hospitals have enjoyed a sustained growth trend in operating and non-operating revenues. St. Louis hospitals' operating and profit margins performed well above national averages.

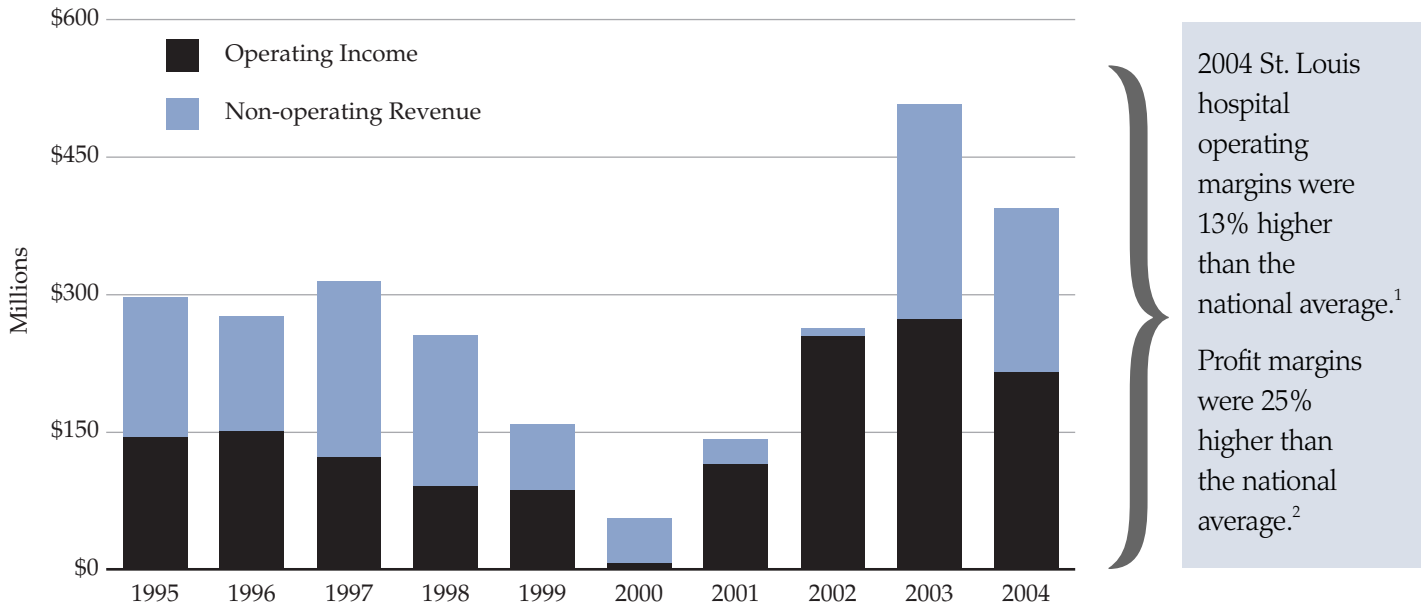
Charges increased substantially again in 2004. Most often, hospitals are paid a fixed rate for services, not charges, from public programs and health plans. Charges have been used to determine future reimbursement rates for procedures. This has resulted in undue charge inflation. In April 2006, Medicare took an important first step to end this practice by proposing to reconfigure its inpatient payment system to one that would weight diagnostic related groups (DRG) based on hospital costs rather than charges. Changing to a cost-based system will more closely align financial incen-

tives with resource use. In addition, CMS plans modest reductions in payments for some overly profitable surgical procedures and increase payments for less profitable, but very necessary medical treatment for stroke and lung disease. While directionally correct, the actual change in payments is small and, therefore, little immediate change in service line profitability is expected as a result of this realignment for community hospitals. However, the change in incentives over time should dampen the 10-year trend of unprecedented annual increases in charges.

Expenses for the St. Louis region grew at a modest 3.8% in 2004. This was about half the national rate of 6.9%. Growth in labor and pharmaceutical costs during this period was moderate. According to discussions with local hospitals, expenses were largely driven by investments in facility renovation and expansion, new services, and their associated costs. These investments will provide future growth in revenue for hospitals and an increasing cost burden for payers. ■



Aggregate Hospital Performance Total Profit Profile St. Louis Area Hospital Industry, 1995-2004



Source: Medicare Cost Reports, audited financial statements, and MHA/AHA Annual Licensing Surveys.

Revenue growth slowed and expenses grew in 2004. Despite a 10-year expense high, hospitals had their second highest rate of total profit during the same period. The average profit margin for the region was 6.5% with a range of profitability among hospital systems from -3% to almost 13% (see page 5 for individual hospital profits). St. Louis hospital **operating and profit margins** again well exceeded the national average.

Total profit information comes from publicly available reports provided by individual hospitals. Differences in accounting practices for expenses and investment income across hospital systems may understate some St. Louis hospital systems' profits. Although consistent with accepted accounting principles, hospital systems may allocate 100% of certain expenses (i.e., executive salaries, etc.) and investment income proportionately to individual subsidiary hospitals while others retain some or all of these dollars at the system level. BHC has worked to collect this information and adjust for differences as possible but due to limited access to data, viewers should make comparisons with this in mind. BHC will continue its efforts to fully accommodate these differences in future reports and will adjust data retrospectively to allow trends to be evaluated.

Where do profits go?

Despite two-year profits in excess of \$800 million for St. Louis' non-profit hospitals, no St. Louis hospital has operational computerized systems for provider order entry, bar code medication administration, or an electronic medical record. These tools have been demonstrated to save lives and save dollars. St. Louis citizens urgently need and deserve adoption of these information technologies by area hospitals. Details about St. Louis hospitals' investments in information technology should be publicly reported. BHC looks forward to recognizing St. Louis hospitals when these systems are operational.

The Centers for Medicare and Medicaid Services (CMS) in April 2006 proposed to significantly reduce Medicare payments for cardiovascular, cancer, and orthopedic services. Excess profits for these services have resulted in duplicative investments in cancer, heart and orthopedic hospitals. Considerable industry pressure persuaded Congress to adopt more moderate payment cuts. Special interest political pressures in health care must be more transparent so the public can be better engaged in these decisions. The public burden is simply too great. ■

2004 Hospital network data



System Name (market share ¹)	Avail. beds	Patient days	Avail. occup. %	Avg. LOS	FTE per occup. bed	Net profit	Profit margin	Profit margin net of deprec.
BJC HealthCare (29.59%)								
Alton Memorial Hospital	129	22,448	47.68%	4.01	4.5	\$ 20,215,095	19.91%	24.93%
Barnes-Jewish Hospital	1,193	280,010	64.30	5.53	6.9	125,914,602	11.58	17.05
Barnes-Jewish Hospital–St. Peters	95	24,417	70.42	3.80	4.7	12,900,820	14.35	19.02
Barnes-Jewish Hospital–West County	67	13,047	53.35	3.81	4.4	12,477,995	16.02	21.38
Christian Hospitals NE/NW	439	101,680	63.46	5.99	4.5	22,627,683	8.73	13.42
Missouri Baptist Medical Center	406	106,825	72.09	4.87	4.5	56,289,050	16.61	22.38
Missouri Baptist Hospital–Sullivan	59	9,030	41.93	4.47	2.9	3,477,349	9.90	14.00
St. Louis Children's Hospital	234	63,955	74.88	6.08	7.9	45,831,000	15.55	22.13
Network Total	2,622	621,412	64.93%	5.29	5.9	\$299,733,594	13.12%	18.61%
SSM Health Care (18.98%)								
Cardinal Glennon Hospital	164	43,779	73.14	8.07	6.3	\$ 30,280,353	16.04%	19.30%
DePaul Health Center	340	100,172	80.72	4.98	4.4	10,945,453	5.08	7.46
St. Joseph Health Center–St. Charles	246	71,002	79.08	4.55	3.8	1,729,509	1.27	4.74
St. Joseph Hospital–Kirkwood	238	32,451	37.36	4.06	4.6	–724,082	–0.78	3.40
St. Joseph Health Center–Wentzville	73	10,840	40.68	4.76	3.9	–5,568,514	–24.26	–17.72
St. Joseph West–Lake St. Louis	85	16,497	53.17	2.92	4.6	1,822,125	3.05	6.74
St. Mary's Health Center	435	84,229	53.05	4.59	5.1	15,369,555	7.04	11.28
Network Total	1,581	358,970	62.21%	4.76	4.7	\$ 53,854,399	5.77%	9.28%
St. John's Mercy Health Care (10.89%)								
St. John's Mercy Medical Center	844	201,992	65.57%	5.45	4.3	\$ 18,022,214	3.37%	8.93%
St. John's Mercy–Washington	157	21,879	38.18	3.53	4.7	2,779,412	3.82	11.18
Network Total	1,001	223,871	61.27%	5.17	4.3	\$ 20,801,626	3.43%	9.20%
Tenet HealthSystem (5.96%)								
Des Peres Hospital	127	36,693	79.16%	4.30	3.6	\$ 4,114,033	4.18%	7.77%
St. Louis University Hospital	332	96,553	79.68	6.38	4.0	–17,798,000	–5.82	–1.06
Network Total	459	133,246	79.53%	5.63	3.9	(\$ 13,683,967)	–3.38%	1.09%
Missouri Non-Merged, Non-Affiliated (19.94%)								
Forest Park Hospital ²	253	47,096	51.00%	4.60	3.9	\$–25,763,659	–24.69%	–18.10%
Jefferson Memorial Hospital	210	36,677	47.85	3.75	4.8	419,328	0.45	5.53
Kindred Hospital	56	10,471	51.23	29.50	3.8	3,573,892	19.64	28.29
Lincoln County Memorial Hospital	27	4,729	47.99	4.31	4.4	12,298	0.05	6.44
St. Alexius Hospital ^{2,3}	332	81,784	67.49	7.18	1.8	–7,140,204	–8.23	–1.29
St. Anthony's Medical Center	575	136,053	64.83	4.88	4.2	26,046,000	7.79	13.07
St. Luke's Hospital	390	83,415	58.60	4.50	4.8	11,215,000	4.06	9.37
Total	1,843	400,225	59.50%	4.94⁵	3.8	\$ 8,362,655	0.89%	6.56%
Illinois Non-Merged, Non-Affiliated (14.64%)								
Anderson Hospital	119	23,246	53.52%	3.80	5.1	\$–3,439,409	–4.28%	0.97%
Gateway Regional Medical Center	222	49,725	61.37	6.01	2.9	10,905,537	12.02	14.79
Kenneth Hall Regional Hospital (East St. Louis, IL) ⁴	169	15,589	25.27	5.09	4.7	2,123,652	4.91	7.65
Memorial Hospital of Belleville	313	67,568	59.14	4.63	5.0	–502,611	–0.31	5.19
St. Anthony's Health Center (Alton, IL)	111	27,473	67.81	3.77	4.9	–2,339,613	–2.63	0.65
St. Elizabeth's Hospital (Belleville)	270	69,218	70.24	4.93	4.5	–1,519,642	–1.04	4.74
St. Joseph Hospital (Breese, IL)	57	7,105	34.15	3.26	5.3	6,025,950	18.94	26.13
Touchette Regional Hospital	105	10,261	26.77	3.92	5.6	1,230,539	3.96	5.92
Total	1,366	270,185	54.19%	4.65	4.5	12,484,403	1.85%	6.90%
Aggregate for 34 St. Louis Hospitals	8,872	2,007,909	62.01%	5.03⁵	4.5⁶	\$381,552,710	6.53%	11.59%

¹ Market share percentages listed by each network are based on total number of discharges for the hospitals in the network. Hospital network configurations are current as of 2006.

² Forest Park Hospital, and St. Alexius Hospitals (formerly Alexian Brothers & SouthPoint Hospitals) were sold to Doctors Community Healthcare Corporation (DCHC) in November 2004 by Tenet Healthcare Corporation. Due to the transfer in ownership in 2004, 2004 data for these hospitals could not be verified.

³ St. Alexius-Broadway and St. Alexius-Jefferson Campus reported on a combined basis under St. Alexius Hospital.

⁴ St. Mary's Hospital of East St. Louis was acquired by the Southern Illinois Healthcare Foundation February 1, 2004 and was renamed Kenneth Hall Regional Hospital.

⁵ Kindred Hospital is not included in the aggregate average LOS figure because Kindred is a long-term acute care hospital.

⁶ St. Louis Area average excludes Barnes-Jewish Hospital and St. Louis University Hospital because they are teaching hospitals with higher numbers of FTEs.



Utilization growth flat in 2004

	1995	1996 ¹	1997 ¹	1998 ¹	1999	2000 ¹	2001	2002	2003	2004
Discharges²										
Medicare	141,606	138,186	134,941	132,780	133,623	144,245	156,330	162,700	161,665	167,798
Medicaid	55,032	51,212	47,656	44,890	46,960	53,770	56,924	59,781	64,082	62,458
Other	154,172	154,715	166,455	172,025	167,027	148,374	158,128	160,464	163,056	167,114
Total	350,810	344,113	349,052	349,696	347,610	346,389	371,382	382,945	388,803	397,370
Inpatient Days²										
Medicare	1,015,363	927,986	884,557	833,923	841,192	886,167	904,159	952,302	958,425	987,742
Medicaid	292,765	253,741	228,163	233,863	252,272	276,843	281,161	308,338	327,655	330,449
Other	662,780	623,289	635,816	670,939	703,165	649,387	656,763	650,086	678,112	689,718
Total	1,970,908	1,805,016	1,765,393	1,738,726	1,796,629	1,812,397	1,842,083	1,910,726	1,964,192	2,007,909
Avg. Length of Stay³										
Medicare	7.2	6.7	6.5	6.2	6.2	6.1	5.7	5.8	5.9	5.9
Medicaid	5.3	4.9	4.8	5.2	5.4	5.1	4.9	5.1	5.1	5.3
Other	4.3	4.0	3.9	3.9	4.2	4.4	4.1	4.0	4.1	4.1
Total	5.6	5.2	5.0	4.9	5.1	5.2	4.9	5.0	5.0	5.1
# of Hospitals	40	39	39	39	39	38	35	35	35	34

¹ As a result of hospital mergers in fiscal years 1996, 1997, 1998, and 2000, incomplete utilization data for those years was estimated to reflect 12 months. Utilization trends in 1999 and 2000 were affected by the closure of four hospitals.⁷

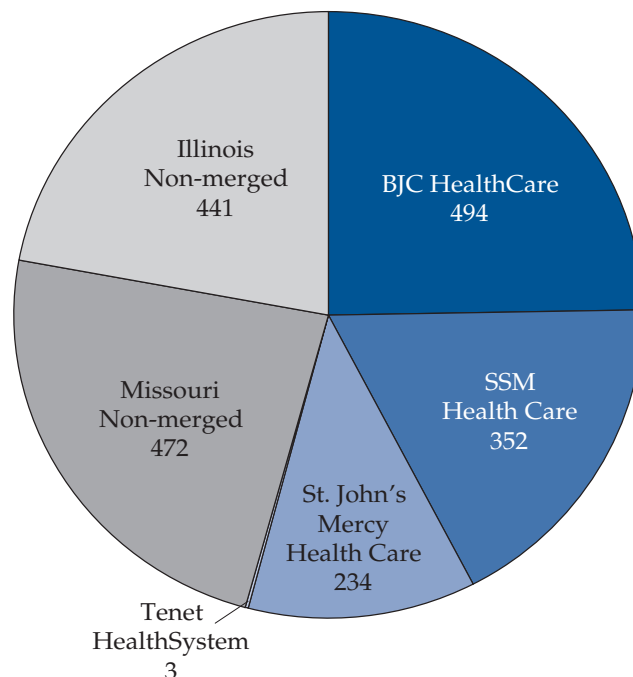
² Utilization categories are defined as 1) Medicare managed care (starting in 1997) and fee for service (indemnity) programs, 2) Medicaid managed care and traditional programs, and 3) Other, including commercially insured, and the uninsured. Changes to previously reported data are based on the most current information.

³ Kindred Hospital is excluded from average length of stay because it is a long-term acute care hospital.

Independent hospital beds decline—excess bed capacity remains high

- In 2004, St. Louis hospitals reported a decrease of 16% in the number of excess beds over 2003. **1,996 excess available acute care beds were reported.**
- Actual beds increased slightly at BJC, SSM, and St. John's Mercy, the three largest hospital systems and declined by a greater number at independent hospitals.
- **Patient days and discharges** increased 2% during this period driven primarily by Medicare growth. 2004 aggregate St. Louis hospital occupancy was 62.01% up from 59.23% in 2003.

Excess Available Beds in 2004 per Network (assuming 80% occupancy is the equivalent of "full")



Sources: Centers for Medicare and Medicaid Services Medicare Cost Reports and internal utilization statements. Hospital network configurations are current as of 2006.

Inpatient Utilization 1996—2004

Hospital occupancy in St. Louis reached its **lowest point of 49.61% in 1996**, the last year of health plans' managed care efforts to reduce unnecessary inpatient admissions. During the nine years that followed, inpatient utilization increased significantly. At the same time, four hospitals closed and available beds were reduced by some of the remaining non-merged hospitals. This combination of factors resulted in a 25% increase in occupancy.



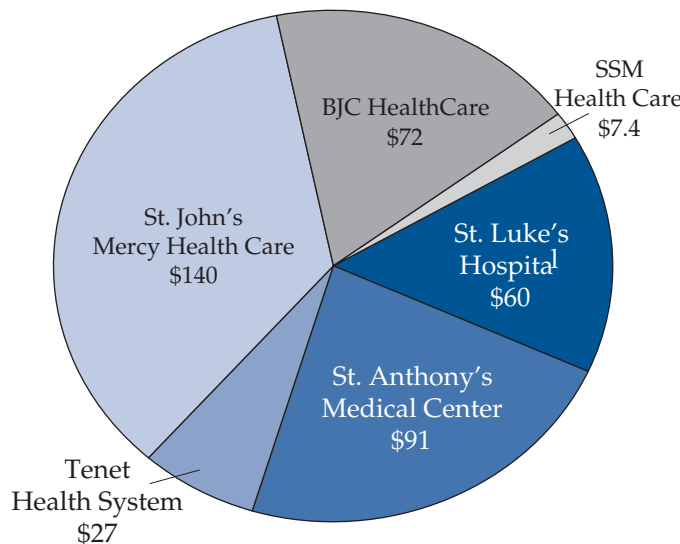
Capital spending plans reported by St. Louis hospitals in the local media in 2006 approach \$400 million. This number is underestimated by the capital expenditures that have not been publicly reported. While some of the investments provide access to new medical treatments, a substantial amount of resources target facility expansion that will duplicate services, particularly outpatient cardiology and radiology diagnostic services. The overbuilding of service centers in these areas mirrors a national trend of investing in services that favor higher payments and return on investment, even when the additional capacity cannot be justified by patient need.

Recognizing that the incentives currently embedded in some payment methods reward capital spending regardless of medical need, CMS proposed to reduce payments for cardiac and orthopedic procedures in April 2006. However, members of Congress and industry were successful in reversing or delaying most of the payment cuts.

In recent years, hundreds of millions of dollars have been spent on renovation and expansion. **While the baby boomers are aging and service use will likely increase, the St. Louis metropolitan area is projected to make only a modest gain in population of 6% over the next 15 years.**³ Yet, current levels of hospital investment and expansion nearly match that of other U.S. cities such as Denver that is expecting 15-year population growth as high as 26%.⁴ **St. Louis' expansion strategy will likely result in further duplication of services and excess capacity financed by taxpayers and a shrinking base of privately insured.**

Information technology and (IT) investments are critically needed to improve quality, efficiency, and patient care processes, ensure basic safety, reduce duplication of services, and even reduce the need for additional capacity (see promising news in blue box below), yet few were reported. ■

2006 Reported Capital Spending Plans, St. Louis Area Hospitals, (in millions)



Information technology reduces need for more capacity

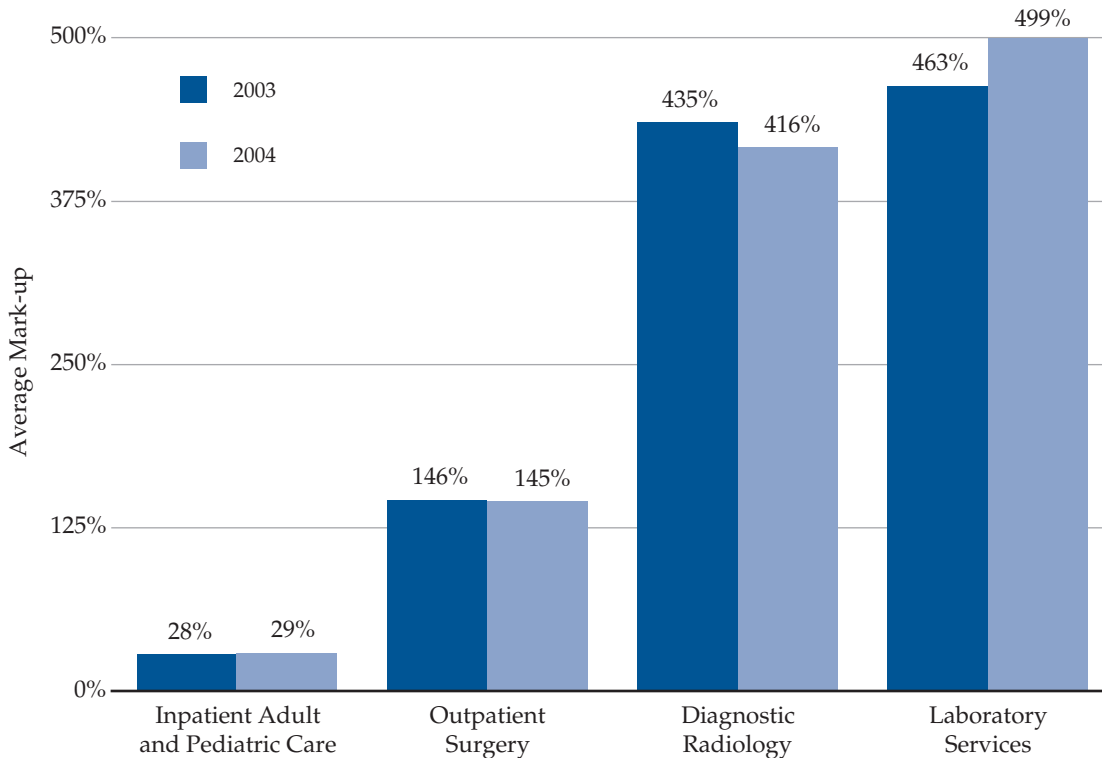
Information technology innovations are transforming the health care delivery system. Improvements in quality and patient safety have overshadowed an important byproduct of this technology – better efficiency. In some cases improvements in efficiency have reduced the need for building additional hospital capacity. **For example, new software currently in use in Washington D.C. resulted in the ability of the emergency department of a busy hospital to handle more than twice as many patients per year. This allowed 70% of them to be diagnosed and treated or admitted in 3 hours or less, down from wait times of 9 hours.** This was accomplished with only a 5% increase in staff and an increase of only a few rooms. ■

Source: Lohr, S., "Microsoft to Offer Software for Health Care Industry," *New York Times*, July 27, 2006.

BJC HealthCare	Siteman Cancer Center \$20 million; Real estate: Chesterfield \$8 million. Missouri Baptist Medical Center: New emergency room (ER), ICU, Orthopedic/Spine Center.
SSM Health Care	DePaul Health Center: ER expansion. St. Mary's Health Center: Vector Vision technology for joint implants.
St. Anthony's Medical Center	Four-story addition: Children's ER, Private rooms, Operating room renovation, Cardiac, Orthopedic, Interventional Radiology services.
St. John's Mercy Medical Ctr.	New Heart Hospital and Emergency Center.
St. Luke's Hospital	New Outpatient Center: Cardiology, Imaging, Rehabilitation, Sports Medicine.
Tenet Health System	Imaging, IT upgrade, Rehabilitation, Cardiac ICU.



Average Mark-up by Hospital Service St. Louis Area Hospital Industry, 2003 to 2004



Average mark-up approximates the relationship between the charge and the cost of providing services. A mark-up of 0% indicates the charge equals the cost of providing the service. A mark-up of 100% indicates charges double the cost of providing the service.

Sources: Centers for Medicare and Medicaid Services Medicare Cost Reports.

In 2004, hospitals continued to lose money on inpatient care but made it up on high margin outpatient and ancillary services. Outpatient average mark-ups remained at five and six times the cost.

Since hospitals are most often paid a negotiated rate that is less than charges, **average mark-up** does not portray the actual profit margin for a service, rather, the relative profitability of services. **It is included here to provide important information about one of the many misaligned financial incentives in health care and to encourage needed reductions in ancillary and outpatient service markups.**

High margins help to justify capital investments and result in an oversupply of expensive service sites and technology. Medical research indicates that for certain services, more service supply results in services being provided to individuals absent medical indication. Economic rewards must align investment decisions with medical need. ■

	Low Mark-up	High Mark-up
Inpatient Care	-66%	206%
Outpatient Surgery	22%	532%
Diagnostic Radiology	94%	958%
Laboratory Services	126%	860%

Space did not allow mark-up by service type for individual hospitals to be included in this report. This information may be obtained from the BHC.

The Dilemma of Supply-induced Demand

Differences in the use of and spending for medical services are not the result of having more sick people in a region. Recent research by John Wennberg, MD of Dartmouth Medical School suggests the primary reason for the differences is the capacity of services. When facilities are available, physicians find a way to use them.

Based on capital expansion plans, St. Louis is on the verge of having a substantial amount of new inpatient and outpatient capacity with no end in sight. **The time to exert market discipline by reducing economic incentives is long overdue.**

Average mark-up percentage by network 1995–2004



System Name	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
BJC HealthCare										
Alton Memorial Hospital	89.1%	112.5%	111.7%	103.0%	125.1%	142.3%	178.2%	190.7%	194.8%	203.5%
Barnes Hospital ¹	79.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Barnes-Jewish Hospital	N/A	84.8	89.8	91.1	104.8	121.7	124.8	114.6	121.6	129.7
Barnes-Jewish Hospital–St. Peters	87.9	100.0	114.0	118.9	131.5	147.0	157.5	171.6	169.1	162.5
Barnes-Jewish Hospital–West County	76.0	87.3	85.5	97.4	104.9	124.4	153.1	162.3	171.0	172.2
Christian Hospitals	99.2	128.7	126.6	119.2	127.2	136.2	144.7	181.7	179.4	182.2
Jewish Hospital ¹	70.9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missouri Baptist Medical Center	97.9	120.1	120.5	126.0	130.8	136.5	153.8	168.1	167.6	168.4
Missouri Baptist Hospital–Sullivan	61.6	70.3	61.8	79.7	66.7	92.8	107.3	123.3	126.3	131.2
St. Louis Children’s Hospital	27.6	35.0	37.8	43.6	51.5	50.4	51.3	52.4	52.1	60.5
Network Total	77.3%	91.1%	94.1%	95.5%	106.0%	118.2%	125.8%	128.5%	132.1%	138.4%
SSM Health Care										
Cardinal Glennon Hospital	41.4%	58.3%	62.1%	64.4%	86.8%	98.2%	92.7%	103.9%	122.4%	121.2%
DePaul Health Center	91.7	101.5	102.0	118.9	131.4	143.8	148.6	180.4	199.0	214.5
St. Joseph Health Center–St. Charles	80.6	101.2	109.4	116.5	140.9	154.9	171.3	193.6	228.4	225.9
St. Joseph Hospital–Kirkwood	88.0	97.8	114.7	138.6	151.1	152.7	170.4	198.4	214.3	202.5
St. Joseph Health Center–Wentzville ²	57.0	52.4	80.3	N/A	73.9	41.5	77.1	93.9	120.9	109.7
St. Joseph Hospital West–Lake St. Louis	82.9	99.3	107.7	131.5	159.2	161.6	187.5	202.7	237.6	235.8
St. Mary’s Health Center	74.8	99.6	117.8	127.4	144.8	164.2	171.5	188.9	208.0	215.3
Network Total	73.9%	91.5%	101.0%	113.5%	129.5%	142.2%	151.0%	172.6%	195.4%	196.3%
St. John’s Mercy Health Care										
St. John’s Mercy Medical Center	86.3%	81.5%	90.9%	107.9%	105.5%	109.1%	116.6%	116.9%	125.5%	142.6%
St. John’s Mercy Hospital–Washington	106.8	104.1	108.3	125.3	111.5	113.0	130.4	133.6	132.6	153.0
Network Total	88.9%	84.5%	93.2%	110.2%	106.3%	109.6%	118.5%	119.2%	126.4%	143.9%
Tenet Health System										
Des Peres Hospital ³	76.9%	85.0	107.1%	115.4%	178.8%	231.7	250.0%	279.8	359.6%	345.1%
St. Louis University Hospital ³	49.8	41.7	65.1	41.4%	98.0	109.1	182.9	170.8	216.9	225.9
Network Total	54.2%	48.9%	68.1%	51.8%	111.8%	130.7%	197.6%	194.9%	248.7%	251.9%
Missouri Non-Merged, Non-Affiliated										
Forest Park Hospital ⁴	78.1%	82.4%	80.4%	108.3%	135.6%	151.2%	221.8%	238.6%	277.8%	210.9%
Jefferson Memorial Hospital	101.3	90.3	93.3	98.0	101.2	101.5	100.4	98.2	95.6	112.8
Kindred Hospital	171.8	195.3	177.1	176.6	201.4	183.0	160.0	165.3	183.1	193.0
Lincoln County Memorial Hospital	89.0	76.9	69.5	63.6	74.7	68.6	74.2	83.3	72.0	83.8
St. Alexius Hospital ⁵	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	229.8
St. Alexius Hospital–Broadway Campus ⁴	74.4	63.1	77.4	68.7	63.8	51.9	68.8	115.9	297.1	N/A
St. Alexius Hospital–Jefferson Campus ⁴	122.9	84.4	99.2	112.5	161.2	206.8	243.2	273.3	226.8	N/A
St. Anthony’s Medical Center ⁶	102.8	100.9	97.9	108.3	104.3	113.9	109.8	93.7	107.5	119.7
St. Luke’s Hospital	99.4	87.9	90.0	109.4	108.1	112.7	118.4	117.9	116.6	125.8
Total	97.0%	90.7%	94.1%	106.6%	113.0%	121.8%	136.2%	135.5%	143.3%	145.0%
Illinois Non-Merged, Non-Affiliated										
Anderson Hospital	73.1%	81.3%	94.0%	100.2%	98.4%	106.1%	109.7%	104.3%	115.1%	126.2%
Gateway Regional Medical Center ⁷	81.1	110.5	113.7	129.6	128.5	115.3	96.7	153.1	189.3	232.5
Kenneth Hall Regional Hospital (E. St. Louis) ⁸	26.8	35.7	33.8	14.6	17.0	9.3	21.3	18.9	21.2	30.7
Memorial Hospital of Belleville	77.7	91.2	98.9	93.4	96.5	97.9	97.2	106.7	108.4	109.3
St. Anthony’s Health Center (Alton) ⁹	108.2	130.4	150.3	188.8	176.5	194.8	208.4	213.4	215.7	223.0
St. Elizabeth’s Hospital (Belleville)	100.4	90.9	103.4	106.0	110.8	113.6	112.2	122.3	128.9	114.8
St. Joseph Hospital (Breese, IL)	54.2	48.2	63.2	64.5	68.7	70.7	71.2	80.1	88.1	91.7
Touchette Regional Hospital	62.9	46.0	61.8	43.4	42.3	36.7	41.0	59.0	49.8	55.6
Total	82.0%	90.7%	101.1%	105.0%	104.6%	106.7%	107.1%	120.3%	128.6%	135.2%
Aggregate for 34 St. Louis Hospitals	78.5%	84.5%	92.2%	97.9%	107.0%	120.9%	133.2%	139.3%	152.6%	157.7%

¹ Barnes Hospital and The Jewish Hospital of St. Louis merged to become Barnes-Jewish Hospital in fiscal year 1996. Their combined 1996 Medicare Cost Report (MCR) included 11 months of Barnes Hospital data and 12 months of Jewish Hospital data.

² St. Joseph Health Center–Wentzville (as the former Doctors Hospital–Wentzville) filed a 7 month Medicare Cost Report for 1996 and fiscal year 1998 information was unavailable. They filed an 8.5 month MCR for fiscal year 2000 just prior to acquisition by Essent Healthcare of Missouri June 28, 2000 and were renamed Crossroads Regional Hospital. They were acquired by SSM Health Care in November 2005 and are currently shown as part of SSM Health Care.

³ Des Peres and St. Louis University Hospitals reported 11 months of data in 1998.

⁴ SouthPointe Hospital was renamed St. Alexius Hospital–Jefferson Campus in 2003. Forest Park Hosp., St. Alexius Hosp.–Broadway Campus (formerly Alexian Bros. Hosp.), and St. Alexius Hosp.–Jefferson Campus were sold to Doctors Community Healthcare Corp. in November 2004 by Tenet Healthcare Corp. Due to this transfer in ownership, 2002, 2003 & 2004 data could not be verified.

⁵ Beginning in 2004, St. Alexius-Broadway Campus and St. Alexius-Jefferson Campus reported on a combined basis under St. Alexius Hospital

⁶ From 1997 to 1999, statistics for St. Anthony’s Medical Center and St. Clement’s Hospital are combined under St. Anthony’s Medical Center.

⁷ Gateway Regional Medical Center (formerly St. Elizabeth’s Medical Center of Granite City) was acquired by Community Health Systems on January 1, 2002.

⁸ St. Mary’s Hospital of East St. Louis was acquired by the Southern Regional Healthcare Foundation February 1, 2004 and was renamed Kenneth Hall Regional Hospital.

⁹ Statistics for St. Anthony’s Hospital and St. Clare’s Hospital are combined under St. Anthony’s Health Center.

Sources: Centers for Medicare and Medicaid Services Medicare Cost Reports and audited hospital financial statements. Data in this table not adjusted for inflation. Note: Changes in previously reported data are based on most current information. Hospitals no longer in operation as of 2004 are not individually listed, but their results for 1995–2004 are included in aggregate figures. Hospital network and affiliate configurations shown on this page are current as of 2006.

Health care is paid for by all Americans, whether they have health benefit coverage or not. Although the money is collected and distributed through government and employer based programs, the American public is the end payer. Individuals pay for health care directly, through premium contributions and service fees when they use care, and indirectly, in less apparent, but very costly ways that reduce real income significantly for many Americans.

Growing health care cost reduces workers' wages and the number of jobs. It also seriously challenges individuals' ability to afford other goods and services. Employer-sponsored health coverage premiums rose 7.7% in 2006.⁵ When increases in employee out-of-pocket payments are considered; **health benefit trends have grown almost three times as much as workers' earnings and overall inflation again this year.** As a result, each year health benefits represent a larger portion of employees' total compensation. Due to high premium cost, some workers decline health care coverage, even when their employer covers a sizable portion of the premium.

Most products and services have health benefit costs embedded in them. This means that American products are more expensive locally, to Americans and abroad. General Motors reported in 2005, that each car it produced had more than \$1,500 of health benefit costs. Starbucks now says it spends more on health care than coffee. McKinsey projects by 2008 the average Fortune 500 company will spend as much on health care benefits as it earns in profits; up from 58% of after tax profits in 2000. Many small businesses simply cannot afford the expense and some experts worry innovation will be stifled in the next decade.

Through taxes, the American public finances the health benefit cost of public sector employees and government programs such as Medicare, Medicaid and other social services. Local municipalities and other public sector employers face the same tough decisions as private employers in attempting to maintain health benefit levels. The public willing, these entities can raise property or other taxes to cover health care expenses. If not, they must find ways to trim other expenses or divert resources from salaries for teachers, fire fighters, police officers, or other services. ■

What are the factors driving health care cost increases?

PWC's work to define and quantify health care cost drivers in 2005 is illustrated in the table at right. Beyond general inflation, cost increases are influenced by a mix of increases in price and utilization. Health care providers often charge higher prices to insured patients to make up for the portion of medical costs left unpaid by the uninsured and Medicaid. According to PWC, this "cost shifting" contributed 6% to 2005's cost increase (see St. Louis specific cost shift figures, page 16). New technologies play an even larger role.

Interestingly, the next largest contributor to higher prices is the broad access to providers offered by health plans and provider consolidation into larger merged organizations. Both of these factors are present in St. Louis. For example, half of the region's hospitals are consolidated into two hospital systems. Broad access and provider consolidation tend to reduce competition that drives higher prices.

Utilization increases, accounting for 43%, were the leading cause of higher cost. Age and lifestyle issues such as obesity, smoking, and physical inactivity are widely acknowledged drivers of service use. Diagnostic testing and defensive medicine also exert a powerful force on utilization as well as new treatments for serious illnesses and "lifestyle" drugs. The most important factor in this category was the considerable information on medical treatments available from internet and direct-to-consumer advertising increasing demand from consumers.

Increase in Premium Costs by Component, 2005

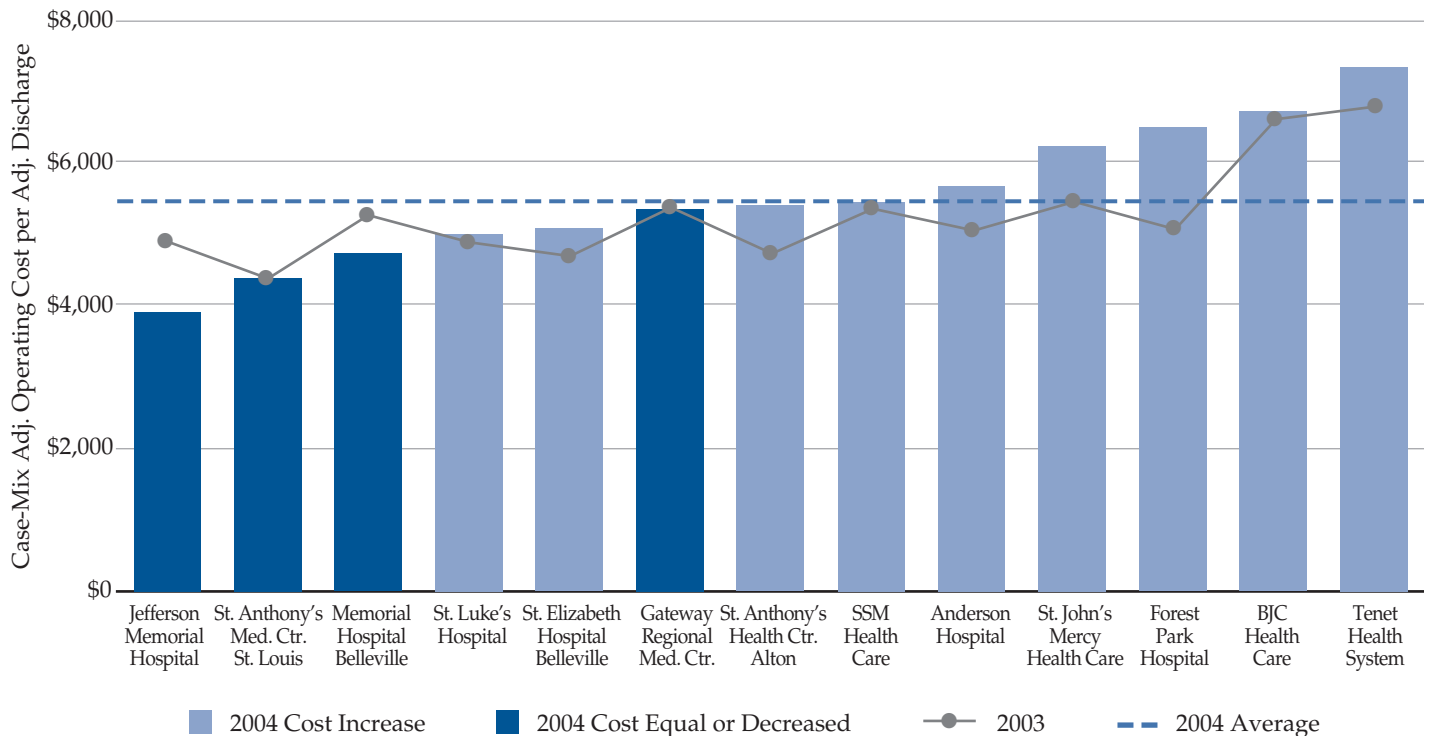
<u>General Inflation</u>	<u>27%</u>
Health Care Price Increases in Excess of Inflation (Above CPI)	<u>30%</u>
6% Cost Shifting	
11% Higher Priced Technologies	
13% Broader Access Plans/ Provider Consolidation	
<u>Increased Utilization</u>	<u>43%</u>
6% Age	
3% Lifestyle	
11% New Treatments	
9% More Intensive Testing/Defensive Medicine	
14% Increased Consumer Demand	

Source: PriceWaterhouseCoopers (PWC) *The Factors Fueling Rising Healthcare Costs 2006*.

Costs of the uninsured, public programs, the building boom, broad networks, provider consolidation, and high use of services are working together to fuel healthcare inflation. Not only is this making health insurance unaffordable, it is creating an unsustainable financial burden on life in America as we know it. ■



Hospital Cost per Discharge, 2003 to 2004



Source: Ingenix ReimbursementAnalysis using publicly available data including CMS Medicare Cost Reports, audited financial statements, MHA/AHA Annual Licensing Surveys, and Commercial insurance. Adjusted Patient Discharges exclude SNF and Home Health and are derived by dividing total discharges by the ratio of inpatient gross charges to total gross charges. Long term acute care, was excluded from the average. Lincoln County Memorial, Kenneth Hall Regional, Kindred, St. Alexius, St. Joseph – Breese, and Touchette Regional Hospitals cost data were excluded from this analysis.

Using case-mix adjustment to accommodate for differences in patient illness severity, a comparison of adjusted operating costs for St. Louis area hospitals is reported for the second year. This case-mix adjustment is based on data from both commercial and Medicare claims for each hospital. When hospital merger activity accelerated in the mid-1990s, the promised benefit for the community was improved efficiency from centralized management and cost reduction from economies of scale. In an effort to make comparisons easier and to better understand system performance, hospital performance is aggregated into an overall system score. The case-mix adjusted cost shown in the chart above provides a two-year direct comparison of individual St. Louis area hospitals and the BJC, SSM, St. John's, and Tenet hospital systems.

In the chart above, hospitals in light blue had cost increases in 2004 and those in dark blue appeared to hold costs at 2003 levels or below. Three out of four St. Louis hospital systems had significantly higher than average costs in 2004 compared to the remaining facilities. **In 2004, the gap widened to 88% between St. Louis hospitals' average highest and lowest cost per discharge.** This disparity has increased by more than one-third between 2003 and 2004.

Efficiency matters to both employers and the community. Hospital cost is one of the major drivers of

health benefits cost. This is BHC's second year of tracking St. Louis hospitals' comparative hospital cost performance. Although it is hard to interpret, trend data will make this information more meaningful. Three-year trend data on hospital cost performance will be available in the next hospital report. BHC is eager to recognize hospitals that realize improvements in efficiency.

Methodology

Provided by ReimbursementAnalysis, a consulting solution from Ingenix, that analyzes profitability and reimbursement rates by payer group (i.e., Medicare, Commercial, etc.) and provides unit cost benchmarking. In this analysis, costs included in operating expenses unrelated to net patient revenues (i.e., cafeteria, parking lot, research, etc.) and those related to SNF and Home Health were removed from each hospital's operating expenses. The resulting expenses related to net patient revenues were divided by the adjusted patient discharges, excluding SNF and Home Health discharges, to calculate an average cost per adjusted patient discharge and then divided by the case-mix index. The case-mix index was estimated by weighting the Medicare and commercial case mix based on discharges. ■



Understanding variation in health care is held out by many as the key to improving health care efficiency, quality, and equity. Dr. John Wennberg, Director of the Center for Evaluative Clinical Sciences (CECS) at Dartmouth Medical School, pioneered small area variation research and has contributed greatly to understanding variation in health care. His work demonstrates that much of the variation in care utilization is related to the variation in medical opinion and supply of resources in local markets. It also illustrates that higher spending often does not result in better outcomes. In 2006, Wennberg and colleagues studied variation in hospital care of seriously ill patients. BHC is pleased to summarize the results of this Dartmouth Atlas study and to report on St. Louis hospitals' aggregate and individual findings. The complete report is available on the Dartmouth Atlas of Health Care website: <http://www.dartmouthatlas.org/>

Why Medicare is the Data Source: Medicare offers a large, accessible, and homogenous dataset (all enrollees are over 65 with the same levels of coverage, and same administrative practices). Other research comparing care quality and cost variations in the Medicare population with the commercial population suggest that findings from Medicare data are likely to be consistent with similar research using commercial data.

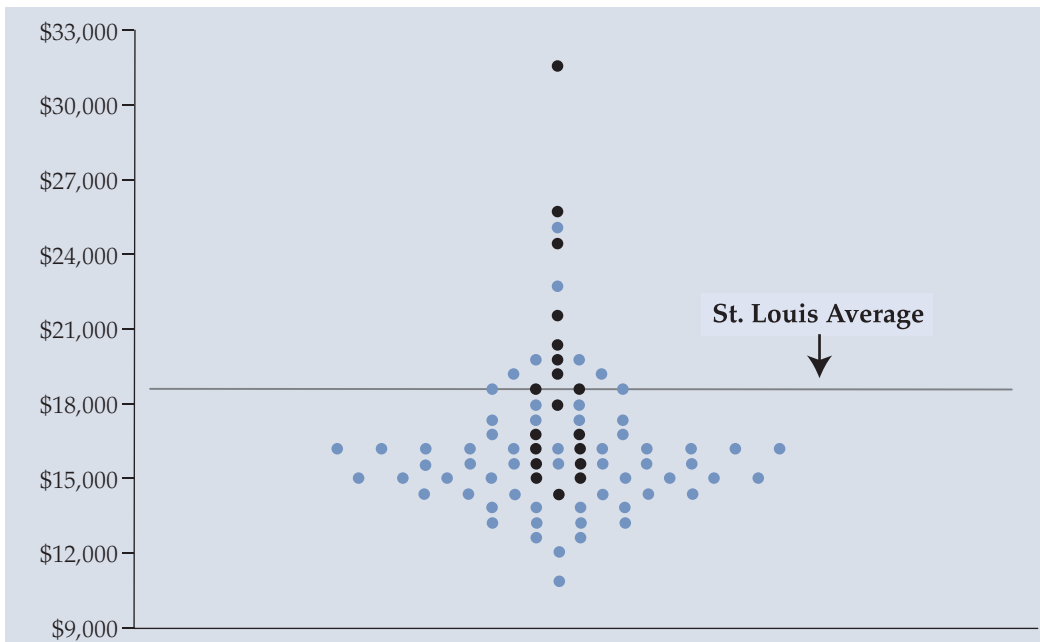
Study Design Overcomes Differences in Illness Severity and Outcome: The study looked at Medicare patients hospitalized for one of 12 serious illnesses such as congestive heart failure

or cancer who died between 2000 and 2003. The study was deliberate in selecting this population so as to avoid any concerns that one hospital's patients were sicker than another hospital's patients or that one hospital achieved better outcomes than another. Since all patients died, the outcomes are equal. Once these patients were identified, the study evaluated the care they received during the last six months of life.

National Findings: Large variation in the use of physician, diagnostic and other hospital services provided to these patients was found across hospitals, communities and states. There was no evidence that higher spending resulted in a better outcome or less suffering during the last six months—suggesting that the treatment patterns of physicians practicing in the higher utilization hospitals did not produce better outcomes than physicians practicing in the lower utilization hospitals.

St. Louis Results: The chart below shows the average combined Medicare payments to hospitals and physicians per decedent for inpatient care at Missouri hospitals during the last six months of life. St. Louis area average end-of-life costs for Medicare patients were \$18,170 during 2000–2003. This was 8% higher than the state-wide Missouri average. In the table on the following page, St. Louis area hospitals are compared with National, Illinois, and Missouri averages. Communities of similar size with better performance than St. Louis are also listed. ■

Medicare Hospital and Physician Payments per Decedent During the Last Six Months of Life Hospital Rates in Missouri (2000–2003)



Each dot in the chart at left represents a Missouri hospital ordered from highest to lowest reimbursements per decedent. St. Louis hospitals are represented by black dots; non-St. Louis Missouri hospitals are represented in blue.

All hospitals shown on the chart met a minimum sample size criteria set forth by Dartmouth to yield a reliable measure of the statistic. Missouri hospitals not meeting these minimum criteria are not included (see Note below the chart). ■

Source: Dartmouth Atlas of Health Care

Note: Hospitals with fewer than 80 deaths among their assigned populations were not included in the weighted average calculations for Part A (hospital) events; hospitals with fewer than 400 deaths among their assigned populations were not included in the weighted average calculations for Part B (physician) events.



The combined Medicare hospital and physician reimbursement for twenty-six St. Louis hospitals over a four-year period during the last six months of life are compared to the average reimbursement per decedent in St. Louis. Averages for the nation, Missouri, Illinois, Milwaukee, Portland, Minneapolis, and Indianapolis are also compared to the St. Louis average.

Since all patients have similar illness severity and the outcomes are similar (death), hospitals in the St. Louis region have an opportunity to learn from these other communities to discover how they have been able to achieve better performance. The complete study provides details on the specific mix of services utilized by individual communities and hospitals. ■

Medicare Hospital and Physician Payments per Decedent During the Last Six Months of Life Hospital Level Rates (2000–2003)

Hospital	Population	Avg. Payment per Decedent	Ratio to Benchmark
St. Louis University Hospital	1,205	\$31,124	1.71
Barnes-Jewish Hospital	4,450	25,293	1.39
Forest Park Hospital	1,813	24,418	1.34
St. Mary's Health Center	2,406	21,429	1.18
Des Peres Hospital	873	19,884	1.09
Illinois Average	217,024	19,667	1.08
St. John's Mercy Medical Center	2,383	19,561	1.08
National Average	4,692,623	18,966	1.04
St. Luke's Hospital	2,927	18,663	1.03
Missouri Baptist Medical Center	2,602	18,317	1.01
*St. Louis Average	61,789	18,171	—
Depaul Health Center	2,266	17,967	0.99
Gateway Regional Medical Center	894	17,863	0.98
Christian Hospitals	3,119	17,843	0.98
Milwaukee Average	44,824	17,225	0.95
St. Elizabeth's Hospital (Belleville)	2,411	17,149	0.94
Memorial Hospital of Belleville	2,217	16,856	0.93
Missouri Average	116,486	16,764	0.92
Barnes-Jewish Hospital–St. Peters	540	16,711	0.92
St. Anthony's Medical Center	3,460	16,521	0.91
Portland Average	19,827	16,109	0.89
Minneapolis Average	36,966	16,101	0.89
Lincoln County Memorial Hospital	402	15,960	0.88
St. Anthony's Health Center (Alton)	1,066	15,953	0.88
Jefferson Memorial Hospital	1,414	15,617	0.86
Missouri Baptist Hospital–Sullivan	457	15,494	0.85
St. Joseph Hospital–Kirkwood	1,442	15,347	0.84
Alton Memorial Hospital	1,078	15,293	0.84
St. Joseph Hospital (Breese, IL)	568	15,265	0.84
Indianapolis Average	52,728	15,038	0.83
St. Joseph Health Center–St. Charles	1,604	14,804	0.81
St. Joseph Hospital West–Lake St. Louis	550	14,380	0.79
St. John's Mercy Hospital–Washington	1,049	\$13,947	0.77

* Benchmark

How do St. Louis area hospitals compare?

St. Louis hospitals should be recognized for organizing care on average 4% less costly than the national average.

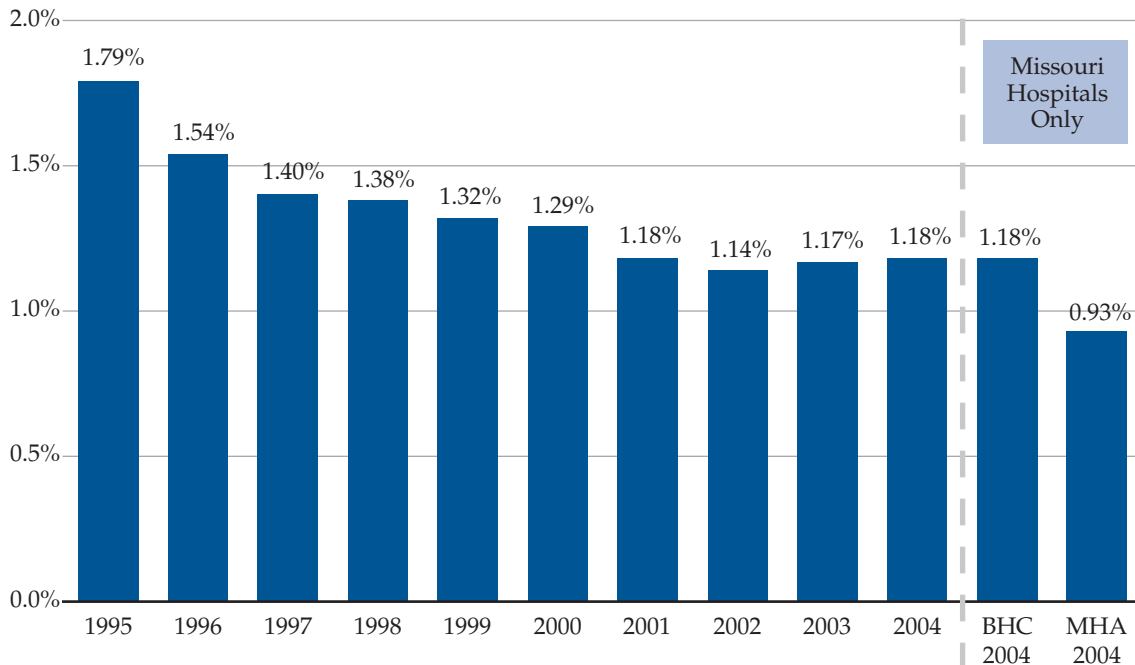
However, St. Louis hospital specific results demonstrate significant variation in how care is provided within our own community. Individual St. Louis hospitals' average payments per decedent in the last six months of life ranged from 1% to 71% above the St. Louis area average.

The Illinois average was 8% above the St. Louis average.

Methodology

Geographic benchmarks (averages) include only the hospitals that met the Dartmouth sample size and other criteria that would produce a reliable estimate. The St. Louis area average represents only the hospitals shown in the table that met the Dartmouth criteria. Similarly, the national, state, and community averages include only the hospitals in their areas that met the criteria. ■

Transparency in Community Benefit Reporting Charity Care as a Percentage of Operating Revenue 1995–2004



Charity care provided by St. Louis area hospitals increased slightly again in 2004. BHC reported higher levels than MHA.

Sources: Centers for Medicare and Medicaid Services Medicare Cost Reports, audited financial statements, internal financial statements, and MHA/AHA Annual Licensing Surveys.

During 2006, many state and national initiatives focused on charity care and community benefit provided by non-profit hospitals. The Catholic Health Association (CHA) and hospital alliance VHA released new community benefit accounting guidelines in June 2006. Notably, for the first time these guidelines exclude Medicare shortfalls and bad debt from consideration as charity care.

In May 2006, the Missouri Hospital Association (MHA) began publicly reporting the amount of community benefit provided by Missouri hospitals on their website www.focusonhospitals.com. BHC commends MHA for providing this information and for separating it into eight possible types of community benefit. This allows the public to view bad debt independently from charity care or to consider for themselves if an expense is truly a community benefit. For example, a hospital's education expense could be considered as more of a marketing expense. It also allows greater insight into the impact of public programs and other changes on charity care and community benefit. As health care costs continue to present a significant burden to St. Louis citizens individually and collectively, the public's interest in St. Louis hospitals' stewardship of community assets is likely to grow.

In September 2006, the Senate Finance Committee held a hearing on non-profit hospitals' charitable care and community benefit policies and the impact of billing and debt collection practices on the uninsured. It considered

to what extent the IRS and non-profit hospitals can achieve uniform disclosure without additional legislation to close the gap between hospital policy and reality and what congressional action may be necessary. CHA and VHA's charity care definition was commended despite the American Hospital Association's opposition.

Why is MHA charity care cost lower than BHC? BHC and MHA start with the same charity care charge figure reported by each hospital. The principal difference is that in the MHA calculation, the portion of bad debt expense covered by Medicare is excluded. This results in lower reported charity care cost. Both the new MHA and traditional BHC charity care data are shown for comparative purposes. BHC prefers the MHA methodology and appreciates the new data source. MHA expects some further refinements of its measure. Once MHA's metric is stabilized and a trend is established BHC will report using solely this metric.

Provision of charity care by St. Louis area hospitals in 2004 was relatively flat for the fourth straight year as measured by BHC. The BHC rate of 1.18% or the lower 0.93% MHA rate (St. Louis area hospitals in Illinois aren't included in the MHA rate) fell far short of the 3% of operating revenue recommended by BHC. According to the hospitals and MHA, the amount has fallen as a result of increased Medicaid enrollment, since services to Medicaid enrollees are not considered as charity care. Given changes to the Medicaid program in 2005, this is not likely to continue. ■

Charity care profile by network 2002–2004



System Name	2002 Operating Revenue	2003 Operating Revenue	2004 Operating Revenue	2002 BHC Charity cost as % of op. rev. ¹	2003 BHC Charity cost as % of op. rev. ¹	2004 BHC Charity cost as % of op. rev. ¹	2004 MHA Charity cost as % of op. rev. ¹
BJC HealthCare							
Alton Memorial Hospital	\$ 80,188,031	\$ 86,039,047	\$ 96,278,828	0.91%	1.00%	1.29%	N/A
Barnes-Jewish Hospital	903,407,776	944,042,713	996,684,525	2.23	2.06	2.15	0.88%
Barnes-Jewish Hospital–St. Peters	73,734,964	81,564,303	86,349,397	0.28	0.33	0.40	0.34
Barnes-Jewish Hospital–West County	70,429,999	76,849,551	78,024,315	0.17	0.22	0.25	0.24
Christian Hospitals	241,129,105	247,495,936	248,509,158	0.86	1.12	1.79	1.48
Missouri Baptist Medical Center	282,733,612	309,049,060	334,038,892	0.17	0.28	0.29	0.26
Missouri Baptist Hospital–Sullivan	24,673,971	30,282,396	35,276,963	1.37	1.16	0.51	0.46
St. Louis Children’s Hospital	246,684,000	257,116,000	271,858,000	1.16	1.07	0.49	1.17
Network Total	\$ 1,922,981,458	\$ 2,032,439,006	\$ 2,147,020,078	1.40%	1.35%	1.40%	0.84%
SSM Health Care							
Cardinal Glennon Hospital	\$ 138,642,205	\$ 145,917,301	\$ 184,597,702	0.47%	0.17%	0.33%	0.24%
DePaul Health Center	171,017,000	199,046,000	215,454,657	0.95	1.12	1.69	1.53
St. Joseph Health Center–St. Charles	128,734,196	141,972,807	135,910,031	0.56	0.75	1.42	1.33
St. Joseph Health Center–Wentzville	20,009,994	23,239,110	22,956,438	N/A ²	0.66	1.04	N/A
St. Joseph Hospital–Kirkwood	78,333,385	82,755,347	92,802,993	0.38	0.43	0.52	0.46
St. Joseph Hospital West–Lake St. Louis	54,515,129	59,601,304	59,893,719	0.33	0.62	1.16	1.02
St. Mary’s Health Center	186,411,473	204,643,986	215,178,013	0.92	0.60	1.78	1.83
Network Total	\$ 777,663,382	\$ 857,175,855	\$ 926,793,553	0.69% ²	0.66%	1.23%	1.16%
St. John’s Mercy Health Care							
St. John’s Mercy Medical Center	\$ 401,363,238	\$ 454,537,124	\$ 534,089,839	1.10%	1.07%	0.94%	1.08%
St. John’s Mercy Hospital–Washington	63,666,797	69,802,186	72,706,996	0.55	0.80	0.71	0.65
Network Total	\$ 465,030,035	\$ 524,339,310	\$ 606,796,835	1.02%	1.03%	0.92%	1.03%
Tenet HealthSystem							
Des Peres Hospital	\$ 82,252,988	\$ 93,500,203	\$ 98,414,763	0.28%	0.27%	0.17%	0.19%
St. Louis University Hospital	306,582,016	312,102,000	305,981,000	1.93	2.77	1.96	1.51
Network Total	\$ 388,835,004	\$ 405,602,203	\$ 404,395,763	1.58%	2.20%	1.52%	1.19%
Missouri Non-Merged, Non-Affiliated							
Forest Park Hospital ³	\$ 121,711,671	\$ 111,888,437	\$ 104,361,647	0.98%	1.02%	0.63%	0.86%
Jefferson Memorial Hospital	79,023,981	81,991,369	91,395,954	0.54	0.47	0.45	1.01
Kindred Hospital	17,627,608	17,687,807	18,189,883	0.06	0.87	N/A	0.00
Lincoln County Memorial Hospital	19,389,849	19,690,767	22,517,906	0.12	0.20	0.21	0.22
St. Alexius Hospital ^{3,4}	N/A	N/A	86,794,253	N/A	N/A	1.26	2.25
St. Alexius Hospital–Broadway Campus ³	43,290,661	48,109,385	N/A	1.71	1.85	N/A	N/A
St. Alexius Hospital–Jefferson Campus ³	58,960,341	39,398,123	N/A	2.11	0.97	N/A	N/A
St. Anthony’s Medical Center	274,472,000	290,918,000	314,980,000	0.94	0.87	0.86	0.77
St. Luke’s Hospital	248,368,000	263,468,000	274,105,000	0.27	0.34	0.32	0.30
Total	\$ 862,844,111	\$ 873,151,888	\$ 912,344,643	0.80%	0.74%	0.63%	0.78%
Illinois Non-Merged, Non-Affiliated							
Anderson Hospital	\$ 68,124,993	\$ 71,311,797	\$ 79,526,939	0.31%	0.30%	0.57%	N/A
Gateway Regional Medical Center	66,002,136	74,031,032	90,746,966	N/A	N/A	0.37	N/A
Kenneth Hall Regional Hospital (E. St. Louis)	32,991,000	36,313,909	43,190,945	4.26	6.02	1.91	N/A
Memorial Hospital of Belleville	148,680,740	156,851,476	159,978,114	0.70	0.71	0.99	N/A
St. Anthony’s Health Center (Alton) ⁵	84,714,951	88,473,759	88,296,847	3.09	3.39	3.30	N/A
St. Elizabeth’s Hospital (Belleville)	129,006,170	142,587,729	141,569,466	0.68	0.76	0.82	N/A
St. Joseph Hospital (Breese, IL)	23,966,893	26,515,322	29,238,411	0.19	0.05	0.13	N/A
Touchette Regional Hospital	26,349,179	28,121,952	31,039,580	0.01	0.02	N/A	N/A
Total	\$ 579,836,062	\$ 624,206,976	\$ 663,587,268	1.20% ⁶	1.38% ⁶	1.15% ⁷	N/A
Aggregate for 34 St. Louis Hospitals	\$ 4,997,190,053	\$ 5,316,915,238	\$ 5,660,938,140	1.14% ^{2,6}	1.17% ⁶	1.18% ⁷	0.93%

¹ BHC Charity care cost is the product of charity care gross charges times the cost-to-charge ratio. Missouri Hosp. Assoc. (MHA) Charity care cost is found on the www.focusonhospitals.com website.

² St. Joseph–Wentzville (as the former Crossroads Regional Hosp.) fiscal year 2002 charity care charges were combined with bad debt expense of \$1,500,920. Also, operating revenues have been excluded from the SSM Health Care Network Total and Aggregate for 34 St. Louis Hospitals total.

³ St. Alexius and Forest Park hospitals were sold to Doctors Community Healthcare Corporation in 2004, and due to the transfer in ownership, 2002, 2003 and 2004 data could not be verified.

⁴ Beginning in 2004, St. Alexius–Broadway Campus and St. Alexius–Jefferson Campus reported on combined basis under St. Alexius Hospital.

⁵ Statistics for St. Anthony’s Hospital and St. Clare’s Hospital are combined under St. Anthony’s Health Center.

⁶ Operating Revenues for Gateway Regional Medical Center have been excluded from these figures, because charity care information was unavailable for 2002 and 2003.

⁷ Operating Revenues for Touchette Regional Hospital have been excluded from these figures, because charity care information was unavailable for 2004.

Sources: Centers for Medicare and Medicaid Services Medicare Cost Reports, audited financial statements, and AHA/MHA Licensing Surveys. Note: In order to assess a hospital’s charitable commitment, it is necessary to evaluate the following: 1) Charity care performance, 2) Bad debt expense, 3) Case-mix (especially as it relates to the Medicaid population), and 4) Other charitable programs in which significant allowances and discounts are provided. All figures are not adjusted for inflation. Hospital network and affiliate configurations shown on this page are current as of 2006.



New thinking on community-benefit accounting guidelines were recently released by the Catholic Health Association (CHA) and hospital alliance VHA. *The Guide for Planning and Reporting Community Benefit* challenges the long-held belief that Medicare payments are insufficient to cover the costs of hospital services. Medicaid shortfalls remain as part of community benefit as this federal program for the poor is widely recognized as under funded. The cost shift for 2005 is expected to increase as a result of cuts to Missouri Medicaid in May 2005; results for 2004 will serve as a baseline for future comparison.

It has been common practice for hospitals to add Medicare “shortfalls” to charity care as part of community benefit and to compensate for this “shortfall” by raising fees to private payers. These higher prices were passed on—or cost shifted—to employers and consumers in the form of higher health benefit costs. *The Guide* has taken Medicare “shortfalls” off the list of community benefit arguing that the point of the prospective payment system was to make facilities efficient, so Medicare losses may actually be the result of poor hospital performance, not underpayment.⁶

Now, with hospital leaders indicating that Medicare payments are reasonable compensation for efficient hospitals it must be asked why the private sector should be expected to pay for so called “Medicare Shortfalls.”

In aggregate, St. Louis area Medicare payments fell from a ratio of \$0.95 in 2003 to \$0.93 in 2004, suggesting that St. Louis hospitals became less efficient relative to Medicare payments. When considering both Medicare and Medicaid, the net public sector cost shift to commercial payers was unchanged from 2003. St. Louis area employers and consumers spend 28 cents more for every dollar to cover the cost of services provided by government programs.

The table below begins to illustrate how the volume of government programs affects private sector payments. Despite having more Medicaid as compared to other hospitals, SSM Health Care achieved the highest ratio of Medicare payments to cost. SSM’s improvement in its Medicare ratio was accompanied by a 4% reduction in its commercial cost shift. St. Luke’s hospital has the smallest cost shift to commercial payers but also has only 1% of its business in Medicaid. ■

St. Louis Area Hospitals Payment to Cost Ratio by Payer Type, 2004

Hospitals and Hospital Systems	Medicare		Medicaid		Commercial	
	Ratio	% Rev.	Ratio	% Rev.	2004	2003
SSM Health Care	\$0.99	49%	\$0.90	21%	\$1.21	\$1.26
Tenet HealthSystem	\$0.86	48%	\$0.89	19%	\$1.29	\$1.34
BJC HealthCare	\$0.93	48%	\$0.91	16%	\$1.43	\$1.35
St. Anthony’s Health Center (Alton)	\$0.75	62%	\$0.94	14%	\$1.50	\$1.48
St. John’s Mercy Health Care	\$0.89	39%	\$0.89	13%	\$1.20	\$1.18
St. Anthony’s Medical Center	\$0.92	57%	\$0.73	9%	\$1.18	\$1.16
St. Luke’s Hospital	\$0.95	63%	\$0.71	1%	\$1.13	\$1.17
St. Louis Aggregate	\$0.93	49%	\$0.91	16%	\$1.28	\$1.28

Note: Ratio represents on average the amount of revenue collected for each dollar of expense by payer. Payments below \$1.00 indicate the hospital is paid less on average than its cost and those above \$1.00 are more than their cost. The percentage of revenues estimates the percent of total revenues at each hospital covered by the payer based on annual discharges. For example, using the information provided and subtracting from 100, one could determine that about 30% of SSM’s revenues come from commercial payers. Since Medicaid is generally the lowest payer, the table is sorted by the highest percentage of Medicaid business. Source: CMS Medicare Cost Reports, audited financial statements, and AHA/MHA Licensing Surveys. Certain data were unavailable for Forest Park, Kindred, St. Alexius, Gateway Regional Medical Center, St. Joseph–Breese, IL, and Touchette Regional and those hospitals were excluded from the aggregate.

Missouri Disproportionate Share (DSH) Hospital Payments 2002–2004



St. Louis City and St. Louis County

The State of Missouri through the State/Federal Medicaid program makes hospital payments over and above other provider reimbursement for Medicaid services to certain hospitals. Hospitals qualify for these additional payments based on a number of factors outlined in Missouri Medicaid Regulations 13 CSR 70-15.010. Hospitals can receive the additional funds through enhancements to their Medicaid per diem rate, a Medicaid add on payment, and/or an uninsured reimbursement payment. The regulations define at least three categories of hospitals eligible for additional payments. In general, hospitals providing the largest amounts of Medicaid services, charity care, and incur the most bad debt receive the highest levels of additional payment. Certain other mental health and state hospitals also qualify for these payments.

Federal Law limits total Disproportionate Share payments to less than 100% of the unreimbursed cost for Medicaid and the cost of the uninsured (13 CSR 70-15.010; 17). Disproportionate

Share Payments to Missouri hospitals in St. Louis City and St. Louis County for fiscal years 2002, 2003, and 2004 are listed in the table below. The State/Federal shares for 2002, 2003, and 2004 were 38.95%/61.05%, 38.81%/61.19%, and 38.59%/61.41% respectively. Future funding for this program is subject to state and federal appropriations.

In the interest of evaluating Disproportionate Share (DSH) payments in relation to the amount of charity care provided, the amount of each hospital's DSH payment is expressed as a percent of its operating revenue, and an aggregate figure is shown at the bottom. On pages 14 and 15, charity care cost is expressed as a percent of operating revenue as well. While DSH payments are intended to offset contractual allowances related to Medicaid and losses due to bad debt, it also covers charity care. For each of the years 2002, 2003 and 2004, DSH payments relative to charity care were more than twice as high as a percent of operating revenue. ■

Provider	2002			2003			2004		
	DSH	Operating Revenue	% of O.R.	DSH	Operating Revenue	% of O.R.	DSH	Operating Revenue	% of O.R.
Barnes-Jewish Hospital	\$ 37,067,305	\$ 903,407,776	4.10%	\$44,017,443	\$ 944,042,713	4.66%	\$ 53,548,521	\$ 996,684,525	5.37%
Barnes-Jewish Hospital–St. Peters	1,349,414	73,734,964	1.83	1,423,697	81,564,303	1.75	1,554,292	86,349,397	1.80
Barnes-Jewish Hospital–West County	576,022	70,429,999	0.82	648,299	76,849,551	0.84	676,206	78,024,315	0.87
Cardinal Glennon/ St. Mary's Health Center	12,138,776	325,053,678	3.73	16,822,723	350,561,287	4.80	20,805,482	399,775,715	5.20
Christian Hospitals	12,303,723	241,129,105	5.10	13,194,836	247,495,936	5.33	13,642,190	248,509,158	5.49
DePaul Health Center	5,963,850	171,017,000	3.49	3,862,123	199,046,000	1.94	5,707,514	215,454,657	2.65
Des Peres Hospital	2,873,566	82,252,988	3.49	1,886,600	93,500,203	2.02	2,149,006	98,414,763	2.18
Forest Park Hospital ¹	9,214,335	121,711,671	7.57	12,912,901	111,888,437	11.54	13,611,517	104,361,647	13.04
Jefferson Memorial Hospital	4,646,465	79,023,981	5.88	3,667,573	81,991,369	4.47	4,104,422	91,395,954	4.49
Kindred Hospital Lincoln County	946,529	17,627,608	5.37	514,629	17,687,807	2.91	289,590	18,189,883	1.59
Memorial Hospital	775,125	19,389,849	4.00	754,843	19,690,767	3.83	884,541	22,517,906	3.93
Missouri Baptist Medical Center	3,166,403	282,733,612	1.12	5,275,157	309,049,060	1.71	6,417,763	334,038,892	1.92
Missouri Baptist Hospital–Sullivan	1,009,326	24,673,971	4.09	1,072,524	30,282,396	3.54	1,179,073	35,276,963	3.34
St. Alexius Hospital ¹	N/A	N/A	N/A	N/A	N/A	N/A	12,648,633	86,794,253	14.57
St. Alexius Hospital–Broadway Campus ¹	3,064,731	43,290,661	7.08	5,986,272	48,109,385	12.44	N/A	N/A	N/A
St. Alexius Hospital–Jefferson Campus ¹	6,132,329	58,960,341	10.40	6,206,800	39,398,123	15.75	N/A	N/A	N/A
St. Anthony's Medical Center	7,418,426	274,472,000	2.70	9,122,027	290,918,000	3.14	12,752,262	314,980,000	4.05
St. John's Mercy Hospital–Washington	2,394,877	63,666,797	3.76	2,533,707	69,802,186	3.63	3,260,298	72,706,996	4.48
St. John's Mercy Medical Center	9,169,252	401,363,238	2.28	10,747,349	454,537,124	2.36	12,240,612	534,089,839	2.29
St. Joseph Health Center–Wentzville	1,310,372	20,009,994	5.14	1,154,199	23,239,110	4.97	1,405,441	22,956,438	6.12
St. Joseph Health Center–St. Charles	3,772,189	128,734,196	2.93	7,940,821	141,972,807	5.59	5,686,695	135,910,031	4.18
St. Joseph Hospital–Kirkwood	1,548,608	78,333,385	1.98	1,392,023	82,755,347	1.68	2,053,177	92,802,993	2.21
St. Joseph Hospital West–Lake St. Louis	1,282,792	54,515,129	2.35	1,124,960	59,601,304	1.89	1,603,348	59,893,719	2.68
St. Louis Children's Hospital	18,525,164	246,684,000	7.51	23,147,516	257,116,000	9.00	26,809,962	271,858,000	9.86
St. Louis University Hospital	17,542,967	306,582,016	5.72	20,811,401	312,102,000	6.67	21,292,206	305,981,000	6.96
St. Luke's Hospital	2,945,206	248,368,000	1.19	3,243,870	263,468,000	1.23	3,194,653	274,105,000	1.17
TOTAL	\$167,137,752	\$4,337,165,959	3.85%	\$199,464,293	\$4,606,669,215	4.33%	\$227,517,404	\$4,901,072,044	4.64%

¹ SouthPointe Hosp. merged with St. Alexius Hospital in 2003 and reported on a combined basis in 2004 as St. Alexius Hospital. Forest Park Hosp., St. Alexius Hospital–Broadway and Jefferson Campus were sold to Doctors Community Healthcare Corporation (DCHC) in November 2004 by Tenet Healthcare Corporation. Due to the transfer in ownership in 2004, 2003 and 2004 data for these hospitals could not be verified by Tenet or DCHC.

Sources: DSH payment information obtained from the Missouri Department of Social Services. Operating revenue obtained from hospital Medicare Cost Reports and audited financial statements. This data was abstracted by the BHC and verified by individual hospitals.

Note: Changes in previously reported data are based on most current information. Data in this table not adjusted for inflation. DSH payments made for 12 month periods beginning July 1 and ending June 30. Hospital fiscal years, on which operating revenue is based, may differ.

This is the second year quality information is included in this report. Comparative information, when available, from 2005 is provided. BHC will continue to show trends over time and is eager to applaud improvements in health care quality.

Hospital Compare, a Centers for Medicare and Medicaid Services (CMS) program provides national reporting on how often hospitals provide care consistent with consensus-based recommendations for three common and costly conditions (www.hospitalcompare.hhs.gov). The table below shows St. Louis hospitals' performance on CMS's 10 Measure Starter Set as compared to other hospitals nationally. The national rankings were provided by *HealthInsight* (www.healthinsight.org), a CMS certified quality improvement organization using the methodology outlined in the box below.

Measures are aggregated and reported at the condition level for two reasons. Early research suggests aggregate reporting makes it easier for consumers and engages them more effectively.

A recent study shows individual measures have only a slight positive correlation with improved outcomes and bigger differences emerge when measures are considered in aggregate.⁸

CMS provides an incentive payment to hospitals that report and reduces payments for hospitals that do not report. CMS will tie future payments to actual results. Seven hospitals improved their results. However, the St. Louis hospitals' aggregate ranking fell two points, indicating greater improvement occurred in other communities. Alton Memorial and St. John's are to be congratulated for scoring above the 90th percentile nationally and/or achieving significant one year improvement. St. Louis University Hospital is acknowledged for the greatest improvement (23 points). ■

Frequency (%) that St. Louis Hospitals Provide Recommended Care and National Performance Rankings: Jan.–Dec. 2005 and 2004

Hospital	Frequency of Recommended Care (Goal = 100%)			National Performance Ranking	
	Heart Attack	Heart Failure	Pneumonia	2005 Nat'l Rank	2004 Nat'l Rank
Alton Memorial Hospital	98%	91%	95%	94th	89th
Anderson Hospital	95%	97%	87%	78th	70th
Barnes Jewish Hospital	95%	94%	72%	54th	69th
Barnes Jewish Hospital, St. Peters	96%	88%	87%	67th	72nd
Christian Hospitals	90%	89%	85%	24th	33rd
De Paul Health Center	95%	90%	85%	62nd	86th
Des Peres Hospital	98%	94%	79%	86th	83rd
Gateway Regional Medical Center	91%	87%	83%	42nd	46th
Jefferson Memorial Hospital	86%	78%	61%	3rd	14th
Memorial Hospital of Belleville	93%	91%	69%	36th	27th
Missouri Baptist Medical Center	94%	90%	84%	57th	39th
St. Anthony's Medical Center	92%	84%	83%	32nd	36th
St. Elizabeth's Hospital, Belleville	91%	79%	76%	18th	31st
St. John's Mercy Hospital, Washington	94%	96%	90%	79th	86th
St. John's Mercy Medical Center	98%	95%	89%	90th	75th
St. Joseph Health Center	97%	96%	87%	79th	96th
St. Joseph Hospital, Kirkwood	93%	92%	88%	61st	73rd
St. Joseph Hospital, West	99%	93%	87%	90th	91st
St. Louis University Hospital	97%	94%	80%	78th	55th
St. Luke's Hospital	95%	100%	92%	88th	86th
St. Mary's Health Center	95%	95%	75%	55th	60th
St. Louis Hospital Average	94%	91%	83%	61st	63rd

CMS's Starter Set

Heart Attack (Acute Myocardial Infarction or AMI)

- Aspirin at arrival
- Aspirin at discharge
- ACE Inhibitor for Left Ventricular Systolic Dysfunction (LVSD)
- Beta Blocker at arrival
- Beta Blocker at discharge

Heart Failure

- Assessment of Left Ventricular Function
- ACE Inhibitors for LVSD

Pneumonia

- Oxygenation Assessment
- Initial Antibiotic Timing
- Pneumococcal Vaccination

Analysis Methodology

The score for each disease state (frequency of recommended care) represents the hospital's combined performance for that disease state's measures.

To compute national rankings, a national comparison group was defined to include all hospitals that reported on eight or more measures and had more than 15 cases for each of the reported measures. Each hospital's performance on each measure was ranked on a 0–1 scale (similar to grading each measure on a curve).

The national rank was computed using the hospital's average rank across all 10 measures. It is expressed as a percentile rank among the 2,378 hospitals in the national sample. The combined St. Louis hospital rank at the 61st percentile, even when grading on a curve, identifies an important opportunity for improvement. ■



The Leapfrog Group is an employer-driven initiative begun by the Business Roundtable. Leapfrog has several programs to spur breakthrough improvements in the safety, quality and affordability of health care. Leapfrog's initial effort is a voluntary survey that tracks and informs consumers about the use of safe practices among hospitals. Leapfrog also provides a forum for employers and health plans to encourage hospitals to hasten the adoption of 30 National Quality Forum safe practices. In its fifth year, the Leapfrog Hospital Quality and Safety Survey has helped

spark a powerful trend in public reporting among US hospitals and is now one of the most recognized ways hospitals demonstrate their commitment to transparency, quality improvement and prevention of medical errors.

Unfortunately for St. Louis residents, several of St. Louis' large non-profit hospitals refuse to complete the survey. Go to www.leapfroggroup.org to see the robust comparative information available to residents of other metropolitan areas and the improvements hospitals are making with patient safety. ■

Selected Leapfrog Leaps

How did the St. Louis area reporting hospitals do?

Computer physician order entry (CPOE)—integrates orders with other patient information and electronically checks for potential errors.

All of the hospitals that reported to Leapfrog are willing to report publicly on CPOE, but did not make the good early stage effort recognition. Nationally, 7% of hospitals that reported to Leapfrog fully met this leap.

Intensivists (ICU)—this standard requires hospitals to have a critical care-trained physician on-site at least eight hours per day, and telephonic availability off-hours.

Anderson Hospital and St. Anthony's Hospital fully meet Leapfrog's ICU Physician Staffing leap. Des Peres Hospital has made a good early stage effort, an improvement from 2005. Lincoln County Medical Center and St. Louis University Hospital are willing to report this information publicly but have not made a good early stage effort. Nationally, 26% of hospitals that reported to Leapfrog fully met this leap.

Leapfrog Safe Practices Score—tracks 27 other safe practices endorsed by the National Quality Forum.

Four out of the five hospitals that reported to Leapfrog fully met NQF's Safe Practices, an improvement from 2005 where only one of the reported hospitals fully met the safe practice. Nationally, 31% of hospitals that reported to Leapfrog fully met this leap.

Five St. Louis Hospitals Report

BHC congratulates the five St. Louis area hospitals that completed the Leapfrog survey. These hospitals provide consumers with comparative health care information on safety practices that have been shown to reduce errors.

More than 2,200 hospitals or 53% of all US hospital beds were targeted in the Leapfrog Survey. Of the targeted hospitals, 47% publicly reported to the Leapfrog Survey. In the St. Louis region, only 12% of hospitals publicly reported to the Leapfrog Survey. In Kansas City, 25% of targeted hospitals reported and in Illinois, 35% of targeted hospitals reported to the Leapfrog Survey. The St. Louis region continues to be one of the lowest hospital participation rates in Leapfrog's 31 regions. ■

Hospital Name	CPOE Could reduce medication errors by 50%	ICU Could reduce mortality by 30%	Quality Index
Anderson Hospital			
Des Peres Hospital			
Lincoln County Medical Center			
Saint Louis University Hospital			
St. Anthony's Medical Center			

- Fully implemented Leapfrog's quality and safety leap
- Good progress
- Good early stage effort
- Willing to report publicly, did not make good early stage effort

Hospitals that Failed to Report to Leapfrog by July 2006

BJC HealthCare

Alton Memorial Hospital
Barnes-Jewish Hospital
Barnes-Jewish Hospital—St. Peters
Barnes-Jewish Hospital—West County
Christian Hospital NE/NW
Missouri Baptist Medical Center
Parkland Health Center—Farmington
St. Louis Children's Hospital

SSM Health Care

Cardinal Glennon for Children
DePaul Health Center
St. Joseph Health Center—St. Charles
St. Joseph Hospital—Kirkwood
St. Joseph Health Center—Wentzville
St. Joseph Hosp. West—Lake St. Louis
St. Mary's Health Center

St. John's Mercy Health Care

St. John's Mercy Medical Center
St. John's Mercy Hospital—Washington

Other

Forest Park Hospital
Jefferson Memorial Hospital
Memorial Hospital of Belleville
St. Alexius Hospital
St. Anthony's Health Center—Alton
St. Elizabeth's Hospital—Belleville
St. Luke's Hospital



Adverse events, or “never events,” are serious and preventable health care events that health care professionals agree should never happen. *When one of these events does happen, it represents a serious breach in public safety.* The National Quality Forum (NQF) maintains a standardized list of adverse events (see table at right).

While 25 states require some level of adverse event reporting, mandating NQF’s list of adverse events in public reporting regulations is early. About eight states, a federal agency (TRICARE), and a Canadian province have adopted the NQF list. Minnesota was the first state to publish a report based on the full NQF-endorsed list and continues to be a leader in innovative efforts to make health care safer for its citizens. A voluntary JCAHO sentinel events reporting system has been available for more than ten years. JCAHO estimates, on average, hospitals report less than one percent of the actual number of events meeting the definition of a reportable sentinel event. As detailed in this report last year, **Missouri hospitals’ record on voluntary reporting is quite poor.** Unlike hospitals in Minnesota and many other states, Missouri hospitals have no legal requirement to report the occurrence of adverse health care events, even to the Department of Health. **BHC urges the Missouri legislature to enact mandatory adverse event reporting in 2007. Missouri citizens deserve better.** Reporting these events provides invaluable insight to improve systems and processes and prevent these events from occurring in the future. Recent research confirms public reporting as a powerful quality improvement tool.

During November 2006, the Leapfrog Group issued a call to all hospitals to publicly commit to the following four actions when a never event occurs. BHC encourages Missouri hospitals to make this public commitment.

1. Apologize to the patient/family;
2. Report occurrence to an external reporting program;
3. Perform a root cause analysis; and,
4. Waive billing for all services related to the never event. ■

NQF’s Reportable Adverse Health Care Events

Surgery-related events:

- Surgery performed on the wrong body part or wrong patient
- Wrong surgical procedure performed on the patient
- Retention of foreign object after surgery or other procedure
- Death due to unusual causes

Care Management events:

- Stage 3 or 4 ulcers (bedsores) acquired after admission to the facility (not necessarily resulting in death)
 - Artificial insemination with the wrong donor sperm or egg
- Death and disability associated with...*

- Medication error
- Administration of incompatible ABO/HLA blood or blood products
- Labor or delivery of low-risk pregnancy
- Hypoglycemia
- Hyperbilirubinemia in neonates in the first 28 days of life
- Spinal manipulative therapy

Environmental events:

- Any incident in which a line designated for oxygen or other gas contains the wrong gas or toxic substance
- Death or disability associated with...*

- Use of restraints or bedrails
- Electric shock or elective cardioversion
- A burn or a fall

Product or devices: *Death or disability associated with...*

- Contaminated drugs or devices
- Device malfunction
- Intravascular air embolism

Patient events:

- Infant discharged to the wrong person
- Death or disability associated with patient disappearance, suicide or attempted suicide

Criminal events:

- Care provided by a person impersonating physician, nurse, etc.
- Abduction of a patient
- Sexual assault of a patient
- Death or disability of patient or staff due to physical assault

Eliminating Health Care Acquired Infections

Process, Not Patients, Drives Infection

Three recent studies published in the American Journal of Quality provide evidence that hospital-acquired infections occur from a breakdown in hospital procedures and are generally an avoidable outcome, even for the sickest patients. The research finds infections arise mainly from:

- poor hand-washing by personnel,
- failure to wear special clothing during medical procedures,
- traffic in and out of operating rooms,
- failure to isolate patients or observe specific isolation procedures, and
- antibiotic overuse.⁹

Among developed nations, the United States has one of the worst records of curbing drug resistant infections.¹⁰

Fortunately, leading hospitals and researchers seem to agree, there is much that can be done to eliminate health care associated infections.

A growing number of hospitals are striving to get to zero hospital-acquired infections. They are accomplishing this through rigorous hand-washing, universal testing of patients to identify those carrying methicillin-resistant staphylococcus aureus (MRSA), meticulous cleaning of rooms between patients, and taking precautions to prevent the spread of these bacteria from infected patients to others on gloves, clothing, equipment and furniture. By using these precautions, The University of Virginia Medical Center, Veterans Affairs Pittsburgh Health System, University of Pittsburgh Medical Center-Presbyterian and a coalition of 29 health care institutions in Iowa have reduced drug-resistant infections by 85% or more in pilot programs. In another example, a group of Pennsylvania hospitals was successful in reducing bloodstream infection rates for central-line catheters by 67% between 2001 and 2005 by adhering to guidelines.¹¹ Their success, along with similar efforts by other hospitals, proves that these precautions work. ■



As a result of legislation passed in 2004, Missouri hospitals began reporting information on certain infections to the Department of Health and Senior Services (DHSS) in July 2006. The Central Line Infection information reported below was published on the DHSS website on December 29, 2006. Information on select surgical site infections will become available during the first half of 2007.

Central Line-Associated Bloodstream Infection by Hospital Compared with State and National Rates By Intensive Care Unit Type

Rates per 1,000 Central Line-Days, July 1, 2005–March 31, 2006

Hospitals and Hospital Systems	Coronary	Medical	Surgical	Neonatal	Pediatric
Barnes-Jewish Hospital	4.5	3.1	4.5	*	*
Missouri Baptist Medical Center	*	*	*	0.0	*
St. Anthony's Medical Center	1.0	*	4.3	*	*
St. John's Mercy Medical Center	0.9	*	*	1.3	2.3
St. Louis University Hospital	2.7	3.0	*	*	*
St. Mary's Health Center	*	5.9	1.8	0.0	*
Cardinal Glennon Hospital	*	*	*	1.2	3.6
St. Louis Children's Hospital	*	*	*	5.7	6.0
Missouri Rate	1.8	2.5	2.7	2.9	5.7
National Rate	3.5	5.0	4.6	6.4	6.6

Note: Hospitals in bold indicate infection rate was higher as compared with all Missouri hospitals based on significance tests. Asterisks (*) indicate a facility was not required to report during the period, did not provide the service, or had an insufficient sample size of data.

- Use **caution** when making decisions on data from one point in time.



- Variation may result from better infection tracking and reporting.
- Such differences are expected to be minimized over time.
- These caveats aside, standard measures and public reporting will translate to significant reductions in the number of preventable infections...a huge step forward in public safety.

What patients can do to protect themselves from health care acquired infections:

- Ask hospital staff to **wash their hands** before treating you
- Ask that stethoscopes and related equipment be **wiped with alcohol**
- If you need a **central line catheter**, ask about one treated with antibiotics or chlorhexidine to prevent infections
- If you need surgery, **choose a surgeon with a low infection rate**
- Three to five days before surgery shower daily with **4% chlorhexidine soap** to remove bacteria on your skin (available at drugstores)
- Ask to be tested for **MRSA**, one week before admission to the hospital
- If you smoke, **stop smoking** well in advance of your surgery
- Remind your doctor you may need an **antibiotic one hour prior to the first incision** on the day of your surgery
- Ask your doctor about **keeping you warm during surgery**
- **Do not shave** the surgical site
- Ask your surgeon to **limit the number of people** in the operating room
- Ask about having **blood sugar levels monitored** during and after surgery
- **Avoid** a urinary tract catheter, if possible. If not, it should be in place no longer than necessary.
- Make sure IV is inserted and removed under clean conditions and **changed every three to four days**

Source: Committee to Reduce Infection Deaths

Infection prevention is good for profits

Treating hospital infections costs an estimated \$30.5 billion a year in the U.S. In comparison, preventing infections is inexpensive. The pilot program at the University of Pittsburgh found that screening tests, gowns and other precautions cost only \$35,000 a year, and saved more than \$800,000 a year in infection costs—as well as saving lives.¹²

Central Line-Associated Bloodstream Infection by Hospital Compared with State and National Rates Rates per 1,000 Central Line-Days, July 1, 2005–March 31, 2006

Hospitals and Hospital Systems	Medical Surgical ICU
Barnes-Jewish St. Peters	1.3
Barnes-Jewish West County	0.0
Christian Hospitals	4.5
DePaul Health Center	2.8
Des Peres Hospital	8.5
Forest Park Hospital	7.0
Jefferson Memorial Hospital	8.1
Lincoln County Medical Center	0.0
Missouri Baptist Hospital, Sullivan	0.0
Missouri Baptist Medical Center	2.1
St. Alexius Hospital	5.0
St. John's Mercy Hospital, Washington	0.0
St. John's Mercy Medical Center	3.0
St. Joseph Health Center	2.6
St. Joseph Hospital Kirkwood	0.0
St. Joseph Hospital West	13.0
St. Luke's Hospital	1.9
Missouri Rate	2.7
National Rate	3.6

Note: Hospitals in bold indicate infection rate was higher as compared with other Missouri hospitals based on significance tests.

Hospital Financial Performance 1995–2004

Summary of Aggregate Financial Statements and Financial Indicators for St. Louis Area Hospitals

All figures are in millions of dollars.	1995	1996 ¹	1997 ¹	1998 ¹	1999 ²	2000 ^{1,2}	2001 ²	2002 ²	2003 ²	2004 ²
Income Summary										
Total Gross Charges	\$6,500	\$6,597	\$6,930	\$7,535	\$8,201	\$9,024	\$10,165	\$11,348	\$12,739	\$14,032
Less: Allowances	2,910	3,058	3,350	3,823	4,412	5,116	5,836	6,504	7,614	8,585
Net Patient Revenue	3,590	3,539	3,581	3,712	3,789	3,908	4,329	4,844	5,125	5,447
Other Operating Revenue	197	188	148	186	201	183	143	153	192	214
Total Operating Revenue	3,787	3,727	3,728	3,899	3,991	4,091	4,472	4,997	5,317	5,661
Total Operating Expenses	3,642	3,576	3,605	3,807	3,961	4,096	4,412	4,810	5,054	5,458
Income (Loss) from Operations	145	151	123	91	29	(4)	60	187	263	203
Non-Operating Revenue	152	125	186	164	71	49	28	(13)	234	179
Excess (Deficit) of Revenues Over Expenses	\$ 297	\$ 276	\$ 309	\$ 255	\$ 100	\$ 45	\$ 88	\$ 174	\$ 497	\$ 382
Balance Sheet										
Current Assets:										
Cash and Marketable Securities	\$ 230	\$ 247	\$ 402	\$ 405	\$ 442	\$ 66	\$ (77)	\$ (73)	\$ (76)	\$ (264)
Net Patient Accounts Receivable	668	713	714	854	885	826	773	769	758	772
Other Receivables	102	70	32	80	25	39	24	22	32	71
Other Current Assets	315	237	194	120	119	8	90	96	119	167
Total Current Assets	1,315	1,267	1,342	1,460	1,471	939	810	814	833	745
Land, Building and Equipment Cost	3,727	3,495	3,798	4,431	4,275	4,462	4,830	5,069	5,391	5,635
Accumulated Depreciation	(1,829)	(1,860)	(2,046)	(2,367)	(2,287)	(2,455)	(2,633)	(2,691)	(2,892)	(3,030)
Net Land, Building and Equipment Cost	1,898	1,635	1,752	2,064	1,988	2,007	2,197	2,378	2,499	2,605
Investments Held by Trustee	72	207	209	309	325	309	353	305	405	502
Deferred Financing Costs	10	9	6	2	2	4	3	1	1	2
Other Cash and Investments	1,162	850	1,140	545	396	436	436	408	471	589
Other Assets	396	535	578	662	744	983	1,071	1,095	1,328	1,511
Total Assets	\$ 4,853	\$ 4,503	\$ 5,026	\$ 5,042	\$ 4,926	\$ 4,678	\$ 4,870	\$ 5,001	\$ 5,537	\$ 5,955
Liabilities and Fund Balance										
Current Liabilities	\$ 742	\$ 717	\$ 597	\$ 665	\$ 695	\$ 649	\$ 736	\$ 737	\$ 779	\$ 743
Long-term Debt	1,194	1,130	1,031	1,303	1,207	1,067	1,120	1,109	1,088	1,111
Other Liabilities and Reserves	176	274	266	117	113	217	238	271	284	280
Fund Balance	2,741	2,382	3,132	2,957	2,911	2,744	2,776	2,884	3,385	3,821
Total Liabilities and Fund Balance	\$4,853	\$4,503	\$5,026	\$5,042	\$4,926	\$4,678	\$4,870	\$5,001	\$5,537	\$5,955
Endowment, Specific Purpose and Other Restricted Fund Balances	\$ 135	\$ 121	\$ 119	\$ 111	\$ 114	\$ 96	\$ 97	\$ 100	\$ 126	\$ 161
Financial Indicators										
Operating Margin	3.96%	4.07%	3.30%	2.34%	2.19%	0.16%	2.55%	5.09%	5.15%	3.82%
Profit Margin	7.73%	7.19%	7.89%	6.27%	2.47%	1.08%	1.95%	3.50%	8.96%	6.53%
Return on Equity	10.85%	11.59%	9.88%	8.62%	3.44%	1.62%	3.17%	6.03%	14.69%	9.99%
Mark-up Percentage (Charges over Cost)	78.5%	84.5%	92.2%	97.9%	107.0%	120.9%	133.2%	139.3%	152.6%	157.7%
Allowances as % of Charges	44.8%	46.4%	48.3%	50.7%	53.8%	56.7%	57.4%	57.3%	59.8%	61.2%

¹ As a result of hospital mergers in 1996, 1997, 1998, and 2000, financial data for certain hospitals were reported for less than 12 months.⁷ Information for Crossroads Regional Hospital (as the former Doctors Hospital–Wentzville) was not available for 1998. Crossroads was acquired by SSM Health Care in November 2005 and is currently named St. Joseph Health Center–Wentzville.

² The following non-operating expenses are included in Operating Expenses for fiscal years 1999 = \$57,896,271, 2000 = \$10,677,065, 2001 = \$54,564,859, 2002 = \$67,005,588, and 2003 = \$10,843,167, and 2004 = \$13,746,204. In 2002, Barnes–Jewish Hospital's (\$21,240,477) non-operating loss was included in non-operating revenue. Normandy Community Hospital has been excluded from fiscal year 1999 and Bethesda General Hospital, Compton Heights Hospital, and Woodriver Township Hospital have been excluded from fiscal year 2000 in this table since extraordinary charges associated with their closure in those years caused results to be unreliable. St. Alexis and Forest Park hospitals were sold to Doctors Community Healthcare Corporation in 2004, and due to the transfer in ownership, 2002, 2003, and 2004 data could not be verified.

Sources: Centers for Medicare and Medicaid Services Medicare Cost Reports and audited hospital financial statements. Note: Changes in previously reported data are based on most current information available including numerous restatements. All figures are rounded. All data in this table are not adjusted for inflation. Differences in accounting practices for expenses and investment income across hospital systems may understate some St. Louis hospital systems' profits. Although consistent with accepted accounting principles, hospital systems may allocate 100% of certain expenses (i.e., executive salaries) and investment income proportionately to individual subsidiary hospitals while others retain some or all of these dollars at the system level. BHC has worked to collect this information and adjust for differences as possible but due to limited access to data, viewers should make comparisons with this in mind. BHC will continue its efforts to fully accommodate these differences in future reports and will adjust data retrospectively to allow trends to be evaluated.



St. Louis Area Hospital Industry 1995–2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Missouri Hospitals										
Barnes Hospital ¹	6.94%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Barnes-Jewish Hospital ¹	N/A	5.43%	4.05%	3.03%	-0.13%	-0.47%	2.79%	3.73%	4.34%	3.58%
Barnes-Jewish Hospital–St. Peters	3.89	4.11	4.35	1.55	3.87	10.79	11.25	18.18	19.08	13.04
Barnes-Jewish Hospital–West County	6.67	6.04	3.99	1.25	4.21	11.04	24.67	26.86	26.82	23.29
Cardinal Glennon Hospital	0.42	6.02	9.07	4.58	5.17	12.72	7.60	12.35	9.93	14.16
Christian Hospitals	1.51	5.60	2.62	-7.50	-9.52	-8.83	-7.87	6.92	6.84	4.78
DePaul Health Center	-10.75	-6.52	-4.17	0.00	-5.90	1.40	-0.47	2.47	4.43	5.09
Des Peres Hospital ²	1.59	-4.45	-11.35	-8.87	11.15	9.66	11.61	13.36	11.95	8.06
Forest Park Hospital ²	4.19	1.97	-25.42	-2.96	7.54	-14.47	-1.45	2.76	2.64	-24.69
Jefferson Memorial Hospital	5.31	4.86	6.90	3.99	1.80	1.89	1.25	-0.50	-0.80	-0.66
Jewish Hospital ¹	2.13	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kindred Hospital	30.74	16.64	22.91	19.33	1.06	-2.57	-7.24	7.71	8.11	19.60
Lincoln County Memorial Hospital	6.69	2.70	-1.91	-7.50	-3.46	-2.63	4.97	3.05	-8.53	-0.05
Missouri Baptist Medical Center	5.93	8.69	8.67	6.18	3.36	4.02	9.36	15.96	15.61	15.42
Missouri Baptist Hospital–Sullivan	4.19	4.27	-3.13	0.37	-6.49	-5.54	-1.85	2.17	9.16	10.52
St. Alexius Hospital ³	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-8.23
St. Alexius Hospital–Broadway Campus ^{2,3}	1.18	1.55	-16.64	-4.84	-2.51	-10.95	-9.63	-8.85	0.37	N/A
St. Alexius Hospital–Jefferson Campus ^{2,3}	8.67	-5.96	-7.34	7.05	9.46	-0.40	6.55	-8.84	-16.73	N/A
St. Anthony’s Medical Center ⁴	6.67	6.28	5.59	6.52	0.72	-7.73	-4.37	-8.47	0.00	2.06
St. John’s Mercy Hospital–Washington	10.89	10.89	9.70	10.78	9.72	3.48	4.88	4.84	3.04	3.88
St. John’s Mercy Medical Center	6.31	6.38	5.43	7.33	5.69	2.73	0.62	2.13	3.44	3.67
St. Joseph Health Center–St. Charles	2.33	4.10	4.38	-0.26	-0.39	-0.43	2.63	2.74	4.12	1.33
St. Joseph Hospital–Kirkwood	0.81	1.70	3.09	4.13	2.99	0.97	0.88	4.22	1.23	-1.03
St. Joseph Health Center–Wentzville ⁵	-8.76	-18.85	2.61	N/A	27.00	-45.50	-25.25	-19.77	-13.93	-24.26
St. Joseph Hospital West–Lake St. Louis	5.49	4.62	3.65	5.75	8.91	3.66	10.62	10.70	4.84	3.29
St. Louis Children’s Hospital	3.04	3.77	2.87	4.25	5.17	3.57	3.68	5.01	4.85	8.44
St. Louis University Hospital ²	5.70	4.66	6.13	-4.37	11.25	1.65	12.55	18.36	7.95	-5.82
St. Luke’s Hospital	4.18	3.44	3.47	4.94	4.12	4.21	4.83	4.51	3.58	3.37
St. Mary’s Health Center	2.72	5.08	9.02	8.50	5.02	3.15	2.11	4.93	5.23	5.72
Aggregate for Missouri Hospitals	4.22%	4.28%	3.40%	2.44%	2.55%	0.40%	3.08%	5.60%	5.58%	4.08%
Illinois Hospitals										
Alton Memorial Hospital	14.48%	6.23%	6.97%	-0.97%	1.93%	2.07%	11.15%	14.19%	15.44%	15.56%
Anderson Hospital	5.84	6.20	11.35	11.30	4.56	1.03	1.61	-0.15	-0.90	-5.48
Gateway Regional Medical Center	-10.17	2.30	-4.13	-2.15	-2.17	-8.35	-11.21	7.75	7.60	12.02
Kenneth Hall Regional Hospital (East St. Louis)	4.84	2.32	3.14	0.00	-1.88	-9.53	-13.67	-25.10	-16.97	4.76
Memorial Hospital of Belleville	1.47	4.22	6.67	2.76	2.30	0.77	-0.82	-0.56	-1.52	-2.01
St. Anthony’s Health Center (Alton) ⁶	1.75	4.20	3.81	2.00	-6.30	-0.46	5.46	4.32	0.36	-3.30
St. Elizabeth’s Hospital (Belleville)	2.05	1.39	1.64	2.20	0.79	-1.41	-4.07	-1.36	2.21	-4.22
St. Joseph Hospital (Breese, IL)	11.02	6.28	13.10	9.53	9.87	9.89	12.14	10.72	12.30	11.82
Touchette Regional Hospital	1.68	-5.86	-9.24	-8.52	-6.15	-7.73	-15.76	0.36	1.22	3.86
Aggregate for Illinois Hospitals	2.45%	2.83%	2.76%	1.79%	0.03%	-1.28%	-0.86%	1.79%	2.36%	2.12%
Aggregate for St. Louis Area Hospitals	3.96%	4.07%	3.30%	2.34%	2.19%	0.16%	2.55%	5.09%	5.15%	3.82%

¹ Barnes Hospital and The Jewish Hospital of St. Louis merged to become Barnes-Jewish Hospital in fiscal year 1996. Their combined 1996 Medicare Cost Report (MCR) included 11 months of Barnes Hospital data and 12 months of Jewish Hospital data.

² As a result of hospital mergers in 1996, 1997, 1998, and 2000, financial data for certain hospitals was reported for less than 12 months.⁷ St. Alexius and Forest Park hospitals were sold to Doctors Community Healthcare Corporation in 2004, and due to the transfer in ownership, 2002, 2003 and 2004 data could not be verified.

³ Beginning in 2004, St. Alexius-Broadway Campus and St. Alexius-Jefferson Campus reported on a combined basis under St. Alexius Hospital.

⁴ From 1997 to 1999, statistics for St. Anthony’s Medical Center and St. Clement’s Hospital are combined under St. Anthony’s Medical Center.

⁵ St. Joseph Health Center-Wentzville (as the former Doctors Hospital-Wentzville) filed a 7 month Medicare Cost Report for 1996 and fiscal year 1998 information was unavailable. They filed a 8.5 month MCR for fiscal year 2000 just prior to acquisition by Essent Healthcare of Missouri June 28, 2000 and were renamed Crossroads Regional Hospital. They were acquired by SSM Health Care in November 2005.

⁶ Beginning in 1992, statistics for St. Anthony’s Hospital and St. Clare’s Hospital are combined under St. Anthony’s Health Center.

Sources: Centers for Medicare and Medicaid Services Medicare Cost Reports and audited hospital financial statements. All data in this table are not adjusted for inflation.

Note: Changes in previously reported data are based on most current information. Hospitals no longer in operation as of 2004 are not individually listed, but their results for 1995-2004 are included in aggregate figures. Normandy Community Hospital has been excluded from fiscal year 1999 and Bethesda General Hospital, Compton Heights Hospital, and Woodrider Township Hospital have been excluded from fiscal year 2000 in this table since extraordinary charges associated with their closure in those years caused financial results to be unreliable.



St. Louis Area Hospital Industry 1995–2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Missouri Hospitals										
Barnes Hospital ¹	7.54%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Barnes-Jewish Hospital ¹	N/A	6.65%	8.40%	7.08%	1.73%	0.78%	3.20%	1.41%	16.80%	11.58%
Barnes-Jewish Hospital–St. Peters	8.28	9.30	9.71	5.60	8.25	10.05	8.22	14.96	21.19	14.35
Barnes-Jewish Hospital–West County	4.19	3.58	1.52	-2.08	-2.37	-0.47	15.12	19.73	20.00	16.02
Cardinal Glennon Hospital	8.56	11.00	16.63	18.03	11.66	19.38	8.29	11.91	10.22	16.04
Christian Hospitals	6.32	7.08	5.05	-5.17	-7.93	-10.80	-10.36	3.86	13.19	8.73
DePaul Health Center	-7.12	-6.30	-4.05	0.15	-5.90	1.55	-0.43	2.58	4.51	5.08
Des Peres Hospital ²	2.04	-4.81	-14.12	-8.87	9.65	7.17	6.15	7.91	7.78	4.18
Forest Park Hospital ²	4.64	0.45	-19.46	-2.99	2.95	-18.91	-4.07	-0.86	2.64	-24.69
Jefferson Memorial Hospital	6.52	4.94	6.89	4.02	1.56	2.40	1.62	0.86	0.71	0.45
Jewish Hospital ¹	5.82	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kindred Hospital	30.74	16.64	22.90	19.33	1.06	-2.57	-7.24	7.76	8.13	19.64
Lincoln County Memorial Hospital	8.27	4.47	-0.45	-5.87	-2.53	-2.15	5.90	3.42	-8.34	0.05
Missouri Baptist Medical Center	8.24	13.75	14.55	11.79	4.75	4.14	7.41	14.69	17.33	16.61
Missouri Baptist Hospital–Sullivan	4.19	4.27	-3.07	-11.56	-6.28	-5.95	-2.95	1.35	8.52	9.90
St. Alexius Hospital ³	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-8.23
St. Alexius Hospital–Broadway Campus ^{2,3}	6.12	3.93	-8.54	-4.07	-10.13	-11.53	-9.39	-8.86	0.37	N/A
St. Alexius Hospital–Jefferson Campus ^{2,3}	9.14	-5.95	-7.15	7.00	8.02	-2.86	2.34	-7.94	-16.71	N/A
St. Anthony's Medical Center ⁴	15.38	15.31	19.73	20.80	0.92	-3.87	-3.98	-7.31	1.88	7.79
St. John's Mercy Hospital–Washington	18.75	20.80	22.36	10.98	6.13	2.23	4.74	4.06	2.95	3.82
St. John's Mercy Medical Center	9.11	9.64	13.89	8.03	3.93	2.73	-0.79	1.52	3.42	3.37
St. Joseph Health Center–St. Charles	4.44	5.25	5.57	1.64	2.97	0.26	2.89	2.91	4.24	1.27
St. Joseph Hospital–Kirkwood	0.67	1.83	2.53	4.33	3.07	0.72	0.91	4.51	1.60	-0.78
St. Joseph Health Center–Wentzville ⁵	-8.76	-18.81	7.19	N/A	27.00	-45.45	-25.58	-19.77	-13.93	-24.26
St. Joseph Hospital West–Lake St. Louis	8.59	8.15	8.49	10.33	13.79	6.22	10.99	11.23	5.20	3.05
St. Louis Children's Hospital	10.42	11.84	10.58	14.08	10.67	5.81	5.30	3.39	16.10	15.55
St. Louis University Hospital ²	8.26	9.74	8.36	-2.48	-2.57	-0.86	3.45	8.04	7.73	-5.82
St. Luke's Hospital	10.45	8.52	5.28	6.48	5.60	5.60	5.90	4.91	4.16	4.06
St. Mary's Health Center	8.54	8.18	12.09	10.56	8.27	5.99	3.58	5.47	5.74	7.04
Aggregate for Missouri Hospitals	7.74%	7.48%	8.29%	6.37%	2.50%	0.95%	2.04%	3.75%	9.55%	6.89%
Illinois Hospitals										
Alton Memorial Hospital	16.39%	6.71%	8.87	1.22%	0.57%	3.48	12.98%	13.96%	21.63%	19.91%
Anderson Hospital	8.67	7.50	13.92	13.40	6.59	3.19	4.13	1.12	0.11	-4.28
Gateway Regional Medical Center	1.47	3.03	-2.91	-2.37	-1.43	-6.37	-9.99	7.75	7.60	12.02
Kenneth Hall Regional Hospital (East St. Louis)	6.43	5.19	7.14	1.03	-0.08	-8.37	-12.49	-25.10	-16.94	4.91
Memorial Hospital of Belleville	13.06	10.89	10.92	8.68	5.37	7.10	1.69	-1.53	0.12	-0.31
St. Anthony's Health Center (Alton) ⁶	4.02	5.52	5.55	5.48	-4.42	1.74	5.42	4.63	2.18	-2.63
St. Elizabeth's Hospital (Belleville)	3.67	3.43	4.66	8.88	4.94	1.08	-0.60	-1.04	5.01	-1.04
St. Joseph Hospital (Breese, IL)	14.25	9.52	16.46	17.35	14.41	14.60	18.49	11.33	19.10	18.94
Touchette Regional Hospital	4.50	-3.54	-7.28	-6.83	-4.72	-7.28	-14.77	0.76	1.69	3.96
Aggregate for Illinois Hospitals	7.67%	5.44%	5.56%	5.68%	2.29%	1.80%	1.39%	1.82%	5.02%	4.21%
Aggregate for St. Louis Area Hospitals	7.73%	7.19%	7.89%	6.27%	2.47%	1.08%	1.95%	3.50%	8.96%	6.53%

¹ Barnes Hospital and The Jewish Hospital of St. Louis merged to become Barnes-Jewish Hospital in fiscal year 1996. Their combined 1996 Medicare Cost Report (MCR) included 11 months of Barnes Hospital data and 12 months of Jewish Hospital data.

² As a result of hospital mergers in 1996, 1997, 1998, and 2000, financial data for certain hospitals was reported for less than 12 months.⁷ St. Alexius and Forest Park hospitals were sold to Doctors Community Healthcare Corporation in 2004, and due to the transfer in ownership, 2002, 2003, and 2004 data could not be verified.

³ Beginning in 2004, St. Alexius-Broadway Campus and St. Alexius-Jefferson Campus reported on a combined basis under St. Alexius Hospital.

⁴ From 1997 to 1999, statistics for St. Anthony's Medical Center and St. Clement's Hospital are combined under St. Anthony's Medical Center.

⁵ St. Joseph Health Center-Wentzville (as the former Doctors Hospital-Wentzville) filed a 7 month Medicare Cost Report for 1996 and fiscal year 1998 information was unavailable. They filed a 8.5 month MCR for fiscal year 2000 just prior to acquisition by Essent Healthcare of Missouri June 28, 2000 and were renamed Crossroads Regional Hospital. They were acquired by SSM Health Care in November 2005.

⁶ Beginning in 1992, statistics for St. Anthony's Hospital and St. Clare's Hospital are combined under St. Anthony's Health Center.

Sources: Centers for Medicare and Medicaid Services Medicare Cost Reports and audited hospital financial statements. All data in this table are not adjusted for inflation.

Note: Changes in previously reported data are based on most current information. Hospitals no longer in operation as of 2004 are not individually listed, but their results for 1995-2004 are included in aggregate figures. Normandy Community Hospital has been excluded from fiscal year 1999 and Bethesda General Hospital, Compton Heights Hospital, and Woodriver Township Hospital have been excluded from fiscal year 2000 in this table since extraordinary charges associated with their closure in those years caused financial results to be unreliable.



Fiscal Year 2005 Financial Data (000)								
St. Louis Area Hospitals	Fiscal Year	2005 Total Revenue	2005 Total Operating Revenue	2005 Total Expenses*	2005 Gain from Operations	2005 Net Profit	2005 Operating Margin	2005 Profit Margin
St. John's Mercy Health Care								
St. John's Mercy Medical Center	6/30	\$590,569	\$590,246	\$580,116	\$10,130	\$10,453	1.72%	1.77%
St. John's Mercy Hospital, Washington	6/30	76,095	75,910	73,446	2,464	2,650	3.25	3.48
Total		\$666,664	\$666,156	\$653,562	\$12,594	\$13,103	1.89%	1.97%
Other								
St. Anthony's Medical Center	6/30	\$353,259	\$335,731	\$330,665	\$5,066	\$22,594	1.51%	6.40%
St. Elizabeth's Hospital (Belleville)	6/30	157,398	153,766	160,291	(6,525)	(2,893)	-4.24	-1.84
St. Joseph Hospital (Breese, IL)	6/30	34,965	32,322	28,533	3,790	6,433	11.72	18.40
St. Luke's Hospital	6/30	296,116	292,693	283,081	9,612	13,035	3.28	4.40
Jefferson Memorial Hospital	9/30	102,319	101,002	100,264	737	2,054	0.73	2.01
Total		\$944,057	\$915,514	\$902,834	\$12,680	\$41,223	1.39%	4.37%

* Total Expenses include non-operating expenses that may have an effect on profit margins. Non-operating expenses are not used in the calculation of operating margins.

Technical Notes

Hospital Financial Data

The St. Louis Area Business Health Coalition (BHC) has analyzed hospital financial data for the last 23 fiscal years. Data for these analyses are gathered from hospital audited financial statements, licensing surveys and Centers for Medicare and Medicaid Services Medicare Cost Reports (MCR). The resulting reports are based upon standard accounting assumptions and procedures.

A financial profile is produced for each institution which is then verified by the individual institutions. When an individual institution disagrees with the financial profile,

supporting documentation is submitted before changes are made to the profile. From the individual reports, aggregate tables are produced reflecting St. Louis area Missouri hospitals and St. Louis area Illinois hospitals.

In some situations, prior year data are updated based on revised MCR and/or current hospital audited financial statements. As a result, the data presented in this document reflect the most current information available to the BHC and may differ from previous reports. ■

Financial Formulas <i>(For Leap years: Use 366 for all formulas using days)</i>	
<p>OPERATING MARGIN</p> $\frac{(\text{Total Operating Revenue} - \text{Operating Expenses})}{\text{Total Operating Revenue}}$	<p>ALLOWANCES AS PERCENT OF CHARGES</p> $\frac{\text{Allowances}}{\text{Total Gross Charges}}$
<p>PROFIT MARGIN</p> $\frac{\text{Excess of Revenue Over Expenses}}{(\text{Total Operating Revenue} + \text{Non-operating Revenue})}$	<p>COST TO CHARGE RATIO</p> $\frac{\text{Total Operating Expenses}}{\text{Total Gross Charges}}$
<p>RETURN ON EQUITY</p> $\frac{\text{Excess of Revenue Over Expenses}}{\text{Fund Balance}}$	<p>OCCUPANCY PERCENTAGE</p> $\frac{\text{Patient Days}}{\text{Number of Beds} \times 365}$
<p>MARK-UP PERCENT</p> $\left(\frac{\text{Total Gross Charges}}{\text{Total Operating Expenses}} \right) - 1$	

Technical Notes

Herfindahl-Hirschman Index

The Herfindahl – Hirschman Index (HHI) has been used by the Department of Justice (DOJ) in the antitrust area as one aid in determining the degree of market concentration when evaluating the potential harm to consumers of proposed mergers in a market. Market concentration is a function of the number of firms in a market and their respective market shares. The HHI was calculated for the St. Louis region by summing the squares of the hospital and health network market shares using hospital admissions as the proxy for market share. Within the St. Louis region, the squared market shares of the individual hospitals and the combined squared market share for each hospital system are summed producing the regional HHI. This technique gives proportionately greater weight to the market shares of larger systems, in accord with their increased potential for exercising market power resulting in anticompetitive behavior such as increased prices (see example below). The geographic market is an important factor in merger analysis and in calculating the HHI as well. For the aggregate statistics produced in this study, the metropolitan statistical area (MSA) has been used to define the geographic market. It is important to note that the Federal Trade Commission (FTC) and the DOJ have used different definitions of the geographic market when analyzing mergers in a region that

have at times been either larger or smaller than the MSA definition depending on the circumstances surrounding the merger. Therefore, the HHI values shown in this study may not be comparable to those values used in specific antitrust investigations conducted by the FTC and the DOJ.

The meaning of the HHI values in evaluating an industry in a given market are broadly defined as 1) Unconcentrated, HHI < 1,000; 2) Moderately Concentrated, HHI >1,000 and <1,800; and 3) Highly Concentrated, HHI >1,800.

After a steady decline since 2000, market concentration in the St. Louis region increased to 1,519 as a result of SSM Health Care's acquisition of St. Joseph Health Center Wentzville (formerly Crossroads Regional Medical Center). In 2007, construction of BJC's new hospital will be complete that will again increase the HHI. Beyond 2007, HHI market concentration may continue to rise with the planned construction of two new hospitals as well as renovation and expansion of existing facilities. Provider consolidation tends to reduce competition in a market and is a recognized driver of healthcare price increases. As discussed earlier in this report, consumers are directly affected since the rising cost of health care benefits reduces real income and increases the cost of other goods and services. ■

Network	Discharges*	Market Share	Market Share Squared	HHI Index
BJC HealthCare	117,573	29.6%	0.087544	875
SSM Health Care	75,421	19.0%	0.036024	360
St. John's Mercy Health Care	43,281	10.9%	0.011863	119
Tenet HealthSystem	23,681	6.0%	0.003551	36
Non-Merged Hospitals				
Anderson Hospital	6,116	1.5%	0.000237	2
Gateway Regional Medical Center	8,271	2.1%	0.000433	4
Forest Park Hospital ¹	10,243	2.6%	0.000664	7
Jefferson Memorial Hospital	9,784	2.5%	0.000606	6
Kenneth Hall Regional Hospital (East St. Louis, IL)	3,065	0.8%	0.000059	1
Kindred Hospital	355	0.1%	0.000001	0
Lincoln County Memorial Hospital	1,098	0.3%	0.000008	0
Memorial Hospital of Belleville	14,580	3.7%	0.001346	13
St. Alexius Hospital ^{1,2}	11,384	2.9%	0.000821	8
St. Anthony's Health Center (Alton)	7,291	1.8%	0.000337	3
St. Anthony's Medical Center	27,856	7.0%	0.004914	49
St. Elizabeth's Hospital (Belleville)	14,039	3.5%	0.001248	12
St. Joseph Hospital (Breese)	2,181	0.5%	0.000030	0
St. Luke's Hospital	18,533	4.7%	0.002175	22
Touchette Regional Hospital	2,618	0.7%	0.000043	0
Sub-total Non-Merged Hospitals+	137,414	34.5%	+	129
Total	397,370	100%	1.000000	1,519

¹ Due to the 2004 transfer in ownership, 2004 data for these hospitals could not be verified by Tenet or DCHC.

² Beginning in 2004, St. Alexius-Broadway Campus and St. Alexius-Jefferson Campus reported on a combined basis under St. Alexius Hospital.

* Source: Centers for Medicare and Medicaid Services 2004 Medicare Cost Reports and internal utilization statements. Market share is based on the number of discharges. Hospital network configurations shown on this page are current as of 2006.

+ Market shares of non-merged hospitals were individually squared and added to create the HHI index.



Glossary

ACE Inhibitor (angiotensin converting enzyme): A type of medicine used to treat heart attacks, heart failure, or a decreased function of the left side of the heart (left ventricular systolic dysfunction). ACE inhibitors can help reduce the risk of death from a heart attack if taken within 24 hours of the first symptoms of a heart attack. Continued use may help prevent heart failure. ACE inhibitors work by blocking an enzyme in the body that is necessary to produce a substance (angiotensin II) that causes blood vessels to constrict. As a result, blood vessels relax and blood pressure is lowered increasing the supply of blood and oxygen to the heart.

Allowances: This element consists principally of Contractual Adjustments, which are differences between gross revenues at established rates and amounts realizable from third party payers under contractual agreements.

Available Acute Bed: A hospital bed in a specific location in a health care institution for which the hospital is prepared to provide needed services when a patient is admitted as reported in Medicare Cost Report, Worksheet S-3. This was used to calculate available occupancy percentage and excess available acute beds.

- **Licensed Acute Bed:** A State authorized bed capacity of a health care institution as reported in Missouri Hospital Profiles, Illinois Department of Health Statistics or other State agency. The numeric counts of licensed beds are typically greater than for available acute beds (see above).
- **Staffed Bed:** A term used within the hospital industry to denote a bed which is fully staffed and ready to receive a patient. A staffed bed is similar to an available bed, but the numeric count is typically less than for available beds.

Average Length of Stay: The number of patient days used divided by the number of discharges.

Average Mark-up: The percentage by which costs are increased to yield gross charges that is typically referred to as charges over costs.

Beta blocker: A type of medicine that is used to lower blood pressure, treat chest pain (angina) and heart failure, and to help prevent a heart attack. Beta blockers relieve the stress on the heart by slowing the heart rate and reducing the force with which the heart muscle contracts (to pump blood). Most heart attack patients should be given a beta blocker within 24 hours of arriving at the hospital.

Central Line-Associated Bloodstream Infection (CLAB): A central line is a flexible tube that is inserted near the patient's heart or into one of the large veins or arteries to

give fluids, measure the amount of fluid in the body, or to give medication. CLAB is an infection in a patient who has a central line that was used within the 48-hour period before the onset of the infection. If the interval is longer than 48 hours, there must be compelling evidence that the infection is related to the central line.

Charity Care: Health services that were never expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria. (American Institute of Certified Public Accountants, 1990)

Contractual Allowance Percent: The percentage of contractual adjustments by which gross charges are discounted from third party payers under contractual agreements.

Fund Balance / Unrestricted Net Assets: The difference between assets and liabilities.

Left Ventricular Systolic Dysfunction (LVSD): A condition characterized by decreased function of the left side of the heart.

Left Ventricular Function Assessment (LVF): A test that checks how the heart is pumping.

Occupancy Rate: This figure is determined by dividing the number of patient days used by the number of available acute beds multiplied by the number of days in the year. Excluded are nursery, skilled nursing facility, and other long term non-acute days and beds.

Operating Margin: The portion of a firm's operating revenue retained as income. See Technical Notes for formula.

Oxygenation Assessment: Tests that check the level of oxygen in the bloodstream. They may include an ABG (arterial blood gas) or pulse oximetry (electrodes attached to a part of the body such as a finger, earlobe, or skin fold).

Patient Days: A unit of utilization calculated by multiplying the number of discharges (or admissions) by the hospital average length of stay. This term is also referred to as "Total Bed Days Used".

Profit (Loss): Excess (deficit) of revenue over expenses.

Profit Margin: Excess of revenue over expenses divided by the sum of total operating revenue and non-operating revenue.

Return on Equity: A ratio that defines the amount of net income earned per dollar of unrestricted net assets or fund balance. It is calculated by dividing the excess of revenue over expenses by the fund balance.



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About the BHC

The St. Louis Area Business Health Coalition (BHC) is a non-profit organization serving St. Louis employers for over 20 years. Its mission is to support employers in their efforts to enhance the quality and overall value of their investments in health benefits while seeking to improve the health of their enrollees.

The BHC Foundation is a separate non-profit subsidiary organization to BHC. The BHC Foundation purpose is to provide pertinent health care information to the community.

About this Report

This report analyzes, summarizes, and presents information and trends on the St. Louis area hospital industry for fiscal years 2004 with limited data for fiscal year 2005. The report includes data from the following sources: Health Insights (QIO), Ingenix, Leapfrog, Centers for Medicare and Medicaid Services (CMS) Medicare Cost Reports and Hospital Compare, audited hospital financial statements, the American Hospital Association (AHA) and Missouri Hospital Association (MHA) annual licensing surveys, as well as additional information voluntarily provided by the hospitals.

Data Limitation and Cautions

BHC has made every effort to provide accurate information. Each hospital was given the opportunity to verify its financial data. As with any analysis of health care industry data, a note of caution accompanies this report. BHC depends upon the accuracy of the individual sources of data and can not guarantee the complete accuracy of all the data in this report, in part, because Medicare Cost Reports contain a level of error. Data inaccuracies that may remain for individual hospitals would have minimal impact on weighted average values and virtually no impact on the overall conclusions regarding St. Louis' hospital performance.

Please read the appendices to become familiar with the technical discussion while reviewing or interpreting the data detailed in this report.

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