COLORADO
Department of Health Care Policy & Financing
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Executive Summary

Hospital Financial Transparency Report

This annual report is prepared by the Department of Health Care Policy & Financing (HCPF) pursuant to Section 25.5-4-402.8, C.R.S. Since the passage of House Bill (HB)19-1001 in 2019, HCPF has worked with Colorado hospitals to compile a dataset of hospital financial and utilization metrics to present a full picture of the hospital industry in Colorado. The Hospital Financial Transparency Report represents the compilation of the historic dataset to date and includes some basic analysis of the dataset.

For the completion of this report, hospitals submit three forms of financial and utilization information: Medicare cost reports, audited financial statements and the completion of a data submission template. Most hospitals made a good-faith effort to satisfy the bill requirements, although some hospitals did not make a statement and/or submit data.

The Hospital Financial Transparency Report presents aggregated information on Colorado hospitals, with hospital-specific information in Appendix C: Hospital Financial Transparency Report Detailed Dataset by Hospital in this report.

HB23-1226, Hospital Transparency and Reporting Requirements, revised the name of the Hospital Expenditure Report to the Hospital Financial Transparency Report and expanded upon the required information that hospitals shall submit to HCPF for analysis and reporting. HB23-1226 became law shortly before hospitals were required to submit fiscal year 2022 data for this report; therefore, much of the new information required by HB23-1226 has not yet been collected and is therefore not included in this annual report. The January 2025 Hospital Financial Transparency report will include this information.

Key Findings

For the comparison period of 2014[1] through 2021, Colorado hospitals' aggregate patient revenues grew measurably faster than operating expenses leading to growing profits and margins. In this timeframe, overall net patient revenue, total operating expenses and uncompensated care have all increased. Hospital fiscal year 2022 was a deviation from

[1] After the 2014 Medicaid expansion, hospitals financially benefited from a large reduction in the uninsured population. Half a million additional Coloradans were enrolled in Medicaid and the Colorado uninsured rate fell from 14.3% in 2013 to 6.7% in 2015. Colorado Health Institute. (2023). Early Results from Colorado's Largest Survey on Health Access. Retreived from https://www.coloradohealthinstitute.org/research/colorado-health-access-survey-2023

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this trend, with operating expenses growing much faster than patient revenues. Operating expense growth was driven by the effects of the COVID-19 pandemic including increased supply costs, vastly increased labor costs, including an alarming increase in contracted labor expense (247.6% since 2019) and inflationary pressure. These factors, combined with investment market downturns, led to narrowing profits and margins.

Looking specifically at uncompensated care, hospitals' data shows that charity care was the primary driver of increases in uncompensated care. The unprecedented influx of migrants into Colorado, especially the Denver area, since 2022 is one likely driver of this change.[2] As the Kaiser Family Foundation noted in November 2022 and September 2023,[3,4] migrants are more likely than United States citizens to have low incomes and lack health insurance, and therefore, hospital charity care plays an important role in ensuring their access to affordable care.

Analysis of the reported data also shows that Colorado hospitals are providing more services through outpatient than inpatient settings. This is most notable in smaller and rural hospitals.

The findings below are aggregated and do not address the unique financial challenges of individual hospitals like Colorado's safety net or the only designated public hospital system, Denver Health, and many of Colorado's struggling rural hospitals.[5]

- With the passage of HB23-1226, which will provide quarterly financial data and more detailed annual data, HCPF will be able to monitor these trends with more recent and more thorough information in the future.
- Overall, due to increasing costs associated with the macro-economic impact of the COVID-19 pandemic, hospital operating expenses have grown faster than patient revenues, leading to narrowing profits and margins. In 2022, the previous trend of patient revenues growing faster than operating expenses has reversed. In 2022, operating expenses grew 10.4% from 2021 while patient revenue grew 5.9% from 2021. Increases in operating expenses is driven by the growth in labor expenses, especially contracted labor expenses, and supply chain and inflation challenges in 2022 resulting from the COVID-19 pandemic.
    - ✔ Net patient revenue grew from $12.1 billion to roughly $21.3 billion between 2014 to 2022, an increase of 75.5% and an average annual increase of 7.3%, or $1.1 billion per year.

[2] coloradosun.com/2024/01/05/denver-migrant-encampment-shelter/
[3] kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/#
[4] kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/
[5] The report includes a consolidated system analysis and a days cash on hand analysis to provide some additional context on these financial challenges. See Table 36 2019-2022 Days Cash on Hand by Hospital or Hospital System and Graph 12 Consolidated National System Operating Profit Margin 2019 through Q3 2023 for more information on how Denver Health and rural hospitals compare with other health systems in Colorado on days cash on hand and profit measurements.

Between 2021 and 2022, net patient revenue increased by 5.9%, or $1.2 billion.

- ✔ Total operating expenses, or costs, which include all expenses related to the operations of the hospitals, have continued to grow consistently over the 2014 to 2022 period. Total operating expenses grew from $11.7 billion to $21.4 billion between 2014 and 2022, an increase of 82.2%. Total operating expenses increased an average of $1.2 billion per year or an average of 7.8% per year between 2014 and 2022.
- ✔ Total operating expenses had the highest growth rate between 2021 and 2022 since 2016. Between 2021 and 2022, total operating expenses increased by $2.0 billion, increasing 10.4% from $19.3 billion in 2021 to $21.4 billion in 2022.
- ✔ Comparatively, the Colorado population grew by 9.2% during the same period of 2014 to 2022, according to the Colorado State Demographer.
- ✔ Total operating expenses growth is driven by increases in salaries, wage, and benefit expenses, especially a large increase in contracted labor over the past few years. Between 2014 and 2022, total payroll expenses (expenses associated with full-time equivalent employees) increased by 62.2%, or $2.7 billion. Between 2014 and 2022, contracted labor expenses increased by 2055%, or $891.2 million.
- ✔ In 2022, contracted labor expenses grew by 73.5%, or $395.8million from 2021 and 247.6% or $665.7 million from 2019. The large increase in contracted labor is due to a variety of factors, including pressure on hospital staffing including frontline health care workers leaving the industry, retention of staff nurses, increased wages, and longer hours being worked by staff (overtime). HCPF will continue to monitor and conduct further analysis of the impacts of the COVID-19 pandemic, along with supply chain and inflation challenges that may be impacting the hospital workforce.
- ✔ HCPF will continue to monitor operating income and determine if the reduction seen between 2021 and 2022 continues, stabilizes, or reverses course and returns to pre-pandemic trends.

- Uncompensated care costs have risen between 2019 and 2022. The rise in uncompensated care was primarily driven by increases in charity care.

- ✔ In 2022, there was $544.0 million in total uncompensated care costs[6], an increase of 12.5% from 2021.
- ✔ Charity care costs made up $325.8 million, or 59.9% of total uncompensated care costs in 2022. Between 2021 and 2022, charity care costs increased by 10.8% or $31.9 million.
- ✔ In 2022, total bad debt costs were $218.3 million, or 40.1% of total uncompensated care costs. Between 2021 and 2022, bad debt costs increased by 15.1% or $28.6 million. The majority of bad debt costs were in the Denver region at $108.7 million, or 49.8% of total bad debt costs. The Denver region is also home to 51% of Coloradans, and is served by the state's largest safety net hospital, Denver Health Medical Center.[7]
- ✔ Uncompensated care costs represent 2.5% of operating expenses in 2022.
- ✔ These uncompensated care trends are expected to continue as more than 36,000 migrants have arrived in Denver during the past year[8]. Migrants are more likely than citizens to utilize hospital charity care.[9] Denver Health reports a $10 million increase in uncompensated care in the past year, which they attribute to the unprecedented number of migrants.[10]

- In 2022, HCPF analyzed profits for patient services, operating, and total net income. Profits have declined recently due to increased operating costs associated with the COVID-19 pandemic. Specifically, labor expenses and supply expenses have increased due to the COVID-19 pandemic, leading to increased operating costs.
  - ✔ Between 2021 and 2022, patient service net income decreased 72.4%, or a reduction of $875.5 million.
  - ✔ Between 2021 and 2022, operating income decreased by $981.0 million or 50.0%.
  - ✔ Between 2021 and 2022, total net income decreased by $3.1 billion or a decrease of 90.2%.
- HCPF has analyzed days cash on hand, a liquidity metric, for Colorado

[6] Costs are calculated using a cost-to-charge ratio that is applied to the respective charges. Charges are the billed amounts from hospitals. For more information, please see the appendix to the report for a full list of definitions.
[7] Denver DOI region includes Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, and Park counties. Source: 2022 county population data from the Colorado State Demography Office.
[8] See footnote 2.
[9] See footnotes 3 and 4.
[10] denvergazette.com/news/new-immigrants-pose-difficult-dilemma-as-denver-health-sees-thousands-of-unpaid-medical-visits/article_93bbba78-b4b0-11ee-83bf-93150c61a814.html

hospitals and systems. HCPF's most recent data show cash reserves have declined from 2021 and 2020 levels. However, cash reserves in 2021 and 2020 were assisted by federal COVID-19 stimulus packages. In 2022, the state median for days cash on hand is 183. While this has been a decrease in cash reserves from previous years, it still remains above the 2019 level of 149.

- Between 2021 and 2022, hospital peer groups had the following findings:[11]
    - ✔ The breakdown of expenses for all peer groups remained about the same between 2021 and 2022.
    - ✔ The large hospital peer group allocated a greater proportion of operating expenses for patients, at 77.2% compared to the small hospital peer group, which allocated 63.2% of operating expenses for patients.
    - ✔ The small hospital peer group had the largest proportion of other expenses at 11.1% and general and administration with 16.6% whereas the large peer group had other expenses at 2.7% and general and administrative with 12.8%.
- On average, in 2022, inpatient care represented 28.7% of total care while outpatient care represented 69.0%; however, larger hospitals are, on average, providing far more inpatient services than their smaller peers.[12]
    - ✔ The disparity between inpatient utilization for small (14.1%) and large hospitals (46.8%) highlights the importance of differing sustainability strategies for rural hospitals, such as investing in rural hospital clinics and outpatient capabilities and divesting in rural hospital inpatient services where appropriate. Future transparency analysis could illuminate specific rural hospital utilization patterns to identify where such opportunities are most evident.
- Payer mix analysis illustrates shifts in payer mix from commercial to Medicare and Medicaid public programs, but that shift was not equal between hospital groups.
    - ✔ Over the period 2014 through 2022, commercial dropped from 36.5% to 30.2%, while public payers represented by Medicare and Medicaid grew from 55.1% to 61.1%.

[11] The three hospital peer groups are as follows: small, with 25 or fewer beds; medium, with 26 to 90 beds; and large, with 91 or more beds.
[12] Inpatient and outpatient splits are calculated by dividing inpatient and outpatient gross charges by total gross charges to determine the percentage of both care settings. The numbers provided here are the average of all hospitals' inpatient and outpatient splits therefore these two numbers will not sum to one-hundred percent.

- ✔ Over the period 2014 through 2022, the payer mix for the large peer group's public programs, Medicare and Medicaid, increased from about 55.2% to 61.5% while its commercial payer mix decreased from about 36.3% to 29.8%. In 2022, the large peer groups commercial payer mix was the lowest out of all peer groups.
- ✔ Between 2014 and 2022, payer mix for the small peer group's public programs, Medicare and Medicaid, decreased from 62.4% to 58.7%. While commercial payer mix for the small peer group did fluxate it remained between 29.0% and 32.8%, and was 30.6% in 2022.
- ✔ The change in commercial payer mix for the peer groups is significant since commercial patients drive hospital operating margins and profitability.

- As reported in previous years, some hospitals are not fully compliant with the reporting requirements, including reporting inconsistently or failing to report some or all required data elements. Additional information is needed to provide comprehensive financial transparency insights. With the enactment of HB23-1226, HCPF will be receiving more comprehensive information in the future, more timely submissions, and will have compliance tools to incentivize full compliance. HCPF will monitor compliance and impose enforcement mechanisms if necessary.

Hospital Financial Transparency Report

Annual Report

February 5, 2024

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Overview

The purpose of the Hospital Financial Transparency Report is to fulfill the statutory requirements enacted through the passage of House Bill (HB)19-1001 and now HB23-1226 to "annually prepare a written hospital transparency report detailing uncompensated hospital costs and the different categories of expenditures".[13] To fulfill this directive, this report provides data summaries and analysis of Colorado hospitals that have submitted financial and utilization data to the Department of Health Care Policy & Financing (HCPF).

Also included in this report is a map of Colorado hospitals as well as the Department of Regulatory Agencies' Division of Insurance (DOI) regions. A list of definitions is available as well.

Legislative Background

Pursuant to § 25.5-4-402.8, C.R.S., HCPF annually prepares a written hospital financial transparency report detailing the uncompensated hospital costs and the different categories of expenditures made by hospitals in the state. HCPF consults with the Colorado Healthcare Affordability and Sustainability Enterprise Board (CHASE Board) in the development of the report. In compiling the Hospital Financial Transparency Report, HCPF uses publicly available data sources whenever possible. Each hospital in the state is required to make information available to HCPF for the compilation of the data set for and the completion of this Hospital Financial Transparency Report.

During the 2023 legislative session, the Colorado General Assembly passed HB23-1226 Hospital Transparency and Reporting Requirements, which expanded and modified HB19-1001 in the following ways:

1. The title of this report was revised from Hospital Expenditure Report to Hospital Transparency Report for clarity.
2. Removal of the good faith effort clause from legislation, requiring hospitals to report all required information.

a. Hospitals will annually submit
    b. A summary of the hospital's transfer of cash, equity, investments, or other assets to and from related parties.
    c. A statement of cash flows.
    d. A narrative report of major planned and completed projects and capital investments greater than $25 million.
    e. Information on current affiliations and a report of physician practice acquisitions.
    f. Salary and total compensation data of the top five highest paid

[13] Hospital Transparency Measures to Analyze Efficacy, HB19-1001. 2019 Regular Session. (2019). Available from www.leg.colorado.gov/bills/hb19-1001.

administrative positions of each nonprofit hospital.

3. In addition, under HB23-1226, hospitals will submit quarterly financial reports including an income and balance sheet.
4. By July 1, 2024, hospitals will submit historic reporting for hospital fiscal years 2014-15 through 2019-20 of the following:
   a. Transfers of cash, equity, investments and other assets to and from related parties.
   b. Information on affiliations and a report of physician practice acquisitions.
5. Finally, by July 1, 2024, hospitals will submit historic reporting for hospital fiscal years 2019-20 through 2022-23 of significant other revenue that would otherwise be reported in the Medicare cost report.

To implement these new requirements as enacted with the adoption of HB23-1226, HCPF is developing rules and guidance for hospitals to provide quarterly income and balance sheet information. HCPF is also developing new guidance for all one time reporting requirements due July 1, 2024. Finally, HCPF is developing revised guidance for the annual reporting requirements through a HCPF-provided template.

With the new compliance measures provided in HB23-1226, HCPF will inform non-reporting hospitals of noncompliance and require a corrective action plan for noncompliant hospitals should noncompliance continue. This new information will inform the January 2025 release of the Hospital Financial Transparency report.

Background to this Report

HB19-1001 requires hospitals to submit Medicare cost reports and audited financial statements and other utilization and financial data. HCPF began gathering 2022 audited financial statements, Medicare cost reports, and financial and utilization metrics in mid-2023 through a HCPF-provided reporting template.

Most Colorado hospitals provided data as required through the HCPF-provided Hospital Financial Transparency Report template, with reported data representing 99.3% of all licensed hospital beds. Through this reporting, HCPF receives high level staffing information; utilization metrics such as discharges, inpatient days and outpatient visits; patient revenue information such as charges, contractual allowances and uncompensated care charges; non-patient revenue information; and expense information both at an operating and a nonoperating level. The appendix: Hospital Financial Transparency Report Detailed Dataset by Hospital, displays the status of hospital data submissions and data for all hospital data submissions for hospital fiscal years 2014 through 2022 with notes when applicable.

Methodology and Limitations

The data within this report represents the cumulation of both historic and current financial and utilization data reported to HCPF. After consultation with the CHASE

Board and the Colorado Hospital Association (CHA), HCPF developed rules for the data collection process to collect data from general hospitals and critical access hospitals (CAH). As provided by legislation, data from psychiatric, long term care, and rehabilitation hospitals was not requested. Data is collected and reported on a hospital fiscal year basis.

HCPF presents the data by peer grouping based on the number of licensed beds. The three hospital peer groups are as follows: small, with 25 or fewer beds; medium, with 26 to 90 beds; and large, with 91 or more beds. HCPF also presents the data by the Department of Regulatory Agencies' Division of Insurance (DOI) geographic regional rating areas.

Appendix C: Hospital Financial Transparency Report Detailed Dataset by Hospital is a representation of the dataset compilation, with both the historic data submissions and the current data submissions. As discussed in the previous section, not all hospitals have submitted data. While all Colorado hospitals are listed in these tables, blank fields indicate hospitals that did not submit data for that year. In some cases, the hospital was not open at that time.

There are limitations in the dataset, including that the historic dataset does not include bad debt and charity care by payer type. Because of this limitation, uncompensated care costs and net patient revenue are not available by payer type for hospital fiscal years 2014 through 2018.

The historic dataset is not fully complete because some hospitals did not report for all years that the hospital was open. For example, if a hospital was acquired by a health system, the health system submission only included data for the years that hospital was part of a health system. To address the limitations of the dataset, HCPF analyzed trends for the most comprehensive period of the dataset, hospital fiscal years 2014 through 2022.

Other limitations include analyzing hospital volume or the number of hospital patients such that there is a challenge in using volume metrics when hospitals have different ways in which they measure volume (example: metrics for inpatient services, discharges or patient days and outpatient visits for outpatient services). Currently, HCPF is not including an analysis that adjusts to a "per patient" or "per bed" basis. HCPF has provided two volume metrics, discharges and outpatient visits within the appendix: Hospital Financial Transparency Report Detailed Dataset by Hospital.

A Note on Submissions

For the completion of this report, the legislation enacted through the passage of HB19-1001 requires hospitals to submit three forms of financial and utilizations information, Medicare Cost Reports, audited financial statements and a completed data submission template. Most hospitals have made a good-faith effort to satisfy

the bill requirements, although some hospitals did not make a statement and/or data submission. The hospitals that did not make a data submission, CommonSpirit (formerly Centura) St. Elizabeth Hospital and St. Vincent Hospital, are not included within the analysis of this report for hospital fiscal year 2022. St. Elizabeth Hospital was purchased by CommonSpirit in the fourth quarter of 2022 and does not have access to the detailed information necessary to complete a full year's report.

HCPF continues to work with hospitals to gather missing data points where possible and improve upon the analysis with future report iterations.

Continuing Impact of the COVID-19 Pandemic

The COVID-19 pandemic began affecting hospital expenses in 2020 with increases to supply expenses beyond typical inflation, increases to salaries and wages to keep up with workforce demands, and reductions in services. Federal stimulus paid to Colorado hospitals, which totaled $1.2 billion, offset reductions in hospital revenue and increases in hospital expenses due to the COVID-19 pandemic.[14][15] The impact of the COVID-19 pandemic has clearly continued into 2023; the full extent of its impact – to Coloradans, employers, the state and to health care providers - will not be completely understood for years to come. While the most recent year of hospital data does show some trends of hospital financial metrics returning to pre-pandemic values such as utilization, other metrics like operating expenses, especially labor expenses, have continued to grow at faster rates than before the pandemic leading to narrowing margins and profits.

HCPF recognizes the impact of COVID-19 related workforce shortages, labor expense increases, and supply chain and inflationary challenges on hospital financials are not fully reflected in this report, as those impacts have continued into 2023, a period not covered by this report. Future HCPF reports will continue to provide clarity into the impacts of the COVID-19 pandemic on hospital financials.

[14] For more information on federal stimulus see the Department's COVID-19's Impact on Colorado Hospitals' Finances (2021). https://hcpf.colorado.gov/sites/hcpf/files/COVID19%20Impact%20on%20Colorado%20Hospitals%20Finances-f.pdf

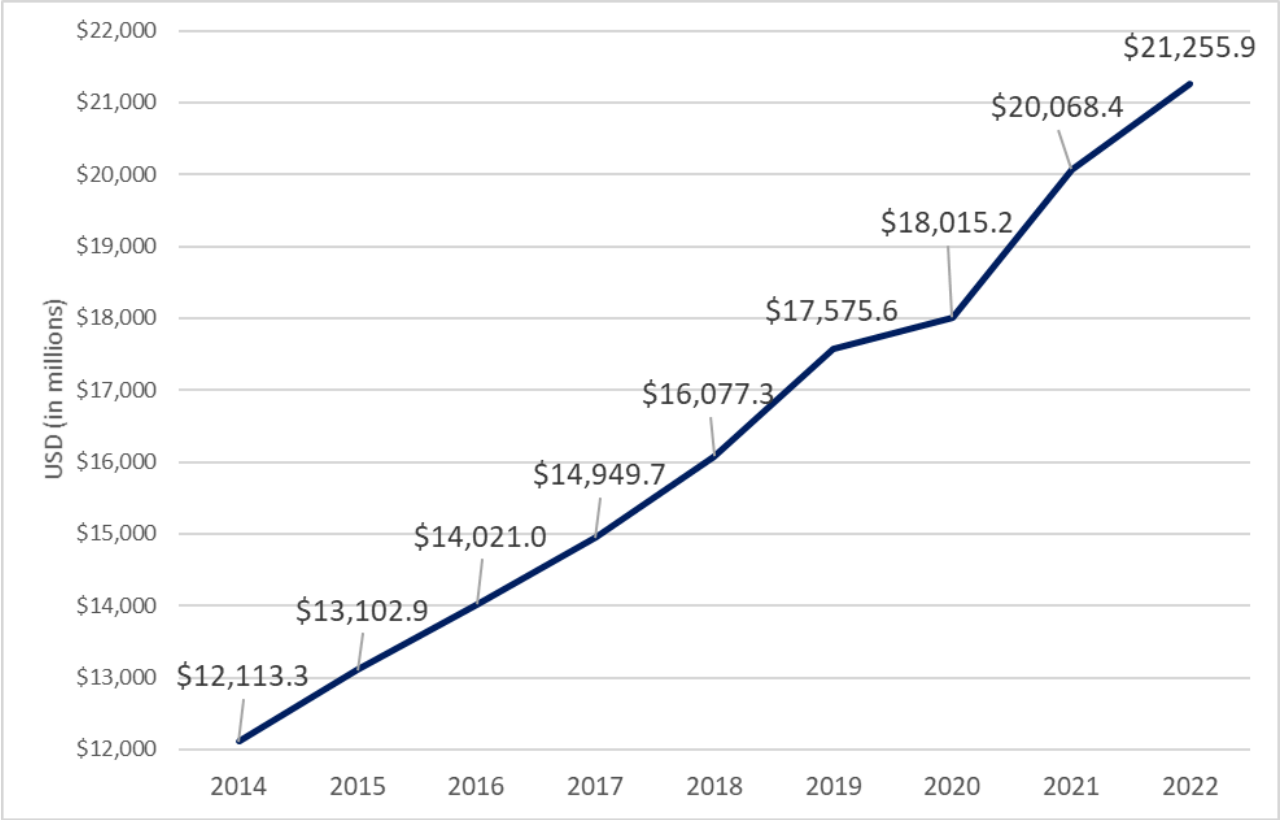
[15] For more information on the impact of the Federal stimulus on Colorado hospitals please see the Colorado Healthcare Affordability and Sustainability Enterprise's (CHASE) Annual CHASE Report Addendum (2023). https://hcpf.colorado.gov/sites/hcpf/files/2023%20CHASE%20Annual%20Report%20FINAL_addendum_0.pdf

Financial Analysis

Historic Financial Analysis

The following section analyzes major hospital financial metrics such as net patient revenue, uncompensated care, operating expenses and income levels for fiscal years 2014 through 2022.

Graph 1 Net Patient Revenue (in millions)



Net Patient Revenue in Total

Net patient revenue approximates the payments a hospital receives for patient services. Net patient revenue is calculated by totaling all charges the hospital billed to patients, subtracting the total of all contractual allowances[16] for each major payer, such as Medicare, Medicaid, commercial, etc., and then subtracting uncompensated care.

Despite the historic impacts of the COVID-19 pandemic on hospital financials, one thing is clear: net patient revenues have continued to rise. Graph 1 illustrates net patient revenue in total for each year presented in the graph. Between 2014 and

[16] Contractual Allowances are the amounts a hospital writes off from their charges as a result of negotiated agreements with insurance companies or government payers.

2022, net patient revenue increased by $9.1 billion, or an increase of 75.5%, an average annual growth of 7.3% for total net patient revenue.[17] Comparatively, the Colorado population grew by 9.2% during the same period 2014 to 2022, according to the Colorado State Demographer.[18]

There was reduced growth between 2019 and 2020 due to the COVID-19 pandemic with a year over year increase of only 2.5%. Notably, this does not include the estimated $1.2 billion of federal stimulus hospitals received during 2020 and recognized throughout 2020 and 2021. While stimulus helped hospitals cover the slower growth of patient revenues during 2020, Federal stimulus funds were also intended to offset increases in expenses from the pandemic. Some hospitals distributed stimulus funds to non-hospital business components, or covered non-operating costs, while other hospitals returned excess stimulus.

That said, between 2020 and 2021 net patient revenue increased by 11.4%, which is in line with pre-pandemic growth rates (in 2019 there was an increase of 9.3% from 2018). Overall net patient revenue has grown consistently since 2014. While there was a decrease in the growth rate between 2019 and 2020, net patient revenue continues to grow similarly to years before the COVID-19 pandemic. Between 2021 and 2022, net patient revenue increased by 5.9% or an increase of $1.2 billion. This is a difference of 1.4 percentage points from the average annual growth rate of 7.3% between 2014 and 2022. For more information on the changes between 2021 and 2022 for net patient revenue see Table 9.

Table 1 illustrates the breakdown of net patient revenue by hospital peer groups. The three groups are small: 25 beds or fewer; medium: 26 to 90 beds; large: 91 beds and more. Each hospital peer group had growth for net patient revenue from 2014 to 2022. Between 2014 and 2022, net patient revenue for the large peer group increased by 55.2%, or $5.8 billion; net patient revenue for the medium peer group increased by 193.8%, or $2.1 billion; and net patient revenue for the small peer group increased by 268.9%, or $1.2 billion.

[17] This calculation is done with a compound annual growth formula to account for compounding over the time period.
[18] Information retrieved from: https://demography.dola.colorado.gov/assets/html/gis_applications.html#population.

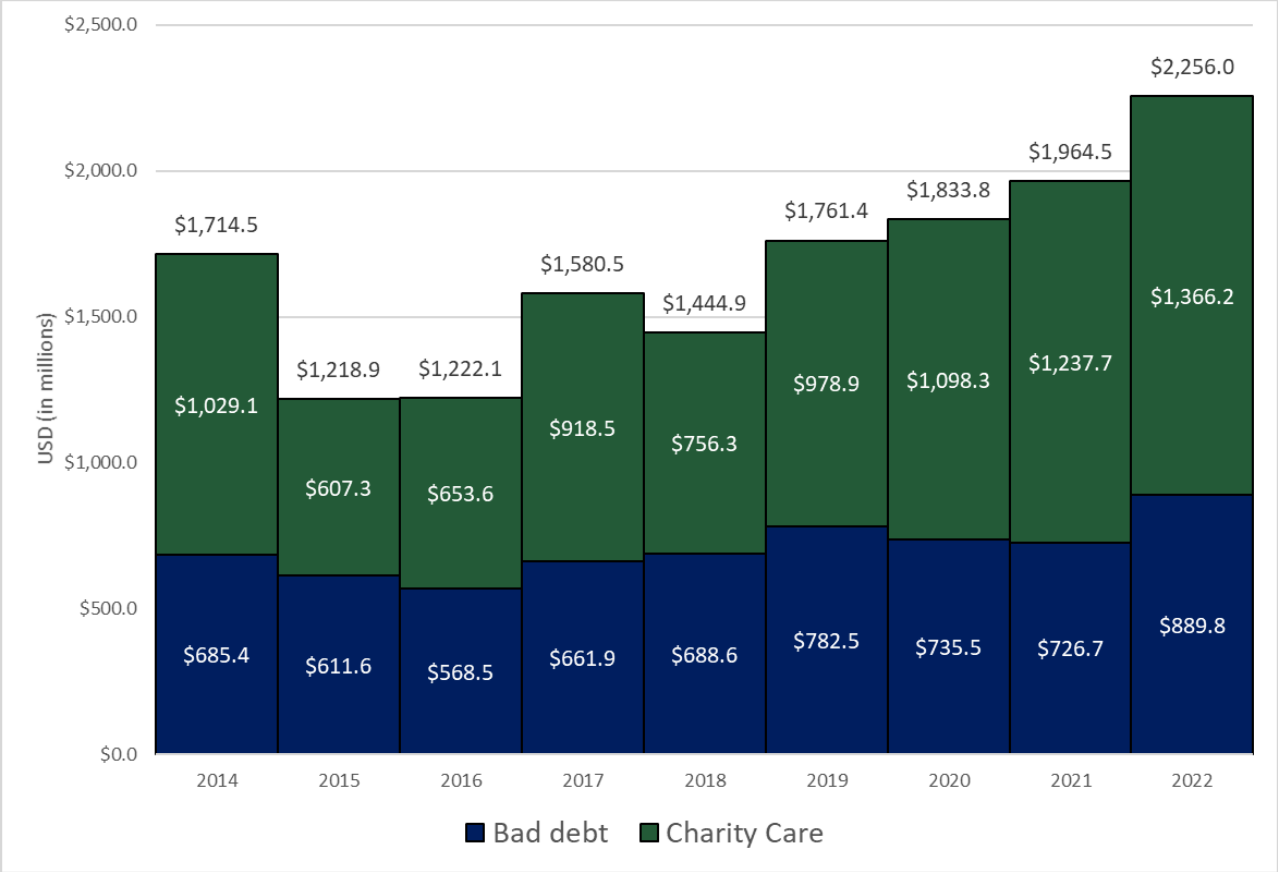
Table 1 Net Patient Revenue by Hospital Peer Groups (in millions)

Year	Large	Medium	Small	Total
2014	$10,583.3	$1,080.5	$449.4	$12,113.3
2015	$11,421.5	$1,177.7	$503.7	$13,102.9
2016	$12,168.6	$1,303.2	$549.2	$14,021.0
2017	$12,973.7	$1,402.0	$574.0	$14,949.7
2018	$13,929.7	$1,514.7	$632.8	$16,077.3
2019	$14,321.4	$2,169.9	$1,084.4	$17,575.6
2020	$14,243.7	$2,507.2	$1,264.3	$18,015.2
2021	$15,700.1	$2,862.1	$1,506.3	$20,068.4
2022	$16,423.2	$3,175.0	$1,657.7	$21,255.9

Uncompensated Care Charges in Total

Uncompensated care charges are the total amount of care a hospital provides that it does not expect or will not receive compensation for. Charges are unique to each hospital and are ultimately set by that hospital's administrative departments. The two main components that make up uncompensated care charges are bad debt and charity care. Both bad debt and charity care are presented within this section of the report as "written off charges." Uncompensated care charges are the billed amounts from hospitals to their patients that are not received, either through charity care or bad debt. In contrast, uncompensated care costs are the costs associated with providing care that is not reimbursed. Costs are described in more detail in a subsequent section. The data in Graph 2 indicate overall uncompensated care declined between 2014 and 2018, but has seen an increase of $811.1 million, or an increase of 56.1%, from 2018 to 2022.

Graph 2 Uncompensated Care Charges by Type



Uncompensated Care Costs in Total

Uncompensated care costs are the estimated amounts that hospitals actually incur to provide services that were unpaid by patients. Uncompensated care costs are calculated by adding charity care and bad debt charges together and multiplying by a cost-to-charge ratio. Each individual hospital has a cost-to-charge ratio, and it is calculated by total expenses (exclusive of bad debt) and dividing that figure by the sum of total charges and other operating revenue. Table 2 shows uncompensated care costs by peer group from 2019 to 2022, while Table 3 shows the percent change of uncompensated care costs between 2019 and 2022. Uncompensated care costs increased by 21.4%, or $96.1 million between 2019 and 2022. More insights into change between hospital fiscal years 2021 and 2022 can be found in the next section of the report.

Table 2 Uncompensated Care Costs by Hospital Peer Groups (in millions)

Year	Large	Medium	Small	Total
2019	$343.6	$63.0	$41.3	$448.0
2020	$371.7	$81.4	$40.8	$493.9
2021	$372.9	$69.0	$41.6	$483.6
2022	$417.1	$77.2	$49.7	$544.0

Table 3 Uncompensated Care Costs Percent Change by Hospital Peer Group

Year	Large	Medium	Small	Total
2019-2020	8.2%	29.1%	-1.2%	10.2%
2020-2021	0.3%	-15.2%	2.0%	-2.1%
2021-2022	11.8%	11.9%	19.5%	12.5%

Charity Care Costs

Charity care is a main component of uncompensated care. It is defined as health services that hospitals do not expect to receive payments in full, or in part, because a hospital has determined, with the assistance of the patient, the patient's inability to pay.[19,20] From 2019 to 2022, charity care costs increased by 32.4%, or an increase of $79.8 million. One driver of this increase in charity care costs is likely the unprecedented recent influx of migrants to Colorado, especially into the greater Denver area. Migrants are more likely than citizens to rely on hospital charity care to access affordable care.[21] Reporting of charity care costs can be found in Table 4 and Table 5.

Table 4 Charity Care Costs by Hospital Peer Group (in millions)

Year	Large	Medium	Small	Total
2019	$204.1	$25.8	$16.0	$246.0
2020	$233.4	$33.0	$10.0	$276.5
2021	$246.8	$36.3	$10.8	$293.9
2022	$271.8	$42.5	$11.5	$325.8

[19] Definition of Uncompensated Care. Retrieved from https://www.aha.org/system/files/2019-01/uncompensated-care-fact-sheet-jan-2019.pdf.
[20] HCPF uses a cost to charge ratio to determine costs within this section. For more information on the cost to charge ratio see the definition within Appendix B of this report.
[21] See footnotes 2, 3, and 4.

Table 5 Charity Care Costs Percent Change by Hospital Peer Group

Year	Large	Medium	Small	Total
2019-2020	14.4%	27.9%	-37.4%	12.4%
2020-2021	5.7%	9.9%	7.9%	6.3%
2021-2022	10.1%	17.0%	6.0%	10.8%

Bad Debt Costs

Bad debt is the other portion of uncompensated care.[22] Bad debt is a record of lost revenue for health services for which a hospital determined the patient had a financial responsibility to pay, but that patient did not pay. This is in contrast to charity care, in which hospitals have determined before the billing process begins that patients would pay none or reduced payments. From 2019 to 2022, bad debt has increased by 8.0% or $16.2 million.

Table 6 Bad Debt Costs by Hospital Peer Group (in millions)

Year	Large	Medium	Small	Total
2019	$139.5	$37.2	$25.3	$202.0
2020	$138.3	$48.3	$30.8	$217.4
2021	$126.2	$32.7	$30.8	$189.7
2022	$145.3	$34.7	$38.3	$218.3

Table 7 Bad Debt Costs Percent Change by Hospital Peer Group

Year	Large	Medium	Small	Total
2019-2020	-0.9%	29.9%	21.7%	7.6%
2020-2021	-8.7%	-32.3%	0.0%	-12.7%
2021-2022	15.2%	6.1%	24.2%	15.1%

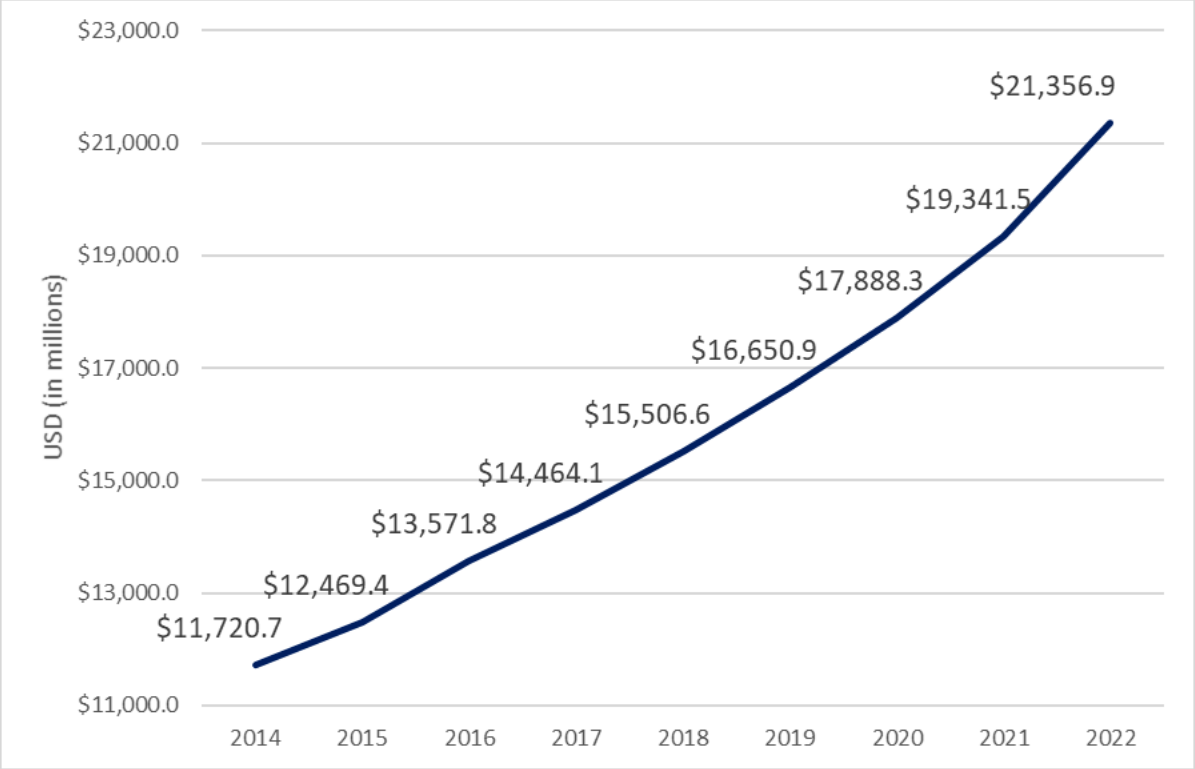
Total Operating Expense Growth

Operating expenses for hospitals are the expenses incurred from the normal business operations of running and operating a hospital. For a hospital, some of these expenses include salaries, rent, management fees, purchase of supplies and utilities.

[22] See footnote 14.

In Graph 3 and Table 8, total operating expenses for all reporting hospitals is displayed for the hospital fiscal years 2014 through 2022. Between this period, the total operating expenses increased by $9.6 billion, or 82.2%. Each year, total operating expenses grew between $2.0 billion and $748.7 million, or between 8.1% and 6.2%, with an average growth of $1.2 billion each year, or 7.8%. Comparatively, the Colorado population grew by 9.2% for the same period 2014 to 2022, according to the Colorado State Demographer.[23] As total operating expenses represent the amount that a hospital spends on the operations, or providing services to patients, changes from unexpected events like the COVID-19 pandemic affect hospitals' total operating expenses. The change in total operating expense from 2019 to 2020 is not markedly high compared to the previous year, nor the following year. However, between 2021 and 2022 total operating expenses had a growth rate of 10.4%, the highest since the period of 2015 to 2016. Discussed further below, this increase has been primarily driven by increases in labor expenses, specifically a significant increase in contracted labor costs.

Graph 3 Total Operating Expense (in millions)



[23] Information retrieved from: https://demography.dola.colorado.gov/assets/html/gis_applications.html#population.

Table 8 Total Operating Expense by Total and by Hospital Peer Group (in millions)

Year	Large	Medium	Small	Total
2014	$10,059.6	$1,040.4	$620.8	$11,720.7
2015	$10,622.5	$1,148.9	$698.0	$12,469.4
2016	$11,530.5	$1,251.7	$789.5	$13,571.8
2017	$12,306.6	$1,329.0	$828.5	$14,464.1
2018	$12,966.1	$1,558.7	$981.8	$15,506.6
2019	$13,209.1	$2,124.4	$1,317.4	$16,650.9
2020	$13,714.8	$2,621.0	$1,552.5	$17,888.3
2021	$14,832.9	$2,736.2	$1,772.3	$19,341.5
2022	$16,224.4	$3,187.3	$1,945.1	$21,356.9

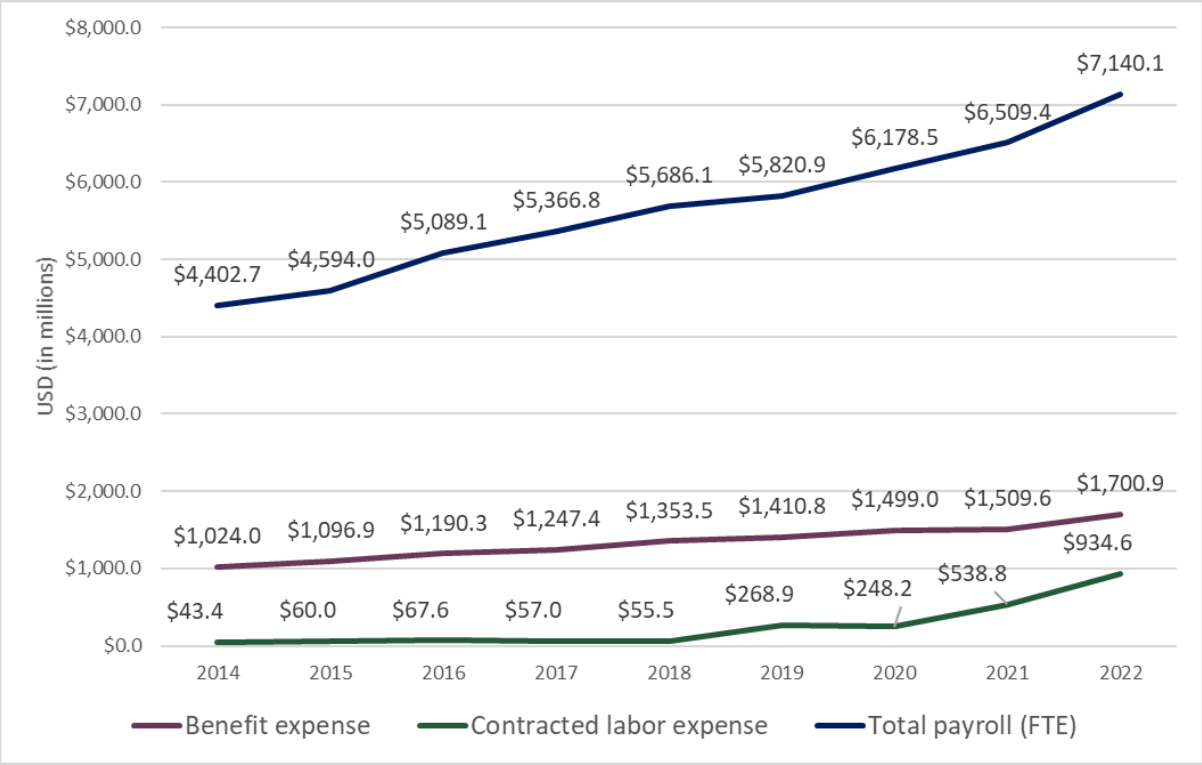
Total labor expenses, which is synonymous with salaries, wages, and benefits within this report, are the largest drivers in operating expenses for hospitals. These expenses include total payroll, which includes all full-time equivalent employees (FTE), contracted labor (workers who are contracted from staffing agencies) and benefit expenses. On average, total salaries, wages, and benefits are 45.6% of all operating expenses between 2014 and 2022. Total payroll expense is the largest portion of all hospitals' operating expenses. Graph 4 shows the three major components of total salaries, wages and benefits: total payroll, contracted labor and benefit expenses.

- Total payroll between 2014 and 2022 grew 62.2% or an increase of $2.7 billion. Between 2014 and 2022, total payroll expenses had an average annual growth of 6.2%.
- Contracted labor expenses grew 2,055% from 2014 or an increase of $891.2 million. The largest growth in contracted labor started in 2019 and has continued to grow since.
    - Between 2019 and 2020 there was a slight reduction in contracted labor of 7.7%, or a decrease of $20.6 million. This reduction is likely explained by the onset of the COVID-19 pandemic, where, at the onset, there was a moratorium on elective surgeries causing overall patient volumes to decline.
    - However, between 2020 and 2021, contracted labor grew by $290.6 million or an increase of 117.1%. This trend continued into 2022, where contracted labor grew by $395.8 million or an increase of 73.5% from

2021.
    - For an expanded look at contracted labor changes see Graph 5.

- Between 2014 and 2022, benefit expenses have grown 66.1% or an increase of $676.8 million. Between 2014 and 2022, benefit expenses maintained a steady growth rate averaging 6.5%. Yet, there has been a larger uptick in the most recent reporting; benefit expenses grew by 12.7% or an increase of $191.3 million between 2021 and 2022.

Graph 4 Total Payroll (FTE), Benefit and Contracted Labor Expenses (in millions)



COLORADO
Department of Health Care Policy & Financing

Graph 5 Contracted Labor Expense (in millions)

COLORADO
Department of Health Care Policy & Financing

Profit Analysis

This section focuses on profits for patient service, operating and total net income. Patient service net income represents the income received from payers such as Medicare, Medicaid and private insurers minus expenses directly associated with patient care. Hospitals do not report expenses directly associated with payers. This is due to how hospitals account for their expenses; rather than tying expenses directly to payers they allocate them to cost centers. Cost centers can include emergency departments, Neonatal Intensive Care Units (NICU), housekeeping departments, etc. HCPF utilizes a cost-to-charge ratio that estimates costs associated with each payer in order to determine patient service net costs. Then those costs are subtracted from reported net patient revenue to calculate patient service net income.

Table 9 Patient Service Net Income by Peer Groups (in millions)

Year	Large	Medium	Small	Total
2019	$1,329.5	$79.2	-$97.6	$1,311.1
2020	$757.4	-$57.2	-$113.3	$586.9
2021	$1,089.0	$181.5	-$60.8	$1,209.8
2022	$420.3	$29.9	-$115.0	$334.3

Table 9 represents total patient service net income by the hospital peer groups between 2019 to 2022. Patient service net income decreased between 2019 and 2020 by 55.2% or a decrease of $724.3 million. Patient service net income grew between 2020 and 2021 by 106.1% or $622.9 million; however, between 2021 and 2022, patient service net income declined 72.4%, or a reduction of $875.5 million. (As a reminder, Federal stimulus funds would not be reflected within patient service net income, though that funding was indeed a stabilizing financial factor for hospitals in that year.) The large peer group has maintained a positive patient service net income over the past three years, whereas the medium and small peer group have both had years of negative patient service net income. Said another way, small hospitals and medium hospitals, which are often independent, rural and CAH hospitals, are not as profitable within their patient service lines compared to large hospitals, which are almost all urban area hospitals and are primarily system hospitals.

Operating net income represents the profit from all operating sources minus all operating expenses. Operating net income gives a lens into how effectively a hospital is operating. Due to limitations in the data operating income is not available for hospital fiscal years 2014 through 2018.

Table 10 Operating Net Income by Peer Groups (in millions)

Year	Large	Medium	Small	Total
2019	$1,816.8	$121.9	-$25.5	$1,913.2
2020	$1,267.3	$38.0	-$8.8	$1,296.5
2021	$1,617.8	$285.8	$58.6	$1,962.3
2022	$893.6	$107.2	-$19.6	$981.3

Table 10 above shows operating income by hospital peer groups and in total. Overall, operating income has oscillated relative to the onset of the COVID-19 pandemic. Table 10 depicts a drop in operating income between 2019 and 2020 (a reduction of 32.2% or $616.6 million) due to reduced patient revenues and growing operating expenses (which grew 7.4% or $1.2 billion between 2019 and 2020). Between 2020 and 2021, operating income increased by 51.4% or $665.8 million. This increase was primarily due to the inclusion of Federal stimulus funds through the Coronavirus Aid, Relief and Economic Security Act (CARES) Act, as well as patients returning to hospitals for care.

Between 2021 and 2022, operating income decreased by $981.0 million or 50.0%. The reduction in operating income over the last period is due to operating revenues, specifically net patient revenues, growing at a slower rate than operating expenses (5.9% and 10.4%, respectively). As mentioned above, contracted labor significantly increased between 2021 and 2022 driving up operating expenses. The large peer group represents a significant portion of total operating income, ranging from 82.4% in 2021 to 97.8% in 2020. Unlike the other peer groups, the small peer group, which includes CAHs and other rural hospitals, experienced negative operating income in most years. HCPF will continue to monitor operating income to determine if the reduction between 2021 and 2022 continues, stabilizes, or reverses course and returns to pre-pandemic trends.

Net income represents all revenues, operating and non-operating, minus all expenses, operating and non-operating. Net income includes all patient service revenues, all revenues from investments and any other revenues a hospital may receive, such as grants.

Table 11 Net Income by Peer Groups (in millions)

Year	Large	Medium	Small	Total
2019	$2,083.3	$155.8	$46.3	$2,285.4
2020	$1,662.8	$53.5	$127.0	$1,843.3
2021	$2,837.7	$358.7	$228.4	$3,424.8
2022	$255.2	$39.5	$41.4	$336.1

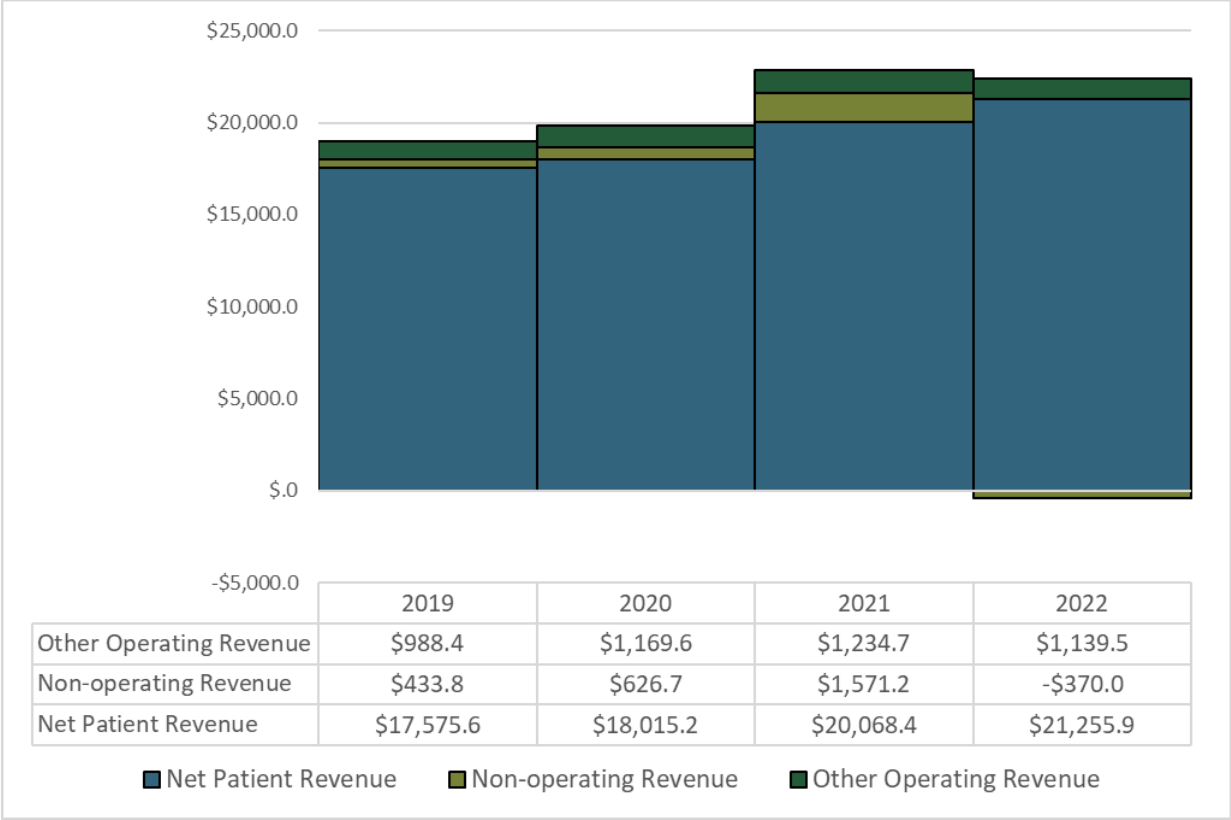
Table 11 shows total net income for peer groups between 2019 and 2022. Table 11 highlights a few areas of interest such as, the effects of the COVID-19 pandemic on operating net income in 2020. Additionally, between 2021 and 2022, total net income decreased again by $3.1 billion or 90.2%. While all peer groups saw a decrease in 2022, the decrease in net income was primarily driven by the large peer group, which decreased by 91.0% or $2.6 billion.

The overall decrease in net income between 2021 and 2022 was largely driven by losses in hospital investments due to a lower than expected year in the investment market.[24] Hospitals have historically profited from investments; therefore, stock market volatility directly influences hospitals' net income position. Over the last few years there has been an increasing number of hospitals with a negative total profit margin, with 13 hospitals in 2020, 11 in 2021, and 40 in 2022.[25] This further highlights the effects of the stock market on hospitals' bottom line. This could be an opportunity for hospitals to evaluate their financial reserve position and reconsider their associated investment policies. HCPF will continue to evaluate hospitals' net income, reserves, and the impact of investment returns and market volatility.

[24] Kaufman Hall sampled over 900 hospitals nationwide, reviewing their investment portfolios. Overall hospital investments were down approximately 3.0%. Retrieved from https://www.kaufmanhall.com/sites/default/files/2023-01/KH_NHFR_2023-01.pdf

[25] For more information about total profit margin by hospital please see Appendix C of this report.

Graph 6 Revenue Streams (2019-2022)



	2019	2020	2021	2022
Other Operating Revenue	$988.4	$1,169.6	$1,234.7	$1,139.5
Non-operating Revenue	$433.8	$626.7	$1,571.2	-$370.0
Net Patient Revenue	$17,575.6	$18,015.2	$20,068.4	$21,255.9

Graph 6, shows the three major revenue streams for hospitals: net patient, other operating, and non-operating revenue. Together, the three revenue types make up all revenues that hospitals receive. This graph does not take into account costs or expenses that are deducted from these revenues. Non-operating revenues are any revenues that are received outside of the normal business operations of a hospital and typically include grants, contributions and gain or losses on investments.[26]

In 2022, total non-operating revenue was -$370.0 million, representing the first negative year in the history of this analysis. Investment losses in 2022 drove the reduction in non-operating revenues; comparing this to total operating income in Table 10 and total net income in Table 11 illustrates the effect of non-operating revenues - or investment returns - on the total profitability for Colorado hospitals.

Current and Previous Year Financial Analysis

This section of the report focuses on the most recent year of the reporting period and analyzes shifts between hospital fiscal years 2021 and 2022. Specifically, it provides a breakdown of financial metrics by peer groups and DOI regions. As mentioned previously, due to the limitation of historic data, payer types have not been presented.

[26] Non-operating line items like gains or losses on investments are typically reported in an aggregate amount and therefore non-operating revenues for 2022 appear negative as losses on investments outweighed other non-operating revenues.

Table 12 Net Patient Revenue Percent Change by Hospital Peer Groups

Peer Group	Net Patient Revenue $ Change in millions (2021-2022)	Net Patient Revenue % Change (2021- 2022)
Large	$723.1	4.6%
Medium	$313.0	10.9%
Small	$151.4	10.1%
Total	$1,187.5	5.9%

In Table 12, the percent change in net patient revenue between 2021 and 2022 for each hospital peer group is displayed. The large peer group increased by $723.1 million, or 4.6%. The medium peer group increased $313.0 million, or 10.9%. The small peer group increased by $151.4 million, or 10.1%.

Net Patient Revenue by Payer Type

Net patient revenue by payer type approximates the payments a hospital receives for a particular payer type.

Table 13 2022 Net Patient Revenue by Payer Type (in millions)

Major Payer Type	Net Patient Revenue	Net Patient Revenue (% of Total)
Medicare	$ 5,792.5	27.3%
Medicaid	$ 3,709.5	17.5%
Commercial	$ 10,397.5	48.9%
Self-Pay	$ 206.8	1.0%
Colorado Indigent Care Program (CICP)/Other[27]	$ 1,149.6	5.4%
Total	$ 21,255.9	100.0%

In Table 13, totals for net patient revenue by payer type is represented in millions. In 2022, total net patient revenue was $21.3 billion. The commercial payer category made up approximately half (48.9%) of total net patient revenue at $10.4 billion. The next largest payer category was Medicare, representing 27.3% of total net patient revenue or $5.8 billion. Medicaid net patient revenue was $3.7 billion, or 17.5% of the total net patient revenue. The two remaining categories representing 6.3% were CICP/Other net patient revenue totaling $1.1 billion and self-pay totaling $206.8million, or 5.4% and 1.0%, respectively.

[27] The CICP/Other category includes CICP, Other, and CHAMPUS/Tricare.

Table 14 2022 Net Patient Revenue by Payer Type by Hospital Peer Group (in millions and as % of Peer Total)

Payer Type	Large	Large (%)	Medium	Medium (%)	Small	Small (%)
Medicare	$ 4,372.8	26.6%	$ 835.6	26.3%	$ 584.2	35.2%
Medicaid	$ 2,958.9	18.0%	$ 468.7	14.8%	$ 281.9	17.0%
Commercial	$ 8,036.4	48.9%	$ 1,696.0	53.4%	$ 665.1	40.1%
Self-Pay	$ 122.8	0.7%	$ 33.9	1.1%	$ 50.1	3.0%
CICP/Other	$ 932.4	5.7%	$ 140.8	4.4%	$ 76.4	4.6%
Total	$ 16,423.2	100%	$ 3,175.0	100%	$ 1,657.7	100%

In Table 14, 2022 net patient revenue by payer type is reported by hospital peer groups. For the large peer group, net patient revenue totaled $16.4 billion or 77.3% of total net patient revenue. The commercial payer category represents about half, or 48.9%, of the large peer group's total at $8.0 billion. For the medium peer group, net patient revenue totaled $3.1 billion, 14.9% of the total for 2022.The commercial payer category was approximately half the medium peer group's net patient revenue with $1.6 billion, or 53.4% and Medicare with $835.6 million, or 26.3%. For the small peer group, net patient revenue totaled $1.7 billion, which was 7.8% of total net patient revenue for 2022. While commercial net patient revenue is the largest portion of the small peer group's total at $665.1 million, or 40.1%, the Medicare category, $584.2 million or 35.2%, represented a larger portion of the small peer groups net patient revenue compared to the large and medium peer groups, 26.6% and 26.3%, respectively. Hospitals in the small peer group are located in rural areas of the state where the population tends to be older and more residents are covered by Medicare compared to urban areas.[28]

[28] See page 8 of Colorado Rural Health Center 2022 Snapshot of Rural Health February Final Release (2022) Retrieved from https://coruralhealth.org/wp-content/uploads/2013/10/2022-Snapshot-of-Rural-Health-February-final-release.pdf

Table 15 2022 Net Patient Revenue by Payer by DOI region (in millions)[29]

Payer Type	Medicare	Medicaid	Commercial	Self-pay	CICP/ Other	Total
Boulder	$359.7	$175.7	$589.5	$10.1	$85.8	$1,220.7
Colorado Springs	$649.5	$378.0	$1,025.9	-$3.8	$211.6	$2,261.2
Denver	$2,790.8	$2,167.4	$6,068.2	$107.0	$569.6	$11,703.0
East	$276.3	$180.7	$238.7	$21.1	$43.5	$760.4
Ft. Collins	$472.9	$147.5	$774.3	$5.0	$55.4	$1,455.0
Grand Junction	$266.2	$137.6	$345.6	$2.6	$52.0	$804.1
Greeley	$156.5	$94.3	$221.5	$6.1	$18.7	$497.2
Pueblo	$243.9	$170.7	$175.2	$7.3	$43.5	$640.6
West	$576.8	$254.3	$958.5	$51.4	$69.5	$1,910.6
Total	$5,792.5	$3,709.5	$10,397.5	$206.8	$1,149.6	$21,255.9

[29] In the Colorado Springs region, self-pay appears as a negative number, this is due to hospitals within that region reporting all of their uncompensated care to the category which overshadows revenues in from those payers.

Table 16 Net Patient Revenue by Payer by DOI Region (as % of Region Total)

Payer Type	Medicare	Medicaid	Commercial	Self-pay	CICP/ Other
Boulder	29.5%	14.4%	48.3%	0.8%	7.0%
Colorado Springs	28.7%	16.7%	45.4%	-0.2%	9.4%
Denver	23.8%	18.5%	51.9%	0.9%	4.9%
East	36.3%	23.8%	31.4%	2.8%	5.7%
Ft. Collins	32.5%	10.1%	53.2%	0.3%	3.8%
Grand Junction	33.1%	17.1%	43.0%	0.3%	6.5%
Greeley	31.5%	19.0%	44.6%	1.2%	3.8%
Pueblo	30.2%	26.6%	50.2%	1.0%	6.8%
West	30.2%	13.3%	50.2%	2.7%	3.6%
Total	27.3%	17.5%	48.9%	1.0%	5.4%

In Table 15 and Table 16, 2022 net patient revenue by payer type is reported by the nine DOI regions. The Denver region represents the majority of net patient revenue at $11.7 billion, or 55.1%. Overall, the Denver region represented most for each of the payer's total net patient revenue. In the majority of regions, commercial net patient revenue represented the highest proportion of total net patient revenue. Except the East region whose highest proportion was Medicare at 36.3% and had the highest self pay proportion at 2.8%.

In 2022, Medicare net patient revenue was approximately 27.3% for the entire state, and Medicaid net patient revenue was 17.5%. In 2022, commercial net patient revenue was almost half of all total net patient revenue with 48.9%. In 2022, CICP/Other net patient revenue was 5.4%, and finally self-pay was 1.0% for the entire state. Across all regions in 2022, Medicaid total net patient revenue averaged 17.7% of total net patient revenue. On average, the commercial percentage of total net patient revenue for each region is 44.4%. Medicare represented the second highest percent of net patient revenue at 31.1% for all DOI regions.

Uncompensated Care Costs in Total

Uncompensated care is the total amount of care a hospital provides that it does not expect to, or will not, receive compensation for providing a service. There are two main components that make up uncompensated care, bad debt and charity care. Costs are determined by applying a cost to charge ratio to uncompensated care write-offs to more accurately estimate the costs borne by hospitals for providing services that go unreimbursed.

Table 17 Uncompensated Care Costs Change by Hospital Peer Groups

Peer Group	Uncompensated Care Costs $ Change in millions (2021-2022)	Uncompensated Care Costs % Change (2021 -2022)
Large	$44.2	11.8%
Medium	$8.2	11.9%
Small	$8.1	19.5%
Total	$60.5	12.5%

Table 17 depicts total uncompensated care growth from 2021 to 2022 for each of the hospital peer groups. Overall, uncompensated care for the large peer group increased by 11.8%, or $44.2 million from 2021 to 2022. The medium peer group uncompensated care increased by $8.2 million, or 11.9%. The small peer group uncompensated care increased overall by 19.5%, or $8.1 million. In Total, uncompensated care costs increased by $60.5 million, or 12.5% between 2021 and 2022.

Charity Care Costs

One main component of uncompensated care is charity care.[30] It is defined as health services for which hospitals do not expect to receive, in full or in part, payment because the hospital had determined, with the patient's assistance, the patient's inability to pay.

Table 18 Charity Care Costs Change by Hospital Peer Group

Peer Group	Charity Care Costs $ Change in millions (2021-2022)	Charity Care Costs % Change (2021 -2022)
Large	$25.0	10.1%
Medium	$6.2	17.0%
Small	$0.7	6.0%
Total	$31.9	10.8%

Table 18 shows the percent change for each hospital peer group from 2021 to 2022. Overall, charity care costs increased by $31.9 million, or 10.8%, from 2021 to 2022. The large peer group represented most of the overall increase with an addition of $25.0 million over the period, or an increase of 10.1%. The medium and small peer

[30] See footnote 19.

groups increased by $6.2 million and $0.7 million, respectively. The medium peer group increased the most, by 17.0% and the small peer group increased by 6.0%.

Bad Debt Costs

The other portion of uncompensated care is bad debt.[31] Bad debt is a record of lost revenue for health services for which a hospital determined the patient had a financial responsibility to pay, but that patient did not pay. This is in contrast to charity care, in which hospitals have determined before the billing process begins that partial or full non-payments would occur for patients.

Table 19 Bad Debt Costs Change by Hospital Peer Group

Peer Group	Bad Debt Costs $ Change in millions (2020 -2022)	Bad Debt Costs % Change (2021 -2022)
Large	$19.1	15.2%
Medium	$2.0	6.1%
Small	$7.5	24.2%
Total	$28.6	15.1%

In Table 19, the percent change of bad debt for each peer group is presented. On the aggregate level, bad debt increased by $28.6 million between 2021 and 2022, or 15.1%. Bad debt for the large peer group increased by $19.1 million, or 15.2%. The medium peer group saw an increase in bad debt of $2.0 million, or 6.1%, while the small peer group saw an increase in bad debt over the period of $7.5 million, or 24.2%. The medium peer group saw the lowest increase in bad debt compared to the large and small group, while it also saw the highest increase in charity care. The recent increases in charity care and bad debt raise concerns about patients' ability to pay for hospital services.

2022 Uncompensated Care Costs by Payer Type

Overall, uncompensated care costs have increased from 2021 to 2022, driven by increases in charity care. Table 20 represents uncompensated care costs by payer types.

[31] See footnote 14.

Table 20 2022 Uncompensated Care Costs by Payer Type (in millions)

Major Payer	Bad Debt Costs	Bad Debt % of Total	Charity Care Costs	Charity Care % of Total	Uncompensated Care Costs	Total costs % of Total
Medicare	$19.2	8.8%	$5.0	1.5%	$24.2	4.4%
Medicaid	$3.2	1.5%	$7.3	2.3%	$10.6	1.9%
Commercial	$58.7	26.9%	$33.1	10.2%	$91.8	16.9%
Self-pay	$119.9	54.9%	$204.6	62.8%	$324.4	59.6%
CICP/ Other	$17.3	7.9%	$75.8	23.3%	$93.1	17.1%
Total	$218.3	100.0%	$325.8	100.0%	$544.0	100.0

In Table 20, uncompensated care costs are represented in total and for bad debt and charity care by payer type. In 2022, uncompensated care costs totaled $544.0 million and was primarily made up of the self-pay category with $324.4 million, or 59.7%. The second highest payer type to contribute to uncompensated care costs was the CICP/Other payer type with $93.1 million in uncompensated care costs. The lowest proportion of uncompensated care costs came from the Medicaid payer type category with $10.6 million in uncompensated care costs, or 1.9%, followed by Medicare with $24.2 million in uncompensated care costs, or 4.4%.

Between 2021 and 2022, total uncompensated care costs increased by 12.5%, an increase of $60.5 million. Charity care costs totaled $325.8 million, or 59.9% of total uncompensated care. The self-pay payer category made up most of charity care in 2022, representing 62.8% of total charity costs, or $204.6 million. The second largest category for charity care costs was the CICP/Other category, at $75.8 million, or 23.3% of total charity care costs. Between 2021 and 2022, total charity care costs increased by 10.8%, or $31.9 million.

Bad debt costs were $218.3 million, representing approximately 40.1% of total uncompensated care costs. The self-pay category made up over half of the costs for bad debt or 54.9%, representing $119.9 million. The next highest category was the commercial payers at 26.9%, or $58.7 million. Between 2021 and 2022, total bad debt costs increased by 15.1%, or $28.6 million.

2022 Charity Care Costs by Payer Type

Table 21 2022 Charity Care Costs by Payer by Peer Group (in millions)

Payer Type	Large	Large (%)	Medium	Medium (%)	Small	Small (%)	Total	Total (%)
Medicare	$3.8	1.4%	$0.4	1.0%	$0.7	6.4%	$5.0	1.5%
Medicaid	$6.8	2.5%	$0.3	0.6%	$0.2	2.1%	$7.3	2.3%
Commercial	$24.2	8.9%	$6.4	15.0%	$2.6	22.3%	$33.1	10.2%
Self-pay	$171.4	63.1%	$28.3	66.7%	$4.8	41.6%	$204.6	62.8%
CICP/ Other	$65.5	24.1%	$7.1	16.6%	$3.2	27.7%	$75.8	23.3%
Total	$271.8	100.0%	$42.5	100.0%	$11.5	100.0%	$325.8	100.0%

In Table 21, charity care costs are broken down by hospital peer groups and by major payer types. In 2022, the large peer group made up the majority of charity care costs, which totaled $271.8 million, or 83.4% of the total charity care costs. Self-pay payer made up 63.1% of charity care costs for the large peer group, or $171.4 million. The medium peer group made up approximately 13.0% of total charity care costs, or $42.5 million. The small peer group made up 3.5% of total charity care costs with $11.5 million. The self-pay payer category made up the majority of the small and medium peer groups' charity care costs at $4.8 million and $28.3 million, respectively. Overall, the large peer group represented the majority of charity care costs for each payer type, ranging from 67.1% (self-pay) and 90.2% (Medicaid).

Table 22 2022 Charity Care Costs by Payer Type by DOI Region (in millions)

DOI Region	Medicare	Medicaid	Commercial	Self-pay	CICP/ Other	Total
Boulder	$0.3	$0.1	$3.6	$10.7	$0.8	$15.6
Colorado Springs	$0.4	$0.0	$3.5	$14.8	$5.9	$24.6
Denver	$1.9	$6.1	$16.7	$136.9	$55.3	$216.8
East	$0.3	$0.1	$1.4	$2.3	$0.5	$4.6
Ft. Collins	$0.1	$0.01	$1.4	$8.3	$4.1	$14.0
Grand Junction	$0.5	$0.3	$0.5	$6.1	$1.8	$9.1
Greeley	$0.0	$0.0	$0.6	$10.0	$0.7	$11.5
Pueblo	$0.9	$0.4	$1.7	$1.3	$0.1	$4.4
West	$0.6	$0.2	$3.5	$14.2	$6.6	$25.2
Total	$5.0	$7.3	$33.5	$204.5	$75.7	$325.8

In Table 22, charity care costs are represented in total for each payer type broken down by DOI regions. In 2022, total charity care costs were $325.8 million. The majority of charity care costs were in the Denver region at $216.8 million, or 66.6%. The second largest region in total for charity care costs was the West region with $25.2 million, or 7.7%.

2022 Bad Debt Costs by Payer Type

Table 23 2022 Bad Debt Costs by Payer by Peer Group (in millions)

Payer Type	Large	Large (%)	Medium	Medium (%)	Small	Small (%)	Total	Total (%)
Medicare	$15.9	11.0%	$0.9	2.7%	$2.3	5.9%	$19.2	8.8%
Medicaid	$3.0	2.0%	$0.1	0.4%	$0.1	0.3%	$3.2	1.5%
Commercial	$41.2	28.4%	$8.6	24.7%	$8.9	23.2%	$58.7	26.9%
Self-pay	$80.5	55.4%	$22.8	65.8%	$16.5	43.2%	$119.9	54.9%
CICP/ Other	$4.7	3.2%	$2.2	6.3%	$10.4	27.3%	$17.3	7.9%
Total	$145.3	100.0%	$34.7	100.0%	$38.3	100.0%	$218.3	100.0%

In Table 23, bad debt costs are reported by hospital peer groups and by major payer types. In 2022, the large peer group made up the majority of bad debt costs which totaled $145.3 million, or 66.6% of the total bad debt costs. Self-pay made up 55.4% of bad debt costs for the large peer group, or $80.5 million. The second largest payer category was the commercial payer, with $41.2 million, or 28.4% of the total large peer group. The medium peer group made up approximately 15.9% of total bad debt costs, or $34.7 million. The self-pay category made up the majority of bad debt costs for the medium peer group with $22.8 million, or 65.8% of total bad debt costs for the medium peer group. The small peer group made up approximately 17.5% of total bad debt costs with $38.3 million. Similar to the large and medium peer group, the self-pay category made up the majority of the small peer group's bad debt costs with $16.5 million, or 43.2% of total bad debt costs for the payer. Overall, the large peer group made up the majority of bad debt costs for each payer type, ranging from 67.2% (self-pay) to 91.6% (Medicaid) except for the CICP/Other category which was largest for the small peer group. The self-pay category made up the majority of total bad debt costs with $119.9 million, or 54.9%; followed by the commercial payer group with $58.7 million, or 26.9%.

Table 24 2022 Bad Debt Costs by Payer Type by DOI Region (in millions)

DOI Region	Medicare	Medicaid	Commercial	Self-Pay	CICP/ Other	Total
Boulder	$0.5	-$0.1	$2.2	$3.7	$0.4	$6.7
Colorado Springs	$1.3	$0.1	$3.7	$10.6	$0.3	$16.1
Denver	$9.8	$1.2	$33.1	$60.1	$4.4	$108.7
East	$0.5	$0.0	$2.2	$7.3	$3.5	$13.6
Ft. Collins	$0.9	-$0.1	$4.4	$9.9	-$0.01	$15.1
Grand Junction	$0.8	$0.1	$2.1	$3.3	$0.01	$6.3
Greeley	$0.4	-$0.2	$1.1	$3.2	-$0.1	$4.4
Pueblo	$3.8	$2.0	$1.4	$0.2	$0.5	$7.9
West	$1.1	$0.1	$8.4	$21.6	$8.3	$39.6
Total	$19.2	$3.2	$58.7	$119.9	$17.3	$218.3

In Table 24, bad debt costs are represented in total for each payer type and broken down by DOI regions. In 2022, total bad debt costs were $218.3 million. The majority of bad debt costs were in the Denver region with $108.7 million, or 50.0%. This is the area where our state's largest safety net hospital, Denver Health Medical Center, is

located and where 51% of Coloradans reside.[32] The second largest region in total for bad debt costs was the West region with $39.6 million, or 18.2%. The Denver region was the driver of bad debt costs in 2022 and made up the largest portion of each payer type, except for the CICP/Other category, which had a higher proportion in the West region, 25.4% and 48.1%, respectively.

Operating Expenses

In this section, HCPF provides total operating expenses by peer group, DOI region and expense type. This section also reviews total operating expenses over the 2020 to 2021 period.

Total Operating Expense Growth

Table 25 Total Operating Expense Percent Change by Hospital Peer Group

Peer Group	Total Operating Expense % Change (2021 -2022)
Large	9.4%
Medium	16.5%
Small	9.7%
Total	10.4%

Table 25 shows the percent change of total operating expenses for each peer group. Between 2021 and 2022, overall operating expenses grew by 10.4%, or an increase of $2.0 billion. This is the highest rate of growth in our data for total operating expense. The next highest occurred between 2015 to 2016, which represented 8.8% growth. The bulk of the overall increase was driven by the large peer group with an increase of $1.4 billion, or 9.4% between 2021 and 2022. The small peer group also increased its total operating expenses with $172.8 million, or 9.7% from 2021 to 2022. For the medium peer group total operating expenses increased by $451.1 million, an increase of 16.5%.

Operating Expense Mix

Hospitals submitted about 30 different types of expenses. These expense types ranged from the highest expense category (salaries, wages, and benefits) to small fill-in categories for expenses like bank fees and debt issuance. To better understand operating expenses, HCPF asked hospitals to allocate expenses into four categories: direct patient, patient other, general and administrative and other, in addition to reporting the total for each expense type.

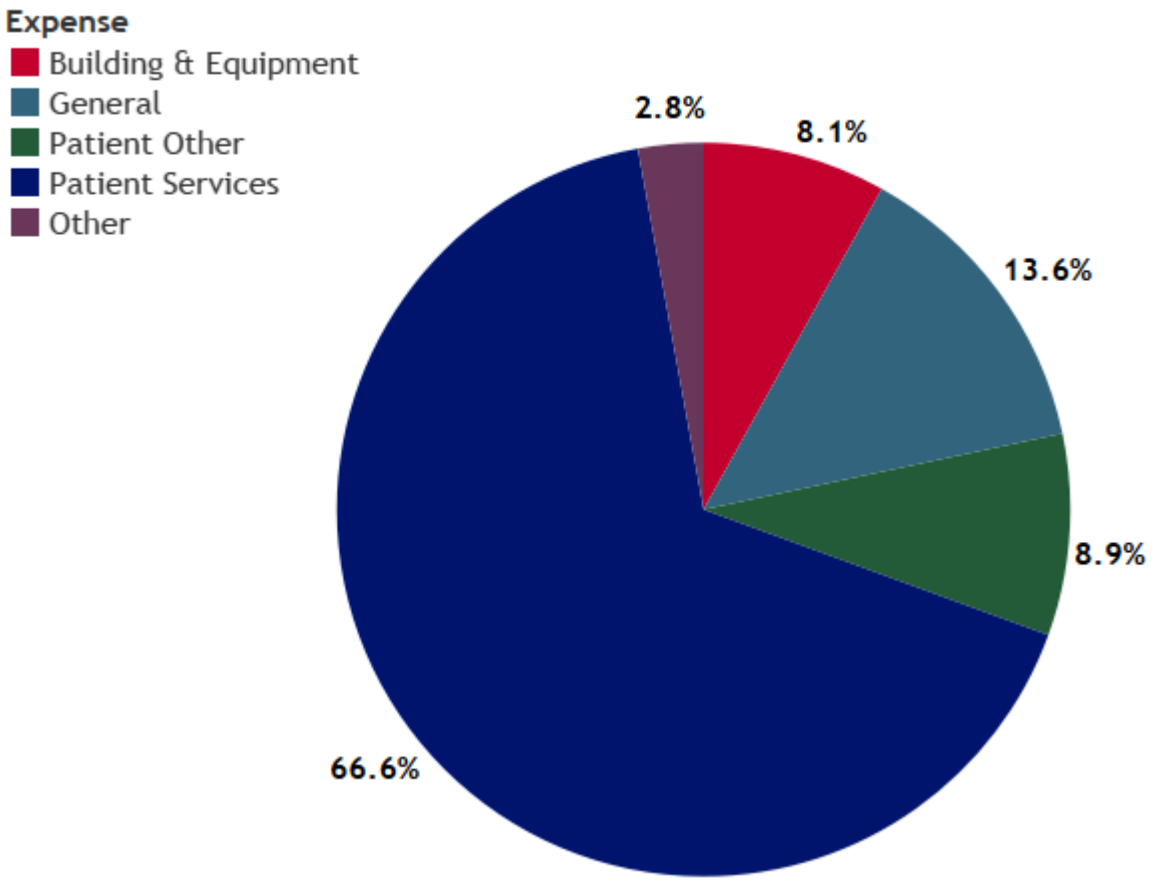
The pie chart in Graph 7 displays a statewide mix of aggregate operating expenses by type for 2022 and illustrates that most Colorado hospital expenses are for patient

[32] Denver DOI region includes Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson and Park counties. Source: 2022 county population data from the Colorado State Demography Office.

services. Table 26 provides a more detailed breakdown of operating expenses and uses colors to indicate how the expenses are included in the operating expense pie chart of Graph 4. As noted in the graphic, patient expenses (service and other) represent approximately 75.5% of Colorado hospital operating expenses. Patient service expenses make up 66.6% of operating expenses and patient other expenses make up 8.9% of operating expenses.[33] Between 2021 and 2022, total patient expenses increased 15.4%.

General and administrative expenses represent 13.6%, while building and major equipment expenses generate 8.1% of operating expenses. Between 2021 and 2022, general and administrative expenses decreased by 1.1% and building and major equipment expenses decreased by 2.1%. Other expenses represent approximately 2.8% of all operating expenses, a decrease of 9.3% from 2021.

Graph 7 2022 Mix of Operating Expenses by Type



[33] For expenses that hospitals allocated as being for patients, HCPF chose expense lines that clearly relate to patient services to be classified as patient services, while the remainder are classified as patient other. Examples of expenses that hospitals reported as being for patients that fall in the patient other category include: contracted services, general other, insurance expense, management fees, provider fees and purchased services.

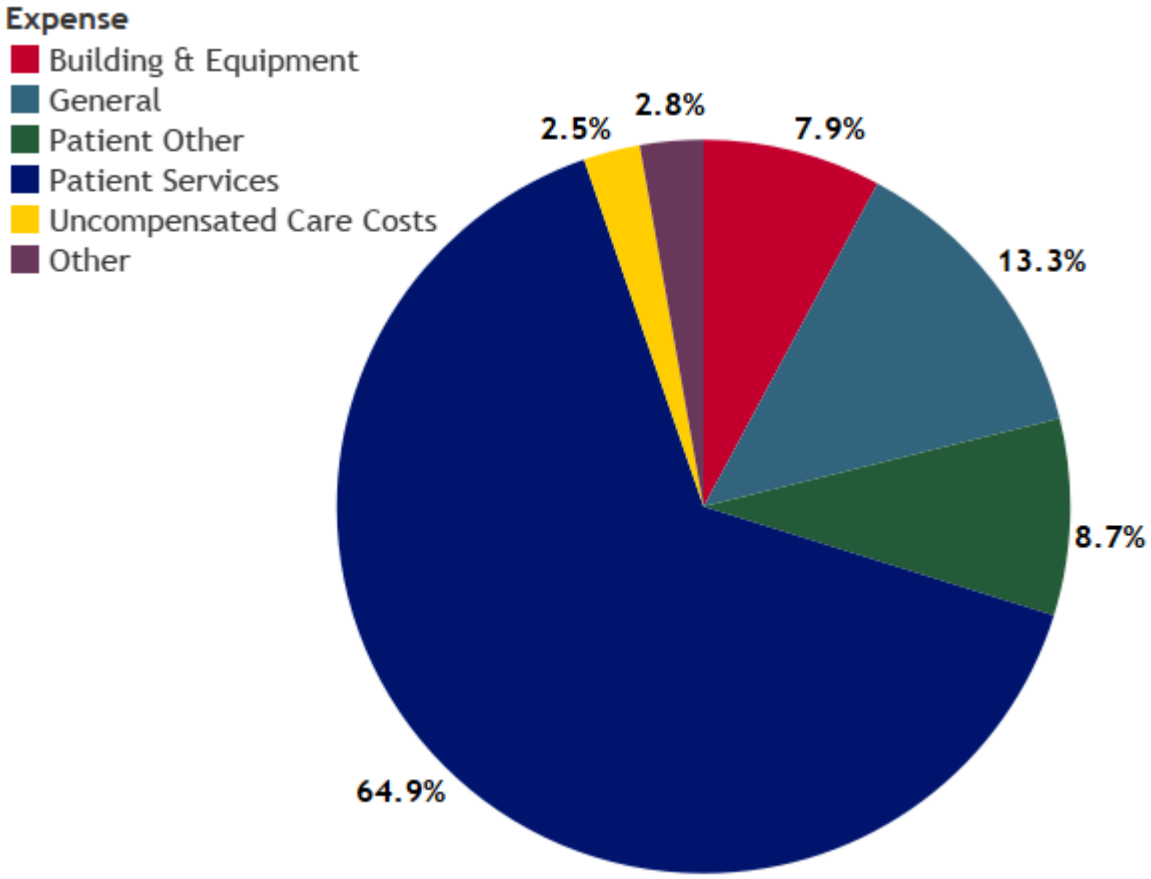
Table 26 2022 Mix of Operating Expenses by Type (in millions)

Expense Type	Expense	Direct Patient	Patient Other	General/ Admin	Other	Total
Services	Salaries, Wages, & Benefits	$7,706.5	$573.8	$1,283.0	$212.3	**$9,775.6**
Services	Contracted Labor[34]	$878.0	$26.9	$31.6	$9.1	**$945.6**
Services	Physician Remuneration	$1,033.7	$27.8	$24.1	$31.2	**$1,116.8**
Services	Total Supplies	$3,965.6	$68.3	$64.4	$35.0	**$4,133.3**
Services	All Other	$544.9	$301.8	$313.6	$143.8	**$1,304.0**
Other	Interest	$113.3	$2.9	$71.0	$19.7	**$206.8**
Other	Provider Fee	$704.9	$269.4	$85.2	$94.0	**$1,153.6**
Other	All Other	$596.5	$212.0	$1,064.9	$72.2	**$1,945.5**
Building & Major Equipment	Depreciation	$861.5	$51.8	$185.5	$54.2	**$1,153.1**
Building & Major Equipment	Leases & Rental	$132.2	$14.8	$39.4	$3.9	**$190.3**
Building & Major Equipment	Maintenance & Utilities	$165.6	$63.3	$127.1	$21.8	**$377.8**
Total	**Total**	**$15,824.7**	**$1,585.8**	**$3,358.2**	**$688.2**	**$21,356.9**

Another way to examine hospital expenses is by including uncompensated care costs as an additional operating expense. As depicted in Graph 8, uncompensated care costs represent 2.5% of costs when included as an operating expense. When compared to previous years, uncompensated care costs have remained similar as a percent of total operating expenses. Starting in 2019, uncompensated care costs were 2.7% of total operating expenses, 2.8% in 2020, and finally 2.5% in 2021. When included as a patient expense, total patient expenses represent 76.1% of operating expenses in 2022.

[34] The Contracted Labor line is a subset and included within Salaries, Wages, and Benefits and should not be included with summing the categories.

Graph 8 2022 Mix of Operating Expenses with Uncompensated Care Costs by Type



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Graph 9 represents the mix of operating expense types by hospital peer group.

Graph 9 2022 Operating Expense Mix by Hospital Peer Group

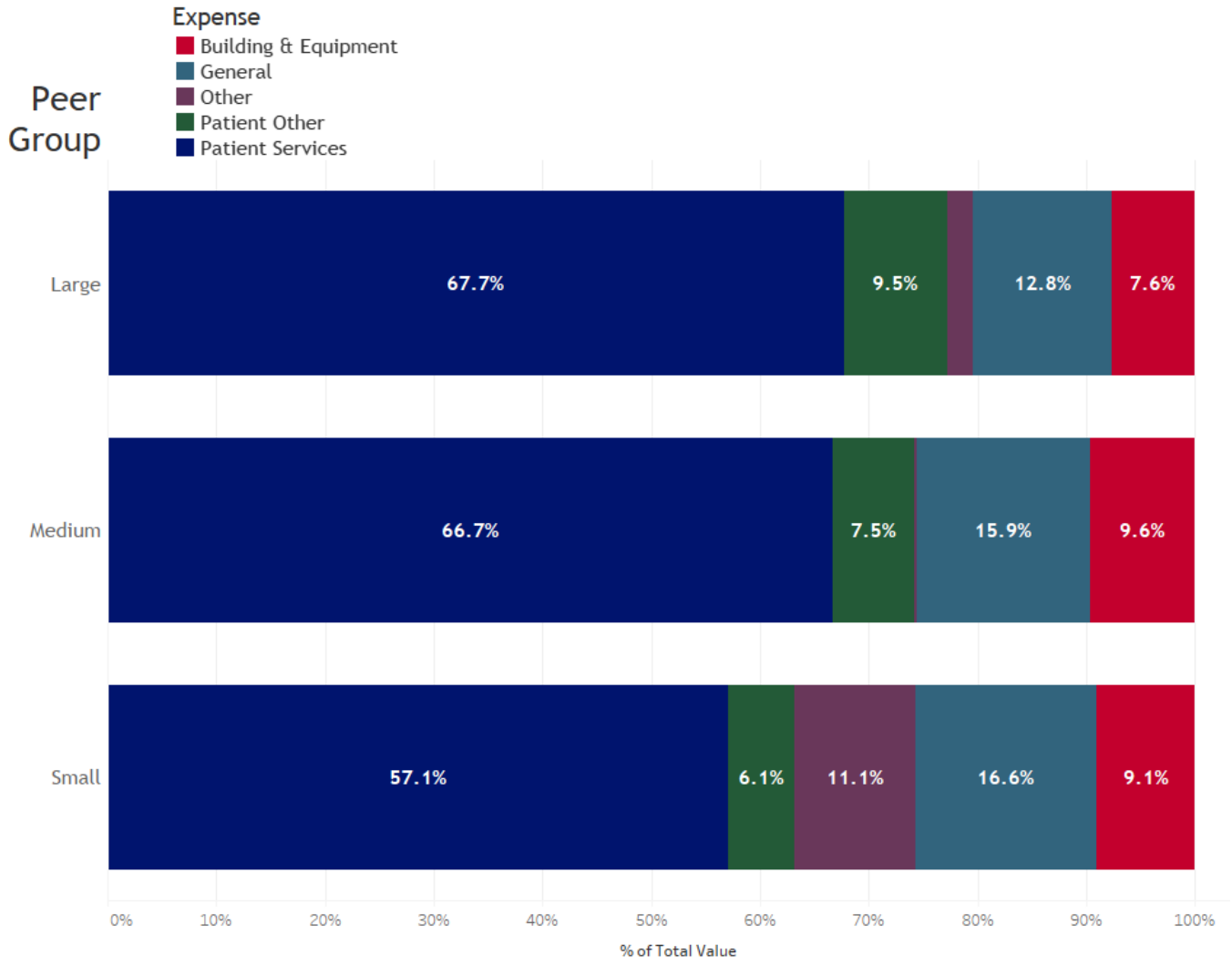

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Table 27 2022 Operating Expense Mix by Hospital Peer Group[35]

Expense Type or Expense	Large	Medium	Small
Patient	**77.2%**	**74.2%**	**63.2%**
Patient Service	67.7%	66.7%	57.1%
Patient Other	9.5%	7.5%	6.1%
General/Administration	**12.8%**	**15.9%**	**16.6%**
Building & Major Equipment	**7.6%**	**9.6%**	**9.1%**
Depreciation	6.2%	7.8%	6.1%
Leases & Rental	0.9%	1.1%	1.0%
Maintenance & Utilities	1.7%	1.5%	3.0%
Other	**2.4%**	**0.2%**	**11.1%**
Grand Total	100.0%	100.0%	100.0%

For the large peer group In 2022, a greater proportion of expenses are allocated to patients than in 2021. Patient services increased from 64.5% to 67.7%. Building and major equipment expenses increased by 1.2% between 2021 and 2022.

For the medium peer group there was an increase in patient service expense from 63.7% to 66.7% leading to an increase in total patient expense from 71.2% to 74.2% from 2021 to 2022. The Medium peer group had the second largest patient service proportion.

For the small peer group, between 2021 and 2022 there was an increase for total patient expense from 60.9% to 63.2%. General and Administrative expenses increased from 16.0% to 16.6% from 2021 to 2022. For all other expenses there was a decrease from 13.6% to 11.1%.

A greater proportion of the large hospital peer group's operating expenses were allocated for patients with 77.2% while the small hospital peer group's proportion of expenses allocated as for patients was the lowest at 62.3%.

[35] Other expenses are significantly larger for the small peer group as small hospitals have less resources to categorize expenses appropriately and when they cannot make the determination that an expense is a patient related expense, hospitals will allocate these expenses into the Other category.

The small hospital peer group has the largest proportion of other expenses of 11.1% and general and administration at 16.6%. Smaller hospitals have more expenses that are not allocated to patient care.

When operating expenses are reviewed by DOI region, Graph 10 and Table 28, there is regional variation for expense mix when allocated to patient and general and administration categories. For example, the Grand Junction region has the highest proportion of expenses allocated to total patient expenses with 79.9% followed by Fort Collins with 79.5%.

On average, in 2022, building and major equipment expenses were approximately 8.0%. Overall, the Greeley region was the highest at 11.9% while the lowest was the Grand Junction region at 5.7%.

Additionally, on average in 2022, general and administrative expenses were approximately 15.9% between all regions. The regions with the highest proportion of general and administrative expenses were the East at 19.9% and West region at 19.6%. This is likely because most hospitals within these regions are small or medium sized hospitals. This aligns with the analysis of expense by the peer groupings.

Graph 10 Operating Expense Mix by DOI Region

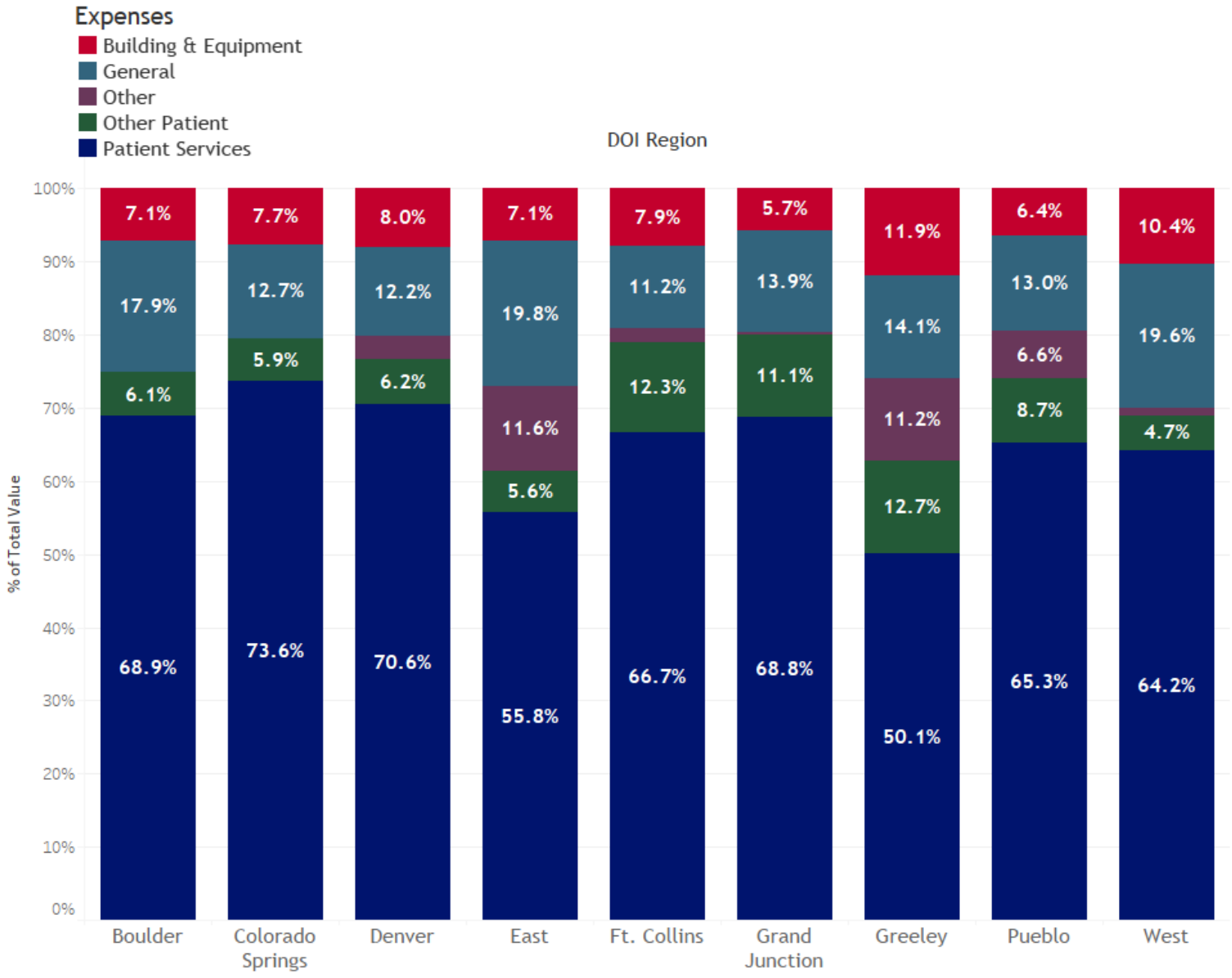

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Table 28 2021 Operating Expense Mix by DOI Region

DOI Region	Boulder	CO Springs	Denver	East	Ft Collins	Grand Junction	Greeley	Pueblo	West
Patient	**75.0%**	**79.5%**	**76.8%**	**61.4%**	**79.0%**	**79.9%**	**62.8%**	**74.0%**	**68.9%**
Patient Service	68.9%	73.6%	70.6%	55.8%	66.7%	68.8%	50.1%	65.3%	64.2%
Patient Other	6.1%	5.9%	6.2%	5.6%	12.3%	11.1%	12.7%	8.7%	4.7%
General/ Administration	**17.9%**	**12.7%**	**12.2%**	**19.8%**	**11.2%**	**13.9%**	**14.1%**	**13.0%**	**19.6%**
Building & Major Equipment	**7.1%**	**7.7%**	**8.0%**	**7.1%**	**7.9%**	**5.7%**	**11.9%**	**6.4%**	**10.4%**
Depreciation	5.5%	6.2%	5.9%	6.0%	6.1%	5.0%	9.0%	4.9%	8.0%
Leases & Rental	0.7%	0.9%	1.0%	1.1%	1.0%	0.6%	0.5%	0.7%	0.5%
Maintenance & Utilities	0.9%	0.6%	1.1%	0.0%	0.8%	0.1%	2.4%	0.3%	0.7%
Other	**0.0%**	**0.0%**	**3.1%**	**11.6%**	**2.0%**	**0.5%**	**11.2%**	**6.6%**	**1.2%**
Grand Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

In Table 29, the percent change for comparable total expense categories are displayed. Between 2021 and 2022, total payroll expenses increased by 9.7%, an increase of $630.7 million whereas total salaries, wages, and benefits increased by 14.2%, an increase of $1.2 billion. In 2022, there was also an increase in contracted labor expenses by 73.5%, or $395.8 million. Comparatively, between 2014 and 2022, total payroll expenses increased 62.2%, or $2.7 billion, whereas contracted labor increased 2055%, or $891.2 million. As discussed above, there has been a significant increase in contracted labor expenses over the last several years. The large increase in contracted labor is due to factors including frontline health care workers leaving the industry, pressure on hospital staffing such as retention of staff nurses, increased wages, and longer hours being worked by staff (overtime and stress on workers). The pressure on hospital staffing has led to increased utilization of travel nurses, who are typically compensated at a higher rate than staff nurses.[36,37] Total payroll has been increasing as well. HCPF has requested a more thorough breakdown of labor expenses through the hospital submitted template; however, that information has not been provided by enough hospitals to provide a robust analysis.

Between 2021 and 2022, employee benefits increased by 12.7% or $191.3 million. This increase is a larger increase than the prior year of analysis, which only saw a 0.7% increase from 2020 to 2021. Between 2019 and 2020, employee benefit

[36]Lagasse, J. (2023, March). Hospitals' labor costs increased 258% over the last three years. Healthcare Finance News. healthcarefinancenews.com/news/hospitals-labor-costs-increased-258-over-last-three-years.
[37]Churchin, Emma (2023, June) How does Travel Nurse Pay Compare to Permanent Staff Nurses? Center for Economic and Policy Research. cepr.net/how-does-travel-nurse-pay-compare-to-permanent-staff-nurses/

expenses increased by 6.2%, and between 2018 and 2019 it increased by 4.2%. The increase in 2022 for employee benefit is larger than the last three years.

Salaries, wages and benefit expenses made up the majority of the increases in total operating expenses in 2022. These increases are not unexpected as there has been volatility within the health care labor market in the last few years. The data suggests labor market strains were especially notable in 2022. HCPF will continue to monitor the impact of staffing agency contracted labor, recognizing the investments made by the General Assembly intended to respond to health care workforce shortages and working conditions.

Between 2021 and 2022, total supplies expenses increased by 8.4%, or $321.0 million. In 2021, total supplies expenses increased by 14.8% or $492.0 million from 2020. Total supplies expenses have been increasing over the last two years faster than in previous years (between 2019 and 2020 there was an increase of 3.7%, or $117.0 million) this is not unexpected due to increased volatility and need for medical supplies and personal protective equipment because of the COVID-19 pandemic. There was a decrease of approximately 0.1%, or $0.1 million, for lease and rental expenses. For maintenance and utilities, there was an increase of 9.1%, or $31.7 million. Finally, interest expenses decreased 3.0% or $6.3 million between 2021 and 2022. HCPF will continue to review and monitor these trends in future years to analyze the impact of the COVID-19 pandemic on hospital expenses.

Table 29 2021 -2022 Operating Expenses Percent Change (in millions)

Expense	$ Change (2021 - 2022)	% Change (2021 - 2022)
Total payroll	$630.7	9.7%
Employee benefits	$191.3	12.7%
Contracted labor	$395.8	73.5%
Total salaries, wages, benefits	$1,217.8	14.2%
Total supplies	$321.0	8.4%
Depreciation	-$69.0	-5.6%
Leases & Rental	-$0.1	-0.1%
Maintenance & Utilities	$31.7	9.1%
Interest	-$6.3	-3.0%

Profit and Liquidity Analysis

This section will look at profits and other financial liquidity metrics to discuss changes in hospitals' financial position in the most recent year. For a hospital or hospital system view of this section please see Appendix C: Hospital Financial Transparency Report Detailed Dataset by Hospital.

Table 30 2022 Patient Service Net Income by Payer by Peer Group (in millions)

Payer Type	Large	Medium	Small	Total
Medicare	-$1,689.2	-$368.6	-$131.8	-$2,189.7
Medicaid	-$806.0	-$158.5	-$30.2	-$994.7
Commercial	$3,302.8	$652.6	$112.9	$4,068.2
Self-pay	-$349.2	-$60.2	-$16.1	-$425.5
CICP/ Other	-$38.0	-$35.3	-$50.7	-$124.0
Total	$420.3	$29.9	-$115.9	$334.3

Table 30 shows patient service net income reported by payer type for each peer group for 2022. As a reminder, HCPF determines costs associated with each payer through the use of a cost-to-charge ratio allowing the breakdown of patient service net income by each payer type.[38] Commercial was the only positive payer group for all peer groups, which offset the rest of the payers for the large and medium peer group totaling $420.3 million and $29.9 million, respectively. The small peer group's commercial patient service net income was fully offset by losses from all other payers, totaling -$115.9 million. In fact, Medicare losses alone were more than the small peer group's commercial income. This is because hospitals in the small peer group are located in rural areas of the state where the population tends to be older and therefore more patients at these hospitals are covered by Medicare compared to urban areas.[39]

[38] Hospitals have high fixed costs and this methodology for estimating patient service net income does not account for fixed costs that should not be attributed to payers. For example, when assuming 50% of costs are the costs for keeping the hospital doors open, lights on, and staff available; 50% of the costs need to be covered whether or not a client walks in the door. In a contribution margin analysis, these costs wouldn't be attributable to payers. If 50% of costs are assumed as fixed costs, then Medicaid patient services have a positive contribution margin, albeit a much lower contribution margin than commercial. HCPF will continue to present and pursue this type of analysis to better present cost structure in the hospital industry.

[39] See footnote 12.

Table 31 2022 Patient Service Net Income by Payer by DOI Region (in millions)

DOI Region	Medicare	Medicaid	Commercial	Self-Pay	CICP/ Other	Total
Boulder	-$213.8	$3.4	$152.2	-$17.2	$43.4	-$31.9
Colorado Springs	-$198.3	-$151.2	$459.2	-$48.7	-$26.7	$34.4
Denver	-$1,024.7	-$696.1	$2,424.2	-$270.8	-$50.9	$381.8
East	-$43.7	$13.0	$52.2	-$0.5	-$12.9	$8.2
Ft. Collins	-$213.1	-$71.4	$368.4	-$23.5	-$3.6	$56.7
Grand Junction	-$128.4	-$14.9	$170.0	-$13.2	-$50.3	-$36.8
Greeley	-$88.7	-$27.0	$89.2	-$10.6	-$3.2	-$40.4
Pueblo	-$102.1	-$14.3	$52.3	$5.1	$2.7	-$66.5
West	-$177.0	-$36.2	$300.5	-$35.9	-$22.6	$28.9
Total	-$2,189.7	-$994.7	$4,068.2	-$425.5	-$124.0	$334.3

Table 31 shows patient service net income reported by payer type for each DOI region for 2022. For more information on values for patient service net income between 2019 and 2022 please see Table 9. Commercial was the only positive patient service net income in total, totaling $4,068.2 million. The commercial category was positive for all DOI regions, ranging from $52.3 million in the Pueblo region to $2,420.6 million in the Denver region. Medicare patient service net income was negative for all regions.

Table 32 2021-2022 Operating Net Income Change by Peer Group (in millions)

Peer Group	Operating Net Income $ Change (2021 -2022)	Operating Net Income % Change (2021-2022)
Large	-$724.2	-44.8%
Medium	-$178.6	-62.5%
Small	-$78.2	-133.4%
Total	-$981.0	-50.0%

Table 32 shows the dollar and percent change of operating net income for each peer group in 2022. For more information on operating net income values between 2019 to

2022 see Table 10. Between 2021 and 2022, the large peer group's operating income decreased by $724.2 million or 44.8%. The medium peer group decreased by $178.6 million or a decrease of 62.5%. The small peer group decreased by $78.2 million or a decrease of 133.4%. While the value of the large peer group's operating income decreased more than the other peer groups it was also the lowest in terms of percentage. In 2021, the small peer group had a positive operating income of $58.6 million, which dropped to -$19.6 million in 2022. As discussed above the small peer group is the only peer group to report a negative operating income between 2019 and 2022.

Table 33 2021-2022 Operating Net Income Change by DOI Region

Peer Group	Operating Net Income $ Change (2021 -2022)	Operating Net Income % Change (2021-2022)
Boulder	-$119.8	-122.0%
Colorado Springs	-$110.5	-61.0%
Denver	-$336.9	-28.8%
East	-$25.6	-47.2%
Ft. Collins	-$97.5	-54.5%
Grand Junction	-$93.5	-124.4%
Greeley	$5.0	-15.3%
Pueblo	-$65.0	-253.5%
West	-$137.2	-65.4%
Total	-$981.0	-50.0%

Table 33 shows the dollar and percent change of operating net income for each DOI region in 2022. See Table 11 for more information on values for net income between 2019 to 2022. Almost all DOI regions saw a reduction in operating income, except for the Greeley region. Changes in operating income between 2021 and 2022 are more noticeable the further one gets away from the Denver regional area, for instance, Grand Junction on the western slope saw a reduction of 124.4% and the East region saw a reduction of 47.2%.

Table 34 2021-2022 Net Income Change by Peer Group

Peer Group	Net Income $ Change (2021 -2022)	Net Income % Change (2021-2022)
Large	-$2,582.5	-91.0%
Medium	-$319.2	-89.0%
Small	-$187.0	-81.9%
Total	-$3,088.7	-90.2%

Table 34 shows the dollar and percent change of net income for each peer group in 2022. When looking at the breakdown of net income by peer groups trends are very similar to that of operating income, see Table 32. However, the magnitude of change between 2021 and 2022 for the large peer group was significantly more than the peer group's loss on operating income. As discussed previously, the decrease in net income was primarily driven by a poor year in investment markets. The lower than expected financial market particularly caused larger hospitals' non-operating revenues to decrease. Investment has the risk of short-term loss. Fortunately, as described in the below, larger hospitals generally have more funds to redistribute back into their operations, or invest through their reserves.

Table 35 2021-2022 Net Income Change by DOI Region

DOI Region	Net Income $ Change (2021 -2022)	Net Income % Change (2021-2022)
Boulder	-$202.0	-145.2%
Colorado Springs	-$172.9	-78.2%
Denver	-$1,376.5	-73.5%
East	-$60.6	-55.4%
Ft. Collins	-$812.7	-123.9%
Grand Junction	-$95.0	-99.6%
Greeley	-$6.3	-18.5%
Pueblo	-$84.8	-180.3%
West	-$290.5	-91.4%
Total	-$3,088.7	-90.2%

Table 35 shows the dollar and percent change of net income for each DOI region in 2022. Looking at the breakdown of net income through a DOI region lens, shows similar findings to Table 34. All hospitals within the Denver region are also a part of the large peer group and therefore the effects of the lower than expected financial markets are seen primarily in this region. While the Denver region was greatly affected by the financial downturn it was not alone, with other regions in Colorado seeing decreases to their bottom line in 2022.

The chart below provides an important indicator of a hospital's financial condition, while illustrating trends over time. Specifically, days cash on hand is a financial metric that measures the number of days an organization can continue to pay its operating expenses given the amount of liquid funds available, including paying employees and buying supplies, among other expenses. Said another way, if a hospital stopped operations and no longer was receiving revenues, its days cash on hand would suggest that the hospital could remain open for that many more days before closing its doors. HCPF's most recent data show cash reserves have declined from 2021 and 2020 levels. However, cash reserves in 2021 and 2020 were assisted by federal COVID-19 stimulus packages. In 2022, the median days cash on hand is 183. While this has been a decrease in cash reserves from previous years, it still remains above the 2019 level of 149.

Table 36 2019-2022 Days Cash on Hand by Hospital or Hospital System[40,41]

Hospital/System Name	Note	2019 Days Cash on Hand	2020 Days Cash on Hand	2021 Days Cash on Hand	2022 Days Cash on Hand
Animas Surgical Hospital		14	116	85	36
Arkansas Valley Regl Med Ctr		98	76	153	141
Aspen Valley Hospital District		235	254	316	249
Banner Health		225	284	256	218
Boulder Community Hospital		325	403	382	267
AdventHealth		238	260	228	167
Commonspirit	‡	153	202	245	176
Children's Hospital Colorado		321	333	358	299
Colorado Canyons		103	85	88	70
Community Hospital		86	144	118	80
Delta County Memorial Hospital		82	108	71	30
Denver Health Medical Center		131	155	117	87
Estes Park Medical Center		151	196	178	96
Grand River Hospital District		154	183	201	201
Gunnison Valley Hospital		324	412	352	282
Haxtun Hospital District		87	288	189	131
HealthOne	[42]	N/A	N/A	N/A	N/A
Heart Of The Rockies Reg Med Center		248	272	289	255
Keefe Memorial Hospital		336	392	316	272
Kit Carson County Memorial Hospital		94	306	325	281
Kremmling Memorial Hospital District	+	33	182	185	140

[40] Hospital Data is from Annual Financial Statements submitted to the Department. Days Cash on Hand represents the consolidated financials of hospitals and systems, both within and outside the state of Colorado. *2019 Hospital data from Medicare cost reports, +Updated days cash on hand from 2019 and 2020 due to more accurate data, ‡ UCHealth and Commonspirit have been updated from reflecting the amount at the end of the calendar year to the amount at the end of the System's fiscal year, matching the rest of the hospitals.

[41] Days Cash on Hand = 365 * (Unrestricted Cash & Cash equivalents + Unrestricted Investments)/(Total Operating Expenses - Depreciation)

[42] HealthONE is an affiliate of HCA, and its cash and investments are held at the parent company level.. In the last several years, HCA has spent accumulated cash on stock repurchases and other investments.These repurchased shares could be resold in the future for additional funds but are not reflected in days cash on hand, meaning that days cash on hand is not a meaningful representation of liquidity for HCA-HealthONE.

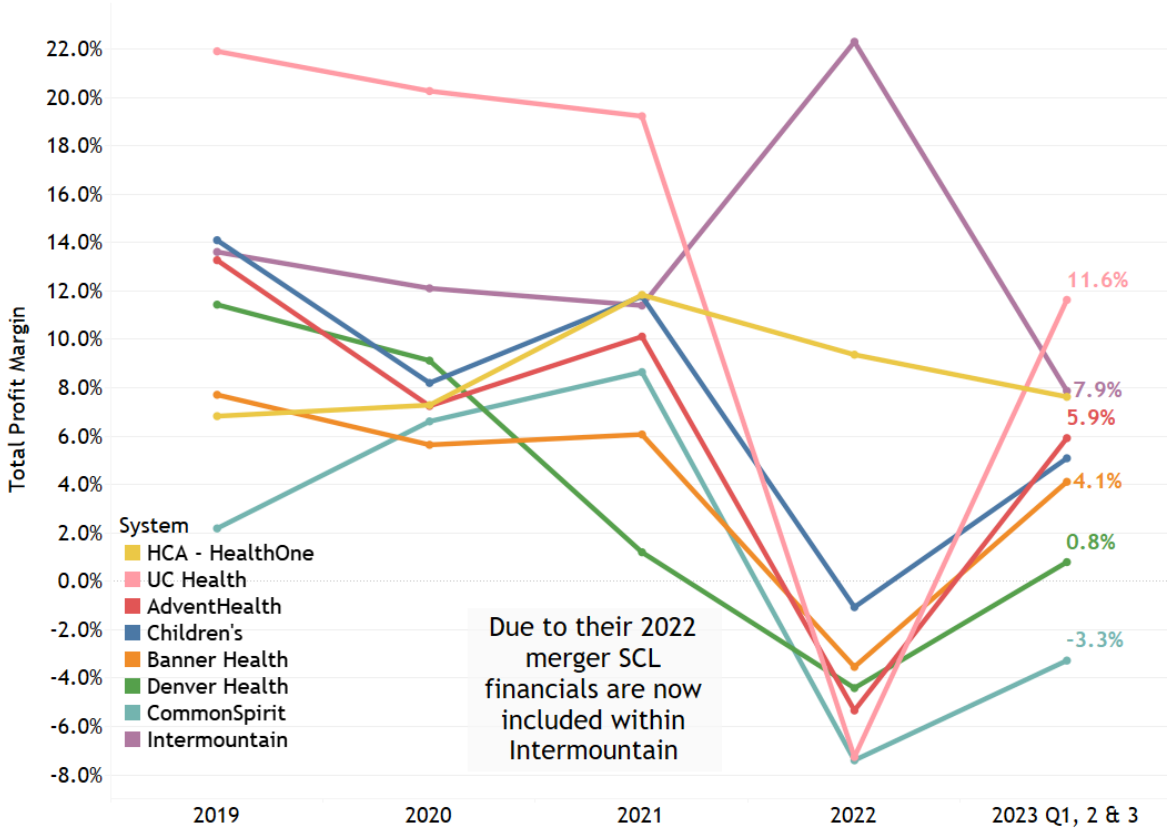
Hospital/System Name	Note	2019 Days Cash on Hand	2020 Days Cash on Hand	2021 Days Cash on Hand	2022 Days Cash on Hand
Lincoln Community Hospital		22	148	123	56
Melissa Memorial Hospital		200	233	190	129
Montrose Memorial Hospital		149	251	198	201
Mt. San Rafael Hospital		120	218	220	199
National Jewish Health	*	97	106	127	111
Pagosa Springs Medical Center		72	189	177	126
Parkview Medical Center	+	195	201	205	156
Pioneers Medical Center		26	132	227	126
Prowers Medical Center		127	193	215	199
Rangely District Hospital		176	321	324	218
Rio Grande Hospital		295	375	352	395
San Luis Valley		186	235	223	100
Intermountain (formerly SCL Health)		334	411	400	343
Sedgwick County Health Center		293	317	318	235
Southeast Colorado Hospital		92	175	130	112
Southwest Memorial Hospital		79	108	117	97
Spanish Peaks Regional Health		77	149	170	276
St. Vincent General Hospital		46	43	4	6
The Memorial Hospital	*	25	100	72	68
UCHealth	‡	346	397	469	325
Vail Valley Medical Center		751	531	527	384
Valley View Hospital		251	281	340	291
Weisbrod Memorial County Hospital		145	331	223	247
Wray Community District Hospital		52	146	177	183
Yuma District Hospital		230	286	333	235
Median of all hospitals		**149**	**218**	**215**	**183**

As a trend, hospital systems, which are generally in the front range area of the state, have higher days cash on hand compared to hospitals in the eastern plains or western slope. Hospitals in the eastern and western portions of the state are typically rural and or critical access hospitals. These hospitals are usually the first to have concerns over financial viability, making payroll, or keeping their doors open. Ensuring these hospitals maintain a strong financial liquidity position helps to ensure health care access to these underserved areas.

In the Denver region, Denver Health Medical Center has the lowest days cash on hand with only 87 days cash on hand in 2022. Denver Health Medical Center is an anomaly compared to other hospitals in the Denver region and even some more rural regions. Similar to rural and CAH, Denver Health Medical Center is a safety net hospital that provides care to a larger share of Medicaid, under and uninsured individuals. Ensuring that Denver Health Medical Center has an efficient operating structure and strong financial position will allow it to continue to provide care to vulnerable Coloradans.

In response to voiced concerns by some hospitals regarding the “old data”, compared to the pandemic’s ever-changing impact on the industry, additional information has been sourced herein to provide more timely, though limited, insights. Specifically, Graph 11 and Graph 12 display data through Q3 2023 (September 2023) utilizing a source that is different from most data in this report, as quarterly reporting was not available during the data collection period. Therefore, HCPF sourced the most timely financial data that is publicly available through the Electronic Municipal Market Access (EMMA) website. Note that quarterly financial information sourced from EMMA is unaudited and subject to changes as audited financial information is developed. Only hospital systems are shown because many smaller or independent hospitals are not required to report this information. These figures include entire national systems and adjusts all systems to a standard calendar year of accounting, and therefore yearly profit and margin numbers may differ from other HCPF analyses, which represent only Colorado hospitals on their specific fiscal years.

Graph 11 Consolidated National System Total Profit Margin (including investments) for 2019 through Q3 2023[43]

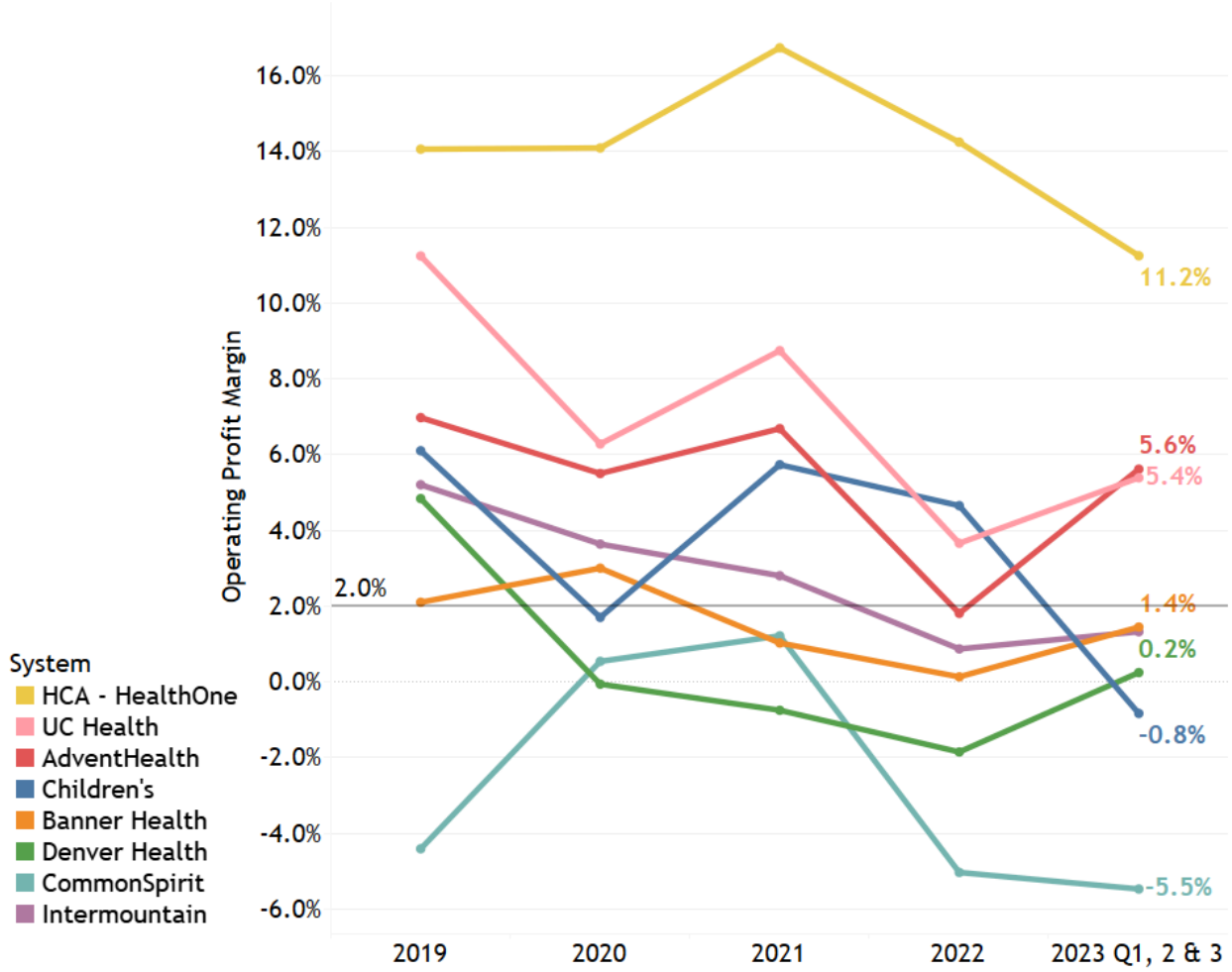


Graph 11 shows total profit margin for systems in Colorado from 2019 to the third quarter of calendar year 2023, including investment returns. In 2022, across all systems except Intermountain Health, there was a drop in total profit margin, which reflects the previous analysis in this report. Intermountain Health had significant merger and acquisition activity in 2022 including a merger with SCLHealth, which led to significant accounting impacts reflected in the abnormally high margin percentage in the above visual. The drop in the for-profit system, HealthONE profits through Q3 2023, still outperforms their 2019 pre-pandemic year.

The upward trajectory noted in Graph 11 above for nearly all systems, from 2022 through September of 2023 indicates that hospital systems are rebounding from the large losses seen in 2022, including the impact of investment returns. HCPF will continue to monitor this continued recovery, wages, investment returns, and other critical factors impacting hospitals' overall financial trends and trajectory.

[43] Information by system is sourced from the Electronic Municipal Market Access (EMMA) website where hospital and hospital systems provide financial statements and quarterly statements for bond compliance. Independent hospitals are not shown as a category. The methods for Total Margin were changed from previous reports to "total net change in assets divided by operating revenue" to standardize calculations across all systems, and minor changes from previous reports will exist. For some hospitals and systems minor differences will exist between net income and net change in assets. Previous reports included other income in the revenue denominator specific to each system.

Graph 12 Consolidated National System Operating Profit Margin 2019 through Q3 2023[44]



Graph 12 shows operating margin for systems in Colorado from 2019 through Q3 2023. While many systems have improved operating margins from 2022, Children's Hospital and Common Spirit are outliers. HCA HealthONE's operating margin is higher than other systems in part due to necessary tax expenses being a non-operating expense. HCA HealthONE's Total Profit Margin displayed in Graph 11 above includes these expenses. Overall, hospital systems' performance is less consistent, when removing the powerful impact of investment income. The department will continue to monitor operating margin in the coming quarters, assisted by the additional reported quarterly information from hospitals through HB23-1226.

[44] Information by system is sourced from the Electronic Municipal Market Access (EMMA) website where hospital and hospital systems provide financial statements and quarterly statements for bond compliance. Independent hospitals are not shown as a category.

Inpatient and Outpatient Service Split

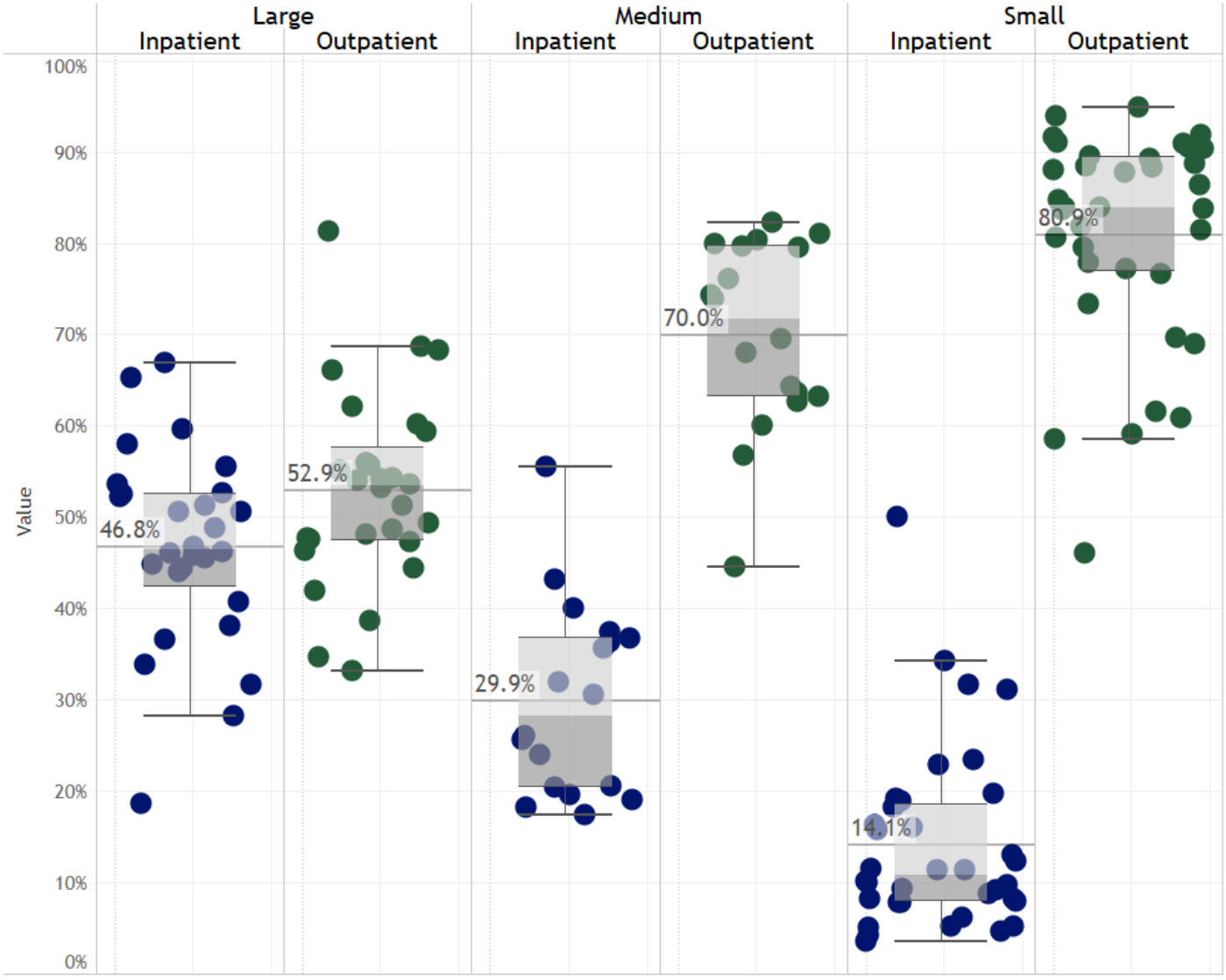
HCPF uses a breakdown of gross charges to determine the split between inpatient and outpatient services. Graph 13 represents all hospitals 2022 estimates of what proportion of delivery of service expenses are for inpatient and outpatient services. On average, 28.7% was for inpatient services and on average, 69.0% for outpatient services.

Graph 13 2022 Inpatient and Outpatient Expense Split

The variation amongst the hospital peer groups is shown by the inpatient and outpatient service split (Graph 14) utilizing a straight average. It should be noted that the average of the large group inpatient services, at 46.8%, are far higher than the medium group (29.9%) and small group (14.1%) inpatient services. Due to the quantity of hospitals in the peer groups, the medium and small peer groups drive the statewide results. The medium peer group's inpatient and outpatient service split reflects the statewide values, with inpatient services representing 29.9% of expenses while outpatient services represent an average of 70.0%. The small peer group's expenses are the most heavily weighted towards outpatient services as hospitals in that peer group reported 80.9% of their service expenses for outpatient

services and 14.1% for inpatient services. It is important to more thoroughly and productively consider the efficiency and sustainability of inpatient care for certain rural hospitals going forward.

Graph 14 2022 Inpatient and Outpatient Expense Split by Hospital Peer Group



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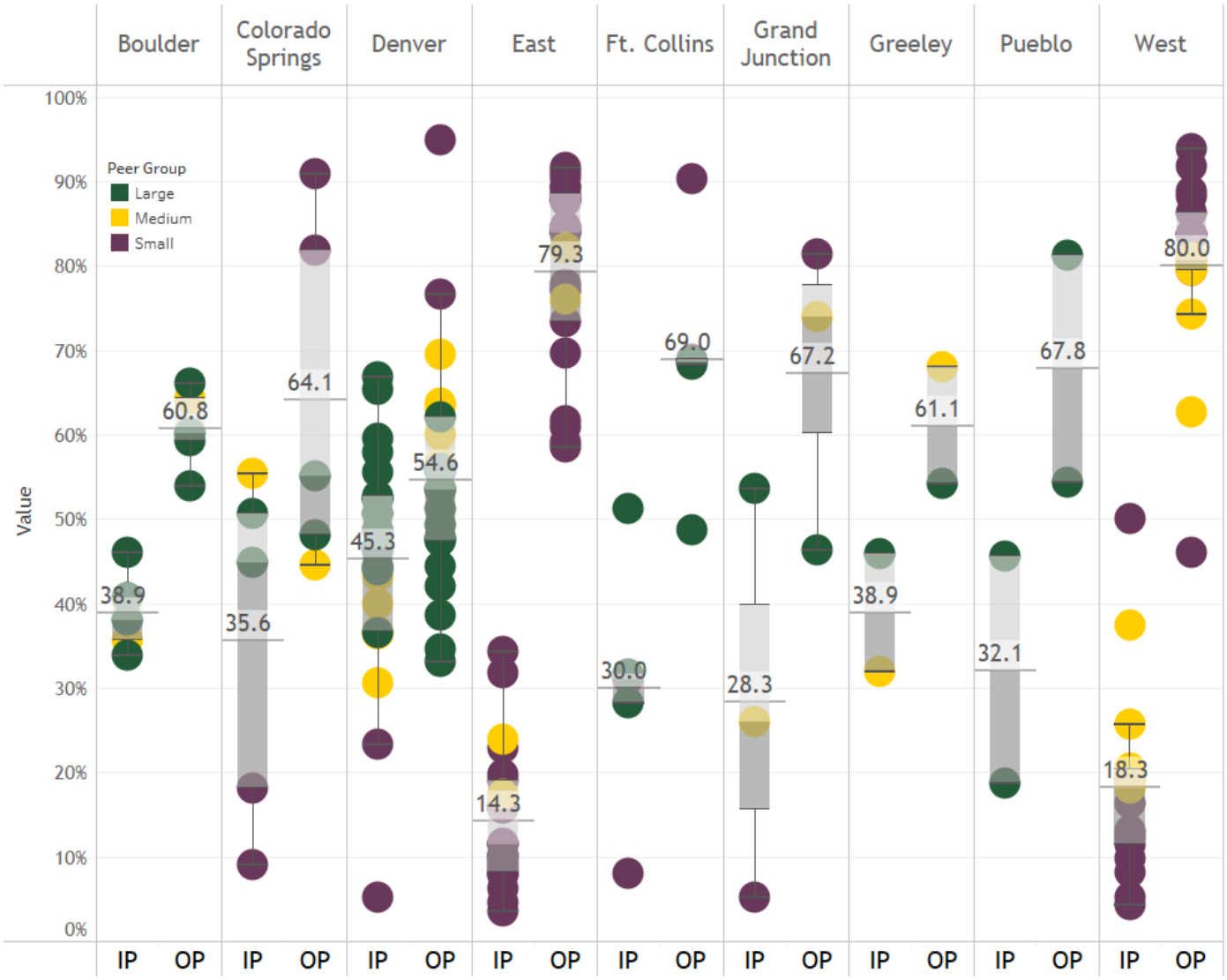
In Graph 15, regions with more small and medium hospitals have more outpatient service expenses than inpatient service expenses. Along with hospital size, distance from the state's most populous metropolitan region, Denver, seems to correspond with the proportion of expenses allocated between inpatient and outpatient services. In the regions with the highest proportion of small and medium hospitals, the East and West regions, the split between inpatient and outpatient is most noticeable. Within these regions, small hospitals have the highest proportion of outpatient services and lower inpatient services compared to their regional peers.

Graph 15 2022 Inpatient (IP) and Outpatient (OP) Expense Split by DOI Region



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Payer Mix

HCPF assesses payer mix by evaluating the proportion of payer types that make up total charges.[45] To assess payer mix, proportions of charges are calculated. The dataset has four payer types: Medicare, Medicaid, commercial and self-pay. The difference between total charges and the sum of these payer types has been labeled as "Other." The difference between the "Other" payer category and CICP/Other shown elsewhere in the report, is that prior to 2019 not all Colorado hospitals were required to submit charge information that accurately broke out CICP; therefore, the categories are not synonymous.

Graph 16 and Table 37 show the changes in payer mix between 2014 and 2022. In 2022, more individuals were insured through public programs (61.1% Medicaid/Medicare payer mix) than in 2014 (55.1% Medicaid/Medicare payer mix). The increase of 6.0% primarily came from a reduction in commercial payer mix. Between 2014 and 2022, commercial payer mix decreased from 36.5% to 30.2%, while the Medicaid hospital payer mix increased from 2014 to 2017, from 19.3% to 22.2%. Medicaid payer mix has remained fairly consistent since 2015 ranging between 21.2% and 22.0%, despite the significant uptake in Medicaid enrollment from 2020 to 2022. However, payer mix does not necessarily indicate utilization of a specific payer, while Medicaid enrollment increased between 2020 and 2022 that does not mean these new members were using hospital services.

[45] A hospital's chargemaster is a layer of financial values tied to services rendered that applies to all patients. Two patients who receive the same services will be "charged" the same amount. What the patients and their insurance coverage will end up paying varies based on their insurance's negotiated rate with the hospital. As the top layer of the charge system is universal amongst patients, charges are a good indication of the proportion of services associated with a payer type. Additionally, using charges to proportion payer mix assumes that the procedure mix is similar across all payer types, e.g. when one payer type receives more high charge procedures it will look as though they have a greater payer mix.

Graph 16 Payer Mix

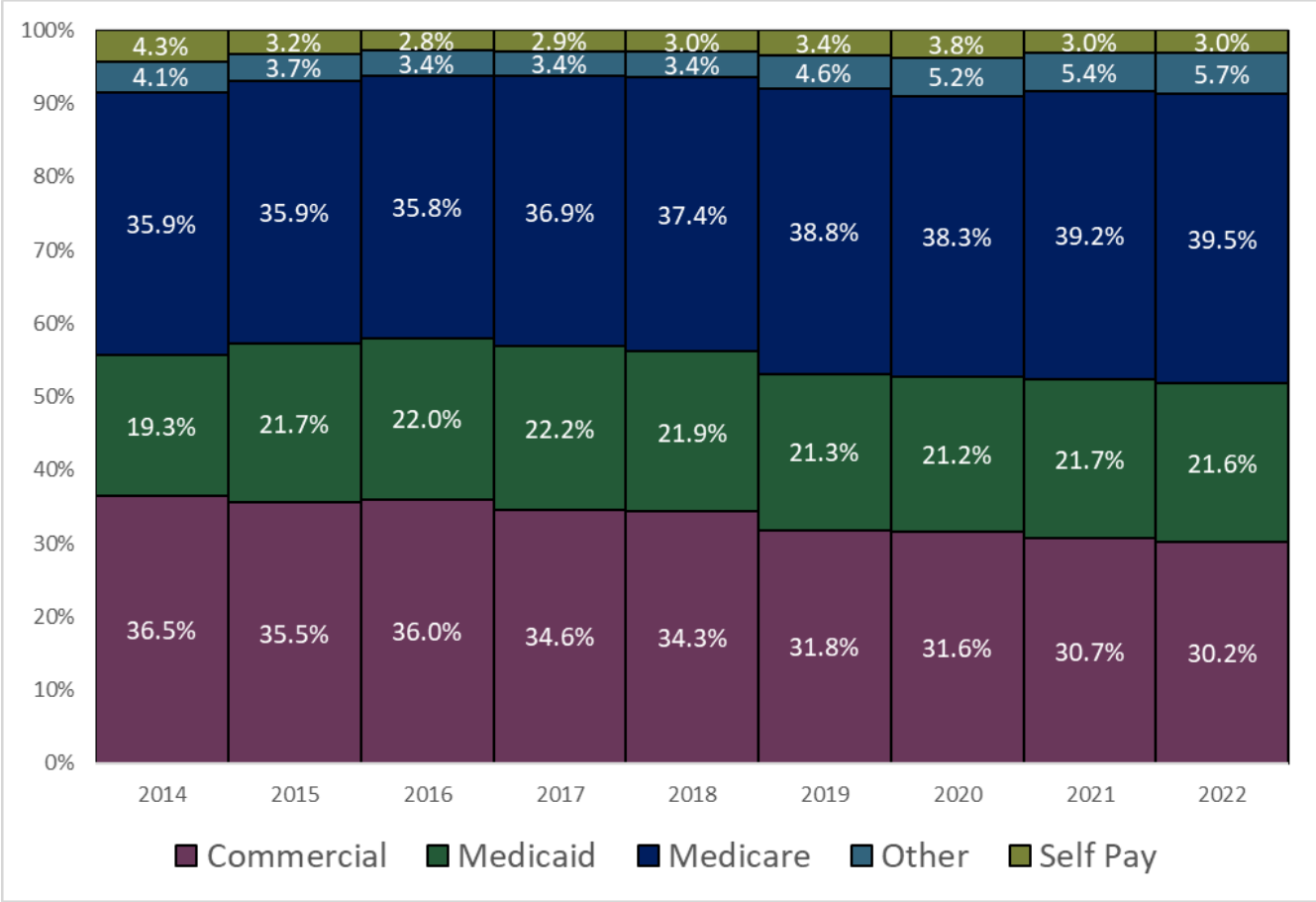

Table 37 Payer Mix

Year	Commercial	Medicaid	Medicare	Self-pay	Other
2014	36.5%	19.3%	35.9%	4.3%	4.1%
2015	35.5%	21.7%	35.9%	3.2%	3.7%
2016	36.0%	22.0%	35.8%	2.8%	3.4%
2017	34.6%	22.2%	36.9%	2.9%	3.4%
2018	34.3%	21.9%	37.4%	3.0%	3.4%
2019	31.8%	21.3%	38.8%	3.4%	4.6%
2020	31.6%	21.2%	38.3%	3.8%	5.2%
2021	30.7%	21.7%	39.2%	3.0%	5.4%
2022	30.2%	21.6%	39.5%	3.0%	5.7%

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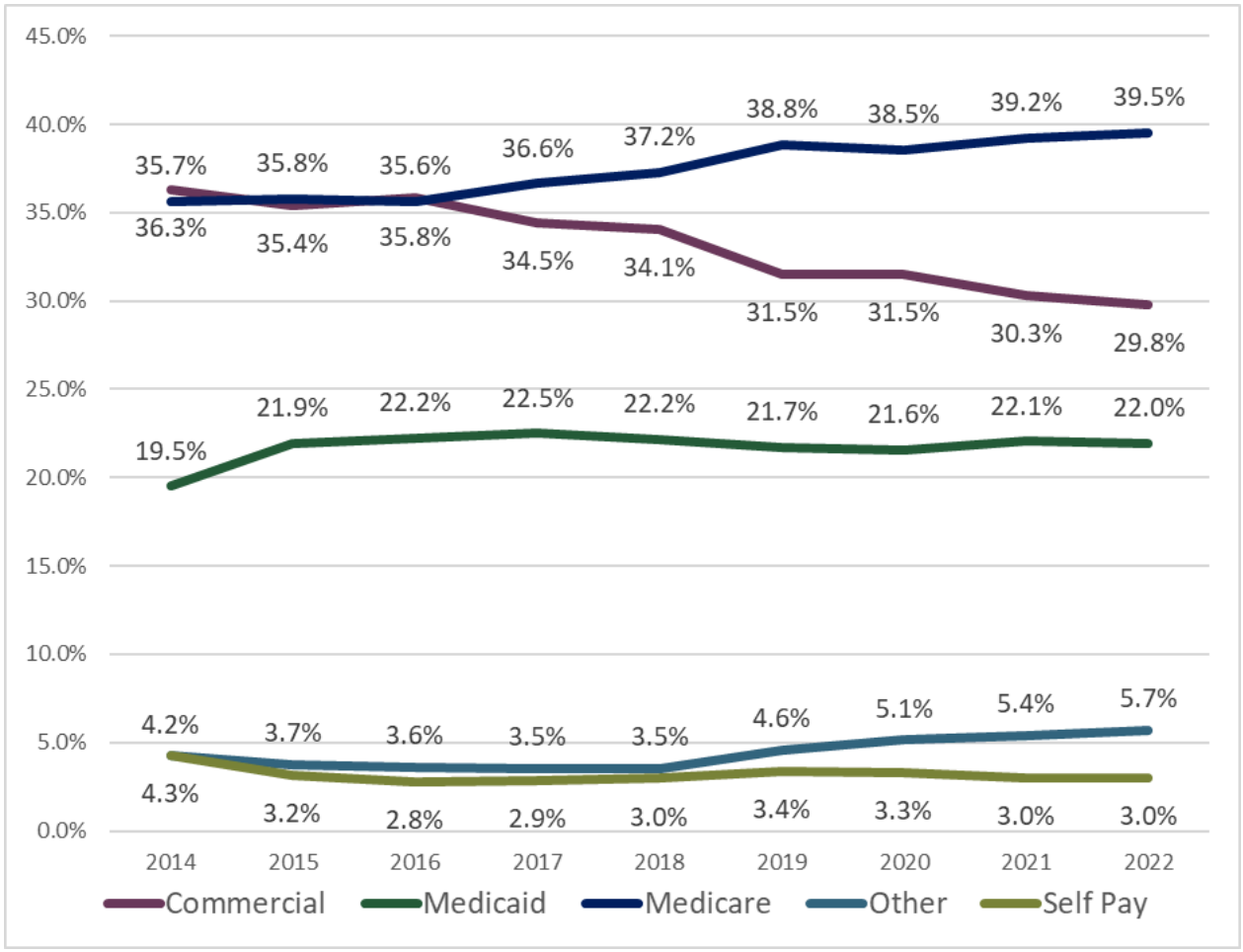
HCPF also reviewed payer mix by the hospital peer groups, displayed in Graph 17, 18 and 19. From this view of the data, it is apparent that the small peer group had the lowest commercial payer mix for most years and 31.7% in 2022. Recently in 2022, the large peer group has fallen below the small peer group in terms of commercial payer mix. For the large peer group, Medicare makes up approximately 39.5% of their payer mix. Historically, most patients at small peer group hospitals are insured through Medicare. Medicare is now the largest payer mix of the large and medium peer group's payer mix as well. The change in commercial payer mix for the large and medium peer groups is significant because commercial patients are where hospitals drive operating margins and profitability, in addition to investment income.

For all hospital peer groups, there was an increase in the proportion of Medicaid payer mix between 2014 and 2017, resulting from Medicaid expansion. Despite the uptake in Medicaid enrollment due to the COVID-induced economic downturn and the continuous coverage federal requirements, beginning in 2020, the Medicaid hospital payer mix has remained relatively consistent between 2018 and 2022 - measurably different from the Medicare payer mix growth.

Graph 17 Large Hospital Peer Group Payer Mix



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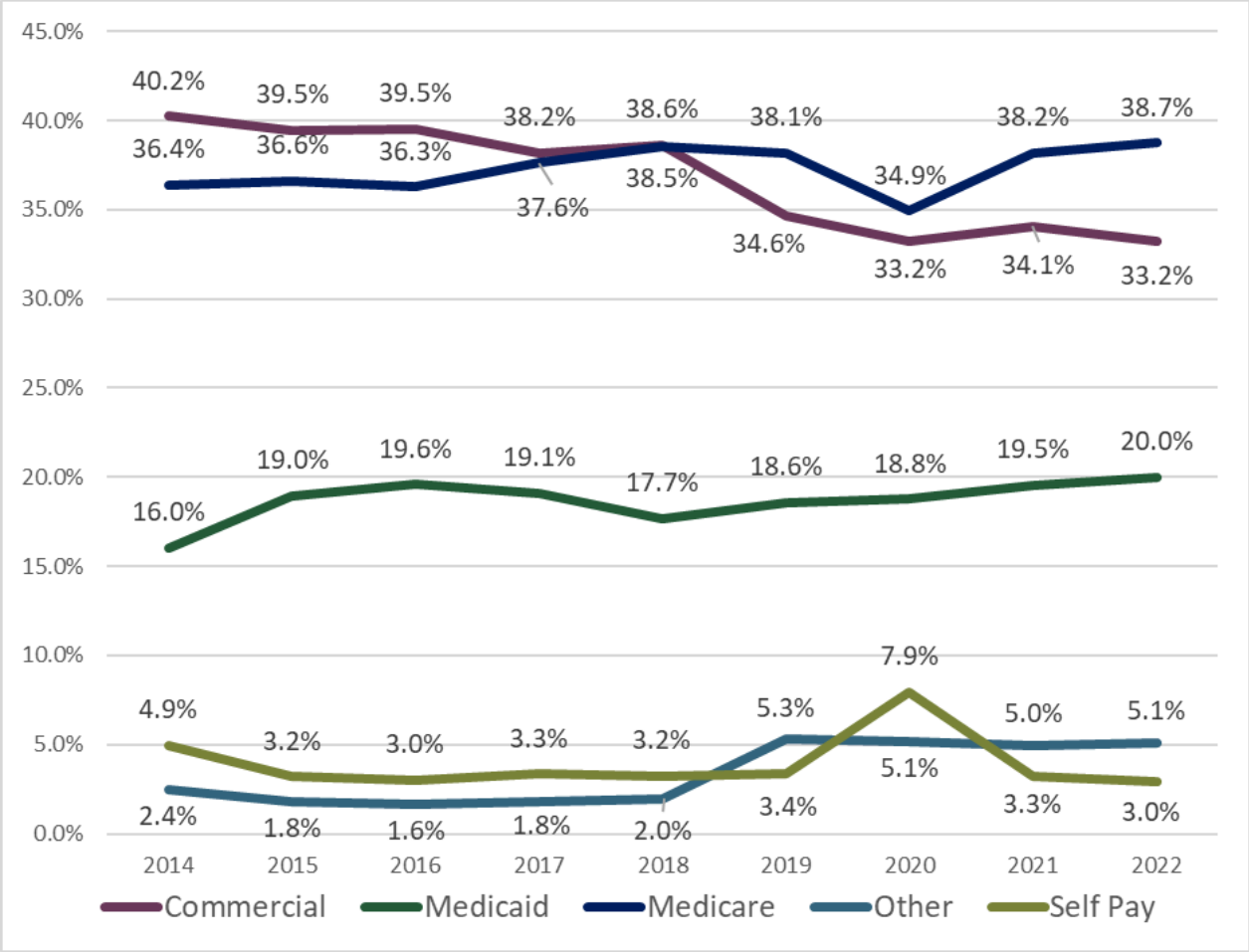
Graph 18 Medium Hospital Peer Group Payer Mix



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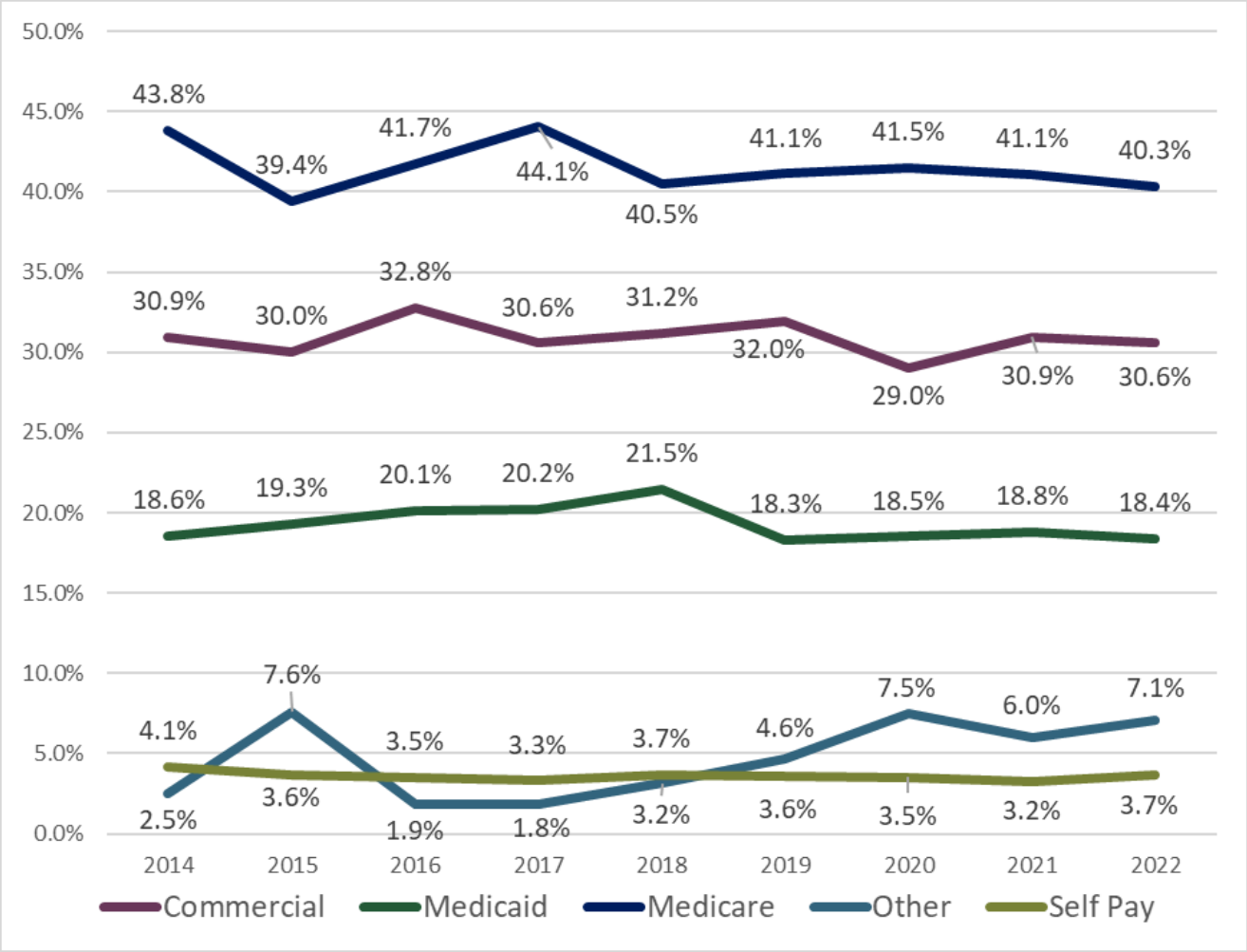
Graph 19 Small Hospital Peer Group Payer Mix



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Conclusion

Overall, due to increasing costs associated with the COVID-19 pandemic, hospital operating expenses have grown faster than patient revenues leading to narrowing profits and margins. In 2022, the historic trend of patient revenues growing faster than operating expenses has reversed. In 2022, operating expenses grew 10.4% from 2021 while patient revenue grew 5.9%. Increases in operating expenses are driven by the growth in labor expenses, especially contracted labor expenses, and supply chain and inflation challenges in 2022 resulting from the COVID-19 pandemic. Between 2021 and 2022, contracted labor expense increased by 73.5% and have increased 247.6% since 2019. The large increase in contracted labor expense is due to a variety of factors, including workers leaving the health care industry, pressure on hospital staffing such as retention of staff nurses, increased wages, and longer hours worked by staff. HCPF will continue to monitor and conduct further analysis of the impacts of the COVID-19 pandemic that may continue to impact the hospital workforce, along with supply chain and inflation challenges.

Between 2014 to 2022, net patient revenue grew from $12.1 billion to $21.3 billion, an increase of $9.1 billion, or 75.5%. That represents an average annual increase of 7.3% a year. More recently, between 2021 and 2022, net patient revenue increased by $1.2 billion, or 5.9%. In 2020 net patient revenue saw an increase of 2.5% from 2019 and an increase of 11.4% in 2021 from 2020. When combined with previous years' growth, it appears that hospital net patient revenues are returning to trends seen before the pandemic.

HCPF has analyzed days cash on hand, a liquidity metric, for Colorado hospitals and systems. HCPF's most recent data show cash reserves have declined from 2021 and 2020 levels. However, cash reserves in 2021 and 2020 were assisted by federal COVID-19 stimulus packages. In 2022, the state median for days cash on hand is 183. While this has been a decrease in cash reserves from previous years, it still remains above the 2019 level of 149.

In 2022, uncompensated care costs totaled $54.0 million, representing an increase of 12.5% from 2021, with charity care generating $325.8 million, or 59.9%, and bad debt costs generating $218.3 million, or 40.1%. The increase in uncompensated care may be driven in part by the recent influx of migrants in Colorado, especially into the greater Denver area, who are more likely to rely on hospital charity care than other populations. Self-pay was the largest portion of uncompensated costs in 2022 totaling $324.4 million. The self-pay category was the largest for both charity care and bad debt costs, $204.6 million and $119.9 million, respectively.

Total operating expenses increased by $2.0 billion from 2021 to $21.4 billion in 2022. In comparison, between 2014 and 2022, total operating expenses grew $1.2 billion each year or 7.8% a year on average. Between 2014 and 2022, net patient revenue

increased on average 7.3% a year. Colorado's population increased 9.2% between 2014 to 2022, according to the Colorado State Demographer.[46]

Since 2020, HCPF's analysis indicates the mix of expenses that make up total operating expenses has remained relatively consistent. Salaries, wages and benefits remain the largest operating expense for all peer groups. However, between 2021 and 2022, the 73.5% increase in contracted staff expenses is remarkable, while the proportions of salaries, wages and benefits among the hospital peer groups varied. The smaller the hospital size peer group, the greater the proportion of salaries, wages and benefits expense and specifically its general and administrative expenses. Overall, between 2014 and 2022, total payroll expense increased 62.2%, or $2.7 billion, whereas contracted labor expense increased 2055%, or $891.2 million. The majority of the increase for contracted labor began in 2019.

In 2022, HCPF analyzed profits for patient services, operating, and total net income. Between 2021 and 2022, patient service net income declined 72.4%, or a reduction of $875.5 million. Between 2021 and 2022, operating income decreased $981.0 million or 50.0%. The reduction in operating income over the last year is due to operating revenues, specifically net patient revenues, growing at a lower rate than operating expenses (5.9% and 10.4%, respectively). Between 2021 and 2022, total net income decreased by $3.1 billion or a decrease of 90.2%. While all peer groups saw a decrease in 2022, the decrease in net income was primarily driven by the large peer group, which decreased by 91.0% or $2.6 billion. The overall decrease in net income between 2021 and 2022 was largely driven by losses in hospital investments due to a lower than expected year in the investment market.[47] Hospitals have historically profited from investments; therefore, stock market volatility directly influences hospitals' net income position.

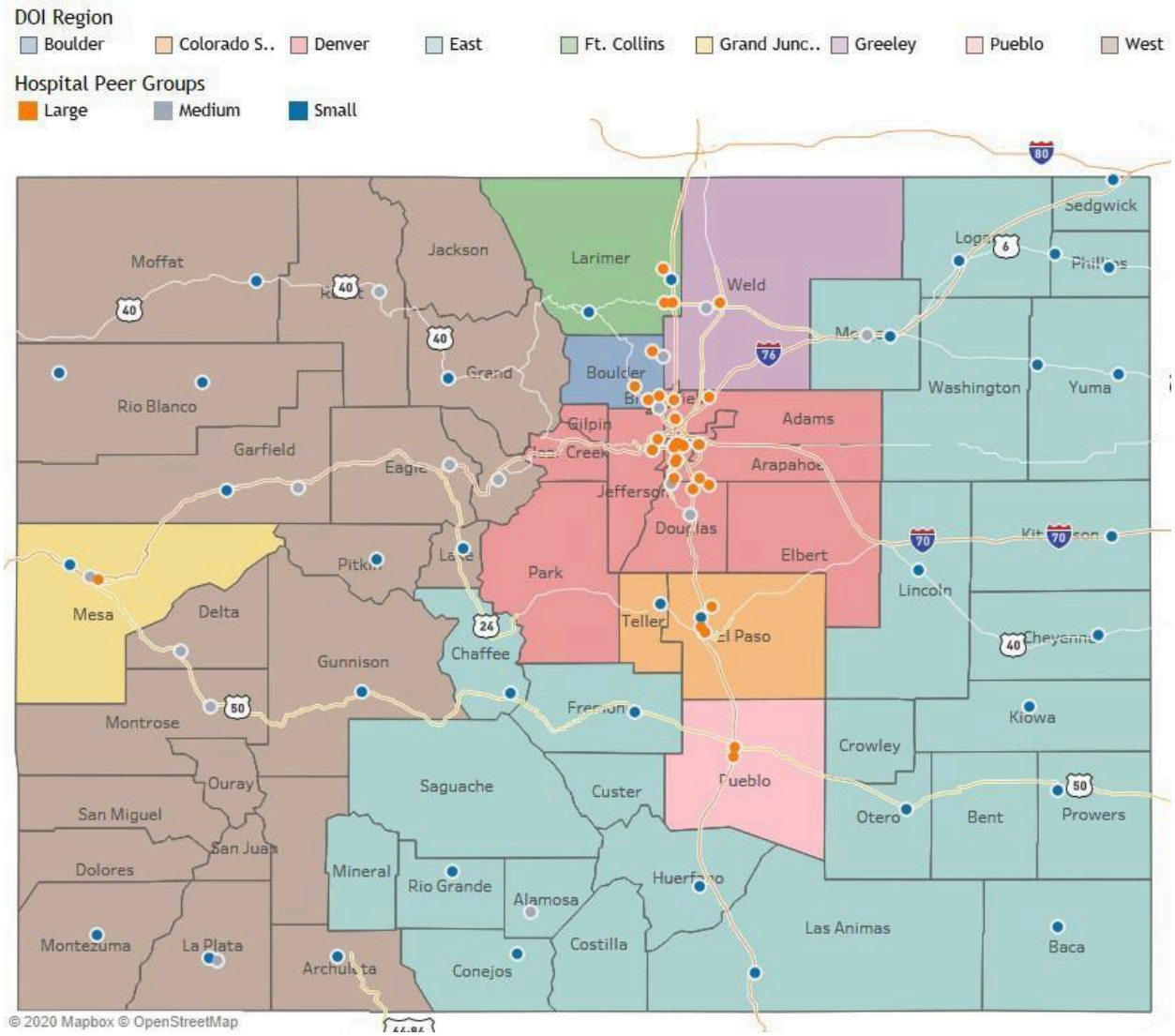
HCPF's payer mix analysis illustrates shifts in payer mix from commercial and self-pay categories to public payers, largely Medicare. In 2014 through 2022, commercial dropped from 36.5% to 30.2%, while public payers represented by Medicare and Medicaid grew from 55.1% to 61.1%. The payer mix for the large hospital peer group had the lowest percentage of commercial when compared to the medium and small hospital peer groups. The change in commercial payer mix for the peer groups is significant since commercial patients drive operating margins and profitability, in addition to investment income.

For a full report of each hospital's data, please see the Hospital Financial Transparency Report Detailed Dataset by Hospital in Appendix C.

[46] Information retrieved from: https://demography.dola.colorado.gov/assets/html/gis_applications.html#population.
[47] See footnote 13.

Appendix A: Map

Graph 20 Map of Colorado Hospitals Identified by Hospital Peer Group and DOI Regions



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Appendix B: Definitions

Affordable Care Act (ACA): The comprehensive federal health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Bad debt: The sum of all charged amounts a provider billed but did not receive payment for the service.

Charity care: The sum of all charged amounts determined by the health care provider to be charity care and thus unreceived revenue.

Colorado Healthcare Affordability and Sustainability Enterprise Board (CHASE Board): The CHASE Board makes recommendations to the Medical Services Board regarding the implementation of the health care affordability and sustainability fee. The CHASE Board also directs the implementation of delivery system reform incentive payments program and monitors the impact of the fee on the healthcare market.

Contractual allowances: Also known as adjustments, contractual allowances are the difference between what a health care provider charges for the care provided to the patient and what the provider will be contractually paid by a third-party (commercial insurer and/or government program such as Medicare, Medicaid, etc.).

Cost-to-charge ratio: A cost-to-charge ratio estimates the costs associated with the charged amount for each procedure. A cost-to-charge ratio helps to determine costs for uncompensated care and patient services which do not have costs directly associated with that care.

Table 38 Cost-to-charge Ratio Calculation

Calculation	Variable
	Total operating expense
÷	Sum of:
	Total gross charges
+	Other operating revenue.
=	Net patient revenue

Critical access hospitals: A hospital qualified as a critical access hospital under 42 U.S.C. § 1395i4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and Environment

Department of Health Care Policy & Financing (Department): A department of the government of the State of Colorado which provides Medicaid, CHP+ and other safety net programs and has a mission to *improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado*.

DATABANK Program: An online program available to Colorado Hospital Association members and serves as a centralized location for the collection of hospital utilization and financial data.

Depreciation expense: The decrease in the fair value of a tangible asset, reported as an expense for the reporting period.

Discharge: A record of a formal release of a patient. This excludes newborns leaving with mothers, death on arrivals and includes death.

General hospital: A hospital licensed as a general hospital by the Colorado Department of Public Health and Environment. Sometimes referred to as a "short-stay, acute care hospital."

Health system: Also known as hospital system. A multi-hospital system is two or more hospitals owned, leased, sponsored or contract managed by a central organization.

Hospital peer groups: For the purposes of this report hospital peer groups are determined by grouping together the number of licensed beds (for a definition of licensed beds please see below). The three (3) peer groups are as follows: the small peer group with 25 or fewer beds, the medium peer group with 26 to 90 beds and the large peer group with 91 or more beds.

House Bill 19-1001: The Hospital Transparency Measures to Analyze Efficacy Bill signed into law on March 28, 2019.

House Bill 23-1226: The Hospital Transparency And Reporting Requirements signed into law on June 2, 2023.

Interest expense: Expenses for mortgages, bonds, notes, lines-of-credit, convertible debt and any other short-term or long-term borrowings.

Licensed beds: The maximum number of beds a licensure agency, such as the state or other governing body, allows a hospital or health facility to operate at any given time. Hospitals provide the number of beds at the end of the fiscal year.

Long-term care hospital: A general hospital that is certified as a long-term care hospital by the Colorado Department of Public Health and Environment. Sometimes

referred to as a sub-acute care hospital or long-term acute care hospital.

Major payer groups: A major payer in healthcare is the entity or individual paying the medical bill or claim. The major payers for the purposes of this report are Medicare, Medicaid, commercial and self-pay. Others can include compensation programs, like workman's compensation and other government programs, like TRICARE/CHAMPUS.

Medicare Cost Reports: Medicare hospital cost report, from Center for Medicare and Medicaid Services (CMS) 2552-96 or CMS 2552-10, or any successor form created by CMS and the annual required submission of worksheets and schedules by Medicare certified providers used for Medicare reimbursement

Net Income: Net income refers to the amount an individual or business makes after deducting costs, allowances and taxes. In commerce, net income is what the business has left over after all expenses, including salary and wages, cost of goods or raw material and taxes.

Net patient revenue: Net patient revenue approximates the payments a hospital receives for patient services. Net patient revenue is calculated by totaling all charges the hospital billed to patients, subtracting contractual allowances and then subtracting bad debt and charity care.

Table 39 Net Patient Revenue Calculation

Calculation	Variable
	Total charges
-	Total contractual allowance
-	Total charity care
-	Total bad debt
=	Net patient revenue

Operating Net Income: Net operating income is a commonly used figure to assess the profitability of a property. The calculation involves subtracting all operating expenses on the property from all the revenue generated from the property. The higher the revenues and the smaller the expenses, the more profitable a property is.

Other expense: The difference between total operating expense and specified categories of expenses (salaries, wages and benefits, supply, interest and depreciation). These expenses might be for taxes, utilization, contract services, fees, insurance, marketing expenses, etc.

Outpatient visit: Determined by counting only one visit day for each calendar day a patient visits an outpatient department or multiple outpatient departments.

Patient Service Net Income: Patient service net income is the difference between net patient revenue and all costs associated with direct patient care.

Psychiatric Hospital: A hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

Rehabilitation hospital: An inpatient rehabilitation facility.

Salaries, Wages and Benefit Expense: Salaries and wages paid to hospital employees and employee benefits paid and provided by the hospital. These include employee expenses for physicians, interns, residents, other trainees, facility employees and home office wages.

Supply expense: The sum of all expenses related to medical supplies, food, housekeeping, maintenance, general facility upkeep, minor equipment, administration and medical drugs.

Total operating expense: The sum of all operating expenses to run the hospital. This includes expenses like materials, supplies, contract services, management fees and home office allocations, depreciation, interest, taxes, consultants' services, utilities, pharmaceuticals and insurance.

Table 40 Total Operating Expense Calculation

Calculation	Variable
	Depreciation
+	Interest
+	Salaries, wages and benefits
+	Supplies
+	All other expenses
=	Total operating expenses

Uncompensated care: Health care or services provided by hospitals or health care providers that are not reimbursed.

Appendix C: Hospital Financial Transparency Report Detailed Dataset by Hospital