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CWAG

Thomas L. Frazier, *Executive Director*

Coalition of Wisconsin Aging Groups

1245 E. Washington Avenue
Madison, WI 53703-3040

608/257-0023
FAX 608/257-8929

**Testimony Before the Joint Committee on Finance**

**March 27, 1995**

**by**

**Thomas L. Frazier**

**I would like to begin by thanking the Co-Chairs and members of the committee for being so responsive to the issues of spousal impoverishment protections and MA Personal Care. I know you will make every effort to eliminate or greatly alleviate the pain associated with these two budget items.**

**I would like to use my brief time to convince you to fix another major issue that will have a tremendous negative impact on 17,000 of Wisconsin's lowest income elderly, blind and disabled people on SSI. The projected administrative savings for Wisconsin is not worth the pain it will cause thousands of people -- 8,000 older persons, 8,600 people with disabilities and 400 children. Not only would these people lose about $60 a month but they would also lose their eligibility for MA. I know that DHSS claims that most of them can regain eligibility for MA through the medically-needy program, but there will be people who are not eligible and, I fear, many people, especially older people, who will not go to the county social service agency to apply for MA. When the state eliminated the $10 a month food stamp "cash out" program, DHSS said the same thing--most people will realize a net gain by getting more than $10 in food stamps. A year or so later the Legislative Audit Bureau did a study which showed that in fact two-thirds of all SSI recipients experienced a net loss.**

**- over -**

**I think funds to continue the 17,000 people on SSI can come from not providing the 6.5% increase to all remaining SSI recipients (SSI recipients tell us that they do not want to benefit at the expense of others) and from caseload reductions which will result from federal legislation which will likely reduce Wisconsin's caseload by 5,000–7,000 persons.**

**In terms of administrative costs I believe a better solution to Wisconsin's problem would be to work to get the federal government to freeze administrative costs or even to rescind administrative cost increases.**

CWAG

Elder Law Center

**Coalition of Wisconsin Aging Groups**

1245 E. Washington Avenue
Madison, WI 53703-3040

608/257-5660
FAX 608/257-8929

TESTIMONY BEFORE THE JOINT COMMITTEE ON FINANCE
March 27, 1995
Betsy Abramson, CWAG Elder Law Center Director

The Coalition of Wisconsin Aging Groups very much appreciates the opportunity to testify today on two budget issues affecting a population about which we have very deep concerns: Wisconsin's children. The Coalition of Wisconsin Aging Groups takes seriously our founders' motto to serve as a "partner in building the Wisconsin of tomorrow for people of all ages."

The Coalition of Wisconsin Aging Groups recognizes that the needs of children represent the needs of "families," just as the needs of the elderly represent the needs of families. We also recognize that the future of our society depends on a healthy, well-educated work force and that basic nutrition, economic security, quality child care and good education are all critical building blocks towards that goal.

There are unfortunately many issues in the Governor's proposed budget that are not consistent with the goals of healthy, well-nourished, well cared for and educated children; today, however, we will focus on only two of these very serious issues: the Governor's proposed elimination of state support for the Supplemental Nutrition Program for Women, Infants and Children (WIC) and the proposed elimination of the $13 million earmarked in Community Aids for child care.

The WIC program provides funds for baby formula, milk, cheese, iron-fortified cereal, juice, eggs, peanut butter, dried beans and peas, and for breast-feeding mothers, tuna and carrots. This program has been demonstrated to be cost and health-effective, WIC reduces low birthweights, premature births and childhood anemia. Numerous studies, including one conducted by the federal government's General Accounting Office, has concluded that for every one dollar spent on WIC food for a pregnant woman, over $3 are saved in medical care costs for her child in the immediate post birth period. WIC is not an entitlement program; there are finite dollars committed to the program. As a result, even with the current funds Wisconsin is still not reaching 30% of eligible Wisconsin women, infants and young children. Waiting lists abound. This proposal could not have come at a worse time. With enormous cuts in the safety net for the poor, especially poor children, being threatened by the federal government, funds for this cost-effective nutrition program are desperately needed in Wisconsin.

*-- over, please --*

Second, the Governor has also proposed removing $13 million currently earmarked for child care in Community Aids. This state money is all targeted at low-income families who need to find and place their children in quality child care settings in order to hold down jobs. At a time when both the federal and state governments are talking about welfare reform, including time-limited benefits and work requirements, clearly we must recognize that access to affordable, quality child care is a critical component of our goals of assisting families in moving from dependence to independence. Without these critically needed child care funds, children will be at risk of being placed in extremely dangerous child care settings, being left alone, or the children's parents will not be able to leave the home to work. Low-income women, working for minimum wage jobs, cannot possibly stay in the work force without assistance with child care costs.

We urge this Committee to reject the Governor's proposals to eliminate both the state supplement for WIC and his proposal to remove earmarked funds for child care. Healthy, well-nourished, well cared for children is both compassionate and critical to the future of Wisconsin for citizens of all ages.

WISCONSIN NUTRITION PROJECT INC.
1245 EAST WASHINGTON AVE . SUITE 76 . MADISON . WISCONSIN 53703
FAX: (608) 251-8545 (608) 251-4153 HNØ169@handsnet.org

Testimony Presented to the Joint Finance Committee
March 27, 1995

Thank you Sen. Leean and Rep. Brancel and Members of the Joint Committee on Finance for this opportunity to speak before you. My name is Carol Huber. I am Executive Director of the Wisconsin Nutrition Project. WNP is a non-profit agency engaged in research, education and advocacy on the nutritional and health needs of low income families in Wisconsin. The issue I would like to address is the proposed elimination of the GPR allocation for the Wisconsin WIC Program.

The WIC program has provided nutrition education, health services and food vouchers to pregnant, breastfeeding and postpartum women, infants and children for over twenty years. This combination of food, health care and nutrition education has been demonstrated to be effective in decreasing the number of babies born at low birthweight, reducing the infant mortality rate and reducing the incidence of childhood anemia. The Government Accounting Office reports that a dollar spent on supplemental foods for a pregnant woman yields a savings of more than three dollars in medical care costs.

In Wisconsin 156,183 persons are estimated to be eligible for WIC services. Eligibility is determined based on income and health and nutritional status. Public health nurses and nutritionists assess each applicants health needs.

Funds for the WIC Program come from the United States Department of Agriculture to the Department of Health and Social Services, as a grant intended to allow the state to serve a specified number of participants. WIC is not, and has not been, an entitlement program. Thus when federal funds are insufficient to serve the number of eligible persons applying for the program, local projects, primarily county public health agencies, must maintain waiting lists.

USDA provides funds for Food and for Nutrition Services and Administration. Participants receive vouchers for specific foods that contain nutrients important to growth and development. These foods include infant formula, milk, eggs, cheese, iron-fortified cereal, juice, peanut butter, dried beans and peas and for breastfeeding women, tuna and carrots. WIC participants redeem their vouchers for the specified foods at grocery stores and pharmacies under contracts with the Department of Health and Social Services.

In many ways WIC in Wisconsin is a good news story. The Department of Health and Social Services has a record of aggressively seeking additional federal dollars with which to expand the program. Wisconsin serves a higher percentage of eligible persons than the national average.

Currently Wisconsin serves 70% of eligible women, infants and children. The national average is 63% served.

However, in 1985, federal policy limited Wisconsin's ability to secure additional funds because then as now the program had outperformed the national rate. Throughout the state local WIC projects were forced to place applicants on waiting lists according to priority. This occurred despite the fact that earlier the Wisconsin WIC program had opted not to serve an entire category of persons eligible for program benefits under the federal rules, postpartum non-breastfeeding women. Members of the Wisconsin Legislature chose to address this situation by allocating state GPR for WIC services.

There was at the time bi-partisan leadership for this move from then Rep. Cate Zeuske and then Sen. Carl Otte. By stepping forward and recognizing the importance of WIC services for achieving major state health goals, Wisconsin acted in the tradition of progressive leadership. Only one-third of the states provide state dollars for WIC services.

The allocation of funds in 1985 and subsequent years had the intended effect of eliminating the waiting lists. Last year Wisconsin once again resumed serving post-partum women. A new development since 1985 is the addition of a third stream of funding namely formula rebates. These funds are equal to $14 million in 1995.

Is state funding still needed? Yes. The rationale for the budget proposal is that additional federal dollars are available to the program and thus state funds are not needed. This scenario ignores the fact that the federal funding situation is quite fluid at the present time. Last week the U.S. House of Representatives voted to include WIC in a family based nutrition block grant as proposed in Title III of the Personal Responsibility Act of 1995. If the Senate passes these same provisions and if the President signs this bill states will have the flexibility to alter the package of health, nutrition education and food vouchers which has proved so successful. The requirement for infant formula cost containment would be removed and thus reduce the amount of funding available to the program. Periodic reallocations of funds would not be an option for securing additional funding as Wisconsin has done in the past. Even now the amount of funding reallocated has decreased substantially as states position themselves for the future. In January 1994, Wisconsin received approximately $700,000 in reallocated funds; in January 1995 the amount was $98,000. In short, it is impossible to say with any confidence what the federal funding level will be for FY96 and beyond. All indicators are that growth in the program will be limited. USDA's analysis projects a decrease of $613,00 per year for Wisconsin.

There is still unmet need for WIC services. Thirty percent, or 47,000 potentially eligible Wisconsin women, infants and children are not being served.

Wisconsin, like other states, has been working to reach a full funding caseload (85% of eligibles) by FY96. The state WIC program has committed funds to local agencies to serve a caseload of 120,000 participants or 77% of those potentially eligible. State and local agencies are engaged in intensive outreach efforts to reach an additional 11,000 participants this year. There is considerable effort needed, including improvements in infrastructure, for such an undertaking to yield quality services. It is my understanding that the state supplement is used for grants to local agencies to cover nutrition services and administration. Federal funds are used to cover food costs.

Continuation of the state supplement will provide the WIC program the needed flexibility to seek additional federal dollars and serve the maximum number of participants the funds allow. WIC works. Milk and juice and cereal are far less expensive than infant intensive care. I urge you to restore the $2.8 million in GPR funding for each year of this budget.

Again, thank you for your attention.

*Recently I have had two suicidal thoughts: either stop working and go back on welfare, or place my children in foster care so that they might have the opportunity for a better life.*[13]

— SINGLE MOTHER IN ARKANSAS

• • • • • • • • •

*I just received a letter saying my transitional services would be expiring in September. I'm wondering if there is another program I can get help from in order to keep my day care and my job. I can't afford to pay my bills and my day care. I'm a single mother and I left my daughter's father. I finally got off public aid and got a job that I like a lot, thanks to the transitional program. My day care lady has helped me as much as she can but she has to be paid. I'm on my own for the first time with my two-year old daughter and I would hate to go back on public aid.*

*P.S. The last time I decided to leave my daughter's father I had to go back to him and an abusive situation because I couldn't afford to pay my bills and work without worrying about where my daughter was going to be. I need help.*

— LETTER TO STATE CHILD CARE ADMINISTRATOR FROM SINGLE WORKING MOTHER.[15]

## Lack of Subsidized Child Care Causes Parents to Return to AFDC

• • • • • • • •

*I am a single parent of one child who receives not one penny in child support, works 40 hours a week trying to make ends meet. I ask for a little bit of assistance from the state and I get put on the waiting list... I am better off unemployed and on welfare... This system makes me very angry.*

— RHODE ISLAND PARENT ON A WAITING LIST FOR AT-RISK CHILD CARE.[35]

• • • • • • • •

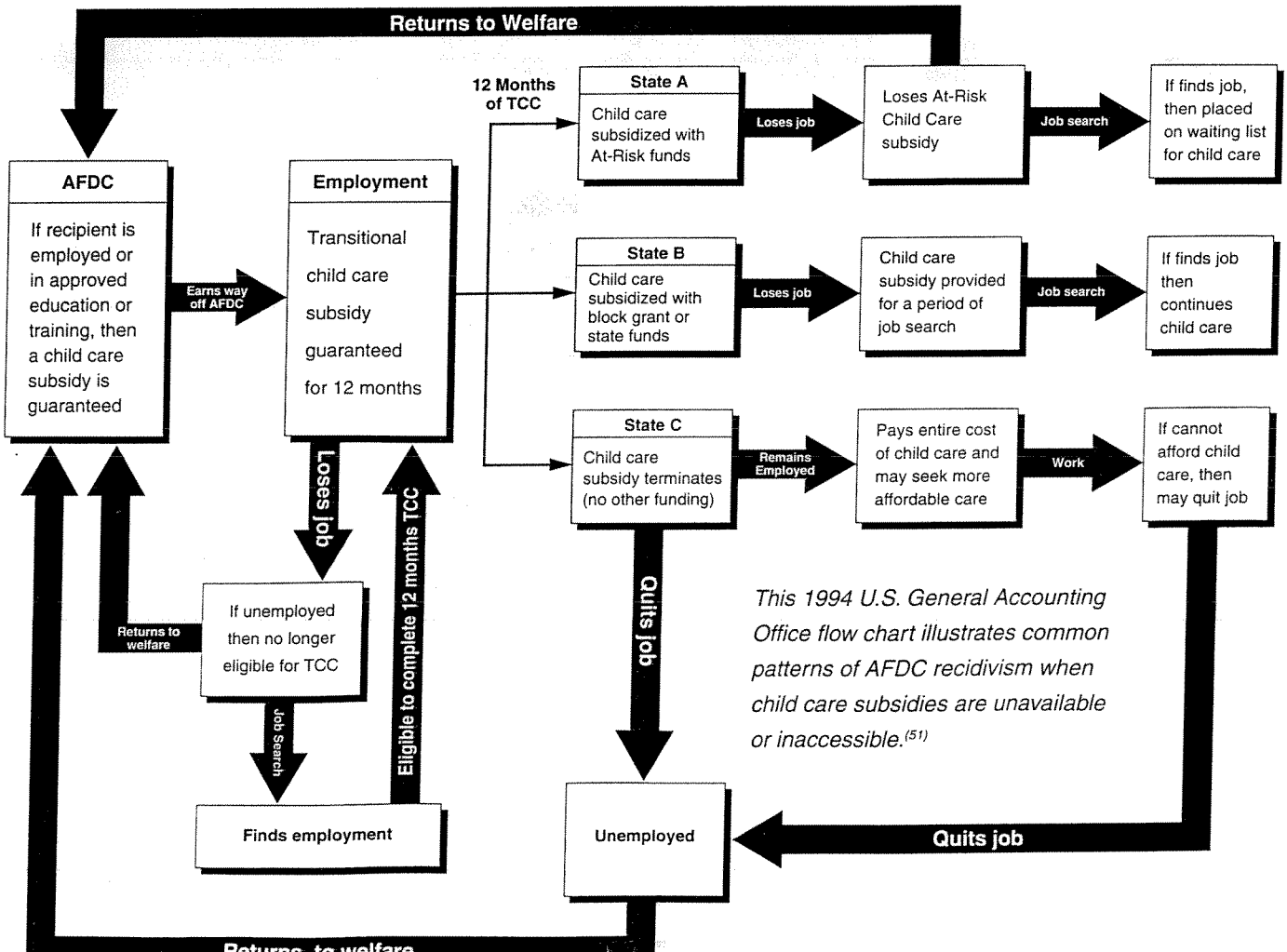
Inadequate and inconsistent child care funding has had the unintended effect of guaranteeing child care only for families who work and receive AFDC, or who are eligible for Transitional Child Care (TCC), forcing all other low-income families to compete for scarce dollars. While child care subsidies could serve as an incentive for poor parents to work, many do not know that assistance is available. Many eligible families who work do not ever receive subsidies because they are not aware of them.

Moreover, insufficient child care funding for poor families who are not guaranteed child care has caused states to prioritize and serve these families only as resources permit. Often these families are never served because they never reach the top of long waiting lists. Many families are forced to return to AFDC while they wait for child care assistance.

- In Texas, working poor families who do not receive AFDC rank fourth in a priority list for child care subsidies. Illinois serves teen parents, child protective services cases, families with special needs, and then working poor families who are not eligible for entitlements to child care.[51]
- In 1991, a California survey found 255,000 children on waiting lists for subsidized child care, and in 1993, there were 13,000 on a waiting list for one payment agency in South Central Los Angeles. In California it takes two to three years for a subsidized child care slot to open.[51]
- An Illinois study found that 68 percent of the families who had completed one year of TCC continued to have incomes low enough to be eligible for "At Risk" child care. Of those families who did not require "At Risk" child care assistance, the primary reason was that the family's youngest child had turned thirteen and was no longer eligible for the program.[3]
- A 1994 study of families on waiting lists for child care in Minnesota found that 24 percent were forced to rely on AFDC while waiting for child care. Fourteen percent of these parents had to leave their jobs, and 71 percent fell into serious debt in order to pay for child care.[54]
- Twenty percent of families studied in Maryland who had left TCC and were put on a waiting list for subsidized child care returned to AFDC while waiting for child care assistance.[6]

- In a Baltimore study, 42 percent of families who were eligible for state subsidized child care applied for AFDC after being on the waiting list for six months or more.[6]
- In Milwaukee County, Wisconsin, one-fourth of families who exhausted their TCC benefits returned to AFDC. The county believes this is due, in large part, to a lack of affordable or subsidized child care.[6]
- In Illinois, researchers found that child care problems caused 20 percent of parents who had left AFDC for work to return to public assistance.[3]
- A 1987 study of the ET job training program in Massachusetts found that one-third of the mothers who had completed the program and left welfare for work returned to public assistance within one year because of child care problems.[5]

## AFDC Recidivism Due To Lack of Child Care




*This 1994 U.S. General Accounting Office flow chart illustrates common patterns of AFDC recidivism when child care subsidies are unavailable or inaccessible.*[51]

MY NAME IS TERRY MCCULLOCH. I AM HERE BECAUSE THERE ARE 6000 PEOPLE WAITING FOR MY WIFE TO DIE. I AM ALSO HERE TO REQUEST YOUR REJECTION TO THE GOVENOR'S PROPOSALS TO DRASTICALLY REDUCE THE SPOUSAL IMPOVERISHMENT LEVELS, CUT MEDICAL ASSISTANCE PERSONAL CARE, CUT SSI BENEFITS, NOT FUND THE COP PROGRAM ADEQUATELY, ELIMINATE FUNDING FOR AFCSP AND WAITC, AND CUT INCOME LIMITS FOR INDIVIDUALS TO QUALIFY FOR MEDICAL ASSISTANCE COVERAGE IN NURSING HOMES.

MY WIFE HAS ALZHEIMERS. JUDY AND I WERE MARRIED 3 YEARS AGO. WITHIN MONTHS I KNEW SOMETHING WAS WRONG. SHE WAS FIRST DIAGNOSED AS HAVING DEPRESSION AND WAS TREATED ACCORDINGLY. HER CONDITION CONTINUED TO DECLINE. SHE WAS DIAGNOSED WITH ALZHEIMERS 4 MONTHS LATER AT AGE 51. THE DISEASE PROGRESSED QUICKLY AND IN JANUARY OF 1994 I HAD TO PLACE HER IN A GROUP HOME. SHE REMAINED THERE FOR 7 MONTHS. WHEN THE LEVEL OF CARE SHE NEEDED INCREASED I MOVED HER TO ELDER HAUS IN DODGEVILLE, WHERE SHE CAN HOPEFULLY REMAIN UNTIL HER PASSING.

ALZHEIMERS HAS ALREADY RUINED US FINANCIALLY. WE LOST OUR HOME, OUR BUSINESS AND OUR SAVINGS IN ORDER TO PROVIDE FOR HER CARE. COP MONEY BECAME AVAILABLE TO JUDY ONLY BECAUSE A WING OF A LOCAL NURSING HOME WAS CLOSED DOWN. BY THAT TIME I WAS ALREADY BELOW THE IMPOVERISHMENT LEVEL AND HAD LOST MY OWN HEALTH INSURANCE AS I COULD NOT AFFORD TO PAY FOR IT AND JUDY'S CARE. SINCE COP FUNDS WERE APPROVED I HAVE TRIED ON SEVERAL OCCASIONS TO SECURE MEDICAL INSURANCE. WHAT I CAN AFFORD HAS SO MANY EXCLUSIONS THAT IT IS NOT WORTH HAVING AND INSURANCE THAT WOULD PROVIDE ADEQUATE COVERAGE EQUAL TO WHAT I HAD PRIOR TO JUDY'S ILLNESS IS WAY OUT OF MY REACH FINANCIALLY.

IF THESE FUNDS ARE NO LONGER AVAILABLE JUDY WILL HAVE TO MOVED TO A NURSING HOME BECAUSE MEDICAID WILL NOT COVER THE COST FOR THE GROUP HOME. NURSING HOME CARE

WILL COST THE STATE 1/3 MORE THAN WHAT THE GROUP HOME CHARGES. JUDY DOES NOT REQUIRE NURSING HOME CARE. SHE FUNCTIONS WELL AT THE GROUP HOME WHERE SHE IS ALLOWED TO WANDER THROUGHOUT THE FACILITY. IF SHE WERE PLACED IN A NURSING HOME SHE WOULD NEED TO BE DRUGGED AND RESTRAINED IN ORDER FOR HER TO BE "MANAGABLE" AND SHE WILL LOSE WHAT LITTLE FREEDOM AND DIGNITY SHE NOW HAS.

THERE ARE 6,000 PEOPLE ON THE WAITING LIST FOR COP FUNDS. THE ONLY WAY ANY OF THESE PEOPLE WILL GET HELP IS WHEN SOMEONE (LIKE MY WIFE) DIES. THE FUNDS WE ARE SPEAKING OF (COP, SSI, MEDICAID) ARE NOT FOR PEOPLE WHO CHOOSE NOT TO PROVIDE FOR THEMSELVES BUT PEOPLE WHO ARE UNABLE. JUDY'S MONTHLY CARE RUNS $3,300. HOW LONG WOULD YOU BE ABLE TO SUPPORT THAT KIND OF CARE AND STILL PROVIDE FOR YOUR OWN LIVING EXPENSES. I UNDERSTAND THAT MANY OF OUR SYSTEMS NEED CHANGE. BUT MOST OF YOU MAKING THE DECISIONS WILL NOT BE DIRECTLY AFFECTED BY THEM. PLEASE PUT YOURSELF IN OUR SHOES WHEN YOU CONSIDER MAKING THESE CHANGES. I HAVE LOST MY WIFE, OUR HOME, OUR BUSINESS, AND MY OWN HEALTH INSURANCE. IT CAN HAPPEN TO ANYONE INCLUDING YOU.

THANK YOU.

Terry McCulloch
S7559 Hwy 12 N26
North Freedom WI 53951
608-643-4207

TO: Senator Joseph Leean, Co-Chair, Joint Finance
Representative Ben Brancel, Co-Chair, Joint Finance
and Other Distinguished Members of the Joint Finance Committee

FROM: Jonathan Bader
115 Pleasant View, DeForest, WI 53532
608-846-2333

# Testimony Regarding Proposed Cuts In Wisconsin's Childhood Lead Poisoning Prevention Program

March 27, 1995

My name is Jonathan Bader and I'm the father of three daughters who were lead poisoned during a home renovation project in DeForest in 1991. I last testified before this committee when the Childhood Lead Poisoning Prevention bill, AB540, introducted by Representative Spencer Coggs, was still under consideration. Were it not for the strong support at that time from members of this committee, Act 450 which was signed 10 months ago, would not have become a reality. In addition to giving DHSS authority to establish screening standards and promulgate rules for contractor training, the bill also provided grants to Public Health Agencies throughout the state to conduct local lead programs. The Governor's proposed budget would cut 24% of this money, just one year after a bi-partisan effort to provide state-wide funding. A cut of this magnitude would severely reduce the effectiveness of Public Health agencies to address lead poisoning at the local level; the very backbone of the legislation.

As you know, lead is a powerful neurotoxin that affects the developing nervous system of young children. Lead exposure causes learning disabilities, attention deficits, behavior problems and other irreversible consequences. Lead paint, found in 3/4 of Wisconsin houses built before 1978, is the primary culprit. Children living in older homes become poisoned when they ingest small chips or unseen dust from deteriorating paint or during renovation and remodeling projects when old paint is disturbed. Lead poisoning crosses all geographic boundaries, racial groups and economic classes and is so common that one child in 11 has elevated levels. Because effects are irreversible, there are numerous long term costs in medical care, special education, clean-up and abatement, not to mention lost potential and heartache for affected families. There are an estimated 39,000 Wisconsin children today with elevated levels. Last year screening located over 9,600 children.

When my family was lead poisoned 3 years ago after purchasing our new house, we encountered misinformation and ignorance:

- To secure our FHA mortgage we were required to conduct repairs following HUD guidelines directing us to scrape and sand leaded paint prior to repainting. At the time HUD handed us these guidelines they reported to Congress that scraping and sanding lead paint is extremely hazardous because it generates large amounts of toxic dust.

- Contractors we consulted before work began were uninformed and routinely recommended and used, improper and dangerous techniques.
- We received no information on lead hazards from our Realtor or building inspector and our bank gave us incomplete and inaccurate information.
- Three weeks into the project when we had our children's blood lead level checked, to be on the safe side, our pediatrician informed us their levels were "only trace" and to check back in three months when we finished. Months later we discovered that the first test had in fact shown that Shireen, then 18 months old, was lead poisoned and had a blood lead level three times what is considered safe today.

Because our pediatrician failed to report the test results to Public Health as required by law, the exposure continued for another 3 months. A retest found all three of our children were poisoned. Shireen had a level 6 times the safe level, Mira, our 3 year old, had a level 3 times normal and 10 year old Sarah was twice the normal level. The pattern of misinformation seemed unending.

**It was not until the Public Health Agency in Dane County got involved that we began to receive the assistance and information we needed.** They immediately visited our home and helped us understand what had happened - unseen dust from our renovation and repainting had severely contaminated both our children and our home. They helped to arrange for a lead inspection, provided information on clean-up and other steps to reduce the exposure. We consulted with them on medical treatment needed by our two youngest. They worked with us over several long months while our home was cleaned, helped us with environmental clearance testing, and followed the medical chellation process of our children. Since their lead program was itself just beginning when there were questions they could not answer they connected us with those who could. Their earnestness to help was remarkable and the emotional support and reassurance they provided and the genuine warmth they demonstrated was as important to us during that crisis as the technical assistance we received.

These are the very services the Governor's budget proposes to cut. Home visits, nursing case management, inspections, follow-up, technical assistance, education for parents and professionals as well as training for Public Health staff themselves. While these services may seem impersonal and remote on paper, I assure you they affect real families in a very personal way. I know too many others with similar experiences.

Lead is persistent. After 3 years, Shireen's blood lead level, while down, has still not returned to normal. If we are ever to reduce the incidence of this preventable disease we must consistently commit the necessary resources to do it. Finding the money may not be easy, but the alternative is to sacrifice our children's potential. Today, at current levels of funding, many lead poisoned children who should receive home inspections and hazard reduction are not receiving them. Not all counties received funding. Combine the proposed cut with others at the state and federal level and Public Health staff will loose ground recently gained. Two years ago the members of Joint Finance were instrumental in recognizing the need to focus state resources on the problem,...I urge you to continue that commitment.

General Lead Information

- Lead is a powerful neurotoxin that affects the developing nervous system of fetuses and young children and causes decreased intelligence, learning disabilities, behavioral problems, stunted growth, hearing loss and short-term memory loss.

- Neurological damage, which is irreversible, has been documented at low levels previously thought to be safe.

- The majority of lead poisoned children do not exhibit recognizable symptoms. The only reliable means of detection is a blood test.

- Recent data (NHANES III, 1994) reveals 8.9% of U.S. children under 6 have elevated blood lead levels. This means 39,000 Wisconsin children have elevated lead levels today.

- Lead paint is the primary source of lead poisoning in children. HUD estimates *that 3/4 of all housing built before 1978* contains some lead. This is about one half of the U.S. housing stock.

- Over 70% of housing in some counties contains lead based paint, including Ashland, Buffalo, Fond du Lac, Grant, Jefferson, Manitowoc, Richland and Vernon Counties. Over 76% of all Milwaukee County housing contains lead paint.

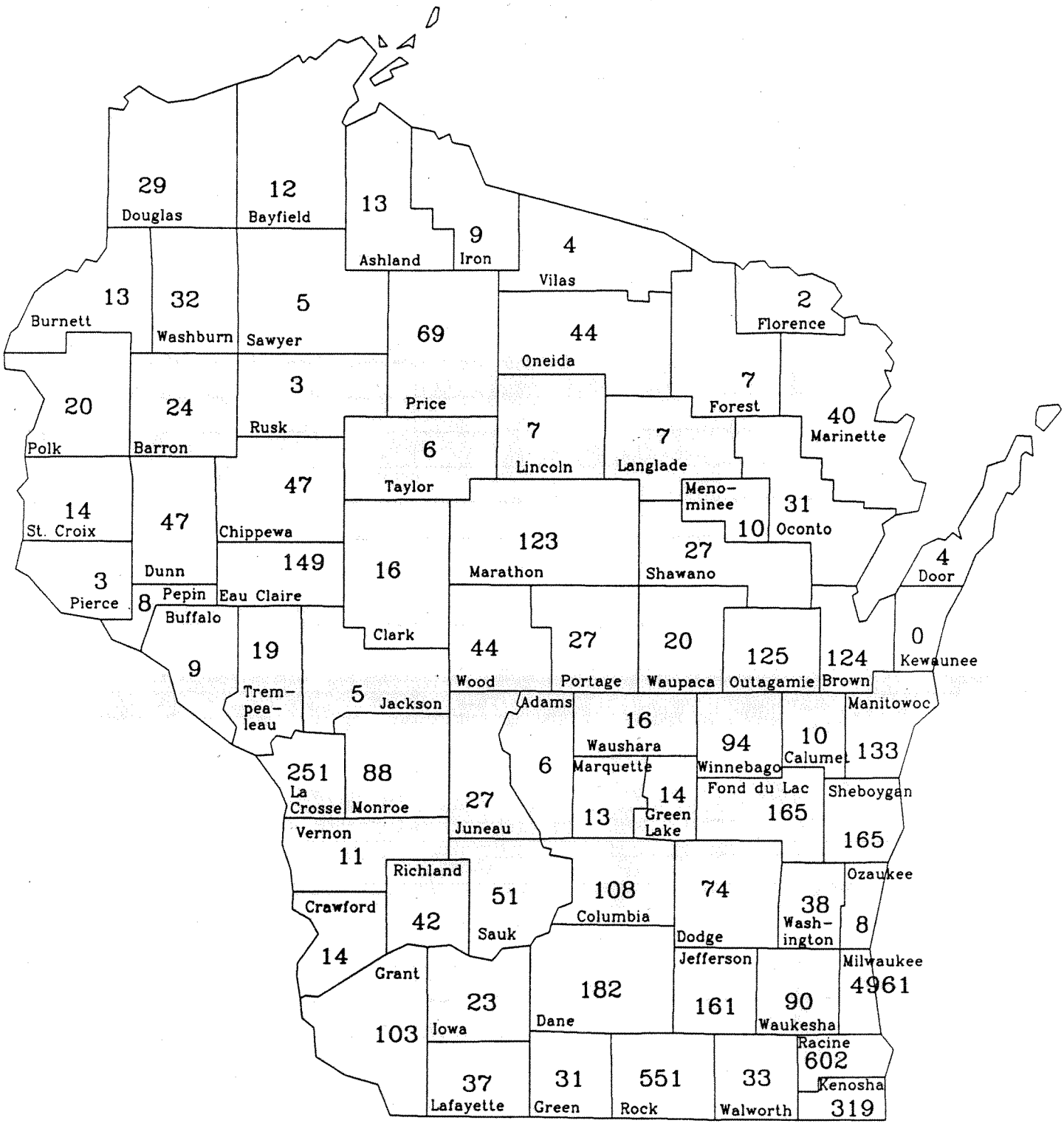
- Lead paint is found equally in upper, middle and lower-income houses. Homeowners and renters are just as likely to have lead-based paint in their homes and apartments.

- Children become exposed to lead hazards from (1) living in older buildings which have deteriorated paint, or (2) living in older buildings which are undergoing renovation or remodeling.

- Last year 12% of Wisconsin children were screened.
  116 children were severely poisoned (>45 ug/dl). 26 live outside Milw. County.
  2,025 children were seriously poisoned >20 ug/dl. 387 live outside Milw. County.
  9,619 children had lead levels >10 ug/dl.

- The CDC recommends that children with lead levels >20 ug/dl should receive an environmental inspection and hazard reduction. Only about half of Wisconsin children in this category had any abatement done on their home.

# Distribution of Wisconsin Children Reported to the Bureau of Public Health with Blood Lead Levels of 10 ug/dL or More by County for the 12 Months Ending 06/30/94




Total Number of Wisconsin Children Reported with Blood Lead of 10 ug/dL or More during the 12 Months Ending 06/30/94 = 9,619

Prepared by the Wisconsin Council on Developmental Disabilities
with Data provided by the Wisconsin Division of Health. 3/95

AMERICAN FEDERATION OF STATE COUNTY AND MUNICIPAL EMPLOYEES
WISCONSIN STATE EMPLOYEES UNION
lOCALS 171 AND 2412
MADISON WI

Reasons why we believe you should act now to remove the "Public Authority" of UWHC from the State of Wisconsin Budget:

- **Millions of tax dollars were used to build and maintain this state of the art hospital.** It is absurd to even consider turning it over to for all intense and purposes a few administrators and doctors to profit from.

- **No additional competition is needed.** We believe the Health Professionals Inc. has provided the necessary competitions. We do not believe the hospital needs to be free to duplicate other hospital's programs and facilities, thus driving up health care costs.

- **Loss of Accountability.** The citizens of Wisconsin will no longer have any control or input on decisions made concerning cost, services or educational programs offered by their hospital. Their record is not beyond question. We have not forgotten the 4.4 million nor the numerous unfair labor practice grievances.

- It **endangers** our **wages**, **benefits** and **job security**

Based on all of the above on behalf of the taxpayers of Wisconsin and the 2300 clericals I represent, I **strongly urge the removal of Public Authority from the budget.**

Presented by: Sylvia A. Sherman
President, Local 2412
27 March 1995

**TESTIMONY FOR JOINT FINANCE COMMITTEE**

**3/27/95**

Thank you for the opportunity to speak today.

I am a board member of Wisconsin Personal Services Alternatives (WPSA) a statewide organization of personal care providers. In addition I am a director of a MA Personal Care Program which provides personal care to some of Dane County's most severely physically disabled citzens.

WPSA would like to thank Senator Leean, Representative Brancel, Senator Ellis and Representative Drewiecki for their leadership in trying to find alternative funding for MAPC.

There are two items in this budget which have a profound negative impact on people with disabilities -- the elimination of MA Personal Care and the cuts in SSI.

MAPC is a program that is cost effective and works for the people it serves.
Will cutting personal care save money? No!

GPR costs (state tax dollars) for MAPC represent significantly less than 1% of the state GPR earmarked for Medical Assistance in the Governor's budget.

While MAPC is eliminated from this budget, institutions will receive a 65 million dollar increase and Wisconsin will lose 58 million dollars in federal matching funds.

We anticipate a 66% reduction in the capacity to provide personal care in Dane County -- more than 275 disabled and elderly citizens will be affected by this cut in our county alone.

We need to spend our long term care dollars wisely **and** humanely. We must respect the personal choices of our citizens and allow them to choose where their cares are provided -- home or institution. Given the choice, which would you prefer? I am certain you would choose to remain in your home as would the majority of those receiving these services.

Wisconsin ranks 6th highest among states in institutionalizing its residents.

In Wisconsin only 33% of the Medical Assistance eligible population is supported in community settings. In the State of Oregon this number is 68% and in Washington State it is 58%.

Wisconsin has 79 nursing home beds per 1,000 of the elderly poulation. The national goal is 45 or fewer. Between 1986 and 1993 Wisconsin has had a 3% decline in its nursing home population.

Nursing homes will receive a 9.25% increase in the budget while personal care is eliminated altogether. Does this make sense or cents?

In this budget Wisconsin proposes to spend more money on increases for institutions than it will on the entire Community Options Program.

Since 1988 Wisconsin has poured more than 330 million new dollars into nursing homes. During this same time nursing home enrollments declined by more than 1,000 people.

We need to drastically enhance our community care supports such as MAPC. It must remain an entitlement. With long waiting lists for COP, MAPC is the only hope many elderly and disabled citizens have to live in their own homes. Let's end the institutional bias and give people a choice.

We must also look at the community cap listed in the budget. A cap of $78.00 per day is not fair to those who have higher needs and wish to remain in their community. $78.00 per day is an average cost for nursing home care and care provided in the community averages out to about the same rate. However, why should consumers with higher costs be sentenced to an institution. If there is no cap for institutional care there should not be one for community care?

Please look closer at the effects of the SSI cuts. These cuts will have a tremendous effect on many people with disabilities who are working or trying to work. Many are uninsurable. If you take away their attendant care, many will lose their jobs and the state will lose another taxpayer and then pay for institutional care. WHY?

Listen closely to this testimony and let all Wisconsin citizens work and live in the community. Thank you.

Sincerely,

Robert Deist
Director of Personal Care Services
Access To Independence

1310 Mendota St.
Madison WI. 53704
608/242-8484

2922 Sachs Street
Madison, WI 53704
March 27, 1995

Joint Committee on Finance
Wisconsin State Capitol
Madison, WI 53701

Dear Honorable Senators and Representatives:

I am an employed, tax-paying homeowner. I work on computers for the State. If I lose my Personal Care Worker, that would change. I need my worker to get me ready and to get me to work on time. My worker helps me keep house, get meals, complete daily chores, and get in and out of my wheelchair. Three-fourths of my worker's salary is paid by MA personal care. If I lose my worker, or can only pay her one-fourth of the salary she now receives, I would lose my job. Without my job, my income is too low to make mortgage payments, so I would also lose my house. Without the housing subsidy I gave up to purchase my own home, I would be unable to afford an apartment in Madison and I would end up in a nursing home. What costs taxpayers more: a working homeowner or a person in a nursing home? I believe I can contribute more to society at my job and in my house than in a nursing home.

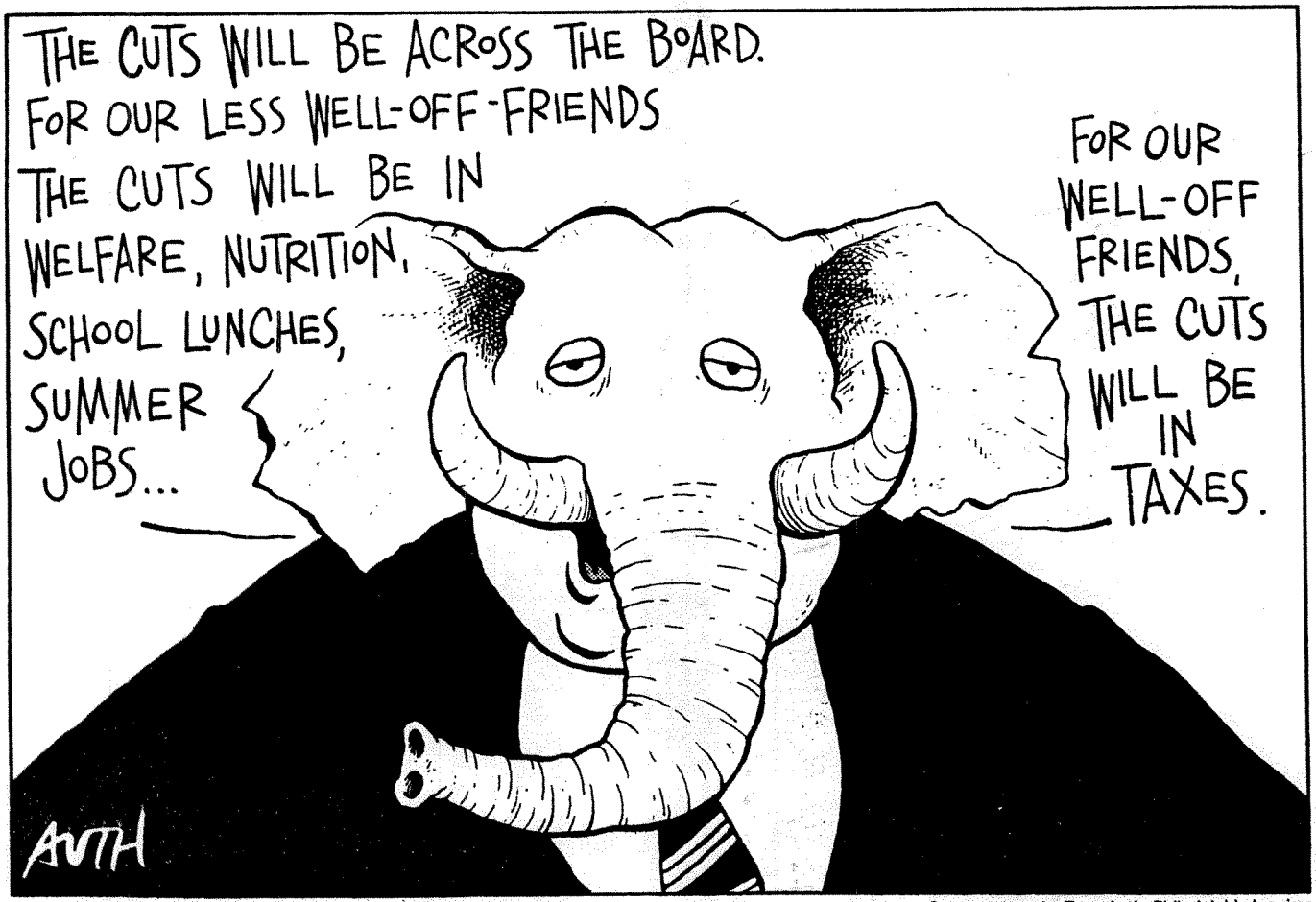
Sincerely,

Tom Welhoefer

Tom Welhoefer

To: Joint Finance Com. Jim Ron Kenkoski 27 March 95

1. If you don't kill the attempts to undermine the Sec. of State, State Treasurer & DPI please; then put those ideas to a vote of all the people, as separate Constitutional Amendments
2. Do not undermine the Merit System in the Revenue Dept. or elsewhere. The people need protection from politicians with "enemies lists". Politicians also need protection from other politicians & from your own fanatical partisan supporters. Recall the federal Civil Service was started after Pres. Garfield was killed by his own fan, who did not get a patronage job.
3. Take the budget apart & study, every bloody paragraph; to find & delete all the foolish ideas, that were added with or without the Governor's knowledge.
4. Cutting MA personal care & forcing people into nursing homes is fiscally foolish - penny wise & dollar stupid!
5. Delay half of the highway construction projects, so funds will be available (Cut from this budget) for schools & other high priority needs.
6. If you eliminate welfare for poor babies born in the future, then fairness demands that you also eliminate the tax credit, exemptions & other subsidies for all babies born of middle & high income adults.
7. After my infant grandniece was diagnosised with Cerebral Palse, her factory worker father had to quit his job to care for her. How will proposed SSI cuts hit families like them?
8. We - the people - paid many millions of $s for our great UW Hospital DO Not give it away, to any corporate interests.
(BofD 6 of 9 picked by Gov.)




Milwaukee Journal 3/18/95

Guest cartoon by Tony Auth, Philadelphia Inquirer

I am writing because I will be affected if medical assistance personal care (MAPC) and SSI are cut from the 1995-1997 executive budget.

If MAPC is cut I will end up in a nursing home, because I would not be able to afford living expenses. MAPC helps pay for the attendants I hire to assist me in my daily living such as showering, dressing, and eating.

The government is seeking for people on benifit packages to work, I assume. I have a degree in Microbiology and am activly seeking employment. I also volunteer at Forest Product Laboratorys. I cannot work or volunteer out of a nursing home, and if I can't work I will end up costing even more government funds to survive, and I'm sure the other taxpayers don't want that.

Socail Security and SSI are also very important to me. I use the money recieved from these programs to help with my living expenses and my private insurance. Without the programs, I will be unable to pay for my private insurance and will be forced to rely on governmental medical assistance. I'm sure that I am not the only person in this situation, either.

Certainly a major concern of these programs is cost. At a nursing home, it would cost $107 a day for me. And that is at the lower end of estimates. Some higher ones are $120 and more. I recieve 8 hours of personal care for just $88 a day. Each year this adds up to $6935. Multip this by the 6000 people on these programs and the

savings will be nearly 4.2 million dollars a year. If MAPC is cut many of the people presently on it will need government assistance to survive. These programs also provide work for my caregivers, often single working mothers. These mothers, without the work would also need government assistance which would cost even more taxpayer money. SSI keeps people in the home instead of in costly nursing homes.

Sincerely

Rory Roberts

I would like to talk to you today as a parent of a daughter who has been legally blind since birth . If you met Ericka you would probably not at first realize that her vision is as limited as it is . She is bright, assertive and doing very well as a senior at the U of WI-Whitewater in spite of the limitations imposed by her vision loss.

I am here today to speak in favor of a separate agency for the blind to direct all services for the blind rather than the present disjointed situation in which all handicaps are grouped together under people who often know very little about blind people and what they really need.

I am not here to tell horror stories about services that were not provided to Ericka. I will have to admit that, except for the brick wall we ran up against in trying to get braille training for her, all the people we have dealt with were kind and caring and tried to do their best for Ericka *IF* we knew what to ask for. The problem, of course, is that we did not always know what she needed or even what was available. There was no one resource to turn to and we were not knowledgable in the needs of blind people. We, as her parents, would always have to be alert and looking for things that might work. There was always this fine kind of balance that had to be maintained between the school, DPI, the Division of Vocational Rehabilitation and any other resources we might hear about. Had there been one agency in charge of all blind related services, perhaps we might have been more knowledgable and services could have been coordinated so helps were available even in a small town. At the very least, there would have been less red tape.

Such a commission as we are proposing should have at least one successful blind person on the committee-- one who has made it in the world of work and who really knows the needs of the blind -- who sees blind persons as capable, intelligent people able, with some adaptations, to live their lives the same as anyone else (to take care of themselves, work, travel, have families, pay taxes); not as objects of pity who need to be taken care of. It would be critical that this be the attitude of all members of the committee. There should also be a member with a business background who could be an advocate for blind persons as workers. A third member could be someone trained in education of the blind, who believes in and is proficient in braille and other blindness skills, to work with schools and agencies to provide the kind of education and services blind people need.

You may say what does braille have to do with setting up a separate agency for the blind? It is, I believe the most critical failing of the current treatment of the blind in the state of Wisconsin. It is sad to say, but in some ways, blind people were better off pre-technology. With the advent of tape recorders, visualtechs, reading machines, etc. , our schools and service agencies have gotten the idea that these are all a blind person needs, that braille is obsolete. They have opted for the easy way out--saying with all this wonderful technology, blind children and adults do not need to be able to read and write braille. That is like your child's teacher telling you that, in your child's case, we have decided not to teach him/her to read or write. We will let the computer do it for him. How would you react? What if your child could not take notes, read a newspaper, read a menu, or fill out a job application and you knew he could be taught a language that would allow him to do these kinds of things? Would you feel your child was going to be ready to compete in school, in jobs, in the world? This is the way parents of blind children feel when

authorities say our children don't need braille.

I can not, of course, know that a separate agency for the blind would insist on the braille and travel skills that blind people need to compete as equals with the rest of society. Yet, the way things are, Wisconsin people can not get the services they need in our state. No one should have to give up citizenship in their own state to get the services they need. Something must happen to turn the tide to provide children not only with technology, but also with the basic skills of blindess such as braille and travel training that will give them the confidence to succeed as people and as employees.

For, what it all comes down to is that what we want for our children is what you want for your children--that they be able to support themselves, that they be able to live where they like, that they be able to travel on their own, that they have a good education including the ability to read and write for themselves. I don't know for sure that a special division that just deals with blindness will be the remedy to all the problems that exist today. A lot would depend on who was chosen to be on the commission and the powers they were given. What I do know is that what is in effect today is not working . Maybe it is time to start over and hopefully do it right.

Blind people neither need nor want to be dependents on the state; but, until they are given the kind of education they need and the kind of job support they need to get them started in the work world they will be an expensive liability. If our nation is trying to get people working so they can get their self respect back and save our tax dollars, then do not forget to include blind people in that effort. A commission such as we are suggesting would be good value for the tax dollar if it means people who were supported by the state are now supporting themselves.

Elaine Bethke

I am here today to ask that you do not allow the state Supplemental Security Income (S.S.I.) payment to be eliminated or reduced as is currently proposed in the governors budget. This cut will adversely affect myself and many others, who may or may not actually receive money in the form of an S.S.I. check. Let me tell you specifically how I would be affected.

I was disabled at age 16 and when the S.S.I. program was started I was eligible. I received full S.S.I. benefits which included Medical Assistance, until 1985 when my father died. At that time I was told by the Social Security Administration that I was eligible for Social Security benefits through my father because I was disabled before age 18. I was also told that I must apply for and accept any Veterans benefits for which I might be eligible. This was due to the fact that my father was a disabled veteran . I applied, and the V.A. found I was eligible because I was disabled before age 18. I did not ask for this money, I was told I must accept these payments. I received S.S.I., Social Security, and V.A. benefits for a few years. The total was the same as I had received from S.S.I. After a few years of cost of living increases in the Social Security and V.A. benefits I was no longer eligible for S.S.I. I was also no longer eligible for M.A. even though I had and continue to have significant medical costs including personal care attendants. I applied to the county for M.A. and was found eligible. I received M.A. through the county until I became employed . At this time I was no longer eligible for M.A. through the county, but due to fact that I have significant job related expenses I am eligible for S.S.I and M.A., even though I receive no cash payment from S.S.I.

My disability significantly limits my employment options. I put alot of effort into my education and finding employment. I enjoy my job and given the choice I would like to keep it. My present job is a state L.T.E. position and offers no medical benefits. My medical expenses are unchanged and remain substantial. I believe I have much to offer and want to contribute to society as much as I can. I pay taxes just like anyone else. If the state S.S.I. payment is eliminated I will no longer be eligible for M.A. Employment will no longer be a viable situation for me. I fail to see how this scenario will save the state money. If I am forced to quit my job, I would no longer be paying taxes and would be relying totally on the system.

As you can see, it not as simple as it seems. People do not fit into easily definable categories. Programs are often highly interrelated and eligibility for one often depends on eligibility for another. This seemly small cut will have effects far beyond decreasing ones income. Many other persons will also face this same choice between employment or remaining eligible for essential services. If you decide to let this proposal pass as it now stands you will be placing one more barrier to employment for persons who are already facing many obstacles. Certainly one more than I can overcome. If the Governor and legislature are serious about getting everyone who can work to do so, you should seriously consider the impact of this cut.

If you have any questions about these issues please feel free to contact me.

Dan Egan
1002 S. Thompson Dr.
Madison,Wi. 53716

DISTRICT 1199W/UNITED PROFESSIONALS FOR QUALITY HEALTH CARE
Affiliated with Service Employees International Union, AFL-CIO, CLC

TO: Joint Finance Committee
FROM: Ruth Robarts,
Executive Director

RE: UPDATE: FINANCES OF UNIVERSITY OF WISCONSIN HOSPITAL AND CLINICS

We have analyzed recent UWHC financial statements and other documents. We conclude that the UWHC is financially sound in the short and long terms. (Information attached.)

We strongly believe that the proposal in AB 150 to create a public authority to operate the UWHC is a policy, not a financing issue, which should be removed from the budget process for serious consideration of the policy issues involved.

The current proposal to privatize the facility and to eliminate collective bargaining rights for all employees in 1997 is unacceptable public policy. The proposal is not necessary for financial reasons. It disrupts longstanding relationships with employee unions for no purpose.

Representing healthcare professionals at UWHC, we are well aware that changes in the financing of health services are creating a new competitive pressure on the UWHC because of its missions of teaching, research and community health outreach, in addition to provision of quality care for very acute patients. We are convinced that the current collective bargaining law needs reform. However, we cannot support the current proposal.

Protecting the competitive strength of UWHC and its missions may require some legislative change. If so, now is the time to set these issues aside for reasoned consideration. Now is the time to create a process of analysis which includes all employees and which provides legislators with options to build on the UWHC's financial strength in ways that give longterm support to its missions. The UWHC has an important role to play as the premier public healthcare facility in Wisconsin. Privatizing is unnecessary and unrelated to that role.

1619 Monroe Street Madison, WI 53711-2021 (608) 284-2140
734 North 26th Street Milwaukee, WI 53233 (414) 342-8898

The University of Wisconsin Hospital & Clinics (hereafter "UWHC" or "the hospital") has shown profits of at least $10.9 million every fiscal year since 1989. (Our file goes back to 1988, when UWHC showed a profit of $5.5 million.) In 1994 profits surged to $23.3 million although SEIU expects a modest weakening to $20.6 million for fiscal 1995. (The hospital's fiscal year runs from July through June.)

From 1992 to 1994, UWHC earned cumulative profits (before extraordinary items) of $40.3 million, and SEIU anticipates profits of approximately $20.6 million in fiscal 1995, yielding a four year total of $60.9 million. From 1992 to 1994, the hospital's average annual profit rate was 5.1%, slightly above the Wisconsin state average of 4.9% for 1992 and 1993 (we don't have national or state profit data for 1994 yet).

It is also worthy of note that UWHC consistenly shows "operating profits," income earned from direct provision of patient care and related services). Many hospitals have operating losses and depend on non-operating revenue (contributions and income from investments) in order to achieve overall profitability.

The hospital's cash flow has also been extremely healthy. Cash flow from operations doubled as a percentage of total revenue from 6.6% in 1992 to 13.2% in 1994. This operating cash flow paid for over $35 million in property, plant, equipment and other assets, retired over $7.5 million of the hospital's long-term debt, and left enough over to add $19.3 million to the hospital's cash reserves.

Wages and benefits combined increased by 7.7% betweeb 1992 and 1994, but this growth in labor compensation was outpaced by the 10.9% increase in operating revenues. (And it was swamped by the 101.6% increase in net profit.) As a percentage of total operating expenses, total compensation declined marginally from 56.0% in 1992 to 55.3% in 1994.

Consequently, UWHC managers would be hard pressed to argue that wages and benefits are squeezing revenues and profits or are crowding out spending for other operating expenses.

As if 1994, the hospital's total cash flow (profit + depreciation + interest) per bed was an astonishing $65,744; nearly 3 times the 1993 Wisconsin state average of $22,974. SEIU predicts an even higher cash flow per bed figure of $73,500 for fiscal 1995.

The hospital is financially sound. It faces no obvious short-term financial crises, and its long-term financial structure is solid.

We don't have detailed utilization data, but what we do have is generally positive. Average length of stay is trending slowly downward from 7.7 days in 1992 to an estimated 7.0 days in 1995. Although the absolute level of ALOS was well above Wisconsin averages, this phenomenon is characteristic of major teaching hospitals, and is therefore probably nothing to worry about.

Admissions and patient days are declining in conformance with national trends (and these declines are accompanied by increasing profits and cash flow). Finally, outpatient visits are increasing. This is a good sign since normally outpatient services are more profitable than inpatient services.

SEIU Research Department ExpressAnalysis
UNIVERSITY OF WISCONSIN HOSPITAL & CLINICS, Madison, WI
(Fiscal Years Ending June 30)

| RATIOS | Actual 1992 | Actual 1993 | Actual 1994 | Budget 1995 | Actual Change 1992-1994 | Direction of **Actual** Change **1992-1994** | Budgeted Change 1994-1995 | Direction of **Budgeted** Change **1994-1995** | UWHC compared to all Wisconsin hospitals 1993 |
|---|---|---|---|---|---|---|---|---|---|
| Operating Cash Flow Ratio (Net Operating Cash Flow/Total Revenue) | 6.6% | 10.6% | 13.2% | N/A | 6.6% | Positive | -13.2% | Negative | N/A |
| Simple Cash Flow Ratio (Simple Cash Flow/Total Revenue) | 9.0% | 8.8% | 11.0% | 11.9% | 2.0% | Positive | 0.9% | Positive | N/A |
| Total Cash Flow Ratio (Total Cash Flow/Total Revenue) | 9.9% | 9.7% | 11.8% | 12.7% | 1.9% | Positive | 0.9% | Positive | N/A |
| Operating Profit Rate (Operating Profit/Operating Revenue) | 3.2% | 2.8% | 4.9% | 3.7% | 1.7% | Positive | -1.2% | Negative | 2.8% vs 4.3% Wisc.; Negative |
| Total Profit Rate (Net Income, BEI/Total Revenue) | 4.8% | 4.2% | 6.2% | 7.3% | 1.4% | Positive | 1.1% | Positive | 4.2% vs 5.4% Wisc.; Negative |
| Return on Assets | 6.5% | 5.4% | 7.4% | 8.5% | 1.0% | Positive | 1.1% | Positive | 5.4% vs 5.7% Wisc.; Neutral |
| Return on Equity | 9.3% | 8.1% | 10.6% | 12.0% | 1.3% | Positive | 1.4% | Positive | N/A |
| Total Compensation as % of Operating Expenses (including Interest Expense) | 56.0% | 56.2% | 55.3% | 55.2% | -0.7% | Neutral | -0.1% | Neutral | 56.2% vs 54.3% Wisc.; Negative |
| Deductions as % of Gross Patient Revenue | 19.4% | 20.0% | 20.2% | 20.8% | 0.8% | Neutral | 0.6% | Neutral | 20.0% vs 23.2% Wisc.; Positive |
| Days Cash on Hand | 26.0 | 38.5 | 47.3 | 45.2 | 21.3 | Positive | -2.1 | Negative | 38.5 vs 56.9 Wisc.; Negative |
| Days in Net Receivables | 79.8 | 69.4 | 66.5 | 69.6 | -13.3 | Positive | 3.1 | Negative | 9.4 vs 61.4 Wisc.; Negative |
| Times Interest Earned | 6.6 | 5.8 | 8.6 | 10.0 | 2.0 | Positive | 1.4 | Positive | N/A |
| Current Ratio | 3.2 | 2.8 | 3.3 | 3.4 | 0.1 | Neutral | 0.1 | Neutral | 2.8 vs 2.6 Wisc.; Neutral |
| Quick Ratio | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Debt Ratio | 0.3 | 0.3 | 0.3 | 0.3 | -0.0 | Neutral | -0.0 | Neutral | N/A |
| Long Term Debt/Equity Ratio | 0.3 | 0.3 | 0.3 | 0.3 | 0.0 | Neutral | -0.0 | Neutral | N/A |
| Total Cash Flow to Total Liabilities Ratio | 0.4 | 0.4 | 0.5 | 0.5 | 0.0 | Neutral | 0.0 | Neutral | 0.4 vs 0.3 Wisc.; Positive |
| Fixed Asset Turnover | 2.7 | 2.6 | 2.8 | 2.8 | 0.1 | Neutral | 0.0 | Neutral | N/A |
| Total Cash Flow per Bed, dollars | 50,801 | 51,761 | 65,744 | 73,492 | 14,943 | Positive | 7,748 | Positive | $51,761 vs $22,974 Wisc.; Positive |

Sources: UWHC Report to the Council of Trustees, October 5, 1994; UWHC (Monthly) Financial Report, December, 1994; Previous SEIU Research Department Analyses.

SEIU Research Department ExpressAnalysis
UNIVERSITY OF WISCONSIN HOSPITAL & CLINICS, Madison, WI
(Fiscal Years Ending June 30)

| INCOME STATEMENT ($000) | Actual 1992 | Actual 1993 | Actual 1994 | SEIU Estimate 1995 | Actual Change 1992-1994 | Actual Percentage Change 1992-1994 | Actual Percentage Change 1992-1993 | Actual Percentage Change 1993-1994 | Estimated Percentage Change 1994-1995 |
|---|---|---|---|---|---|---|---|---|---|
| REVENUE | | | | | | | | | |
| Inpatient Gross Patient Service Revenue | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Outpatient Gross Patient Service Revenue | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| TOTAL GROSS PATIENT SERVICE REVENUE | 302,448 | 325,477 | 339,472 | 349,182 | 37,024 | 12.2% | 7.6% | 4.3% | 2.9% |
| Less Contractual & Other Allowances | (58,695) | (65,242) | (68,713) | (72,696) | (10,018) | 17.1% | 11.2% | 5.3% | 5.8% |
| NET PATIENT SERVICE REVENUE | 243,753 | 260,235 | 270,759 | 276,486 | 27,006 | 11.1% | 6.8% | 4.0% | 2.1% |
| Other Operating Revenue | 5,684 | 5,699 | 5,991 | 5,615 | 307 | 5.4% | 0.3% | 5.1% | -6.3% |
| TOTAL OPERATING REVENUE | 249,437 | 265,934 | 276,750 | 282,100 | 27,313 | 10.9% | 6.6% | 4.1% | 1.9% |
| OPERATING EXPENSES (Excluding Interest Expense) | | | | | | | | | |
| Wages, Salaries, & Employee Benefits | 135,114 | 145,239 | 145,522 | 150,024 | 10,408 | 7.7% | 7.5% | 0.2% | 3.1% |
| Depreciation & Amortization | 10,949 | 12,425 | 13,622 | 14,101 | 2,673 | 24.4% | 13.5% | 9.6% | 3.5% |
| Provision for Bad Debts | 4,044 | 4,396 | 4,523 | 3,258 | 479 | 11.8% | 8.7% | 2.9% | -28.0% |
| Supplies & Other Operating Expenses | 89,122 | 94,086 | 97,242 | 101,903 | 8,120 | 9.1% | 5.6% | 3.4% | 4.8% |
| TOTAL OPERATING EXPENSES | 239,229 | 256,146 | 260,909 | 269,286 | 21,680 | 9.1% | 7.1% | 1.9% | 3.2% |
| OPERATING PROFIT | 10,208 | 9,788 | 15,841 | 12,814 | 5,633 | 55.2% | -4.1% | 61.8% | -19.1% |
| NON-OPERATING GAINS & LOSSES | 3,837 | 3,823 | 3,606 | 10,051 | | | | | |
| EARNINGS BEFORE INTEREST | 14,045 | 13,611 | 19,447 | 22,865 | 5,402 | 38.5% | -3.1% | 42.9% | 17.6% |
| Interest Expense | 2,144 | 2,339 | 2,269 | 2,286 | 125 | 5.8% | 9.1% | -3.0% | 0.7% |
| NET PROFIT (before extraordinary items) | 11,901 | 11,272 | 17,178 | 20,579 | 5,277 | 44.3% | -5.3% | 52.4% | 19.8% |
| Extraordinary Gains (Losses), net | (343) | (391) | 6,122 | 0 | N/A | N/A | 14.0% | -1665.7% | N/A |
| NET PROFIT (after extraordinary items) | 11,558 | 10,881 | 23,300 | 20,579 | 11,742 | 101.6% | -5.9% | 114.1% | -11.7% |
| NET OPERATING CASH FLOW (From Cash Flow Statement) | 16,838 | 28,602 | 37,051 | N/A | 20,213 | 120.0% | 69.9% | 29.5% | -100.0% |
| SIMPLE CASH FLOW (Net Profit ,BEI + Depreciation) | 22,850 | 23,697 | 30,800 | 34,680 | 7,950 | 34.8% | 3.7% | 30.0% | 12.6% |
| TOTAL CASH FLOW (Simple Cash Flow + Interest Exp.) | 24,994 | 26,036 | 33,069 | 36,966 | 8,075 | 32.3% | 4.2% | 27.0% | 11.8% |

Sources: UWHC Report to the Council of Trustees, October 5, 1994; UWHC (Monthly) Financial Report, December, 1994; Previous SEIU Research Department Analyses.

SEIU Research Department ExpressAnalysis
UNIVERSITY OF WISCONSIN HOSPITAL & CLINICS, Madison, WI
(Fiscal Years Ending June 30)

| BALANCE SHEET ($000) | Actual 1992 | Actual 1993 | Actual 1994 | End of Six Months 1995 | Actual Change 1992-1994 | Actual Percentage Change 1992-1994 | Annual Percentage Change 1992-1993 | Annual Percentage Change 1993-1994 | Percentage Change June 30 1994 to Dec. 30 1994 |
|---|---|---|---|---|---|---|---|---|---|
| ASSETS | | | | | | | | | |
| Current Assets | | | | | | | | | |
| Cash & Temporary Investments | 16,383 | 25,954 | 32,318 | 31,870 | 15,935 | 97.3% | 58.4% | 24.5% | -1.4% |
| Net Receivables | 53,294 | 49,482 | 49,345 | 52,711 | (3,949) | -7.4% | -7.2% | -0.3% | 6.8% |
| Other Current Assets | 5,058 | 5,519 | 4,211 | 5,643 | | | | | |
| TOTAL CURRENT ASSETS | 74,735 | 80,955 | 85,874 | 90,224 | 11,139 | 14.9% | 8.3% | 6.1% | -93.4% |
| FUNDS DESIGNATED FOR CAP. REPLACEMENT & DEBT RETIREMENT | 16,000 | 24,934 | 41,321 | 51,321 | 25,321 | 158.3% | 55.8% | 65.7% | 24.2% |
| NET FIXED ASSETS | 91,958 | 98,279 | 97,545 | 98,151 | 5,587 | 6.1% | 6.9% | -0.7% | 0.6% |
| OTHER ASSETS | 1,439 | 3,290 | 5,975 | 1,964 | 4,536 | 315.2% | 128.6% | 81.6% | -67.1% |
| TOTAL ASSETS | 184,132 | 207,458 | 230,715 | 241,660 | 46,583 | 25.3% | 12.7% | 11.2% | 4.7% |
| LIABILITIES | | | | | | | | | |
| TOTAL CURRENT LIABILITIES | 23,652 | 28,804 | 26,303 | 26,932 | 2,651 | 11.2% | 21.8% | -8.7% | 2.4% |
| TOTAL LONG-TERM DEBT | 32,139 | 39,260 | 42,544 | 43,682 | 10,405 | 32.4% | 22.2% | 8.4% | 2.7% |
| TOTAL LIABILITIES | 55,791 | 68,064 | 68,847 | 70,614 | 13,056 | 23.4% | 22.0% | 1.2% | 2.6% |
| FUND BALANCE (EQUITY) | 128,341 | 139,394 | 161,868 | 171,046 | 33,527 | 26.1% | 8.6% | 16.1% | 5.7% |
| Net Working Capital | 51,083 | 52,151 | 59,571 | 63,292 | 8,488 | 16.6% | 2.1% | 14.2% | 6.2% |

Sources: UWHC Report to the Council of Trustees, October 5, 1994; UWHC (Monthly) Financial Report, December, 1994; Previous SEIU Research Department Analyses.

SEIU Research Department ExpressAnalysis
UNIVERSITY OF WISCONSIN HOSPITAL & CLINICS, Madison, WI
(Fiscal Years Ending June 30)

| STATEMENT OF CASH FLOWS ($000) | Actual 1992 | Actual 1993 | Actual 1994 | First Six Months Fiscal 1995 | Actual Change 1992-1994 | Actual Percentage Change 1992-1994 | Actual Percentage Change 1992-1993 | Actual Percentage Change 1993-1994 | Percentage Change June 30 1994 to Dec. 30 1994 |
|---|---|---|---|---|---|---|---|---|---|
| NET CASH PROVIDED BY OPERATING ACTIVITIES | 16,838 | 28,602 | 37,051 | 13,545 | 20,213 | 120.0% | 69.9% | 29.5% | -63.4% |
| Cash flows from investing activities: | | | | | | | | | |
| Additions to property, plant, & equipment & other assets | (12,648) | (9,461) | (13,482) | (4,308) | (834) | 6.6% | -25.2% | 42.5% | -68.0% |
| Increase in limited purpose assets | 0 | (8,934) | (16,387) | (10,001) | (16,387) | ERR | ERR | 83.4% | -39.0% |
| Other adjustments | 1,832 | 1,962 | 1,177 | 597 | (655) | N/C | N/C | N/C | N/C |
| NET CASH PROVIDED BY INVESTING ACTIVITIES | (10,816) | (16,433) | (28,692) | (13,712) | (17,876) | 165.3% | 51.9% | 74.6% | -52.2% |
| Cash flows from financing activities | | | | | | | | | |
| Payment of long-term obligations | (2,608) | (2,598) | (2,379) | (581) | 229 | -8.8% | -0.4% | -8.4% | -75.6% |
| Other adjustments | 0 | 0 | 384 | 300 | ERR | ERR | ERR | ERR | ERR |
| NET CASH PROVIDED BY FINANCING ACTIVITIES | (2,608) | (2,598) | (1,995) | (281) | 613 | -23.5% | -0.4% | -23.2% | -85.9% |
| Extraordinary adjustment | | | | | | | | | |
| Net increase (decrease) in cash | 3,414 | 9,571 | 6,364 | (448) | 2,950 | 86.4% | 180.3% | -33.5% | -107.0% |
| Cash, beginning of year | 12,969 | 16,383 | 25,954 | 32,318 | 12,985 | 100.1% | 26.3% | 58.4% | 24.5% |
| Cash, end of year | 16,383 | 25,954 | 32,318 | 31,870 | 15,935 | 97.3% | 58.4% | 24.5% | -1.4% |

Sources: UWHC Report to the Council of Trustees, October 5, 1994; UWHC (Monthly) Financial Report, December, 1994; Previous SEIU Research Department Analyses.

SEIU Research Department ExpressAnalysis
UNIVERSITY OF WISCONSIN HOSPITAL & CLINICS, Madison, WI
(Fiscal Years Ending June 30)

| UTILIZATION | Actual 1992 | Actual 1993 | Estimated 1994 | SEIU Estimate 1995 | Actual Change 1992-1994 | Actual Percentage Change 1992-1994 | Annual Percentage Change 1992-1993 | Annual Percentage Change 1993-1994 | Percentage Change June 30 1994 to Dec. 30 1994 |
|---|---|---|---|---|---|---|---|---|---|
| Beds | 492 | 503 | 503 | 503 | 11 | 2.2% | 2.2% | 0.0% | 0.0% |
| Patient Days | 141,357 | 137,376 | 133,000 | 131,500 | (8,357) | -5.9% | -2.8% | -3.2% | -1.1% |
| Admissions | 18,405 | 18,332 | 17,700 | 18,900 | (705) | -3.8% | -0.4% | -3.4% | 6.8% |
| Average Length of Stay (ALOS) | 7.7 | 7.5 | 7.5 | 7.0 | (0) | -2.2% | -2.4% | 0.3% | -7.4% |
| Average Daily Census | 387 | 376 | 364 | 360 | (23) | -5.9% | -2.8% | -3.2% | -1.1% |
| Outpatient Visits | N/A | 363,396 | 376,900 | 390,000 | 376,900 | N/C | N/C | 3.7% | 3.5% |
| Clinic Visits | N/A | 288,136 | 295,000 | N/A | N/A | N/A | N/A | N/A | N/A |
| Ambulatory Surgery Visits | N/A | 5,750 | 6,100 | N/A | N/A | N/A | N/A | N/A | N/A |
| Emergency Room Visits | N/A | 25,050 | 25,000 | N/A | N/A | N/A | N/A | N/A | N/A |
| Radiotherapy Visits | N/A | 29,600 | 28,500 | N/A | N/A | N/A | N/A | N/A | N/A |

Sources: UWHC Report to the Council of Trustees, October 5, 1994; UWHC (Monthly) Financial Report, December, 1994; Previous SEIU Research Department Anal

SEIU Research Department ExpressAnalysis
UNIVERSITY OF WISCONSIN HOSPITAL & CLINICS, Madison, WI
(Fiscal Years Ending June 30)

| COMMON SIZE INCOME STATMENT (NPSR set to 100.0%) | Actual 1992 | Actual 1993 | Actual 1994 | SEIU Estimc 1995 | Actual Percentage Point Change 1992-1994 | Actual Percentage Point Change 1992-1993 | Actual Percentage Point Change 1993-1994 | Estimated Percentage Point Change 1994-1995 |
|---|---|---|---|---|---|---|---|---|
| REVENUE | | | | | | | | |
| Inpatient Gross Patient Service Revenue | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Outpatient Gross Patient Service Revenue | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| TOTAL GROSS PATIENT SERVICE REVENUE | 124.1% | 125.1% | 125.4% | 126.3% | 1.3% | 1.0% | 0.3% | 0.9% |
| Less Contractual & Other Allowances | -24.1% | -25.1% | -25.4% | -26.3% | -1.3% | -1.0% | -0.3% | -0.9% |
| NET PATIENT SERVICE REVENUE | 100.0% | 100.0% | 100.0% | 100.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Other Operating Revenue | 2.3% | 2.2% | 2.2% | 2.0% | -0.1% | -0.1% | 0.0% | -0.2% |
| TOTAL OPERATING REVENUE | 102.3% | 102.2% | 102.2% | 102.0% | -0.1% | -0.1% | 0.0% | -0.2% |
| OPERATING EXPENSES (Excluding Interest Expense) | | | | | | | | |
| Wages, Salaries, & Employee Benefits | 55.4% | 55.8% | 53.7% | 54.3% | -1.7% | 0.4% | -2.1% | 0.5% |
| Depreciation & Amortization | 4.5% | 4.8% | 5.0% | 5.1% | 0.5% | 0.3% | 0.3% | 0.1% |
| Provision for Bad Debts | 1.7% | 1.7% | 1.7% | 1.2% | 0.0% | 0.0% | -0.0% | -0.5% |
| Supplies & Other Operating Expenses | 36.6% | 36.2% | 35.9% | 36.9% | -0.6% | -0.4% | -0.2% | 0.9% |
| TOTAL OPERATING EXPENSES | 98.1% | 98.4% | 96.4% | 97.4% | -1.8% | 0.3% | -2.1% | 1.0% |
| OPERATING PROFIT | 4.2% | 3.8% | 5.9% | 4.6% | 1.7% | -0.4% | 2.1% | -1.2% |
| NON OPERATING GAINS & LOSSES | 1.6% | 1.5% | 1.3% | 3.6% | -0.2% | -0.1% | -0.1% | 2.3% |
| EARNINGS BEFORE INTEREST | 5.8% | 5.2% | 7.2% | 8.3% | 1.4% | -0.5% | 2.0% | 1.1% |
| Interest Expense | 0.9% | 0.9% | 0.8% | 0.8% | -0.0% | 0.0% | -0.1% | -0.0% |
| NET PROFIT (before extraordinary items) | 4.9% | 4.3% | 6.3% | 7.4% | 1.5% | -0.6% | 2.0% | 1.1% |
| Extraordinary Gains (Losses), net | -0.1% | -0.2% | 2.3% | 0.0% | 2.4% | -0.0% | 2.4% | -2.3% |
| NET PROFIT (after extraordinary item) | 4.7% | 4.2% | 8.6% | 7.4% | 3.9% | -0.6% | 4.4% | -1.2% |
| NET OPERATING CASH FLOW (From Cash Flow Statement) | 6.9% | 11.0% | 13.7% | 0.0% | 6.8% | 4.1% | 2.7% | -13.7% |
| SIMPLE CASH FLOW (Net Profit + Depreciation) | 9.4% | 9.1% | 11.4% | 12.5% | 2.0% | -0.3% | 2.3% | 1.2% |
| TOTAL CASH FLOW (Simple Cash Flow + Interest Exp.) | 10.3% | 10.0% | 12.2% | 13.4% | 2.0% | -0.2% | 2.2% | 1.2% |

Sources: UWHC Report to the Council of Trustees, October 5, 1994; UWHC (Monthly) Financial Report, December, 1994; Previous SEIU Research Department Analyses.

SEIU Research Department ExpressAnalysis
UNIVERSITY OF WISCONSIN HOSPITAL & CLINICS, Madison, WI
(Fiscal Years Ending June 30)

COMMON SIZE BALANCE SHEET (Total Assets set to 100.0%)

| | Actual 1992 | Actual 1993 | Actual 1994 | End of Six Months 1995 | Total Percentage Point Change 1992-1994 | Annual Percentage Point Change 1992-1993 | Annual Percentage Point Change 1993-1994 | Percentage Pt. Change June 30 1994 to Dec. 30 1994 |
|---|---|---|---|---|---|---|---|---|
| ASSETS | | | | | | | | |
| Current Assets | | | | | | | | |
| Cash & Temporary Investments | 8.9% | 12.5% | 14.0% | 13.2% | 4.3% | 3.6% | 1.5% | -0.8% |
| Net Receivables | 28.9% | 23.9% | 21.4% | 21.8% | -7.1% | -5.1% | -2.5% | 0.4% |
| Other Current Assets | 2.7% | 2.7% | 1.8% | 2.3% | -0.4% | -0.1% | -0.8% | 0.5% |
| TOTAL CURRENT ASSETS | 40.6% | 39.0% | 37.2% | 37.3% | -3.3% | -1.6% | -1.8% | 0.1% |
| FUNDS DESIGNATED FOR CAP. REPLACEMENT & DEBT RETIREMENT | 8.7% | 12.0% | 17.9% | 21.2% | 12.5% | 3.3% | 5.9% | 3.3% |
| NET FIXED ASSETS | 49.9% | 47.4% | 42.3% | 40.6% | -9.3% | -2.6% | -5.1% | -1.7% |
| OTHER ASSETS | 0.8% | 1.6% | 2.6% | 0.8% | 0.0% | 0.8% | 1.0% | -1.8% |
| TOTAL ASSETS | 100.0% | 100.0% | 100.0% | 100.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| LIABILITIES | | | | | | | | |
| TOTAL CURRENT LIABILITIES | 12.8% | 13.9% | 11.4% | 11.1% | -1.7% | 1.0% | -2.5% | -0.3% |
| TOTAL LONG-TERM DEBT | 17.5% | 18.9% | 18.4% | 18.1% | 0.6% | 1.5% | -0.5% | -0.4% |
| TOTAL LIABILITIES | 30.3% | 32.8% | 29.8% | 29.2% | -1.1% | 2.5% | -3.0% | -0.6% |
| FUND BALANCE (EQUITY) | 69.7% | 67.2% | 70.2% | 70.8% | 1.1% | -2.5% | 3.0% | 0.6% |
| Working Capital | 27.7% | 25.1% | 25.8% | 26.2% | -1.6% | -2.6% | 0.7% | 0.4% |

Sources: UWHC Report to the Council of Trustees, October 5, 1994; UWHC (Monthly) Financial Report, December, 1994; Previous SEIU Research Department Analyses.