

Hospital Compliance Project Interim Report (Summary of Reported Data)

I. Introduction

This is an interim report on the Hospital Compliance Project (Project) initiated by the Exempt Organizations (EO) function of IRS Tax Exempt and Government Entities to study nonprofit hospitals and community benefit. The Project involves the reporting of types and amounts of potential community benefit expenditures in various areas, including uncompensated care, medical education and training, medical research, and community programs. Community programs reported by the respondents include immunization programs, medical screenings, community health education, community health needs assessments, and other health promotion activities. The Project also includes an executive compensation component that is not addressed in this report because examinations in that area are ongoing.

The data in this report is derived from the responses of 487 hospitals to the Project questionnaire and from Forms 990 recently filed by those hospitals. The hospitals in the Project sample include small, medium and large nonprofit hospitals located throughout the United States. Most (89%) of the hospitals described themselves as general medical and surgical hospitals, with the remainder indicating a particular specialty.

This report merely summarizes the data as reported by the hospitals; the data has not been independently verified. Not every hospital answered every question, and most of the data is based on fewer than 487 responses. Throughout the report we state the number of responses that underlie particular data. In certain cases the failure by some hospitals to answer a particular question may distort the results. In addition, some definitions, including that of uncompensated care, were not uniformly applied. For these reasons, the data may not fully depict the community benefit actually provided by the respondents or by the nonprofit hospital sector as a whole. Notwithstanding these limitations, the Project gives the IRS a unique and valuable insight into the manner in which nonprofit hospitals report on how they attempt to meet the community benefit standard.

The IRS is in the process of analyzing the data. This interim report reflects our review to date and is subject to modification as our review continues. However, at this preliminary stage we believe it is appropriate to note the following:

1. Uncompensated care made up the largest reported expenditure item (56% of reported aggregate total community benefit expenditures), and was the most frequently reported type of community benefit (97% of the hospitals reported uncompensated care amounts). A summary of uncompensated care and other expenditures reported by the respondents is contained in Parts V and VI of this report.
2. Approximately 2% (11) of the hospitals that were sent questionnaires did not respond and were referred to our Review of Operations (ROO) unit for additional follow-up.
3. Next steps:

- Analyze the reported data to determine whether differences in reporting, such as the treatment of bad debt and shortfalls as uncompensated care, may be isolated and adjusted to allow more meaningful comparisons across the respondents.
- Obtain additional research and analyze the differences in community benefit expenditure amounts and types to take into account varying demographics, such as rural and urban communities and hospitals.
- Test the reported community benefit amounts and types by conducting data analysis, compliance checks, or examinations of individual hospitals, and by other means, including with respect to outliers in the reported data.

Part II summarizes the development of the legal basis for exemption of nonprofit hospitals. Part III describes the purposes and scope of the Project. Part IV describes the design of the questionnaire and the process of collecting data. Part V summarizes the reported data and is structured to follow the outline of the questionnaire. Part VI summarizes the aggregate uncompensated care and other expenditures reported by the respondents for miscellaneous programs. Part VII highlights certain preliminary summary information, and Part VIII lists interim recommendations and next steps. This interim report does not address whether the respondent hospitals meet the community benefit standard.

II. Background Information Regarding Exemption Requirements

Evolution of the Legal Standard for Exemption

Neither the Code nor the Treasury regulations specifically lists hospitals as organizations that are exempt under section 501(c)(3) or specifically defines exempt purposes to include the promotion of health. Nevertheless, the IRS and the courts long have recognized that nonprofit hospitals may qualify for exemption as organizations described in section 501(c)(3) if they further charitable purposes and are not operating on a proprietary basis.

Originally, hospitals were considered charitable because they provided relief to the poor. In 1956, the Commissioner published guidance providing requirements that a hospital must satisfy to be exempt as a charitable organization. Revenue Ruling 56-185, 1956-1 C.B. 202, required, among other things, that a hospital must operate to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay, and ordinarily must not refuse to accept patients in need of hospital care who cannot pay for such services.

The enactment of Medicare and Medicaid resulted in significant changes in the health care industry. These changes led to an IRS review of the 1956 standard. This review culminated in the issuance of Revenue Ruling 69-545, 1969-2 C.B. 117, which uses a “community benefit” standard to determine whether a nonprofit hospital is exempt as a charitable organization.

The Community Benefit Standard: Revenue Rulings 69-545 and 83-157

Revenue Ruling 69-545 describes several factors that the IRS takes into account in determining whether a hospital qualifies for tax exemption. The factors include:

- (a) Whether the governing body of the hospital is composed of independent members of the community;
- (b) Whether medical staff privileges in the hospital are available to all qualified physicians in the area, consistent with the size and nature of the facilities;
- (c) Whether the hospital operates a full-time emergency room open to all regardless of ability to pay;
- (d) Whether the hospital otherwise admits as patients those able to pay for care, either themselves or through third-party payers such as private health insurance or government programs such as Medicare; and
- (e) Whether the hospital's excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training, education, and research.

Revenue Ruling 69-545 also provides that the IRS will weigh all facts and circumstances in each case and that the absence of these factors or the presence of other factors will not necessarily be determinative. Likewise, the courts have held in numerous cases that community benefit is a flexible standard based on the totality of the circumstances and that a hospital need not demonstrate every factor to be exempt.

Although Revenue Ruling 69-545 removed the more restrictive requirements of Revenue Ruling 56-185 relating to caring for patients without charge or at rates below cost, providing free or below cost services to the poor is still a factor that may demonstrate a hospital promotes health for the benefit of the community.

The emergency room element of Revenue Ruling 69-545 was modified by Revenue Ruling 83-157, 1983-2 C.B. 94. Revenue Ruling 83-157 provides that if a hospital does not operate an emergency room, either because the appropriate governmental health agency has determined that this would unnecessarily duplicate other emergency services and facilities in the community, or because it is a specialized hospital that treats conditions unlikely to require emergency treatment, it nevertheless could qualify for exempt status based on other factors demonstrating community benefit. More recently, Revenue Ruling 98-15 and subsequent court decisions applied the community benefit standard to hospital joint ventures with for-profit companies.

III. Purpose and Scope of the Project

The purposes of the Hospital Compliance Project include: (1) determining whether and how nonprofit hospitals demonstrate their qualification for exemption as organizations described in section 501(c)(3) under the community benefit standard, and (2) identifying how hospitals establish executive compensation and halting abuses by hospitals that pay excessive executive compensation. Information gathered with respect to potential community benefit was intended to enable the IRS to determine how the Form 990 should capture reporting of community benefit activities and to:

- Determine whether non-emergency services are available to everyone with the ability to pay;
- Ascertain whether hospitals treat Medicare and Medicaid patients in a nondiscriminatory manner;
- Ascertain how hospitals deal with the uninsured;
- Ascertain whether and how determinations of financial responsibility of patients are made;
- Determine the nature and extent of a hospital's uncompensated care policy and, if such a policy exists, ascertain how the hospital distinguishes uncompensated care from bad debt;
- Ascertain the nature and extent of medical research programs;
- Look into hospitals' participation in partnerships, limited liability companies, joint ventures and S corporations;
- Ascertain hospitals' financial relationships with staff members and other closely connected individuals and entities; and
- Determine whether additional guidance, education and/or compliance actions are appropriate.

The executive compensation component of the Hospital Compliance Project is a part of EO's ongoing review of executive compensation in the tax-exempt sector. Similar to the Tax-Exempt Executive Compensation Initiative that was the subject of a Final Report issued by EO in March 2007, this component was undertaken to enhance compliance and to obtain information about compensation practices and procedures that exempt organizations use to determine compensation of executives, physicians and others with the potential to influence or control the affairs of the organization.

IV. Methodology

Overview

A total of 544 organizations, identified as IRC 501(c)(3) hospitals, were selected as the Project sample. Compliance check questionnaires requesting detailed information on areas related to potential community benefit expenditures and executive compensation practices were delivered to all 544 organizations during the week of May 15, 2006. A Hospital Compliance Project Team (the Project Team) reviewed the responses and compiled, summarized, and reported the data.

Appendix A contains a detailed explanation of the steps outlined above. The Project data is summarized in Parts V and VI.

Design of Compliance Check Questionnaires

Form 13790, *Compliance Check Questionnaire Tax Exempt Hospitals* (see exhibit # 1), consists of 81 questions and is organized into the following three parts:

Part I, Organization, contains identifying information about the organization completing the questionnaire (name, EIN, and most recently completed tax period).

Part II, Operations (72 questions), gathers general demographic information about the entity's operation and requests information about:

- Patients
- Emergency Room
- Board of Directors
- Medical Staff Privileges
- Medical Research
- Professional Medical Education and Training
- Uncompensated Care
- Billing Practices
- Community Programs

Part III, Compensation Practices (9 questions), requests information on compensation paid to disqualified persons and the practices the organization employs to set their compensation.

Reconciliation of Questionnaires Sent to Responses

Number of questionnaires sent out to hospitals	544	100%
Non-responders	11	2%
Total responses	533	98%
Respondents stating not a 501(c)(3) hospital	46	8%
Number of 501(c)(3) hospital respondents for the Project	487	90%

Forty-six hospitals responded that they were not exempt under section 501(c)(3). In most of these cases the hospital had recently ceased operations and was still in the process of winding down, or had recently merged with another hospital and was therefore no longer a separate entity for reporting purposes. Eleven hospitals did not to respond to the questionnaire and have been referred for additional follow-up. These fifty-seven entities were treated as exclusions from the original sample of 544 organizations, yielding a sample of 487 responding hospitals.

V. Project Data Regarding Demographics and Operations of Respondent Hospitals

This part summarizes the data derived from the compliance questionnaire responses pertaining to potential community benefit expenditures that might be included in a community benefit assessment.

The questionnaire asked the hospitals to base their responses on their most recently completed tax period. Certain information not requested on the questionnaire, such as total revenue reported on Form 990, Line 12, was taken from the respondents' most recent Forms 990 that were available to the IRS. Because a hospital may have completed a tax period and not yet filed the corresponding Form 990, the information reported by the hospital on the questionnaire and the information taken from the hospital's Form 990 may have come from different tax years.

The questionnaire asked each hospital whether it conducted certain programs or activities, including uncompensated care, medical education and training, medical research, and specified community programs. Each hospital was asked whether it conducted such programs, and, if so, how much it spent on them. In certain cases the number of hospitals that reported they had engaged in a program differed from the number that reported spending amounts on the program.

These and other limitations make it difficult to generalize about the information reported by the respondents. Because the questionnaire did not specify a particular method for reporting expenditures, variations are likely to exist in the reporting of indirect costs, and in the reporting of contributions made, or costs incurred, by affiliates within a hospital system. In addition, as will be seen below, not all hospitals answered all questions, leaving a variation in the number of respondents to each question.

Demographics

The questionnaire requested information regarding the type of hospital, annual patient visits, and patient insurance coverage, for each respondent hospital.

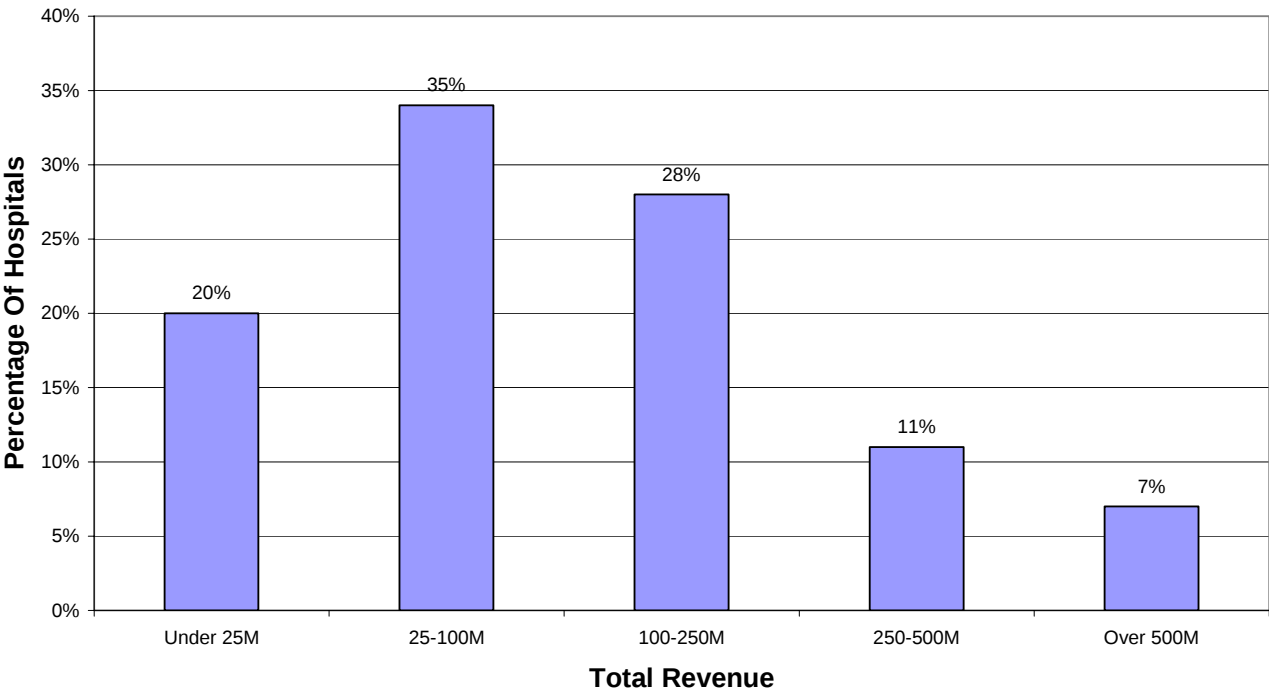
Type of hospital - Question 1

Of 487 responding hospitals, 432 (89%) described themselves as general medical and surgical hospitals. The other 55 hospitals described themselves as a specialty hospital of some type.

Annual total revenues (obtained from Forms 990)

The Project Team obtained annual total revenue information for 482 respondent hospitals from their Forms 990. The average (mean) annual total revenue was \$169 million and the median annual total revenue was \$83 million. A breakdown of the percentage of the responding hospitals falling into various annual total revenue categories follows:

**Annual Total Revenue (Form 990, Line 12)
(n=482)**

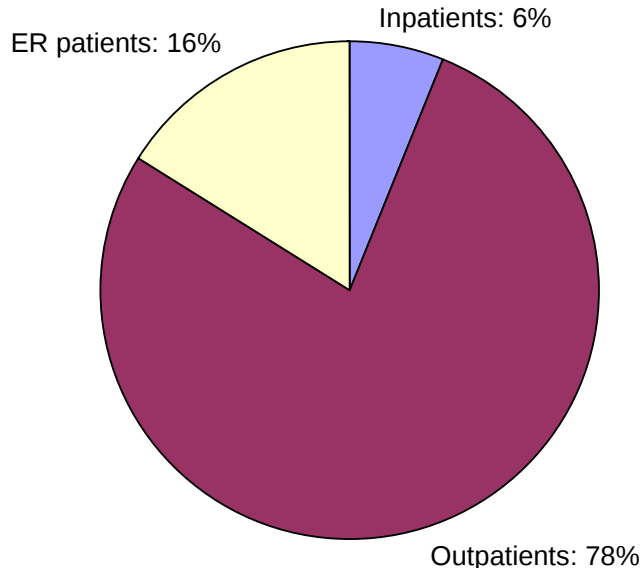


Annual patients - Question 2

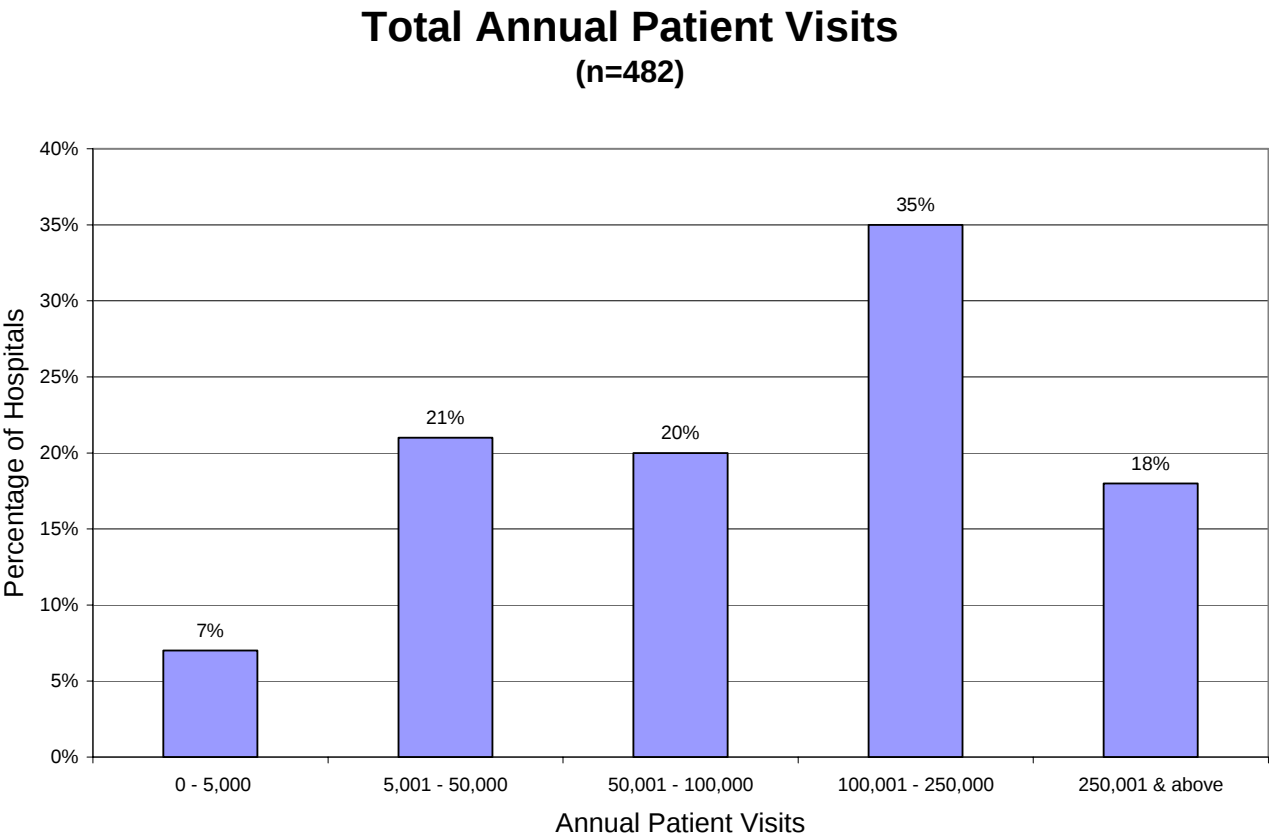
Question 2 asked for the total number of inpatients, outpatients, and emergency room patients. The question did not specify whether to report the number of patient visits (with multiple visits by a single person constituting multiple patients) or the number of patients served (with multiple visits by a single person constituting a single patient). The 482 responding hospitals indicated an average number of patients of 172,814 with a median of 107,542. Inpatients accounted for 6% of all patients, while 78% were outpatients and 16% were emergency room patients.

Based on a review of narrative responses, it appears that in most cases the respondents reported patient visits rather than persons served, with multiple patient visits by a single person during the year reported as multiple patients. However, it is unclear whether the reported data refers to the number of patient visits, the number of persons served, or the number of encounters, admissions, or other measures a hospital might use for reporting or other purposes. For this reason, the charts below may not reflect the information that the respondents were trying to convey.

Patient Types Served (n=482)

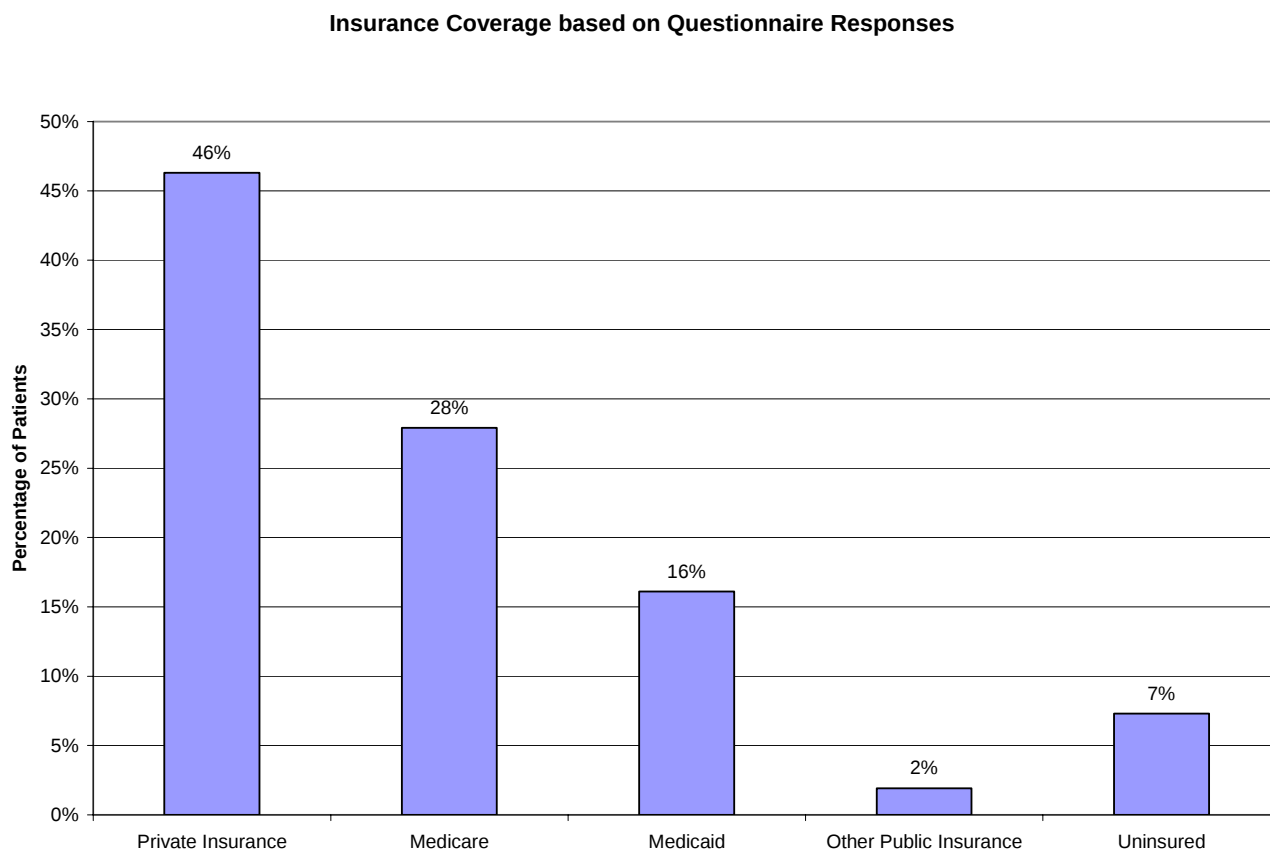


A breakdown of the patient totals, described by us as patient visits, is as follows:



Insurance Coverage - Questions 3 through 7

Based on responses from over 480 hospitals, 7% of all patients had no insurance of any kind, 46% had private insurance, 28% had Medicare, 16% had Medicaid, and 2% had some other form of public insurance.



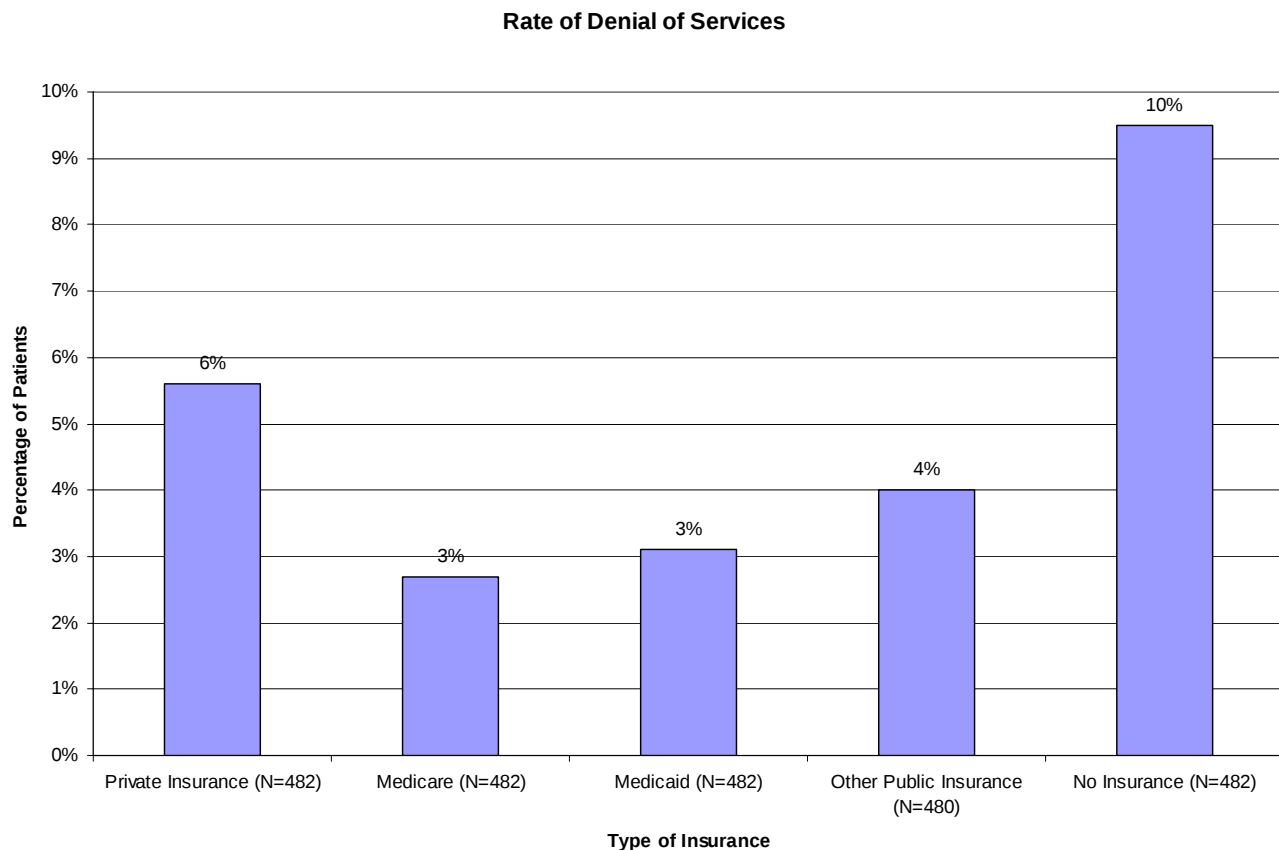
Denial of Medical Services - Question 8

One of the community benefit factors set forth in Revenue Ruling 69-545 is whether the hospital admits as patients all those in the community able to pay for care, either themselves or through third-party payers such as private health insurance or government programs such as Medicare. The questionnaire asked hospitals whether they denied medical services to any individual, based upon insurance status.

Public insurance: 469 (97%) of 482 respondents reported that they do not deny medical services to any individuals who have Medicare. 467 (97%) reported never denying services to any individuals who have Medicaid. 461 (96%) of 480 respondents reported that they do not deny medical services to those with some other form of public insurance.

Private insurance: 455 (94%) of 482 respondents reported that they do not deny medical services to any individuals who have private insurance.

No insurance: 436 (90%) of 482 respondents reported never denying services to any individuals who have no insurance, public or private.



The primary reasons hospitals reported for denying medical services were:

- The hospital determines that a patient does not have an emergency medical condition, is unable to pay for services or make payment arrangements, and does not qualify for free care from the hospital for the services requested. Some hospitals noted in their narrative responses that they never deny emergency services based on a patient's insurance status.
- The hospital (or its emergency room) is unable to provide the services requested because it has reached its capacity, lacks sufficient staffing, or is unable to treat a particular medical condition. For instance, specialty hospitals generally treat only patients with conditions that fall within their specialties, and refer other patients to more appropriate facilities.
- The patient requesting non-emergency services has an outstanding account balance but refuses to make arrangements to pay off that balance.
- Uninsured patients who do not qualify for free care are unable or unwilling to pay an up-front deposit for non-emergency services.

A few hospitals reported that they do not accept Medicaid or Medicare patients in certain circumstances (e.g., the patient is from out-of-state and requests non-emergency services, services are not reasonable and necessary under Medicare regulations, or the hospital treats only existing Medicaid patients but not new referrals).

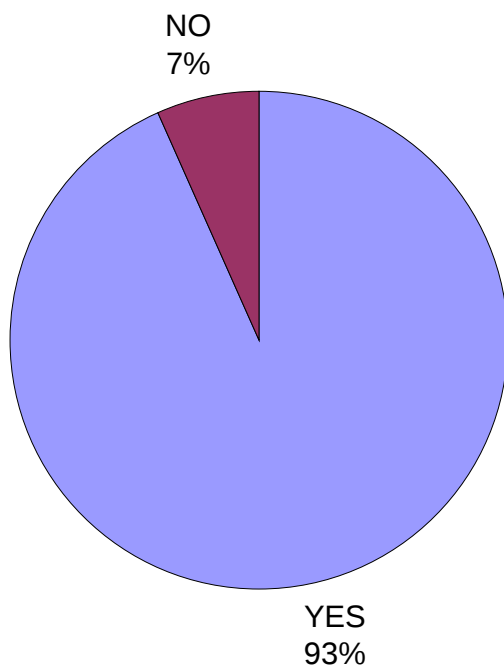
Emergency Room - Questions 9 through 14

One of the community benefit factors set forth in Revenue Ruling 69-545 is whether the hospital operates a full-time emergency room open to all, regardless of ability to pay. Revenue Ruling 83-157 provides that a hospital need not operate an emergency room under certain circumstances. The questionnaire asked for information about the existence and hours of an emergency room and whether the hospital operated a trauma center.

Existence of Emergency Room

93% (451) of the 483 respondents reported that they operate an emergency room. The respondents that do not operate emergency rooms generally fell into the following categories: specialty hospitals (e.g., orthopedic, eye and ear, rehabilitation, rheumatology, psychiatric); ambulatory clinics for outpatient care; long-term acute care centers for inpatient care; or hospitals affiliated with another hospital, within the same health system, that operates an emergency room in the community.

Hospitals With Emergency Rooms (n=483)



Emergency Room Hours of Operation

Of the 451 respondents that reported operating an emergency room, 99% (448) reported that the emergency room is open 24 hours a day, 365 days a year. Some hospitals reported that, in addition to operating a 24-hour emergency room on their main campus, they also operate emergency rooms on satellite campuses that are open only part of the day (e.g., 7 a.m.—9 p.m.).

Denial of Emergency Room Services

Of the 451 respondents that reported operating an emergency room, 100% reported that they provide emergency room services to all members of the community regardless of their ability to pay. Some noted that they are required to do so by the Emergency Medical Treatment and Active Labor Act (“EMTALA”), 42 U.S.C. 1395dd, which generally requires a hospital that participates in the Medicare program to conduct a medical screening examination of any patient who comes to the hospital's emergency room and, if the patient has an emergency medical condition, to provide the patient with stabilizing treatment.

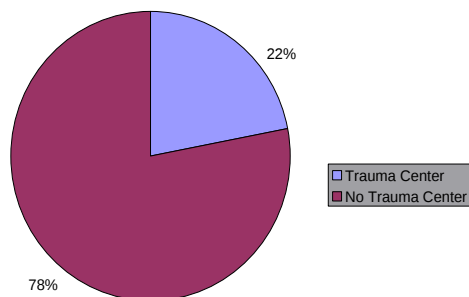
Of the 451 hospitals that reported operating an emergency room, 98% (440) reported that they do not deny emergency room services to any person who requested such services. The two primary reasons hospitals reported for denying emergency room services are:

- When the hospital or its emergency room reaches capacity (which some hospitals said happens rarely), the hospital diverts ambulances to another hospital. However, hospitals that reported that they diverted ambulances emphasized that they do not deny services to patients who arrive at their emergency room by other means, even when the emergency room is at full capacity.
- The hospital determines that a patient who comes to the hospital's emergency room does not have an emergency medical condition.

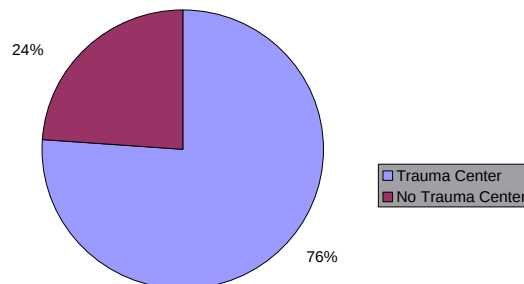
Trauma Centers

Of the 451 respondents that reported operating an emergency room, 32% (146) reported that they have a trauma center. Hospitals with trauma centers tend to be large hospitals that serve a great number of patients, as reflected in the following charts:

Total Annual Patient Count of under 50,000



Total Annual Patient Count of Over 500,000

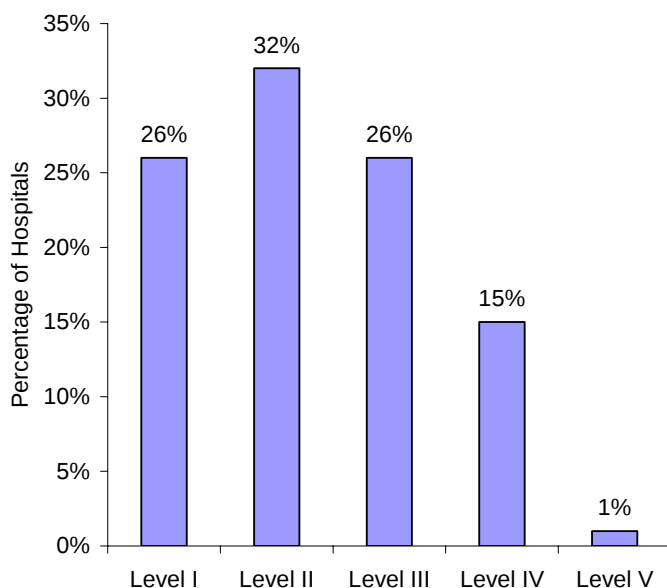


All but one of the 146 hospitals that reported having a trauma center indicated the level of certification. The following chart shows how the 145 reported trauma centers break down by Trauma Center Level under the American College of Surgeons Committee on Trauma Classification System. Those levels are:

- Level I: Available 24 hours per day, with specialists and equipment available 24 hours per day. Level I centers also have a trauma research and education component (i.e., surgical residency).
- Level II: Collaborates with a Level I center and supplements the Level I center's expertise. A Level II facility still has 24 hour availability of specialists and equipment, but is not required to have a research or educational component.
- Level III: Does not have 24 hour availability of specialists, but can still provide emergency resuscitation, surgery and intensive care for most trauma patients.
- Level IV: Stabilizes and treats severely injured patients where no alternative care is available.

Level V trauma centers are not formally recognized by the American College of Surgeons, but the designation is used by some states to further categorize hospitals providing life support prior to transfer.

Level of Trauma Center Certification (of those Hospitals Reporting a Trauma Center) (n=145)



Some of the hospitals that reported not operating trauma centers indicated that they are seeking designation or verification of their facilities as trauma centers by their respective state governments or the ACS.

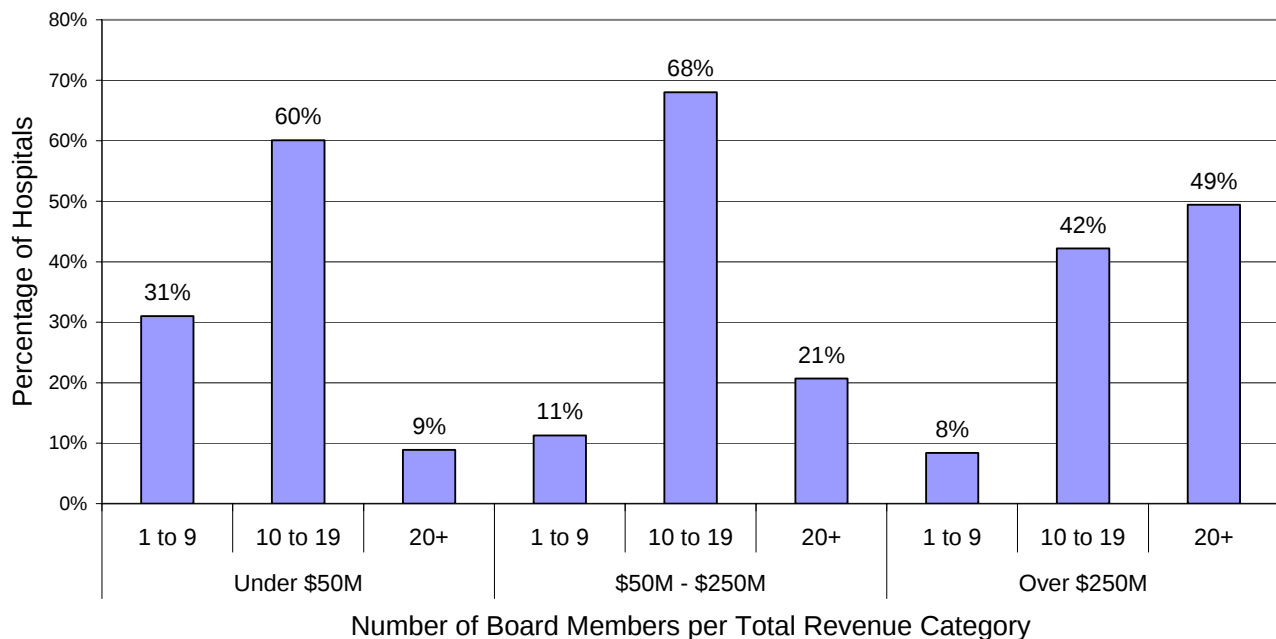
Governance (Board of Directors) - Questions 15 through 18

One community benefit factor set forth in Revenue Ruling 69-545 is whether the hospital's governing body is composed of independent members of the community. The questionnaire asked about the composition of the hospital's governing body, the frequency of its board meetings, and the professional backgrounds of its board members.

Board Size

The mean (average) size of the board of directors of 476 respondents was 17 members. Most respondents (62%) had 10 to 19 directors, 17% had 4 to 9 directors, and 21% had at least 20 directors. Several hospitals reported having as few as four directors, while several others reported having over 100 directors. Hospital board size tended to increase with hospital revenues, as reflected in the following chart:

Size of Board of Directors compared to Total Revenue
(n=476)



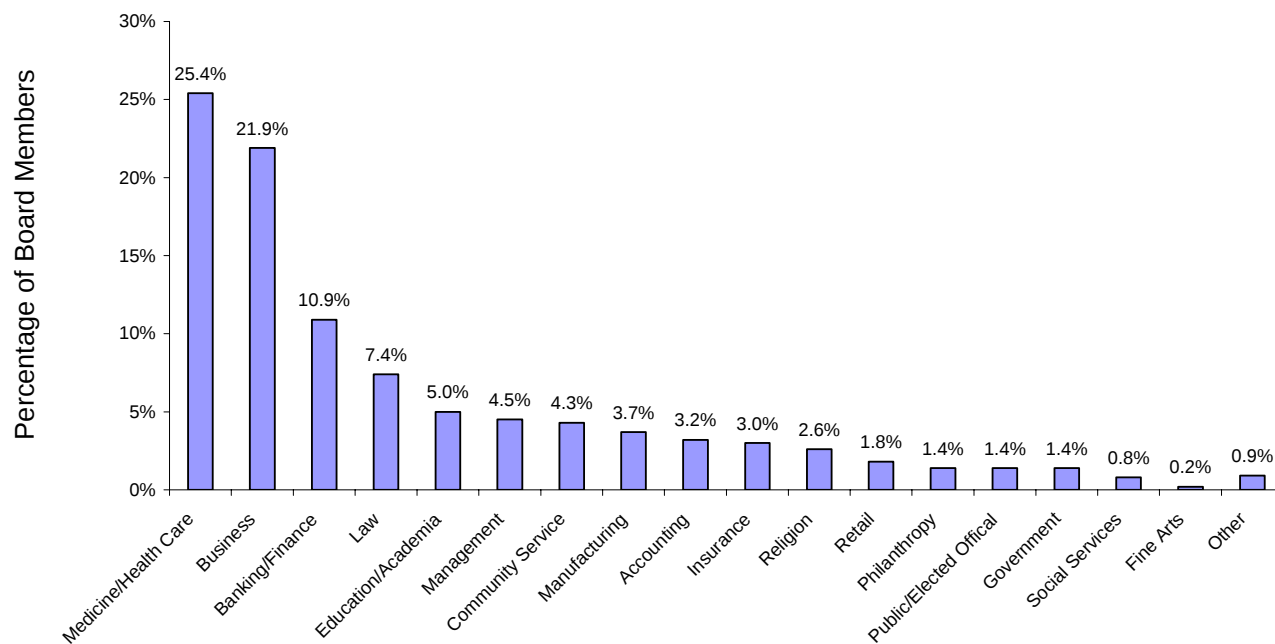
Frequency of Board Meetings

55% of 487 respondents reported that their boards met monthly. For the others, 17% met bi-monthly, 9% met quarterly, and less than 1% met only annually. Based on 480 responses, the mean (average) number of directors present at a board meeting was 13.

Professional Backgrounds of Board Members

Hospitals reported that their board members had a wide range of professional backgrounds. The percentage breakdown of these directors, by professional background, is as follows:

Board of Directors Professional Backgrounds

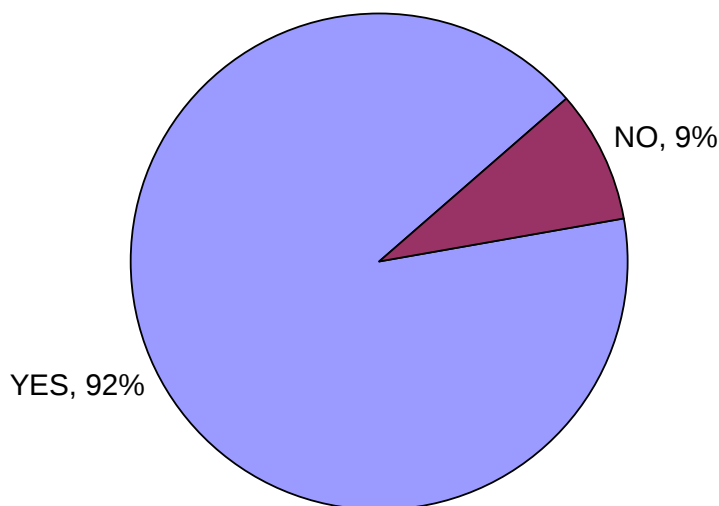


Medical Staff Privileges – Questions 19 and 20

Another community benefit factor set forth in Revenue Ruling 69-545 is whether the hospital makes medical staff privileges available to all qualified physicians in its community, consistent with the size and nature of its facilities. 92% (439) of 480 respondents reported that all qualified physicians in their communities were eligible for medical staff privileges at their hospital.

Were all Qualified Physicians eligible for Medical Staff Privileges?

(n=480)



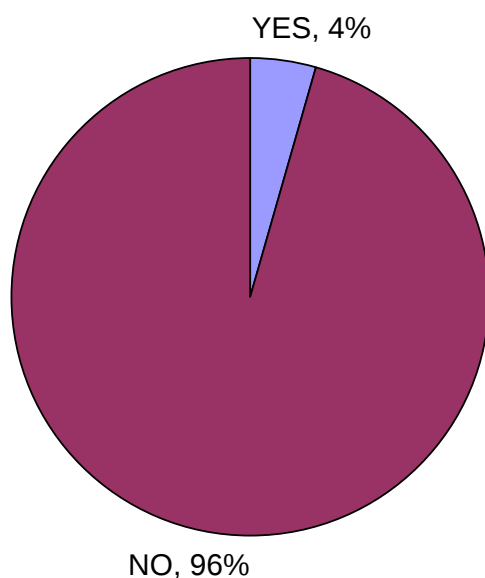
Based on narrative responses, most hospitals that restricted medical staff eligibility reported doing so for the following reasons:

- The hospital entered into exclusive contracts for the provision of certain services (e.g., anesthesiology, pathology, emergency, radiology).
- The hospital has a closed staff model, in which all staff physicians must be employed by the hospital and/or one of its affiliates (e.g., another hospital or physician group in hospital's health system or local medical school).
- The hospital limits the number of physicians per department or specialty, based on factors such as community need and the hospital's capacity.

Many hospitals with open medical staffs explained that physicians must meet various credentialing requirements and eligibility criteria (e.g., Board certification, licensure, acceptable practice and malpractice history, character, adequate training, adequate insurance) to qualify for membership on the hospital's medical staff.

96% (461) of 482 respondents reported that they had not denied any qualified physician's application for medical staff privileges.

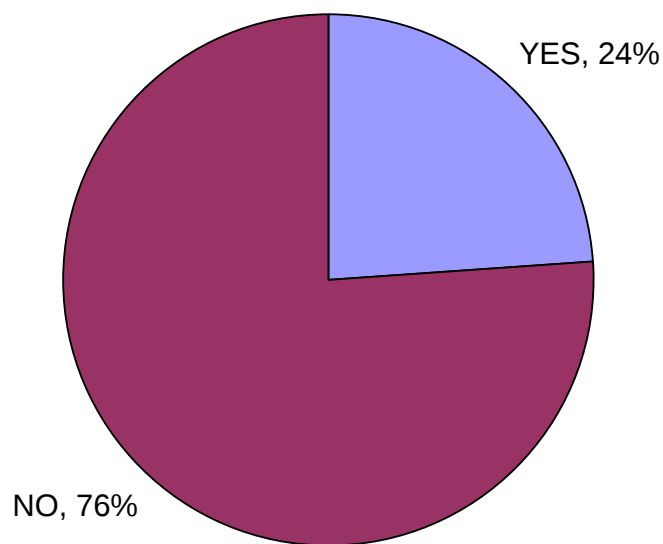
**Were any applications from Qualified Physicians
denied?**
(n=482)



Medical Research – Questions 21 through 29

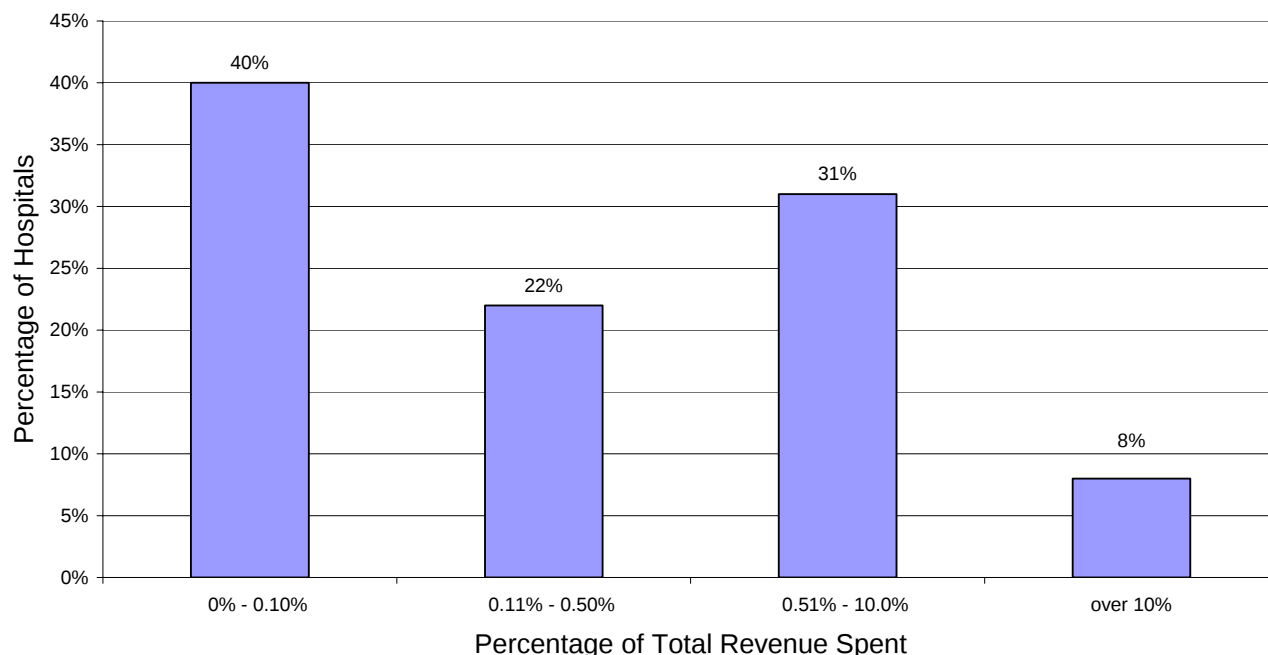
Another factor set forth in Revenue Ruling 69-545 is whether the hospital used surplus funds to conduct medical research. 76% (367) of 482 respondents reported they did not conduct medical research programs; 24% (115) reported that they did.

Hospitals Conducting Medical Research (n=482)



101 hospitals reported medical research expenditure amounts in their responses. The mean (average) of the percentages of total revenues spent on medical research by these 101 hospitals was 8% with a median of 0.24%. A more complete picture of the distribution of spending on medical research by the 101 hospitals is shown in the following illustration:

Percentage of Total Revenue Spent on Medical Research (n=101)



Grants for Medical Research Programs

Hospitals that reported they conducted medical research programs were asked how much they provided in grants to individuals or organizations to fund such programs. Of 38 hospitals responding, the maximum spent for such grants was \$14,973,602, with a mean (average) amount spent of \$1,986,066 and a median amount of \$326,412. When compared to total revenue, the highest ratio of medical research grants to total revenue reported by an individual hospital was 2.18%. The mean (average) expenditure was 0.37% and the median was 0.16% of total revenue.

Public Access to Research

90% (129) of 143 respondents that reported conducting medical research also reported that they did not limit public access to the findings or results of their medical research programs. (Note: The number of hospitals that responded to this question (143) exceeded the number that reported conducting medical research (116)). The remaining 10% (14) reported that they placed limitations on public access, with the most common reason being that the research was conducted at the expense of a third party that maintained control over the dissemination of the results.

98% (205) of 209 respondents reported they did not limit public access to the findings or results of medical research programs for which they provided grants. The remaining 2% (4) reported that they retained the right to publicly disseminate the results of any research they fund, and that such dissemination is made only after review of the results.

Medical Research Trials

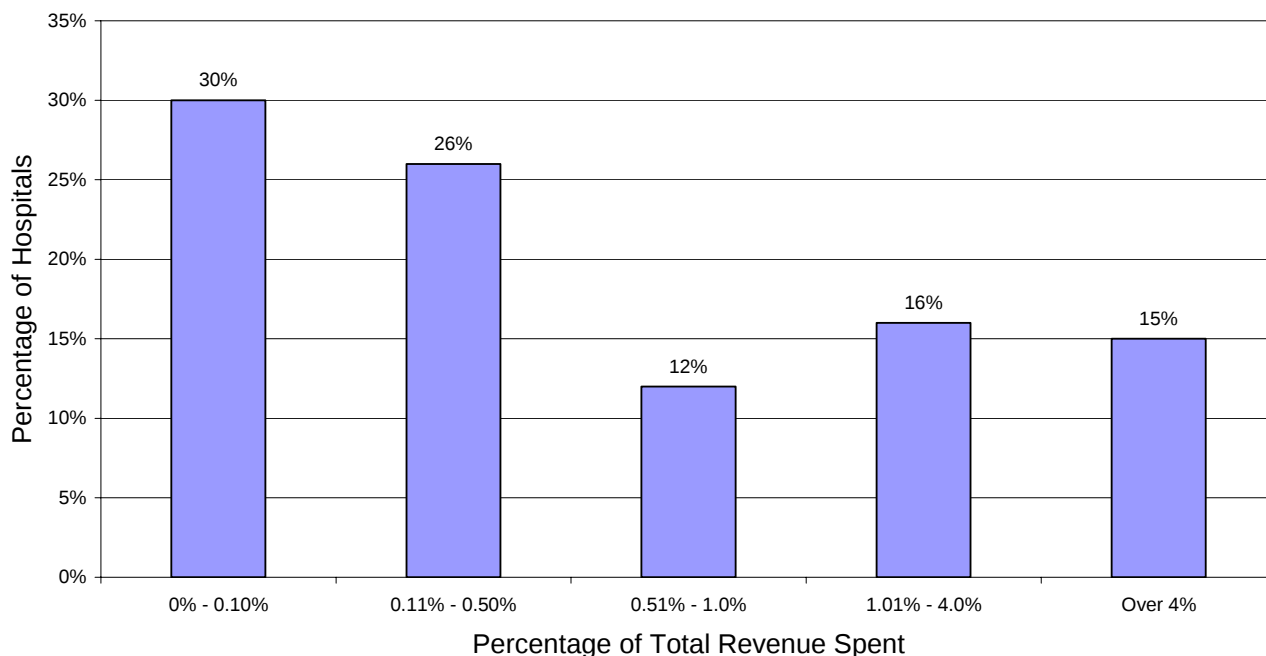
69% (328) of 474 respondents reported they did not conduct any medical research trials; 31% (146) of the hospitals reported that they did. 83% (166) of 199 responding hospitals reported that the results of medical research trial studies were not subject to any access limitations; 17% (33) reported that public access was limited. Based on narrative responses, the most common explanation for limiting public access was that the hospital was not the sponsor of the trial study and therefore had no rights to, or control over, the dissemination of the findings and results.

Professional Medical Education and Training – Questions 30 through 33

Another community benefit factor set forth in Revenue Ruling 69-545 is whether the hospital used surplus funds to conduct any professional medical education and training programs. 81% (393) of 484 respondents reported they offered such programs while 19% (91) reported they did not. The narrative responses suggest that there is a lack of clarity regarding what constitutes professional *medical* education and training. Some hospitals included within this category such things as training in hospital accounting and other administrative tasks, so the actual medical training amounts and percentages may be less than as reported by some of the respondents.

Of the 368 hospitals reporting expenditures on medical education and training programs, the mean (average) amount spent was \$5,625,108 and the median was \$241,112. The mean (average) of the percentages of total revenues spent by individual hospitals on such programs was 1.68% and the median was 0.35%. The following bar graph displays the distribution of the hospitals' expenditures on medical education and training as a percentage of total revenue:

**Percentage of Total Revenue Spent on Medical
Education and Training**
(n=368)



Hospitals reported that 55% of the funding for their medical education and training programs came from public sources (based on responses from 154 hospitals), while only 3% of the funding came from private sources (based on 137 hospital responses).

77% (370) of 480 respondents reported they did not provide grants to individuals or organizations to fund professional medical education and training while 23% (110) reported they did provide such grants. The amounts spent by a hospital for such purposes ranged

from \$500 to nearly \$16.5 million. The mean (average) amount spent by individual hospitals was \$420,956 and the median was \$56,093. The mean (average) of the percentages of total revenues spent by individual hospitals on grants to fund medical education and training was 0.89% and the median was 0.06%.

Uncompensated Care – Questions 34 through 42

Another factor set forth in Revenue Ruling 69-545 is whether the hospital provides some services (e.g., emergency room services) without charge to persons who cannot afford them. The questionnaire asked a number of questions about uncompensated care, including how much was spent on uncompensated care and whether bad debt, shortfalls and other items were treated as uncompensated care. The questionnaire did not refer to the term “charity care” or specify a particular method or definition for reporting uncompensated care. The definitions used by respondents to answer these questions were not uniform. The variations in responses and the content of the narrative responses of some of the hospitals indicate that the uncompensated care amounts reported by certain hospitals, and thus the aggregate reported uncompensated care amount and total community benefit amount, include amounts that would be excluded under a more narrowly defined charity care measure, such as providing care to persons who are low-income, uninsured or otherwise vulnerable or medically indigent.

Uncompensated Care Provided to Inpatients, Outpatients, and Emergency Room Patients

99% (477) of 482 respondents reported that they provide some *inpatient* services without compensation. Of those hospitals that reported not providing any inpatient services without compensation, one treated only outpatients, while another indicated that all of its patients had private or public insurance.

99% (471) of 478 respondents reported that they provide some *outpatient* services without compensation. Of those hospitals that reported not providing any outpatient services without compensation, one treated only inpatients, while another reported that its outpatient services were elective services limited to patients who were able to afford the care.

98% (447) of 458 respondents reported that they provide some *emergency room* services without compensation. Of those hospitals that reported not providing any emergency room services without compensation, several reported that they are specialty hospitals without emergency rooms. One reported treating only inpatients, while another reported treating only outpatients.

Written Uncompensated Care Policy

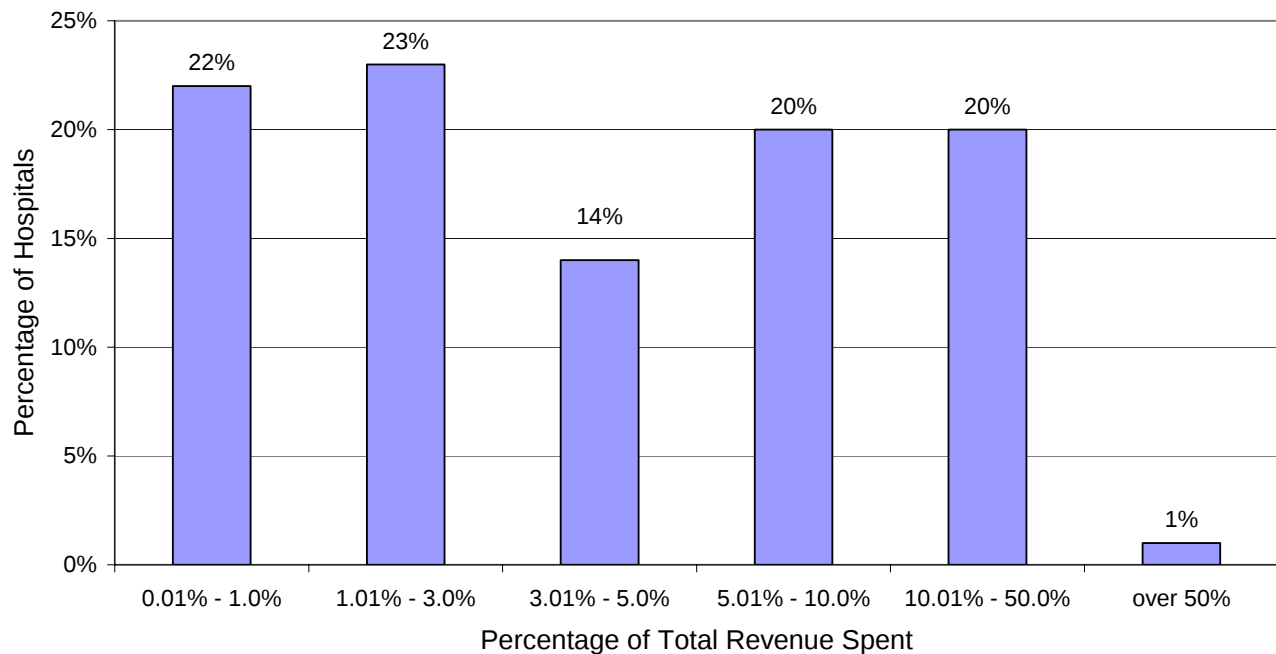
97% (465) of 478 respondents reported that they have a *written* policy stating the circumstances under which they provide uncompensated care. Of those hospitals that do not have such a written policy, several reported having an *unwritten* uncompensated care policy.

Delivery of Uncompensated Care

The hospitals were asked how many individuals received uncompensated care and how much they spent on uncompensated care. Assuming that respondents generally reported the number of patient visits rather than the number of patients cared for (see total patients and patient visits discussion above), the information submitted by 437 respondents indicates that the median amount of uncompensated care per patient per visit during which the hospital provided uncompensated care was \$880 and the mean (average) was \$2,510.

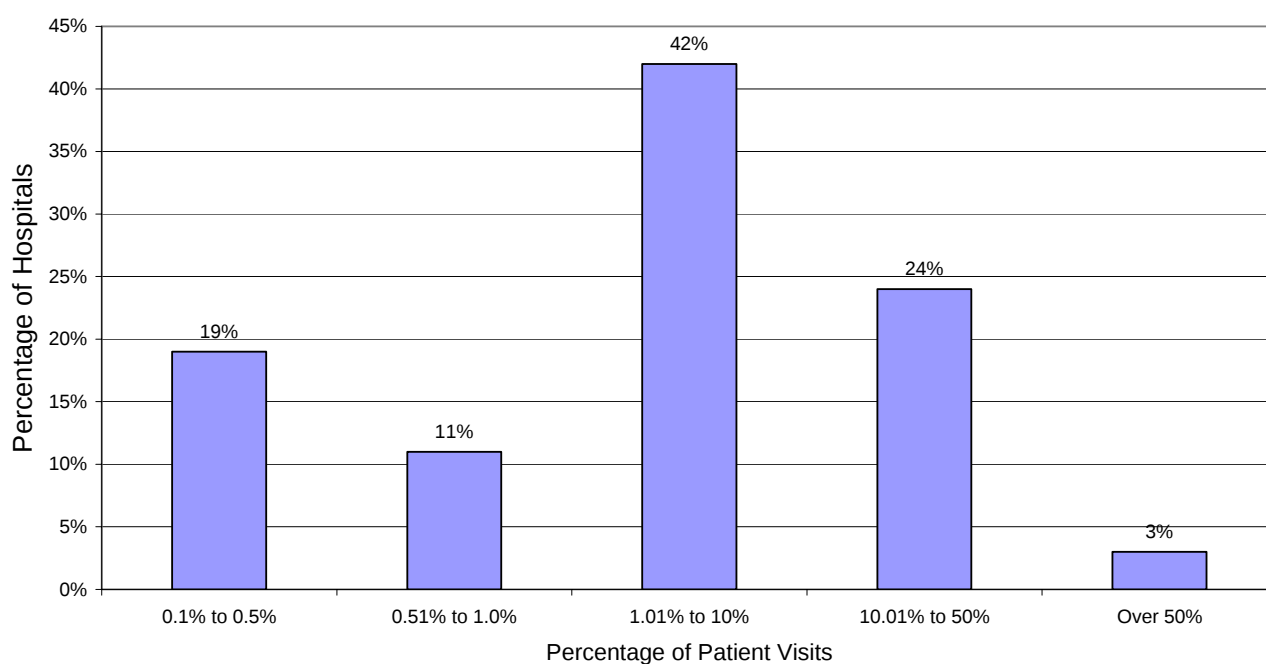
The median percentage of 472 respondents' total revenue that was spent on uncompensated care was 3.86% and the mean (average) of such individual hospital percentages was 7.44%. The following percentage breakdown is reflective of the 472 respondents: 22% of the respondents spent up to 1% of their total revenue on uncompensated care; 23% spent between 1% and 3% of their total revenue on uncompensated care; 14% spent between 3% and 5% of their revenue on uncompensated care; 20% spent between 5% and 10% of their revenue on uncompensated care; 20% spent between 10% and 50% of their revenue on uncompensated care; and 1% spent over 50% of their revenue on uncompensated care.

**Percentage of Total Revenue Spent on
Uncompensated Care**
(n=472)



Based on 439 responses, the median percentage of patient visits that resulted in provision of uncompensated care was 3.46% and the mean (average) of individual respondents' percentages was 9.66%. 19% of the respondents provided uncompensated care to between 0.1% and 0.5% of their patients. 11% provided uncompensated care to between 0.51% and 1.0% of their patients. 42% provided uncompensated care to between 1.01% and 10% of their patients. 24% provided uncompensated care to between 10.01% and 50% of their patients, and 3% provided uncompensated care to over 50% of their patients.

Total Patient Visits Resulting in Provision of Uncompensated Care (n=439)



A large portion of the variation in the percentage of patients who receive uncompensated care, and the level of expenditures for such care, may be attributable to differing interpretations of what constitutes uncompensated care.

The following items were often among those included in a hospital's calculation of the amount spent on uncompensated care:

1. difference between cost of services provided and amount paid by any private or public insurer (Medicare, Medicaid, other public insurance programs)
2. difference between billed charges and the amount paid by any public or private insurance program
3. difference between cost of services provided and amount paid by self-pay patients
4. difference between billed charges and the amount paid by self-pay patients
5. amount of a patient's bill discharged under a hospital's uncompensated care policy
6. bad debts (calculated either with respect to billed charges or cost of services provided)
7. uncollected patient deductibles and co-payments

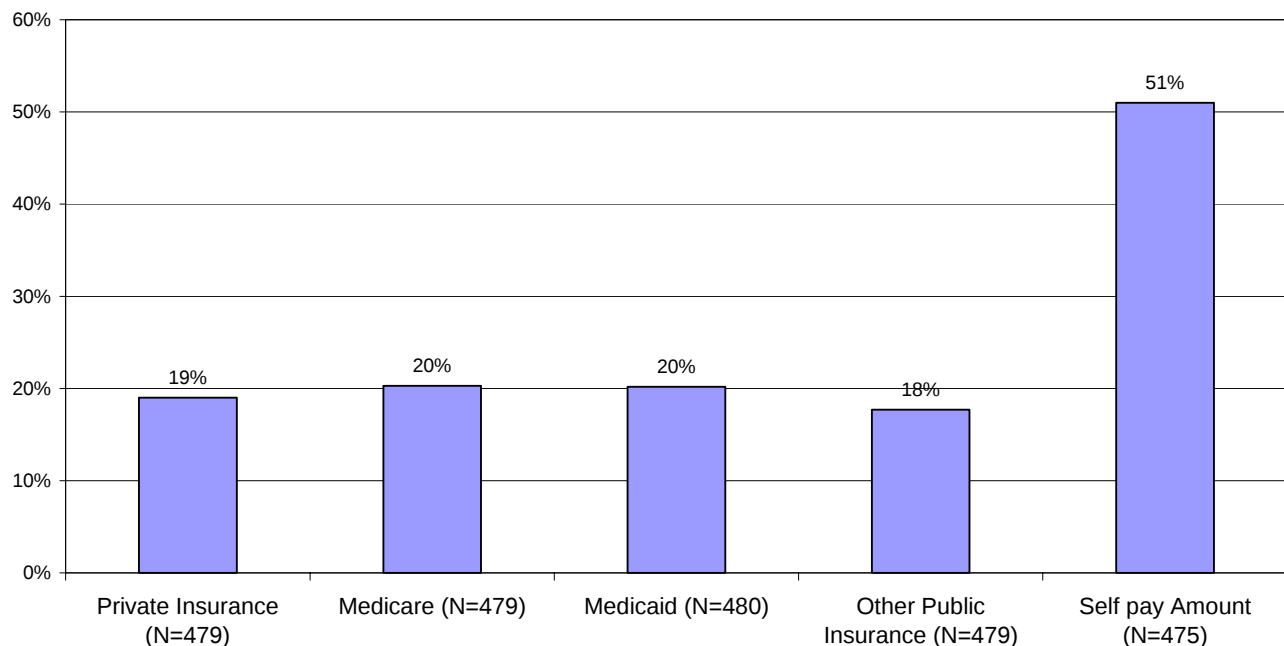
8. deductibles and co-payments that are approved as uncompensated care under a hospital's policy
9. amounts paid by a hospital into a state sponsored or administered "charity care" subsidy fund

Some respondents noted that courtesy discounts given to self-pay patients and early payment discounts given to patients who pay their bills quickly (typically within 5 to 10 days) were specifically excluded from their calculation of the amount spent on uncompensated care. In addition, many respondents excluded items 1, 2, and 6 (above) from their calculation of uncompensated care, further underscoring the lack of uniformity in defining uncompensated care.

Shortfalls (Charges over Payments)

The hospitals were asked whether, in calculating their uncompensated care amounts, they included the difference between the amounts they charged for services and either (i) amounts paid by various public and private insurers (including patient co-pays and deductibles) or (ii) amounts paid by uninsured individuals.

Percentage of Hospitals that Include Shortfall Amounts (Charges over Payments) in Uncompensated Care



- 19% (91) of 479 respondents reported that they included the difference between hospital charges and the amount private insurance paid or allowed for services in their calculation of uncompensated care

- 20% (97) of 479 respondents reported that they included the difference between hospital charges and the amount Medicare paid or allowed for services in their calculation of uncompensated care
- 20% (97) of 480 respondents reported that they included the difference between hospital charges and the amount Medicaid paid or allowed for services in their calculation of uncompensated care
- 18% (85) of 479 respondents reported that they included the difference between hospital charges and the amount other public insurance paid or allowed for services in their calculation of uncompensated care
- 51% (240) of 475 respondents reported that they included the difference between hospital charges and the amount paid by individuals without insurance in their calculation of uncompensated care

Thus, most (approximately 80%) of the respondents did not include shortfalls from private or public insurance as uncompensated care. Many of the hospitals that said that they did consider the difference between charges and amounts paid by private insurers to be uncompensated care specified that they were referring only to patient co-pays and deductibles that qualified for uncompensated care discounts, and in some cases to unpaid patient co-pays and deductibles that were considered bad debt.

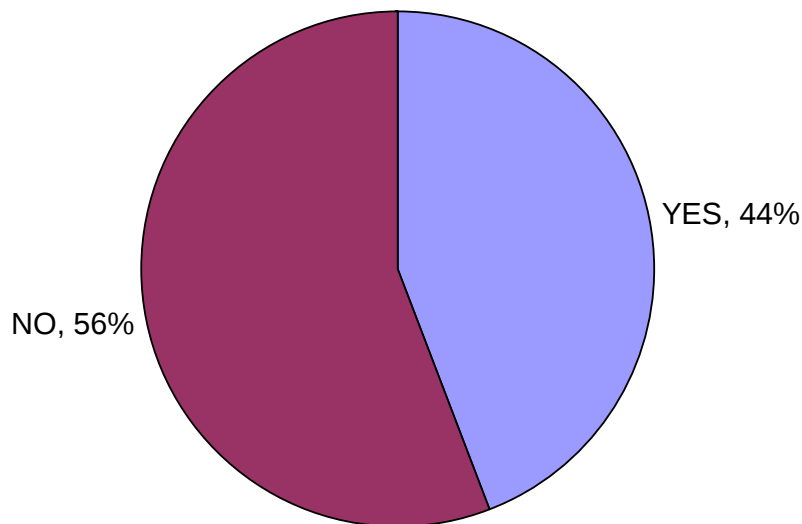
Where a public insurance program had deductibles or co-pays, the same analysis was often applied to those programs as was applied to a private insurer (amount allowed by the public insurance program was a discount with respect to charges, not uncompensated care, but discounted portions of the patient's co-payments or deductible amounts could be included in uncompensated care, and bad debts resulting from non-payment of the co-payments was sometimes also considered uncompensated care). Sometimes the difference between the cost of providing services and the amount allowed by Medicaid was also considered uncompensated care, and occasionally the difference between charges and the amount allowed by Medicaid was considered uncompensated care.

By contrast, a majority (51%) of the respondents considered the difference between the charge for a hospital service and the amount that a self-pay (uninsured) patient actually paid to be uncompensated care, whether that amount was attributable to a self-pay discount or to a further discharge of the patient's responsibility under an uncompensated care policy. A few hospitals only considered the self-pay discount as part of uncompensated care if the patient qualified for charity care under the hospital's uncompensated care policy. Others included in uncompensated care all uncollected amounts from uninsured patients who received emergency room care. Some hospitals only considered the difference between the cost of a service (not its charge) and the amount paid by a self-pay patient to be uncompensated care. In some cases, hospitals reported using state definitions of uncompensated care.

Bad Debt Expense

44% (211) of 478 respondents reported that they treat bad debts as uncompensated care. Some of the hospitals reported that their state requires that bad debt be included in the uncompensated care amount that is reported to that state. Many pointed out that they believe that some of their bad debt would have qualified for treatment as uncompensated care if the individual responsible for the debt had applied for free or discounted care pursuant to the hospital's uncompensated care policy. Many indicated that they keep track of bad debt and charity care-related uncompensated care separately, regardless of how they are reported. Some that reported bad debt as uncompensated care reported converting the debt from charges to cost before reporting it, using a charge-to-cost ratio defined by Medicare, Medicaid, or their state. A significant number of respondents reported only bad debt from emergency room care as uncompensated care. One hospital reported that accounts returned from a collection agency were reclassified as uncompensated care.

Bad Debt Included in Uncompensated Care (n=478)



Other Types of Uncompensated Care

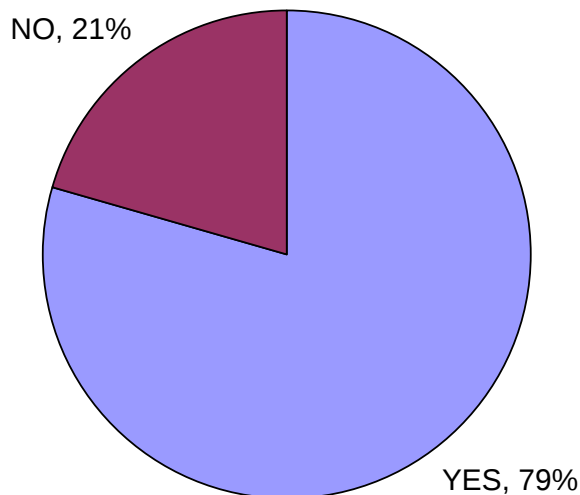
25% (119) of 482 respondents reported that they included other items or costs as uncompensated care, including the following:

1. costs of free prescriptions for Medicare and Medicaid patients
2. uncompensated costs of running primary care clinics
3. payments to a state uncompensated care pool
4. costs of participating in health fairs and community clinics

Reporting to State Governments of Uncompensated Care

79% (382) of 481 respondents reported that they report expenditures for uncompensated care to a state government. For some of these hospitals, the uncompensated care amount reported to the state is different from the amount they reported on the questionnaire. For example, one hospital that was located near a state border reported all of its uncompensated care on the questionnaire, while only the amount of uncompensated care attributable to the residents of its home state was reported to the state. Other discrepancies were attributable to the particular requirements of the state reporting regime, such as including or excluding cost shortfalls for Medicare patients. Some hospitals reported that their states explicitly include some portions of bad debt in their reporting requirements.

Uncompensated Care Reported to State Government (n=481)



Notification of Eligibility for Uncompensated Care to Patients

For each category of patient (inpatient, outpatient, and emergency room patient), the hospitals were asked at what time in the patient care and post-care process eligibility for uncompensated care was determined. Hospitals were asked to indicate if eligibility was determined at or before the patient received services, less than 30 days after the patient received services, 30 to 90 days after the patient received services, more than 90 days after the patient received services, at the time that an insurance program denied all or part of the claim that arose from provision of services, or at some other time. Respondents checked all the boxes that applied to their policy for determining patient eligibility for uncompensated care, and many hospitals checked multiple boxes for all three types of patients.

The following table shows the responses received for each type of patient:

Patient type	At or before providing service	Less than 30 days after providing service	30-90 days after providing service	More than 90 days after providing service	When insurance denied all or part of a claim	Other
Inpatient	79.1%	68.4%	71.0%	67.4%	67.6%	24.9%
Outpatient	78.9%	68.0%	71.3%	66.6%	67.1%	19.8%
Emergency room patient	59.8%	65.3%	67.4%	63.0%	62.6%	20.2%

The respondents provided explanations of the “other” times at which they might determine that a patient is eligible for uncompensated care. These answers varied widely and could be based on time (such as within 30 days of provision of services, within 6 months of provision of services, within a year of provision of services, within 3 years of provision of services), or on actions taken by the patient (after application for discounted care is completed) or actions taken by the hospital (review of application). In addition, some hospitals specified that they considered applications for uncompensated care only until an account was sent to a collection agency, while others indicated that they considered applications even after a patient’s account had been sent to a collection agency. Other hospitals simply stated that they would consider a patient for uncompensated care at “any time” or “as soon as possible.”

Uncompensated Care Policies

In response to the questions requesting an explanation of their uncompensated care policies, many respondents attached their written policies or provided narratives explaining the circumstances in which they provide free and discounted care to patients. The policies had varying names, one of the most common of which was “charity care.” Four issues that these policies generally discuss are: (1) the definition and measurement of uncompensated care; (2) the promotion of awareness of uncompensated care policies; (3) the uncompensated care application process; and (4) the types of uncompensated care and eligibility criteria.

Definition and Measurement of Uncompensated Care

The policies and narratives that were submitted with the responses demonstrate that the hospitals do not use a common definition or measurement of uncompensated care. Many respondents described their uncompensated care as care provided to low-income or needy patients for free or on a discounted basis, based on those patients’ qualification under certain income-related eligibility criteria. Many referred to such care as “charity care,” while others referred to it as “free care,” “discounted care,” or “financial assistance.” Other respondents defined uncompensated care more broadly, including some or all of their bad debt expense and Medicaid or Medicare shortfalls in addition to charity care. Some of those hospitals distinguished bad debt and Medicare/Medicaid shortfalls from charity care, as separate subsets of uncompensated care. Our preliminary review of narrative responses and attachments has shown that “charity care” is generally a narrower category than what hospitals typically consider “uncompensated care.”

Respondents measured how much uncompensated care they provide in various ways, the most common being:

- The difference between a hospital's *charges* for providing such care and the amount of revenue received for such care; and
- The difference between a hospital's *costs* for providing such care and the amount of revenue received for such care. Some hospitals reported using their actual costs in determining this difference, while others reported using estimated costs derived from application of a Medicare, Medicaid, or state-defined charge-to-cost ratio.

Some hospitals reported that they measure and report their uncompensated care differently for different reporting purposes (e.g., state reports, Medicare reports, Medicaid reports, financial statements, public reports), using both costs and charges in their various calculations. Some states mandate how uncompensated care should be measured for state reporting purposes.

Promotion of Awareness of Uncompensated Care Policies

Many of the hospitals that submitted uncompensated care narratives described how they promote the availability of uncompensated care to their patients. The following are the most common means of promotion described in those narratives:

- The display of posters (sometimes multi-lingual posters) in admitting and registration areas, financial offices, emergency rooms, and other locations to notify patients of the availability of uncompensated care.
- The placement of uncompensated care brochures or flyers in admitting and registration areas.
- Referral by registration personnel of uninsured, and/or low-income patients to financial counselors or advisors to discuss payment options.
- The availability of financial counselors and advisors to meet with patients to explain uncompensated care options, eligibility criteria, and payment plan options.
- The notification via billing statements of the availability of financial assistance and the contact information of a financial counselor or other account representative.

Many hospitals that provided uncompensated care narratives with their responses did not indicate whether or how they promote the availability of such care to their patients. Some hospitals reported that their patients are responsible for contacting financial counselors or other hospital representatives to initiate an uncompensated care application, and generally did not describe any efforts they make to promote the availability of uncompensated care.

Uncompensated Care Application Process

Most hospitals that described their uncompensated care application process require patients to take several steps to confirm their eligibility for full or partial discounts. The following are the most commonly reported requirements:

- A patient must speak with a financial counselor or some other hospital representative about obtaining uncompensated care.
- The patient must have received medically necessary services, as opposed to elective procedures such as cosmetic surgery.
- A patient must exhaust all forms of public assistance (e.g., Medicaid, Medicare, state assistance) before he or she becomes eligible for uncompensated care from the hospital. Many hospitals provide financial counselors or advisors to assist patients in identifying and applying for public assistance.
- The patient must complete and submit an uncompensated care application, typically within 10-30 days of the date the hospital provides the patient the application. Some hospitals allow a patient to file an application at any point during the collection process; others impose filing deadlines (e.g., one year from date of service; before patient's account is turned over to a collection agency).
- The patient must submit proof of identity, number of dependents, and address as part of the application process. Some hospitals limit all or certain types of uncompensated care only to residents of their states or geographic service areas.
- The patient must meet income-based eligibility criteria. To determine whether the patient meets these criteria, the hospital requires the patient to submit documentation that the hospital can use to verify household income from employment (e.g., pay stubs for past 1-3 months, W-2 form(s), tax return(s)); child support and alimony; pensions and other retirement accounts; lottery winnings; rentals; and public benefits received (e.g., unemployment, worker's compensation, Social Security, Medicaid, Medicare). Some hospitals also require documentation of patients' monthly or annual expenses.
- The patient must meet asset-based eligibility criteria. To determine whether the patient meets these criteria, the hospital requires the patient to submit documentation of his or her tangible and intangible assets, including bank and other account statements; IRA and other retirement account statements; insurance information; food stamp allocation; automobile(s) year, make, and model; and real estate tax and mortgage statements.
- The patient must provide proof of Medicaid denial.
- Most uncompensated care applications are approved by hospital staff. However, certain applications for uncompensated care, particularly for patients who do not meet federal poverty guideline thresholds or who incur medical bills above a certain level, must be approved by an uncompensated care committee, the CFO, or another committee or officer of the hospital.

- The patient's uncompensated care determination is effective for a certain period (e.g., 1-12 months) from the date of determination. After that period expires, the patient would need to re-apply for uncompensated care.
- Some patients, particularly uninsured patients, must pay a deposit before receiving certain services, to the extent they do not qualify for free or discounted care.

In addition, several hospitals reported that their provision of uncompensated care is dependent, in part, on whether they have reached or exceeded their budgeted uncompensated care allocation for the year, or on other internal financial factors.

Types of Uncompensated Care and Eligibility Criteria

Most hospitals that described their uncompensated care policies reported providing different types of free and discounted care to patients who meet income-based and/or asset-based eligibility criteria.

Free Care: Most hospitals that submitted uncompensated care policies or narratives reported that they provide some amount of free care to low-income patients. These hospitals generally offer free care to patients whose family income is less than the amount specified in the U.S. Department of Health and Human Services federal poverty guidelines ("FPG"), or some percentage thereof (e.g., 150%, 200%, 250%). The majority of those hospitals that reported their FPG thresholds for free care set that threshold at 100% or 200% of FPG.

Discounted Care on Sliding Scale. Many hospitals also reported offering discounts to qualified patients on a sliding income scale. The following is a common example of such a scale:

<u>Income as Percent of FPG</u>	<u>Amount of Discount.</u>
100% of FPG or less	100%
101-150% of FPG	75%
151-200% of FPG	50%
201-250% of FPG	25%
Greater than 250% of FPG	0%

Some hospitals also require that the value of a patient's assets be less than a certain amount for the patient to qualify for free or discounted care.

Medically Indigent Discounts. Some hospitals reported providing additional discounts for "medically indigent" persons who are unable to pay their medical bills when such bills exceed a certain percentage of their annual family income, net worth, or FPG (e.g., 15-50%). Some hospitals cap a medically indigent patient's balance due at the same percentage. Some only provided such discounts if a patient's medical expenses exceeded the value of the patient's assets, usually excluding the value of a primary residence and one automobile.

Uninsured Discounts. Many hospitals reported that they offer an additional discount to uninsured patients, typically 5-50% of their charges. Some discounts equal the hospital's Medicaid or Medicare discount, while others are tied to insurance company-negotiated discounts.

Other Discounts. Some hospitals reported that they provide free or discounted care to homeless patients or to estates of deceased patients. Many hospitals reported providing additional uncompensated care discounts on a case-by-case basis, based on each applicant's facts and circumstances. Generally, awards of uncompensated care to patients who did not meet such hospitals' eligibility criteria require approval of the hospital's CFO, director of patient accounts, director of financial services, or another senior officer.

As noted above, some of these hospitals reported restricting their provision of some or all forms of uncompensated care to residents of their state or geographical service area. Several other hospitals restrict provision of uncompensated care to United States residents only. Some hospitals provide uncompensated care discounts to persons outside of their state or service area, and to non-U.S. residents, for emergency services only.

Billing and Collection Practices – Questions 43 through 56

General Overview

85% or more of the responding hospitals, determined as follows, reported that they did not require payment (or making arrangement to pay) prior to or at the time they provided inpatient, outpatient, or emergency room services. 14% (65) of 481 respondents did require payment or making an arrangement to pay before providing inpatient services, and 15% (72) of 480 respondents required payment or making arrangement to pay before providing outpatient services. 4% (20) of 462 respondents required payment or making arrangement to pay before providing emergency room services.

Hospitals were asked to explain their payment policies for inpatients, outpatients and emergency room patients. Most responses fell into a general pattern. In all three categories, the hospitals reported that they first confirmed coverage by a private insurer or public insurance program (if the patient claimed to have such coverage) and billed that insurer. If the insurance required a co-payment by the patient, that amount was attempted to be collected from the patient at or before the time of admission. Some hospitals also attempted to collect the amount of the patient's deductible at the time of collection of co-payment. Many hospitals reported that if a patient did not have any insurance coverage, they attempted to determine if the patient was eligible for coverage by any public program. This attempt could include the services of a financial counselor to assist the patient in filling out and filing paperwork or might simply mean that the patient was given written information about the available programs.

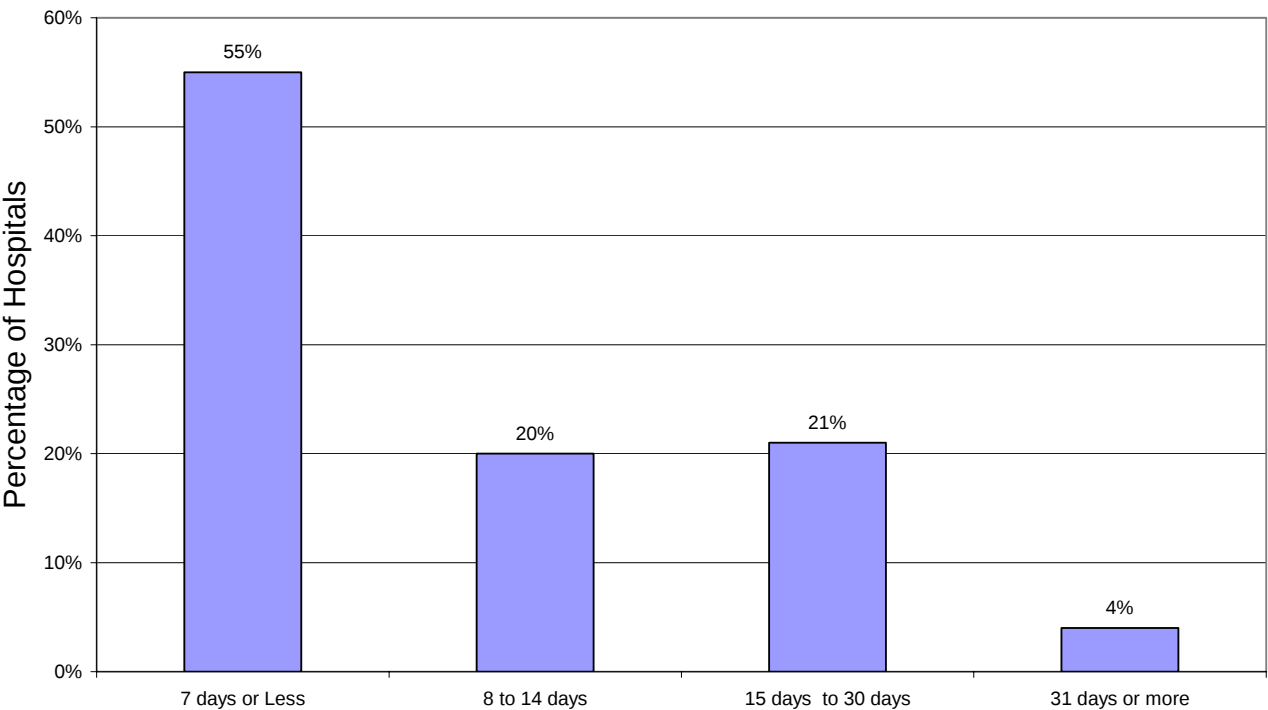
After payment or refusal of payment by an insurance company or program, the hospitals billed patients for any balance left on their accounts. Generally patients received a series of bills over several weeks or months before a bill was considered bad debt or referred to a bill collection process. Many hospitals offered extended payment plans to patients who could not pay bills at the time they were due. Installment payment plans are diverse and may include restrictions on the time period over which the bill may be paid and minimum percentages of the balance that must be paid each month. Many hospitals stated that they turned over delinquent accounts to a private collection agency. A few hospitals stated that they had put restrictions on the actions that a collection agency could take to collect a bill.

Most hospitals did not mention differences in their payment policies for inpatient, outpatient and emergency room patients. Those that did generally reported that they did not require

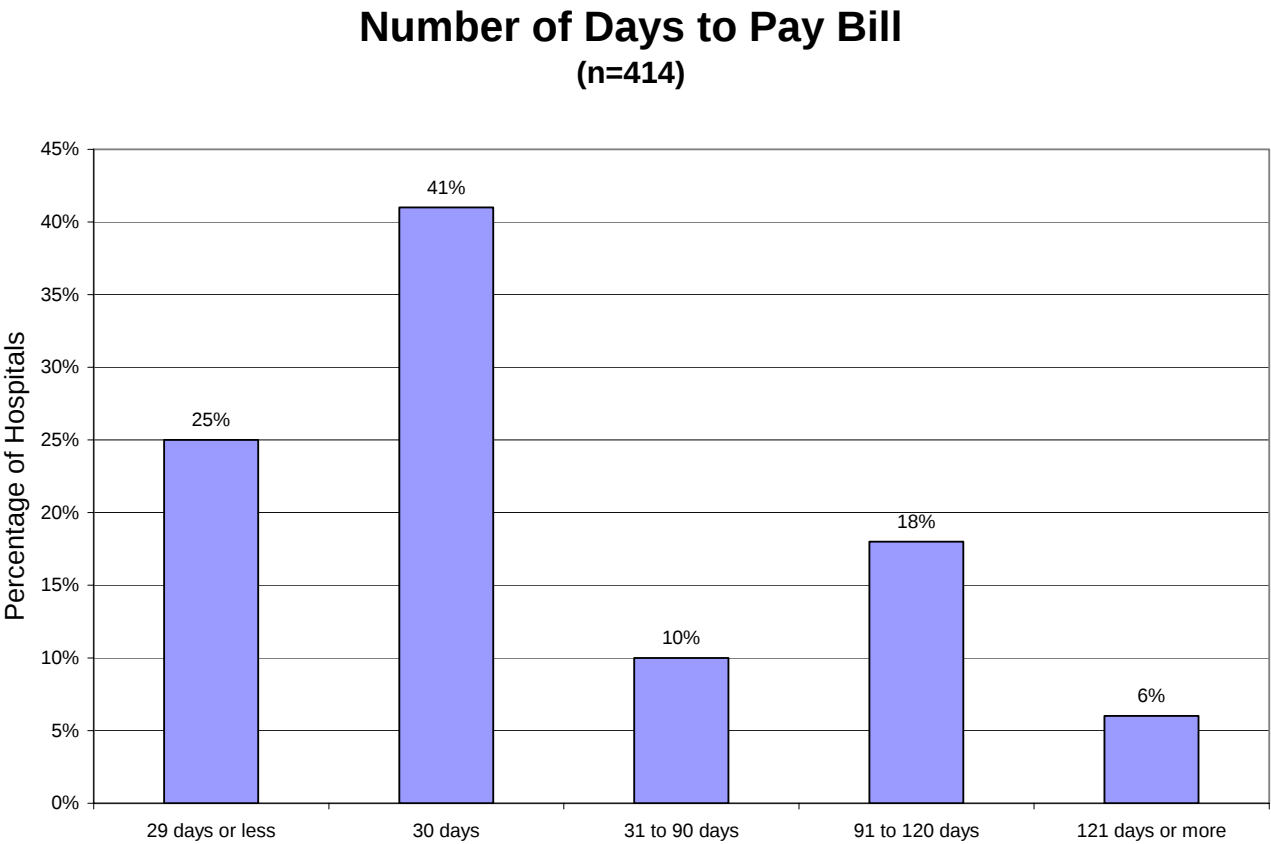
emergency room patients to pay or provide proof of insurance until after any necessary urgent treatment had been provided.

Hospitals were asked how many days after the provision of services was the patient billed. If the response was given in the form of a range of days, the highest number in the range was used for purposes of this report. The mean (average) number of days for 385 respondents was 13 and the median number of days was 7.

Number of Days before Bill Issued
(n=385)

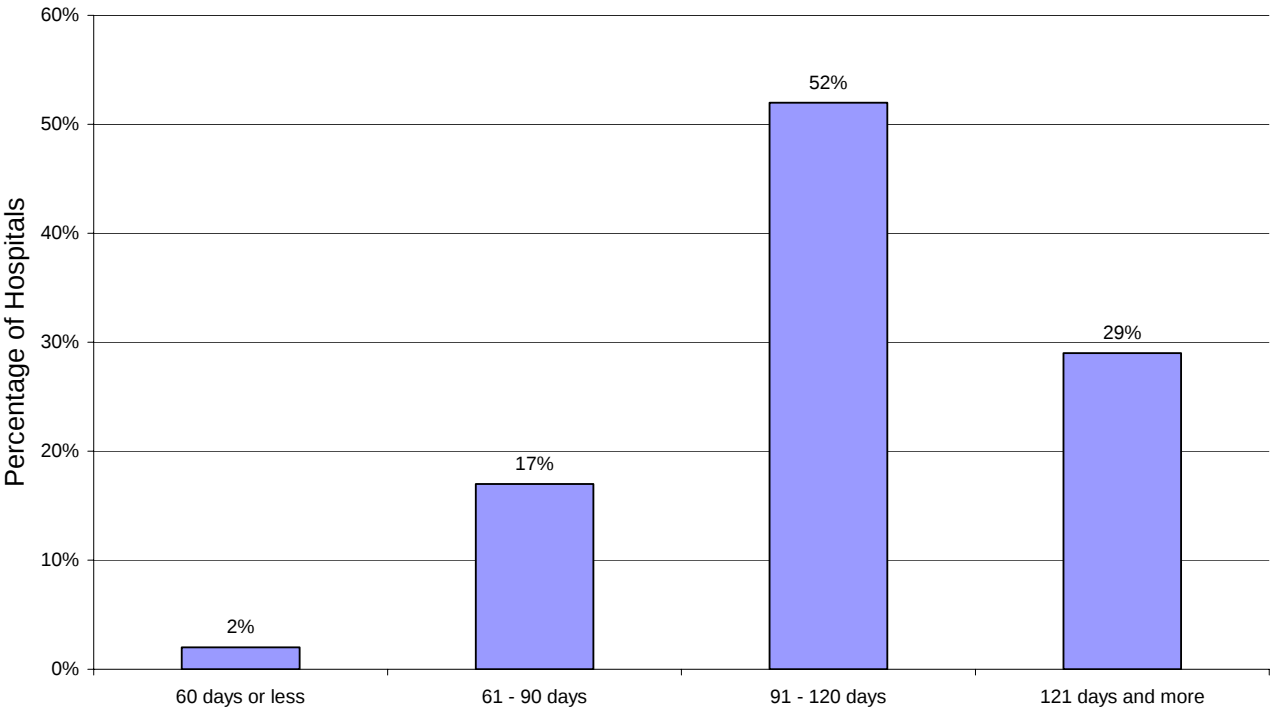


Based on 414 respondents, the mean (average) number of days a patient had to pay that bill after the billing date was 55 days, and the median number of days was 30, as shown in the following table:



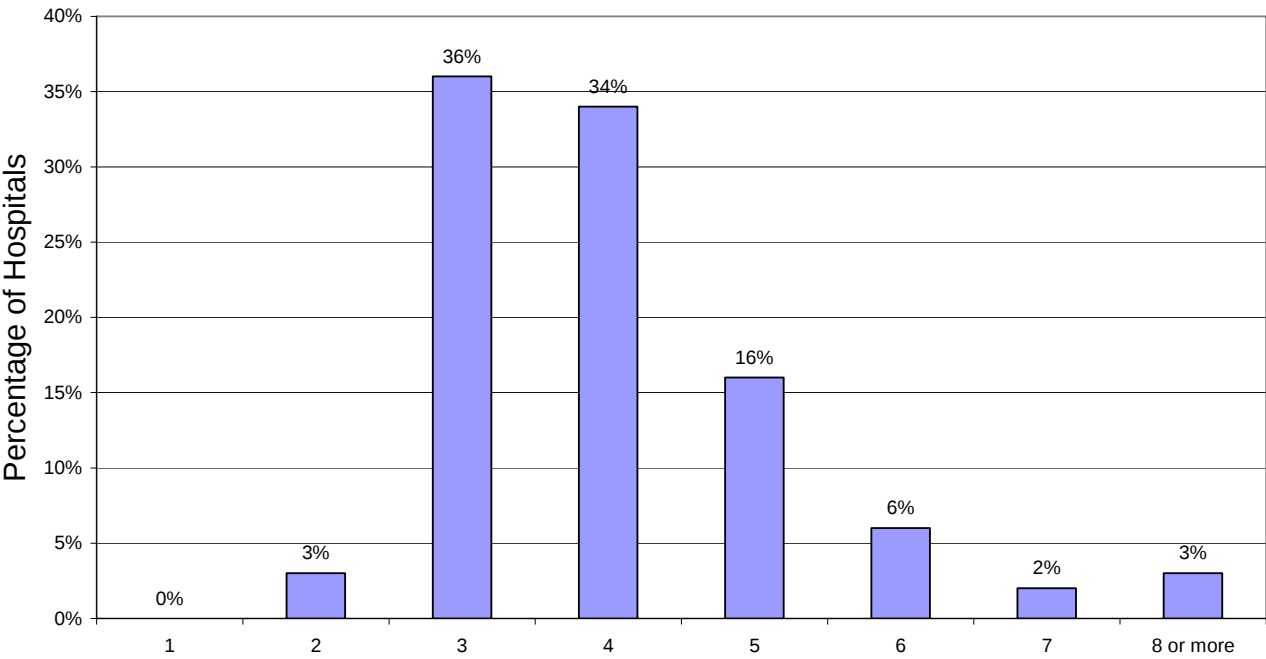
Of 407 respondents, the average number of days after a patient had not paid all or part of a bill before a hospital would classify a balance due as bad debt was 126 (with a median of 120 days).

Number of Days before Bad Debt Classification
(n=407)



Of 429 respondents the median number of notices sent to the patient before commencement of collection activities was 4.

Number of Notices Issued before Collections Referral
(n=429)

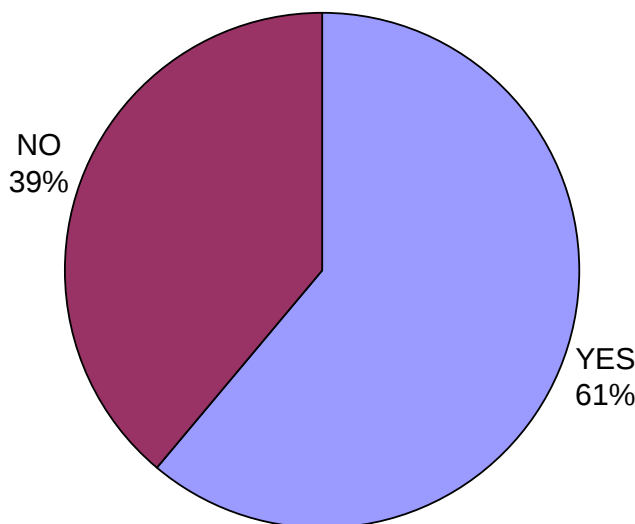


Private Collection Agencies and Collection of Unpaid Bills

61% (294) of 481 respondents reported that they referred all past due bills to collection agencies.

Does the Hospital refer accounts to Private Collection Agencies?

(n=481)



Many hospitals provided narrative responses to supplement their responses to the questions regarding collection practices and policies. Because not all hospitals provided such supplemental information, the information contained in the narratives and summarized below does not purport to describe the overall experience of the hospital respondents regarding their collection practices.

These partial narrative responses indicate that some hospitals used strong measures to collect unpaid bills. Others did not discuss using these measures and still others explicitly stated that they refrained from using certain measures in collecting unpaid bills. Some of the measures that some hospitals engaged in to collect unpaid bills were:

- Placing a lien on a patient's third party liability claims (such as accident settlements);
- Placing a lien on the patient's personal property;
- Placing a lien on a patient's residence;
- Adding attorneys fees (and all other costs of collection) to the patient's bill if the hospital uses an attorney to start collection procedures;
- Filing claims against a decedent's estate; and
- Garnishing a patient's wages.

Some of the hospitals that refrained from these measures reported that they imposed explicit restrictions on themselves and their collection agencies including the following:

- Using a “soft” collections approach;
- Refusing to foreclose on a patient’s primary residence;
- Placing a lien on a patient’s home in lieu of requiring immediate payment if the patient would have qualified for uncompensated care but for having too much equity in their home (hospital recovers charges when the house is next transferred);
- Not reporting a patient’s failure to pay a bill to a credit agency;
- Not taking legal action unless the hospital believes that the patient has the ability to pay and then only for bills over a certain amount;
- Suspending billing in some instances such as death of the patient, bankruptcy, and pending application for assistance;
- Not garnishing wages;
- Requiring hospital executives or board of directors to approve actions taken to collect bills such as actions taken by collection agencies, legal action, and attachment of personal residence or automobile; and
- Not attempting to collect amounts that the hospital has determined to qualify for uncompensated care.

Installment Agreements

Over 97% (465) of 479 respondents said that installment agreements were available to patients who were unable to pay the balance due immediately. The hospitals were asked to describe the circumstances in which they would enter into installment agreements or other extended payment arrangements with patients who were unable to pay. Hospitals described a number of different circumstances in which they would enter these arrangements, including the following:

- Based on the facts and circumstances of each case (including the size of the bill and the income and assets of the patient);
- Instituted almost automatically when the patient pays part of a bill, but not all of it, but limited in time (3 months, 6 months and one year were all mentioned);
- Under a standardized program with long terms available for payment of the entire bill (5 years was mentioned by several hospitals, though up to 2 years was more common) and relatively low minimum payments per month (as low as \$5 per month was mentioned);
- Only upon payment of a certain percentage of the bill (up to 50% was mentioned); and
- For a relatively short amount of time (defined explicitly by a limit on the amount of time the patient may take to pay, or implicitly by a relatively high minimum monthly payment).

Some extended payment plans did not impose interest, and a few hospitals required patients to sign promissory notes in order to participate. Some hospitals referred patients that do not make the required payments to collections. A hospital may proactively offer installment plans to patients or offer their program only to patients who request it. Both insured and self-pay patients may participate in many plans.

Uniform Chargemaster

When asked whether they charged all patients the same price for the same services, only two of the 483 respondents answered that they did not charge all patients the same price for the same services. However, in response to questions about whether the hospital charged different prices based on factors such as type of insurance coverage or a patient's ability to pay, eight hospitals reported that they charged different prices as follows:

- Two charged patients with private insurance higher prices for hospital services than patients with public insurance (including Medicare and Medicaid);
- One charged patients with no insurance higher prices for hospital services than patients with public insurance (including Medicare and Medicaid);
- One charged patients with no insurance higher prices for hospital services than patients with private insurance and
- Four charged patients different prices for hospital services based on their income, assets or ability to pay for such services.

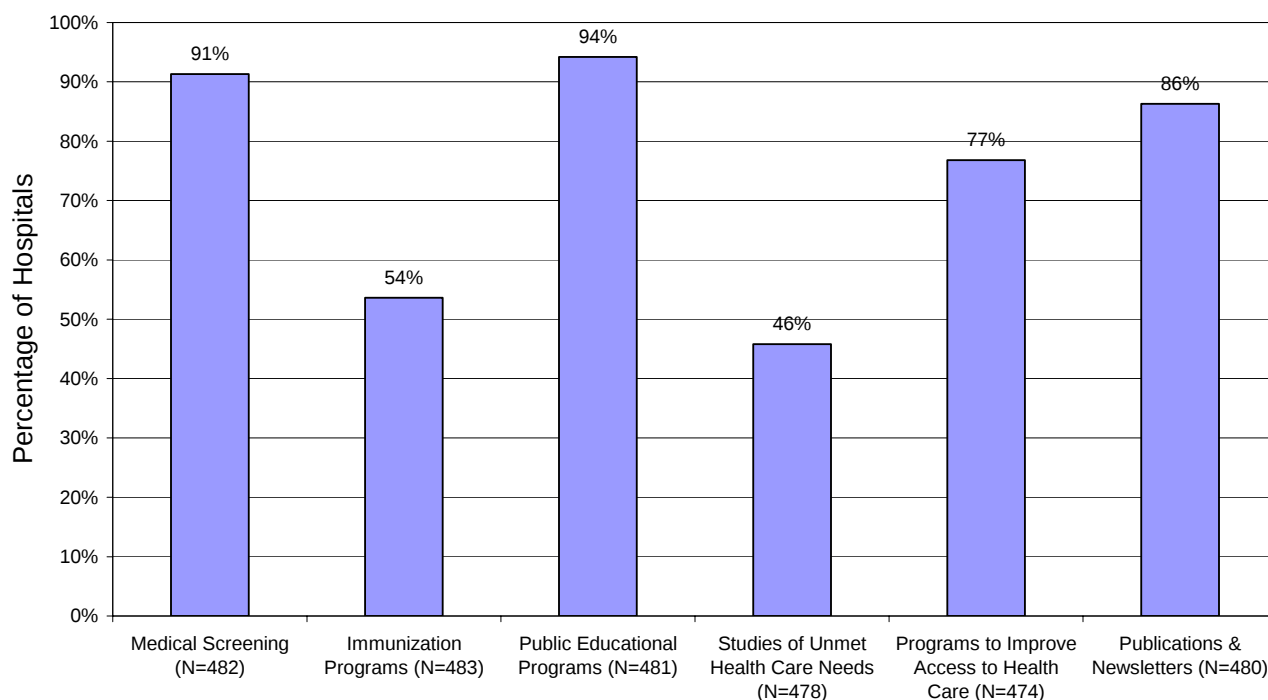
One hospital that reported that it did not always charge the same price for the same services explained that all of the hospital's patients were charged the same amounts, but that the hospital provided lab and x-ray services to an occupational health provider and charged that particular provider a separate negotiated rate.

The narrative responses to these questions indicate that hospitals often accept less than 100% of the billed amount from many different categories of patients in complete discharge of their indebtedness. The most common reasons hospitals mentioned for accepting less than the "chargemaster" amount in satisfaction of a patient's bill were: Medicare or Medicaid only allows or pays a lower amount for the service, private insurers negotiate discounts and lower allowable amounts with the hospitals for the service, the patient was given a discount because he or she did not have insurance, and the patient was given a discount for paying his or her bill promptly.

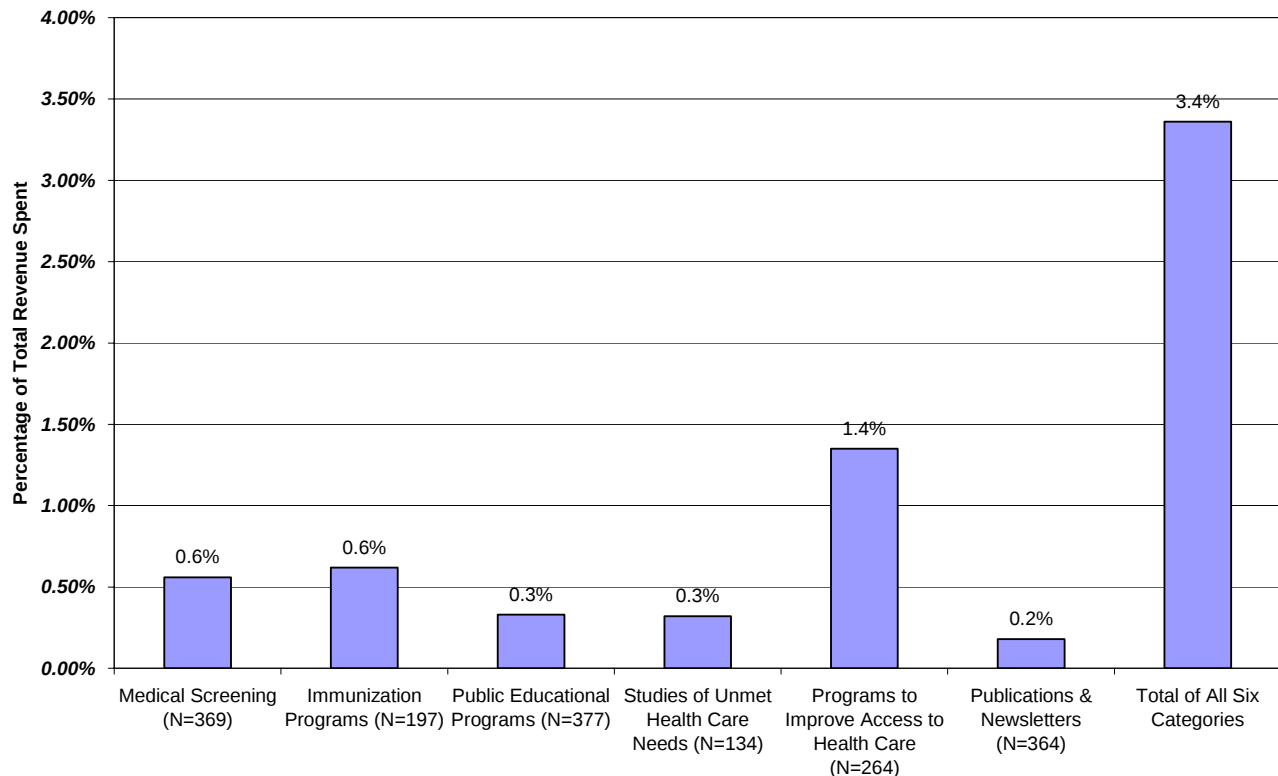
Community Programs – Questions 57 through 72

The following two tables represent a composite of the respondents' various community programs, as well as an illustration of the average amount of total revenue expended on such programs. The first table shows the respective percentages of hospitals reporting that they provided various types of community programs. The second table reports the mean (average) of the individual hospital percentages of total revenues spent on each type of community program. (Note: This mean (average) is not the same measure as the aggregate percentage of total revenues spent by all 487 respondent hospitals on these programs.)

Percentage of Hospitals Providing Community Programs



Percentage of Total Revenue Spent on Community Programs



Medical Screening Programs

Over 91% (440) of 482 hospitals responding said that they provide medical screening programs for the community. The mean (average) of the percentages of total revenues spent by 369 respondents reporting expenditures on such programs was 0.56% of total revenue, with the median being 0.02% of total revenue.

92% (402) of 439 hospitals responding said that all members of the community were eligible for the hospital's medical screening programs. Of the 8% (37) of hospitals reporting that not all screenings were open to the entire community, the most common explanation was that a local employer paid the hospital to conduct a screening of all of its employees, in which case only those employees were eligible for that particular screening.

41% (178) of 440 respondents reported charging a fee for certain community medical screening programs while 59% (262) of the hospitals said that no such fee was charged. The most common explanation was that nominal charges were sometimes imposed to cover the costs of the program or associated lab costs.

Immunization Programs

54% (259) of 483 hospitals responding reported that they provided immunization programs for the community. The mean (average) of the percentages of total revenues spent on immunization programs was 0.62% (with a median of 0.01%) of total revenue (based upon 197 responses). 71% (189) of 267 respondents reported that all members of the community were eligible for the hospital's immunization programs. Of the 29% (78) who limited eligibility

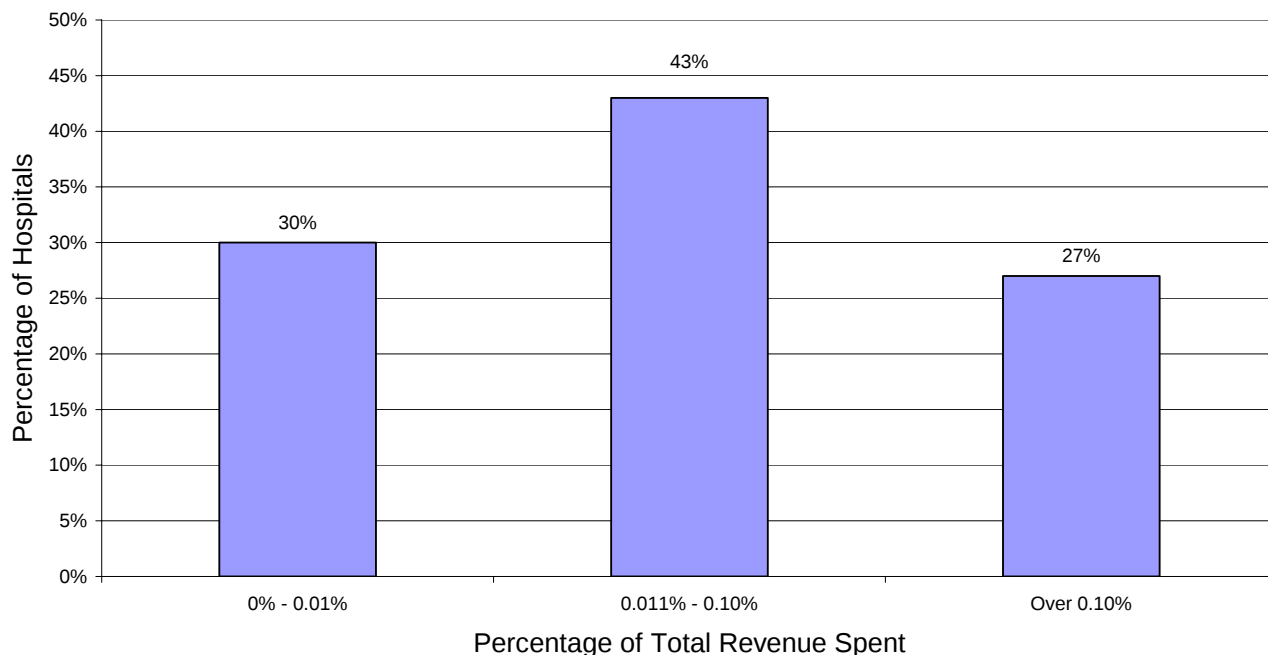
for immunization programs, the most common explanation was that on certain occasions, large employers in the area arranged for the hospital to provide immunizations for its employees. In such instances, only that particular segment of the community was eligible.

44% (117) of 268 hospitals responding reported that no fee was charged for any of its community immunization programs. 56% (151) of the hospitals indicated that a fee was sometimes charged to cover costs associated with the immunization program.

Community Education Programs

94% (453) of 481 hospitals responding reported that they offered lectures, seminars, and other educational programs for the community. The mean (average) of the percentages of total revenues spent on such programs by 377 respondents was 0.33% of total revenue and the median was 0.04%. The distribution of amount of total revenue spent on such programs is shown in the graph below:

Percentage of Total Revenue Spent on Community Educational Programs
(n=377)

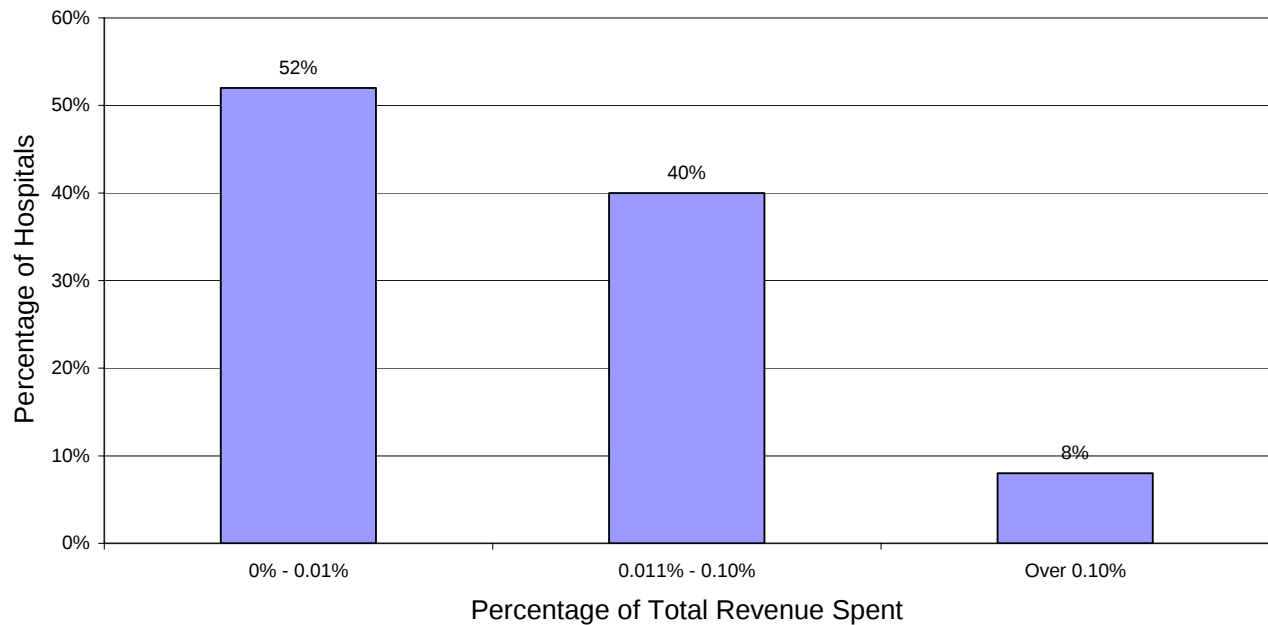


98% (440) of 451 hospitals responding reported that all members of the community were eligible for the hospital's community education programs. 64% (293) of 455 hospitals responding reported that no fee was charged for any of its community education programs, while 36% (162) said that a fee was sometimes charged to cover costs associated with a given program.

Studies of Unmet Health Care Needs of the Community

46% (219) of 478 responding hospitals reported conducting studies on the unmet health care needs of the community while 54% (259) of the hospitals did not. The mean (average) of the percentages of total revenues spent on such studies by 134 responding hospitals was 0.32% and the median was 0.01%. The distribution of the amounts spent on such programs, as compared to total revenue, is as follows:

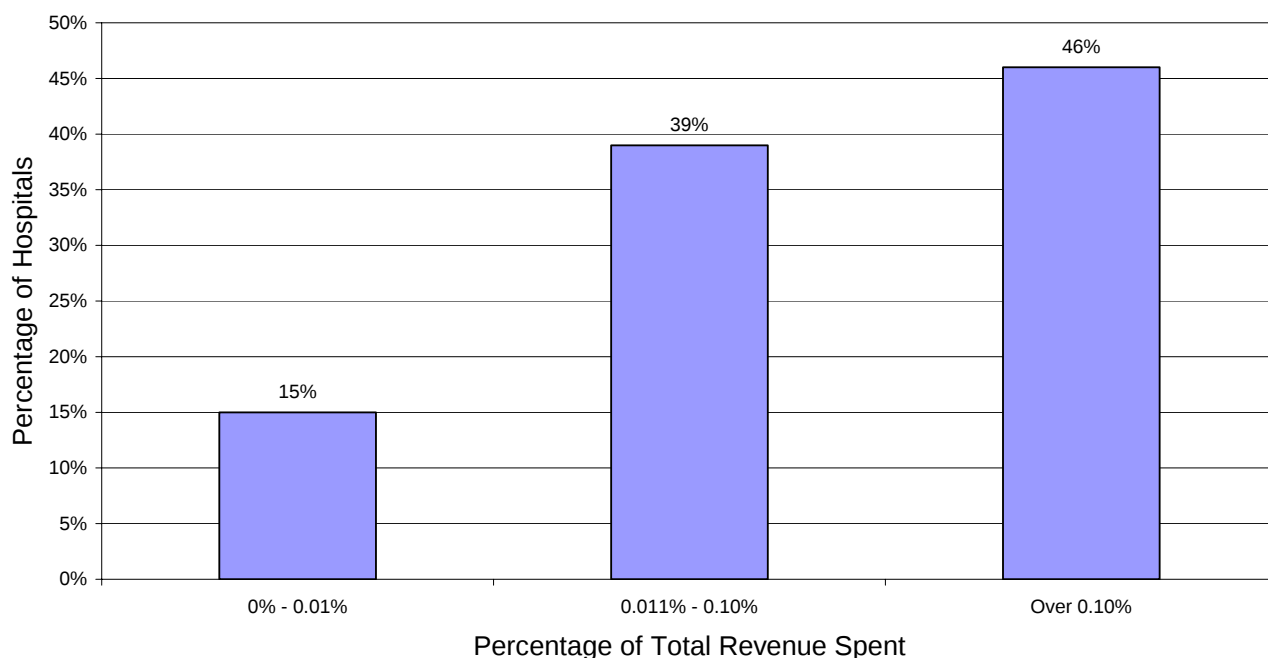
**Percentage of Total Revenue Spent on Studies of
Unmet Health Care Needs
(n=134)**



Programs to Improve Access to Health Care

77% (364) of the 474 hospitals responding reported that they have programs to improve access to health care for individuals who lacked insurance. The mean (average) of the percentages of total revenues spent on such programs by 264 respondents was 1.35% of total revenue, and the median was .08% of total revenue. A more complete picture follows:

Percentage of Total Revenue Spent on Programs to Improve Access to Health Care (n=264)

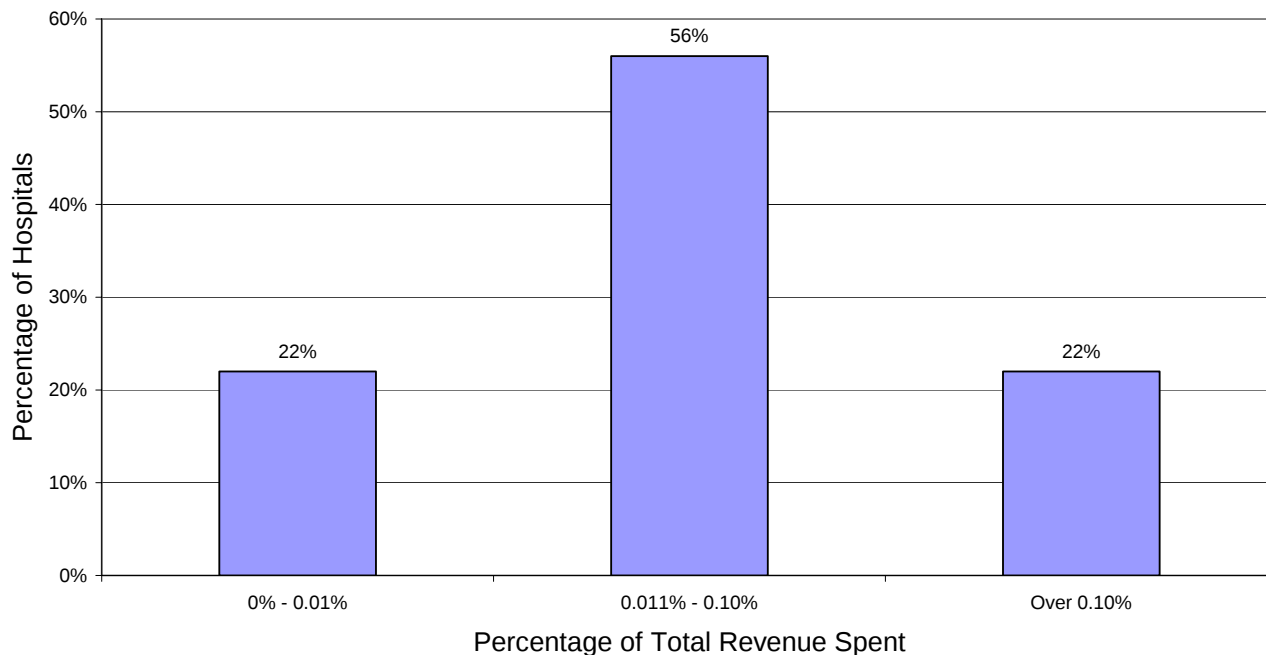


Based upon our preliminary review, it appears that hospitals interpreted this question in different ways. For example, the amount some respondents reported spending on programs to improve access to health care for those who lack insurance is the same amount they reported spending on uncompensated care (coincidentally, or otherwise).

Production of Publications and Newsletters

86% (414) of 480 respondents reported that they produced newsletters or publications that provided information to the community on health care issues. The mean (average) of the percentages of total revenues spent on such programs by 364 respondents was 0.18%.

Percentage of Total Revenue Spent on Publications and Newsletters (n=364)



Other Health Promotion Programs

85% (402) of 475 respondents reported that they offered other community programs or activities that promoted the health of the community. The types of programs described by respondents were diverse, but typically included blood drives, support groups, community clinics, child car seat safety programs, smoking cessation programs, and exercise programs. Hospitals were also asked to state how much was spent on these programs, although the question did not clearly state whether they were to provide an aggregate amount or separate amounts for each type. A large number of respondents included estimates or indicated "unknown" instead of a true numerical response. Accordingly, no meaningful data may be reported regarding the amount of expenditures relating to such activities.

VI. Summary of Aggregate Community Benefit Expenditures

Part VI summarizes aggregate potential community benefit expenditure amounts as reported by the respondents. It summarizes information by type of expenditure, displays the various categories of reported aggregate community benefit expenditures as a percentage of aggregate total revenues of the hospitals, and provides a list of the number of hospitals that reported expenditure amounts in the various categories.

In order to obtain an estimate of reported aggregate community benefit expenditures as a percentage of total revenues of the hospitals, the Project Team obtained revenue data contained in the IRS Return Information Classification System (RICS).

Aggregate Potential Community Benefit Expenditures (By Type Reported)

In response to specific questions on the questionnaire, the 487 respondents that submitted a questionnaire reported aggregate potential community benefit expenditures of these specific items of \$9.3 billion.

The following table summarizes the aggregate of potential community benefit expenditures, by category, for the 487 respondents.

Category of Potential Community Benefit Expenditure	Aggregate Potential Community Benefit Expenditures	% of Aggregate Potential Community Benefit Expenditures
Uncompensated care	\$5.2 billion	56%
Medical education and training	\$2.1 billion	23%
Medical research	\$1.4 billion	15%
Community programs	\$0.6 billion	6%
Total potential community benefit expenditures	\$9.3 billion	100%

The following table provides a breakdown of the \$0.6 billion of community program expenditures, in increasing order, reported by the 487 respondents.

Category of Community Program Expenditure	Aggregate Community Program Expenditures	% of Aggregate Potential Community Benefit Expenditures
Studies on community's unmet health care needs	\$6.4 million	0.0%
Immunization programs	\$12.0 million	0.1%
Newsletters or publications	\$31.7 million	0.3%
Medical screening programs	\$32.3 million	0.3%
Lectures, seminars, educational programs	\$54.0 million	0.6%
Improving access to health care	\$206.9 million	2.2%
Other health promotion activities	\$245.5 million	2.6%
Total community program expenditures	\$588.8 million	6.1%

Reported Potential Community Benefit Expenditures (by Type, as % of Respondents' Total Revenues)

To put the reported expenditures in perspective, the Project Team calculated each respondent's reported expenditures as a percentage of total revenue. The mean (average) of the percentages of total revenues spent by the 487 individual hospital respondents on potential community benefit expenditures was 8.8%. The median percentage of total revenues spent on community benefit expenditures by all 487 hospitals was 5.4%. Although it appears that the definitions of uncompensated care used by certain of the hospitals resulted in the inclusion of some items that might not constitute community benefit, the reported expenditures do not necessarily reflect all aspects of community benefit that might have been provided by the respondents. Our preliminary work indicates that other measures, such as expenditures as a percentage of total expenses or direct medical care outlays, might help portray a more complete picture of the extent of community benefit provided by nonprofit hospitals.

The following charts display the percentage of total revenue that the 487 hospitals reported spending on community benefit expenditures:

Aggregate Reported Community Benefit Expenditures as a Percentage of Total Revenue	# of Hospitals	% of Hospitals
0.0 % to 1.9 %	105	21.6 %
2.0 % to 4.9 %	130	26.7 %
5.0 % to 9.9 %	112	23.0 %
10.0 % to 19.9 %	96	19.7 %
20 % and over	44	9.0 %
	487	100.0 %

The following table displays the number of the 487 respondents that reported amounts for the various types of community benefit expenditures, along with the aggregate community benefit expenditure amounts for each type, as reported above.

Category of Reported Expenditure	# of Respondents Reporting Such Expenditures	% of 487 Respondents Reporting Such Expenditures	Aggregate Reported Expenditures (487 hospitals)	% of Total Revenues Spent on Such Expenditures
Uncompensated care	472	97%	\$5.2 billion	56%
Medical education & training	368	76%	\$2.1 billion	23%
Medical research	101	21%	\$1.4 billion	15%
Studies on unmet community needs	134	28%	\$6.4 million	-
Immunization programs	197	40%	\$12 million	-
Newsletters & publications	364	75%	\$32 million	-
Medical screenings	369	76%	\$32 million	-
Lectures, seminars, educational programs	377	77%	\$54 million	1%
Improving access to health care	264	54%	\$207 million	2%
Other health promotion activities	154	32%	\$246 million	3%
Total community benefit expenditures	479	98%	\$9.3 billion	100%

To summarize, most respondents reported community benefit expenditures in multiple categories. The most commonly reported community benefit expenditure categories were uncompensated care, medical education and training, and certain of the other community programs (medical screenings, educational programs, and newsletters and publications). The largest aggregate expenditures were reported in uncompensated care, followed by medical education and training, medical research, and certain other community programs (improving access to health care and programs described as “other” by the respondents).

VII. Preliminary Summary Information

While this report is interim in nature and there remains a significant quantity of information to evaluate, the following summary information is available at this time:

1. Nearly all (98%) of the hospitals responded to the compliance check questionnaire. The 11 hospitals that did not respond to the questionnaire have been referred to the Review of Operations unit in EO Examinations for additional follow-up.
2. Hospital type, size, patient mix, emergency room services, governance, and medical staff privileges:
 - 89% of the respondents classified themselves as general medical and surgical hospitals, with the remainder reporting a particular specialty. The average total annual revenue per respondent was \$169 million with a median of \$83 million.
 - Uninsureds represented 7% of total patients, 46% of total patients were covered by private insurance, and 46% were covered by public programs (Medicare: 28%; Medicaid: 16%; and other public insurance: 2%).
 - 93% of the responding hospitals operated an emergency room, and 99% of those did so 24 hours a day, 365 days a year. 32% of the respondents with emergency rooms also operated trauma centers. All hospitals that reported operating an emergency room reported that they provide emergency room services to all members of the community regardless of their ability to pay. Only a small percentage (2%) reported denying emergency room services to any person, with the primary reasons being diversion to another facility when at full capacity, or the patient is determined not to have an emergency medical condition.
 - In general, the greater a hospital's revenue the larger the size of its board. Most boards have between 10 and 20 directors; some boards were as small as 4 directors and others had over 100 directors. Most boards (81%) met at least quarterly – over half (55%) met at least monthly. 25% of all board members had medical or health care backgrounds.
 - 92% of respondents reported that all qualified physicians in their communities were eligible for medical staff privileges; 96% reported they had not denied any applications for medical staff privileges.
3. Most respondents reported they did not deny medical services to persons with private insurance, Medicare, Medicaid, other public insurance, or without insurance. 10% of respondents reported denying medical services to uninsured persons, 6% to privately insured persons, and 3-4% to persons with public insurance. Although most respondents reported that they did not require payment, or that payment arrangements be made, prior to delivery of care, 14% required advance payment or payment arrangements for inpatient services, 15% for outpatient services, and 4% for emergency room services.
4. The mean (average) of the percentages of total revenues spent by the 487 individual hospital respondents on potential community benefit expenditures was 8.8%. The

median percentage of total revenues spent on community benefit expenditures by all 487 hospitals was 5.4%.

5. The largest reported community benefit category was uncompensated care, which accounted for 56% of the total community benefit expenditures reported by the 487 respondents. The next largest reported community benefit categories, ranked as a percentage of total community benefit expenditures, were medical education and training (23%), research (15%), and community programs (6%).
6. The reported uncompensated care should be analyzed further to determine the extent to which it includes amounts for free or discounted care provided to persons across various demographics, including low-income populations, uninsured persons, and persons covered by Medicaid, Medicare, and other government programs. Until this analysis is completed, it is premature to conclude that the reported community benefit expenditure amounts, over half of which in the aggregate include reported uncompensated care, accurately portray the community benefit actually provided by the respondent hospitals.
7. Percentages of respondents reported to have engaged in various activities:
 - 76% of the respondents reported medical education and training expenditures.
 - 21% of the respondents reported medical research expenditures.
 - o Of these, approximately 90% reported they did not limit public access to the research findings, and 98% reported they did not limit public access to research findings or results for which they provided grants.
 - 30% of the respondents reported they conducted medical trials.
 - o Of these, approximately 83% reported they did not limit public access to the findings.
 - 97% of the respondents reported uncompensated care expenditures.
 - o The median percentage of patient visits that resulted in provision of uncompensated care was 3.46% and the mean average was 9.66%.
 - o Most (approximately 80%) of the respondents do not include shortfalls from private insurance or public insurance (the excess of gross charges over amounts received as payment) as uncompensated care.
 - o By contrast, a majority (51%) of the respondents considered the difference between the gross charge for a hospital service and the amount that an uninsured patient actually paid to be uncompensated care.
 - o 79% of respondents report uncompensated care to state officials.
 - Most respondents reported conducting one or more other types of community health programs, as follows:
 - o 28% reported expenditures to study the unmet health needs of the community;
 - o 40% reported immunization program expenditures;
 - o 54% reported expenditures for programs to improve access to health care;
 - o 75% reported expenditures for producing publications and newsletters;
 - o 76% reported medical screening expenditures;
 - o 77% reporting public educational program expenditures;

- o 32% reported expenditures for conducting other programs that promoted the health of the community.
- 8. 97% of responding hospitals reported they had a written uncompensated care policy. However, there was no uniform definition of “uncompensated care” or “charity care”. Most hospitals reported providing some free care to low income patients, many reported providing discounted care on a sliding income scale, and others reported providing discounts to the poor, uninsured, or other vulnerable persons. More than half of the respondents (56%) reported they did not include bad debt expense as uncompensated care. There appear to be differences in the reporting of other forms of community benefit as well.
- 9. Billing and collection practices
 - 481 of 483 respondents answered that they charged all patients the same price for the same services. 8 hospitals reported that they charged different prices based on factors such as type of insurance coverage or patient’s ability to pay. Narrative responses indicate, however, that respondents often accept less than 100% of the billed amount (gross charges) from many different categories of patients in complete discharge of their indebtedness.
 - The average number of days from the delivery of care to the date of billing was 13 days and the median number of days was 7.
 - The average number of days a patient had to pay after the billing date was 55 days, and the median number of days was 30.
 - Over 97% of respondents said that installment agreements were available to patients who were unable to pay the balance due immediately.
 - The average number of days before a hospital would classify a balance due as bad debt was 126 (with a median of 120 days), and the median number of notices sent to the patient before commencement of collection activities was 4.
 - Over 61% of hospitals referred all past due bills to collection agencies.

VIII. Interim Reporting Recommendations and Next Steps

The Project Team recommended the development of a schedule to the Form 990 that would enable a hospital to report activities that demonstrate its efforts to meet the community benefit standard.

It recommended that the schedule be developed in consultation with the sector to ensure that the requisite questions are present and that the terminology used is consistent with community usage and includes the questions necessary to permit hospitals to report the full range of appropriate community benefit activities.

It also recommended that the instructions accompanying the schedule provide clear, unambiguous guidance to avoid interpretive disparities from one hospital to the next, and to obtain more uniform and useful reporting.

The Project Team concluded that proper development and implementation of additional reporting requirements, via a hospital schedule, has the potential for providing the following benefits:

1. More consistency in how the various factors relevant to the community benefit standard are reported
2. Creation of a self-reporting mechanism which would enable the IRS to better define the universe of tax-exempt hospitals
3. Enhancement of the IRS' ability to properly administer its oversight responsibilities in this area by providing the IRS additional tools in identifying potentially noncompliant organizations
4. Greater transparency to the public

The redesigned Form 990 discussion draft released for public comment on June 14, 2007, contains Schedule H, *Hospitals*, which would require, among other things, reporting at cost the charity care and other community benefits provided by the filing organization. Schedule H also would require information regarding the organization's charity care policies, revenue profile, bad debt expense, collection practices, and certain other activities. The IRS is currently working with interested stakeholders on possible modifications and refinements to the proposed Schedule H and will also consider future analysis of data reported in this Project.

The Project will include the following next steps:

1. Analyze the reported data to determine whether differences in reporting, such as of the treatment of bad debt and shortfalls as uncompensated care, may be isolated and adjusted to allow more meaningful comparisons across the respondents.
2. Obtain additional research and analyze the differences in reported community benefit expenditure amounts to take into account varying demographics, such as rural and urban communities and hospitals.
3. Test the reported community benefit amounts and types by conducting data analysis, compliance checks or examinations of individual hospitals, and by other means, including with respect to outliers in the reported data.

APPENDIX A

Methodology, including Selection of Project Sample and Certain Information Regarding Questionnaire

Selection of Project Sample

In order to meet the pre-defined Project objectives, the determination was made that the Project sample should be composed of IRC 501(c)(3) hospitals. The first step was to query the Exempt Organizations Master File (EOMF) to isolate Foundation Code 12 (FC12) entities. The query excluded FC12 entities that had not filed Form 990 in their last two taxable periods. This additional filter was added to reduce the number of inactive and dissolved entities included in the universe. Our internal EOMF records do not contain the requisite entries that would enable us to identify a universe composed exclusively of hospitals. The universe we electronically identified (FC12) was composed of IRC Sec. 170(b)(1)(A)(iii) organizations. This universe includes not only hospitals, but also other medical care, education, and research organizations. The resulting query identified a universe of 6,002 entities. Since this number included both hospitals and other medical care, education, and research organizations, additional steps were necessary to isolate the hospitals. Due to the inclusion of non-hospitals in the FC12 universe and the manual process required to identify hospitals from the broader universe, the final sample is defined as a non-probability judgment sample rather than a probability sample. Consequently, any results obtained from the judgment sample cannot be projected to the entire universe of tax exempt hospitals. Findings are only reflective of the organizations that provided responses to the individual questions, and not every hospital responded to every question. As a result, where appropriate, the specific number of respondents is provided within the discussion.

The following is a description of the process utilized to identify a sample composed solely of hospitals from the FC12 universe:

- 500 entities were randomly selected from the universe of 6,002 tax-exempt FC12 medical organizations.
- The team checked all 500 organizations on this list to determine which organizations were hospitals. Other criteria about the retained organizations were also checked (see below). The team used the internet extensively to explore an organization's business activities. The organization's own website was the most commonly used source of this information. Other internet-based sources (such as databases about the hospitals in a particular state) were used when a website for the organization or its associated system was not available. In addition, a recent version of an organization's Form 990 was consulted in some cases.
- After the initial list was checked, approximately 265 organizations were confirmed as hospitals. Because of concerns with an unknown response rate, the Project team wanted a larger sample and requested a second randomly generated list.
- A second list of 2,000 randomly selected tax-exempt health care organizations was received. Some entries on this list of 2,000 overlapped the original list of 500.
- The team utilized the same search method and criteria as were used for the first list to isolate hospitals from the listing of 2,000.
- The final list consisted of 544 organizations that had been confirmed as hospitals.

The following reasons were used to exclude an organization from the final list:

- The organization was a clinic rather than a hospital. An organization that lacked overnight facilities and operated less than 24 hours per day was considered a clinic rather than a hospital.
- The organization was a medical research institute or grant making organization.
- The organization included more nursing home and assisted living beds than hospital beds.
- The organization had ceased operations (generally due to bankruptcy) and was disposing of its assets.
- The organization was a “public” hospital that was associated with a state or local government.
- The organization was a hospital holding company, but the hospital was operated under a different Employer Identification Number (EIN) and organization.

Issuance of Compliance Check Questionnaires

The Hospital Compliance Project cover letter, Form 4105 and Publication 4386, *Compliance Checks*, were included with the compliance check questionnaire package issued to the 544 organizations included in the Project sample. The EO Compliance Unit (EOCU) mailed 531 compliance check questionnaire packages and the remaining 13 organizations, which were already under examination, received compliance check questionnaire packages from the agent assigned to the examination.

Recipients of the compliance check questionnaire package were asked to submit their completed questionnaire to the EOCU in thirty days. The EOCU developed procedures for follow-up on non-responsive organizations. Talking points were developed for the EOCU and CAS to assist them in responding to inquiries about the Hospital Compliance Project and the processing of any questions received from organizations regarding the completion of the questionnaire.

Processing of Compliance Check Questionnaire Responses

As responses were received, EOCU personnel entered data from the questionnaires into electronic spreadsheets. The EOCU was responsible for transcribing the following information into the electronic spreadsheets:

1. All Part I – Organization data fields;
2. All checkbox and yes/no response data fields; and
3. All numeric data entry fields.

EOCU personnel were not responsible for transcribing data from respondent attachments or narrative fields.

The completed electronic spreadsheets were then forwarded to the Project analyst. The individual spreadsheets were then consolidated into a master spreadsheet, which was used to populate the data fields of the Project database designed to capture the questionnaire responses.

Hard copy questionnaires and attachments were mailed to the Project team in Chicago to be screened for examination potential. Copies were made in Chicago and complete files were forwarded to the R&A Project Team for more comprehensive analysis.