NOT-FOR-PROFIT VS FOR-PROFIT HOSPITALS IN METRO ATLANTA

COMPARATIVE ANALYSIS OF TAX STATUS AND COMMUNITY BENEFIT

BY

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PROJECT SUMMARY

INTRODUCTION

The study compared Community Benefit across not-for-profit and for-profit hospitals in the Atlanta Metropolitan Statistical Area (MSA). The reason for choosing this market is due to availability of a good representative sample of both types of hospitals in this MSA, and being a resident of Georgia, I was interested to find out the behavior of the two types of hospitals.

The importance of the project stems from:

- Growing controversy and opinions about Community Benefit and how much not-for-profits should provide, above for-profits, to continue to enjoy tax exempt status.
- Various tax exemptions in 2002 were estimated to be $12.6 billion according to Congressional Budget Office (CBA. 2006). Federal and others equal half the share.

The analysis of the data revealed that (Appendix P1, P2, Q1, Q2 and Z):

- Without tax components, not-for-profits provide a higher percent of net revenue as Community Benefit over the for-profits.
- With federal, state and local taxes included, the for-profits did much better in Community Benefit provision.
- A significant amount of federal, state, and property taxes are lost from not-for-profit hospitals, which can be used to provide more Community Benefits.

METHODS

Data Sources & Analysis

- Income statement components and cost/revenue components of the variables used in the calculation of Community Benefit were obtained from Medicare Cost Report.
- Tax rate components were obtained from corporate offices of the for-profits.
- Each hospital's Community Benefit component was calculated as a percent of net revenue and the overall Community Benefit was calculated.
- The study focused initially on 17 not-for-profit and 7 for-profit hospitals, in Atlanta Metropolitan Statistical Area (MSA)
- The variables relating to Community Benefit were: patient revenue, margins, uncompensated care, and shortfalls in SCHIP, Medicaid, and Georgia Indigent Care Program (GICP).
- The study expanded to include all the 27 not-for-profit and 9 for-profit hospitals.
- Both approaches grouped the hospitals into five revenue sizes and compared the Community Benefit of the two groups.

- Revenue sizes: 1. Under $100million, 2. $100million-under $250million, 3. $250 million-under $500million, 4. $500million-under $1billion, and 5. Over $1billion

Community Benefit Definition

- A planned, managed, organized, and measured approach to a health care organization's participation in meeting identified community health needs.
- Of special significance is to benefit its residents-particularly the poor, minorities, and other underserved groups-by improving health status and quality of life (CHA. 2006).

Community Benefit meets at least one of the following criteria:

1. Generates a low or negative margin
2. Responds to needs of special populations, such as minorities, frail elderly, poor persons with disabilities, the chronically mentally ill and persons with AIDS, and
3. The services or programs would likely be discontinued if the decision were made on a purely financial basis.

LIMITATIONS

Some or all of the following might have a material impact on the study results:

- The results are with no adjustments for variables in demographics and facility characteristics.
- This study calculated results by neglecting overpayments for government programs.
- No uniform methodology for calculating Community Benefit at this time because some facilities use cost accounting method while others use a cost-to-charge ratio.
- Variations in the way organizations define, measure, and report Community Benefit components.
- This variation may reflect certain inaccuracies in the data, which is not easy to separate and compare uniformly across the two types of hospitals.
- A variable not used is sales tax, which for-profits pay. If this were obtained, this would add to the Community Benefit of for-profits above that of not-for-profits.
- Also, if the actual tax amounts would have been provided by for-profits, the Community Benefit calculations would be more accurate.

RESULTS (APPENDIX P1, P2, Q1, Q2, AND Z)

In the first sample, using the selected hospitals, it was found that:

- Without tax not-for-profits provided 7.67% average Community Benefit and for-profits, 5.83%; a difference of **-1.84% in favor of the not-for-profits**.
- With tax of 4.8%, not-for-profits provided the same 7.67% while the for-profit share increased to 10.63%, a **+2.96% difference in favor of the for-profits** .

- Factoring negative income and margins (Appendix P & Q), and at 2.74% tax rate for-profit share declined to 8.57% a **+0.90% difference in favor of the for-profits**.

In the second sample, including all the hospitals, the following results were found:

- Not-for-profits provided reduced Community Benefit of 6.60% in comparison to 5.63% provided by for-profits, a difference of **-0.97% in favor of not-for-profits**.
- With tax rate of 4.8, not-for-profits provided the same 6.60% while the for-profit share increased to 10.43%, a **+3.83% difference in favor of the for-profits.**
- Factoring negative income and margins (Appendix P & Q), and at 2.74% tax rate for-profit share declined to 8.37% a **+1.77% difference in favor of the for-profits**.

CONCLUSIONS:

In both samples, the selected and entire list, (Appendix Z):

- Without tax, the not-for-profits provided more Community Benefit in comparison with the for-profits, i.e. 1.84% and 0.97%
- In the selected study sample, with the two tax rate scenarios of 4.8% and 2.74%, for-profits provide a higher Community Benefit of 2.96% and 0.90% respectively.
- In the entire hospital study sample, with the two scenarios, the Community Benefits increase in the for-profits to 3.83% and 1.77% respectively.

In both samples, the selected and entire list, (Appendix P1, P2, Q1 & Q2)

- The taxes saved by selected not-for-profits are $66.9 million federal, $17.2million state, and $16.3million property. These are large Community Benefit resources.
- The taxes saved by all not-for-profit hospitals are $115.6million federal, $29.7million state, and $22.6million property. Once again large Community Benefit resources.

Subject to the limitations above, the results show significant difference in Community Benefits provided by not-for-profit and for-profit hospitals in the Atlanta MSA. It can be argued that Community Benefit is a local issue and the impact of this loss, should be considered without the federal component. Federal government does contribute matching dollars towards state Medicaid payments, and so is an important tax burden that for-profits provide. Even without the federal component, if only the state taxes (income and sales), and local property tax, are factored in the for-profits would still provide higher Community Benefit. Unfortunately, though, a large sales tax burden which for-profit hospitals bear is difficult to factor in as this information was unavailable and was not included in the analysis.

INTRODUCTION

CHARITY CARE & TAX EXEMPTION

Not-for-profit hospitals are considered 501(c) (3) organizations by the Internal Revenue Service. This designation provides several benefits including exemption from federal taxes, qualification for tax-exempt bond issue, and the ability of donations to be tax deductible (Ferris et al. 1999; IRS 1069). These tax advantages provide significant financial support to not-for-profit hospitals in their delivery of care. They also provide a means of indirect subsidization to not-for-profit hospital organizations that are supporting charity care (End Notes[3]). To qualify and maintain their tax-exempt status, not-for-profit hospitals must have a charitable mission, provide charity care, relieve the government of a health care burden, and operate without a profit motive (Chestek. 2000; IRS 1969).

For tax-exempt organizations, benefiting the community is the reason for existence(End Notes[3]). Without it, these organizations may as well be taxable entities (Figure 1; End Notes[3]). The social cost of tax exemption is earned through broad-based community benefit. So, while the reporting burdens created by the new Internal Revenue Service (IRS) Form 990, and accompanying schedule, schedule H, are daunting, it is critical that the words and numbers reported reflect the essence of what the organization is trying to accomplish (IRS. 2009). There are several ways in which hospitals give back to their communities, including services that generate little or no revenue, such as emergency, burns, neonatal, and trauma care; health fairs & free screenings; support of clinics that provide care for the indigent, such as cancer clinics; health and wellness programs; and other initiatives that improve community residents' health (CBO. 2006; AHA. 2006). Many of these activities are common among both not-for-profit and for-profit hospitals. These charitable endeavors meet the healthcare needs of residents, particularly those who otherwise would be unable to afford such services, and enhance quality of life for the entire community. Charity care is just one example of the community benefit that hospitals provide (IRS. 1969; AHA. 2006; AHA. 2005)

According to Becker and Potter (2002), the social responsibility of the not-for-profit charitable mission becomes a threat to the organization when the risk of community care reduces

hospital efficiency. As not-for-profit hospitals struggle to remain competitive and financially viable, their ability to continue to make decisions consistent with their values is seriously threatened. According to Metcalfe (2002), the growing commercialization of health care, the intense competitive pressures, and the reduced support from the government are stretching the ability of many not-for-profit hospitals to meet their communities' needs (GAO. 2008).

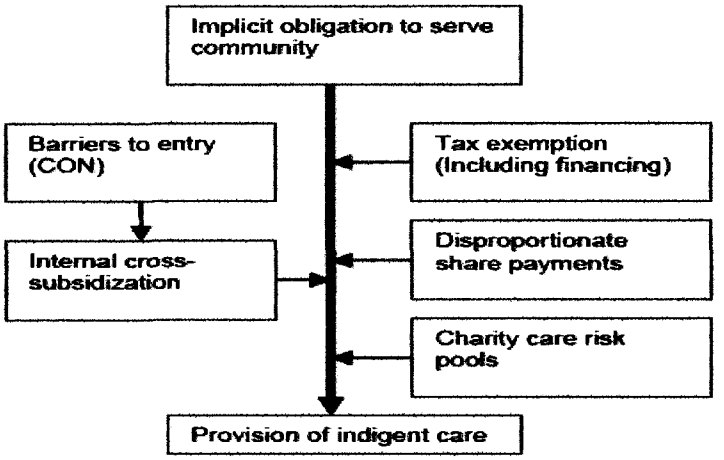
Tax exemption is perhaps the most widespread subsidy provided to non-profit general hospitals. Non-profit tax status allows hospitals to avoid property and income tax (federal & state) in exchange for an obligation to serve the community (GAO. 2008). However, Kane and Wubbenhorst (2000) found that the amount of charity care provided by hospitals is significantly less than the amount of tax benefit accrued through non-profit status (End notes[4]; Kane. 2004). Thus, even if tax exemption were the only means for hospitals to fund indigent care, the amount of the benefit on average appears to be more than sufficient to fund prevailing levels of indigent care.

Indigent Care and Cross-Subsidization

The indigent care issue has several components. The first issue has to do with the practice on the part of general hospitals to meet their implicit obligation to serve the community by cross-subsidizing low-margin services with high-margin services combined with other government subsidies (End notes[3]), including as Disproportionate Share Hospital (DSH) payments, and revenues to cover some of the shortfalls such as State Children Health Insurance Program (SCHIP), Medicaid, and State Indigent Care Program (in this study Georgia Indigent Care Program-GICP) (Lewin et al. 2000). Many of the former state rate regulation programs were explicitly designed to help acute care hospitals meet these obligations; however, all but one of the state rate regulation programs were dismantled during the 1990s (Fournier and Campbell 1997; Schneider 2003). In the absence of state rate regulation, hospitals have relied on six other mechanisms to pay for unprofitable services (Figure 1): (1) tax-deductible donations, (2) tax-exempt bond financing, (3) exemption from income and property taxes, (4) internal cross-subsidization, (5) Medicaid disproportionate share payments (additional payment for treating a

disproportionate share of Medicaid patients), and (6) state-administered charity care risk pools (Lewin et al. 2000).

Figure 1
Non-Profit General Hospital Methods for Funding Indigent Care



Tax-Exempt Status & Community Benefit Federal Standard

The federal government bases a hospital's tax-exempt status on whether it meets the "community benefit standard" articulated by Revenue Ruling 69-545, issued by the IRS in 1969 (IRS. 1969; Levenson. 2008). Chief among the revenue ruling's requirements are that hospitals must:

* Accept and treat Medicare and Medicaid patients
* Open their emergency departments (EDs) to all people, regardless of their ability to pay
* Have an open medical staff that allows credentialed physicians to practice at their facilities
* Operate under a community board's control

Needless to say, with these guidelines and expectations, there is no acceptable and mandated standard or framework as to what constitutes Community Benefit and as to how to report these accordingly, to maintain tax exemption. The only existing and accepted guideline and the one that forms the basis of all reference is what is advocated by the Catholic Health Association (CHA), (CHA. 2006). The IRS is hopeful that its February 2009 report: IRS Exempt

Organizations Hospital Compliance Project Final Report, and the new IRS Form 990 Schedule H, which was developed as a result, would enable all not-for-profit hospitals to comply with the reporting requirements (IRS. 2009). It would also benefit law makers and federal agencies involved with attacking and questioning not-for-profit commitment to Community Benefit to also adopt a policy that would require for-profits to also report in this form, so that meaningful and more accurate comparisons can be drawn between the two groups of hospitals.

The Need for a Clear Definition

Although tax-exempt hospitals are different from taxable hospitals in many distinct ways, the former hospitals have not always done a good job articulating those distinctions in the public domain, through the annual filing of the IRS Form 990, which are publicly accessible documents (Levenson. 2008). Based on what's currently transpiring at the federal level, the government does not seem ready to change the community benefit standard that not-for-profit hospitals use to obtain or keep their tax-exempt status. The Form 990 revision, however, does give an indication about the government's mood (IRS.2007; IRS. 2009). These forms will now disclose in the public domain what hospitals are doing to meet their community benefit obligations. Although the federal government has not yet issued a standard that articulates a minimum charity care or community benefit requirement, putting hospitals' data on publicly accessible forms will increase people's examination of them (IRS.2007; IRS. 2009). As hospitals draw public attention, the organizations that appear to be neglecting their community benefit obligation will be subject to criticism not only from the public, but also from lawmakers who are in the position to change the law (Levenson. 2008).

The Problem of the Uninsured

Providing health care to people who have no health insurance is a factor that significantly complicates the community benefit issue. Health care for the uninsured is an issue that leading Senate Finance Committee members strongly advocate, and it is a vastly greater issue than charity care itself (GAO. 2008; Levenson. 2008). Most tax-exempt hospitals maintain charity care policies targeted to low-income individuals whose income falls below three to five times the federal poverty guidelines for the community in which they live (Levenson. 2008). Uninsured

individuals who fall within Medicaid or Medicare guidelines or within a hospital's charity care guidelines will qualify for free or discounted health care at virtually all tax-exempt hospitals. But a critical segment of the uninsured population still remains unaccounted for (U.S. Census Bureau; GAO. 2005. Levenson. 2008). This segment, the largest segment of the uninsured, in fact, is a group often called the "working uninsured." Most of the working uninsured would fail to satisfy a hospital's charity care guidelines, at least upon their initial need for hospital services (Levenson. 2008). At some point, an employed but uninsured individual could drop into an income or asset bracket in which he or she would qualify for charity care under a hospital's guidelines (Levenson. 2008). But such a change could not always be expected to occur, and in most cases, such individuals will neither qualify for charity care nor fall within the Medicaid guidelines either. Some individuals may fall within Medicare guidelines, but few of the working uninsured will be old enough to meet these guidelines (Levenson. 2008).

PROBLEM STATEMENT

There is increased concern in Congress, individual states and communities, that not-for-profit hospitals are not providing enough charity care that would justify their tax exempt status. The social contract that not-for-profit hospitals have undertaken on behalf of their respective communities and the reciprocal enjoyment of tax subsidies are under attack. It is a multi-faceted onslaught that has been occurring over the last 18 to 24 months (CBO. 2006; GAO. 2005; GAO. 2008; IRS. 2009). What we've begun to see is a focus on the obligations of not-for-profits, and what they need to give back to the community in exchange for the tax breaks they receive. With such an onslaught comes the inherent issue of whether tax exempt status for not-for-profit hospital is an unfair advantage. This is especially significant when comparing its charity care cost and community benefit cost share of patient revenue, marker share or total costs, over that of a for-profit hospital. In addition there is still no consensus in qualifying what constitutes community benefit, so that a uniform and standardized reporting format can be followed by hospitals (IRS. 2009; GAO. 2008; CBO. 2006).

The new IRS form 990 attempts to fill this gap, but there is no clear cut framework, and no consensus, which allows and obligates not-for-profit hospitals to breakdown and report their

community activities and relate them to their revenues and cost structure in order to be allowed to operate tax free. Not-for-profit hospitals have been granted tax exemptions at the local, state and federal levels (GAO. 2008). These exemptions allow hospitals favorable interest rates on bonds, and also allow favored treatment against paying property tax, corporate income tax and sales tax (GAO. 2008). This provides huge savings to these hospitals, and allows them to project greater earnings. In return, state and federal governments expect hospitals to provide a significant amount of community benefit mostly in the provision of charity care to its citizens in need (IRS. 1969; IRS. 2009; CBO. 2006; GAO. 2008). The provision of community benefit by these hospitals is helpful because it relieves the government of this burden. However, questions are now being raised about whether not-for-profit hospitals are really doing enough, in comparison with for-profits (Reference is made to Senator Charles Grassley's communication, which formed the basis for GAO's study (GAO. 2008). In general the questions want to know if the amount hospitals give to their communities is enough to justify the significant benefit the government has conveyed to them by granting them a tax exemption. It is recognized that for-profits pay corporate income taxes (federal & state), and state sales and property tax, while the non-profits enjoy these exemptions. This study provides a comparative analysis of the hospitals in the Atlanta Metropolitan Statistical Area (MSA) of the behavior of these two types of hospitals with regards to their Community Benefit commitments.

Congress and states are increasingly concerned about this problem and are demanding that non-profit hospitals fulfill their charity care obligation (GAO. 2008; IRS. 2009; CBO. 2006). The only accepted national standard for charity care is the Catholic Health Association guidelines, which has been rewritten and revised in 2005, as to how much care must be given by not-for-profit hospitals to fulfill this obligation (CHA. 2006). The American Hospital Association has come up with its own framework, obviously to support and protect its hospital members and stifle the national movement towards revisiting the issue of tax exemption (AHA. 2006). This is one of the biggest problems facing the industry as a whole as there are renewed attention to review tax exempt status, amidst high expectations of hospitals to provide charity care.

As I study this problem and attempt to answer my research questions, my suggestion is to come up with a formula of a benchmark target, above what for-profits provide as Community Benefit. If not-for-profits just catch up with the for-profits in terms of the percent of net revenue of Community Benefit, they behave as pure for-profit entities. The benchmark target I propose is a certain percentage range over the for-profits' Community Benefit provision, say 3% to 5%, which should be able to justify continued tax exemption.

This study attempts to find out which group provides greater community benefit, by comparing the these two types of hospitals in the Atlanta MSA from available data. The findings should shed some light on how the Atlanta MSA is functioning in relation to Community Benefit expectations of the policymakers, reimbursing and taxing federal agencies and the public, in general. The discussion and conclusion would serve the objective of coming to terms with this problem statement for the identified Atlanta MSA.

REASONS FOR THIS STUDY

Not-for-profit hospitals act as social columns that support the health care for millions of Americans. As a result, not-for-profit hospitals serve a population of individuals that are not normally profitable within the private health care sector. Frequently, the effectiveness of not-for-profit hospitals is measured by the degree to which the institution provides services to indigent patients and offers services that are unprofitable or result in a disproportionate share of bad debts and face increasing shortfalls in Medicare, Medicaid, and SCHIP programs (GAO. 2008; CBO. 2006; IRS. 2009). There is also the issue of what other community activities can qualify as community benefit. This study is undertaken to review existing literature and previous research and find out whether not-for-profit hospitals are justifying their tax-exempt status in meeting their community obligations in comparison with their for-profit peers in the Atlanta MSA.

The latest wave of controversy in the hospital sector has risen from questions about whether the levels of charity care and community benefit provided by not-for-profit hospitals are consistent with their tax-exempt status. First, in June 2004, the U.S. Congress held three hearings to examine hospital business practices, tax status, charitable activities, and alleged aggressive billing practices (Fong and Tieman 2004). State and local property tax authorities also

began to review hospital tax exemptions at the local level. In Illinois, the Department of Revenue denied property tax exemption to at least one hospital and is reviewing other not-for-profits in the state (Appleby 2004). Second, between June and August of 2004, more than 40 class-action lawsuits were filed against not-for-profit hospitals, alleging that the overly aggressive billing and collection practices of these hospitals were in violation of their tax-exempt status (Appleby 2004). In a growing wave of litigation and scrutiny, critics charge that modern not-for-profit hospitals and healthcare systems fail to qualify for charitable status under state and federal laws. A battle is brewing over the legal status of not-for-profit hospitals and healthcare systems. The opening salvo was fired in the summer of 2004 when plaintiffs' attorneys, led by The Scruggs Law Firm of tobacco litigation fame, filed federal class-action lawsuits in eight states against roughly a dozen not-for-profit hospital systems (Webcast. 2006). The suits alleged that the not-for-profit institutions had violated their "explicit or implicit contract" with the federal government to serve uninsured patients, in return for significant tax breaks. These not-for-profits, the suits claimed, had charged uninsured patients "premium" rates even though insurers, Health Maintenance Organizations (HMO) and government programs paid steeply discounted rates (Webcast. 2006). Some suits also cited aggressive billing and collection tactics, including placing liens on homes and assessing interest, fines and legal fees (Webcast. 2006). In the wake of this litigation, other parties across the country quickly stepped up their scrutiny of not-for-profit healthcare organizations (CBO. 2006; GAO. 2005; GAO. 2008; IRS. 2009). In May 2004, the Internal Revenue Service (IRS) announced that it was unveiling an enforcement program that will scrutinize not-for-profit organizations that violate tax laws (McLaughlin 2004).

Community advocates, state and municipal tax commissions, and state attorneys general all began asking one central question: Are charitable hospitals living up to their stated mission of providing charitable care to all who need and apply for it? The follow up questions want to know if the proportion of charity care at least equals that provided by taxable, for-profit hospitals, plus their tax exempt amount, as a benchmark to maintain tax exemption. What we've begun to see is a focus on the obligations of not-for-profits, and what they need to give back to the community in exchange for the tax breaks they receive, (Webcast. 2006).

It is uncertain to what end Congress will pursue its inquiry, but this much is clear: Continued governmental scrutiny of hospitals' tax-exempt status is not going away anytime soon (Levenson. 2008). Washington D.C. is exhibiting a heightened sensitivity for budget scrutiny, and with funds for discretionary programs scarce, Congress is spending money on a pay-as-you-go basis. With dwindling tax revenue available, the House and Senate tax-writing committees are vigorously watching tax dollar use. That is why tax-exempt hospitals must be prepared to justify their tax status, (Levenson. 2008).

BACKGROUND

Ownership Forms

The hospital industry in the United States includes a mix of ownership forms. Nonprofit hospitals are the most common type, but for-profit and government hospitals also play substantial roles (End Notes[5]). Of the 630,000 beds in Medicare-certified community hospitals in the United States in 2003, 68 percent were located in nonprofit hospitals, 16 percent were located in for-profit hospitals, and 15 percent were located in government (nonfederal) facilities (CBO. 2006).

Differences in Ownership Structure

Ownership of a business entity entails the right to direct the operations of that business and the right to receive its profits. Like for-profits, not-for-profit hospitals have governing boards that guide their operations. And, like for-profits, nonprofit hospitals may earn surpluses or accounting profits, meaning an excess of revenues over expenses (CBO.2006). But not-for-profits face a "nondistribution constraint," which means that they do not have shareholders and may not distribute surpluses to managers, individual owners, or members of the governing board. Surpluses generated by not-for-profit hospitals' activities are expected to be reinvested in the hospitals' operations rather than distributed to individual owners (CBO.2006).

HISTORICAL PERSPECTIVES

Hospitals began as charitable institutions supported solely by donations to provide comfort for those who could not afford personal medical care. This beginning established a strong heritage of charity care for hospitals and was the driving factor in the original designation of private not-for-profit hospitals as tax-exempt organizations by the IRS (IRS 1956). However, with

the evolution of medical technology in the early twentieth century, the need for collective resources moved medical care away from the home and into the hospital, as advanced treatments necessitated the pooling of resources in a common arena of care (Burns 2004). This evolution spawned both public and private interests attempting to fill the needs of respective communities (Burns 2004).

Historically, public hospitals have relied on tax revenue for monetary support, while private for-profit hospitals have relied on earnings and securities for capital needs. Conversely, private not-for-profit hospitals have depended on charitable donations and governmental grants for capital in exchange for providing free or below-cost care to the indigent (Roska 1989). Yet sustained advances in medical technology and the corresponding evolution in the acceptable standards of care over the past century have created capital needs greater than those received from government and charitable funding sources. This has forced most not-for-profit hospitals to seek out alternative funding sources, increase operating efficiency, and reinvest "net income" (or increase in net asset) to continually provide an acceptable standard of care to all patients (Wood. 2001). However, as not-for-profit hospitals have continued to evolve, the government has continued to question their tax-exempt status (Wood. 2001; GAO. 2008; CBO. 2006).

One justification for the tax-exempt status of nonprofit hospitals is the amount of uncompensated or unreimbursed services they provide to residents of the community they serve. However, while the volume of unreimbursed care may have been larger, it is unclear that these hospitals still provide a level of uncompensated care that is significantly greater than that provided by for-profit hospitals. In addition, there is some concern that a larger portion of disproportionate share payments have been flowing to hospitals which have not been the traditional "safety net" hospitals (Seidman. 1998). Also, if differences in charity care provision among the two types of hospitals are less pronounced, there is a rationale for nonprofits' tax-exempt status to be questioned, as is the recent aggressive trend (GAO. 2008).

Taxpayers yield the right to collect taxes on not-for-profit hospitals in exchange for a quasi-ownership stake in their assets. The premise is that not-for-profit hospitals are deemed community assets due to the favorable tax treatment and subsidization received. Net income that

exceeds a level necessary to operate the business must be reinvested in the organization and must not directly or indirectly benefit any private shareholder or individual (Becker et al. 2002). Based on their role as community assets, not-for-profit hospitals are considered a public good and the provision of charity care is an organizational requirement. According to economic theory, public goods are generally not produced in sufficient quantities within competitive markets due to cost and a limited level of financial resources. Not-for-profit hospitals that supply public goods are providing a community benefit to receive state tax benefits. These benefits vary significantly among states and jurisdictions (Nicholson et al. 2000; GAO. 2008).

Metcalfe (2002) also suggests that not-for-profit institutions place a higher priority on research and Medical training, which may be deemed public goods. As a result, not-for-profit institutions invest in the capital, personnel, and other resources required to support public goods. Many not-for-profit organizations are willing to invest in these types of activities because it facilitates their missions, adds prestige, and results in higher patient volumes that may lead to an increased market share. There is however no consensus on whether medical research and training of facility personnel qualify as Community Benefit, other than the current, accepted, CHA qualifying guidelines (CHA. 2006).

The charitable mission of a not-for-profit hospital is a primary driver for hospital operations to ensure continued receipt of favorable tax treatment (IRS. 1956; IRS. 1969; IRS. 1983). Charitable missions are increasingly being challenged as not-for-profit organizations struggle to adapt to increasing expenses and lower reimbursements, as the aging population continues to expand and public and private health insurance continues to reduce hospital compensation. The growing aging population coupled with the higher cost of private health insurance is significantly increasing the need for uncompensated care. According to Metcalfe (2002), more than 39 million Americans are uninsured while millions more are underinsured. This number was as high as 47 million in 2005, and is a growing strain on the healthcare delivery system (U.S. Census Bureau. 2006; GAO. 2005), as these individuals are more likely than insured individuals to rely on hospital emergency rooms for medical care (GAO. 2005). Some of these individuals with serious illness or injuries are admitted as inpatients to the hospital,

incurring substantial treatment costs (IOM. 2003). Because uninsured individuals may lack the ability to pay for their medical care, hospitals absorb some of the costs associated with providing uncompensated care, either through a charity care program or as expenses written off as bad debt (End Notes[13]).

Given the benefits available to tax-exempt hospitals, policymakers have been interested in determining the extent to which hospitals share the burden of caring for uninsured individuals. This is compounded by the impact of double-digit increases in health insurance premiums and the continual expansion in the number of Medicare beneficiaries. According to Morrisey (2001), as managed care penetration rises, not-for-profit hospitals are less adept at managing expenses and are forced to care for more elderly Medicare patients and absorb more uncompensated care. This issue becomes further complicated because society may not be valuing the services provided to Medicare and Medicaid patients, as evidenced by low reimbursement rates for their care (Nicholson et al. 2000). While voters conceptually support the provision of elderly and indigent care, the Balanced Budget Act (BBA) of 1997 is evidence that this verbal support does not translate into adequate hospital reimbursement rates (Stensland et al. 2002). Although the BBA of 1997 succeeded in curtailing the rate of growth in Medicare expenditures, it placed tremendous pressures on nonprofit hospitals. Nonprofit hospitals may see similar numbers of Medicare patients as their for-profit counterparts but lack alternative revenue streams to offset the decreases in Medicare reimbursement (Stensland et al. 2002). This is particularly true of small, rural hospitals that do not have the economies of scale available to spread fixed cost across multiple lines of business (Stensland et al. 2002). The federal government relatively quickly realized the extent of damage that was being inflicted on these institutions and enacted the Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000 to increase the reimbursements to hospitals (Stensland et al. 2002). According to Stensland et al (2002), despite these increases in hospital compensation, small rural hospital profit margins declined 9.8% from 1998 to 2002. In the 2005 GAO report: 21st Century Challenges: Reexamining the Base of the Federal Government, ensuring that all Americans have access to a

defined minimum core of essential health services and allocating responsibility for financing such services are identified as major health care challenges for the 21st century (GAO. 2005).

EVOLUTION: HOW WE GOT HERE

Not-For-Profits and For-Profits

Historically, not-for-profit hospitals were largely funded by donations within the geographic areas they served. As this source of revenue decreased and the pace of technological change increased, not-for-profit hospitals were required to focus on additional means of raising capital to continue operation and acquire enhanced technology. As a result, many not-for-profit hospitals have converted to for-profit legal status to raise the capital required for operations and expansions (Young & Desai. 1999). These not-for-profit hospital entities have departed from their original charitable mission and now behave in a less socially responsible manner (Phillips. 1999). As discussed by Ferris and Graddy (1999), not-for-profit hospitals are responding to organizational and market challenges by modeling the for-profit hospital industry and are operating more like publicly held companies, which will probably benefit the community, as my study shows that for-profits do provide more Community Benefit than their not-for-profit counterparts. One of the main reasons for this phenomenon is that for-profit facilities are accountable to their corporate oversight and as such operate at much higher effectiveness, efficiency and economies of scale. Also their main responsibility is to churn out higher margins and increase shareholder wealth, which they seem to succeed in addition to providing higher Community Benefit. Hence, for-profit entities generally have to operate at higher levels of operating efficiency. Not-for-profit hospitals will be forced to adapt by implementing for-profit business practices to ensure survival, if their Community Benefit provision does not match for-profits' provision. If and when this landscape is reviewed across the entire country, and if further research provided new evidence that not-for-profits indeed fail in their commitment to serve their community, not-for-profits will face stricter mandates and regulations, and possible penalties and threats of loosing tax exemption. Young and Desai (1999) found that many not-for-profit hospitals are looking to for-profit companies for financial resources and management expertise. This frequently involves maximizing revenues from payers while curtailing expenditures.

There are many provisions within the prospective payment system to adjust payments for rural entities, teaching hospitals, and catastrophic cases, yet despite these adjustments and the budget refinements of 1999 and 2000, many hospitals continue experiencing declining profitability. As a result, many not-for-profit hospitals must generate larger amounts of cash to pay obligations and continue operation. For-profit entities by contrast have several avenues available to raise capital including the sale of stock. According to McCue et al (2000), many not-for-profit hospitals lack the capital to support their operations, provide charity care, and replace plant equipment. The Balance Budget Act (BBA) of 1997 and reductions in Medicare funding have negatively impacted the ability of not-for-profit hospitals to remain financially viable. It has also placed not-for-profit hospitals in a situation where marginal costs exceed marginal revenues. To ensure the continued viability and solvency of the institution, many not-for-profit hospitals are taking decisive actions. Unfortunately, many of these actions, which are critical to ensuring its survival, are not consistent with the not-for-profit hospital's mission. As discussed by Phillips (1999), not-for-profit hospitals act as social columns that support the health care for millions of Americans. As a result, not-for-profit hospitals serve a population of individuals that are not normally profitable within the private health care sector. Frequently, the effectiveness of not-for-profit hospitals is measured by the degree to which the institution provides services to indigent patients and offers services that are unprofitable or results in a disproportionate share of bad debts. The key challenge for not-for-profit hospitals is to maximize the efficiency of operations while furthering their charitable missions.

When evaluating the differences between not-for-profit and for-profit hospitals, the level of services provided to diverse patient populations provides insight into their divergent missions. Care for the medically indigent is generally termed uncompensated care and represents those services provided to patients for which there is no expectation of payment. This is different than bad debts resulting when care was provided with an expectation that payment would be made and subsequently became uncollectible. Not-for-profit hospitals are expected to provide higher levels of uncompensated care in the community with a particular focus on improving the health status of the most vulnerable members of their communities, especially the uninsured,

underinsured, children, elderly, minorities, disabled, and economically disadvantaged (Metcalfe. 2002). As not-for-profit hospitals increasingly support these communities, the solvency of the organization is often threatened. According to Nicholson et al (2000), not-for-profit hospitals have higher operating expenses, provide more care to Medicare patients, and do less cost shifting among payer types than their for-profit counterparts.

Government Role in Healthcare Delivery

The establishment of Medicare and Medicaid as reimbursement sources substantially reduced the amount of charity care provided by hospitals, as a significant portion of a hospital's charity care was provided to patients who were now covered by either Medicare or Medicaid (Burns 2004). The institution of these programs further emphasized the need for not-for-profit hospitals to maintain their tax-exempt status through the benefit they provide to the community as a whole. The Community Benefit standard continues to be the standard that the IRS uses to classify not-for-profit hospitals as charitable organizations at the federal level (IRS. 1952; IRS. 1969; IRS. 1983). Similarly, state and local governments also use the Community Benefit standard as one of the deciding factors on whether to exempt hospitals at the state and local levels (Burns 2004). As evidenced by the information above, not-for-profit hospitals have a strong heritage of providing community-based charity care. However, as the government has become increasingly involved in the public's procurement of care, not-for-profit hospitals have been repeatedly forced to redefine their role in the community. These redefinitions, along with various market changes, have catalyzed the evolution of not-for-profit hospitals from charitable institutions to tax-exempt businesses whose charitable basis is so hotly debated.

Community Benefit standard

In 2005, Congress began shining a light on the topic and began to probe whether tax-exempt hospitals and health systems were benefiting their communities enough to earn tax exemption (Levenson. 2008). Soon after, the media picked up the story and made it national news. Several lawsuits challenging tax exemption for hospitals that employed aggressive collections tactics against uninsured patients brought unfavorable media attention, and the Senate Finance Committee called hearings on the matter (Levenson. 2008). Some committee

members started urging the IRS to better enforce the current Community Benefit standard, which justifies the tax exemption. At the same time, committee members encouraged the IRS to consider whether the Community Benefit standard, which has not been changed since 1969, needed a revision (IRS. 1969; Levenson. 2008). In testimony before the Senate Finance Committee, one not-for-profit hospital industry association, the Catholic Health Association (CHA), articulated its approach to quantifying Community Benefit, charity care, and shortfalls in means-tested government programs, like SCHIP, Medicaid, and state indigent care programs (CHA. 2005). Many not-for-profit hospitals already comply with the CHA's standard, and it is the one for which influential committee members expressed a preference (CHA.2005).

The American Hospital Association (AHA) promotes an alternative standard, which aligns with the CHA's standard, but has its expanded version to benefit its member hospitals (AHA.2006). Unlike the CHA, the AHA believes community benefit quantification should include both bad debt (i.e., unrealized revenues from patients who fail to pay their medical expenses) and Medicare cost shortfalls (i.e., the gap between Medicare program costs and reimbursements), among others. According to generally accepted business norms and accounting standards, bad debt is considered a cost of doing business, and not included in study.

Testing the bounds of what might be considered community benefit, the IRS sent three-part questionnaires to more than 500 randomly selected, tax-exempt hospitals in 2006 (IRS. 2007). The questionnaires asked the hospitals to provide general organizational information, operations information, and executive compensation information. The IRS said the data hospitals returned would form the basis of a revised Form 990, the annual information return for tax-exempt organizations (IRS. 2007). Around the same time the IRS sent its questionnaires, the AHA commissioned Ernst & Young to study AHA members' responses to the IRS questionnaire (E & Y. 2007). This study reviewed that, of the nearly 120 questionnaires disclosed, AHA member hospitals participating in the project appeared to meet the existing Community Benefit standard. By contrast, the IRS's own 2007 Hospital Compliance Project Interim Report did not conclude whether reporting hospitals were meeting the current community benefit standard (IRS. 2007). The review of the final report data by the IRS, however, did appear consistent with

the information reviewed by the AHA study to reach its conclusion, taking into account the different sampling sizes (IRS. 2009).

In the spring of 2007, the IRS issued a draft redesigned Form 990, which the agency last overhauled in 1979 (IRS. 2007). Piecemeal changes made to the form in the nearly 30 ensuing years did not, according to the IRS, sufficiently keep pace with changes in the tax-exempt community or the law. The Form 990 redesign seeks to accomplish three things, 1. Provide a more realistic picture of an organization's operations and a better basis for comparison among organizations, thereby enhancing the filing organizations' transparency, 2. Promote compliance with an accurate reflection of an organization's assets and its use of those assets, and 3. Minimize filing burdens and avoid unwarranted recordkeeping and reporting through the use of plain language (IRS. 2007; Levenson. 2008). The revised Form 990's Schedule H addendum (Appendix W) attempts to provide tax-exempt hospitals with a method for quantifying their Community Benefit based on the Catholic Health Association (CHA) standard, while also offering them the opportunity to describe, in words, other ways in which they benefit their communities (IRS. 2009; Levenson. 2008). Although portions of the revised form will be phased into use over the next two years, the form is scheduled to be in effect for tax years beginning in 2009 (IRS. 2008; IRS 2009).

An Uncertain Regulatory Landscape

When the 109th Congressional session began in 2006, the House and Senate adopted a "pay-as-you-go" rule for public programs known as "PAYGO", (Levenson. 2008). Congress has since frequently adopted PAYGO when government's high budgetary expenditures demand it. The rule basically requires any new increase in federal spending to be offset by a decrease in federal dollars elsewhere to pay for the new program (Levenson. 2008). In response to the uncertainty that this rule creates, organizations must go to extraordinary lengths to convince Congress that their organization deserves government financing or tax-preferred treatment. Congress and the IRS will continue their scrutiny of tax-exempt organizations and may continue to consider legislating a quantifiable Community Benefit standard, including, at some point, a revised charity care definition (IRS. 1969; GAO. 2008; IRS. 2009. Levenson. 2008).

A Blurred Distinction

Much of the uncertainty has been created by change that has occurred since the IRS issued its 1969 revenue ruling. The 1969 revenue ruling had, itself, substantially overhauled a 1956 revenue ruling that contained a general charity care requirement (IRS. 1969). The 1969 ruling replaced the general charity care requirement with two more specific requirements: First, it required that EDs be open to everybody, regardless of a person's ability to pay, and second, it required that all with the ability to pay, including Medicare and Medicaid patients, be treated as well (IRS. 1969). Medicare and Medicaid were relatively new programs in 1969, and the federal government likely had concerns some hospitals would not participate in them. But history has shown us most for-profit hospitals do participate in Medicare and Medicaid. Beyond those programs, the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) ensures public access to emergency medical services regardless of one's ability to pay (Levenson. 2008). Although the EMTALA rules appear to limit hospitals' medical care provision obligations to the point of patient stabilization, the IRS's 1969 revenue ruling may have a broader scope, as far as indigent care is concerned (Levenson. 2008). Nevertheless, there can be little doubt that EMTALA's passage, along with taxable hospitals' voluntary Medicare and Medicaid patient treatment, somewhat blurred the line between tax-exempt and taxable hospitals.

What Are Tax-Exempt Hospitals Doing?

No reasonable person could expect tax-exempt hospitals alone to solve the issue of the uninsured. The problem calls for a broader solution that, in all likelihood, will require government involvement. Some states have already enacted laws to provide coverage for uninsured children, the State Children Health Insurance Program (SCHIP), regardless of where they obtain treatment. The provision of health care to the uninsured and the provision of health care to charity care and indigent patients are separate, distinct issues, and they must be treated as such (Levenson. 2008).

What are tax-exempt hospitals to do while the government decides whether it will modify the Community Benefit standard to include a charity care requirement and valuing community benefit versus tax exemption. A number of proactive, tax-exempt hospitals have undertaken

efforts to calculate the value of their tax-exempt status (Levenson. 2008). Hospitals that pursue this tack compare the value of such status with the amount of charity care and other associated benefit they give back to their community. This approach gives a hospital a quantifiable metric that suggests whether it is providing enough benefit or needs to provide more. It is important to recognize that appraising the value of a hospital's tax-exempt status is more difficult than simply applying state and federal government income tax rates to the financial statement's audited revenues (Levenson. 2008). First, if a hospital's status changed to taxable, a lot of the financial statement's numbers would need to be adjusted to arrive at taxable income. Second, the largest tax benefit to most tax-exempt health systems arises from the exemption from state and local property and sales tax. For example, in calculating the value of the income tax exemption, gifts and grants tax-exempt hospitals count as revenue would in all likelihood disappear if the hospital were to become a taxable entity. In addition, the favorable interest rate a hospital might pay using tax-exempt bond financing would also disappear, and those loans would have to be refinanced with higher-rate taxable debt. The status change would increase the hospital's interest expense and increase its interest deduction, in their current financial statement. Last, but not least, the newly taxable hospital would have to determine its state and local property tax and sales tax rates because sales and property tax breaks would no longer be available. These additional taxes would, of course be deductible for federal income tax purposes.

Employing better public relations

A number of hospitals also have undertaken efforts to do a better job communicating to the public the hospital's Community Benefit. The revised Form 990 allows space, through an addendum, for filers to put into words the extent to which they earn their preferred tax status through good works in the communities they serve (IRS. 2007; IRS. 2009). Here, a seasoned tax adviser who understands tax-exempt hospitals' industry best practices can prove to be an indispensable strategic ally. Beyond communicating good works to the IRS, tax-exempt hospitals could do a better job communicating their charity care policies to incoming patients so that more individuals who qualify for charity care actually claim it. There are myriad reasons individuals do not claim charity care to which they are eligible, and often when those individuals receive care,

the costs are written off as "bad debt." Tax-exempt hospitals that can grow their charity care rolls while shrinking their bad debt rolls increase their Community Benefit. Such a move is in alignment with the CHA's guidelines, which some influential lawmakers seem to favor (CHA. 2006). Still, better charity care policy communication may not, at the end of the day, appreciably increase the number of patients who claim it.

A Fair Assessment

The determination of which tax-exempt hospitals are providing adequate Community Benefit should not be predicated upon a hospital's geographic location (Levenson. 2008). Charity care is dispensed disproportionately among hospitals located in inner cities and suburbs, and as one would expect, inner-city hospitals see more charity care patients than do hospitals in the suburbs. This fact should not preclude suburban residents from having access to tax-exempt hospitals in their communities as long as these hospitals offer a reasonable charity care policy that is made available to all those in need who present themselves to that hospital.

In short, Community Benefit is difficult to value and there is no cookie cutter solution. It is best for not-for-profit hospitals to remain vigilant while awaiting further government moves. They need to anticipate community scrutiny and embrace it and not shy away from it. If not-for-profit hospitals can recognize the scrutiny as an opportunity to communicate, and demonstrate, how they help the community served, and make sure to tell that story to all of the hospital's stakeholder groups, they will avoid the controversy and backlash.

LITERATURE REVIEW

Internal Revenue Service (IRS) Study Report

This report results from an IRS study of nonprofit hospitals begun in 2006. The study was conducted so that the IRS and other stakeholders could better understand nonprofit hospitals and their Community Benefit and executive compensation practices and reporting (IRS. 2009). The report is based on the responses to questionnaires the IRS sent to a sample of more than 500 nonprofit hospitals. As part of the study, the IRS also examined 20 nonprofit hospitals regarding their executive compensation practices. To obtain information about Community Benefit practices and reporting, the questionnaire requested information regarding the hospital's patient mix,

emergency room, board of directors, medical staff privileges, and a variety of programs (specifically, its medical research, professional education and training, uncompensated care, and community programs).

This final report in February, 2009 summarizes the reported Community Benefit across various demographics, including the type of community in which the respondent hospital is located (community type) and the hospital's revenue size (IRS. 2009). The study also analyzed patient mix and excess revenues across these demographics.

The four community types, based on U.S. Census Bureau data and other information, are:

- High-population hospitals – hospitals located in the 26 largest urban areas in the United States
- Other urban and suburban hospitals – those hospitals located in urban and suburban areas other than the 26 largest urban areas
- Critical access hospitals – rural hospitals designated as such under federal law
- Other rural hospitals – rural hospitals not designated as critical access hospitals.

The report also provides results based on five groupings of the individual hospital's annual revenues:

- Under $25 million
- $25 million to $100 million
- $100 million to $250 million
- $250 million to $500 million
- Over $500 million.

Summary of Community Benefit Findings

In addition to analyzing Community Benefit expenditure data across the demographics described above, the study also analyzed reported Community Benefit expenditures by income and health insurance coverage levels of the areas surrounding the hospitals and by hospitals reporting large medical research expenditures (IRS. 2009).

The report's key community benefit findings are (IRS. 2009):

• There was considerable diversity in the demographics, Community Benefit activities, and financial resources among the respondent hospitals. In particular, significant differences were observed between the critical access hospitals and the high population hospitals, and between the smallest and largest hospitals based on revenue size.

• The average and median percentages of total revenues reported as spent on Community Benefit expenditures were 9% and 6%, respectively. Among the community types, these percentages were lowest for rural hospitals (both critical access and non critical access hospitals) and highest for high population hospitals. The percentage spent on reported Community Benefit expenditures generally increased with revenue size.

• Uncompensated care was the largest reported Community Benefit expenditure for each of the study's demographics, other than for a group of 15 hospitals reporting large medical research expenditures (93% of all research expenditures reported by the study's respondents). Overall, the average and median percentages of uncompensated care as a percentage of total revenues were 7% and 4%, respectively. Uncompensated care accounted for 56% of aggregate Community Benefit expenditures reported by the hospitals in the study.

• After uncompensated care, the next largest categories of Community Benefit expenditures, ranked as a percentage of total Community Benefit expenditures, were medical education and training (23%), research (15%), and community programs (6%). The expenditure mix, however, varied both by community type and revenue size. Further, the group of 15 hospitals reporting large medical research expenditures materially impacted the overall numbers in this area. For example, when the research group is removed, the percentage of total community benefit expenditures reported as spent on uncompensated care increases from 56% to 71%, and that spent on medical research decreases from 15% to 1%.

• The overall group of hospitals reported excess revenues (total revenues less total expenses) of 5% of total revenues. Reported excess revenues varied across the

community type and revenue size demographics, with large revenue size hospitals generally the most profitable and critical access hospitals the least profitable. Also, 21% of the hospitals reported total expenses greater than total revenues; the percentage of hospitals reporting a deficit varied by community type and revenue size.

- Uncompensated care and Community Benefit expenditures were concentrated in certain hospitals and unevenly distributed. For example, 9% of the hospitals reported 60% of the aggregate Community Benefit expenditures of the overall group; 14% of the hospitals reported 63% of the aggregate uncompensated care expenditures.
- No correlation was found between Community Benefit expenditure levels and per capita income levels of the hospital's surrounding area. However, Community Benefit expenditure levels generally increased as uninsured rates of the hospital's surrounding area increased.

Limitations of the Analysis

The reported data has limitations and may not accurately reflect the respondent group or represent the nonprofit hospital sector as a whole. For example, although the IRS designated the general categories of activities that could be reported as Community Benefit for purposes of the study, determining what was treated as Community Benefit (for example, bad debt or government program shortfalls) and how to measure it (cost versus charges) was largely within the respondents' discretion (IRS. 2009). In addition, except for the compensation data reviewed in the examinations, the reported data was not independently tested or verified.

Observations

Both the Community Benefit and reasonable compensation standards have proved difficult for the IRS to administer (IRS. 2009). Both involve application of imprecise legal standards to complex, varied and evolving fact patterns (IRS. 2009). Some have suggested that these standards need to be revised (GAO. 2008; CBO. 2006; AHA. 2006; CHA. 2006). As these discussions occur, and despite the limitations described above, the study provides important information. The size, complexity and importance of this segment will continue to be a challenge to those who consider refining or revising the exemption standard (IRS. 2009).

The data suggests that any attempt to refine the standard will seriously impact the existing tax exempt hospital sector because of the hospitals' varying practices and financial capabilities. Put another way, any revised standard would affect the different types and sizes of hospitals depending upon the types of activities required to be taken into account as Community Benefit, the quantitative measure (if any) included in such a standard, and the extent the rule provides for exceptions or special rules (e.g., an exception from a quantitative standard if the hospital is the sole provider in the community or has a designation as a critical access hospital). As discussions about the Community Benefit standard continue, additional information may be available as more accurate and complete data on community benefit expenditures is expected to be available through Schedule H of the Form 990, (IRS. 2009), starting from tax year 2009.

Government Accountability Office (GAO) Study Report

This study is highlighted in a report to the Ranking Member, Committee on Finance, U.S. Senate, Senator Charles Grassley and titled "Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements (GAO. 2008). This study came about as part of Senator Grassley' s effort in 2007, when he distributed a paper discussing potential reforms to the community benefit standard (GAO. 2008). Among other things, he sought feedback on whether hospitals should be required to devote a minimum percentage of patient operating expenses or revenues (whichever is greater) to charity care in order to continue to qualify for federal tax exemption (GAO. 2008). He also expressed interest in gaining a better understanding of nonprofit hospitals' provision of community benefits in relation to their tax-exempt status, and raised concerns about the extent to which nonprofit hospitals define, measure, and report community benefits in a consistent and transparent manner.

According to the study report, not-for-profit hospitals qualify for federal tax exemption from the Internal Revenue Service (IRS) if they meet certain requirements, but since 1969, IRS has not specified that these hospitals have to provide charity care to meet these requirements, so long as they engage in activities that benefit the community (GAO. 2008). Many of these activities are intended to benefit the approximately 47 million uninsured individuals in the United States who need financial and other help to obtain medical care (U.S. Census Bureau. 2006; GAO.

2005). Previous studies indicated that not-for-profit hospitals may not be defining community benefit in a consistent and transparent manner that would enable policymakers to hold them accountable for providing benefits commensurate with their tax-exempt status (GAO. 2008).

GAO was asked to examine (1) IRS's community benefit standard and the states' requirements, (2) guidelines nonprofit hospitals use to define the components of community benefit, and (3) guidelines nonprofit hospitals use to measure and report the components of community benefit. To address these objectives, GAO analyzed federal and state laws; the standards and guidance from federal agencies and industry groups; and 2006 data from California, Indiana, Massachusetts, and Texas. GAO also interviewed federal and state officials, and industry group representatives. IRS stated that the report in general was accurate, but noted several concerns regarding the description of the community benefit standard and CMS did not have any comments (GAO. 2008).

The summary concludes that, IRS's community benefit standard allows nonprofit hospitals broad latitude to determine the services and activities that constitute community benefit (GAO.2008). Furthermore, state community benefit requirements that hospitals must meet in order to qualify for state tax-exempt or nonprofit status vary substantially in scope and detail (GAO. 2008). For example, 15 states have community benefit requirements in statutes or regulations, and 10 of these states have detailed requirements. GAO found that among the standards and guidance used by nonprofit hospitals, consensus exists to define charity care, the unreimbursed cost of means-tested government health care programs (programs for which eligibility is based on financial need, such as Medicaid), and many other activities that benefit the community as community benefit (GAO. 2008). However, consensus does not exist to define bad debt (the amount that the patient is expected to, but does not, pay) and the unreimbursed cost of Medicare (the difference between a hospital's costs and its payment from Medicare) as community benefit (GAO. 2008). Variations in the activities nonprofit hospitals define as community benefit lead to substantial differences in the amount of community benefits they report (GAO. 2008). Even if nonprofit hospitals define the same activities as community benefit, they may measure the costs of these activities differently, which can lead to inconsistencies in

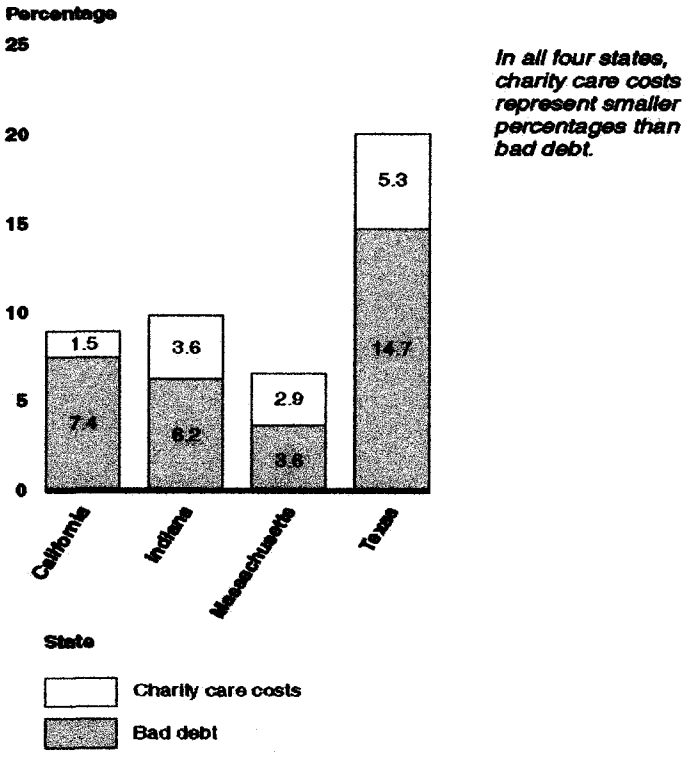
reported community benefits. For example, standards and guidance vary on the level at which hospitals may report their community benefit (e.g., at an individual hospital level or a health care system level) and the method hospitals may use to estimate costs of community benefit activities (GAO. 2008). State data demonstrate that differences in how nonprofit hospitals measure charity care costs and the unreimbursed costs of government health care programs can affect the amount of community benefit they report (GAO. 2008). With the added attention to community benefit, has come a growing realization of the extent of variability among stakeholders in what should count and how to measure it (GAO. 2008). At present, determination and measurement of activities as community benefit for federal purposes are still largely a matter of individual hospital discretion (GAO. 2008). Given the large number of uninsured individuals, and the critical role of hospitals in caring for them, it is important that federal and state policymakers and industry groups continue their discussion addressing the variability in defining and measuring community benefit activities (GAO. 2008).

One major area of contention is whether to include bad debt in Community Benefit calculation. Bad debt is generally defined as the uncollectible payment that the patient is expected to, but does not pay (GAO. 2008). Centers for Medicare & Medicaid Services (CMS) does not have a position on community benefit; however, its reporting instrument collects information on uncompensated care and defines the term to include bad debt (GAO. 2008). State community benefit requirements vary in whether they define bad debt as community benefit. Of the 15 states with community benefit requirements, 3 states explicitly include bad debt as community benefit, 2 states explicitly exclude bad debt, and 10 states do not specify (GAO. 2008). Whether nonprofit hospitals define bad debt as community benefit has an important effect on the resulting amount of community benefit reported. Specifically, nearly all of the nonprofit hospitals in the four states GAO examined reported bad debt, and the amounts were typically substantial when compared to charity care. For example, in 2006 in California, the average percentage of total operating expenses devoted to bad debt was 7.4 percent—almost five times the average percentage devoted to charity care costs (Figure 2). Moreover, the amounts of hospitals' bad debt varied widely across hospitals. For example, among nonprofit hospitals in

Texas, which had the most variation, the middle 50 percent of hospitals reported bad debt ranging from 7.4 to 19.1 percent of total operating expenses in 2006. Among the middle 50 percent of nonprofit hospitals in Massachusetts, which had the least variation, the span was still notable with bad debt ranging from 2.2 to 4.6 percent of total operating expenses in 2006. In their study, GAO did not reduce bad debt expenses to costs because it found that hospitals did not consistently report bad debt in costs or charges.

Figure 2: Average Percentage of Total Operating Expenses Devoted to Charity Care Costs and Bad Debt among Nonprofit Hospitals in Selected States, 2006

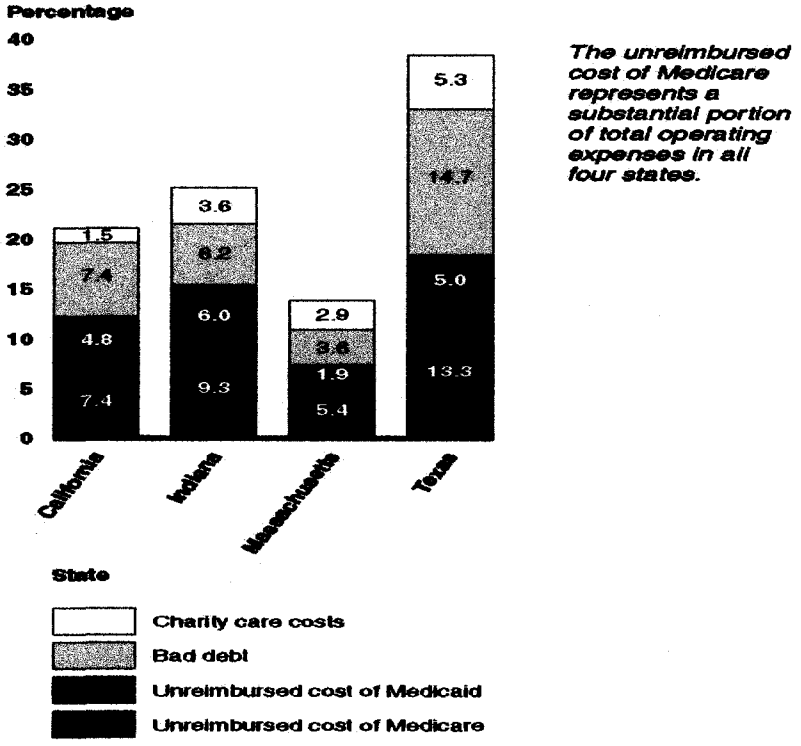
Notes: Nonprofit hospitals include nongovernmental, acute care, general hospitals. Percentages are calculated only among those hospitals that reported having charity care costs and bad debt expenses. Ninety-six percent of hospitals in California, 81 percent of hospitals in Indiana, 97 percent of hospitals in Massachusetts, and 100 percent of hospitals in Texas reported charity care costs. Ninety-nine percent of hospitals in California, 99 percent of hospitals in Indiana, 97 percent of hospitals in Massachusetts, and 91 percent of hospitals in Texas reported bad debt.



Source: GAO analysis of 2006 California, Indiana, Massachusetts, and Texas data.

Figure 3: Average Percentages of Total Operating Expenses Devoted to Charity Care Costs, Bad Debt, and the Unreimbursed Costs of Medicaid and Medicare among Nonprofit Hospitals in Selected States, 2006

Notes: Nonprofit hospitals include nongovernmental, acute care, general hospitals. Percentages are calculated only among those hospitals that reported having charity care costs, unreimbursed costs of Medicaid or Medicare, or bad debt expenses. Ninety-six percent of hospitals in California, 81 percent of hospitals in Indiana, 97 percent of hospitals in Massachusetts, and 100 percent of hospitals in Texas reported charity care costs. Ninety-nine percent of hospitals in California, 99 percent of hospitals in Indiana, 97 percent of hospitals in Massachusetts, and 91 percent of hospitals in Texas reported bad debt. Eighty-one percent of hospitals in California, 88 percent of hospitals in Indiana, 89 percent of hospitals in Massachusetts, and 87 percent of hospitals in Texas reported unreimbursed costs of Medicaid. Eighty-four percent of hospitals in California, 83 percent of hospitals in Indiana, 81 percent of hospitals in Massachusetts, and 93 percent of hospitals in Texas reported unreimbursed costs of Medicare.



Source: GAO analysis of 2006 California, Indiana, Massachusetts, and Texas data.

Congressional Budget Office Study Report

This is a study by the Congressional Budget Office (CBO) (CBO. 2006). In this paper, the CBO measured the provision of certain community benefits and compared nonprofit hospitals with for-profit hospitals. Since for-profit hospitals do not receive tax exemptions and are not required to meet community-benefit standards, the level of community benefits provided by for-

profit hospitals served CBO, therefore, as a useful benchmark against which to compare nonprofit hospitals. The analysis also examined the provision of community benefits by nonfederal government hospitals (End Notes[6]). Although nonprofit hospitals must provide community benefits in order to receive tax exemptions, there is little consensus on what constitutes a community benefit or how to measure such benefits (CBO. 2006).

For the purposes of this analysis, Community Benefits included the provision of uncompensated care, the provision of services to Medicaid patients, and the provision of certain specialized services that have been identified as generally unprofitable. Those services were selected because they benefit the community but are not typically considered financially rewarding. In general, the comparisons of nonprofit and for-profit hospitals yielded mixed results. CBO found that, on average, nonprofit hospitals provided higher levels of uncompensated care than did otherwise similar for-profit hospitals. Among individual hospitals, however, the provision of uncompensated care varied widely, and the distributions for nonprofit and for-profit hospitals largely overlapped. Nonprofit hospitals were more likely than otherwise similar for-profit hospitals to provide certain specialized services but were found to provide care to fewer Medicaid-covered patients as a share of their total patient population. On average, nonprofit hospitals were found to operate in areas with higher average incomes, lower poverty rates, and lower rates of uninsurance than for-profit hospitals.

Provision of Uncompensated Care

The level of uncompensated care provided by community hospitals was examined in this study for hospitals located in five states—California, Florida, Georgia, Indiana, and Texas—using data from 2003 (the latest year for which such data are available) (End Notes[7]). In the CBO study interpretation, "Uncompensated care" refers to the sum of charity care (services for which a hospital does not expect payment) and bad debt (services for which a hospital expects but does not collect payment). Although charity care is a better measure of the community benefits provided by a hospital, data limitations precluded CBO from analyzing charity care and bad debt separately. The five selected states were chosen in part because sufficiently reliable data on uncompensated care were available in those areas.

Key findings:

- In the five states analyzed, nonprofit hospitals provided a total of about $3 billion in uncompensated care, government hospitals provided more than $3 billion, and for-profit hospitals provided about $1 billion in uncompensated care. The difference in the total amount of uncompensated care provided by nonprofit and for-profit hospitals is largely attributable to the fact that nonprofit hospitals accounted for a much larger share of the hospital market than did for-profits.
- The average "uncompensated-care share"—the cost of uncompensated care as a share of hospitals' operating expenses—was much higher at government hospitals (13.0 percent) than at either nonprofit hospitals (4.7 percent) or for-profit hospitals (4.2 percent).
- Individual hospitals varied widely in their uncompensated-care shares. Although nonprofit hospitals, on average, have slightly higher uncompensated-care shares than for-profits (by 0.5 percentage points), the distributions of uncompensated-care shares among those two types of hospitals overlap to a large extent.
- When regression techniques were used to adjust for the hospitals' size and location and for the characteristics of the local populations, nonprofit hospitals were estimated to have an average uncompensated care share that was 0.6 percentage points higher than that for otherwise similar for-profit hospitals. That estimated difference corresponds to nonprofit hospitals in the five selected states providing between $100 million and $700 million more in uncompensated care than would have been provided if they had been for-profits (End Notes[8]).

Provision of Medicaid-Covered Services

According to CBP paper, Medicaid's payment rates have, in general, been found to be somewhat below the costs that hospitals incur in providing Medicaid-covered services (CBO. 2006). Because providing hospital services to Medicaid patients is often unprofitable and serves a needy population, it can be thought of as a type of community benefit. Among all community hospitals nationwide, CBO found that the Medicaid share—Medicaid-covered days as a share of

all patient days—was, on average, 1.5 percentage points lower among nonprofit hospitals than it was among for-profit hospitals (15.6 percent versus 17.2 percent). The Medicaid share was substantially higher among government hospitals (27.0 percent). When regression techniques were used to control for hospital characteristics, nonprofit hospitals were found to have adjusted Medicaid shares that were 1.3 percentage points lower than those of otherwise similar for-profit hospitals.

Provision of Specialized Services

CBO also examined the share of hospitals of different ownership types that provide four specific types of specialized patient services: intensive care for burn victims, emergency room care, high-level trauma care, and labor and delivery services (End Notes [9]). Each of those services addresses a community need and has been identified as being generally unprofitable. Among all community hospitals nationwide, emergency room care and labor and delivery services were both quite common, whereas few hospitals provided burn intensive care or high-level trauma care. CBO found that nonprofit hospitals were more likely than for-profit hospitals to provide each of the four specialized services examined. After adjustment for hospital characteristics, nonprofit hospitals were found to be significantly more likely than for-profit hospitals to provide two of the four specialized patient services (emergency room care and labor and delivery services). Compared with otherwise similar for-profit hospitals, the share of nonprofit hospitals providing emergency room care was 3.8 percentage points higher, and the share providing labor and delivery services was 10.5 percentage points higher. CBO did not attempt to quantify the value to the community of the availability of those specialized services (CBO. 2006). This point is interesting, since these are not yet accepted as Community Benefit in the CHA guidelines (CHA. 2005). Only emergency and trauma are listed in the AHA Community Benefit reporting framework, under subsidized health services (AHA. 2006).

CBO Measures of Community Benefits

Because of the lack of general consensus on the definition of community benefits, many different types of services and activities could be regarded as community benefits. The CBO analysis focuses on the provision of uncompensated care, the provision of Medicaid-covered

services, and the provision of certain specialized facilities or services (burn intensive care, emergency room care, high-level trauma care, and labor and delivery services). Although uncompensated care is the focus of this CBO paper and has frequently been analyzed by other researchers, it has substantial limitations as a measure of community benefits. The most significant limitation is that it does not distinguish between the provision of charity care for the indigent, which is more clearly a type of community benefit, and bad debt, which is not necessarily a community benefit. A hospital may incur bad debt when providing services to a high-income individual with insurance, for example, if the individual fails to pay the deductible for a hospital stay. There is very little direct evidence on the income and insurance status of the patients who account for hospitals' uncompensated care. Two surveys of uncompensated-care patients, both limited to hospitals in Massachusetts, showed that most uncompensated care was attributable to uninsured patients (Weissman et al. 1992), and that the great majority of bad debt was attributable to patients with incomes below 200% of the federal poverty line (Weissman et al. 1999). Those findings support the validity of the use of uncompensated care as a measure of community benefits, but they are not necessarily generalizable nationwide.

Medicaid's payment rates have, in general, been found to be lower than the costs that hospitals incur for providing Medicaid-covered services. Providing hospital services to Medicaid patients is generally unprofitable and serves a needy population and can, therefore, be thought of as a type of community benefit. Like uncompensated care, however, the provision of Medicaid-covered services has significant limitations as a measure of community benefits. The profitability of providing care to Medicaid patients appears to vary widely from state to state and also probably varies from hospital to hospital, and from case to case. Because providing Medicaid-covered services is not always unprofitable, it is not always appropriate to treat it as a community benefit.

The four specialized services analyzed by CBO (burn intensive care, emergency room care, high-level trauma care, and labor and delivery services) were selected because they serve community needs and have been identified by other researchers as being generally unprofitable,

and because data are readily available on which hospitals provide them (CBO. 2006). CBO did not attempt directly to measure the profitability of each of the four specialized services.

Methods of Analysis

CBO used two approaches to compare the level of community benefits provided by the three different types of hospitals. The first approach was an "unadjusted" analysis that compared simple weighted averages among hospitals of different ownership types. The second approach was an "adjusted" analysis that measured the differences between hospitals of different ownership types, holding constant certain hospital characteristics, such as the size of the facility, the state in which it is located, and the income level of the community in which it is located. Those unadjusted and adjusted analyses were first applied to uncompensated-care shares, and then the same approach was used to analyze the provision of Medicaid-covered services, and the provision of certain specialized services. The use of both unadjusted and adjusted analyses can help determine whether any observed differences among hospitals of different ownership types were attributable to the hospitals' location and size or to some other factor correlated with ownership status. As other researchers have pointed out, hospitals of different ownership types tend to be located in disparate geographic areas with divergent patient populations (CBO. 2006). One can think of different geographic areas as having varying levels of demand for uncompensated care, with low-income areas and areas with high numbers of uninsured people having higher levels of demand. The unadjusted uncompensated-care shares reflect both hospitals' willingness and ability to provide such care and their decision to locate in areas with high or low levels of demand for uncompensated care. The differences in adjusted uncompensated-care shares, by contrast, reflect differences in hospitals' willingness and ability to supply uncompensated care, after controlling for differences in the communities in which the hospitals are located and other hospital characteristics. Conceptually, the adjusted differences represent the differences that would occur if hospitals of all ownership types were located in the same areas and were the same in all respects other than ownership status (End Notes [11]). To calculate the adjusted differences in uncompensated care shares, CBO regressed uncompensated-care shares on state indicator variables, local population characteristics, a

measure of hospital size, case mix (in other words, the average intensity of illness and resource needs among a hospital's patients), and indicator variables for nonprofit and government ownership status. ("For-profit" ownership was the omitted reference group). That regression yielded adjusted differences in uncompensated-care shares for each state and the average for the entire five-state sample (CBO. 2006). That technical adjustment has the effect of correcting for differences in hospital size and local community characteristics that may affect the uncompensated-care share of a hospital, leaving a clearer picture of the differences in community benefits that are attributable solely to differences in ownership type (CBO. 2006).

Differences in the Provision of Uncompensated Care

CBO's analysis of uncompensated care as a share of operating expenses was conducted using 1,057 community hospitals in the five selected states—California, Florida, Georgia, Indiana, and Texas—for which data on uncompensated care were available. Of those 1,057 community hospitals, 462 (44 percent) were nonprofit, 308 (29 percent) were for-profit, and 287 (27 percent) were government-owned. In the five states analyzed, nonprofit hospitals provided a total of about $3 billion in uncompensated care, government hospitals provided more than $3 billion, and for-profit hospitals provided about $1 billion in uncompensated care. In the unadjusted results, nonprofit hospitals were found to devote a slightly larger share of their operating expenses to uncompensated care than did for-profits (a statistically significant difference of 4.7 percent versus 4.2 percent). The adjusted differences reflect the estimated differences in uncompensated-care shares after controlling for the following variables: the hospital's size; the state in which it is located; the degree of urbanization of the community in which it is located; its case mix; the percentage of the surrounding county's population that lives in poverty; the percentage of the county's population that is uninsured; and the percentage of the county's population that is eligible for Medicare. After adjustment, the difference between nonprofit and for-profit hospitals in their average uncompensated-care share was a statistically significant 0.6 percentage points.

Differences in the Provision of Medicaid-Covered Services

Some industry experts and researchers include the so called Medicaid shortfall as an additional type of community benefit (CBO. 2006). The Medicaid shortfall is the difference

between the costs that hospitals incur as a result of providing services to Medicaid enrollees and Medicaid's payments to hospitals for those services. On the basis of data from the American Hospital Association, the Lewin Group estimates that Medicaid's payments over the past several years have covered about 95 percent of the Medicaid-related costs that hospitals incur (End Notes[12]). Hospitals that treat a large number of Medicaid patients, therefore, are likely to face a larger Medicaid shortfall than hospitals that treat fewer Medicaid patients. To examine differences among nonprofit, for-profit, and government hospitals in the provision of care to Medicaid patients, CBO analyzed the "Medicaid share," which is calculated for each hospital and equals the percentage of inpatient days accounted for by Medicaid patients. The Medicaid analysis included all community hospitals nationwide for which data were available (N = 4,397).51 In 2003, the average Medicaid share among for-profit hospitals was 17.2 percent, among nonprofit hospitals it was 15.6 percent, and among government hospitals it was 27.0 percent. CBO calculated adjusted differences in Medicaid shares using regression models similar to those used to analyze the uncompensated-care share. After accounting for hospitals' characteristics and local population characteristics, CBO estimated that nonprofit hospitals had a Medicaid share that was 1.3 percentage points lower than for-profit hospitals, a difference that was statistically significant. The difference in Medicaid shares can be used to estimate the differences in the Medicaid shortfall as a share of operating expenses among different types of hospitals. On the basis of Lewin's estimated national average, the shortfall from treating Medicaid patients would equal about 5 percent of a hospital's Medicaid-related operating expenses. As a share of operating expenses, the Medicaid shortfall is estimated to be less than one-tenth of one percentage point higher at for-profit hospitals than at nonprofit hospitals. The fact that not-for-profit hospitals tend to treat fewer Medicaid patients than otherwise similar for-profit hospitals implies that they probably face less of a Medicaid shortfall; but, as a share of operating expenses, the difference appears to be quite small.

Differences in the provision of specialized services

This is not relevant to this researcher's definition of Community Benefit assumptions and calculations, and therefore not included.

Study of Virginia Hospitals

In one of the more recent studies by McDermott (2007), comprising 72 Virginia hospitals, he determined whether (a) for-profit hospitals' community contributions exceed their profits and (b) nonprofit hospitals' community contributions exceed the for-profits' contributions in addition to the nonprofits' forgone taxes.

Methodology/Approach

Based on audited fiscal year 2004 financial statements, six null hypotheses were tested for significant differences between the two independent variables, namely, hospital charter and size, and the three dependent variables, including (a) operating income, (b) the ratio of community contributions to net patient revenues, and (c) the ratio of community contributions to operating income (McDermott. 2007).

Findings

No significant differences were found to exist between (a) hospital charter and operating income, (b) hospital charter and the percentage of community contributions to net patient revenues, and (c) hospital charter and the percentage of community contributions to operating income. The community contributions of nonprofits exceeded their taxes forgone by a wide margin, but they fell short of exceeding the for-profits' community contributions plus the taxes forgone by a very slight margin (McDermott. 2007).

Practice Implications

Hospital management, in conjunction with health care policy planners, needs to develop mutually acceptable standards on required level of hospitals' community contributions. It is proposed that the most equitable standard is "quartile comparisons" for a given hospital's financial performance and its level of community contributions. Also, to reduce charity care, it is imperative that high-cost hospital treatment of primary health care for indigent patients be shifted to lower cost delivery systems (McDermott. 2007).

Study Comparing Specialty & Not-For-Profit Hospitals

In another study, Greenwald et al. (2006) clarified and compared community benefits of for-profit specialty hospitals and their not-for-profit competitors. Based on the ten specialty hospitals and twenty one community hospitals in six cities, which they studied, they found that specialty hospitals incurred a greater net community benefit burden than their not-for-profit competitors (End notes[1]). They estimated the sum of uncompensated care costs and taxes paid by these hospitals. They also computed the difference between uncompensated care costs and the value of the tax exemption received by nonprofits (this definition might better account for the value of unprofitable activities, since lower margins result in lower values of tax exemption). Equating uncompensated care cost with community benefit, for comparing to taxes or tax exemption, is a standard approach in this literature (Kane et al. 2000; Frizzel 1998; Gentry et al. 2000). Under both definitions, the specialty hospitals the authors studied provided more net community benefits than their not-for-profit competitors as a share of total revenues: 5.5 percent versus 2.5 percent under the first definition, and 1.0 percent versus -0.4 percent under the second. According to the authors of this study, on average, the low community benefit burden of not-for-profits did not justify the value of their tax exemption. The higher net community benefits generated by specialty hospitals were attributable almost entirely to the taxes they paid as for-profit entities. Their results are also generally consistent with findings that uncompensated care in not-for-profits costs somewhat less than the value of their tax exemption (Kane et al. 2000; Frizzel.1998; Gentry et al. 2000).

Study on Economic & Policy Analysis of Specialty Hospitals

This study report is based on data from four different sources. All sections rely on data drawn from published studies and reports (Schneider et al. 2005). For some of the arguments and analyses undertaken by the authors, there is limited relevant published literature and reports, primarily because the debates over pros and cons of specialty hospitals are a relatively new occurrence. In cases where there is an insufficient supply of published data and analyses, the authors conducted analyses based on data collected from (1) site visits, (2) secondary data sources, and (3) their own survey of specialty hospitals. The secondary data sources used for this

analysis include Medicare Cost Reports (HCRIS), quality data from Health Grades, and market area data from the Bureau of Health Profession's Area Resource File (ARF).

Throughout the report, the authors describe some of the findings from case studies of five surgical hospitals, two in central California and three in South Dakota. These states were chosen due to the relatively high proportion and maturity of specialty hospitals. Site visits generally involved question and answer sessions with all levels of the management team (including physician owners) at each facility, followed by tours. Also provided were documents on management strategy, quality assurance, consumer satisfaction, physician ownership, and cost management. The main goal of the site visits was to improve the authors' understanding of the layout and functioning of specialty hospitals. In addition to secondary data and site visits, the authors conducted a survey of the 70 specialty hospitals belonging to the American Surgical Hospital Association (ASHA). The survey achieved a 50 percent response rate, but incorporating existing data from ASHA resulted in item-level response rates ranging from 50 to 90 percent. Descriptive statistics from the survey are provided in Appendix A and the survey instrument is provided in Appendix B.

Although specialty hospitals generally provide less charity care per facility (approximately 2.1 percent of gross patient care revenues, Appendix A), they contribute on average approximately $2 million annually in state and federal taxes (Schneider et al. 2005). This represents an additional 5.1 percent of gross patient care revenues (Appendix A). The combined 7.2 percent of gross patient care revenues exceeds the average charity care provision of tax-exempt general hospitals, which is approximately 5 to 6 percent of revenues, American Hospital Association (AHA. 2005).

Older Studies in the Provision of Uncompensated Care

There are numerous other empirical studies on the provision of charity care. Interpreting this literature is complicated, however, not only by the mixed results of prior studies, but also by the dramatic changes which have affected the U.S. health care system in recent years. A number of studies using data from the 1980s have examined the provision of uncompensated care by hospitals. Studies using national data tend to find nonprofits providing slightly more charity care

than for-profits, though the rates are generally quite similar, especially when compared to the much higher amounts provided by public hospitals (Gray 1991; Frank et al. 1990). Similarly, analyses of self-reported American Hospital Association (AHA) figures consistently find little difference between the two private hospital types (with uncompensated care typically representing around 4 percent of gross patient revenues), and sometimes even indicate that for-profits provide a slightly higher level of uncompensated care than do nonprofits (Gray 1991; GAO 1990).

Papers by Weissman (1996) and Mann, et al. (1997) document changes in the distribution of uncompensated care over the 1980s and early 1990s. While total uncompensated care as a percentage of hospital costs has remained a fairly constant 6 percent, the relative shares of various hospital types has changed. Public hospitals have always provided more uncompensated care than private hospitals, both as a percentage of their total costs and relative to their overall market share. Between the early 1980s and mid-1990s, public hospitals' share of uncompensated care expenditures increased. Mann, et al. (1997) show that the increase was most pronounced for public hospitals in urban areas. Figures presented by both Weissman and Mann, et al. indicate that among private hospitals, nonprofits provided slightly more uncompensated care than for-profits in the early 1980s, but the difference between the two had decreased by the early to mid-1990s. One problem with national studies is that comparisons between nonprofit and for-profit hospitals may be confounded by inter-state differences in economic conditions and public policies affecting the need for charity care. Gray (1991) argues that for-profits tend to locate in states with a relatively low need for charity care. Studies by Ermann and Gabel (1985) and Norton and Staiger (1994) also suggest that differences across ownership type in the provision of charity care are strongly influenced by differences in where for-profit, nonprofit, and public hospitals locate. These problems are mitigated somewhat in studies which compare nonprofit and for-profit hospitals within a particular state.

Focusing on five states with significant for-profit sectors, Lewin, et al. (1988) find that, in most cases, nonprofits provide more uncompensated care than do for-profits—ranging from about 50 percent more in Florida (7.6 percent versus 4.9 percent) and North Carolina (6.7 percent

versus 4.8 percent) to more than twice as much (10.5 percent versus 4.8 percent) in Tennessee. The one exception is California, where for-profits and nonprofits provide about the same low amount of uncompensated care (just 3 percent of total expenses). Similar figures are reported by Gray (1991) and the General Accounting Office, GAO (1990), though this isn't surprising since the data come mostly from the same sources. The atypical California findings are generally attributed to the very low overall level of uncompensated care in the state. This, in turn, is attributed to California's historically generous Medicaid program (called MediCal), and its fairly large public hospital system—since otherwise, with its higher than average rates of uninsured, California might be expected to have higher than average levels of uncompensated care (End notes[2]). Because of its size, diversity, and well-established hospital ownership mix, California hospitals have been studied perhaps more than any others with regard to the provision of uncompensated care. The majority of studies using data from California find essentially no difference between nonprofits and for-profits in terms of the provision of uncompensated care, and some suggest that for-profits may provide somewhat more.

Study on the Threat of Charity Care at Not-For-Profit Hospitals

Another study clearly demonstrates that not-for-profit hospital managers are faced with declining profitability and are challenged to reduce hospital-operating expenses while meeting their charitable mission (Harrison et al. 2004). Additionally, the greater size and increased clinical complexity of not-for-profit hospitals are increasing organizational overhead. In many cases, the increased clinical complexity is a commitment to the organizational mission of providing a full range of services to the community. From a policy perspective, the study suggests that not-for-profit hospitals have aging facilities and reduced cash flow due to lower profit margins. As a result, many not-for-profit hospitals face potential bankruptcy and closure (Harrison et al. 2004). This study clearly documents a threat to the provision of charity care in local communities and the long-term viability of the not-for-profit health care industry in the United States. Not-for-profit hospitals provide significant charitable services to their local communities. The delivery of charitable services relieves the government of many of the financial and administrative burdens of providing charitable care in exchange for favorable tax advantages. Unfortunately, these

advantages are only marginally mitigating the heightened organizational and environmental challenges that not-for-profit hospitals face. These hospitals may be jeopardizing their long-term survival by striving to achieve their core not-for-profit missions and objectives.

Not-for-profit hospitals historically operated with significant revenues from charitable sources and other donations. Currently, these donations represent a small percentage of total income as insurance, government, and other third-party payers have assumed primary payment responsibility. As a result, not-for-profit hospitals are being challenged to increase efficiency to gain greater access to capital and remain competitive in the changing health care market. Furthermore, governments at all levels are requiring not-for-profit hospitals to provide higher volumes of charitable care to continue justifying their tax exemptions. Not-for-profit hospitals are responding to these challenges by modeling for-profit hospital organizations, including their clinical services, internal operating procedures, efficiency measures, and focus on profitability often to the detriment of charity care provision. According to Harrison et al (2004), as industry pressures mount, many not-for-profit hospitals are merging, being acquired by for-profit entities, or closing (Harrison et al. 2003). The paradox faced by not-for-profit hospitals is that their charitable mission makes it increasingly difficult to survive in today's competitive market. The likelihood of hospital failure increases as more charity is provided, more Medicare patients are served, and more uncompensated care is rendered.

COMMUNITY BENEFIT REGULATIONS & TAX IMPLICATIONS

The main study objective is to gauge if the proportion of charity care and overall community benefits provided by non-profit hospitals is at least equal to that provided by taxable, for-profit hospitals, plus their tax exempt amount (similar to the federal, state and local taxes charges to for-profits), as a benchmark to maintain tax exemption. The second objective is to infer if tax exempt not-for-profit hospitals are fulfilling their charitable missions in the Atlanta MSA, to justify preferred tax treatment.

SUMMARY OF IRS REGULATIONS

The IRS defines not-for-profit hospitals as charitable organizations under section 501 (c)(3) of the Internal Revenue Code, despite the fact that hospitals are not specifically named in

the document. The IRS has developed a practical definition of community benefits for the purpose of granting tax exemptions. The federal criteria for providing tax exemptions to nonprofit hospitals have changed over time and have been gradually loosened.

Initially, the IRS determined in Revenue Ruling 56-185 that to be tax exempt, a hospital "must be operated 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 (IRS. 1956)." That 1956 revenue ruling specified clearly that bad debt did not constitute charity and that incurring bad debt did not satisfy the criteria for the tax exemption. The IRS criteria included a charity-care requirement, meaning specifically that, as not-for-profit hospitals began serving the whole community, instead of limiting services to the indigent, the IRS revised how it granted tax-exempt status to hospitals.

In 1969, Revenue Ruling 69-545 created the "Community Benefit Standard" as a metric to determine whether or not a hospital should be granted tax-exempt status (IRS. 1969). The IRS significantly loosened the criteria for nonprofit hospitals to receive the federal income tax exemption and defined promoting the health of any broad class of persons as a community benefit, including, perhaps, such activities as charity care, health screening, community education about health risks, emergency room services, and basic research (IRS. 1969; CBO. 2006). A hospital could satisfy the 1969 community-benefit requirement by offering emergency room services to all people regardless of their ability to pay, even if the hospital did not otherwise admit individuals who were unable to pay. The IRS identified five factors for this determination: (1) whether a board of trustees control the hospital, and if so, whether civic leaders control the board; (2) whether a hospital extends privileges to all qualified physicians in the area; (3) whether the hospital operates an active and accessible emergency room, regardless of patients' ability to pay. This ruling, however, was overruled in Revenue Ruling 83-157 in 1983, (IRS. 1983); (4) whether the hospital provides medical care to all persons able to pay; and (5) whether surplus funds, when used, improve the quality of patient care. Factors 1 and 5 (whether community leaders or shareholders determine the direction of the hospital and whether earnings are reinvested or distributed) are perhaps most widely associated with tax-status determination.

In 1983, the IRS loosened the guidelines further when it specified that a nonprofit hospital could receive the federal income tax exemption even if it did not operate an emergency room (IRS. 1983; CBO. 2006).

Qualification for Tax Exemption: Federal and State

Federal Tax

IRS's community benefit standard that hospitals must meet to qualify for federal tax exemption provides broad latitude to the hospitals in determining the nature and amount of the community benefits they provide, as indicated (GAO. 2008). Specifically, IRS, in a 1969 revenue ruling that established the current community benefit standard, modified the existing tax-exemption requirement that focused primarily on the level of charity care that a hospital provided (IRS. 1969). This 1969 revenue ruling also listed the five factors that demonstrated how a nonprofit hospital could benefit the community in a way that relieved governmental burden and promoted general welfare. The five factors were (1) the operation of an emergency room open to all members of the community without regard to ability to pay; (2) a governance board composed of independent civic leaders; (3) the use of surplus revenue for facilities improvement, patient care, and medical training, education, and research; (4) the provision of inpatient hospital care for all persons in the community able to pay, including those covered by Medicare and Medicaid; and (5) an open medical staff with privileges available to all qualifying physicians, (IRS. 1969). While IRS recognized these five factors as supportive of a nonprofit hospital's tax-exempt status, it also stated that a nonprofit hospital seeking exemption need not meet all five factors to qualify for tax-exempt status; instead, the determination is based on all the facts and circumstances, and the absence of a particular factor may not necessarily be conclusive. As stated by the Commissioner of Internal Revenue, some of the five factors are now common practice in the hospital community and are less relevant in distinguishing tax-exempt hospitals from their for-profit counterparts (Statement of Mark Everson, Commissioner of Internal Revenue, testimony before the full House Committee on Ways and Means, May 26, 2005). For example, having an open medical staff, participating in Medicare and Medicaid, and treating all emergency patients without regard to ability to pay are common features of both tax-exempt and for-profit hospitals.

Although the focus of IRS policy is no longer the level of charity care that hospitals provide, the 1956 revenue ruling remains relevant, and IRS and various courts have continued to take into account the extent to which a hospital provides charity care when determining an organization's tax-exempt status. For example, among the factors that the Tax Court and several United States Courts of Appeals have considered in determining whether an organization met IRS's tax exemption requirements were existence of a charity care policy, provision of free or below-cost services to individuals financially unable to make the required payments, and provision of additional community benefit—other than making hospital services available to all in the community—that either further the function of government-funded institutions or would not likely be provided within the community without a hospital subsidy (GAO. 2008).

State Tax

To qualify for exemption from state corporate income taxes and for exemption from state and local property and sales taxes, hospitals are subject to local requirements that may differ from federal requirements. State and local governments have, in many cases, required that, in order to receive tax exemptions, hospitals meet standards that are stricter than those imposed by the IRS (CBO. 2006). Furthermore, state community benefit requirements that hospitals must meet in order to qualify for state tax-exempt or nonprofit status vary substantially in scope and detail (GAO.2008). In addition to the variation in scope among state community benefit requirements, the level of detail among such requirements also varies substantially (GAO. 2008). Specifically, of the 15 states with community benefit requirements, 10 states have detailed requirements and 5 states have less detailed requirements. The 10 states with detailed requirements are California, Idaho, Illinois, Indiana, Maryland, New Hampshire, New York, Pennsylvania, Texas, and West Virginia. The five states with less detailed requirements are Alabama, Colorado, Mississippi, North Dakota, and Wyoming. The community benefit requirements of the 10 detailed states typically include some combination of the following factors: a definition of community benefit, requirements for a community benefit plan that sets forth how the hospital will provide community benefits, community benefit reporting requirements, and penalties for non compliance. For example, California requires its nonprofit hospitals to adopt and

annually update a community benefit plan, and annually submit a description of community benefit activities provided and their economic values, among other things (GAO. 2008). Similarly, Illinois requires its hospitals to develop an organizational mission statement and a community benefits plan for serving the community's health care needs, and to submit an annual report of its community benefits plan, including a disclosure of the amount and types of community benefits actually provided (GAO. 2008). These states also typically define community benefit using examples of, and guidance on, the types of activities considered to be community benefit. For example, Illinois defines community benefit using examples of activities that the state considers to be community benefit and Maryland defines community benefit using both examples and guidance (GAO. 2008). Illinois defines community benefit to include the unreimbursed cost of providing charity care, language assistant services, government-sponsored indigent health care, donations, volunteer services, education, government-sponsored program services, research, subsidized health services, and collecting bad debts. Illinois' definition explicitly excludes the cost of paying taxes or other governmental assessments (GAO. 20080. Maryland defines community benefit as an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including health services provided to vulnerable or underserved populations, such as Medicaid, Medicare, or Maryland Children's Health Program enrollees; financial or in-kind support of public health programs; donations of funds, property, or other resources that contribute to a community priority; health care cost containment activities; and health education, screening, and prevention services (GAO. 2008). In contrast, the remaining five states with less-detailed requirements either only require the provision of charity care or do not provide guidance on what counts as community benefit. For example, Alabama's requirement only provides that charity care must constitute at least 15 percent of a hospital's business in order for the hospital to be exempt from property tax and Wyoming's requirement does not specify which activities its nonprofit hospitals must provide, but makes clear that hospitals must provide benefit to the community to obtain or maintain tax-exempt status. In 1985, the Utah Supreme Court ruled that, to qualify for the property-tax exemption, hospitals must engage in some "act of giving," such as providing charity care (CBO.

2006). In Illinois, property-tax exemptions are limited to nonprofit hospitals that dispense charity care to all who need it (CBO. 2006). Some states have already taken or have proposed taking the additional step of imposing specific reporting and performance requirements on nonprofit hospitals (CBO. 2006). For example, in Texas, to receive a property-tax exemption, nonprofit hospitals must regularly report on the charity care and other community benefits that they provide and must meet specified quantitative standards (Kathryn. 2005). Those state and local requirements can represent significant constraints on nonprofit hospitals, given the financial value to nonprofit hospitals of the exemptions from state and local taxes.

The Value of Tax Exemptions for Nonprofit Hospitals

The Joint Committee on Taxation (JCT) recently examined the value to nonprofit hospitals and their supporting organizations of the major tax exemptions they receive from federal, state, and local governments (CBO. 2006). Together, the value of the various tax exemptions in 2002 was estimated to be $12.6 billion, with exemptions from federal taxes accounting for about half of the total and exemptions from state and local taxes accounting for the remaining half (Table below). JCT also estimated the value of some of the tax exemptions for nonprofit hospitals located in the five states for which uncompensated-care data were available. In the five states (California, Florida, Georgia, Indiana, and Texas), in which CBO undertook the study: non- profit hospitals and the provision of Community Benefit, the exemptions from federal and state corporate income taxes, state and local sales taxes, and local property taxes were valued at $2.5 billion. (Two important categories of tax exemptions—tax-exempt bond financing and the deductibility of charitable contributions—were included in the national totals but not available for the five states and not included in the five-state total).

Estimated Value of Tax Exemptions Provided to Nonprofit Hospitals, 2002

Value (Billions of Dollars)	
Corporate Income Tax (Federal)	2.5
Tax-Exempt-Bond Financing (Federal)	1.8
Charitable Contributions (Federal)	1.8
Corporate Income Tax (State)	0.5
Sales Tax (State and local)	2.8
Property Tax (Local)	3.1
Total	**12.6**

In terms of reduced tax revenues, the costs to the various levels of government of the tax exemptions for nonprofit hospitals are difficult to quantify. Part of the difficulty in measuring the value of the tax exemptions arises from the fact that nonprofits, because of their tax-exempt status, do not file the same types of tax returns as for-profits and, thus, do not provide some information needed to calculate their potential tax liability (CBO. 2006). A more fundamental issue in valuing the tax exemptions provided to nonprofits is the fact that nonprofit hospitals, if they were to lose their tax-exempt status, would likely change their behavior, more likely to mirror other for-profits. This might be a desired outcome.

SUMMARY OF COMMUNITY BENEFIT

Defining Community Benefits

The current interpretation and application of the Community Benefit Standard by the IRS is determined by the Healthcare Provider Reference Guide, which is available to providers on the IRS web site, www.irs.gov. This reference guide includes an exemption checklist and is a tool for both IRS agents and providers who want insight into the current tax-exemption standards. The 2004 guide communicates that tax-exempt healthcare providers must also meet the 501 (c) (3) standards in addition to the Community Benefit Standard outlined in Revenue Ruling 69-545; it also expands the definition of charity care to include medical research. The guide also follows questions provided by the IRS in a March 2001 Field Service Advice Memorandum, which clarified the requirements of the Community Benefit Standard (Broccolo 2004). To evaluate how nonprofit hospitals currently meet the community benefits standard, the IRS recently distributed a questionnaire to a selected group of nonprofit hospitals to invite responses relating to a variety of issues relating to Community Benefit and executive compensation, among other aspects relating operations and provision of care to the community(IRS. 2007; 2008).

Although nonprofit hospitals receive tax exemptions, in return for providing community benefits, there is little consensus on what constitutes a community benefit or how to measure community benefits. In the academic literature, community benefits have been defined as "those programs and services that are generally thought to be provided at low or negative margin and are intended to improve access by disadvantaged groups or to address important health care

matters for a defined population (Weissman. 1996)." Community benefits and collective goods are linked—if a hospital chooses to provide a particular medical service despite its being unprofitable, that may indicate that the hospital views that service as a collective good that is worth providing because it benefits the community (CBO. 2006). In identifying and measuring the community benefits that hospitals provide, it seems reasonable, therefore, to focus on services that are uncompensated or relatively unprofitable.

The Catholic Health Association (CHA) recently released a set of guidelines for hospitals to use in identifying community benefits, which was a modification and improvement of an earlier framework, which was referred to as accepted standard and followed by hospitals, policy makers, and federal and state governments (CHA. 2006). CHA's guidelines, which are in some ways stricter than the IRS's standards, specify that community benefits should include services that are "offered to the broad community [and] designed to improve community health," and for which the hospital either is not compensated at all or is undercompensated relative to the costs of providing the service. CHA guidelines include charity care as a community benefit but specifically exclude bad debt (CHA. 2006).

Differential Tax Treatment and Community Benefit Expectation

Nonprofit hospitals receive tax exemptions that allow them to use funds that would have been paid in taxes for patient care or other purposes. Tax exemptions provided to nonprofit hospitals, therefore, can be viewed as a form of government subsidy for the activities of a certain type of hospital. Whether that subsidy is justified from a public policy perspective depends on whether policymakers believe that the activities of hospitals in general should be subsidized, and, if so, whether those subsidies should be targeted at hospitals that organize themselves as nonprofits (CBO.2006). One possible rationale for providing tax exemptions to nonprofit hospitals would be if nonprofit hospitals tended to provide more collective goods than did for profit hospitals. The provision of uncompensated medical care to an indigent individual might be thought of as a type of collective good: the medical care directly benefits the indigent individual who receives it and might also benefit members of the community (by fulfilling compassionate impulses, for example, or by preventing the spread of a communicable disease). Collective goods

are defined as goods or services that, when used or consumed, generate well-being or utility for more than one individual at the same time (Burton. 1998). Tax exemptions for nonprofit hospitals are one approach to promoting the provision of collective goods and other approaches are identified as well (CBO. 2006). The managers of nonprofit organizations, because they do not directly receive the profits from the activities they oversee, might, in principle, be more willing than the managers of for-profit firms to provide collective goods when doing so is unprofitable (End Notes[10]).

ADVANTAGES & DISADVANTAGES IN LITERATURE

The subject is filled with challenges and opportunities. There are documented benefits and pitfalls in the way charity care and overall Community Benefits are treated currently. Studies have reviewed the performance of hospitals and attempted to find out what approach or framework should be adopted to standardize the definition, measurement, and reporting of charity care, bad debt, shortfalls in the cost versus payments of various means-tested programs, such SCHIP, Medicaid, state and/or local indigent care, and the diverse community programs undertaken by the hospitals. Changing the landscape of Community Benefit definition and transparency in the measurement and reporting standards would be first steps towards effectively and efficiently computing and evaluating the provision of Community Benefit for not-for-profit hospitals to better comprehend the challenge of tax dollars saved and costs of caring for Community.

The disadvantages in the literature highlight the numerous limitations while comparing the two types of hospitals. They range from the discrepancies in the variables (charity care, bad debt, shortfalls, community programs, medical education and training, research, etc.) institutions include and the way they are reported to an array of mismatch of demographic variables (the county, indigent population from neighboring counties, population mix, payer mix, per-capita income mix, insurance coverage mix, health status mix, ethnic mix, age and sex mix), to mismatch in the characteristics of hospitals (size, ownership, resources utilization, operational strategies & priorities, geographic & market variables), to case mix index (comparing severity of illness and policies and activities of the two types of hospitals towards dealing with this issue), to

deciding on what is Community Benefit and what to measure and how to report. From this perspective until all statistically significant variables are included in the analysis, errors of validity, accuracy, reliability and confounding would result and deem the findings unacceptable. Thus it is not easy to impose new policy and regulatory rulings based on interpretation of a few research findings, whose focus of study objectives differ, and penalize not-for-profit hospitals by revoking tax exemption or eliminating or reducing payments. This would have unintended, serious and far reaching consequence, to our healthcare delivery and health status management landscape. Some examples support the challenges and opportunities.

Reference to GAO and CBO studies

In 2005, the Government Accountability Office (GAO) reported on the amount of uncompensated care that nonprofit, for-profit, and government hospitals provided (End Notes[14]; GAO. 2005 b). GAO found that nonprofit hospitals devoted only slightly more of their patient operating expenses to uncompensated care, on average, than their for-profit counterparts. GAO also found that the burden of uncompensated care was not evenly distributed among nonprofit hospitals—a small number of nonprofit hospitals provided substantially more uncompensated care than other hospitals receiving the same tax preference. In 2006, the Congressional Budget Office (CBO) also reported wide variation in the provision of uncompensated care among nonprofit hospitals (End Notes[15]; CBO. 2006). These studies indicated that nonprofit hospitals may not be defining community benefit in a consistent manner that would enable policymakers to hold them accountable for providing benefits commensurate with their tax-exempt status (GAO. 2008).

Charity Care & Bad Debt

Consensus exists among the standards and guidance that nonprofit hospitals use to define charity care as community benefit (GAO. 2008). Specifically, among the five government and industry guidance documents GAO examined, four—IRS, AHA, CHA & VHA, and HFMA—define charity care as community benefit, as did all four state hospital associations we interviewed. While CMS does not have a position on community benefit, its reporting instrument collects information on uncompensated care and defines the term to include charity care. CMS

added this reporting instrument pursuant to section 112(b) of the BBRA, which does not use the term "community benefit," but requires short stay, acute care hospitals to submit data on costs incurred by the hospital for providing services for which the hospital is not compensated, including non-Medicare bad debt, charity care, and charges for Medicaid and indigent care GAO. 2008). In addition, of the 15 states with community benefit requirements, 14 either explicitly define community benefit to include charity care or, in the absence of a definition, mention charity care as an example of community benefit 9GAO. 2008).

Consensus does not exist among the standards and guidance that nonprofit hospitals use to define bad debt as community benefit (GAO. 2008). Among the five government and industry guidance documents GAO examined, CHA & VHA, and HFMA—specify that bad debt should not be defined as community benefit. CHA & VHA state that hospitals have the responsibility to better identify patients eligible for charity care, and thus distinguish charity care from bad debt (GAO. 2008). Making such charity care determinations is based in large part on information supplied by the patient or on the patient's behalf in the form of documentation, such as federal tax returns, pay stubs, bank statements, etc. There are many reasons that hospitals may be unable to obtain the necessary documentation. For example, a hospital association official GAO spoke with stated that hospitals are required to treat and stabilize emergency patients before inquiring about the patients' need for charity care, but patients may leave the hospital before hospital officials can speak to them about financial assistance (GAO. 2008). Other reasons include patient embarrassment or a lack of understanding of the hospital's charity care policy. Citing the difficulty of obtaining appropriate documentation to determine charity care eligibility, HFMA, while it does not define bad debt as community benefit, has stated that hospital charity care policies should address how to determine eligibility when patients do not provide sufficient information to formally make a determination (GAO. 2008). Specifically, HFMA stated that hospitals may refer to external sources, such as credit reports, to help support charity care determinations (GAO. 2008). Some of the hospital and hospital association officials GAO spoke with are either using or exploring the possibility of using external sources, such as zip codes in conjunction with per-capita income data, credit reports, and migrant worker status, as proxies to

make charity care eligibility determinations in the absence of patient-provided documentation (GAO. 2008). HFMA further stated that providers should make every effort to determine charity care eligibility before or at the time of service, but such determinations can also be made during a specific time period following patient care (GAO. 2008). In contrast, AHA defines bad debt as community benefit, as do three of the four state hospital associations GAO interviewed (GAO. 2008). AHA asserts that it should be defined as community benefit because the majority of bad debt is attributable to low-income patients who would qualify for charity care if hospitals were able to obtain the necessary documentation to formally make this determination (GAO. 2008).

IRS, on the other hand, has not taken a position on whether to define bad debt as community benefit (GAO. 2008. IRS. 2008). The agency recognizes the divergence of practices and views in this area and, as stated by its officials, would like more information on the amount of bad debt attributable to low-income patients. As a result, IRS's community benefit reporting instrument—Form 990, Schedule H—will collect data on bad debt separately from the list of hospital activities that are traditionally included as community benefit, permit hospitals to explain why certain portions of bad debt should be defined as community benefit, and allow hospitals to estimate how much bad debt is attributable to low-income patients (IRS. 2008; GAO. 2008). CMS does not have a position on community benefit; however, its reporting instrument collects information on uncompensated care and defines the term to include bad debt (GAO. 2008. CMS Form, Appendix X). State community benefit requirements vary in whether they define bad debt as community benefit. Of the 15 states with community benefit requirements, 3 states explicitly include bad debt as community benefit, 2 states explicitly exclude bad debt, and 10 states do not specify.

RESEARCH QUESTIONS

1. How do not-for-profit hospitals compare with their for-profit counterparts, in the provision of community benefit as a percentage of net revenue, in Metropolitan Statistical Area (MSA) Atlanta?
2. Are tax exempt not-for-profit hospitals fulfilling their charitable missions in the MSA Atlanta market, to justify preferential tax treatment?

METHODOLOGY

Study Design

My research design is a descriptive, retrospective, comparative case study analysis of the amount of community benefit, as a percentage of net revenue, which not-for-hospitals provide in comparison to that provided by for-profit hospitals in MSA Atlanta.

The study focuses on charges, cost, and revenues attributable to uncompensated care, SCHIP, Medicaid, and Georgia Indigent Care Program data from Medicare Cost Report.

The study's aim is to study Medicare Cost Report data to arrive at an unbiased review of whether tax exemption to not-for-profit hospitals is justifiable.

The study focuses on three approaches to Community Benefit provided by not-for-profit hospitals and for-profit hospitals, namely, 1. Comparing the two groups' Community Benefit within a similar revenue size, 2. Comparing the Average Community Benefit of the entire not-for-profit group with the for-profit group, and, 3. Comparing the Median Community Benefit among the two groups.

For this study and for the purpose of comparing the two types of hospitals, the following table lists the expenditures in relation to net revenue for calculating community benefit, as well as government subsidies or offset payments to DSH qualifying hospitals, which will be deducted:

Table 1: Qualifying Expenditures and Payments for Community Benefit Calculation

1. Uncompensated Care Cost (According to what is reported in the Medicare Cost Report)
2. SCHIP payment Shortfall
3. Medicaid Payment Shortfall
4. Georgia Indigent Care Payment Shortfall
5. Income Tax (Federal & State)
6. Property Tax
7. DSH Payments to Qualifying hospitals

Population under Study

The population studied consists of two groups of hospitals. One group comprises tax exempt, not-for-profit hospitals in the Metro-Atlanta area and the second group is the tax-paying, for-profit hospitals in the same Metro-Atlanta area. The MSA Atlanta hospital list was provided by Georgia Hospital Association (GHA). The list originally included 27 not-for-profit hospitals, but due to lack of availability of data, 10 were omitted. The resulting 17 hospitals are well represented across a wide revenue size range and there is a matching revenue size range for the for-profit hospital group of 7. The number of hospitals in the for-profit group was originally 9, but two were dropped due to inadequate data. The final list is tabulated in Table 2A & 2B below.

The hospitals in both the groups are well distributed across the Atlanta MSA, with some directly in the Atlanta city location, while the others are spread out in the remaining MSA (map in Appendix T). All the hospitals have been operating for over 10 years, and are considered community hospitals within their MSA Atlanta counties.

Table 2A: Revenue Size based Listing of Not-For-Profit Hospitals in Atlanta MSA

No	MC Id	Facility Name	City	Revenue Size
1	110042	WellStar Paulding Hospital	Dallas	Under $100 M
2	112007	WellStar Windy Hill Hospital	Marietta	Under $100 M
3	110015	Tanner Medical Center/Villa Rica	Villa Rica	Under $100 M
4	110183	Emory-Adventist Hospital	Smyrna	$100M - Under $250 M
5	110018	Newton Medical Center	Covington	$100M - Under $250 M
6	110161	Northside Hospital-Cherokee	Canton	$100M - Under $250 M
7	110011	Tanner Medical Center/Carrollton	Carrollton	$250M - Under $500 M
8	110091	Rockdale Hospital & Health Systems	Conyers	$250M - Under $500 M
9	110215	Piedmont Fayette Hospital	Fayetteville	$250M - Under $500 M
10	110165	Southern Regional Medical Center	Riverdale	$5000M - Under $1 B
11	110143	WellStar Cobb Hospital	Austell	$5000M - Under $1 B
12	110078	Emory Crawford Long Hospital	Atlanta	$5000M - Under $1 B
13	110082	Saint Joseph's Hospital of Atlanta	Atlanta	Over $1 B
14	110079	Grady Memorial Hospital	Atlanta	Over $1 B
15	110083	Piedmont Hospital	Atlanta	Over $1 B
16	110035	WellStar Kennestone Hospital	Marietta	Over $1 B
17	110161	Northside Hospital	Atlanta	Over $1 B

Table 2B: Revenue Size based Listing of For-Profit Hospitals in Atlanta MSA

No	MC id	Facility Name	Ownership	City	Revenue Size
1	110045	Barrow Community Hospital	HMA	Winder	Under $100 M
2	110046	Walton Regional Medical Center	HMA	Monroe	$100M - Under $250 M
3	110030	Cartersville Medical Center	HCA	Cartersville	$250M - Under $500 M
4	110031	Spalding Regional Hospital	Tenet	Griffin	$5000M - Under $1 B
5	110219	South Fulton Medical Center	Tenet	East Point	$5000M - Under $1 B
6	110198	North Fulton Regional Hospital	Tenet	Roswell	$5000M - Under $1 B
7	110115	Atlanta Medical Center	Tenet	Atlanta	Over $1 B

DATA SOURCES

The secondary data sources to be used for the analysis include Medicare Cost Reports and Disproportionate Share Hospital (DSH) data from Centers for Medicare and Medicaid (CMS) website. Georgia Hospital Medicare provider id and list of not-for-hospitals and for-profit hospitals in MSA Atlanta were obtained from Georgia Hospital Association (GHA), and income and property tax information from the for-profit hospital corporate offices of Tenet, HMA, and HCA.

The variables data, other than DSH and the tax data, was based on the list in Appendix A. These variables are based on hospital reporting in their location in CMS form 2552-96, section S-10 (hospital uncompensated care data) and G3 (statement of revenue and expenses). The reported data files were obtained from two sources to compare and cross reference for errors and accuracy: Dr. Richard Lindrooth, Project Committee Chair, Medical University of South Carolina and Cleverley and Associates. Dr. Bill Cleverley was one of the professors in my Healthcare Financial Management Course.

Table 3: 2007 Year Ending Variables and their Sources (Details in Appendix A)

Variable	Data Source
Patient Revenues (Total & Net), Expenses, Net Income & Margin	Medicare Cost Report
Ratio of Cost to Charges	Medicare Cost Report
Uncompensated Care Charges and Cost	Medicare Cost Report
SCHIP Charges, Cost, and Revenue	Medicare Cost Report
Medicaid Charges, Cost, and Revenue	Medicare Cost Report
Georgia Indigent Care Program Cost, Charges, Revenue	Medicare Cost Report
DSH Payments	CMS Website
Taxes (Federal, State and Property)	Corporate Offices of HCA, HMA, and Tenet
Medicare Id and List of MSA Atlanta Hospitals	Robert Bolden Vice President Georgia Hospital Association

The researcher believes that the analysis of data would result in valid and reliable findings assuming that the data reported and available from the sources are reliable, and the tax treatment acceptable. It is generally understood that all reporting entities, including hospitals, prepare their financial statements according to Generally Accepted Accounting Principles (GAAP), but it is also a well known fact that organizations, hospitals included, do attempt to use creative methods to boost their operating and financial outcomes.

DATA ANALYSIS

Based on the data available and collected, I have quantitatively analyzed the data and computed community benefit share of net revenue from three approaches, as mentioned in the study design. For these approaches, the Community Benefit is calculated by adding the percentage of net revenue of six identified variables, which are recognized currently as providing Community Benefit (CHA. 2005; AHA. 2006). These are uncompensated care cost, shortfall in SCHIP payment, shortfall in Medicaid payment, shortfall in Georgia Indigent Care Program Payment, Federal & State Income Tax and Property Tax. Community Benefit is calculated in accordance with the formula below:

Table 4: Community Benefit Calculation for Not-For-Profit & For-Profit Hospitals.

$$\text{Community Benefit} = \frac{\text{Uncompensated care cost} + \text{Shortfalls in (SCHIP} + \text{Medicaid} + \text{Georgia Indigent Care)} - \text{DSH}}{\text{Net Patient Revenue}}$$

Three methods were utilized to calculate and compare the Community Benefit provided by not-for-profit hospitals and for-profit hospitals. The first approach,1. Organized the two groups of hospitals into corresponding revenue sizes, i.e., a. Under $100M, b. $100M – Under $250M, c. $250M – Under $500M, d. $500M – Under $1B, and e. $ Over 1B. The 17 not-for profit hospitals and 7 for-profit hospitals were grouped within respective revenue sizes and their Community Benefits analyzed with respect to net revenues for each revenue size and compared, and the second approach, 2. Rank ordered all the hospitals in both the groups from the lowest total revenue to the highest total revenue and the average Community Benefit was calculated once again with respect to net revenue. Both groups of hospitals were then compared with each other, and the third approach, 3. Rank ordered all the hospitals in both the groups from the lowest total

revenue to the highest total revenue and the median Community Benefit was calculated once again with respect to net revenue. Both groups of hospitals were then compared with each other.

RESULTS

All data collected and analyzed are provided in Appendix A to Y. The not-for-profit and for-profit Community Benefit analysis are illustrated in the Appendices section and the complete list of variables and their locations of access, as well as map of MSA Atlanta (Appendix T), List of Hospitals (Appendix U), new IRS Form 990 Schedule H (Appendix V), Glossary (Appendix W), county profiles of the two types of hospitals (Appendix X), and county population breakdown (Appendix Y) are also included in the appendices.

In Appendix B and Appendix C, for example, the Community Benefit calculations are tabulated for not-for-profit and for-profit hospitals respectively within five distinct revenue sizes. Tables 5A and 5B below show tabulation of operating results of the not-for-profit and for-profit hospitals grouped within revenue size. Two tax rate scenarios 1 & 2 at 4.8% and 2.74% (at the reduced rate, due to adjusting for three for-profits with negative margins) are calculated and the two groups compared. Appendix D is a tabulation of the Average and Median Community Benefits for the two groups of hospitals with tax burden shared by for-profit hospitals compared with not-for-profit hospitals. Appendix E to M tabulates and analyzes the data for the individual variables contributing to the total Community Benefit, such as uncompensated care cost, and shortfalls for SCHIP, Medicaid, and Georgia Indigent Care Program. Each of these variables' cost and shortfall as a percent of net revenue are calculated in these Appendices. Finally Appendix N and O tabulates and analyzes the DSH payments received by not-for-profit and for-profit hospitals as percent of net revenues. Appendices P & Q relate to revenue size based profit and Community Benefit of not-for-profits and for-profits respectively. Appendix R & S tabulate median Community Benefit Calculations for not-for-profits and for-profits, while Appendix W is a listing of hospitals by county.

Appendix Z is added to show what happened when the original selected list was expanded to include all hospitals, which either reported at least one variable or none at all. The results of the selected and all hospitals are summarized in the first section of this paper.

The 17 not-for-profit hospitals and 7 for-profit hospitals are grouped into five classes of revenue sizes to better compare the two groups within each revenue size. As can be seen in tables 5A, in the not-for-profit group, three hospitals fall within the first class, three in the next class, three in the third and fourth classes and five in the fifth revenue size classification. In table 5B, the for-profit group has one hospital within the first, second, third and fifth revenue size class while three hospitals are in the fourth revenue size class and one in the fifth revenue size.

Table 5A: Operating Results of Not-For-Profit Hospitals

Atlanta Metropolitan Statistical Area Not-For-Profit Hospitals
Operating Results

Revenue Size	Facility Name	Total Patient Revenue	Cont Adj	Net Patient Revenue	Operating Expenses	Income	Gross Margin
Under $100M	WellStar Paulding Hospital	90,638,062	46,542,633	44,095,429	46,723,864	2,628,435	-2.90%
	WellStar Windy Hill Hospital	92,290,023	47,989,588	44,300,435	35,835,422	8,465,013	9.17%
	Tanner Medical Center/Villa Rica	94,431,433	56,808,481	37,622,952	27,318,539	10,304,413	10.91%
$100M - Under $250M	Emory-Adventist Hospital	118,412,417	76,802,762	41,609,655	42,624,681	1,015,026	-0.86%
	Newton Medical Center	191,534,977	121,441,217	70,093,760	74,480,560	4,386,800	-2.29%
	Northside Hospital-Cherokee	228,829,893	146,935,708	81,894,185	82,152,722	258,537	-0.11%
$250M - Under $500M	Tanner Medical Center/Carrollton	312,501,237	183,113,758	129,387,479	146,199,945	16,812,466	-5.38%
	Rockdale Hospital & Health Systems	322,043,620	210,975,930	111,067,690	120,158,608	9,090,918	-2.82%
	Piedmont Fayette Hospital	426,106,142	284,495,763	141,610,379	143,321,227	1,710,848	-0.40%
$500M - Under $1000M	Southern Regional Medical Center	690,612,152	453,649,201	236,962,951	254,626,019	17,663,068	-2.56%
	WellStar Cobb Hospital	742,247,281	463,177,804	279,069,477	278,594,371	475,106	0.06%
	Emory Crawford Long Hospital	940,506,061	531,065,928	409,440,133	398,740,145	10,699,988	1.14%
Over $1000M	Saint Joseph's Hospital of Atlanta	1,052,532,404	693,232,129	359,300,275	372,904,000	13,603,725	-1.29%
	Grady Memorial Hospital	1,200,306,427	864,199,512	336,106,915	678,973,626	342,866,711	-28.56%
	Piedmont Hospital	1,481,718,617	945,407,521	536,311,096	520,638,356	15,672,740	1.06%
	WellStar Kennestone Hospital	1,608,501,821	1,003,172,646	605,329,175	556,440,653	48,888,522	3.04%
	Northside Hospital	1,621,618,625	1,003,521,424	618,097,201	620,346,593	2,249,392	-0.14%

Table 5B: Operating Results of For-Profit Hospitals

Atlanta Metropolitan Statistical Area For-Profit Hospitals
Operating Results

Revenue Size	Facility Name	Total Patient Revenue	Cont Adj	Net Patient Revenue	Operating Expenses	Income	Gross Margin
Under $100M	Barrow Community Hospital (HMA)	71,270,163	52,544,326	18,725,836	22,816,390	4,090,553	-5.74%
$100M - Under $250M	Walton Regional Medical Center (HMA)	106,172,046	71,439,475	34,732,571	33,778,177	954,394	0.90%
$250M - Under $500M	Cartersville Medical Center (HCA)	468,079,393	357,480,163	110,599,230	87,607,427	22,991,803	4.91%
$500M - Under $1000M	Spalding Regional Hospital (Tenet)	530,015,916	415,865,950	114,149,966	98,536,636	15,613,330	2.95%
	South Fulton Medical Center (Tenet)	554,025,888	447,511,369	106,514,519	114,322,616	7,808,097	-1.41%
	North Fulton Regional Hospital (Tenet)	715,574,720	571,267,098	144,307,623	131,254,970	13,052,653	1.82%
Over $1000M	Atlanta Medical Center (Tenet)	1,009,485,872	769,276,553	240,209,319	245,466,859	5,257,540	-0.52%

The tax percent used in scenario 1 assumes the approximate tax rate of 4.8%, based on discussion with corporate offices of Tenet, HCA and HMA. This rate is applied on all the for-profits irrespective of the nature of their net income and profit margins. The second scenario corrects for the negative income and margins of three for-profits and uses 2.74%. Table 6A below shows two scenarios 1 & 2, and the Average Community Benefits that not-for-profit and for-profit hospitals provided. Out of the 17 not-for-profit hospitals, 5 did not participate in the Georgia Indigent Care Program (GICP) and out of the 7 for-profit hospitals, 4 did not participate in GICP. The summary of the data and analysis indicates that the not-for-profits provided 7.67% Average Community Benefit as a group with tax exempt status and the for-profit group contributed

Average Community Benefit of 5.83% not taking into account their Tax Contributions to Community Benefit. When the Tax rate of 4.8% from scenario 1 is factored in, the for-profits provided 10.63% Average Community Benefits in comparison to the 7.67% Average Community Benefit provided by not-for-profits. When tax rate of 2.74% is used in scenario 2, the for-profits provided 8.57% Average Community Benefit in comparison to the same 7.67% Average Community Benefit provided by the not-for-profits. The difference in scenario 1 is 2.96% in comparison to scenario 2, which is 0.90%.

Table 6A: Average & Total Community Benefit with 4.8% and 2.52% Tax Impact

										Scenario 1		Scenario 2	
			Average Uncompensated Percent of Net Revenue for	Average SCHIP Shortfall Percent of Net Revenue for	Average MCAID Percent of Net Revenue for	Average GICP Percent of Net Revenue for	Average DSH Percent of Net Revenue for	Average Community Benefit as Percent of Net Revenue for	Tax Percent (Income + Property) 4.80%	Total Community Benefit	Tax Percent (Income + Property) 2.74%	Total Community Benefit
Type of hospitals	Average Net Revenue	Average Community Benefit	RevenueSize	RevenueSize	RevenueSize	RevenueSize	RevenueSize	Revenue Size				
All Not-For-Profit Hospitals	240,135,246	18,439,465	8.17%	0.01%	0.85%	0.17%	-1.53%	7.67%	0.00%	7.67%	0.00%	7.67%
All For-Profit Hospitals	169,891,295	6,421,068	6.59%	0.01%	0.89%	1.18%	-2.64%	5.83%	4.80%	10.63%	2.74%	8.57%
DIFFERENCE	130,243,951	12,018,398	-1.58%	0.00%	-4.16%	1.01%	-1.11%	-1.84%	4.80%	2.96%	2.74%	0.90%

Table 6B below shows the Median Community Benefits that not-for-profit and for-profit hospitals provided. Out of the 17 not-for-profit hospitals, 5 did not participate in the Georgia

Indigent Care Program (GICP) and out of the 7 for-profit hospitals, 4 did not participate in GICP. The summary of the data and analysis indicates that the not-for-profits provided 6.45% Median Community Benefit as a group with tax exempt status and the for-profit group contributed Median Community Benefit of 5.65% not taking into account their Tax Contributions to Community Benefit. When the Tax rate of 4.8% in scenario 1 is factored in, the for-profits provided 10.45% Median Community Benefits in comparison to the 6.45% Median Community Benefit provided by not-for-profits. In scenario 2, when the tax rate of 2.74% is factored in, the for-profits provided 8.39% Median Community Benefit in comparison to the same 6.45% provided by the not-for-profits.

Table 6B: Median & Total Community Benefit with 4.8% and 2.52% Tax Impact

				Scenario 1		Scenario 2	
Type of hospitals	Median Net Revenue	Median Community Benefit	Median Benefit as Percent of Net Revenue	Tax Percent (Income + Property) 4.80%	Total Community Benefit	Tax Percent (Income + Property) 2.74%	Total Community Benefit
All Not-For-Profit Hospitals	141,610,379	9,130,930	6.45%	0.00%	6.45%	0.00%	6.45%
All For-Profit Hospitals	110,599,230	6,243,994	5.65%	4.80%	10.45%	2.74%	8.39%
DIFFERENCE	31,011,149	2,886,936	-0.80%	4.80%	4.00%	2.74%	1.94%

The Median Community Benefit provided by the not-for-profit hospital group in scenario 1 is 1.22% smaller than the Average Community Benefit provided by the same group while the Median Community Benefit provided by the for-profit group in scenario 1 is (-0.18)% smaller than the Average Community Benefit provided by the for-profit group. In scenario 2, with a lower tax bracket of 2.74%, the Median Community Benefit provided by the not-for-profit hospital group is

the same 6.45% which is 1.22% smaller than the Average Community Benefit provided by the same group while the Median Community Benefit provided by the for-profit group in scenario 2 is 0.18% smaller than the Average Community Benefit provided by the for-profit group. The following tables summarize the average and median dollar values of the Community Benefits provided by the not-for-profits and for-profits.

Table 7A: Average Community Benefit for Not-For-Profit as Total Dollar Value

$$\frac{\text{\$18,439,466 of Average Community Benefit}}{\text{\$240,135,246 Average Net Revenue of Not-For-Profits}} = \text{7.68\% Avg. Community Benefit}$$

Table 7B: Average Community Benefit for For-Profit as Total Dollar Value

$$\frac{\text{\$6,421,068 of Average Community Benefit}}{\text{\$109,891,294 Average Net Revenue of For-Profits}} = \text{5.84\% Avg. Community Benefit}$$

Table 8A: Median Community Benefit for Not-For-Profit as Total Dollar Value

$$\frac{\text{\$9,130,930 of Median Community Benefit}}{\text{\$141,610,379 Median Net Revenue of Not-For-Profits}} = \text{6.45\% Median Community Benefit}$$

q

Table 8B: Median Community Benefit for For-Profit as Total Dollar Value

$$\frac{\text{\$6,243,994 of Median Community Benefit}}{\text{\$110,599,230 Median Net Revenue of For-Profit}} = \text{5.65\% Median Community Benefit}$$

As a summary of Tables 7A, 7B, 8A, and 8B, the average and median Community Benefit (**$18,439,466 vs. $9,130,930**) of not-for-profits vary far more than the average and

median Community Benefit (**$6,421,068 vs. $6,243,994**) of for-profits. This indicates that some relatively large hospitals in the not-for-profits have net revenues that are much higher than the median net revenues. This in fact is the case, as one hospital in the $500 million to under $1 billion is three times and three hospitals in the over $1 billion have about four times median revenues (Appendix E).

Other interesting results emerged when I rank ordered the revenue sizes and relative Community Benefit for the not-for-profit and for-profit groups of hospitals within these revenue size classification. Tables 9A and 9B show this characteristic. The revenue size ranking differs among the not-for-profit and for-profit groups in the way the Community Benefit progresses from the highest to the lowest. For the not-for-profits the highest to the lowest Community Benefit follows the revenue size in the order over $1 billion, $250 million to under $500 million, under $100 million, $100 million to under $250 million, and the final revenue class $500 million to under $1 billion. In contrast, the for-profit had a different Community Benefit ranking in relation to the revenue size classification, namely, under $100 million, $100 million to under $250 million, over $1 billion, $250 million to under $500 million and finally $500 to under $1 billion. Every revenue size had a positive impact to Community Benefit. What is interesting is that except the revenue sizes $500 to under $1 billion, $100 million to under $250 million, and under $100 million, where for-profits provided higher Community Benefit, the not-for-profits provided higher Community Benefit than the for-profits in the over $1 billion and $250 million to under $500 million. In this last category, the not-for-profits provided higher Community Benefit than for-profits when the lower tax rate was taken and also without tax, but the for-profits provided higher Community Benefit if the higher tax rate of 4.8% was taken.

Table 9A: Rank Ordering Community Benefit of Not-For-Profits to Revenue Size

Revenue Size based Community Benefit of Not-For-Profits based on Net Revenue Rank Order of the Revenue Size based on Community Benefit

	All Not-For-Profits	
	Community Benefit as Percent of Net Revenue	
Revenue Size	Scenario 1	Scenario 2
Over $1000M	12.16%	12.16%
$250M - Under $500M	8.63%	8.63%
Under $100M	5.83%	5.83%
$100M - Under $250M	4.66%	4.66%
$500M - Under $1000M	3.60%	3.60%

Table 9B: Rank Ordering Community Benefit of For-Profits to Revenue Size

Revenue Size based Community Benefit of For-Profits based on Net Revenue Rank Order of the Revenue Size based on Community Benefit

	All For-Profits		
	Community Benefit as Percent of Net Revenue		
	Scenario 1	Scenario 2	
Revenue Size	4.8% tax rate	2.74% tax rate	Without tax
Under $100M	16.57%	14.51%	11.77%
$100M - Under $250M	12.31%	10.25%	7.51%
Over $1000M	11.43%	9.37%	6.63%
$250M - Under $500M	10.44%	8.38%	5.64%
$500M - Under $1000M	10.09%	8.03%	5.29%

DISCUSSION

The Metropolitan Statistical Area of Atlanta is a very dense, highly populated environment with a diverse patient mix, payer mix, socio-economic status, and an array of insurance coverage for the demographic base. The hospitals in the group have good opportunities for market share and revenue growth but face equal challenges due to reimbursement issues, from both public and private payers, as well as escalating resource consumption costs, such as supply and labor costs among others. Due to the hospitals being located in Metro Atlanta, which is a thriving and active environment for business and industrial growth, all hospitals also operate under similar conditions regarding managed care contracts, pricing and contractual adjustments with both public and private payers. What would be challenging to quantify is the patient mix, the per-capita income, insurance coverage levels, and people who are able to pay but who choose to remain uninsured or take limited insurance. Also not all hospitals qualify for DHS payments and this would become evident in the findings, tables and Appendices.

There are a large number of uninsured and indigent care populations, which affect several hospitals, in particular safety net hospitals such as Grady Memorial which is just surfacing from the brink of bankruptcy, with a new CEO and a restructured Board. The State's policy has been very active and favorable to funding SCHIP and Georgia Indigent Care Program as well as contributes substantial dollars to Medicaid, which is currently undergoing some allocation issues due to state revenue shortfall.

FINDINGS

The results clearly point to the deficiency in the Community Benefit that is expected from not-for-profit hospitals which operate in their communities. Granting tax exemption to not-for-profits clearly deprives an equivalent dollar amount available to the community as stated in the literature (IRS. 2009; GAO. 2008). The tax contributions of the for-profits save the local, State and federal governments from having to provide additional healthcare dollars for improving access to better health and healthcare delivery for the communities served by community hospitals.

The results of the data analysis show how deficient and varied not-for-profit hospitals are in the provision of expected Community Benefits in comparison to for-profits, and as such do not justify the exemption of taxes. All general community hospitals provide a broad array of programs and services when they are classified under Medicare guidelines and provider identification, as

acute care hospitals. Most if not all of them offer emergency services. It is also assumed that all of the hospitals are further located in comparable markets within each revenue size, since no demographic information was obtainable for each county represented hospital.

In the comparative analysis, based on the three approaches i.e. the revenue size model, the group average and median models, the for-profit hospitals provide a higher percentage of their net revenues as Community Benefit, except in one revenue size classification as shown below.

In the revenue size model, the not-for-profits provided Community Benefits of 5.83%, 4.66%, 8.63%, 3.60%, and 12.16%, in the order of increasing revenue size (Appendix B), while the for-profits provide Community Benefit of 11.77%, 7.51% , 5.64%, 5.29%, and 6.63%, and without the inclusion of their tax components of Community Benefit as represented in Appendix C. In scenario 1, where tax rate is 4.8%, the Community Benefit increased to 16.57%, 12.31%, 10.44%, 10.09%, and 11.43% (Appendix C). In scenario 2, the reduced tax rate of 2.74% (adjusting for negative income and margins of three hospitals), changed the Community Benefit to 14.51%, 10.25%, 8.38%, 8.03%, 9.37% (Appendix C). At both these tax rates, the Community Benefits provided by the for-profits exceed those provided by the not-for-profits in all revenue sizes, except in the over $1 billion and $250 million to under $500 million categories.

If hospitals in both not-for-profit and for-profit groups are compared (slides 63 and 64) within each revenue size classification, and using only scenario 1, then the actual differences in Community Benefit between not-for-profit and for-profit hospitals would be as follows: under $100millin→ **10.74%** (16.57% for-profit contribution – 5.83% not-for-profit contribution), $100 million – under $250 million→ **7.65%** (12.31% for-profit contribution – 4.66% not-for-profit contribution), $250 million – under $500 million→ **1.81%** (10.44% for-profit contribution – 8.63 % not-for-profit contribution), $500 million – under $1 billion→**6.49%** (10.09% for-profit contribution – 3.60% not-for-profit contribution), and over $1 billion→ **(-1.20)%** (11.43% for-profit contribution – 12.63% not-for-profit contribution). The largest differences rank down from 10.74% for the smallest revenue size hospitals, to 7.65% (the second smallest revenue size), to 6.49% (the second largest revenue size), to 1.81% (the third largest revenue size), and to -1.20% (the largest

revenue size), where the not-for-profit group provided a 1.20% largest percent of Community Benefit. This largest revenue size group also has a big outlier, Grady memorial, which provides 47.71% total Community Benefit out which 50.58% is uncompensated care percent of net revenue. In the revenue size model, scenario 1, these differences indicate that for-profits gave Community Benefits of 184% more, 164% more, 21% more, 180% more and 6% less in the five revenue categories respectively. To catch up, the not-for-profits would need to provide additional net revenues of $9,493,715, $14,810,216, $6,915,386, $60,063,169 and (-$29,461,735) respectively in the five revenue size classifications. Across the entire group of revenue sizes, the total is approximately $61,820,751. In scenario 2, the differences are 8.68%, 5.99%, (-0.25)%, 4.43%, (-2.79)% in the lower to higher revenue size. These relate to $7,672,760, $11,596,496, (-$955163), $40,998,434, and -$68,498,536 respectively for a total of (-$9,186,009) more, which not-for-profits provided.

In the hospital grouping model, the average and median Community Benefits were calculated for both scenarios 1 &2 (slides 65 and 66). The tabulation of the data analysis once again reinforces the findings that the Community Benefit as a percent of net revenue is lower for not-for-profits in comparison to for-profits, when for-profits' tax burden as a percent of net revenue are factored in. In slide 65, Scenario 1, just to catch up with the for-profits, the not-for-profits have to provide on average, 2.96% more Community Benefit (10.63% for-profit total Community Benefit – 7.67% not-for-profit total Community Benefit), and if the median results are utilized for comparison, the not-for-profits have to provide 4.00% more Community Benefit (10.45% for-profit total Community Benefit – 6.45% not-for-profit total Community Benefit). These differences in average and median Community Benefit equate to for-profits giving approximately 38.59% and 62.17% more in both models in terms of average and median Community Benefits respectively. To catch up with the for-profits, the not-for-profits would need to provide on average, an additional $7,108,032 in the average mode and $5,664,415 in the median mode as calculated by the Community Benefit percent of net revenue.

Table 10: Average and Median Community Benefits of Not-For-Profits and For-Profits

Type of hospitals	Average Net Revenue	Average Community Benefit	Average Uncompensated Percent of Net Revenue for Revenue Size	Average SCHIP Shortfall Percent of Net Revenue for Revenue Size	Average MCAID Percent of Net Revenue for Revenue Size	Average GICP Percent of Net Revenue for Revenue Size	Average DSH Percent of Net Revenue for Revenue Size	Average Community Benefit as Percent of Net Revenue for Revenue Size	Scenario 1: Tax Percent (Income + Property) 4.80%	Scenario 1: Total Community Benefit	Scenario 2: Tax Percent (Income + Property) 2.74%	Scenario 2: Total Community Benefit
All Not-For-Profit Hospitals	240,135,246	18,439,466	8.17%	0.01%	0.85%	0.17%	-1.53%	7.67%	0.00%	7.67%	0.00%	7.67%
All For-Profit Hospitals	109,891,295	6,421,068	6.59%	0.01%	0.69%	1.18%	-2.64%	5.83%	4.80%	10.63%	2.74%	8.57%
DIFFERENCE	130,243,951	12,018,398	-1.58%	0.00%	-0.16%	1.01%	-1.11%	-1.84%	4.80%	2.96%	2.74%	0.90%

Type of hospitals	Median Net Revenue	Median Community Benefit	Median Benefit as Percent of Net Revenue	Scenario 1: Tax Percent (Income + Property) 4.80%	Scenario 1: Total Community Benefit	Scenario 2: Tax Percent (Income + Property) 2.74%	Scenario 2: Total Community Benefit
All Not-For-Profit Hospitals	141,610,379	9,130,930	6.45%	0.00%	6.45%	0.00%	6.45%
All For-Profit Hospitals	110,599,230	6,243,994	5.65%	4.80%	10.45%	2.74%	8.39%
DIFFERENCE	31,011,149	2,886,936	-0.80%	4.80%	4.00%	2.74%	1.94%

In slides 65 and 66, and in Scenario 2, just to catch up with the for-profits, the not-for-profits have to provide on average, 0.90% more Community Benefit (8.57% for-profit total Community Benefit – 7.67% not-for-profit total Community Benefit), and if the median results are utilized for comparison, the not-for-profits have to provide 1.94% more Community Benefit (8.39% for-profit total Community Benefit – 6.45% not-for-profit total Community Benefit). These differences in average and median Community Benefit equate to for-profits giving approximately 11.73% and 30.08 more in both models in terms of average and median Community Benefits respectively. To catch up with the for-profits, the not-for-profits would need to provide on average, an additional $2,161,217 in the average mode and $2,747,241 in the median mode as calculated by the Community Benefit percent of net revenue.

The study highlights the three methods of computing and comparing Community Benefits of not-for-profit and for-profit. In scenario 1, variation of $54,712,719 is between the revenue size model and average net revenue model, and $56,156,336 between the revenue size model and median revenue model. Also the variation between the average and median models is $1,443,617, which is difference between them.

Additionally, Appendix P and Appendix Q are tabulated results for not-for-profit and for-profit profit margins and Community Benefit, exclusive of tax. It is seen that 11 of the not-for-profits are operating in red with negative income and gross margin, on a net income basis (excess revenue over expense) and the for-profits, on an EBIDTA basis (earnings before interest, depreciation, taxes and amortization). The Lowest margin of -28.56% is for Grady Memorial (a safety net hospital, which is bombarded with charity care cost and bad debt, and an outlier in terms of its uncompensated care and GICP costs). Grady provides total Community Benefit of 47.71% and uncompensated care costs of 50.58%. IRS combines charity care and bad debt and refers to them as uncompensated care cost (IRS.2009), while others do not (CHA. 2006). This researcher's study does not have the breakdown of uncompensated care. The other not-for-profits' profit margins range from -5.38% to 10.91% (Tanner Medical Center at Carrollton at the lower end to Tanner Medical Center at Villa Rica in the higher end) and the not-for-profits provide Community Benefit in the range of 0.52% to 15.67% (Wellstar Windy Hill at the lower end to

Tanner Medical Center in Villa Rica at the higher end). Tanner in Villa Rica has a healthy margin of 10.91%. Tanner Medical Center in Carrollton also provides a high percent, 13.85%, of Community Benefit while having a negative margin of -5.38%. Both the Tanner hospitals have a high percent of net revenue for uncompensated care cost, and shortfalls in SCHIP and Medicaid. In comparison, the profit margins of the for-profits range from -5.74% to 4.91% (Barrow Community Hospital at the lower end to Cartersville Medical Center at the higher end) and Community Benefit range of 1.20% to 11.78% (North Fulton Regional at the lower end to Barrow Community Hospital at the higher end). Barrow has a high percent of net revenue for uncompensated care and Medicaid while North Fulton has a low uncompensated care cost as a percent of net revenue. All of the for-profits have a DSH offset ranging from1.36% to 4.13%, and the no-for-profits have DSH offset ranging from 0% to 4.04%, deducted from Community Benefit calculations since they are favorable offsets of disproportionate care.

The findings see good correlation between not-for-profits and lower Community Benefit in all the three models chosen, and suggest that to tax or not to tax should be tied to a consensus driven formula that stipulates a certain minimum Community Benefit provision by the not-for-profits over and above the taxed for-profits. If the not-for-profits are allowed only to catch up with the for-profits, then they are behaving like for-profits and ought to pay the respective taxes similar to their for-profit counterparts. Under this scenario, all else being equal, in terms of the market, demographic base, patient mix, payer mix, socio-economic status, and indigent population, the two groups would exist as for-profit hospitals, and there is no justification to allow tax exemption.

Having discussed the topic of taxes with HCA, HMA and Tenet corporate offices, I was informed that on average, the federal income tax was 35% of Net Income (EBIDTA), 6% (1-0.65%) = 3.9% is Georgia state tax, and property tax varied around 0.30 to 0.40%. They suggested that I utilize 3.5% for federal tax on net revenue, 0.90% for state tax on net revenue and 0.40% property tax for Georgia. The tax information for the for-profit hospitals is tabulated in Table 11 and corresponding Community Benefit equivalent data is included. The data is for 2007 year end and it shows that $36,923,475 was spent on overall taxes out of which $26,923,367 was the federal component and $6,923,152 and $3,076,956 were state and property tax components.

The only caveat, is that three for-profits, Barrow Community Hospital, South Fulton Medical Center and Atlanta Medical Center have negative income and margins and the tax base of 4.8% applied to them on net revenue would not be entirely valid (of course, in this study, the tax rate is applied on positive net revenue and not on net income, on which corporate taxes are based on). If I applied the 4.8% to four of the profitable for-profits and 0% taxes to the three with negative income and margins, I would have a tax base of 2.74% (Table 13). If this more realistic analysis is applied, then the 2.74% lowers the taxable contribution to $11,063,829 from the 4.8% value of $36,923,475, i.e. a difference of $25,859,646. This tax base differential of 2.74% is a significant amount, which when added to the not-for-profit community benefit of 7.67% and 6.45% in the average and median models (Table 10 above), would substantially increase the community benefit contribution of the not-for-profits. An incomes statement of Tenet for three years show negative net income for years 2006, 2007, which turned positive in 2008 (Yahoo. 2009). There is an addition of tax component to net income in the negative income years of 2006 and 2007, and this continues for year 2008, even though the operations turned a positive net income. This is possibly the tax provision to include losses, which are carried forward. Since no individual hospital data is available for this type of financial statement, the only possibility is to project different scenarios, and I chose two, with 4.8% and 2.74%. How for-profit corporations like, Tenet, HCA, and HMA apply income or loss to individual facilities precludes this study from further study and analysis, which is beyond the scope of the project. The fact remains that even with 0% taxes, for-profit Community Benefit is 0.04% and 0.17% respectively in the average and median models respectively. This is an extreme situation and tax rate is unlikely to be 0% for the for-profits.

In light of these for-profit tax data, it is not surprising that new attempts are made to start reviewing Community Benefit burden held by not-for-profits. Public, including members of Congress and government agencies such as the IRS, GAO, CBO, CMS have much higher expectations of the not-for-profit hospitals. To compensate hospitals, which share an excessive burden of low-income patients who qualify for Medicaid, and who do not have access to and not able to pay for care, a disproportionate share hospital (DSH) payment is made. DSH payments and its Community Benefit percent of net revenue are tabulated in Appendix N and Appendix O.

These payments are deducted from the numerator of the Community Benefit calculation, since these payments are considered as additional revenue to compensate for losses incurred by hospitals in caring for low-income Medicaid and Medicare patients. Even though Medicare payment shortfalls are excluded from Community Benefit Calculation in this study, DSH payments are included since they cover Medicaid eligible patients enrolled in the program. The addition of DSH reduces Community benefit, and it is interesting to note that DSH payments amounting to $20,283,652 (2.64% of net revenue) were paid to for-profit hospitals while $62,641,214 (1.53% of net revenue) were paid to not-for-profits.

To catch up with the for-profits, not-for-profits would need to provide approximately on average $20,843,689, in additional Community Benefit across the entire 17 hospitals (Table 13), (with profits having negative margins taking $0 income and state tax). This amount falls in between the revenue size shortfall of approximately $61,820,751 that had to be picked up by the not-for-profits to catch up with the for-profits and the average Community Benefit shortfall of approximately $7,108,032 that had to be picked up by the not-for-profits to catch up with the for-profits. If similar tax treatment is applied to not-for-profits, they would pay an amount of 100,460,423 in additional Community Benefit as taxed. At this rate and amount they behave as a for-profit and not doing anything different for the Community. Still the Community Benefit impact is significant.

Table 12 below lists the group of not-for-profit hospitals and calculated their tax burden by assuming a uniform 3.5% federal tax, and 0.9% state tax on net revenue, similar to that of for-profit tax structure informed by HCA, Tenet and HMA. Normally it is a challenge to estimate these tax rates since the behavior of the hospitals could change if they were subject to taxation. They might even be forced to change culture and start emulating for-profits as some literature has reported. Changes can be experienced in managing expenses, write-offs, participation in SCHIP, GICP, Medicaid, etc. The corporate tax figures in Table 12, if combined with the savings from property taxes, which are not linked to corporate performance and profit margins, highlights the gravity of tax exemptions that if lost could drastically alter a hospitals operating and performance structures.

The intent of policy makers and government agencies to allow tax exempt status to not-for-profits is based on the expectation of Community Benefits beyond the operating costs and shortfalls incurred during the care of the indigent, vulnerable, and the extremely sick, poor and aged population with limited or no access to quality care. The results are actually a dichotomy as it seems that the for-profits behave like not-for-profits and not-for-profits behave like the for-profits. The data and results of tabulation and calculations give an indication as to the extent of the failure of the policy and legislative intent. The inherent intent and expectations is that not-for-profits have an obligation, due to the preferred status, to provide a much greater percent of Community Benefit than their for-profit counterparts.

Finally the findings of this study highlight the significantly higher Community Benefit provided by for-profit hospital groups whether it was assessed by the revenue size model or the average and median models. The major component of the difference is the sizable tax portion of Community Benefit. It is assumed, of course, in this study that 4.80% would be the overall tax bracket for the for-profits, assumed further to be distributed into 3.5% federal, 0.90% state, and 0.40% property. This was based on discussions with corporate finance and tax staff at HCA, HMA, and Tenet. Several literature have indicated that tax obligations of for-profit hospitals play a big role in Community Benefit as they subsidize businesses and individuals to pay less which increases discretionary income for healthcare, etc. Community Benefit is enhanced via taxes paid by the for-profits, as taxes are apportioned into the federal and state budgets, which is then allocated to increasing Community Benefit and providing for the health of the community. Large federal and state dollars are also budgeted towards cost of caring for Medicaid and other low income programs, such as SCHIP, GICP, etc. in addition to public health programs such as wellness, prevention, and screening. Some of these take place at the federally qualified healthcare clinics. On account of such a significant advantage to the community from tax contributions by for-profit hospitals, it has become imperative that there is policy and legislative consensus as to how and when clear and distinguishable criteria is established, to enable and mandate not-for-profit hospitals to better focus their internal efforts to qualify and quantify Community Benefit more accurately in line with these guidelines.

Table 11: For-Profit Tax and Community Benefits

For-Profit Tax Calculation

Facility Name	Ownership	Revenue Size	Total Patient Revenue	Net Patient Revenue	Federal Tax 3.50%	State Tax 0.90%	Property Tax 0.40%	Total Tax 4.80%	Benefit as Percent of Net Revenue
Barrow Community Hospital	HMA	Under $100 M	71,270,163	18,725,836	655,404	168,533	74,903	898,840	4.80%
Walton Regional Medical Center	HMA	$100M - Under $250 M	106,172,046	34,732,571	1,215,640	312,593	138,930	1,667,163	4.80%
Cartersville Medical Center	HCA	$250M - Under $500 M	468,079,393	110,599,230	3,870,973	995,393	442,397	5,308,763	4.80%
Spalding Regional Hospital	Tenet	$500M - Under $1 B	530,015,916	114,149,966	3,995,249	1,027,350	456,600	5,479,198	4.80%
South Fulton Medical Center	Tenet	$500M - Under $1 B	554,025,888	106,514,519	3,728,008	958,631	426,058	5,112,697	4.80%
North Fulton Regional Hospital	Tenet	$500M - Under $1 B	715,574,720	144,307,623	5,050,767	1,298,769	577,230	6,926,766	4.80%
Atlanta Medical Center	Tenet	Over $1 B	1,009,485,872	240,209,319	8,407,326	2,161,884	960,837	11,530,047	4.80%
TOTAL				[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Table 12 Tax Implications for Not-For-Profits if no Exempt Status (with Original Tax Base) Calculations on 4.8% tax assuming Positive Margins for all For-Profits Hospitals

Facility Name	Revenue Size	Total Patient Revenue	Net Patient Revenue	Operating Expenses	Net Income	Gross Margin	Federal Tax 3.50%	State Tax 0.90%	Property Tax 0.40%	Total Tax 4.80%	Total Tax 2.74%
WellStar Paulding Hospital	Under $100 M	90,638,062	44,095,429	46,723,864	2,628,435	-2.90%	1,543,340	396,859	176,382	2,116,581	176,382
WellStar Windy Hill Hospital	Under $100 M	92,290,023	44,300,435	35,835,422	8,465,013	9.17%	1,550,515	398,704	177,202	2,126,421	2,126,421
Tanner Medical Center/Villa Rica	Under $100 M	94,431,433	37,622,952	27,318,539	10,304,413	10.91%	1,316,803	338,607	150,492	1,805,902	1,805,902
Emory-Adventist Hospital	$100M - Under $250 M	118,412,417	41,609,655	42,624,681	1,015,026	-0.86%	1,456,338	374,487	166,439	1,997,263	166,439
Newton Medical Center	$100M - Under $250 M	191,534,977	70,093,760	74,480,560	4,386,800	-2.29%	2,453,282	630,844	280,375	3,364,500	280,375
Northside Hospital-Cherokee	$100M - Under $250 M	228,829,893	81,894,185	82,152,722	258,537	-0.11%	2,866,296	737,048	327,577	3,930,921	327,577
Tanner Medical Center/Carrollton	$250M - Under $500 M	312,501,237	129,387,479	146,199,945	16,812,466	-5.38%	4,528,562	1,164,487	517,550	6,210,599	517,550
Rockdale Hospital & Health Systems	$250M - Under $500 M	322,043,620	111,067,690	120,158,608	9,090,918	-2.82%	3,887,369	999,609	444,271	5,331,249	444,271
Piedmont Fayette Hospital	$250M - Under $500 M	426,106,142	141,610,379	143,321,227	1,710,848	-0.40%	4,956,363	1,274,493	566,442	6,797,298	566,442
Southern Regional Medical Center	$5000M - Under $1 B	690,612,152	236,952,951	254,626,019	17,663,069	-2.56%	8,293,703	2,132,667	947,852	11,374,222	947,852
WellStar Cobb Hospital	$5000M - Under $1 B	742,247,281	279,059,477	278,594,371	475,106	0.06%	9,767,432	2,511,625	1,116,278	13,395,335	13,395,335
Emory Crawford Long Hospital	$5000M - Under $1 B	940,506,061	409,440,133	398,740,145	10,699,988	1.14%	14,330,405	3,684,961	1,637,761	19,653,126	19,653,126
Saint Joseph's Hospital of Atlanta	Over $1 B	1,052,532,404	359,300,275	372,904,000	13,603,725	-1.29%	12,575,510	3,233,702	1,437,201	17,246,413	1,437,201
Grady Memorial Hospital	Over $1 B	1,200,306,427	336,165,915	678,973,626	342,866,711	-28.56%	11,763,742	3,024,962	1,344,428	16,133,132	1,344,428
Piedmont Hospital	Over $1 B	1,481,718,617	536,311,096	520,638,356	15,672,740	1.06%	18,770,888	4,826,800	2,145,244	25,742,933	25,742,933
WellStar Kennestone Hospital	Over $1 B	1,606,501,821	605,329,175	556,440,653	48,888,522	3.04%	21,186,521	5,447,963	2,421,317	29,055,800	29,055,800
Northside Hospital	Over $1 B	1,621,618,625	618,097,201	620,346,593	2,249,392	-0.14%	21,633,402	5,562,875	2,472,389	29,668,666	2,472,389
TOTAL			[redacted]				[redacted]				

Table 13: Tax Implications for Not-For-Profits if no Exempt Status (with Revised Tax Base)

Facility Name	Ownership	Total Patient Revenue	Net Patient Revenue	Operating Expenses	Net Income (Income from Operations)	Gross Margin	Federal Tax 3.50%	State Tax 0.90%	Property Tax 0.40%	Total Tax 4.80%	Total Tax 2.74%
Barrow Community Hospital	HMA	71,270,163	18,725,836	22,816,390	-4,090,553	-5.74%	655,404	168,533	74,903	898,840	74,903
Walton Regional Medical Center	HMA	106,172,046	34,732,571	33,778,177	954,394	0.90%	1,215,640	312,593	138,930	1,667,163	1,667,163
Cartersville Medical Center	HCA	468,079,393	110,599,230	87,607,427	22,991,803	4.91%	3,870,973	995,393	442,397	5,308,763	5,308,763
Spalding Regional Hospital	Tenet	530,015,916	114,149,966	98,536,636	15,613,330	2.95%	3,995,249	1,027,350	456,600	5,479,198	5,479,198
South Fulton Medical Center	Tenet	554,025,888	106,514,519	114,322,616	-7,808,097	-1.41%	3,728,008	958,631	426,058	5,112,697	426,058
North Fulton Regional Hospital	Tenet	715,574,720	144,307,623	131,254,970	13,052,653	1.82%	5,050,767	1,298,769	577,230	6,926,766	6,926,766
Atlanta Medical Center	Tenet	1,009,485,872	240,209,319	245,466,859	-5,257,540	-0.52%	8,407,326	2,161,884	960,837	11,530,047	960,837
TOTAL		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

LIMITATIONS

All government agencies such as the IRS, GAO, CMS, and private agency such as AHA (organization to which all hospitals are affiliated as members), have differences of opinions, and there is still no clear cut guidelines or regulations to steer the hospitals towards a standard Community Benefit framework. Even the February report from the IRS does not clarify and

mandate a Community Benefit pathway for consistency and reliability (IRS.2009). What the IRS has done though is modify its Form 990 with changes in the form of section H, to ensure that it captures genuine activities that may be considered as Community Benefit. The form is also intended to make sure that non compliant and irregularly and inconsistently reporting hospitals are held liable to stricter scrutiny, and possible future regulation to suspend tax exemption. This is the beginning of a long and hard fought policy, and legislative landscape, to force not-for-profit hospitals to meet a larger Community Benefit burden above that provided by taxed for-profit hospitals, in order to maintain tax exemption.

Some of the activities such community programs (screening, vaccination, health fairs, etc.), medical education & training, medical research, and marketing campaigns (to educate the community), are argued as Community Benefit components (IRS. 2009; GAO. 2008). Some others include bad debt, and donations to charitable causes as well as Medicare shortfalls (GAO. 2008; Figure 3). Many hospitals regularly advocate and perform several activities that are extremely beneficial to their communities. An example is breast cancer support group, which is one of several community based support activities for patients and care givers. This study qualifies uncompensated care, shortfalls in SCHIP, Medicaid, and state indigent care program (GICP) along with DSH payments received as the acceptable, defensible and supported by the literature and the industry (CHA. 2005; IRS. 2009).

Quality, safety, effectiveness, timeliness, and access to care can be debated about their impact on the community, but not necessarily directly attributable as Community Benefit in terms of revenue relationship. These are very difficult to quantify and all hospitals are required for accreditation standards to ensure these attributes are synonymous with their hospitals. Communities will shun hospitals if these are compromised. Numerous opponents and proponents would question the general feeling that not-for-profits provide a better patient care environment and quality of care and thereby benefit the community more than the for-profits. On the contrary, one of the studies shows that for-profits, on account of their ownership stake as well as other factors provided better quality of care than not-for-profits (McClellean. 2005).

Medical education and training benefit and equip individuals to further their careers and benefit financially in the long term. Medical research is conducted by accredited academic centers and by large revenue size classified hospitals which have the budget size to accommodate such infrastructure and operations. Generally, certain research studies might enroll local population for clinical trials, but predominantly, the bigger research facilities carry out research that do not directly impact the community. Finally community programs have also been questioned as to the revenue based benefit impact to the community. This is more often seen as a marketing and advertising activity.

One of the limitations deals with the components of uncompensated care. The February 2009 report from the IRS documents that overall, and for each community type (such as high population and other urban and suburban populations), and revenue size, a greater percentage of hospitals reported that they had included bad debt and self pay shortfalls in uncompensated care than any other shortfalls. If this were the case with the hospitals in this study, the accuracy of the uncompensated care cost between hospitals would be subject to question as there would be error in analysis and reporting of the findings. This will be due to variations in reporting these items.

The data reported from this study corresponds to a single tax year, i.e. 2007, and results may not be representative for a different tax year or on an ongoing basis. Results for a different year could vary significantly depending on a variety of factors, including for example, the economic climate.

It is also important to note that 17 not-for-profit hospitals were dropped from the original list of 34, and 2 for-profit hospitals were dropped from the original list of 9, due to unavailable data in the Medicare Cost Report. The list was provided by the Georgia Hospital Association. The percentage of not-for-profit hospitals in the various analysis used in the study may not represent the overall group adequately. This may have an effect on certain findings of the study results. Also one of the hospitals, Grady Memorial can be considered as an outlier, as its high values of Community Benefit, and negative profitability would skew the results for the group.

The data extracted from Medicare Cost Reports are assumed to be accurate, valid and reliable. The fact remains that significant variations can and do exist in community benefit

reporting by the hospitals (IRS. 2009). Beginning with 2009 tax years, the new IRS Form 990 Schedule H (Appendix S), should start to standardize and unify Community Benefit and executive compensation reporting (IRS. 2009). Understating of community benefit can happen if uncompensated care costs, and shortfalls such as Medicaid, SCHIP and state indigent care programs are excluded or under reported. Overstating of the community benefit can result if these are inflated. There are no mandatory reporting guidelines or oversight to vouch for the data reported to CMS by all hospitals in a standardized and reliable way. The above reasons can question the accuracy and authenticity of the date set in the Cost Reports.

The other limitation relates to demographic and market-oriented variations of the city or county within the Atlanta MSA. Variables which can affect the results are patient mix, payer mix, insurance coverage levels, socio-economic status, community type (high population and other urban and semi urban population), competitive nature of the environment, and diversity in demographics (age, sex, ethnic origin, per capita income, poverty level, health status etc.) operational activities, and financial resources of the facilties. As an example, Grady Memorial is an outlier hospital due to its highly disproportionate share of uncompensated and Medicaid care provided, due to its location in inner city Atlanta.

Finally, the tax rates are not allied on net revenue, rather on net income. Having discussed the topic with the corporate offices of the three owners of the 7 for-profit hospitals, it became evident that the federal and state taxes on net income (35%, 6% on 1-35%) needed to be reworked to approximate these rates on net revenue. They agree that it is reasonable to assume a federal tax rate of 3.5% on net revenue, and state tax rate of 0.9% on net revenue. Property tax was an unclear issue, and it was decided that an approximation of 0.4% should suffice for Atlanta MSA. The issue with the tax implication, as applied to community benefit comparison between not-for-profits and for-profits, has to do with the profitability of the for-profit facility. Since none of these corporate owners of the for-profit hospitals breakdown their overall U.S. operations based on individual facilities, it is difficult to calculate the taxes accurately for these for-profits. Several factors can affect the taxes paid during each tax year. These would include losses instead of profits, large write-offs (including bad debt), quickening the drawdown of

depreciable assets in the early years, and big accounts receivables. In this study, Barrow Community Hospital owned by HMA has a negative 2007 reporting year income and margin of -5.74%, South Fulton Medical Center owned by Tenet had a negative income and margin of -1.41% and Atlanta Medical Center, also owned by Tenet also had a negative income and margin of -0.52%. So obviously it is challenging to use the 4.8% used across the for-profits to calculate their tax portion of community benefit as a percent of net revenue.

To overcome a major portion of this limitation, these three hospitals were assigned 0% taxes and the other four kept their 4.8% taxes and scenario 2 reflected this calculation for Community Benefit.

RECOMMENDATIONS

Based on the results of data analysis, findings and limitations in the study, the following are suggested as possible approaches to ensure a fair, accurate, consistent, more reliable and valid community benefit outcomes reporting. After this, not-for-profits and for-profits can be compared for the quality and quantity of community benefit provided to the communities they operate in and then gauged if tax exemption is a justification for not-for-profits.

- Among the not-for-profit hospitals, referring to Appendix P, two of the three hospitals in the lowest revenue size seem to have the highest margins (10.91% and 9.17) and yet only one of them provided a community benefit of 15.67% while the other provided only 0.52% uncompensated care and no other community benefit component, since some of them received more payment and were taken as 0%. In fact it gained 8.35% of net revenue component from SCHIP, MCAID, and GICP, which should have been given to the community in terms of higher charity care, which accounted for a small 0.52% of net revenue of Community Benefit.
  Such a mismatch in margins and community benefit should be looked at by the IRS and policy makers, after a thorough study by authorized government agencies like the Government Accountability Office (GAO), IRS and others, to see if any hospital is bucking the trend of expectations of greater community benefit provision, at least equal to those provided by the for-profits. Regulatory guidelines and rules must be in

place to ensure that not-for-profits do not renege on their mission to serve the community and share a larger community benefit burden to ease this share off the local, state and federal government. This is the main reason for the exemption from paying taxes afforded to not-for-profits. I believe that a reasonable 3% to 5% over the community benefit provided by for-profits can serve as a base for the maintenance of tax exempt status.

- Referring to the same Appendix P, one of the hospitals, Grady Memorial, has a very large negative net income and a high negative margin of (-28.56)%, yet this hospital provided 50.58% of uncompensated care and an overall community benefit of 47.71%. This hospital had some relief in the form of excess GICP payments and a fairly reasonable DSH payment. This hospital is in downtown Atlanta and serves a large population of indigent and low income population. Until a few months ago, there was doubt about the viability and survival of this hospital. For such hospitals, which go above and beyond their call of the community mission, and struggle to stay afloat, government must have a policy and regulation in place to offer much needed assistance to offset some of the negative margin that is related to the community benefit component. One way to do this would be increase the DSH payment percent as a match to the shortfall between the negative margin and the positive community benefit. In this case it would be a further 19.15% of net patient revenue, which would improve margin by 5.36%, by adding to the net income $64,364,474. Of course, in the case of this hospital it would still need to undertake a major cost-cutting restructuring initiative to stem expenses in relation to the patient activities, from a historical trend-based forecasting. Still it is a challenge for this hospital to maintain viability.
- Tax exemption and not-for-profit status should not be tied together. What needs to change is the way all hospitals, especially the not-for-profits, report community benefit. The change might happen sooner than we expect with the introduction of the new IRS Form 990 Schedule H, which is going into effect for 2009 year tax reporting

period (IRS.2009). To ensure that all not-for-profit hospitals report on time and accurately, an incentive as well as penalty should be in place for improving compliance.

- As the study indicates, there is a marked differential in the community benefit provision between the not-for-profit and the for-profit. On the basis of this study, it is my belief that tax exemption instead of motivating the not-for-profits (to provide community benefit at least equal to if not greater than that provided by the for-profit) has on the contrary allowed these hospitals to increase their reserves and grow bigger and more competitive at the expense of tax disadvantaged for-profits and government. If researched and documented shortage of community benefit provision by the not-for-profit clearly exists, there must be a financial penalty which equals the community benefit disparity with for-profits. Alternatively, some of this penalty can be recognized by reducing or eliminating DSH payments if these not-for-profits are qualified DSH recipients.
- Reimbursement agencies (public and private), policy making bodies and legislators should continue to challenge and demand guarantees and proofs of community benefit that equals for-profits as the first step. At this stage the not-for-profits would seem like for-profits. Otherwise, they should challenge the tax exemption of such hospitals that do not actively and meticulously pursue the goal of meeting their obligations, beyond this.
- Healthcare costs are escalating out of control and the new administration is aggressively seeking to rein in costs by an optimistic reform agenda. Under a magnifying lens zooming in on the areas where costs can be curtailed, it would be incumbent upon hospital executives to transform the way they operate and contribute to savings that can be ploughed back into healthcare costs for the poor and the needy with no ability to pay. If these patients are allowed to crash into the emergency department, this would further escalate costs. In scenario 1, in all of the three models of calculating and analyzing the data (the revenue, average, and median models), it

was seen that the for-profits are providing $$61,820,751, $7,108,032 and $5,664,415 of Community Benefits above the not-for-profits. If not-for-profits provided the same percentage of Community Benefits as the for-profits, there could be these additional dollars annually that could be utilized to provide care for the poor and needy with no ability to pay. This study highlights that this amount of additional funds can be made available from just one single geographic location from one state, such as Georgia. Imagine the amount of additional dollars that could be generated and made available for the entire country. I strongly believe that this must form one of the basic elements in any healthcare reform agenda. If not-for-profits do not voluntarily change behavior, and impact their communities in much larger proportions, then this must be mandated with the warning of revoking tax exemption, or forcing them to become for-profit with tax contributions.

- Similar to CMS pay-for-performance, there should be a reward system that reimburses the for-profits hospitals a certain percentage if they allocate additional percentage of their margins for increasing community benefit contributions. This will motivate not only the for-profits further, but will also be an impetus for the not-for-profits to follow.
- There should be clarity and clear definition as to what constitute charity care and public service to receive and maintain tax exemption. Currently, this is one of the major drawbacks of the tax exempt status qualification requirements.

  The IRS rev. rul. 69-545, which was issued in 1969, states that a not-for-profit hospital claiming exemption under section 501(c)(3) of the Code is to be operated to serve a public rather than a private interest (IRS. 1969). With the 2009 IRS report in February and the ensuing new IRS Form 990 Schedule H, which is slated to go into effect for tax year 2010, it is imperative that the IRS modifies rev. rul. 69-545, and issues new guidelines that complement and standardizes community benefit criteria to maintain tax exemption.

> To qualify for exemption from Federal income tax under section 501(c)(3) of the Code, a nonprofit hospital must be organized and operated exclusively in furtherance of some purpose considered 'charitable' in the generally accepted legal sense of that term, and the hospital may not be operated, directly or indirectly, for the benefit of private interests.
>
> In the general law of charity, the promotion of health is considered to be a charitable purpose. A nonprofit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose. If it meets the other requirements of section 501(c)(3) of the Code, it will qualify for exemption from Federal income tax under section 501(a) (IRS. 1969).

FURTHER STUDY

Before 2008, the IRS Form 990 did not provide for the reporting of community benefit activities or request important information regarding how not-for-profit hospitals serve the public consistent with the tax exemption. The changes being implemented require reporting of community benefit and other important information pertinent to exempt status on Schedule H (IRS.2009).

Schedule H includes six parts: Part I, Charity Care and Certain Other Community benefits at Cost; Part II, Community Building Activities; Part III, Bad Debt, Medicare, & Collection Practices; Part IV, Management Companies and Joint Ventures; Part V, Facility Information; Part VI, Supplemental Information. A copy of Schedule H is provided in Appendix S.

- Impending changes to the community benefit reporting and other pertinent information related to tax exemption is scheduled to become official for tax year 2009. With even one year of data from this report, a new study, should be undertaken that would extract the standardized community benefits reported by not-for-profits and this would result in more accurate, reliable, and valid data for analysis and discussions. At that point, this data should be a more authentic representation of how the not-for-profits stack up with the for-profits and if tax exemption should be

continued or not. There should be a legislative ruling that also mandates for-profits to report in a similar, if not same form, so standardized comparisons can be drawn about Community Benefits.

- One of the areas of contention is whether to include bad debt, Medicare shortfall, private insurance shortfall, and self pay shortfall in the community benefit calculation. There is no clear cut consensus or evidence in the literature to justify inclusion of any of these other shortfalls in revenue, other than the established and accepted formula elucidated by the Catholic Health Association (CHA. 2005;Keehan. 2006). With the introduction of the new IRS Form 990 Schedule H, debates in Congress and among individual states, and private member agencies such as AHA, there could come a point in time when some or all of the above shortfalls may be allowed for inclusion in the calculation of community benefit. A study at that time would compare how not-for-profits and for-profits behave towards their community and in keeping up to their mission, while easing the escalating federal and state healthcare burden.
- Expenditures, such as medical education and training (for students), medical research, community programs (vaccination, screening, support groups, etc.), community education (health fairs, community forums, etc.), and others have all been debated about their place in community benefit calculation. Though the latter part of this list relates directly to improving community awareness and knowledge of health status, wellness and prevention (which are important as community benefit), they are at this point considered benefitting hospitals as marketing and advertising to grow market share and revenue. This could be an area for further study to showcase how much not-for-profits and for-profits invest in such community helpful activities. Whether they would be allowable for inclusion in community benefit calculations is uncertain.
- Since quality of care surfaced earlier on, this might be an area for study, since a healthier and better cared for person also benefits the community in terms of less absence from work and improved productivity, which contribute to the economy of the

community. It would be interesting to see how not-for-profits and for-profits compare in terms of quality of care. With pay-for-performance and HCAHPS reporting on 25 plus indicators, this area of study could focus on comparative performance of not-for-profit hospitals and for-profits on quality metrics.

- Since this study focused on Atlanta MSA, it would be interesting to see the findings of a study or studies that looks at the entire state of Georgia or the whole of USA. The most number of states any study has looked at, other than the recent IRS (IRS. 2009), GAO(GAO. 2008) and CBO (CBO.2006), have been four most populous states such as California, Texas, Florida, and Mexico.
- Several hospitals across the country report uncompensated care in diverse ways, for example, some may show only charity care, others may include bed debt, and shortfalls in self pay, and public and private payer shortfalls. A study could be undertaken to dissect the data to determine if differences in reporting, such as the treatment of all of the above shortfalls as uncompensated care, can be isolated and adjusted to allow more meaningful comparisons across the not-for-profits and for-profits.
- A further study could research and analyze the differences in community benefit expenditure amounts and types to take into account varying demographics, such as rural, semi urban, urban, communities and hospitals in these communities.
- Other research and analysis efforts could focus on the demographics, such as per-capita income and insurance coverage in determining community benefit expenditures to see if there is any correlation.
- Another study that focuses on the impact of patient mix and payer mix on the percent of net revenue that is provided as community benefit would offer a comparison of how not-for-profits and for-profits behave in similar environment.

CONCLUSION

Based on the findings, the key observations are:

1. The study of the selected 17 Not-For-Profit and 7 For-Profit hospitals shows that in the average model, for-profits provided higher community benefits in both scenario 1 and scenario 2. For-profits provided 10.63% at the 4.8% tax base and 8.57% at the lower 2.74% tax base (due to incorporating three hospitals with negative income and margins at 0% tax base). Not-for-profits share were 7.67% and 7.67% respectively. The for-profits provided 38.59% and 11.73% higher community benefit in terms of net revenue in the two scenarios of tax rates, in the average approach.
2. As the study results show, in general, not-for-profits in Atlanta MSA do not do well in their commitment towards fulfilling community benefit obligations commensurate with their tax exemption as a minimum, whether one looks at scenario 1 or scenario 2 in the average and median models. The group averages are 7.67% and 10.63% for the not-for-profits and for-profits using the 4.8% tax rate across the hospital positive net revenue base. This produces a differential of 2.96%. At this differential, to catch up with the for-profits, the not-for-profits, on average have to provide additional Community Benefit of $7,108,032. The group averages change to 7.67% and 8.57% for the not-profit and for-profit groups using the 2.74% reduced rate across the hospital positive net revenue base (due to three hospitals having negative income and margins). This produces a differential of 0.90% between the two groups. At this differential, to catch up with for-profits, the not-for-profits have to provide, on average, additional benefit of $2,161,217.
3. In the revenue size model, at 4.8% tax rate, and on an individual basis though, two hospitals, such as Tanner Medical Center in Villa Rica exceeded the for-profit average model benchmark of 10.63% by providing 15.67% of Community Benefit and Tanner Medical Center at Carroll also exceeded the benchmark by providing 13.85%. Obviously both of them also exceeded the average Community Benefit benchmark of 8.57% of for-profits at the lower tax base of 2.74%. Two other hospitals also

exceeded the for-profit benchmark of 7.82% at the lower tax base. Emory-Adventist provided 8.44% and Southern Regional Medical Center provided 8.59%.

4. In the revenue size model, one not-for-profit hospitals in the under $100 million provided Community Benefit of 15.67% in close proximity to the similar revenue size hospital in the for-profits, which provided 16.58% at the 4.8% tax base, and at 2.74% tax rate it was lower at 14.52% . In revenue size $250 million to under $500 million, Tanner Medical Center at Carroll had the highest individual Community Benefit of 13.85%, with group average of 7.12%, which skewed this revenue size group higher than the for-profit of similar revenue size at 5.65%.
5. For-profits' higher community benefit contribution is due to taxes paid to the federal, state, and local governments. There is no guarantee that these tax dollars are allocated to caring for the indigent population and the under and uninsured groups.
6. Tax exemption and consequent favorable behavior from not-for-profit hospitals are not synonymous and are not to be taken for granted. The government's intention has been to alleviate its burden of healthcare to the indigent, and the poor and low income. The caveat for uninsured and underinsured, is that they could be employed and above poverty levels among the communities' populations and they are not expected to seek free treatment. The interesting aspect to the for-profits providing higher community benefit than their not-for-profit counterparts is that they are doing this without the advantage of tax exemption and this can also be debated as lowering their competitive advantage in the market and community where they share the operations with not-for-profits.
7. Until there are clearly defined and articulated criteria for community benefit standard, it is extremely difficult and inappropriate to question the justification of tax exemption. The new IRS form 990, schedule H is intended to bridge the gap and enable for-profit hospitals to comply fully with regards to the type and quantity of community benefits being provided as well as other pertinent information relating to tax exemption (IRS. 2009).

There is no one-size-fits-all solution. It is best to remain vigilant while awaiting further government moves. This would become more apparent and imminent since the most recent IRS (IRS. 2009), CBO (CBO. 2006), and GAO (GAO.2008) reports have highlighted the complexity and gravity, but the imperative and urgency to resolve community benefit standardization and reporting. Hospitals should not shy away from the converging forces of change, rather they ought to recognize the scrutiny as an opportunity to communicate, and to demonstrate how they help the communities they serve. Then they should make sure to tell that story to all of the hospital's stakeholder groups.

Not-for-profit organizations must clearly demonstrate their value to the communities they serve. Otherwise, with more and more research findings becoming ammunition, governments and taxpayers will increasingly question the tax advantages and charitable funding provided in support of the not-for-profit mission. The decline in citizen support for not-for-profit activities is an indication that the public is not clear on the value that is being received from not-for-profit hospitals. Hospital executives must ensure that the organization mission is consistent with environmental and market demands in such a way that it can align its strategies with the organizational mission.

Though documenting, quantifying and communicating the community benefit that hospitals provide is a challenge for many hospitals, with the vigorous regulatory enforcements and federal and state actions calling into question tax exempt status, it is in the best interests of not-for-profit hospitals to implement a sound policy of compliance. It would help hospitals qualify and quantify the cost of such uncompensated care, and relate this to the share of patient revenue, market share or total costs, and device a methodology to link the quantifiable amount to the advantage gained via tax exempt status. In this connection the American Hospital Association has developed its own framework as a more elaborate version of the original CHA's guidelines, which has been and still remains the preferred method of calculating community benefit (AHA. 2006).

AHA released its new community benefit reporting framework on Monday November 13, 2006. The AHA's new framework, for reporting community benefit, helps hospitals report those

benefits in a quantitative manner, and in a way that will connect directly with their community members. The framework recognizes and builds on the community benefit categories provided by the Catholic Health Association of the U.S./VHA *Guide for Planning and Reporting Community Benefit* (CHA. 2005). However, the AHA framework goes one step further to include the reporting of bad debt and Medicare underpayment at cost. In an accompanying "Special Message," AHA Chief Operating Officer & President-elect Richard Umbdenstock said the form will allow hospitals to report the financial value of the full range of benefits they provide to their communities, including not only the dollar amount of service provided, but the total number of people served. In the message, Umbdenstock encouraged hospitals to "[t]ell the full story, not only to elected officials and government agencies, but to your employees (they will be proud of their work), medical staff, your local media and everyone in the community you serve," adding, "They deserve to know how hard you work to meet their most important needs and their high expectations (AHA. 2006)."

It remains to be seen if there is any impetus and consensus towards this format of reporting. In my opinion, the consensus would evolve from the CHA's guidelines as a base and the various federal agencies, especially the IRS, would develop a more robust, standardized, and accepted framework. For the sake of current information, the AHA framework is provided below (AHA. 2006):

Community Benefit Reporting Framework
Quantifiable Benefits

1. **Charity care (at cost)** $_____

2. **Bad debt (at cost)** $_____

3. **Government-sponsored health care (net expense)** $_____
   Unpaid cost of Medicare, Medicaid, indigent care programs, SCHIP and other safety net programs

4. **Community Benefit Programs (net expense)** $_____

   Research, e.g.,
   - Clinical
   - Community health

   Health Professions Education, e.g.,
   - Physicians; medical students
   - Nurses; nursing students
   - Scholarships; funding for education

   Community Health Services, e.g.,
   - Health education
   - Clinical services

   Subsidized Health Services, e.g.,
   - Emergency and trauma services
   - Hospital outpatient services
   - Behavioral health services
   - Palliative care and hospice

   Community Building, e.g.,
   - Physical improvements and housing
   - Economic development
   - Environmental improvements
   - Coalition building

   Financial and In-kind Contributions, e.g.,
   - Cash donations
   - Grants
   - In-kind donations

   Community Benefit Operations, e.g.,
   - Dedicated staff
   - Community health needs and assessments

Total Value of Quantifiable Benefits Provided to the Community $_____

Define

One of the biggest challenges that hospitals face when it comes to documentation is defining what community benefit is and recording examples within their systems. This is all the more imperative for charity care and protecting the tax exempt status.

Quantify

So how does a not-for-profit hospital capture all of the examples of community benefit within its service area? What does it do with this information once it has it? The Catholic Health Association of the United States, VHA, Inc., and Lyon Software took the lead in establishing standards for quantifying community benefit in their 1998 publication, Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint (HFMA. 2006). The guidelines were revised in a 2005 resource manual, Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability (CHA. 2005). This comprehensive report serves as a model for many organizations in determining what community benefit is, how to calculate the costs of community benefit, and guidelines for financial reporting. More recently the American Hospital Association released its own framework as an extension of the CHA guidelines (AHA. 2006). AHA framework allows a very broad classification of variables to be included as community benefit, which is under debate and a source of continued disagreement and contention. There is obviously no agreement regarding a standard framework.

"The same rigor we apply to measuring outcomes in the practice of medicine and in running the operations of the hospital should be applied to community benefit planning," said Michael Blaszyk, executive vice president and CFO, Catholic Healthcare West, part of the Catholic Health Association (HFMA. 2006). "There are tools available to help record community benefit activity. These tools, together with a clear understanding of what counts as community benefit and what does not, and a focused call to improve quality of life, will lead to a successful, well-developed community benefit program", (HFMA. 2006).

Communicate

Staff education and frequent reminders to document community benefit can also prove helpful. "Each year gets easier as everyone becomes more familiar with the process and has a better understanding of the importance of collecting and maintaining records," said Lyn Hester, vice president, community services, INTEGRIS Health. "The more people know what to collect and how to collect the information, the easier it becomes", (HMFA. 2006).

There are a number of ways that not-for-profit hospitals can share the story of the community benefit they provide within the communities they serve:

- Create an annual community benefit report
- Put a human face on the community benefit their system provides
- Make sure the information is easily accessible to board members, senior leadership, and managers, who can then use this information in community presentations
- Use paid advertising to reinforce the message of ways in which the hospital is giving back to the community

Chief Financial Officers (CFO) can enhance community benefit reporting by:

- Educating managers on what community benefit is, and how to document it
- Generating excitement among staff about the community benefit that the organization provides, so that employees will be more likely to document examples of community benefit
- Providing quarterly reminders to staff on the need to document community benefit
- Simplifying the way in which managers record this information
- Recognizing staff & physicians for exemplary commitment to community benefit initiatives

Health services researchers have long been interested in the factors influencing the provision of hospital care to the needy and, in particular, how the provision of such care varies by hospital ownership type. While there is a large body of literature on hospital charity care, several recent developments suggest the need for a new look at this topic.

ADDITIONAL FINDINGS & INTERPRETATIONS

IA. Note on Not-For-Profit behavior (Appendix Z)

The inclusion of 10 hospitals (all 27 not-for-profits), brought down the overall Community Benefit from 7.67% to 6.60%. The uncompensated component, which was the single largest contributor, came down from 8.17% to 6.94%. Out of the five additional hospitals in the under $100M revenue size, three did not report any variables, while one reported all except uncompensated care and the other reported all except GICP. The one addition in the $100M to under $250M size reported all except Medicaid. In the $250M to under $500M size, one addition reported all except GICP, in the $500M to under $1B, one addition did not report any variables, and in the over $1B size, one reported only GICP and none of the others (this is surprising since it is Emory University, and a private academic medical center), and the other reported uncompensated and SCHIP and did not report Medicaid and GICP.

IB. Note on For-Profit behavior (Appendix Z)

The inclusion of 2 hospitals (for a total of 9 for-profits), brought down the overall Community Benefit from 5.83% to 5.63% (without tax consideration). The uncompensated component, which was the single largest contributor, came down from 6.59% to 6.35%. Out of the two additional hospitals in the under $100M revenue size, both did not report any variables and were taken as 0.

In the selected list, and scenario 1, with 4.8% tax rate, the Community Benefit dropped from 10.63% to 10.43% and in scenario 2, with 2.74% tax rate, it dropped from 8.57% to 8.37%.

In the revised list, and scenario 1, with 4.8% tax rate, the For-Profits provided 10.43% vs. 6.60% for Not-For-Profits and in scenario 2, with 2.74% tax rate, the For-Profits provided 8.37% vs. 6.60% for Not-For-Profits when all hospitals are included without regard to what was reported.

Comparison of For-Profits and Not-For-Profits

In the selected list, For-Profits provided 5.83% vs. 7.67% for Not-For-Profits (without tax) and 10.63% and 8.57% in the tax rates, 4.8% and 2.74% respectively.

In the revised list, For-Profits provided 5.63% vs. 6.60% for Not-For-Profits (without tax) and 10.43% and 8.37% in the two tax rates, 4.8% and 2.74% respectively.

II. State and Local Community perspective (Appendix P1, P2, Q1 & Q2)

If only the state tax and the property tax components are taken for comparison, then 0.9% (state component and 0.4% (Property tax component) add up to 1.3%. If 1.3% is added to the average Community Benefit of For-Profits, then the For-Profits would provide in this revised list, 5.63% + 1.3% = 6.93% vs. Not-For-Profits Community Benefit of 6.60%, a 0.33% higher Community Benefit provided by For-Profits.

Though local Community Benefit is relevant and important to the State and County Commissioners, these numbers also ignore the 6% sales tax which For-Profits pay for most if not all supplies and equipment. There are exceptions for items such as prosthetic devices, etc. but there are still several high cost items in the overall expense, that are taxed and which drive margins. If this component is also factored in, then the Not-For-Profits would come up much shorter, even from a local state and county perspective. This is important, especially since state and county budgets are struggling to cope with costs of providing care to their respective indigent populations, who are unable to pay. Under these situations, the additional tax amounts saved by Not-For-Profits can assist in the care of these population groups enormously.

A caveat is, even though the state and community public officials grapple with the gravity of the health care issues for their respective population groups, the federal taxes foregone by the Not-For-Profits cannot be ignored, as the federal cost of health care is $2.2 trillion and consumes nearly 17% of the GDP.

III. Policy perspective:

The new administration is pushing for healthcare reform and even the insurers have come forward with their accommodations, that they will drop the pre existing condition criteria for coverage of their enrolled members, reduce premiums, etc. (with the condition of course that all Americans must have coverage).

Under a government mandated insurance coverage, whether a hospital is a for-profit or not-for-profit, they will continue to see the patients who were earlier categorized into charity care costs and shortfalls for government sponsored programs, such as SCHIP, Medicaid, and state indigent care programs. In fact more patients would flow through the two types of hospitals

as mandated insurance cover for all would remove some of the barriers to seek and obtain care.

Since for-profits do not enjoy tax breaks for providing community benefit, and the controversy surrounded the inadequacy of community benefits provided by not-for-profits in relation to their tax exempt status, they should also be treated as a for-profit. This way all hospitals would be categorized as one type of facility for healthcare delivery.

Also, with dwindling financial resources and escalating healthcare costs, over $2.2 trillion and 17% of GDP, the taxes would provide additional resources to the federal, state and local governments who all take part in tax receipts from for-profits.

The concern I have is that during the first quarter of 2009, according to AHA, 50% of the hospitals, had negative margins. So if not-for-profits were to convert to for-profits to neutralize tax preferential treatment, then several hospitals would face viability and sustainability issues to continue to serve their missions. From a policy perspective, I do not foresee any legislation that would give a tax break for providing community benefits, as the for-profits do not enjoy such.

The only scenario for tax breaks would come in the form of continued tax exemption, if the not-for-profits provide much greater community benefit than their for-profit counterparts. This can be achieved in a regulated environment for not-for-profits after the revised schedule H of IRS Form 990 is used for a couple of years and comparisons are framed between not-for-profits and for-profits.

In theory, though all hospitals could be treated alike, from Feldstein's perspectives and policy marketplace, the not-for-profits will fight to the death to preserve their tax advantages, regardless of the realities of their market behavior. In addition to the theoretical issues, there are likely political challenges that will be faced by anyone who wants to reform the system of tax benefits for not-for-profits.

END NOTES

1. The authors compared specialty hospitals with not-for-profit competitors only, since not-for-profit hospitals receive special consideration (exemption from income, property, and sales taxes) in exchange for providing community benefits, particularly uncompensated care. For-profits receive no such special consideration.

2. In 1994, 23.7 percent of nonelderly Californians were uninsured compared to 17.3 percent nationally. Only two states (Texas and New Mexico) had a higher percent uninsured than California (Employee Benefit Research Institute 1995).

3. Acute care hospitals' implicit obligation to serve the community is based on two policies: the Hospital Survey and Construction Act of 1946 and non-profit tax exemption. The nominal intent of the Hospital Survey and Construction Act of 1946 (commonly known as the Hill-Burton Act) was to bolster the relatively under-developed postwar hospital industry by requiring states "to develop programs for the construction of such public and other non-profit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people" (*Hospital Survey and Construction Act* 1946).

4. A summary of these issues can also be found in Nancy Kane's testimony to the Subcommittee on Oversight of the U.S. House Committee on Ways and Means (Kane 2004).

5. The terms "nonprofit" and "tax-exempt" (or "untaxed") are sometimes used interchangeably, but they are technically distinct. For the purposes of federal taxation, an organization may be deemed tax-exempt by meeting the requirements of section 501 of the Internal Revenue Code. Nonprofit status, on the other hand, is granted by state governments on the basis of criteria that vary from state to state. In CBO's analysis, hospitals that identify themselves as nonprofit in Medicare Hospital Cost Reports are assumed to be exempt from federal, state, and local taxes.

6. Hospitals are identified as nonprofit, for-profit, or governmental on the basis of classifications reported by hospitals in the "control type" variable in the Medicare Hospital Cost Report. According to the control type variable, "nonprofit" refers to voluntary nonprofit (with or without church affiliation); "for-profit" refers to proprietary hospitals owned by individuals, corporations,

partnerships, or other entities; and "government" refers to state, county, city county, city, hospital-district, or other governmental entities (federal hospitals were excluded from the analysis).

7. "Community hospitals" include nonfederal short-term general hospitals. This definition includes most hospital facilities but excludes, for example, federal hospitals run by the Veterans Administration, psychiatric hospitals, and long-term-care hospitals. Several of the key data sources used were Medicare administrative files. Therefore, only Medicare-certified community hospitals were included in the analyses in this paper. Throughout the text "all community hospitals" *referred to all Medicare-certified community hospitals. The findings were referred to* as representing the year 2003, but the data were actually taken from either 2003 or 2002. For the analysis of uncompensated care, which included hospitals in only five states, the data for 57 percent of hospitals were from federal fiscal year (FFY) 2003, and those for 43 percent of hospitals were from FFY 2002. For convenience, 2003 was used to describe the findings because the majority of hospitals report data for FFY 2003. For consistency, the analysis for all community hospitals used the same data years that were used to analyze uncompensated care costs in the five states. The FFY 2003 data were used for all hospitals not in the five states. For the other analyses, which included hospitals in all of the states, 90 percent of hospitals had FFY 2003 data and 10 percent of hospitals had FFY 2002 data.

8. The range of $100 million to $700 million represents the 90 percent confidence interval from the underlying statistical analysis.

9. In CBO's analysis, a hospital provides "high-level trauma care" if it is a level 1 or level 2 adult trauma center (stand-alone pediatric trauma centers are not included). A hospital may be designated as a trauma center if it meets certain criteria developed by the American College of Surgeons. Trauma centers are assigned a level ranging from 1 through 5, with level 1 being the highest. To be designated a level 1 or level 2 trauma center, a hospital must "[provide] comprehensive trauma care" and must "have immediate availability of trauma surgeons, anesthesiologists, physician specialists, nurses, and resuscitation equipment." See Ellen J. MacKenzie and others, "National Inventory of Hospital Trauma Centers," *Journal of the American Medical Association*, vol. 289, no. 12 (March 26, 2003), pp. 1515-1522.

10. A concept in the discipline of economics that is similar to a collective good is that of a "public good." Public goods are defined as having two properties: (1) non rivalry in consumption (meaning that one person's consumption does not diminish another person's ability to consume the same good) and (2) non excludability
(meaning that, because of the nature of the good, it is not feasible, once the good has been produced, to stop someone from consuming it; therefore, it is not possible for a seller of the good to recoup adequate payment for it). If non indigent members of the community are made better off when indigent individuals are given health care, and if it is not possible for the hospital that provides such care to prevent non indigent community members who have not contributed to the hospital from being made better off, then the provision of uncompensated care to poor people fits the definition of a public good. Because people can benefit from a public good without paying anything toward its production, a private marketplace may not produce an appropriate amount of such goods. Governments may intervene to bring about adequate production of public goods by either having the government produce those goods or by providing subsidies to private producers of such goods. Prevention of the spread of communicable disease also fits the definition of a public good and provides an additional rationale for subsidization of certain hospital activities, including care for the indigent.

11. Nonprofit hospitals operating in the same market as for-profits appear to imitate their behavior to some extent. See Cutler and Horwitz, "Converting Hospitals from Not-for-Profit to For-Profit Status: Why and What Effects?"; Silverman and Skinner, "Medicare Upcoding and Hospital Ownership"; and Jonathan Gruber, "The Effects of Competitive Pressure on Charity-Hospital Response to Price Shopping in California," Journal of Health Economics, vol. 13, no. 2 (1994), pp. 183-212. That phenomenon has led some researchers to focus not on the effect of the ownership status of individual hospitals, but, instead, on the effect of the share of hospitals that are for-profit in defined geographic areas. See, for example, Mark Duggan, "Hospital Market Structure and the Behavior of Not-for-Profit Hospitals," Rand Journal of Economics, vol. 33, no. 3 (Autumn 2002), pp. 433-446. CBO did not analyze any market-level ownership effects or interaction effects among hospitals. Possible interaction effects might include crowding

out (the existence of governmental hospitals could reduce the uncompensated care provided by nongovernmental hospitals in
the same market) and imitation effects.

12. Al Dobson and others, Executive Summary: Evaluation of the Adequacy of Medicaid Payments to Hospitals in Pennsylvania (prepared by the Lewin Group for the Hospital and Healthsystem Association
of Pennsylvania, June 2005), available at:
www.haponline.org/downloads/Evaluation_of_the_Adequacy_of_Medicaid_Payments_to_Hospitals_in_Pennsylvania_LEWIN_Exec_Summ.pdf.

13. Hospitals may not absorb all the costs associated with caring for the uninsured because they receive direct payments from different government sources to help cover their unreimbursed costs, including those for charity care, bad debt, and low-income patients. For example, Medicare and Medicaid make payments to hospitals that serve a disproportionate share of low-income patients under their respective disproportionate share hospital programs. Other state payments may also be available to hospitals, although their specific types vary widely. For example, hospitals may receive payments from special revenues, such as tobacco settlement funds; uncompensated care pools that are funded by provider contributions; and payment programs targeted at certain services, such as emergency services.
Bad debt is generally defined as the uncollectible payment that the patient is expected to, but does not pay.

14. For this study, the Government Accountability Office (GAO) analyzed 2003 data from five geographically diverse states—California, Florida, Georgia, Indiana, and Texas—with substantial representation of the three ownership groups. For each state, GAO determined the three ownership groups' percentages of total uncompensated care costs and patient operating expenses devoted to uncompensated care. GAO 2005. *Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits*, GAO-05-743T.

15. Congressional Budget Office (CBO) found that, on average, nonprofit hospitals provided more uncompensated care than otherwise similar for-profit hospitals, although the ranges of uncompensated care provided by the two types of hospitals largely overlapped.

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ILLUSTRATIONS

APPENDIX A

THE VARIABLE LIST

VARIABLES	LOCATION in CMS FORM 2552-96		
1. Total Operating Patient Revenues:	Worksheet G3	Line# 1	Column# 1
2. Contractual Allowances & Discounts:	Worksheet G3	Line# 2	Column# 1
3. Net Patient Revenues:	Worksheet G3	Line# 3	Column# 1
4. Total Operating Expenses	Worksheet G3	Line# 4	Column# 1
5. Net Income	Worksheet G3	Line# 5	Column# 1
6. Ratio of Cost to Charges:	Worksheet S10	Line# 24	Column# 1
7A. Uncompensated Charges	Worksheet S10	Line# 30	Column# 1
7B. Uncompensated Cost	Worksheet S10	Line# 31	Column# 1
7C. Uncompensated Revenue	Worksheet S10	Line# 17	Column# 1
8. (SCHIP):			
A. SCHIP Charges	Worksheet S10	Line# 26	Column# 1
B. SCHIP Cost	Worksheet S10	Line# 27	Column# 1
9. (SCHIP):			
A. SCHIP Revenues (Payment Received)	Worksheet S10	Line# 19	Column# 1
10. (Medicaid):			
A. MCAID Charges	Worksheet S10	Line# 28	Column# 1
B. MCAID Cost	Worksheet S10	Line# 29	Column# 1
11. (Medicaid):			
A. MCAID Revenues (Payment Received)	Worksheet S10	Line# 17.1	Column# 1
12. Georgia Indigent Care Program Costs:			
A. GICP Charges	Worksheet S10	Line# 23	Column# 1
B. GICP Cost	Worksheet S10	Line# 25	Column# 1
13. Georgia Indigent Care Program Revenue:			
A. GICP Revenue (Payment Received)	Worksheet S10	Line# 18	Column# 1
14. DSH Payments	http://www.cms.hhs.gov/CostReports/02_HospitalCostReport.asp		
15. Income Tax	Tenet, HCA, HMA (Corporate office)		
16. Property Tax	Tenet, HCA, HMA (Corporate office		
17. Other Tax	Tenet, HCA, HMA (Corporate office)		

APPENDIX B

MSA ATLANTA NOT-FOR-PROFIT HOSPITALS
REVENUE SIZE BASED COMMUNITY BENEFIT

Cost of Uncompensated Care and Shortfalls in SCHIP, Medicaid, Georgia Indigent Care Program as percentage of Net Revenue for each Revenue Size

	All								Scenario 1		Scenario 2	
Revenue Size	N	% of all Hospitals	Uncompensated Percent of Net Revenue for RevenueSize	SCHIP Shortfall Percent of Net Revenue for RevenueSize	MCAID Percent of Net Revenue for RevenueSize	GAIC Percent of Net Revenue for RevenueSize	DSH Percent of Net Revenue for RevenueSize	Community Benefit as Percent of Net Revenue	Tax Percent (Income + Property) 0.00%	Total Community Benefit	Tax Percent (Income + Property) 0.00%	Total Community Benefit
Under $100M	3	18%	3.84%	0.04%	1.72%	0.67%	-0.44%	5.83%		5.83%		5.83%
$100M - Under $250M	3	18%	4.81%	0.01%	0.85%	0.46%	-1.47%	4.66%		4.66%		4.66%
$250M - Under $500M	3	18%	7.12%	0.03%	2.85%	0.26%	-1.63%	8.63%		8.63%		8.63%
$500M - Under $1000M	3	18%	5.72%	0.00%	0.83%	0.50%	-3.45%	3.60%		3.60%		3.60%
Over $1000M	5	29%	12.53%	0.00%	0.61%	0.02%	-1.00%	12.16%		12.16%		12.16%
All	17	100%	8.17%	0.01%	0.86%	0.17%	1.53%					

17 hospitals (represents all revenue sizes) were chosen from a list of 34 not-for-profit hospitals provided by the Georgia Hospital Association (GHA), due to unavailability of data or unreported data for 17, in the CMS Medicare Cost Report File. For hospitals in the **under $100 Million Total Patient Revenue range**, and for their average Net Patient Revenue, the three hospitals provided average **Community Benefit of 5.83%** after adjusting for 0.44% of DSH payment. In the **$100 Million to under $250 Million range**, three hospitals provided average **Community Benefit of 4.66%** after adjusting for 1.47% of DSH payment. In the **$250 Million to under $500 Million range**, three hospitals provided average **Community Benefit of 8.63%** after adjusting for 1.63% of DSH payment. In the **$500 Million to under $1 Billion range**, three hospitals provided average **Community Benefit of 3.60%** after adjusting for 3.45% of DSH payment. Finally, in the **over $1 Billion range**, five hospitals provided average **Community Benefit** of 12.16% after adjusting for 1.00% of DSH payment.

Data for For-Profit Hospitals is provided in Appendix C.

APPENDIX C

MSA ATLANTA FOR-PROFIT HOSPITALS
REVENUE SIZE BASED COMMUNITY BENEFIT

Cost of Uncompensated Care and Shortfalls in SCHIP, Medicaid, Georgia Indigent Care Program as percentage of Net Revenue for each Revenue Size

	All								Scenario 1		Scenario 2	
Revenue Size	N	% of all Hospitals	Uncompensated Percent of Net Revenue for RevenueSize	SCHIP Shortfall Percent of Net Revenue for RevenueSize	MCAID Percent of Net Revenue for RevenueSize	GAIC Percent of Net Revenue for RevenueSize	DSH Percent of Net Revenue for RevenueSize	Community Benefit as Percent of Net Revenue	Tax Percent (Income + Property) 4.80%	Total Community Benefit	Tax Percent (Income + Property) 2.74%	Total Community Benefit
Under $100M	1	14%	10.85%	0.54%	2.21%	0.20%	-1.83%	11.77%	4.80%	16.57%	2.74%	14.51%
$100M - Under $250M	1	14%	7.68%	0.00%	1.44%	1.02%	-2.63%	7.51%	4.80%	12.31%	2.74%	10.25%
$250M - Under $500M	1	14%	7.04%	0.00%	0.00%	0.00%	-1.40%	5.64%	4.80%	10.44%	2.74%	8.38%
$500M - Under $1000M	3	43%	6.97%	0.00%	1.30%	0.00%	-2.98%	5.29%	4.80%	10.09%	2.74%	8.03%
Over $1000M	1	14%	5.99%	0.00%	0.00%	3.63%	-2.99%	6.63%	4.80%	11.43%	2.74%	9.37%
All	7	100%	6.59%	0.01%	0.69%	1.18%	-2.64%	5.83%		10.63%		8.57%

7 hospitals (represents all revenue sizes) were chosen from a list of 9 for-profit hospitals provided by the Georgia Hospital Association (GHA), due to unavailability of data or unreported data for two, in the CMS Medicare Cost Report File. In Scenario 1, for hospitals in the **under $100 Million Total Patient Revenue range**, and for their average Net Patient Revenue, one hospital provided average **Community Benefit of 11.77%** after adjusting for 1.83% of DSH payment. In the **$100 Million to under $250 Million range**, one hospital provided average **Community Benefit of 7.51%** after adjusting for 2.63% of DSH payment. In the **$250 Million to under $500 Million range**, one hospital provided average **Community Benefit of 5.64%** after adjusting for 1.40% of DSH payment. In the **$500 Million to under $1 Billion range**, three hospitals provided average **Community Benefit of 5.29%** after adjusting for 2.98% of DSH payment. Finally, in the **over $1 Billion range**, one hospital provided average **Community Benefit** of 6.63% after adjusting for 2.99% of DSH payment.

Further, if tax components are added to the community benefit of for-profit group, then these hospitals in the respective revenue size groups, improve their Total Community Benefits, in scenario 1 with 4.8% tax, to 16.57%, 12.31%, 10.44%, 10.09%, and 11.43% respectively in the five revenue range. In scenario 2, with 2.74% tax, they drop to 14.51%, 10.25%, 8.38%, 8.03%, and 9.37% in the five revenue sizes respectively.

APPENDIX D

MSA ATLANTA NOT-FOR-PROFIT AND FOR-PROFIT HOSPITALS AVERAGE & MEDIAN HOSPITAL TYPE BASED COMMUNITY BENEFIT

Type of hospitals	Average Net Revenue	Average Community Benefit	Average Uncompensated Percent of Net Revenue for RevenueSize	Average SCHIP Shortfall Percent of Net Revenue for RevenueSize	Average MCAID Percent of Net Revenue for RevenueSize	Average GICP Percent of Net Revenue for RevenueSize	Average DSH Percent of Net Revenue for RevenueSize	Average Community Benefit as Percent of Net Revenue for Revenue Size	Scenario 1 Tax Percent (Income + Property) 4.80%	Scenario 1 Total Community Benefit	Scenario 2 Tax Percent (Income + Property) 2.74%	Scenario 2 Total Community Benefit
All Not-For-Profit Hospitals	240,135,246	18,439,466	8.17%	0.01%	0.85%	0.17%	-1.53%	7.67%	0.00%	7.67%	0.00%	7.67%
All For-Profit Hospitals	109,891,295	6,421,068	6.59%	0.01%	0.69%	1.16%	-2.64%	5.83%	4.80%	10.63%	2.74%	8.57%
DIFFERENCE	130,243,951	12,018,398	-1.58%	0.00%	-0.16%	1.01%	-1.11%	-1.84%	4.80%	2.96%	2.74%	0.90%

Type of hospitals	Median Net Revenue	Median Community Benefit	Median Benefit as Percent of Net Revenue	Scenario 1 Tax Percent (Income + Property) 4.80%	Scenario 1 Total Community Benefit	Scenario 2 Tax Percent (Income + Property) 2.74%	Scenario 2 Total Community Benefit
All Not-For-Profit Hospitals	141,610,379	9,130,930	6.45%	0.00%	6.45%	0.00%	6.45%
All For-Profit Hospitals	110,599,230	6,243,994	5.65%	4.80%	10.45%	2.74%	8.39%
DIFFERENCE	31,011,149	2,886,936	-0.80%	4.80%	4.00%	2.74%	1.94%

APPENDIX E

MSA ATLANTA NOT-FOR-PROFIT HOSPITALS
COST OF UNCOMPENSATED CARE: YEAR ENDING 2007

Based on FORM CMS- 2552-96-Section S10 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3609.4)

Facility Name	Total Patient Revenue	Net Patient Revenue	Cost to Charge Ratio	Uncompensated Care Charge	Uncompensated Care Cost	Uncompensated Care Cost as Percent of Net Revenue
WellStar Paulding Hospital (37) & (?)	90,638,062	44,095,429	0.3993	1,614,524	644,749	1.46%
WellStar Windy Hill Hospital (117) &(150)	92,290,023	44,300,435	0.3708	621,584	230,507	0.52%
Tanner Medical Center/Villa Rica (11)	94,431,433	37,622,952	0.3664	27,956,170	3,588,931	9.54%
Emory-Adventist Hospital (67) & (99)	118,412,417	41,609,655	0.2978	11,200,000	3,329,914	8.00%
Newton Medical Center (12) & (13)	191,534,977	70,093,760	0.3169	4,960,755	2,106,884	3.01%
Northside Hospital-Cherokee (8)	228,829,893	81,894,185	0.2400	11,658,156	2,798,027	3.42%
Tanner Medical Center/Carrollton (10) & (10)	312,501,237	129,387,479	0.3333	75,000,000	11,000,000	8.50%
Rockdale Hospital & Health Systems (42) & (58)	322,043,620	111,067,690	0.2957	27,122,520	8,019,017	7.22%
Piedmont Fayette Hospital (142) & (116)	426,106,142	141,610,379	0.2827	28,296,560	7,998,079	5.65%
Southern Regional Medical Center (113) & (95)	690,612,152	236,962,951	0.3025	34,481,602	10,429,478	4.40%
WellStar Cobb Hospital (60) & (87)	742,247,281	279,069,477	0.3178	21,154,047	9,051,349	3.24%
Emory Crawford Long Hospital (37) & (50)	940,506,061	409,440,133	0.3739	107,131,000	39,007,000	9.53%
Saint Joseph's Hospital of Atlanta (39) & (53)	1,052,532,404	359,300,275	0.3022	26,128,938	7,897,262	2.20%
Grady Memorial Hospital (38) & (51) (RLWKS)	1,200,306,427	336,106,915	0.4098	430,000,000	170,000,000	50.58%
Piedmont Hospital (66) & (54) (BCWKS)	1,481,718,617	536,311,096	0.3031	60,536,508	18,350,371	3.42%
WellStar Kennestone Hospital (31) & (24) (RLWKS)	1,608,501,821	605,329,175	0.2934	69,579,125	23,814,710	3.93%
Northside Hospital (110) & (92)	1,621,618,625	618,097,201	0.2978	51,824,083	15,432,020	2.50%
TOTAL		[illegible]			[illegible]	8.17%

17 hospitals (represents all revenue sizes) were chosen from a list of 34 not-for-profit hospitals provided by the Georgia Hospital Association (GHA), due to unavailability of data or unreported data in the CMS Medicare Cost Report File. Not-For-Profit Hospitals together provided 8.17% of their Net Patient Revenue as Uncompensated Care Cost. Grady Memorial Hospital skews this result upwards due to its large uncompensated care burden of 50.58%. If this hospital results are removed, the Uncompensated Care Cost drops to 4.01% for the Not-For-Profit group. In comparison, the For-Profit group provided 6.59% of Community Benefit as shown in Appendix F.

APPENDIX F

MSA ATLANTA FOR-PROFIT HOSPITALS
COST OF UNCOMPENSATED CARE: YEAR ENDING 2007

Based on FORM CMS- 2552-96-Section S10 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3609.4)

Facility Name	Ownership	Total Patient Revenue	Net Patient Revenue	Cost to Charge Ratio	Uncompensated Care Charge	Uncompensated Care Cost	Uncompensated Care Cost as Percent of Net Revenue
Barrow Community Hospital (26)	HMA	71,270,163	18,725,836	0.3280	6,005,912	1,994,707	10.65%
Walton Regional Medical Center (27)	HMA	106,172,046	34,732,571	0.2988	8,947,666	2,665,909	7.68%
Cartersville Medical Center (18)	HCA	468,079,393	110,599,230	0.1681	34,500,000	7,790,100	7.04%
Spalding Regional Hospital (19)	Tenet	530,015,916	114,149,966	0.1684	50,800,000	8,530,042	7.47%
South Fulton Medical Center (80)	Tenet	554,025,888	106,514,519	0.1937	80,800,000	11,600,000	10.89%
North Fulton Regional Hospital (73)	Tenet	715,574,720	144,307,623	0.1645	10,300,000	3,695,064	2.56%
Atlanta Medical Center	Tenet	1,009,485,872	240,209,319	0.1936	48,535,022	14,395,992	5.99%
TOTAL			[illegible]			[illegible]	[illegible]

7 hospitals (representative of all revenue sizes) were chosen from a list of 9 for-profit hospitals provided by the Georgia Hospital Association (GHA). Two did not have available data or did not report data to CMS and were not in Medicare Cost Report File. For-Profit Hospitals together provided 6.59% of their Net Patient Revenue as Uncompensated Care portion of Community Benefit. North Fulton Regional Hospital provided much lower uncompensated care in comparison to the others in the same revenue size. Even if it took on a similar uncompensated care burden as the others in the group, the group Community Benefit component of Uncompensated Care would go up by 1% to 7.59%. In comparison, the Not-For-Profit Group provided 8.17% of Community Benefit in terms of uncompensated care.

APPENDIX G

MSA ATLANTA NOT-FOR-PROFIT HOSPITALS
COST OF SHORTFALL IN SCHIP CARE: YEAR ENDING 2007

Based on FORM CMS- 2552-96-Section S10 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3609.4)

Facility Name	Total Patient Revenue	Net Patient Revenue	Cost to Charge Ratio	SCHIP Charge	SCHIP Cost	SCHIP Revenue	SCHIP Shortfall	SCHIP Shortfall as Percent of Revenue	Average SCHIP as Percent of Net Revenue for RevenueSize
WellStar Paulding Hospital	90,638,062	44,095,429	0.3993	1,255,926	501,545	735,699	0	0.00%	
WellStar Windy Hill Hospital	92,290,023	44,300,435	0.3708	128,936	47,814	128,936	0	0.00%	
Tanner Medical Center/Villa Rica	94,431,433	37,622,952	0.3664	135,943	49,813	0	49,813	0.13%	
									0.04%
Emory-Adventist Hospital	118,412,417	41,609,655	0.2978	84,223	26,848	24,184	2,664	0.01%	
Newton Medical Center	191,534,977	70,093,760	0.3169	99,755	31,616	25,802	5,814	0.01%	
Northside Hospital-Cherokee	228,829,893	81,894,185	0.2400	0	0	0	0	0.00%	
									0.005%
Tanner Medical Center/Carrollton	312,501,237	129,387,479	0.3333	187,029	62,345	0	62,345	0.05%	
Rockdale Hospital & Health Systems	322,043,620	111,067,690	0.2957	124,929	36,936	23,714	13,222	0.01%	
Piedmont Fayette Hospital	426,106,142	141,610,379	0.2827	574,468	162,375	100,707	61,668	0.04%	
									0.03%
Southern Regional Medical Center	690,612,152	236,962,951	0.3025	412,690	124,824	111,795	13,029	0.01%	
WellStar Cobb Hospital	742,247,281	279,069,477	0.3178	3,510,566	1,115,591	1,450,566	0	0.00%	
Emory Crawford Long Hospital	940,506,061	409,440,133	0.3739	0	0	0	0	0.00%	
									0.00%
Saint Joseph's Hospital of Atlanta	1,052,532,404	359,300,275	0.3022	0	0	0	0	0.00%	
Grady Memorial Hospital	1,200,306,427	336,106,915	0.4098	202,993	82,957	95,274	0	0.00%	
Piedmont Hospital	1,481,718,617	536,311,096	0.3031	248,545	75,341	47,604	27,737	0.01%	
WellStar Kennestone Hospital	1,608,501,821	605,329,175	0.2934	2,585,566	758,727	1,856,545	0	0.00%	
Northside Hospital	1,621,618,625	618,097,201	0.2978	0	0	0	0	0.00%	
									0.00%

[redacted]

17 hospitals (representative of all revenue sizes) were chosen from a list of 34 not-for-profit hospitals provided by the Georgia Hospital Association (GHA), due to unavailability of data or unreported data in the CMS Medicare Cost Report File. Not-For-Profit Hospitals together provided 0.01% of their Net Patient Revenue as SCHIP portion of their Community Benefit. In comparison, the For-Profit Group also provided 0.01% of Community Benefit in terms of SCHIP care as shown in Appendix H.

APPENDIX H

MSA ATLANTA FOR-PROFIT HOSPITALS
COST OF SHORTFALL IN SCHIP CARE: YEAR ENDING 2007

Based on FORM CMS- 2552-96-Section S10 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3609.4)

Facility Name	Total Patient Revenue	Net Patient Revenue	Cost to Charge Ratio	SCHIP Charge	SCHIP Cost	SCHIP Revenue	SCHIP Shortfall	SCHIP Shortfall as Percent of Revenue	Average SCHIP as Percent of Net Revenue for RevenueSize
Barrow Community Hospital	71,270,163	18,725,836	0.3280	892,448	421,934	320,000	101,934	0.54%	0.54%
Walton Regional Medical Center	106,172,046	34,732,571	0.2988	0	0	0	0	0.00%	0.00%
Cartersville Medical Center	469,365,346	110,903,079	0.1686	175,167	29,446	30,905	0	0.00%	0.00%
Spalding Regional Hospital	530,015,916	114,149,966	0.1684	0	0	0	0	0.00%	
South Fulton Medical Center	554,025,888	106,514,519	0.1937	0	0	0	0	0.00%	
North Fulton Regional Hospital	715,574,720	144,307,623	0.1645	0	0	0	0	0.00%	
									0.00%
Atlanta Medical Center	1,009,485,872	240,209,319	0.1936	0	0	0	0	0.00%	0.00%

17 hospitals (representative of all revenue sizes) were chosen from a list of 34 not-for-profit hospitals provided by the Georgia Hospital Association (GHA), due to unavailability of data or unreported data in the CMS Medicare Cost Report File. The For-Profit group provided 0.01% of Community Benefit in terms of SCHIP care as shown, while the Not-For-Profit Hospital group also provided 0.01% of their Net Patient Revenue as SCHIP portion of their Community Benefit.

APPENDIX J

MSA ATLANTA NOT-FOR-PROFIT HOSPITALS
COST OF SHORTFALL IN MEDICAID CARE: YEAR ENDING 2007

Based on FORM CMS- 2552-96-Section S10 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3609.4)

Facility Name	Total Patient Revenue	Net Patient Revenue	Cost to Charge Ratio	MCAID Charge	MCAID Cost	MCAID Revenue	MCAID Shortfall	MCAID Shortfall as Percent of Revenue	Average MCIAD as Percent of Net Revenue for RevenueSize
WellStar Paulding Hospital	90,638,062	44,095,429	0.3993	7,512,875	3,000,214	4,614,675	0	0.00%	
WellStar Windy Hill Hospital	92,290,023	44,300,435	0.3708	4,335,545	1,607,785	4,335,545	0	0.00%	
Tanner Medical Center/Villa Rica	94,431,433	37,622,952	0.3664	17,749,900	6,504,007	4,560,153	1,943,854	5.17%	
									1.72%
Emory-Adventist Hospital	118,412,417	41,609,655	0.2978	4,755,274	1,412,416	988,857	423,559	1.02%	
Newton Medical Center	191,534,977	70,093,760	0.3169	11,497,244	3,643,845	3,757,500	0	0.00%	
Northside Hospital-Cherokee	228,829,893	81,894,185	0.2400	27,345,011	6,562,967	5,301,422	1,261,545	1.54%	
									0.85%
Tanner Medical Center/Carrollton	312,501,237	129,387,479	0.3333	42,459,101	14,153,402	6,039,919	8,113,483	6.27%	
Rockdale Hospital & Health Systems	322,043,620	111,067,690	0.2957	60,251,796	17,813,986	16,123,185	1,690,801	1.52%	
Piedmont Fayette Hospital	426,106,142	141,610,379	0.2827	27,158,896	7,676,516	6,605,333	1,071,183	0.76%	
									2.85%
Southern Regional Medical Center	690,612,152	236,962,951	0.3025	164,650,361	49,800,971	46,172,018	3,628,953	1.53%	
WellStar Cobb Hospital	742,247,281	279,069,477	0.3178	116,290,155	36,954,802	34,290,155	2,664,647	0.95%	
Emory Crawford Long Hospital	940,506,061	409,440,133	0.3739	108,326,586	40,505,477	48,856,326	0	0.00%	
									0.83%
Saint Joseph's Hospital of Atlanta	1,052,532,404	359,300,275	0.3022	23,195,560	7,010,672	4,645,400	2,365,272	0.66%	
Grady Memorial Hospital	1,200,306,427	336,108,915	0.4098	215,000,000	87,900,000	85,100,000	2,800,000	0.83%	
Piedmont Hospital	1,461,718,617	536,311,096	0.3031	45,271,737	13,723,176	10,549,507	3,173,669	0.59%	
WellStar Kennestone Hospital	1,608,501,821	605,329,175	0.2934	157,000,000	46,000,000	46,000,000	0	0.00%	
Northside Hospital	1,621,618,625	618,097,201	0.2978	153,211,331	45,622,811	39,699,627	5,923,184	0.96%	
									0.61%

17 hospitals (representative of all revenue sizes) were chosen from a list of 34 not-for-profit hospitals provided by the Georgia Hospital Association (GHA), due to unavailability of data or unreported data in the CMS Medicare Cost Report File. The Not-For-Profit group together provided 0.86% of their Net Patient Revenue as Medicaid portion of their Community Benefit. In comparison, the For-Profit group provided 0.69% of Community Benefit in terms of Medicaid care as shown in Appendix K.

APPENDIX K

MSA ATLANTA FOR-PROFIT HOSPITALS
COST OF SHORTFALL IN MEDICAID CARE: YEAR ENDING 2007

Based on FORM CMS- 2552-96-Section S10 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3609.4)

Facility Name	Total Patient Revenue	Net Patient Revenue	Cost to Charge Ratio	MCAID Charge	MCAID Cost	MCAID Revenue	MCAID Shortfall	MCAID Shortfall as Percent of Net Revenue	Average MCAID as Percent of Net Revenue for RevenueSize
Barrow Community Hospital	71,270,163	18,725,836	0.3280	6,198,834	2,027,527	1,613,140	414,387	2.21%	2.21%
Walton Regional Medical Center	106,172,046	34,732,571	0.2988	8,988,012	2,678,508	2,177,125	501,383	1.44%	1.44%
Cartersville Medical Center	469,365,346	110,903,079	0.1686	55,300,000	9,291,376	10,800,000	0	0.00%	0.00%
Spalding Regional Hospital	530,015,916	114,149,966	0.1684	93,200,000	15,600,000	11,700,000	3,900,000	3.42%	
South Fulton Medical Center	554,025,888	106,514,519	0.1937	146,643,067	30,318,018	29,788,648	529,370	0.50%	
North Fulton Regional Hospital	715,574,720	144,307,623	0.1645	78,500,000	12,900,000	13,200,000	0	0.00%	
									1.30%
Atlanta Medical Center	1,009,485,872	240,209,319	0.1936	172,288,481	33,353,672	34,227,276	0	0.00%	0.00%

17 hospitals (representative of all revenue sizes) were chosen from a list of 34 not-for-profit hospitals provided by the Georgia Hospital Association (GHA), due to unavailability of data or unreported data in the CMS Medicare Cost Report File. The For-Profit group provided 0.69% of Community Benefit in terms of Medicaid care as shown in comparison to the Not-For-Profit group which provided 0.86% of their Net Patient Revenue as Medicaid portion of their Community Benefit.

APPENDIX L

MSA ATLANTA NOT-FOR-PROFIT HOSPITALS
COST OF SHORTFALL IN GEORGIA INDIGENT CARE PROGRAM: YEAR ENDING 2007

Based on FORM CMS- 2552-96-Section S10 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3609.4)

Facility Name	Total Patient Revenue	Net Patient Revenue	Cost to Charge Ratio	Georgia Indigent Care Ch	Georgia Indigent Care Co	Georgia Indigent Revenue	Georgia Indigent Shortfall	Shortfall as Percent of Revenue	Average GICP as Percent of Net Revenue for RevenueSize
WellStar Paulding Hospital	90,638,062	44,095,429	0.3993	2,091,478	835,217	2,091,478	0	0.00%	
WellStar Windy Hill Hospital	92,290,023	44,300,435	0.3708	1,414,970	524,725	1,414,970	0	0.00%	
Tanner Medical Center/Villa Rica	94,431,433	37,622,952	0.3664	12,717,029	4,659,837	3,900,000	759,837	2.02%	
									0.67%
Emory-Adventist Hospital	118,412,417	41,609,655	0.2978	0	0	0	0	0.00%	
Newton Medical Center	191,534,977	70,093,760	0.3169	17,007,970	5,390,370	4,429,603	960,767	1.37%	
Northside Hospital-Cherokee	228,829,893	81,894,185	0.2400	0	0	0	0	0.00%	
									0.46%
Tanner Medical Center/Carrollton	312,501,237	129,387,479	0.3333	26,828,657	8,943,118	7,929,603	1,013,515	0.78%	
Rockdale Hospital & Health Systems	322,043,620	111,067,690	0.2957	4,118,074	1,217,546	2,200,000	0	0.00%	
Piedmont Fayette Hospital	426,106,142	141,610,379	0.2827	0	0	0	0	0.00%	
									0.26%
Southern Regional Medical Center	690,612,152	236,962,951	0.3025	29,589,732	8,949,858	5,949,858	3,000,000	1.27%	
WellStar Cobb Hospital	742,247,281	279,069,477	0.3178	17,828,232	5,665,473	17,828,232	0	0.00%	
Emory Crawford Long Hospital	940,506,061	409,440,133	0.3739	108,326,586	40,505,477	39,500,000	1,005,477	0.25%	
									0.50%
Saint Joseph's Hospital of Atlanta	1,052,532,404	359,300,275	0.3022	1,463,408	442,303	64,496	377,807	0.11%	
Grady Memorial Hospital	1,200,306,427	336,106,915	0.4098	164,000,000	66,800,000	102,000,000	0	0.00%	
Piedmont Hospital	1,481,718,617	536,311,096	0.3031	0	0	0	0	0.00%	
WellStar Kennestone Hospital	1,608,501,821	605,329,175	0.2934	48,600,000	14,300,000	48,600,000	0	0.00%	
Northside Hospital	1,621,618,625	618,097,201	0.2978	0	0	0	0	0.00%	
									0.02%

[redacted]

17 hospitals (representative of all revenue sizes) were chosen from a list of 34 not-for-profit hospitals provided by the Georgia Hospital Association (GHA), due to unavailability of data or unreported data in the CMS Medicare Cost Report File. The Not-For-Profit group together provided 0.17% of their Net Patient Revenue as Georgia Indigent Care Program portion of their Community Benefit. In comparison, the For-Profit group provided 1.18% of Community Benefit in terms of Georgia Indigent Care Program portion as shown in Appendix J.

APPENDIX M

MSA ATLANTA FOR-PROFIT HOSPITALS
COST OF SHORTFALL IN GEORGIA INDIGENT CARE PROGRAM: YEAR ENDING 2007

Based on FORM CMS- 2552-96-Section S10 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3609.4)

Facility Name	Total Patient Revenue	Net Patient Revenue	Cost to Charge Ratio	Georgia Indigent Care Ch	Georgia Indigent Care Co	Georgia Indigent Revenue	Georgia Indigent Shortfall	Shortfall as Percent of Revenue	Average GICP as Percent of Net Revenue for RevenueSize
Barrow Community Hospital	71,270,163	18,725,836	0.3280	605,209	312,202	275,000	37,202	0.20%	0.20%
Walton Regional Medical Center	106,172,046	34,732,571	0.2988	1,131,218	355,141	0	355,141	1.02%	1.02%
Cartersville Medical Center	469,365,346	110,903,079	0.1686	185,863	31,244	85,234	0	0.00%	0.00%
Spalding Regional Hospital	530,015,916	114,149,966	0.1684	0	0	0	0	0.00%	
South Fulton Medical Center	554,025,888	106,514,519	0.1937	0	0	0	0	0.00%	
North Fulton Regional Hospital	715,574,720	144,307,623	0.1645	0	0	0	0	0.00%	
									0.00%
Atlanta Medical Center	1,009,485,872	240,209,319	0.1936	50,409,386	9,758,854	1,038,955	8,719,899	3.63%	3.21%
[redacted]									
Doctors Hospital	737,836,817	206,992,473	0.1955	0	0	0	0	0.00%	
Fairview Park Hospital	248,492,556	87,838,305	0.2339	146,085	34,175	94,955	-60,780	-0.07%	
Trinity Hospital of Augusta	93,906,351	36,725,611	0.3797	187,296	71,125	7,210	63,915	0.17%	

17 hospitals (representative of all revenue sizes) were chosen from a list of 34 not-for-profit hospitals provided by the Georgia Hospital Association (GHA), due to unavailability of data or unreported data in the CMS Medicare Cost Report File. The For-Profit group provided 1.18% of Community Benefit in terms of Georgia Indigent Care Program portion while the Not-For-Profit group together provided 0.17% of their Net Patient Revenue as Georgia Indigent Care Program portion of their Community Benefit.

APPENDIX N

DSH PAYMENTS FOR MSA ATLANTA NOT-FOR-PROFIT HOSPITALS

No	MC Id	Facility Name	Total Patient Revenue	Net Patient Revenue	DSH Payments	DSH as Percent of Net Revenue	Average DSH as Percent of Net Revenue for Revenue Size
1	110042	WellStar Paulding Hospital (37) & (?)	90,638,062	44,095,429	60,115	0.14%	
2	112007	WellStar Windy Hill Hospital (117) &(150)	92,290,023	44,300,435	0	0.00%	
3	110015	Tanner Medical Center/Villa Rica (11)	94,431,433	37,622,952	449,288	1.19%	
							0.44%
4	110183	Emory-Adventist Hospital (67) & (99)	118,412,417	41,609,655	243,949	0.59%	
5	110018	Newton Medical Center (12) & (13)	191,534,977	70,093,760	1,580,400	2.25%	
6	110161	Northside Hospital-Cherokee (8)	228,829,893	81,894,185	1,295,476	1.58%	
							1.47%
7	110011	Tanner Medical Center/Carrollton (10) & (10)	312,501,237	129,387,479	2,261,460	1.75%	
8	110091	Rockdale Hospital & Health Systems (42) & (58)	322,043,620	111,067,690	3,499,362	3.15%	
9	110215	Piedmont Fayette Hospital (142) & (116)	426,106,142	141,610,379	0	0.00%	
							1.63%
10	110165	Southern Regional Medical Center (113) & (95)	690,612,152	236,962,951	7,669,669	3.24%	
11	110143	WellStar Cobb Hospital (60) & (87)	742,247,281	279,069,477	8,591,613	3.08%	
12	110078	Emory Crawford Long Hospital (37) & (50)	940,506,061	409,440,133	16,540,398	4.04%	
							3.45%
13	110082	Saint Joseph's Hospital of Atlanta (39) & (53)	1,052,532,404	359,300,275	0	0.00%	
14	110079	Grady Memorial Hospital (38) & (51) (RLWKS)	1,200,306,427	336,106,915	12,434,704	3.70%	
15	110083	Piedmont Hospital (66) & (54) (BCWKS)	1,481,718,617	536,311,096	0	0.00%	
16	110035	WellStar Kennestone Hospital (31) & (24) (RLWKS)	1,608,501,821	605,329,175	6,719,304	1.11%	
17	110161	Northside Hospital (110) & (92)	1,621,618,625	618,097,201	1,295,476	0.21%	
							1.00%
		TOTAL		[illegible]	62,641,214	1.53%	

APPENDIX O

DSH PAYMENTS FOR MSA ATLANTA FOR-PROFIT HOSPITALS

No	MC id	Facility Name	Ownership	Total Patient Revenue	Net Patient Revenue	DSH Payments	DSH as Percent of Net Revenue	Average DSH as Percent of Net Revenue for Revenue Size
1	110045	Barrow Community Hospital (26)	HMA	71,270,163	18,725,836	341,987	1.83%	1.83%
2	110046	Walton Regional Medical Center (27)	HMA	108,172,046	34,732,571	913,896	2.63%	2.63%
3	110030	Cartersville Medical Center (18)	HCA	468,079,393	110,599,230	1,546,106	1.40%	1.40%
4	110031	Spalding Regional Hospital (19)	Tenet	530,015,916	114,149,966	3,936,679	3.45%	
5	110219	South Fulton Medical Center (80)	Tenet	554,025,888	106,514,519	4,404,052	4.13%	
6	110198	North Fulton Regional Hospital (73)	Tenet	715,574,720	144,307,623	1,959,773	1.36%	
								2.98%
7	110115	Atlanta Medical Center	Tenet	1,009,485,872	240,209,319	7,181,159	2.99%	2.99%
		TOTAL			[illegible]	20,283,652	2.64%	

APPENDIX P

REVENUE SIZE BASED PROFIT AND COMMUNITY BENEFIT OF NOT-FOR-PROFITS

Facility Name	Revenue Size	Total Patient Revenue	Net Patient Revenue	Operating Expenses	Net Income (Income from Operations)	Gross Margin	Uncompensated Care Cost as Percent of Net Revenue	Average Cost as Percent of Net Revenue for RevenueSize	SCHIP Shortfall as Percent of Revenue	MCAID Shortfall as Percent of Revenue	GCP Shortfall as Percent of Revenue	DSH as Percent of Net Revenue	Without Tax Community Benefit as Percent of Net Revenue
WellStar Paulding Hospital	Under $100 M	90,638,062	44,095,429	46,723,664	2,628,435	-2.90%	1.46%		0.00%	0.00%	0.00%	0.14%	1.32%
WellStar Windy Hill Hospital	Under $100 M	92,230,023	44,300,435	35,835,422	8,465,013	9.17%	0.52%		0.00%	0.00%	0.00%	0.00%	0.52%
Tanner Medical Center/Villa Rica	Under $100 M	94,431,433	37,622,952	27,318,539	10,304,413	10.91%	9.54%		0.13%	5.17%	2.02%	1.19%	15.67%
								3.04%					
Emory-Adventist Hospital	$100M - Under $250 M	118,412,417	41,609,655	42,624,681	1,015,026	-0.85%	8.00%		0.01%	1.02%	0.00%	0.59%	8.44%
Newton Medical Center	$100M - Under $250 M	191,534,977	70,093,760	74,480,560	4,386,800	-2.29%	3.01%		0.01%	0.00%	1.37%	2.25%	2.14%
Northside Hospital-Cherokee	$100M - Under $250 M	228,829,093	81,694,165	82,152,722	258,537	-0.11%	3.42%		0.00%	1.54%	0.00%	1.56%	3.38%
								4.81%					
Tanner Medical Center/Carrollton	$250M - Under $500 M	312,501,237	129,387,479	146,199,945	16,812,465	-5.38%	8.50%		0.05%	6.27%	0.78%	1.75%	13.85%
Rockdale Hospital & Health Systems	$250M - Under $500 M	322,043,620	111,067,690	120,158,608	9,090,918	-2.82%	7.22%		0.01%	1.52%	0.00%	3.15%	5.60%
Piedmont Fayette Hospital	$250M - Under $500 M	425,106,142	141,610,379	143,321,227	1,710,848	-0.40%	5.65%		0.04%	0.76%	0.00%	0.00%	6.45%
								7.12%					
Southern Regional Medical Center	$500M - Under $1 B	650,612,152	236,952,951	254,626,019	17,663,068	-2.55%	4.40%		0.01%	1.53%	1.27%	3.24%	3.97%
WellStar Cobb Hospital	$500M - Under $1 B	742,247,281	270,069,477	270,594,371	475,105	0.05%	3.24%		0.00%	0.95%	0.00%	3.06%	1.11%
Emory Crawford Long Hospital	$500M - Under $1 B	940,506,051	409,440,133	398,740,145	10,699,988	1.14%	9.53%		0.00%	0.00%	0.25%	4.04%	5.74%
								5.72%					
Saint Joseph's Hospital of Atlanta	Over $1 B	1,052,532,404	359,300,275	372,904,000	13,603,725	-1.29%	2.28%		0.00%	0.66%	0.11%	0.00%	2.97%
Grady Memorial Hospital	Over $1 B	1,200,306,427	336,106,915	678,973,626	342,866,711	-28.56%	50.58%		0.00%	0.83%	0.00%	3.76%	47.71%
Piedmont Hospital	Over $1 B	1,481,718,617	536,311,096	520,638,356	15,672,740	1.05%	3.42%		0.01%	0.59%	0.00%	0.00%	4.02%
WellStar Kennestone Hospital	Over $1 B	1,608,501,821	605,329,175	555,440,653	49,888,522	3.04%	3.97%		0.00%	0.00%	0.00%	1.11%	2.82%
Northside Hospital	Over $1 B	1,621,618,625	618,097,201	620,346,593	2,249,392	-0.14%	2.50%		0.00%	0.95%	0.00%	0.21%	3.25%
								12.53%					

APPENDIX Q

REVENUE SIZE BASED PROFIT AND COMMUNITY BENEFIT OF FOR-PROFITS

Facility Name	Revenue Size	Total Patient Revenue	Net Patient Revenue	Net Income (Income from Operations)	Gross Margin	Uncompensated Care Cost as Percent of Net Revenue	SCHIP Shortfall as Percent of Revenue	MCAID Shortfall as Percent of Net Revenue	GICP Shortfall as Percent of Revenue	DSH as Percent of Net Revenue	Without Tax Community Benefit as Percent of Net Revenue
Barrow Community Hospital	Under $100 M	71,270,163	18,725,836	4,090,553	-5.74%	10.65%	0.54%	2.21%	0.20%	1.83%	11.78%
Walton Regional Medical Center	$100M - Under $250	106,172,046	34,732,571	954,394	0.90%	7.68%	0.00%	1.44%	1.02%	2.63%	7.50%
Cartersville Medical Center	$250M - Under $500	468,079,393	110,599,230	22,991,803	4.91%	7.04%	0.00%	0.00%	0.00%	1.40%	5.65%
Spalding Regional Hospital	$5000M - Under $1 B	530,015,916	114,149,966	15,613,330	2.95%	7.47%	0.00%	3.42%	0.00%	3.45%	7.44%
South Fulton Medical Center	$5000M - Under $1 B	554,025,888	106,514,519	7,808,097	-1.41%	10.89%	0.00%	0.50%	0.00%	4.13%	7.26%
North Fulton Regional Hospital	$5000M - Under $1 B	715,574,720	144,307,623	13,052,653	1.82%	2.58%	0.00%	0.00%	0.00%	1.36%	1.20%
											5.30%
Atlanta Medical Center	Over $1 B	1,009,485,872	240,209,319	5,257,540	-0.52%	5.99%	0.00%	0.00%	3.63%	2.99%	6.63%

APPENDIX P1 (SELECTED LIST OF 17 NOT-FOR-PROFIT HOSPITALS)

REVENUE SIZE BASED PROFIT MARGINS AND POTENTIAL TAX BURDEN

Facility Name	Revenue Size	Total Patient Revenue	Net Patient Revenue	Operating Expenses	Net Income (Income from Operations)	Gross Margin	Federal Tax 3.50%	State Tax 0.90%	Property Tax 0.40%	Total Tax 4.80%	Total Tax 2.74%
WellStar Paulding Hospital	Under $100 M	90,638,062	44,095,429	46,723,864	2,628,435	-2.90%	0	0	176,382	176,382	176,382
WellStar Windy Hill Hospital	Under $100 M	92,290,023	44,300,435	35,835,422	8,465,013	9.17%	1,550,515	398,704	177,202	2,126,421	1,213,832
Tanner Medical Center/Villa Rica	Under $100 M	94,431,433	37,622,952	27,318,539	10,304,413	10.91%	1,316,803	338,607	150,492	1,805,902	1,030,869
Emory-Adventist Hospital	$100M - Under $250 M	118,412,417	41,609,655	42,624,681	1,015,026	-0.86%	0	0	166,439	166,439	166,439
Newton Medical Center	$100M - Under $250 M	191,534,977	70,093,760	74,490,560	4,396,800	-2.29%	0	0	280,375	280,375	280,375
Northside Hospital-Cherokee	$100M - Under $250 M	228,829,893	81,894,185	82,152,722	258,537	-0.11%	0	0	327,577	327,577	327,577
Tanner Medical Center/Carrollton	$250M - Under $500 M	312,501,237	129,387,479	146,199,945	16,812,466	-5.38%	0	0	517,550	517,550	517,550
Rockdale Hospital & Health Systems	$250M - Under $500 M	322,043,620	111,057,690	120,158,608	9,090,918	-2.82%	0	0	444,271	444,271	444,271
Piedmont Fayette Hospital	$250M - Under $500 M	426,106,142	141,610,379	143,321,227	1,710,848	-0.40%	0	0	566,442	566,442	566,442
Southern Regional Medical Center	$500M - Under $1 B	690,612,152	236,962,951	254,626,019	17,663,068	-2.56%	0	0	947,852	947,852	947,852
WellStar Cobb Hospital	$500M - Under $1 B	742,247,281	279,069,477	278,594,371	475,106	0.06%	9,767,432	2,511,625	1,116,278	13,395,335	7,646,504
Emory Crawford Long Hospital	$500M - Under $1 B	940,505,061	409,440,133	398,740,145	10,699,988	1.14%	14,330,405	3,684,961	1,637,761	19,653,126	11,218,660
Saint Joseph's Hospital of Atlanta	Over $1 B	1,052,532,404	359,300,275	372,904,000	13,603,725	-1.29%	0	0	1,437,201	1,437,201	1,437,201
Grady Memorial Hospital	Over $1 B	1,200,306,427	336,106,915	678,973,626	342,866,711	-28.56%	0	0	1,344,428	1,344,428	1,344,428
Piedmont Hospital	Over $1 B	1,481,718,617	536,311,096	520,638,356	15,672,740	1.06%	18,770,888	4,826,800	2,145,244	25,742,933	14,694,924
WellStar Kennestone Hospital	Over $1 B	1,608,501,821	605,329,175	556,440,653	48,888,522	3.04%	21,186,521	5,447,963	2,421,317	29,055,800	16,586,019
Northside Hospital	Over $1 B	1,621,618,625	618,097,201	620,346,593	2,249,392	-0.14%	0	0	2,472,399	2,472,399	1,472,399
TOTAL		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

APPENDIX P2 (ENTIRE LIST OF 27 NOT-FOR-PROFIT HOSPITALS)

REVENUE SIZE BASED PROFIT MARGINS AND POTENTIAL TAX BURDEN

Facility Name	Revenue Size	Total Patient Revenue	Net Patient Revenue	Operating Expenses	Net Income (Income from Operations)	Gross Margin	Federal Tax 3.50%	State Tax 0.90%	Property Tax 0.40%	Total Tax 4.80%	Total Tax 2.74%
WellStar Paulding Hospital	Under $100 M	90,638,062	44,095,429	46,723,864	2,628,435	-2.90%	0	0	176,382	176,382	176,382
WellStar Windy Hill Hospital	Under $100 M	92,290,023	44,300,435	35,835,422	8,465,013	9.17%	1,550,515	398,704	177,202	2,126,421	1,213,832
Tanner Medical Center/Villa Rica	Under $100 M	94,431,433	37,622,952	27,318,539	10,304,413	10.91%	1,316,903	338,607	150,492	1,805,902	1,030,869
Jasper Memorial Hospital	Under $100 M	11,551,762	9,563,331	9,085,359	477,972	4.14%	334,717	86,070	38,253	459,040	262,035
Higgins General Hospital	Under $100 M	54,093,852	23,945,695	18,198,448	5,747,247	10.62%	838,099	215,511	95,783	1,149,393	656,112
Ridgeview Institue	Under $100 M	48,601,340	28,257,137	27,968,825	288,312	0.59%	989,000	254,314	113,029	1,356,343	774,246
Decatur Hospital	Under $100 M	38,556,056	14,905,212	19,485,937	4,580,725	-11.88%	0	0	59,621	59,621	59,621
Sumter Regional Hospital	Under $100 M	83,273,544	34,466,059	68,258,226	33,792,167	-40.58%	0	0	137,864	137,864	137,864
Emory-Adventist Hospital	$100M - Under $250 M	118,412,417	41,609,655	42,624,681	1,015,026	-0.86%	0	0	166,439	166,439	166,439
Newton Medical Center	$100M - Under $250 M	191,534,977	70,093,760	74,460,560	4,366,800	-2.28%	0	0	280,375	280,375	280,375
Northside Hospital-Cherokee	$100M - Under $250 M	228,829,893	81,894,185	82,152,722	258,537	-0.11%	0	0	327,577	327,577	327,577
WellStar Douglas Hospitals	$100M - Under $250 M	231,786,261	87,488,950	82,061,290	5,427,660	2.34%	3,062,113	787,401	349,956	4,199,470	2,397,197
Tanner Medical Center/Carrollton	$250M - Under $500 M	312,501,237	129,387,479	146,199,945	16,812,466	-5.38%	0	0	517,550	517,550	517,550
Rockdale Hospital & Health Systems	$250M - Under $500 M	322,043,620	111,067,690	120,158,608	9,090,918	-2.82%	0	0	444,271	444,271	444,271
Piedmont Fayette Hospital	$250M - Under $500 M	426,106,142	141,610,379	143,321,227	1,710,848	-0.40%	0	0	566,442	566,442	566,442
Henry Medical Center	$250M - Under $500 M	368,116,899	133,480,008	147,582,372	14,102,364	-3.83%	0	0	533,920	533,920	533,920
Southern Regional Medical Center	$500M - Under $1 B	690,612,152	236,962,951	254,626,019	17,663,068	-2.56%	0	0	947,852	947,852	947,852
WellStar Cobb Hospital	$500M - Under $1 B	742,247,281	279,069,477	278,594,371	475,106	0.06%	9,767,432	2,511,625	1,116,278	13,395,335	7,646,504
Emory Crawford Long Hospital	$500M - Under $1 B	940,506,061	409,440,133	398,740,145	10,699,988	1.14%	14,330,405	3,684,961	1,637,761	19,653,126	11,218,660
Decatb Medical Center	$500M - Under $1 B	623,213,735	231,069,225	207,386,524	23,681,701	3.80%	8,087,388	2,079,614	924,273	11,091,275	6,331,269
Saint Joseph's Hospital of Atlanta	Over $1 B	1,052,532,404	359,300,275	372,904,000	13,603,725	-1.29%	0	0	1,437,201	1,437,201	1,437,201
Grady Memorial Hospital	Over $1 B	1,200,306,427	336,106,915	678,973,626	342,866,711	-28.56%	0	0	1,344,428	1,344,428	1,344,428
Piedmont Hospital	Over $1 B	1,481,718,617	536,311,096	520,638,356	15,672,740	1.06%	18,770,888	4,826,800	2,145,244	25,742,933	14,694,924
WellStar Kennestone Hospital	Over $1 B	1,608,501,821	605,329,175	556,440,653	48,888,522	3.04%	21,186,521	5,447,963	2,421,317	29,055,800	16,586,019
Northside Hospital	Over $1 B	1,621,618,625	618,097,201	620,346,593	2,249,392	-0.14%	0	0	2,472,399	2,472,399	2,472,399
Emory University	Over $1 B	1,173,307,258	554,944,297	523,162,781	31,781,516	2.71%	19,423,050	4,994,499	2,219,777	26,637,326	15,205,474
Gwinnett Hospital System	Over $1 B	1,231,669,757	457,760,397	449,073,374	8,687,023	0.71%	16,021,614	4,119,844	1,831,042	21,972,499	12,542,635
TOTAL											

APPENDIX Q1 (SELECTED LIST OF 7 FOR-PROFIT HOSPITALS)

REVENUE SIZE BASED PROFIT MARGINS AND TAX BURDEN

Facility Name	Ownership	Total Patient Revenue	Net Patient Revenue	Operating Expenses	Net Income (Income from Operations)	Gross Margin	Federal Tax 3.50%	State Tax 0.90%	Property Tax 0.40%	Total Tax 4.80%	Total Tax 2.74%
Barrow Community Hospital	HMA	71,270,163	18,725,836	22,816,390	-4,090,553	-5.74%	655,404	168,533	74,903	898,840	74,903
Walton Regional Medical Center	HMA	106,172,046	34,732,571	33,778,177	954,394	0.90%	1,215,640	312,593	138,930	1,667,163	1,667,163
Cartersville Medical Center	HCA	468,079,393	110,599,230	87,607,427	22,991,803	4.91%	3,870,973	995,393	442,397	5,308,763	5,308,763
Spalding Regional Hospital	Tenet	530,015,916	114,149,966	98,536,636	15,613,330	2.95%	3,995,249	1,027,350	456,600	5,479,198	5,479,198
South Fulton Medical Center	Tenet	554,025,888	106,514,519	114,322,616	-7,808,097	-1.41%	3,728,008	958,631	426,058	5,112,697	426,058
North Fulton Regional Hospital	Tenet	715,574,720	144,307,623	131,254,970	13,052,653	1.82%	5,050,767	1,298,769	577,230	6,926,766	6,926,766
Atlanta Medical Center	Tenet	1,009,485,872	240,209,319	245,466,859	-5,257,540	-0.52%	8,407,326	2,161,884	960,837	11,530,047	960,837
TOTAL		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

APPENDIX Q2 (FULL LIST OF 9 FOR-PROFIT HOSPITALS)

REVENUE SIZE BASED PROFIT MARGINS AND TAX BURDEN

Facility Name	Total Patient Revenue	Net Patient Revenue	Operating Expenses	Net Income (Income from Operations)	Gross Margin	Federal Tax 3.50%	State Tax 0.90%	Property Tax 0.40%	Total Tax 4.80%	Total Tax 2.74%
Barrow Community Hospital	71,270,163	18,725,836	22,816,390	-4,090,553	-5.74%	655,404	168,533	74,903	898,840	74,903
Anchor Hospital	40,586,346	19,715,740	12,758,363	6,957,377	17.14%	690,051	177,442	78,863	946,356	78,863
Sylvan Grove	30,621,220	9,626,950	8,776,233	850,717	2.78%	336,943	86,643	38,508	462,094	38,508
Walton Regional Medical Center	106,172,046	34,732,571	33,778,177	954,394	0.90%	1,215,640	312,593	138,930	1,667,163	1,667,163
Cartersville Medical Center	468,079,393	110,599,230	87,607,427	22,991,803	4.91%	3,870,973	995,393	442,397	5,308,763	5,308,763
Spalding Regional Hospital	530,015,916	114,149,966	98,536,636	15,613,330	2.95%	3,995,249	1,027,350	456,600	5,479,198	5,479,198
South Fulton Medical Center	554,025,888	106,514,519	114,322,616	-7,808,097	-1.41%	3,728,008	958,631	426,058	5,112,697	426,058
North Fulton Regional Hospital	715,574,720	144,307,623	131,254,970	13,052,653	1.82%	5,050,767	1,298,769	577,230	6,926,766	6,926,766
Atlanta Medical Center	1,009,485,872	240,209,319	245,466,859	-5,257,540	-0.52%	8,407,326	2,161,884	960,837	11,530,047	960,837
TOTAL	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

APPENDIX R

MEDIAN COMMUNITY BENEFIT OF NOT-FOR-PROFITS

Facility Name	City	Revenue Size	Total Patient Revenue	Net Patient Revenue	Uncompensated Care Cost	SCHIP Shortfall	MCAID Shortfall	GICP Shortfall	DSH Payments	TOTAL CB	Median Community Benefit and Net Revenue	Median Community Benefit
WellStar Paulding Hospital	Dallas	Under $100 M	90,638,062	44,895,429	644,749	0	0	0	68,115	584,634		
WellStar Windy Hill Hospital	Marietta	Under $100 M	92,290,023	44,300,435	230,507	0	0	0	0	230,507		
Tanner Medical Center/Villa Rica	Villa Rica	Under $100 M	94,431,433	37,622,952	3,568,931	49,813	1,943,864	759,837	449,288	5,893,147		
Emory-Adventist Hospital	Smyrna	$100M - Under $250 M	118,412,417	41,609,655	3,329,914	2,664	423,559	0	243,949	3,512,188		
Newton Medical Center	Covington	$100M - Under $250 M	191,534,977	70,093,760	2,106,894	5,814	0	960,767	1,530,400	1,493,055		
Northside Hospital-Cherokee	Canton	$100M - Under $250 M	228,829,893	81,994,185	2,798,927	0	1,261,545	0	1,295,476	2,764,996		
Tanner Medical Center/Carrollton	Carrollton	$250M - Under $500 M	312,501,237	129,387,479	11,000,000	62,345	8,113,483	1,913,515	2,261,460	17,927,803		
Rockdale Hospital & Health Systems	Conyers	$250M - Under $500 M	322,043,629	111,067,690	8,019,017	13,222	1,690,901	0	3,499,362	6,223,678		
Piedmont Fayette Hospital	Fayetteville	$250M - Under $500 M	426,106,142	[redacted]	7,998,079	61,668	1,071,103	0	0	9,130,930	[redacted]	
Southern Regional Medical Center	Riverdale	$500M - Under $1 B	690,612,152	236,952,351	10,429,478	13,029	3,628,953	3,000,000	7,669,669	9,491,791	[redacted]	
WellStar Cobb Hospital	Austell	$500M - Under $1 B	742,247,281	279,069,477	9,951,249	0	2,664,647	0	8,591,613	3,124,383		
Emory Crawford Long Hospital	Atlanta	$500M - Under $1 B	940,506,961	409,440,133	39,907,000	0	0	1,005,477	16,540,398	23,472,879		
Saint Joseph's Hospital of Atlanta	Atlanta	Over $1 B	1,052,532,404	359,300,275	7,897,262	0	2,365,272	377,907	0	10,640,341		
Grady Memorial Hospital	Atlanta	Over $1 B	1,200,306,427	336,496,915	170,000,000	0	2,000,000	0	12,434,704	160,365,297		
Piedmont Hospital	Atlanta	Over $1 B	1,491,718,617	536,311,096	18,350,371	27,737	3,173,669	0	0	21,551,777		
WellStar Kennestone Hospital	Marietta	Over $1 B	1,698,501,821	685,329,175	23,814,710	0	0	0	6,719,304	17,095,466		
Northside Hospital	Atlanta	Over $1 B	1,621,618,625	618,697,201	15,432,020	0	5,923,184	0	1,295,476	20,059,728		
TOTAL			[redacted]									

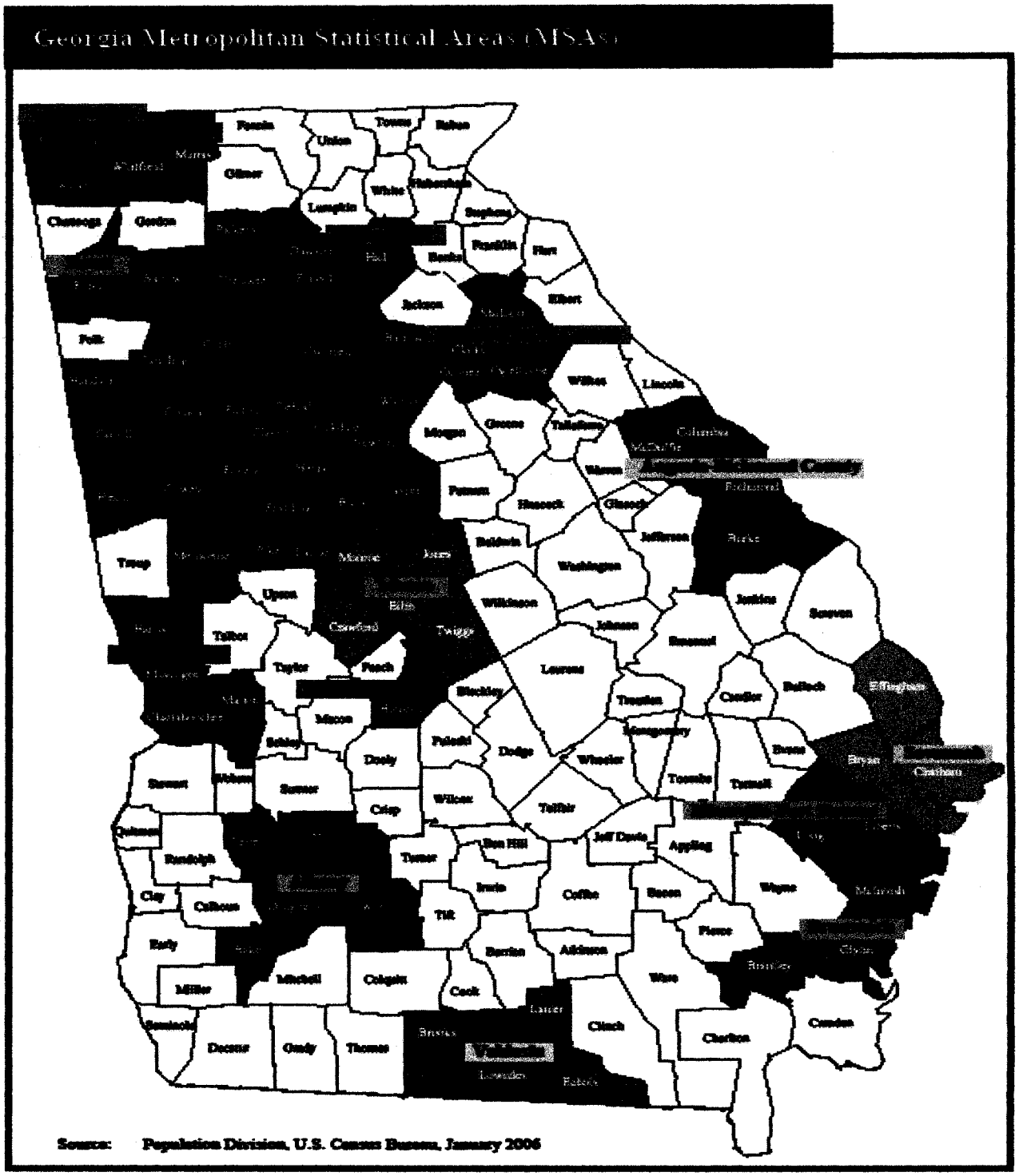
APPENDIX S

MEDIAN COMMUNITY BENEFIT OF FOR-PROFITS

Facility Name	Revenue Size	Total Patient Revenue	Net Patient Revenue	Uncompensated Care Cost	SCHIP Shortfall	MCAID Shortfall	GICP Shortfall	DSH Payments	TOTAL CB	Median Community Benefit and Net Revenu	Median Community Benefit
Barrow Community Hospital	Under $100 M	71,270,163	18,725,836	1,994,707	101,934	414,387	37,202	341,987	2,206,243		
Walton Regional Medical Center	$100M - Under $250 M	106,172,046	34,732,571	2,665,909	0	501,383	355,141	913,896	2,608,537		
Cartersville Medical Center	$250M - Under $500 M	468,079,383	110,599,230	7,790,100	0	0	0	1,546,106	6,243,994	[redacted]	
Spalding Regional Hospital	$500M - Under $1 B	530,015,916	114,149,966	8,530,042	0	3,900,000	0	3,936,679	8,493,363	[redacted]	[redacted]
South Fulton Medical Center	$500M - Under $1 B	554,025,868	106,514,519	11,600,000	0	529,370	0	4,404,052	7,725,318		
North Fulton Regional Hospital	$500M - Under $1 B	715,574,720	144,307,623	3,695,064	0	0	0	1,959,773	1,735,291		
Atlanta Medical Center	Over $1 B	1,009,485,872	240,209,319	14,395,992	0	0	8,719,899	7,181,159	15,934,732		
TOTAL			[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		

APPENDIX T

MAP OF METROPOLITAN STATISTICAL AREA OF ATLANTA
BLUE COLOR REPRESENTS THE ATLANTA MSA COUNTIES



APPENDIX U

LIST OF HOSPITALS BY COUNTY

FOR PROFIT HOSPITALS

No	Facility Name	Owner	County
1	Barrow Community Hospital	HMA	Barrow
2	Walton Regional Medical Center	HMA	Walton
3	Cartersville Medical Center	HCA	Bartow
4	Spalding Regional Hospital	Tenet	Spalding
5	South Fulton Medical Center	Tenet	Fulton
6	North Fulton Regional Hospital	Tenet	Fulton
7	Atlanta Medical Center	Tenet	Fulton

NOT-FOR-PROFIT HOSPITALS

No	Facility Name	County
1	WellStar Paulding Hospital	Paulding
2	WellStar Windy Hill Hospital	Cobb
3	Tanner Medical Center/Villa Rica	Villa Rica
4	Emory-Adventist Hospital	Cobb
5	Newton General Hospital	Newton
6	Northside Hospital-Cherokee	Cherokee
7	Tanner Medical Center/Carrollton	Carrollton
8	Rockdale Hospital & Health Systems	Rockdale
9	Piedmont Fayette Hospital	Fayette
10	Southern Regional Medical Center	Clayton
11	WellStar Cobb Hospital	Cobb
12	Emory Crawford Long Hospital	Fulton
13	Saint Joseph's Hospital of Atlanta	Fulton
14	Grady Memorial Hospital	Fulton
15	Piedmont Hospital	Fulton
16	WellStar Kennestone Hospital	Cobb
17	Northside Hospital	Fulton

APPENDIX V

IRS FORM 990, SCHEDULE H

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ To be completed by organizations that answer "Yes" to Form 990, Part IV, line 20.

▶ Attach to Form 990.

OMB No. 1545-0047

2008

Open to Public Inspection

Name of the organization

Employer identification number

Part I Charity Care and Certain Other Community Benefits at Cost *(Optional for 2008)*

		Yes	No
1a	Does the organization have a charity care policy? If "No," skip to question 6a	1a	
b	If "Yes," is it a written policy?	1b	
2	If the organization has multiple hospitals, indicate which of the following best describes application of the charity care policy to the various hospitals. ☐ Applied uniformly to all hospitals ☐ Applied uniformly to most hospitals ☐ Generally tailored to individual hospitals		
3	Answer the following based on the charity care eligibility criteria that applies to the largest number of the organization's patients.		
a	Does the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing free care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☐ Other _____ %	3a	
b	Does the organization use FPG to determine eligibility for providing *discounted* care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ %	3b	
c	If the organization does not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization uses an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.		
4	Does the organization's policy provide free or discounted care to the "medically indigent"?	4	
5a	Does the organization budget amounts for free or discounted care provided under its charity care policy?	5a	
b	If "Yes," did the organization's charity care expenses exceed the budgeted amount?	5b	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c	
6a	Does the organization prepare an annual community benefit report?	6a	
b	If "Yes," does the organization make it available to the public?	6b	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Charity Care and Certain Other Community Benefits at Cost

Charity Care and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Charity care at cost (from *Worksheets 1 and 2*)						
b Unreimbursed Medicaid (from *Worksheet 3, column a*)						
c Unreimbursed costs—other means-tested government programs (from *Worksheet 3, column b*)						
d Total Charity Care and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)						
j Total Other Benefits						
k Total (line 7d and 7j)						

Part II Community Building Activities Complete this table if the organization conducted any community building activities. *(Optional for 2008)*

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development						
9	Other						
10	Total						

Part III Bad Debt, Medicare, & Collection Practices *(Optional for 2008)*

Section A. Bad Debt Expense

			Yes	No
1	Does the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		
2	Enter the amount of the organization's bad debt expense (at cost)	2		
3	Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's charity care policy.	3		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, or rationale for including other bad debt amounts in community benefit.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5		
6	Enter Medicare allowable costs of care relating to payments on line 5	6		
7	Enter line 5 less line 6—surplus or (shortfall)	7		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit and the costing methodology or source used to determine the amount reported on line 6, and indicate which of the following methods was used: ☐ Cost accounting system ☐ Cost to charge ratio ☐ Other			

Section C. Collection Practices

9a	Does the organization have a written debt collection policy?	9a		
b	If "Yes," does the organization's collection policy contain provisions on the collection practices to be followed for patients who are known to qualify for charity care or financial assistance? Describe in Part VI	9b		

Part IV Management Companies and Joint Ventures *(Optional for 2008)*

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					

Part V Facility Information *(Required for 2008)*

Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)

Part VI Supplemental Information (Optional for 2008)

Complete this part to provide the following information.

1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's charity care policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Community building activities.** Describe how the organization's community building activities, as reported in Part II, promote the health of the communities the organization serves.

6 Provide any other information important to describing how the organization's hospitals or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

7 If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

APPENDIX W
GLOSSARY OF TERMS

AVERAGE (OF NET PATIENT REVENUE)

In the Community Benefit analysis, one of the approaches is the average of revenues and total Community Benefit, required for calculating Average Community Benefit percentage of net revenue.

BAD DEBT

Patient charges not paid (excluded contractual adjustments). This results from failure of patients to pay their portion of a bill, which is their responsibility.

CHARITY CARE

Charity care is free or discounted health and health-related services to persons without ability to pay.

GEORGIA INDIGENT CARE PROGRAM (GICP)

This is a health insurance program for the medically indigent provided by the State of Georgia. It pays hospitals for care delivered to beneficiaries that are determined to be eligible by the State for this program. Citizens that do not qualify for Medicaid but are considered low-income might be eligible for coverage. Payments from GICP to hospitals that do not cover the cost of providing care are considered government sponsored health care shortfalls (defined below)

COMMUNITY BENEFIT

Expenses associated with providing charity care, plus government sponsored health care payment shortfalls (SCHIP, Medicaid, GICP), plus the dollar amount paid in corporate income tax and property tax. They also should technically include sales tax, but this is not taken into account in this research, as it is challenging to obtain this. These components are summed up to determine the Community Benefit as percent of net revenue.

CONTRACTUAL ADJUSTMENT

The resulting difference in the amount charged for services by hospitals, less the amount received as payment from HMOs, PPOs and governmental payors.

FOR-PROFIT HOSPITALS

Hospitals organized not only to provide hospital care to patients but also to earn profits that increase value to shareholders. This group consists of hospitals that pay both corporate income tax and property tax. They do not receive tax exemption by the government.

GOVERNMENT SPONSORED HEALTH CARE PAYMENT SHORTFALL

Government sponsored health care payment shortfall includes unpaid costs of public programs. It is the "shortfall" created when a facility receives payments that are less than its costs for providing care to the beneficiaries. This "payment shortfall" is not the same as a contractual allowance, which is the difference between charges and government payments received. Categories included in this research are SCHIP, Medicaid, and GICP.

MEDIAN

In Community Benefit analysis, one approach is the median of revenues and total Community Benefit, required for calculating Median Community Benefit percentage of net revenue.

MEDICARE

This is a federally funded health insurance for the aged (65 and older). Some patients with certain medical conditions qualify at a younger age.

MEDICAID

Funded by federal and state governments, this is health insurance program for the poor. Also referred to as a state's "welfare program." Payments from Medicaid to hospitals that do not cover the cost of providing care are considered government sponsored health care shortfalls.

NON-PROFIT HOSPITALS

These are private, non-profit and non-government hospitals organized with a charitable purpose to provide hospital services in their communities. They receive tax exemption from the federal and state governments and do not pay taxes.

REVENUE SIZE

Hospitals are grouped according to the size of their total revenues in one approach for Community Benefit.

APPENDIX X

County Profile of the two types of Hospitals (Appendix T and U)
Both types of hospitals are located in the following counties according to their revenue size:

Revenue Size	County	Not-For-Profit	For-Profit
Under $100M	Paulding	Three Hospitals	One Hospital
	Cobb		
	Villa Rica		
	Barrow		One Hospital
$100M – under $200M	Cobb	Three Hospitals	
	Newton		
	Cherokee		
	Walton		One Hospital
$200M – under $500M	Carroll	Three Hospitals	
	Rockdale		
	Fayette		
	Bartow		One Hospital
$500M – under $1 B	Clayton	Three Hospitals	
	Cobb		
	Fulton		Two Hospitals
	Spalding		One Hospital
$Over 1 B	Fulton	Five Hospitals	
	Fulton		
	Fulton		
	Cobb		
	Fulton		One Hospital

APPENDIX Y

Resident Population Projections by Year and Planning Area 2007

Physical Rehabilitation Planning Areas *09-Apr-09*

Year	County	Total	TOTWhite	TOTNonWh	TOTMale	TOTFemale	TOT0017	TOT1864	TOT6579	TOT8084	TOT85UP
2007											
Area 1											
	Barrow	63,252	52,551	10,701	31,673	31,579	19,750	36,672	4,667	978	1,185
	Bartow	96,532	82,151	14,381	47,871	48,661	29,630	55,621	8,006	1,529	1,746
	Carroll	113,804	90,213	23,591	55,904	57,900	33,460	66,269	9,765	1,919	2,391
	Cherokee	199,589	173,699	25,890	100,286	99,303	61,816	119,722	13,317	2,247	2,487
	Clayton	290,859	53,091	237,768	140,741	150,118	104,159	171,710	11,137	1,962	1,891
	Cobb	697,488	421,866	275,622	347,566	349,922	203,212	433,156	44,034	7,986	9,100
	Fayette	109,090	85,874	23,216	53,273	55,817	27,301	68,095	9,858	1,723	2,113
	Fulton	823,629	383,620	440,009	413,849	409,780	235,664	515,523	47,615	10,709	14,118
	Newton	95,233	70,907	24,326	46,458	48,775	30,536	53,454	7,987	1,546	1,710
	Paulding	124,217	109,716	14,501	62,342	61,875	41,577	72,941	7,224	1,184	1,291
	Rockdale	81,396	51,452	29,944	40,563	40,833	23,189	46,897	6,665	1,259	1,386
	Spalding	63,313	41,578	21,735	30,745	32,568	18,219	36,071	6,169	1,259	1,595
	Walton	81,039	67,731	13,308	39,830	41,209	24,156	47,026	6,896	1,345	1,616
	Total	2,839,441	1,684,449	1,154,992	1,411,101	1,428,340	852,669	1,725,157	183,340	35,646	42,629
Total		2,839,441	1,684,449	1,154,992	1,411,101	1,428,340	852,669	1,725,157	183,340	35,646	42,629

Prepared By: Georgia Department of Community Health

Source: Governor's Office of Planning and Budget

Note: White male and female projections do not include Hispanics. Nonwhite male and female projections include Hispanics of any race.

APPENDIX Z

MSA ATLANTA (SELECTED AND ALL) NOT-FOR-PROFIT AND FOR-PROFIT HOSPITALS AVERAGE COMMUNITY BENEFIT IN TWO TAX RATE SCENARIOS

Type of hospitals	Average Net Revenue	Average Community Benefit	Average Uncompensated Percent of Net Revenue for Revenue Size	Average SCHIP Shortfall Percent of Net Revenue for Revenue Size	Average MCAID Percent of Net Revenue for Revenue Size	Average GICP Percent of Net Revenue for Revenue Size	Average DSH Percent of Net Revenue for Revenue Size	Average Community Benefit as Percent of Net Revenue for Revenue Size	Scenario 1 Tax Percent (Income + Property) 4.00%	Scenario 1 Total Community Benefit	Scenario 2 Tax Percent (Income + Property) 2.74%	Scenario 2 Total Community Benefit
Selected 17 Not-For-Profit Hospitals	240,135,246	18,439,466	8.17%	0.01%	0.85%	0.17%	-1.53%	7.67%	0.00%	7.67%	0.00%	7.67%
Selected 7 For-Profit Hospitals	189,891,295	6,421,068	6.59%	0.01%	0.69%	1.18%	-2.64%	5.83%	4.80%	10.63%	2.74%	8.57%
DIFFERENCE	130,243,951	12,018,398	-1.58%	0.00%	-0.16%	1.01%	-1.11%	-1.84%		2.96%		0.90%

Type of hospitals	Average Net Revenue	Average Community Benefit	Average Uncompensated Percent of Net Revenue for Revenue Size	Average SCHIP Shortfall Percent of Net Revenue for Revenue Size	Average MCAID Percent of Net Revenue for Revenue Size	Average GICP Percent of Net Revenue for Revenue Size	Average DSH Percent of Net Revenue for Revenue Size	Average Community Benefit as Percent of Net Revenue for Revenue Size	Scenario 1 Tax Percent (Income + Property) 4.00%	Scenario 1 Total Community Benefit	Scenario 2 Tax Percent (Income + Property) 2.74%	Scenario 2 Total Community Benefit
All 27 Not-For-Profit Hospitals	209,562,167	13,828,275	6.94%	0.02%	0.73%	0.29%	-1.38%	6.60%	0.00%	6.60%	0.00%	6.60%
All 9 For-Profit Hospitals	88,731,306	4,994,164	6.35%	0.01%	0.67%	1.14%	-2.54%	5.63%	4.80%	10.43%	2.74%	8.37%
DIFFERENCE	120,830,861	8,834,111	-0.59%	-0.01%	-0.06%	0.85%	-1.16%	-0.97%		3.83%		1.77%