IRS EXEMPT ORGANIZATIONS (TE/GE)
HOSPITAL COMPLIANCE PROJECT
FINAL REPORT

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I. INTRODUCTION AND SYNOPSIS

A. Introduction and Limitations on Analysis

The IRS commenced its Hospital Compliance Project (Project) in May 2006 to study nonprofit hospitals and community benefit, and to determine how nonprofit hospitals establish and report executive compensation. The Project involved mailing out a comprehensive compliance check questionnaire to 544 nonprofit hospitals and analyzing their responses.[1] The questionnaire (see Appendix B) requested information regarding the hospital's activities, governance, expenditures, and executive compensation practices. The Project also involved examinations of 20 hospitals regarding executive compensation issues.

The hospitals included in the study represent a modest portion of the nonprofit hospital sector. See Section III, below, for a discussion of background on U.S. hospitals and of other recent government reports on community benefit and executive compensation provided by nonprofit hospitals.

The IRS issued its Interim Report on Hospital Compliance Project on July 19, 2007 (Interim Report). The Interim Report addressed only the community benefit aspects of the questionnaire and presented data gathered from the questionnaire responses of 487 hospitals and certain information reported on Forms 990 filed by responding hospitals. The executive compensation component of the Project was not addressed in the Interim Report because the examinations were ongoing at the time of the report's release.

The Final Report addresses the "next steps" identified in the Interim Report. These are:

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

[1] A copy of the questionnaire is attached as Appendix B. In selecting the hospitals to be contacted, the IRS queried its files to identify nonprofit hospitals exempt under section 501(c)(3). From an initial identified universe of approximately 6,000 entities, the IRS selected 544 organizations that it confirmed as hospitals. The IRS sent compliance questionnaire letters to each of these hospitals, which were of varying sizes and types and were located in different regions and communities across the United States. Some judgment was used to identify hospitals which were not uniquely identifiable in the IRS database. The resulting sample may or may not reflect the nonprofit hospital sector in general.

The IRS also indicated it would (1) follow up on the 11 hospitals that did not respond to the questionnaire; (2) continue its work on the Form 990, Schedule H, Hospitals;[2] and (3) complete the executive compensation component of the project.

The IRS continued to study the information provided by the responding hospitals, and obtained additional information regarding 11 hospitals that initially did not respond to the questionnaire. The numbers reported in the Interim Report have been adjusted in the Final Report to reflect this further study and additional information. Significant adjustments to the data reported in the Interim Report are listed in Section II, below. The Final Report includes 489 respondent hospitals that reported community benefit expenditures, but generally summarizes data for the 485 hospitals that actually provided sufficiently complete community benefit data. There are other situations in which certain respondents did not provide sufficient information to permit categorization of all of the indices/variables considered in this report. Sample sizes will vary as a result.

Throughout the report, certain information was not included or was combined with other information to prevent potential identification of respondent hospitals. In addition, because of rounding conventions, some figures may not reconcile (including that, in some cases, the combined data for individual categories of a group may be slightly more or less than 100%).

The findings of the Final Report are subject to a number of limitations. Except for certain compensation data that was reviewed through examinations, the data reported by the respondents was not independently verified. In addition, the data reported responds to a single tax year and may not be representative of results 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 the percentage of hospitals included in the various categories used in the report (e.g., community type) may not be representative of the sector at large. This may have an effect on certain findings in the report.

The study found significant variations from community benefit reporting that will be required by the new Form 990 Schedule H beginning with 2009 tax years. The community benefit expenditures reported by some hospitals appear to overstate Form 990 reportable community benefit, due to reporting uncompensated care based on charges rather than on costs, or including bad debt, Medicare shortfalls, and private insurance shortfalls as community benefit. On the other hand, exclusion by some hospitals of shortfalls from Medicaid, other means-tested public programs, or uninsured patients as uncompensated care, may understate the Form 990 reportable community benefit attributable to those programs.

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[2] See Appendix C for a copy of Form 990, Schedule H, released in official form on December 24, 2008.

For these and other reasons, the summarized community benefit data is subject to material limitations, and may not accurately depict the community benefit actually provided by the respondents or by nonprofit hospitals as a whole. Notwithstanding these limitations, some interesting findings are suggested in both the community benefit and compensation areas of the study.

B. Demographics and Key Findings

The hospitals were classified into four community types based on location of the hospital and in part on Census Bureau data: high population, other urban and suburban, critical access hospitals, and rural non-critical access hospitals. The 94 hospitals (19%) located in the 26 largest urban areas in the United States were categorized in the high population category. The other 249 hospitals (51%) located in Census Bureau urban areas were included in the other urban and suburban category. The 68 hospitals (14%) designated as critical access hospitals under federal law were categorized in the critical access hospital (CAH) category. The 78 hospitals (16%) that are not CAHs and not located in any Census Bureau urban area were categorized in the rural (non-CAH) category.

The hospitals also were classified by revenue size based on annual revenues as reported on Forms 990 as follows: (1) under $25 million, 85 hospitals (17%); (2) $25 million to $100 million, 173 hospitals (36%); (3) $100 million to $250 million, 133 hospitals (27%); (4) $250 million to $500 million, 61 hospitals (13%); and (5) over $500 million, 36 hospitals (7%). For purposes of this section, reporting of revenue size categories generally is limited to the smallest and largest categories, where the differences are most pronounced.

The hospitals also were categorized and examined based on health insurance coverage and per capita income of the area surrounding the hospital. In addition, a group of 15 hospitals reporting nearly all (93%) of the reported medical research expenditures was studied.

1. Diversity of nonprofit hospitals. There was considerable diversity in the demographics, activities, and financial resources among the respondent hospitals. The types and amounts of uncompensated care and other community benefit expenditures varied by the hospitals across revenue size, income and insurance coverage levels of the surrounding area, and the hospital's setting within a rural, suburban, or urban community. In particular, significant differences were observed between the groups of critical access hospitals and hospitals in the high population areas, and between the smallest and largest groups of hospitals based on revenue size (e.g., in general, larger hospitals reported higher community benefit expenditures and higher excess revenues).

2. Aggregate community benefit. The average and median percentages of total revenues reported as spent on aggregate community benefit expenditures were 9% and 6%, respectively, for the overall group. Among the community types,

these percentages were lowest for rural hospitals (CAH and non-CAH) and highest for hospitals in the high population areas. These percentages generally increased with revenue size. For the group of 15 hospitals reporting disproportionately large medical research expenditures, the average and median percentages of total revenues reported as spent on aggregate community benefit expenditures were both 19%.

3. Types of community benefit. Uncompensated care was the largest reported community benefit expenditure overall and across all demographics, other than for the group of 15 hospitals that reported nearly all of the aggregate medical research expenditures. Overall, the average and median percentages of uncompensated care as a percentage of total revenues were 7% and 4%, respectively. Reported uncompensated care expenditures were 56% of aggregate community benefit expenditures. Medical education and training expenditures constituted 23% of aggregate reported expenditures, followed by medical research (15%), and community programs (6%). This mix varied by community type and revenue size, and as described below, materially changed when the group of 15 hospitals reporting disproportionately large medical research expenditures was excluded.

4. Concentration of expenditures in small group of hospitals. Uncompensated care and aggregate community benefit expenditures were unevenly distributed among hospitals and concentrated in a relatively small group. The study looked at reported community benefit compared to certain specified revenue levels. Overall, 58% of hospitals reported uncompensated care amounts less than or equal to 5% of total revenues. Overall, 21% of the hospitals reported aggregate community benefit expenditures less than 2% of total revenues; 47% reported aggregate community benefit expenditures less than 5% of revenues. Critical access hospitals and the smallest hospitals generally reported higher percentages of hospitals below these levels. High population hospitals and the largest hospitals generally reported lower percentages of hospitals below these levels.

5. Revenues vs. expenses. Reported excess revenues (total revenues less expenses) varied across the demographics. Overall, when data was aggregated for all hospitals, revenues exceeded expenses by 5%. This percentage was 3% for the smallest hospitals and increased with revenue size. Among the community types, critical access hospitals reported the smallest percentage, and other rural hospitals reported the largest percentage. Overall, 21% of the hospitals reported a deficit (total expenses greater than total revenues). The percentage of hospitals reporting deficits varied by community type and revenue size.

6. Community income and insurance coverage levels. The study did not find a correlation between community benefit expenditure levels and per capita income levels of the area surrounding the hospital. The study did, however, observe that

community benefit expenditure levels generally increased as uninsured rates of the area surrounding the hospital increased.

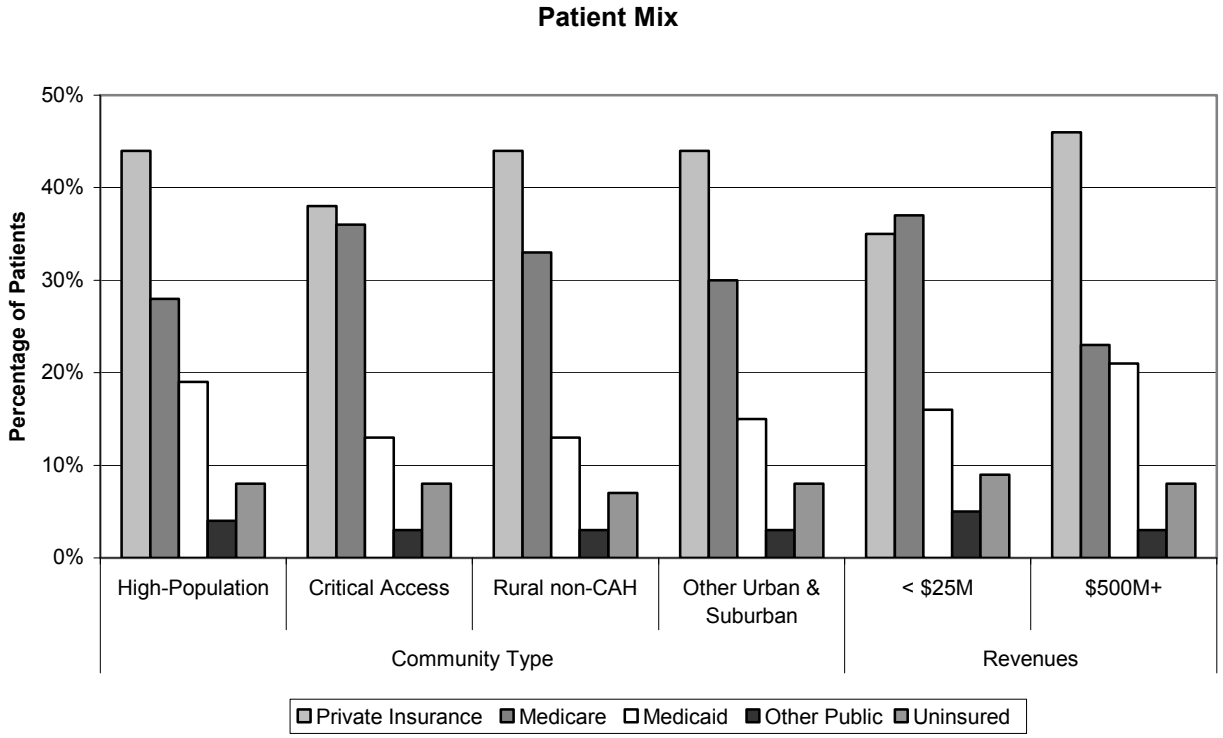
7. Compensation practices. Nearly all hospitals in the study reported complying with key elements of the rebuttable presumption procedure available to establish compensation of certain executives and disqualified persons. Based on traditional risk analysis and the compensation examinations of 20 hospitals, the study found widespread compliance with the Section 4958 excess benefit transaction rules. Although many reported compensation amounts appeared to be high, nearly all amounts reviewed in these examinations were upheld as established pursuant to the rebuttable presumption process and within the range of reasonable compensation.

C. Summary of Demographics and Community Benefit

The following summarizes key demographic or community benefit measures.

1. Patient Mix

The reported patient mix of the overall group of hospitals showed that the highest percentage of patients was private insurance patients (43%), followed by Medicare (31%), Medicaid (15%), uninsured (8%), and other public programs (3%).

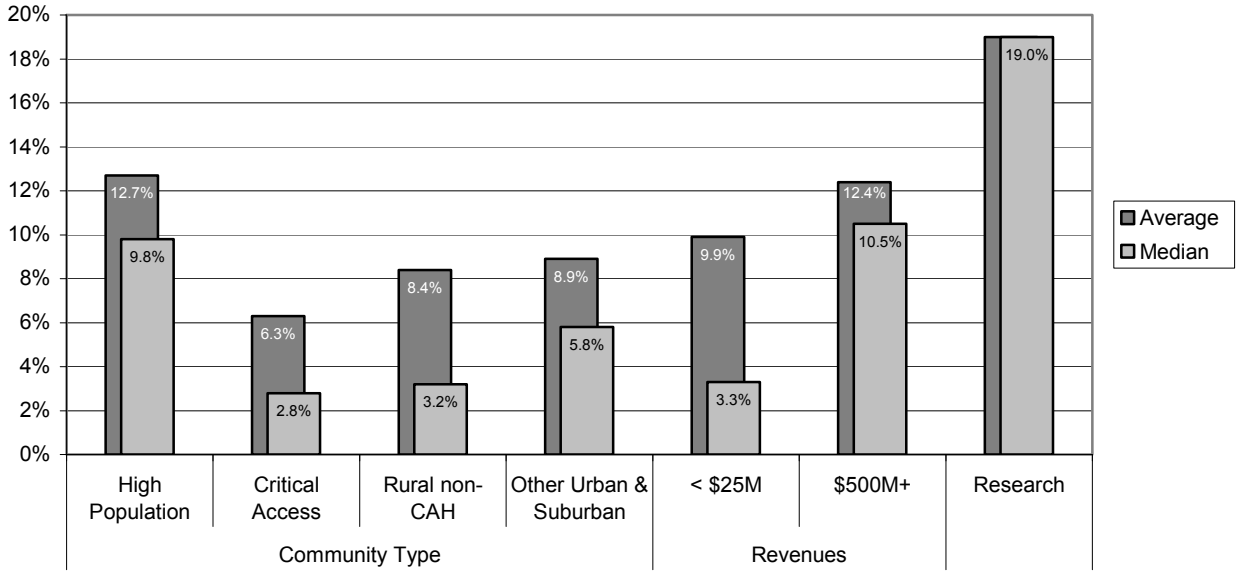


Critical access hospitals and the smallest hospitals reported the lowest percentage of private insurance patients and the highest percentage of Medicare patients. High population hospitals and the largest hospitals had the highest percentage of Medicaid patients.

2. Community Benefit Expenditures (percentages of total revenues)

The overall average and median percentages of total revenues reported as spent on aggregate community benefit expenditures were 9% and 6%, respectively. These percentages varied across community type and revenue size. Aggregate community benefit expenditures were not evenly distributed by the hospitals in the study, but were concentrated in a relatively small number of hospitals. 9% of the hospitals reported 60% of the aggregate community benefit expenditures; 19% of the hospitals reported 78% of the aggregate community benefit expenditures.

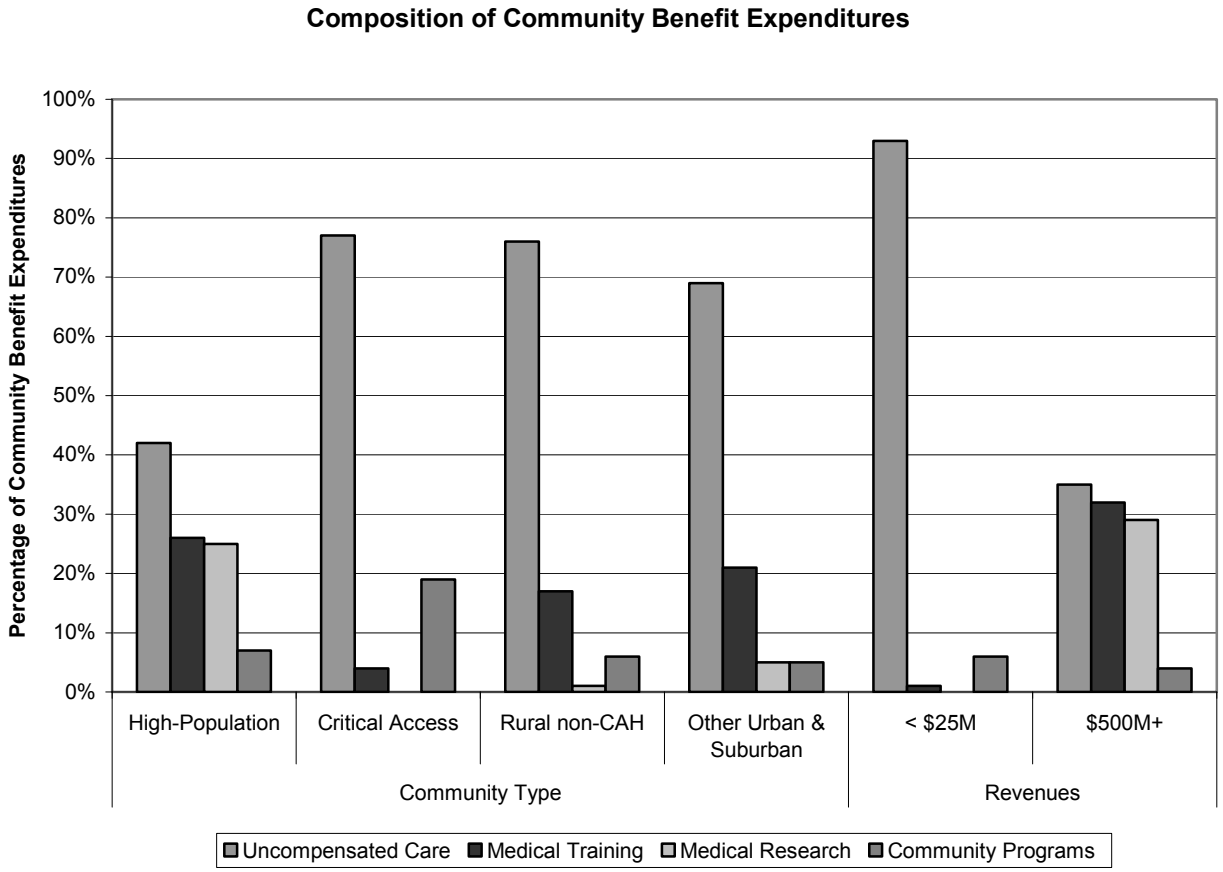
Community Benefit Expenditures as Percentage of Total Revenues



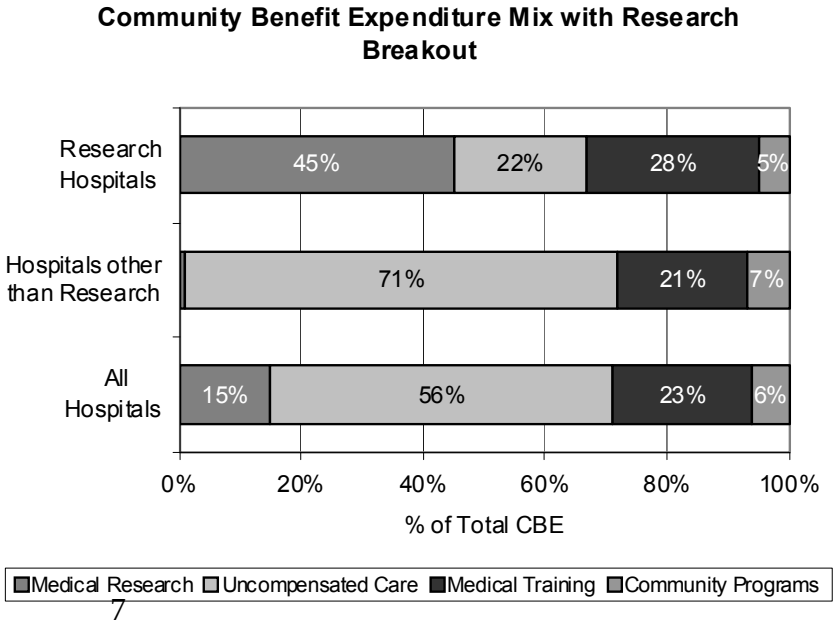
Among community types, the percentages were lowest for critical access hospitals and highest for high population hospitals. The percentages of total revenues generally increased with revenue size. The highest reported average and median percentages were by the group of 15 hospitals that reported nearly all of the medical research expenditures (referred to as "research hospitals" for this section).

3. Community Benefit Expenditures Mix (uncompensated care, medical education and training, medical research, community programs)

Uncompensated care was the largest component of reported community benefit for each community type and revenue size category, but the composition varied across the demographics.



Uncompensated care as a percentage of overall community benefit expenditures was greatest for CAHs, other rural hospitals, and the smallest hospitals. Significant variations were observed in reported expenditures for medical education and training expenditures and medical research across the community types. Both medical education and training and medical research expenditures as a percentage of overall community benefit expenditures increased with revenue size. The inclusion of bad debt and various shortfalls impacted the uncompensated care levels reported. Overall, and for each community type and revenue size, greater percentages of hospitals reported including bad debt and self pay shortfalls in uncompensated care than any other types of shortfalls.



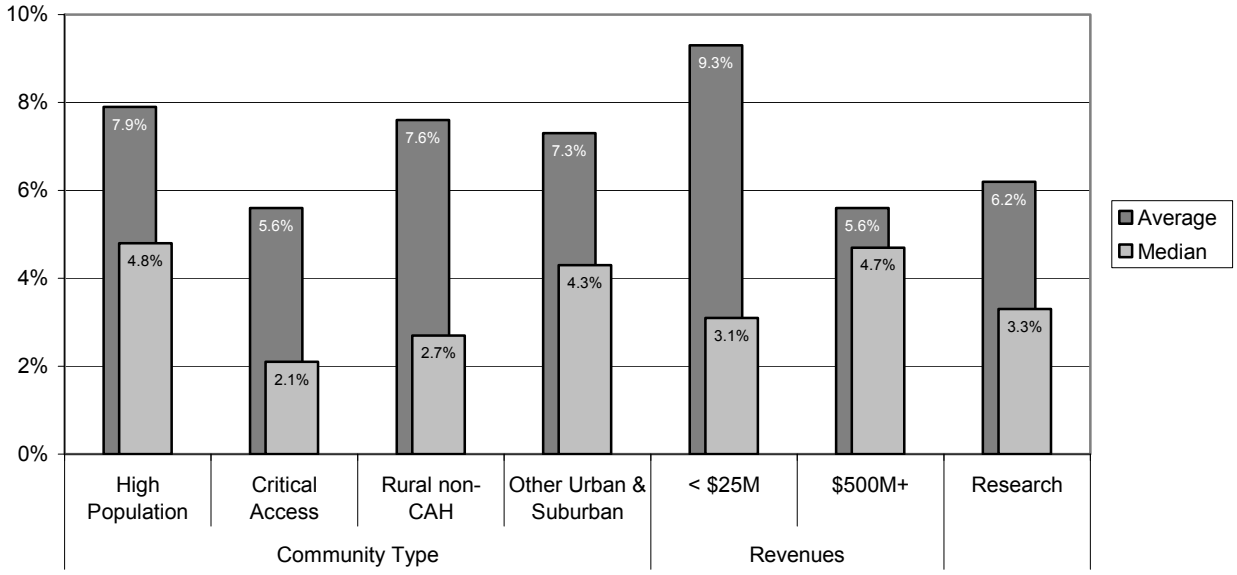
The community benefit mix changed materially when

the group of 15 hospitals that reported nearly all of the medical research expenditures was removed. The figure above shows the mix for the overall group, the group of 15 hospitals reporting nearly all of the medical research expenditures, and the overall group without the 15 hospitals.

4. Uncompensated Care (percentages of total revenues)

The average and median percentages of total revenues reported as spent on uncompensated care were 7% and 4%, respectively. Uncompensated care expenditures were not evenly distributed among the hospitals in the study, but were concentrated in a relatively small number of hospitals. 14% of the hospitals reported 63% of the aggregate uncompensated care expenditures; 26% of the hospitals reported 82% of the aggregate uncompensated care expenditures.

Uncompensated Care as Percentage of Total Revenues



Critical access hospitals reported the lowest percentages and high population hospitals reported the highest percentages among the community types. The group of smallest hospitals reported the highest average percentage, but the lowest median percentage, among the revenue size groups.

5. Comparison of Reported Uncompensated Care and Community Benefit Expenditures against Specified Percentage of Revenue Levels

The figure below displays the percentage of hospitals with reported community benefit and uncompensated care expenditures at or less than specified percentage of revenue levels.

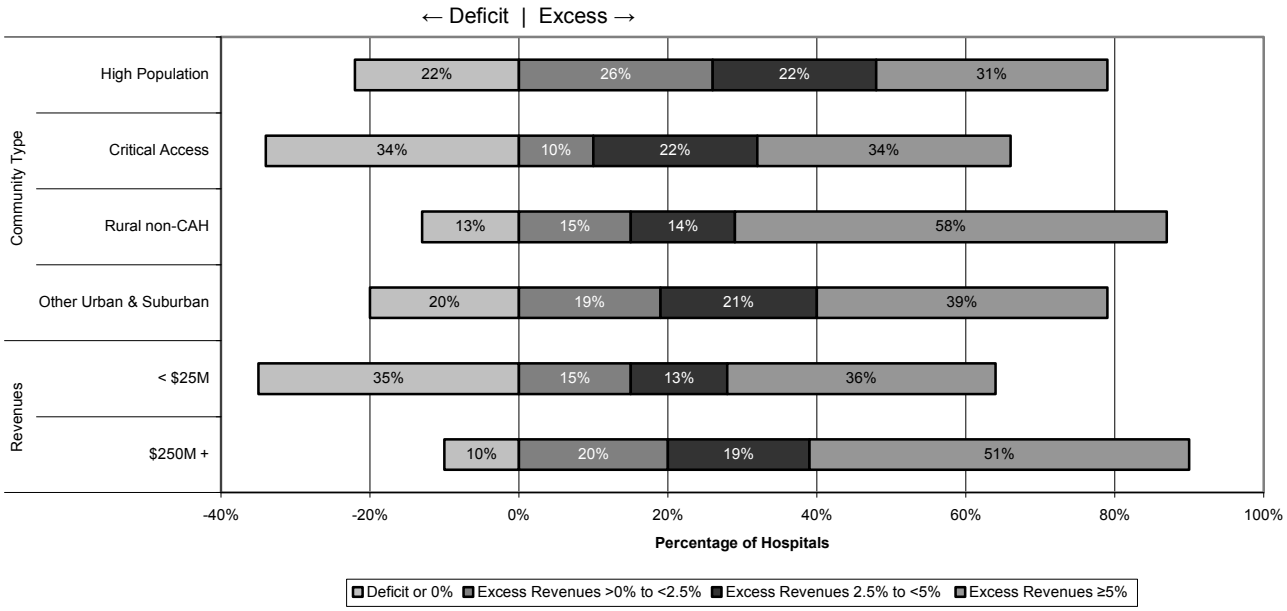
Demographic:	% of hospitals with community benefit expenditures <2% of revenues	% of hospitals with community benefit expenditures <5% of revenues	% of hospitals with uncompensated care expenditures ≤3% of revenues	% of hospitals with uncompensated care expenditures ≤5% of revenues
High population	11%	32%	33%	52%
CAH	39%	61%	59%	67%
Rural – non CAH	31%	57%	52%	65%
Other urban and suburban	17%	46%	39%	55%
Under $25 million	34%	60%	49%	60%
$25 million to under $100 million	30%	56%	49%	61%
$100 million to under $250 million	12%	42%	37%	55%
$250 million to under $500 million	*	*	34%	49%
Over $500 million	*	*	33%	60%
Overall	21%	47%	43%	58%

* The two largest revenue sizes were combined to prevent potential identification of respondent hospitals. In the combined group ($250 million and over), the percentage of hospitals with community benefit expenditures less than 2% of revenues is 5%, and less than 5% of revenues is 27%.

6. Revenues vs. Expenses

79% of the hospitals reported excess revenues (revenues exceeding expenses as reported on the Form 990), and 21% reported that total expenses exceeded total revenues (i.e., reported a deficit). The percentage of hospitals that reported revenue deficits decreased as revenue size increased, and varied across the community types. CAHs and the smallest hospitals had the highest percentage of hospitals reporting a deficit.

Distribution of Hospitals by Excess Revenue



Overall, excess revenues expressed as a percentage of total revenues was 4.6% and increased with revenue size. Among community types, critical access hospitals reported the lowest percentage (4%), and other rural hospitals reported the highest percentage (6%).

D. Executive Compensation

The study's questionnaire asked various questions regarding each hospital's compensation practices. These involved reporting compensation amounts for the hospital's officers, directors, trustees, and key employees, as well as information regarding certain policies and practices used to establish compensation for such persons. In addition, the study involved the examination of 20 organizations regarding their executive compensation practices.

In general, the hospitals reported widespread compliance with key indicators of sound compensation practices, including use of formal written compensation policies, use of comparability data, approval in advance by persons without a conflict of interest, and setting compensation within the range of comparability data. This pattern was reported consistently across the community types and revenue size categories, and was confirmed in the examinations of the 20 hospitals.

The average and median compensation amounts paid to the top management official as reported on the questionnaire were $490,000 and $377,000, respectively. Compensation amounts varied across demographics, but generally increased as the hospital's revenue size increased. Generally, rural hospitals (CAH and non-CAH) paid lower compensation than did urban and suburban hospitals (high population and other urban and suburban).

For the 20 hospital compensation examinations, the average and median compensation amounts paid to the top management official were $1.4 million and $1.3 million, respectively. Because the examined hospitals were selected on the basis of higher reported compensation amounts, a disparity between the overall group and the examined hospitals was expected.

II. INTERIM REPORT AND ADDITIONAL WORK UNDERTAKEN FOR FINAL REPORT

A. Questionnaire Content Included in Final Report

The primary focus of the Final Report's work was to analyze differences in community benefit expenditures among the respondent hospitals. This Final Report provides breakdowns by demographics for several of the questionnaire's key areas, including aggregate community benefit expenditures, uncompensated care, medical education and training, medical research, and community programs. These include the following questions:

- Patients covered by private insurance, Medicare, Medicaid, other public insurance, no insurance – questions 2 through 7
- Medical research expenditures – questions 21 and 22
- Professional medical education and training – questions 30 and 31
- Uncompensated care – questions 35 through 38, 40
- Community programs – questions 57, 58, 61, 62, 65, 66, 69 through 71

B. Significant Adjustments to the Interim Report

The Interim Report included data comparing various hospital expenses, including certain community benefit expenditures, as a percentage of total revenue. These revenue numbers were derived from the organizations' most recently filed Forms 990 that had been received by the IRS at the time the questionnaire information for that hospital was being reviewed and analyzed. After the issuance of the Interim Report, additional Forms 990 for certain of the respondent hospitals were received by the IRS, allowing the use of revenue information from the tax year to which the questionnaire's expense and community benefit expenditure information pertains. Accordingly, in this Final Report, the total revenue information is taken from the Form 990 that corresponded to the tax year which each hospital used to complete the questionnaire.

This adjustment significantly changed some of the calculations of expenses reported as a percentage of revenue for those hospitals that had a large change in revenue from the Form 990 for the tax year initially used in the Interim Report. Changes also resulted from continued analysis of narrative and other information provided by the responding hospitals and from correcting data entry and transcription errors.

The most significant changes are described as follows.

1. Average and median annual total revenues of the responding hospitals. The Interim Report reported average and median annual total revenues of all of the hospitals in the study as $169 million and $83 million, respectively. The average and median annual total revenues of all of the

hospitals in the study were adjusted upward to $179 million and $89 million, respectively. These upward adjustments in total revenues affected many of the percentages reported in the Interim Report that used total revenues in the denominator (e.g., percentage of total revenues spent on community program expenditures).

2. Patient Mix. The Final Report shows a change in the reported patient insurance coverage mix from 46% to 43% for private insurance, 46% to 49% for public programs (Medicare, Medicaid, and other public programs), and 7% to 8% with no insurance coverage.
3. Medical Research. The average of the percentages of total revenues spent on medical research by these hospitals was adjusted downward from 8% to 2% while the median decreased from 0.24% to 0.22%.[3]
4. Community Programs. The averages and medians of the percentages of total revenue spent on aggregate community programs, and on the various components of community programs (e.g., immunization programs), have been revised. The most significant change was the downward adjustment of the average percentage of total revenue reported to have been spent on aggregate community programs from 3.4% to 0.9%.

C. Breakdown of Hospitals by Community Types (High Population, Critical Access Hospital (CAH), Rural (non-CAH), and Other Urban and Suburban Hospitals)

To assess differences in community benefit expenditure amounts and types to take into account varying demographics such as rural, suburban, and urban communities and hospitals, the Final Report establishes four "community types" and reports much of the aggregate community benefit expenditure data across these four community types. These community types attempt to reflect demographic areas commonly regarded as urban, suburban, and rural.

The hospitals located in rural areas were divided between those that are critical access hospitals and those that are not critical access hospitals (as described in more detail below). These groups are referred to as "critical access hospitals" (or "CAH") and "rural (non-CAH)." The remaining hospitals were divided into two groups. Those hospitals located in the 26 largest urban areas in the United States were categorized in the "high population" category. The other hospitals located in urban or suburban areas were included in the "other urban and suburban" category (referred to in the figures as "other").

Based on the reported data, the 489 hospitals were classified into community types as follows:

- "High population" – 94 hospitals (19%)

[3] A significant component of the downward adjustment in the average is due to the correction of a data entry and transcription error made during the study.

- “Critical access hospitals (CAH)” – 68 hospitals (14%)
- “Rural (non-CAH)” – 78 hospitals (16%)
- “Other urban and suburban” – 249 hospitals (51%).

The community types are defined as follows:

High population. “High population” refers to the hospitals in the study that are located in the 26 urban areas in the United States that had populations of 1.5 million or more people, based on the 2000 Census. The U.S. Census Bureau defines an urban area as core census block groups or blocks that have a population density of at least 1,000 people per square mile, and surrounding census blocks that have an overall density of at least 500 people per square mile.[4] Based on this definition, some of the hospitals in this group are located in what people commonly consider the suburbs of large cities, but other hospitals located in many large cities are not included in this group.

The urban areas included in the high population community type are displayed in the map below.

Other urban and suburban. “Other urban and suburban” refers to hospitals that are located in any Census Bureau urban area that had a population of less than 1.5 million according to the 2000 Census. Accordingly, these hospitals are located in all the Census Bureau urban areas other than the 26 largest urban areas included in the high population category.

[4] See www.census.gov (http://www.census.gov/geo/www/ua/ua_2k.html).

Critical access hospitals (CAHs). "Critical access hospital" refers to all the hospitals in the study that are designated critical access hospitals by the Department of Health and Human Services or otherwise under federal law.

CAHs must be certified by the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services. A facility that meets the following criteria may be designated by CMS as a CAH:[5]

- Is located in a State that has established with CMS a Medicare rural hospital flexibility program; and
- Has been designated by the State as a CAH; and
- Is currently participating in Medicare as a rural public, non-profit or for-profit hospital; or was a participating hospital that ceased operation during the 10-year period from November 29, 1989 to November 29, 1999; or is a health clinic or health center that was downsized from a hospital; and
- Is located in a rural area or is treated as rural; and
- Is located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles); and
- Maintains no more than 25 inpatient beds; and
- Maintains an annual average length of stay of 96 hours per patient for acute inpatient care; and
- Complies with all CAH Conditions of Participation, including the requirement to make available 24-hour emergency care services 7 days per week.

Rural (non-CAH). "Rural (non-CAH)" refers to the hospitals in the study that are not located in any Census Bureau urban area and are not CAHs. CMS provided the IRS with a list of rural hospitals that are not CAHs which CMS used in its Fiscal Year 2009 inpatient prospective payment system (IPPS) proposed rule impact file. IPPS is used to set payment rates for acute care hospitals that are not compensated under the CAH system. This CMS list was then compared to the list of hospitals in the study as a way of confirming these were located outside of Census Bureau urban areas.

D. Breakdown of Hospitals by Revenue Size

The Final Report provides breakdowns of aggregate information by revenue size, based on annual revenue as reported in Forms 990. Based on reported data, the IRS was able to classify 488 hospitals as follows:

- Under $25 million – 85 hospitals (17%)
- $25 million to $100 million – 173 hospitals (36%)

[5] See www.cms.hhs.gov (http://www.cms.hhs.gov/CertificationandComplianc/04_CAHs.asp); 42 U.S.C. 1395X(mm); 42 U.S.C. 1395i-4(e); 42 C.R.F. 485.606.

- $100 million to $250 million – 133 hospitals (27%)
- $250 million to $500 million – 61 hospitals (13%)
- Over $500 million – 36 hospitals (7%).

E. Hospitals Reporting Largest Amounts of Medical Research Expenditures

The Final Report categorizes a group of 15 hospitals that reported 93% of the medical research expenditures reported by the respondent hospitals. The report also summarizes key community benefit expenditure data regarding this group, and isolates the impact of this group's medical research expenditures on the overall group's reported community benefit expenditures. See Section VI.B, below.

F. Analysis of Bad Debt and Shortfalls as Uncompensated Care

The Final Report analyzes reporting of bad debt and shortfalls from insurance, government programs, and uninsured patients, across community types and revenues sizes. These results are described in Section VI.C, below.

G. Comparison of Reported Community Benefit Expenditures Across Communities Based on Income and Insurance Coverage Levels

The Final Report analyzes reporting of community benefit expenditures along certain per capita income and insurance coverage levels to determine whether reported uncompensated care varied by income and insurance coverage levels of the communities served by the responding hospitals. See Section VI.D, below.

H. Executive Compensation

The Final Report summarizes the data provided by the respondent hospitals in response to the questions contained in Part III – Compensation Practices, of the questionnaire. In addition, the Final Report summarizes the results of the 20 examinations that addressed certain executive compensation issues. See Section VII, below.

I. Form 990, Schedule H, Hospitals

The Final Report describes the final Form 990, Schedule H, Hospitals, effective for 2008 and later tax years, and explains how that schedule addresses many of the reporting concerns in this study. See Section VIII, below.

III. BACKGROUND ON U.S. HOSPITALS AND PRIOR STUDIES

A. Background on U.S. Hospitals

According to the American Hospital Association (AHA), there are 5,708 registered hospitals in the United States.[6] These include 4,897 community hospitals, which are defined as all nonfederal, short-term general, and other special hospitals (obstetrics and gynecology; eye, ear, nose, and throat; rehabilitation; orthopedic; and other individually described specialty services).[7] The community hospitals include the following:

- 2,913 nongovernment nonprofit community hospitals (59% of community hospitals)
- 873 investor-owned for-profit community hospitals (18% of community hospitals)
- 1,111 state and local government community hospitals (23% of community hospitals).[8]

AHA reports 1,997 rural community hospitals (41%) and 2,900 urban community hospitals (59%).[9] In its 2006 report on community benefit, the Congressional Budget Office reported that 51% of nonprofit hospitals were in large urban areas, 34% were in small urban or suburban areas, and 14% were in rural areas.[10]

According to the Congressional Budget Office, the distribution of hospitals across nonprofits, for-profits and government hospitals "varies markedly by region. In the Northeast, 89 percent of the hospitals are nonprofits, whereas in the South only 43 percent of the hospitals are nonprofits. For-profit hospitals are common in the South and West, but not in the Northeast and Midwest."[11] This is consistent with the 2005 GAO report, which reported that "states in the Northeast

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[6] http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html (Fast Facts on US Hospitals). The information from AHA's web site was as last updated on November 7, 2008. For this purpose, a registered hospital is a hospital that satisfies AHA's criteria for registration as a hospital facility, including both AHA member hospitals and nonmember hospitals.

[7] The remaining 811 non-community hospitals include federal government hospitals, nonfederal psychiatric hospitals, nonfederal long term care hospitals, prison hospitals, college infirmaries, and other facilities.

[8] This breakdown is similar to that reported by the Congressional Budget Office (CBO) in 2006: nonprofit hospitals (58%), for-profit hospitals (18%), and government hospitals (24%). Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits," December 2006, pages 12-13 (Tables 2 and 3). It is also similar to the breakdown reported in the 2005 United States Government Accountability Office (GAO) report, "Nonprofit, For-Profit, and Government Hospitals, Uncompensated Care and Other Community Benefits," May 2005, page 4 (nonprofit hospitals – 62%, government hospitals – 20%, and for-profit hospitals – 18%).

[9] The AHA fact sheet did not describe how the hospitals were classified as rural or urban.

[10] Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits," December 2006, page 13.

[11] Id. at 12.

and Midwest had relatively high concentrations of nonprofit hospitals, whereas in the South the concentration was relatively low."[12]

The 2006 CBO study also reported the following, based on data from 2003:[13]

- Nonprofit hospitals tend to be larger than for-profit hospitals and are more likely to be teaching hospitals
- Nonprofit hospitals have higher average total assets, fixed assets, net patient revenues, and operating expenses than both for-profit and government hospitals
- Nonprofit hospitals have a total margin (3.9%), measured as total payments from all sources over all costs as a share of payments, that is somewhat higher than government hospitals (2.9%) but lower than for-profits (9.1%)

Critical Access Hospitals. The Medicare Rural Hospital Flexibility Program, created by Congress in 1997, allows certain hospitals to be licensed as critical access hospitals. Critical access hospitals generally must be located in a rural area or in an area treated as rural, and satisfy certain specified requirements allowing them to be designated as such.[14] Under federal law, critical access hospitals differ from urban and other rural hospitals, both in terms of how they are reimbursed under Medicare programs and in their organization and operations.

As of September 2008, there were 1,294 critical access hospitals in 45 states across the United States.[15] The five states with the greatest number of critical access hospitals were Kansas (83), Iowa (82), Minnesota (79), Texas (74), and Nebraska (65). Three heavily populated states – California (27), Florida (11), and New York (13) – have fewer critical access hospitals. Five states – Connecticut, Delaware, Maryland, New Jersey, and Rhode Island – did not participate in federal programs required for critical access designation and did not have any critical access hospitals in their states.

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[12] United States Government Accountability Office (GAO) report, "Nonprofit, For-Profit, and Government Hospitals, Uncompensated Care and Other Community Benefits," May 2005, page 4.

[13] Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits," December 2006, pages 12-14.

[14] See Section II.C for a description of the requirements for critical access hospital designation.

[15] www.flexmonitoring.org/cahlistRA.cgi (CAH Information). The information described here is as reported by the Flex Monitoring Team, which consists of the Rural Health Research Centers at the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine. The team members are recipients of a cooperative agreement award from the Federal Office of Rural Health Policy to monitor and evaluate the Medicare Rural Hospital Flexibility Program. The monitoring project assesses the impact of the flexibility program on rural hospitals and communities and the role of states in achieving overall program objectives, including improving access to and the quality of health care services; improving the financial performance of critical access hospitals; and engaging rural communities in health care system development.

Unlike other hospitals which are reimbursed under the Medicare prospective payment system, critical access hospitals receive cost-based reimbursement for inpatient and outpatient care. These differences may affect financial performance, and the incentives, financial management, and utilization practices under the two Medicare payment methods may differ substantially.[16]

The Flex Monitoring Team (see footnote 15 for an explanation of the Flex Monitoring Team) reviews 20 financial indicators in six domains – profitability, liquidity, capital structure, revenue, cost, and utilization – and prepares annual reports regarding these indicators for critical access hospitals across the United States. For example, in its August 2008 report (for 2006), the team reported a "total margin" (net income divided by total revenue) of 3.6% for critical access hospitals across the United States;[17] the total margin reported in the team's August 2007 report (for 2005) was 2.6%.[18] Profitability varied materially across the states – for 2005, critical access hospitals in 7 states had aggregate negative "total margins" and 4 states reported total margins exceeding 5% of total revenue.[19] For 2006, 4 states reported aggregate negative total margins, and 14 states reported total margins exceeding 5% of total revenue.[20] The Flex Monitoring Team reports demonstrate that financial performance for critical access hospitals varies considerably across the various states.

B. Other Studies on Community Benefit Provided by Nonprofit Hospitals

Other recent studies have explored community benefit reporting by nonprofit and other hospitals. These studies include a 2006 study by the Congressional Budget Office,[21] and two separate studies by the Government Accountability Office – one in 2005[22] and the other in 2008.[23] As described below, these studies generally found that community benefit reporting varied by type of hospital, and that uncompensated care and community benefit expenditures often were concentrated in a relatively small number of hospitals, whether nonprofit, for-profit, or government hospitals.

2005 GAO Report. In May 2005, the GAO issued a report to the Committee on Ways and Means, House of Representatives of the United States Congress,

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[16] Flex Monitoring Team Data Summary Report No. 5, "CAH Financial Indicators Report: Summary of Indicator Medians by State," August 2008, page 2.
[17] Id. at 4.
[18] Flex Monitoring Team Data Summary Report No. 4, "CAH Financial Indicators Report: Summary of Indicator Medians by State," August 2007, page 4.
[19] Id.
[20] Flex Monitoring Team Data Summary Report No. 5, "CAH Financial Indicators Report: Summary of Indicator Medians by State," August 2008, page 4.
[21] Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits," December 2006.
[22] United States Government Accountability Office (GAO) report, "Nonprofit, For-Profit, and Government Hospitals, Uncompensated Care and Other Community Benefits," May 2005.
[23] United States Government Accountability Office (GAO) report, "Nonprofit Hospitals, Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements," September 2008.

regarding uncompensated care and other community benefits provided by nonprofit, for-profit and government hospitals. The study looked at data from 5 states – California, Florida, Georgia, Indiana, and Texas. The study defined community benefits to include uncompensated care as well as services such as the provision of health education and medical research. GAO found that government hospitals generally devoted substantially larger shares of their patient operating expenses to uncompensated care (defined to include charity care and bad debt) than did nonprofit and for-profit hospitals.[24] Further, within each group, the burden of uncompensated care costs was not evenly distributed among hospitals but instead was concentrated in a small number of hospitals, meaning that a small number of nonprofit hospitals accounted for substantially more of the uncompensated care than did other nonprofit hospitals.[25] For all three groups, the top quarter of hospitals devoted substantially greater percentages of their patient operating expenses to uncompensated care, on average, compared with the bottom quarter of hospitals.[26]

2006 Congressional Budget Office Report. This study measured the provision of certain community benefits and compared nonprofit hospitals with for-profit hospitals. It also examined the provision of community benefits by nonfederal government hospitals.

The 2006 CBO Report found that 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.[27] CBO found that, on average, nonprofit hospitals provided higher levels of uncompensated care (for purposes of this study, the sum of charity care and bad debt) than did otherwise similar for-profit hospitals, but that among individual hospitals, the provision of uncompensated care varied widely.[28] Uncompensated care as a share of hospitals' operating expenses was much higher at government hospitals (13.0%) than at either nonprofit hospitals (4.7%) or for-profit hospitals (4.2%).[29]

CBO also found that nonprofit hospitals were more likely than for-profit hospitals to provide certain specialized services that have been identified by certain

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[24] United States Government Accountability Office (GAO) report, "Nonprofit, For-Profit, and Government Hospitals, Uncompensated Care and Other Community Benefits," May 2005 (What GAO Found).
[25] Id.
[26] Id. at 13-14.
[27] Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits," December 2006, page 1.
[28] Id. at 1-2. CBO observed that uncompensated care, when measured by including bad debt, has "substantial limitations" as a measure of community benefits, as it does not distinguish between the provision of charity care for the indigent and bad debt. Id. at 9.
[29] Id. at 2.

researchers as being generally unprofitable, including emergency room care, labor and delivery services, burn intensive care, and high-level trauma care.[30]

2008 GAO Report. In September 2008, the GAO issued its Report to the Ranking Member, Committee on Finance, U.S. Senate, regarding community benefit reporting by nonprofit hospitals.[31] In this study, 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 found that the IRS's community benefit standard allows nonprofit hospitals broad latitude to determine the services and activities that constitute community benefit, and that state community benefit requirements that hospitals must meet to qualify for state tax-exempt or nonprofit status vary substantially in scope and detail.[32] GAO found that variations in the activities nonprofit hospitals define as community benefit lead to substantial differences in the amount of community benefits they report, and that nonprofit hospitals measure costs of these activities differently, which can lead to inconsistencies in reported community benefits.[33]

C. Study on Executive Compensation of Nonprofit Hospitals

2006 GAO Nonprofit Hospital System Survey on Executive Compensation Policies and Practices. In response to a request by the House Ways and Means Committee, the GAO surveyed executive compensation issues at selected private, nonprofit hospital systems to gain an understanding of the policies and practices related to the salaries, benefits, travel, gifts and entertainment expenses paid by these hospital systems.[34] The study's key questions were as follows:

- What corporate governance structure do selected hospital systems report as having in place over executive compensation?
- What is the basis for the compensation and benefits earned by, awarded to, or paid to the executives as reported by selected hospital systems?
- What internal controls do selected hospital systems report as having in place over the approval, payment, and monitoring of executive travel and entertainment expenses, gifts, and other perquisites?[35]

The GAO found that the hospital systems reported similarities in certain governance and compensation policies and practices, such as:

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[30] Id. at 3, 20.
[31] United States Government Accountability Office (GAO) report, "Nonprofit Hospitals, Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements," September 2008.
[32] Id. (see What GAO Found).
[33] Id.
[34] United States Government Accountability Office, Nonprofit Hospital Systems, Survey on Executive Compensation Policies and Practices, June 2006.
[35] Id. at 1.

- having an executive compensation committee or entire board with primary responsibility for approving executives' base salary, bonuses, and perquisites;
- having a conflict of interest policy that covers members of the executive compensation committee and compensation consultants; and
- relying upon comparable market data of total compensation and benefits prior to making compensation determinations.[36]

The GAO found, however, that the hospital systems reported a range of practices with respect to entertainment, travel expenses, payment for perquisites such as memberships in recreational and social clubs, and audits of perquisites and entertainment expenses.[37]

[36] Id. at 2.
[37] Id.

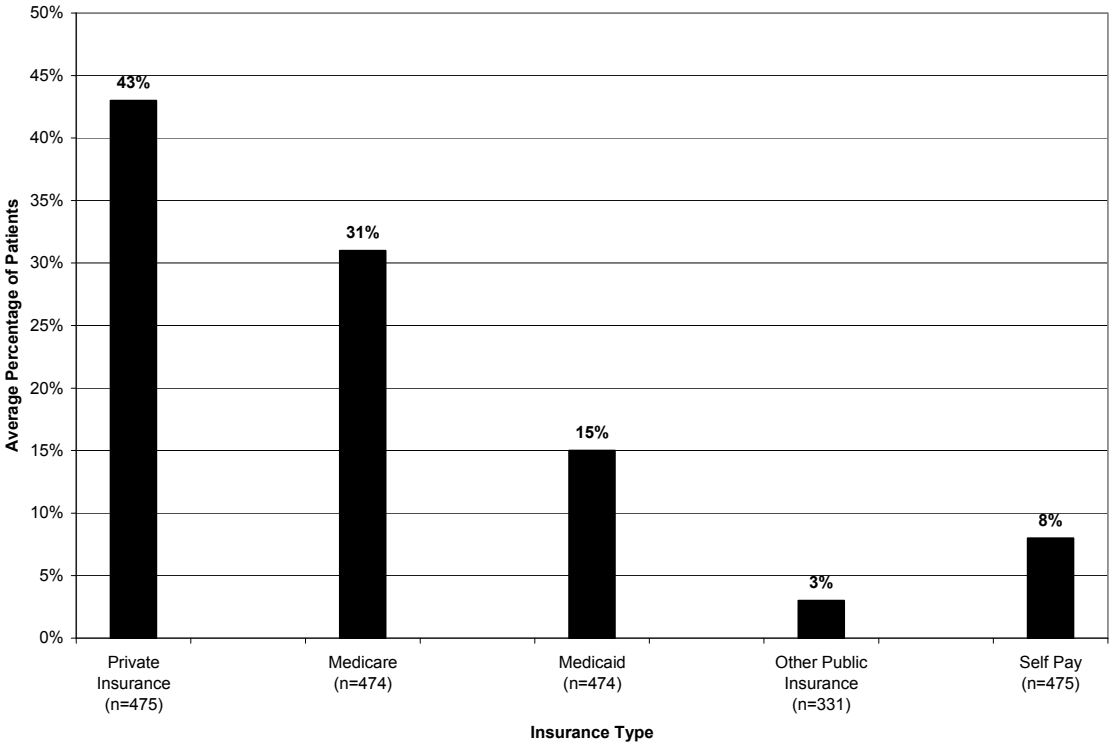
IV. DEMOGRAPHICS - PATIENT MIX, REVENUES, EXCESS REVENUES

This section provides demographic information for the hospitals included in the study. Section IV.A reports insurance coverage based on questionnaire responses. Section IV.B summarizes basic financial information (by revenue size) of the hospitals that reported revenues and expenses for their Form 990. Section IV.C provides financial information by community type. Section IV.D describes the demographic overlap of the community type and revenue size categories. Section IV.E provides a further breakdown by excess revenue categories.

A. Patient Insurance Coverage

Based on 480 responses, the average percentage of patients with no insurance was 8%, with private insurance was 43%, with Medicare was 31%, with Medicaid was 15%, and with some other form of public insurance was 3%. Figure 1, below, displays the breakdown.

Figure 1. Average Percentage of Insurance Coverage



B. Revenues and Excess Revenues By Revenue Size

This section classifies the hospitals into five revenue categories, and reports revenue, expense, and excess revenue information for these categories. Key findings of this section include the following:

1. The average and median total revenue amounts were $179 million and $89 million, respectively. The average and median excess revenue amounts were $8.3 million and $2.5 million, respectively.

2. The largest hospitals reported a disproportionately large percentage of aggregate total revenues. 7% of all hospitals (those with revenues over $500 million) reported 40% of aggregate total revenues.

3. Overall, excess revenues as a percentage of total revenues was 4.6%. Excess revenues as a percentage of total revenues was lowest for the group of hospitals with revenues under $25 million (3.3%), and increased with revenue size. Each revenue size category reported an aggregate excess revenue amount, as well as average and median excess revenue amounts, greater than zero.

4. 79% of all hospitals reported excess revenues. 39% reported excess revenues as a percentage of total revenues in the 0% to 5% range. 40% reported excess revenues as a percentage of total revenues in the over 5% range.

5. 21% of the overall group reported a deficit (total expenses greater than total revenues) or zero excess revenues. The percentage of hospitals reporting a deficit or zero excess revenues was greatest for the group of smallest hospitals (35%) and decreased with revenue size.

The aggregate annual revenues reported on Form 990 by the 488 hospitals was $87.5 billion. A relatively small number of larger hospitals reported a disproportionately large portion of the overall reported revenues.

Figure 2, below, shows the distribution of hospitals by annual revenues and compares the percentages of hospitals in each revenue size group to the percentages of aggregate revenues reported by each group.

Figure 2. Distribution of Hospitals by Aggregate Annual Revenues

	Respondent Profile		Aggregate Reported Revenue	
Annual Revenues	**#**	**% of all hospitals**	**$Billion**	**% of aggregate revenue**
Under $25M	85	17%	$1.2	1%
$25M to under $100M	173	36%	$9.8	11%
$100M to under $250M	133	27%	$21.0	24%
$250M to under $500M	61	13%	$20.8	24%
$500M and over	36	7%	$34.7	40%
Total	488	100%	$87.5	100%

The smallest revenue size comprised 17% of the hospitals, but only 1% of the aggregate reported revenues. The largest group comprised 40% of aggregate revenues even though it comprised only 7% of the total number of hospitals.

Figure 3, below, displays total annual revenues, total expenses, and the excess/deficit revenues (difference between total revenues and total expenses) as reported on Form 990 for each category. Separate charts are provided below for total revenues and excess revenues.

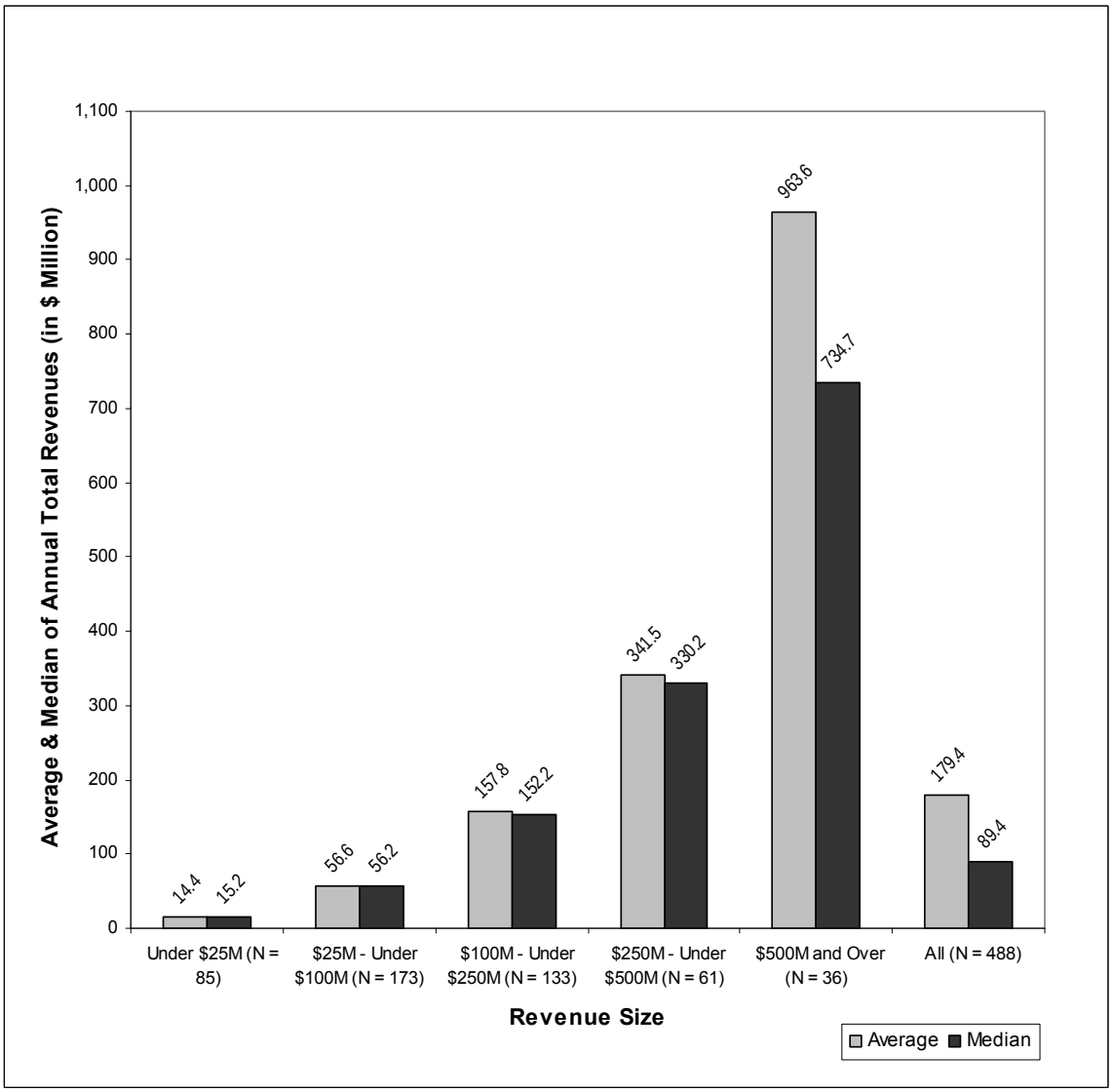
Figure 3. Annual Total Revenues, Total Expenses, and Excess/Deficit Revenue by Revenue Size

Revenue Size	Annual Total Revenues			Annual Total Expenses			Annual Excess/Deficit Revenue		
	Aggregate	Average	Median	Aggregate	Average	Median	Aggregate	Average	Median
	(Billion $)	(Million $)	(Million $)	(Billion $)	(Million $)	(Million $)	(Million $)	(Million $)	(Million $)
Under $25M (N = 85)	1.224	14.4	15.2	1.184	13.9	15.0	40.6	0.5	0.3
$25M - Under $100M (N = 173)	9.795	56.6	56.2	9.425	54.5	52.8	370.2	2.1	1.7
$100M - Under $250M (N = 133)	20.985	157.8	152.2	20.184	151.8	146.9	801.0	6.0	4.9
$250M – Under $500M (N = 61)	20.829	341.5	330.2	19.903	326.3	310.9	925.9	15.2	16.2
$500M and Over (N = 36)	34.690	963.6	734.7	32.769	910.3	698.6	1,920.9	53.4	38.3
Overall (N = 488)	87.523	179.4	89.4	83.464	171.0	87.1	4,058.5	8.3	2.5

The average total annual revenue, as reported on the respondents' Forms 990, Line 12, was $179 million, and the median was $89 million. Each revenue size category reported positive numbers for average and median excess revenues.

The charts below display the average and median total revenues and excess revenue by revenue size category.

Figure 4. Average and Median of Annual Total Revenues by Revenue Size



In general, the average and median amounts are relatively close within each of the different groups. The difference between the average and median for hospitals with revenues of $500 million and over, however, varies more than for the others. This indicates that some relatively large hospitals have total revenues that are much higher than the median total revenues for the $500 million and over group.

Figure 5. Average and Median of Annual Excess Revenue by Revenue Size

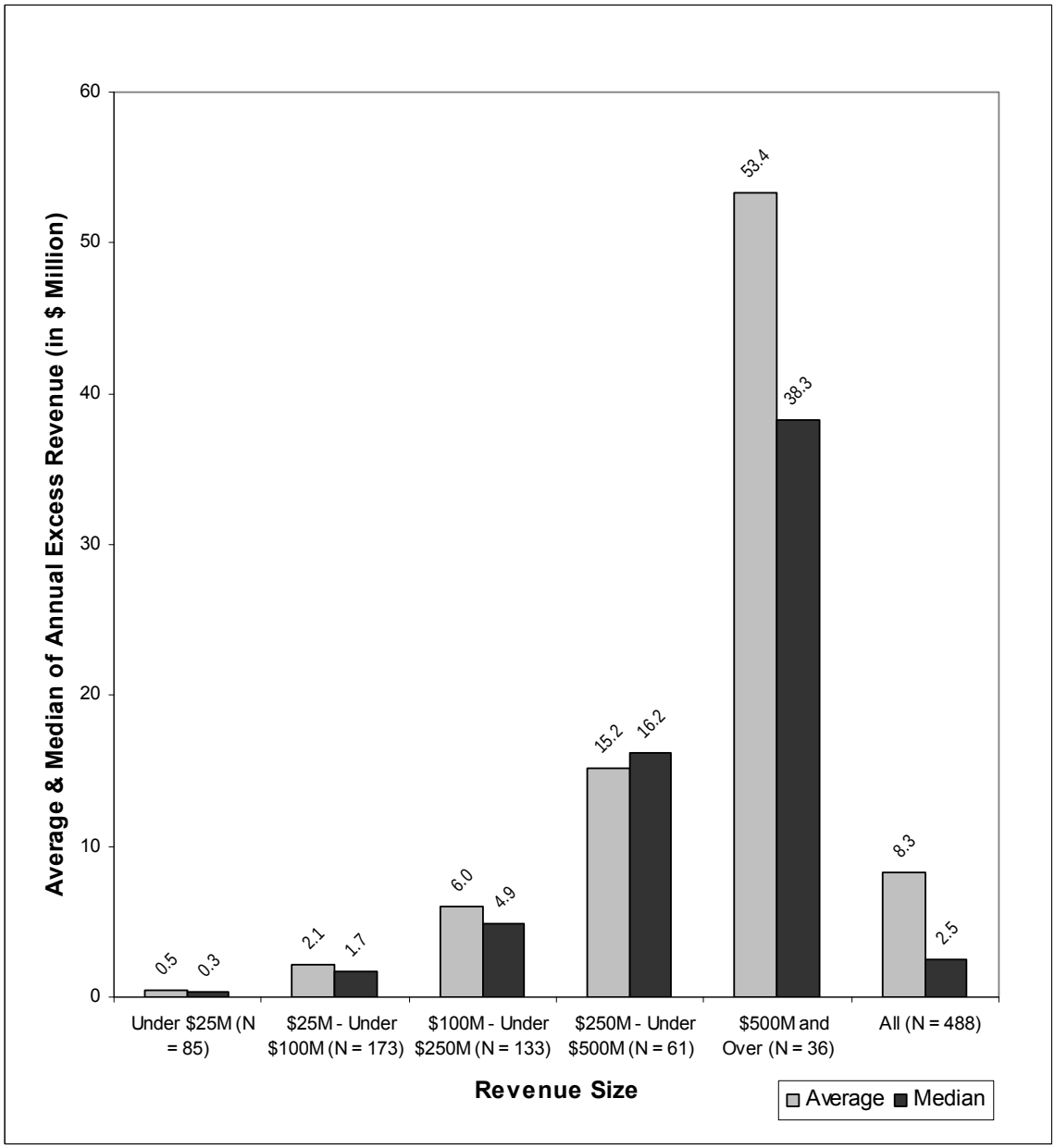


Figure 6, below, shows the reported aggregate excess revenues as a percentage of aggregate total revenues for each revenue size category and overall. These calculations are based on aggregate amounts reported in Figure 3 above. For example, the overall 4.6% figure represents $4.1 billion of aggregate excess revenues divided by $87.5 billion of aggregate total revenues.

Figure 6. Excess Revenue as a Percentage of Total Revenue

Revenue Size	Excess revenue as a percentage of total revenue
Under $25 million (N = 85)	3.3%
$25 million to $100 million (N = 173)	3.8%
$100 million to $250 million (N = 133)	3.8%
$250 million to $500 million (N = 61)	4.4%
Over $500 million (N = 36)	5.5%
Total (N = 488)	4.6%

The aggregate excess revenue as a percentage of aggregate total revenue generally increased across the categories, from a low of 3.3% for the under $25 million category to a high of 5.5% for the over $500 million category. The overall average was 4.6%.

Figure 7, below, shows the distribution of negative/positive excess revenues as a percentage of revenues.

Figure 7. Distribution of Excess Revenue as a Percentage of Annual Total Revenue by Revenue Size

Revenue Size	All		Excess Revenues as Percentage of Total Revenues Range									
			0% or Negative		Positive to < 2.5%		2.5% - < 5%		5% - < 10%		10% & Over	
	N	% of all hospitals	N	% of revenue size	N	% of revenue size	N	% of revenue size	N	% of revenue size	N	% of revenue size
Under $25M	85	17	30	35	13	15	11	13	19	22	12	14
$25M - Under $100M	173	36	39	23	29	17	41	24	43	25	21	12
$100M - Under $250M	133	27	25	19	30	23	29	22	39	29	10	8
$250M and Over	97	20	10	10	19	20	18	19	40	41	10	10
All	488	100	104	21	91	19	99	20	141	29	53	11

Figure 7, above, shows that overall 21% of the hospitals reported total expenses greater or equal to total revenues, and 39% of the hospitals reported excess revenues as a percentage of total revenues in the range of greater than 0% to 5%. 40% of all hospitals reported excess revenues as a percentage of total revenues of at least 5%; 11% reported excess revenues of at least 10% of total revenues.

The percentage of hospitals reporting a deficit or zero excess revenue decreased as revenue size increased. The $500 million and over revenue size had the smallest percentage of hospitals reporting zero or a deficit.[38]

[38] The two largest revenue sizes were combined to prevent potential identification of respondent hospitals.

C. Revenues and Excess Revenues by Community Type

This section classifies the hospitals into four community types, and reports revenue, expense, and excess revenue information for these categories. Key findings of this section include the following:

1. Rural hospitals generally reported smaller total revenues and excess revenues than did other community types. The rural community types had a disproportionately small percentage of aggregate total revenues (30% of the hospitals, 10% of aggregate revenues), while the high population community type had a disproportionately large percentage of aggregate revenues (19% of hospitals, 41% of aggregate revenues).

2. Each community type reported aggregate excess revenues and average and median excess revenues as a percentage of total revenues greater than zero. CAHs reported the smallest average and median total revenues ($29 million and $20 million, respectively) and the smallest average and median excess revenue amounts ($1.0 million and $0.5 million, respectively). High population hospitals reported the largest average and median amounts, both for total revenues ($389 million and $196 million, respectively) and for excess revenues ($17.5 million and $4.2 million, respectively).

3. CAHs reported the smallest percentage of excess revenues as a percentage of total revenues (3.5%); rural (non-CAH) hospitals reported the largest percentage (6.0%). 34% of CAHs reported a deficit (total expenses greater than total revenues) or zero excess revenue compared to 13% for rural (non-CAH) hospitals and 21% overall.

The table below shows the distribution of hospitals and aggregate total revenues by community types.

Figure 8. Distribution of Hospitals and Total Revenues by Community Type

	Respondent Profile		Aggregate Reported Revenue	
Community Type	**#**	**%**	**$Billion**	**%**
High Population	93	19%	$36.2	41%
Rural – CAH	68	14%	$2.0	2%
Rural – Non CAH	78	16%	$7.3	8%
Other	249	51%	$42.1	48%
Total	488	100%	$87.5	100%

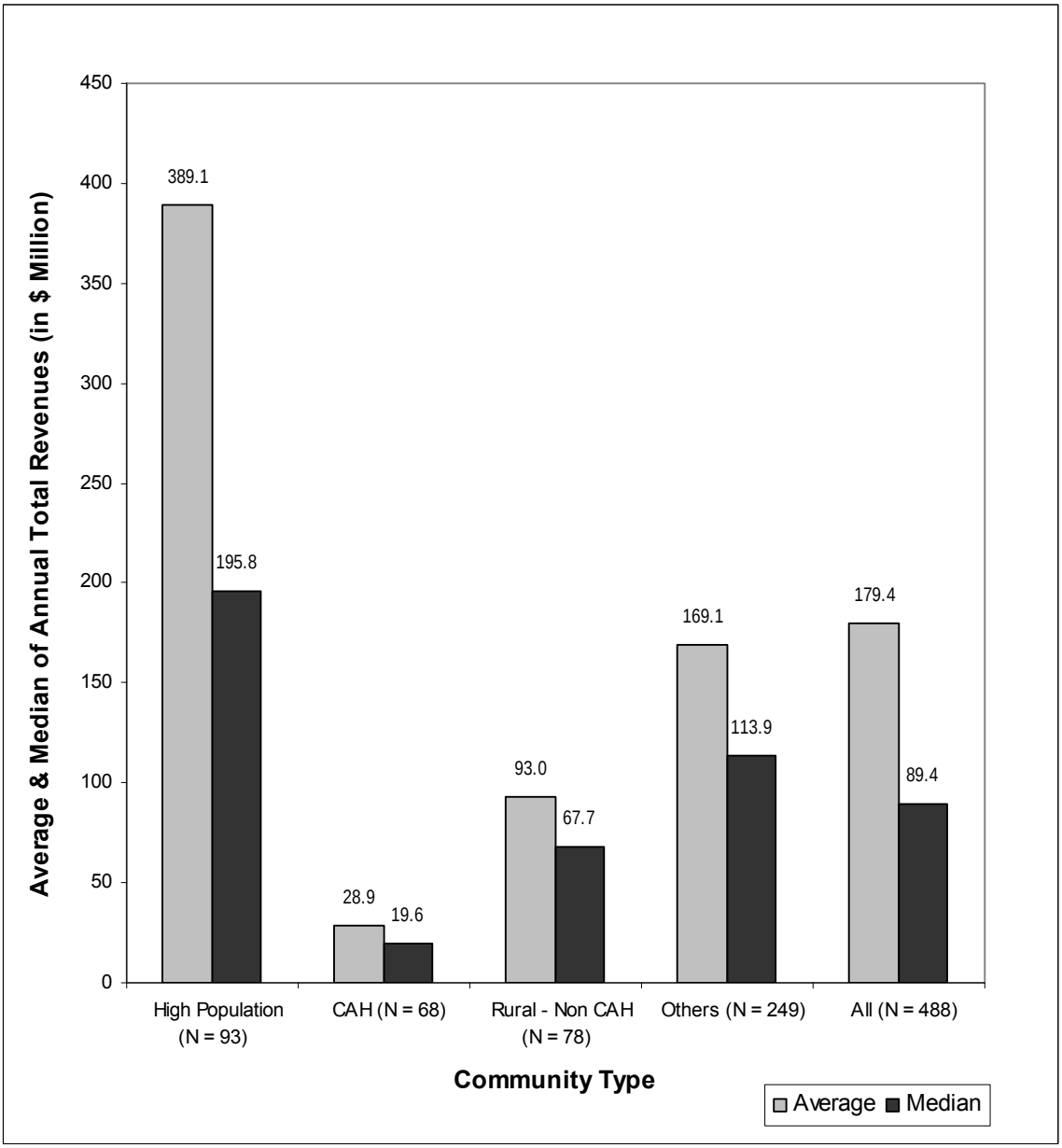
The rural community types had a disproportionately small percentage of aggregate total revenues while the high population community type had a disproportionately large percentage of aggregate revenues. The other urban and suburban category comprised approximately half of the number of hospitals and overall reported total revenues.

Figure 9, below, includes the aggregate, average and median total revenues, total expenses, and excess of revenues over expenses by community type. Figure 10 and Figure 11 display total revenues and excess revenues by community type.

Figure 9. Annual Total Revenues, Total Expenses, and Excess/Deficit Revenue by Community Type

Community Types	Annual Total Revenues			Annual Total Expenses			Annual Excess/Deficit Revenue		
	Aggregate (Billion $)	Average (Million $)	Median (Million $)	Aggregate (Billion $)	Average (Million $)	Median (Million $)	Aggregate (Million $)	Average (Million $)	Median (Million $)
High Population (N = 93)	36.184	389.1	195.8	34.557	371.6	196.7	1,627.5	17.5	4.2
Rural - CAH (N = 68)	1.965	28.9	19.6	1.896	27.9	19.3	69.3	1.0	0.5
Rural - Non CAH (N = 78)	7.256	93.0	67.7	6.823	87.5	64.8	433.3	5.6	3.4
Others (N = 249)	42.117	169.1	113.9	40.189	161.4	109.7	1,928.4	7.7	3.1
Overall	87.523	179.4	89.4	83.464	171.0	87.1	4,058.5	8.3	2.5

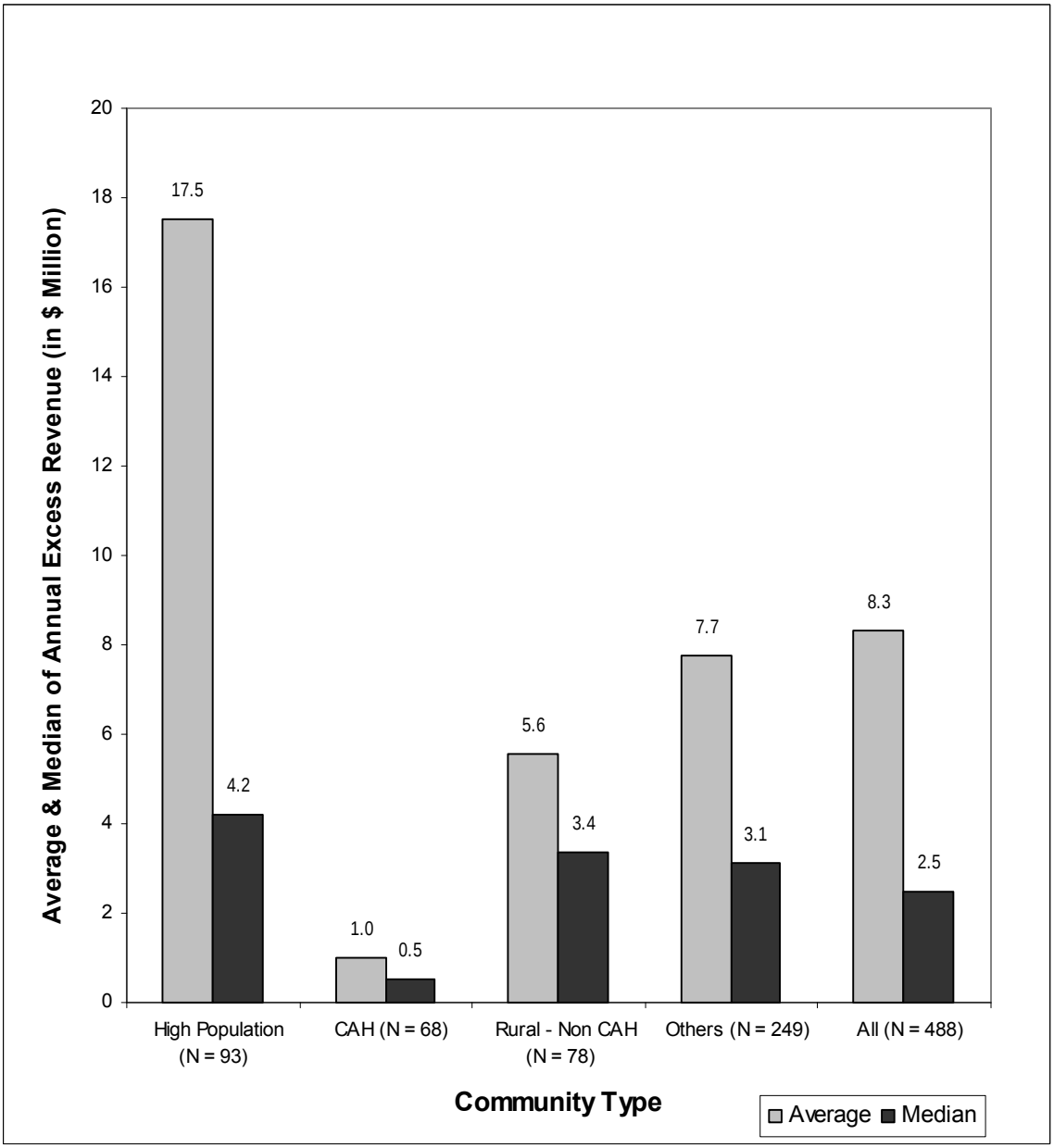
Figure 10. Average and Median Annual Total Revenue by Community Type



The CAHs reported the smallest average and median revenue amounts of any community type. The average annual total revenue for hospitals in the high population group is more than double the average annual total revenue for hospitals in the other urban and suburban category, the next largest group, and more than double the average annual total revenue for the entire group of hospitals.

The high population group shows the largest difference between average revenue and median revenue. This deviation indicates that there are a number of extremely large hospitals (relative to the others in the group) located in high population areas.

Figure 11. Average and Median Annual Excess Revenue by Community Type



As was the case with total revenues, the greatest variation between average and median excess revenue amounts was with the high population group.

The table below shows the reported excess revenues as a percentage of total revenues for each community type. These calculations are based on aggregate amounts reported in Figure 9, above. For example, the overall 4.6% figure represents $4.1 billion of aggregate excess revenues divided by $87.5 billion of aggregate total revenues.

Figure 12. Excess Revenue as a Percentage of Total Revenue by Community Type

Community Type	Excess revenues as a percentage of total revenue
High population (N = 93)	4.5%
Rural - CAH (N = 68)	3.5%
Rural - Non CAH (N = 78)	6.0%
Others (N = 249)	4.6%
All 488 hospitals	4.6%

The overall measure of excess revenues as a percentage of total revenues was 4.6%. All four community types reported revenues greater than expenses for the year. The CAH community type reported the smallest percentage of excess revenues as a percentage of total revenues (3.5%) and rural (non-CAH) hospitals reported the largest percentage (6%). High population and other urban and suburban hospitals were approximately at the overall percentage.

Figure 13, below, shows the distribution of negative/positive excess revenues as a percentage of revenues by community type.

Figure 13. Distribution of Excess Revenues as a Percentage of Annual Total Revenue by Community Type

Community Type	All		Excess Revenue as Percentage of Revenue Range									
			0% or Negative		Positive to < 2.5%		2.5% - < 5%		5% - < 10%		10% & Over	
	N	% of all hospitals	N	% of community type	N	% of community type	N	% of community type	N	% of community type	N	% of community type
High Population	93	19	20	22	24	26	20	22	21	23	8	9
CAH	68	14	23	34	7	10	15	22	17	25	6	9
Rural - Non CAH	78	16	10	13	12	15	11	14	32	41	13	17
Others	249	51	51	20	48	19	53	21	71	29	26	10
All	488	100	104	21	91	19	99	20	141	29	53	11

CAHs reported the largest percentage of hospitals with a deficit or zero excess revenues, and other rural hospitals reported the smallest.

D. Relationship between Community Type and Revenue Size

The figures below show the overlap of community type and revenue size within the respondent hospitals. For example, in Figure 15, the middle vertical bar in the under $25 million revenue size shows there are 50 rural hospitals (CAH and non-CAH) under $25 million in revenue size. Figure 15 shows the distribution of community types across the revenue size categories, and Figure 16 shows the distribution of revenue size across community types.

Figure 14. Number of Hospitals by Revenue Size and Community Type

	Under $25 million	$25 -$100 million	$100 - $250 million	Over $250 million	Total
High Population	3	20	33	37	93
CAH/Rural Non-CAH	50	72	17	7	146
Other	32	81	83	53	249
Total	85	173	133	97	488

Figure 15. Number of Hospitals by Community Type and Revenue Size

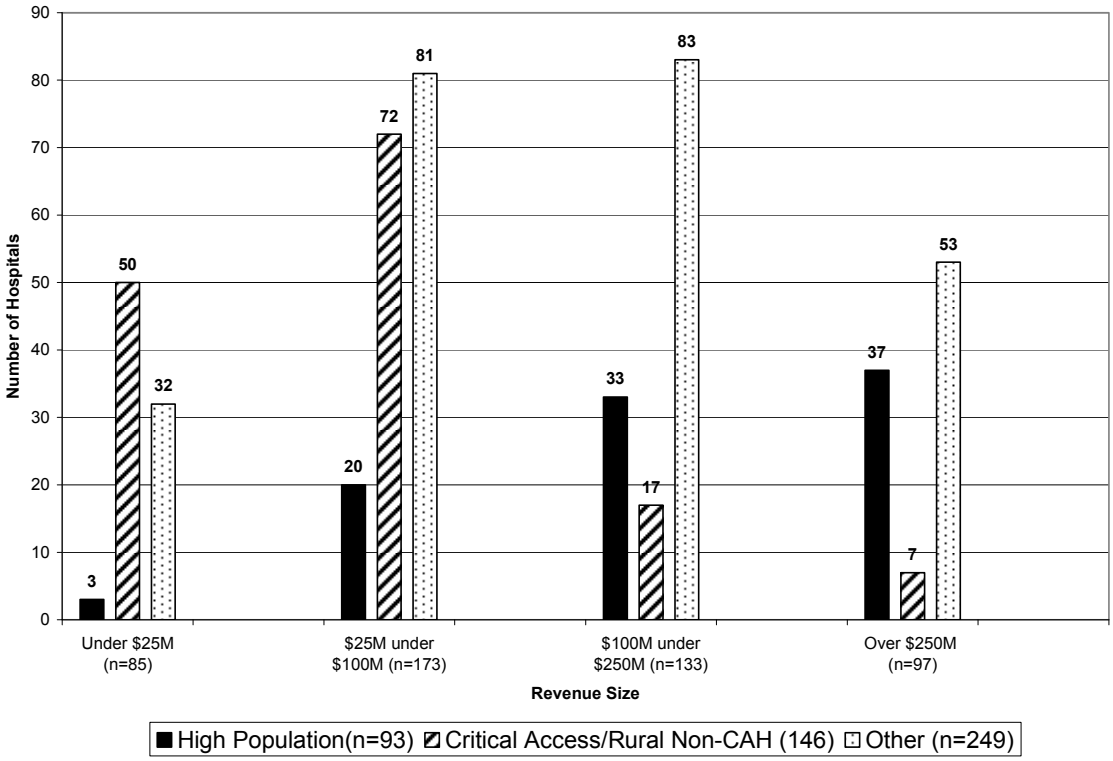
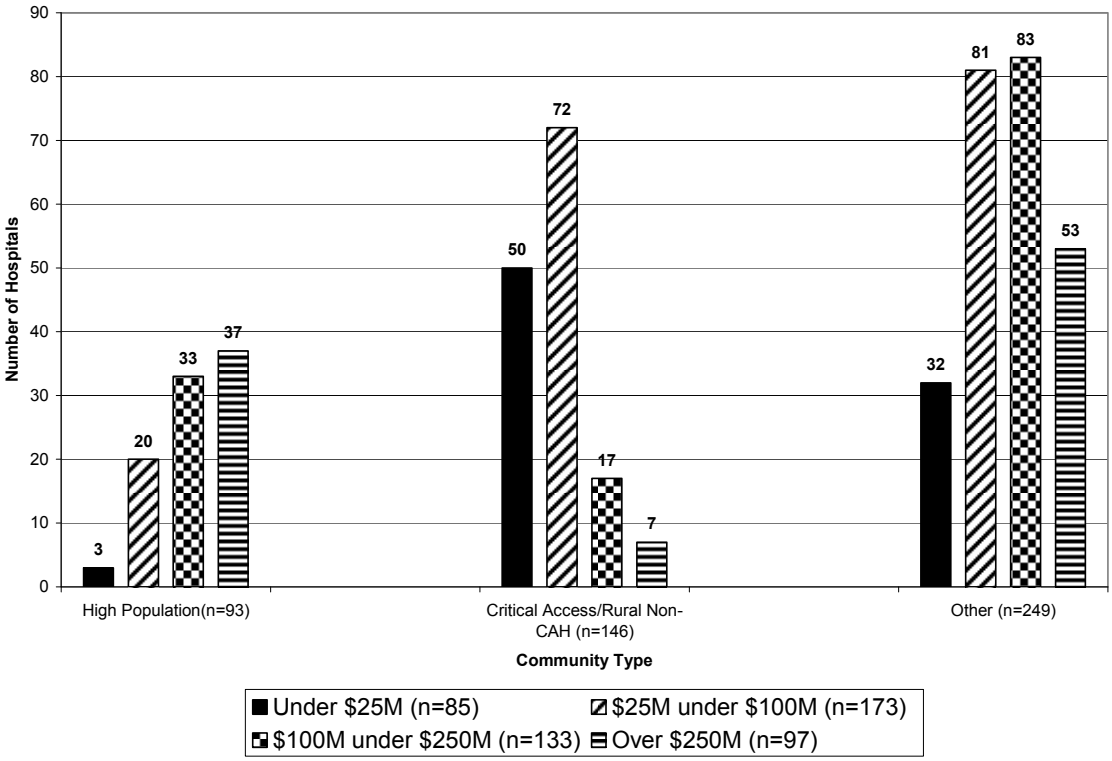


Figure 16. Number of Hospitals by Revenue Size and Community Type



As might be expected, there generally was a strong correlation between community type and revenue size. Most rural hospitals (84%) reported total revenues under $100 million. 75% of high population hospitals reported total revenues over $100 million, and high population hospitals constituted 58% of these reporting total revenues over $500 million.[39] More than 20% of high population hospitals and more than 5% of other urban and suburban hospitals were in the over $500 million revenue size. More than 55% of CAHs were in the lowest revenue size.

E. Groupings by Excess Revenues

The previous sections reported revenues and excess revenues based on revenue size and community type categories. This section classifies the 488 hospitals into five categories based on the amounts of the excess revenues over expenses reported on the Forms 990. Overall, the hospitals reported $4.1 billion of excess revenues. Figure 17, below, shows the distribution of hospitals and aggregate excess revenues by these five excess revenue categories.

[39] The two groups of rural hospitals and the two largest revenue sizes were combined in the figures to prevent potential identification of respondent hospitals.

Figure 17. Distribution of Hospitals and Aggregate Excess Revenue by Excess Revenue Size

Annual Excess Revenues	Respondent Profile		Aggregate Reported Excess Revenue	
	#	%	$M	%
$0 or under	104	21%	$-373	-9%
$1 to under $2.5M	138	28%	$158	4%
$2.5M to under $7.5M	109	22%	$484	12%
$7.5M to under $15M	60	12%	$647	16%
$15 M and over	77	16%	$3,143	77%
Total	488	100%	$4,059	100%

The table shows the bulk of reported excess revenues was reported by a relatively small group of hospitals. The group of hospitals reporting $15 million or more of excess revenues comprised 16% of the hospitals, but reported 77% of the aggregate excess revenues.

The table below displays total revenues, total expenses, and the excess/deficit revenues for each excess revenue category listed above. Figure 19 and Figure 20 display total revenues and excess revenues by excess revenue category.

Figure 18. Annual Total Revenues, Total Expenses, and Excess/Deficit Revenues by Excess Revenue Size

	Annual Total Revenues			Annual Total Expenses			Annual Excess/Deficit Revenue		
Excess Revenue Size	Aggregate	Average	Median	Aggregate	Average	Median	Aggregate	Average	Median
	(Billion $)	(Million $)	(Million $)	(Billion $)	(Million $)	(Million $)	(Million $)	(Million $)	(Million $)
$0 or Under (N = 104)	10.525	101.2	57.1	10.898	104.8	59.5	-373.3	-3.6	-1.6
$1 - Under $2.5M (N = 138)	7.543	54.7	32.5	7.385	53.5	32.0	158.3	1.1	1.2
$2.5M - Under $7.5M (N = 109)	13.389	122.8	83.3	12.905	118.4	76.9	484.1	4.4	4.0
$7.5M - Under $15M (N = 60)	12.798	213.3	178.8	12.151	202.5	168.7	646.6	10.8	10.8
$15M or Over (N = 77)	43.268	561.9	386.7	40.126	521.1	357.2	3,142.9	40.8	29.5
Overall (N=488)	87.523	179.4	89.4	83.464	171.0	87.1	4,058.5	8.3	2.5

Figure 19. Average and Median Annual Total Revenue by Excess Revenue Size

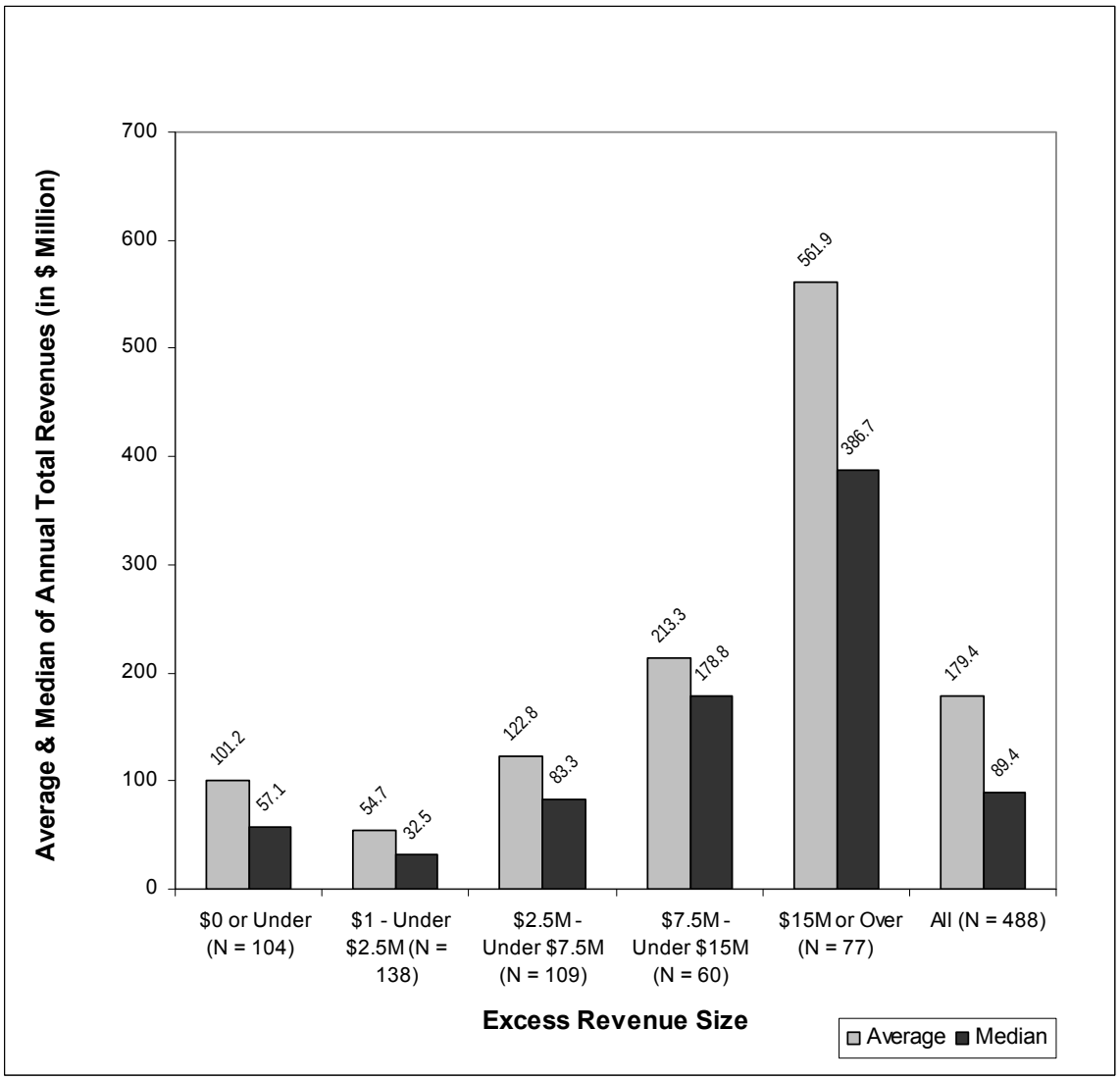


Figure 20. Average and Median Annual Excess Revenue by Excess Revenue Size

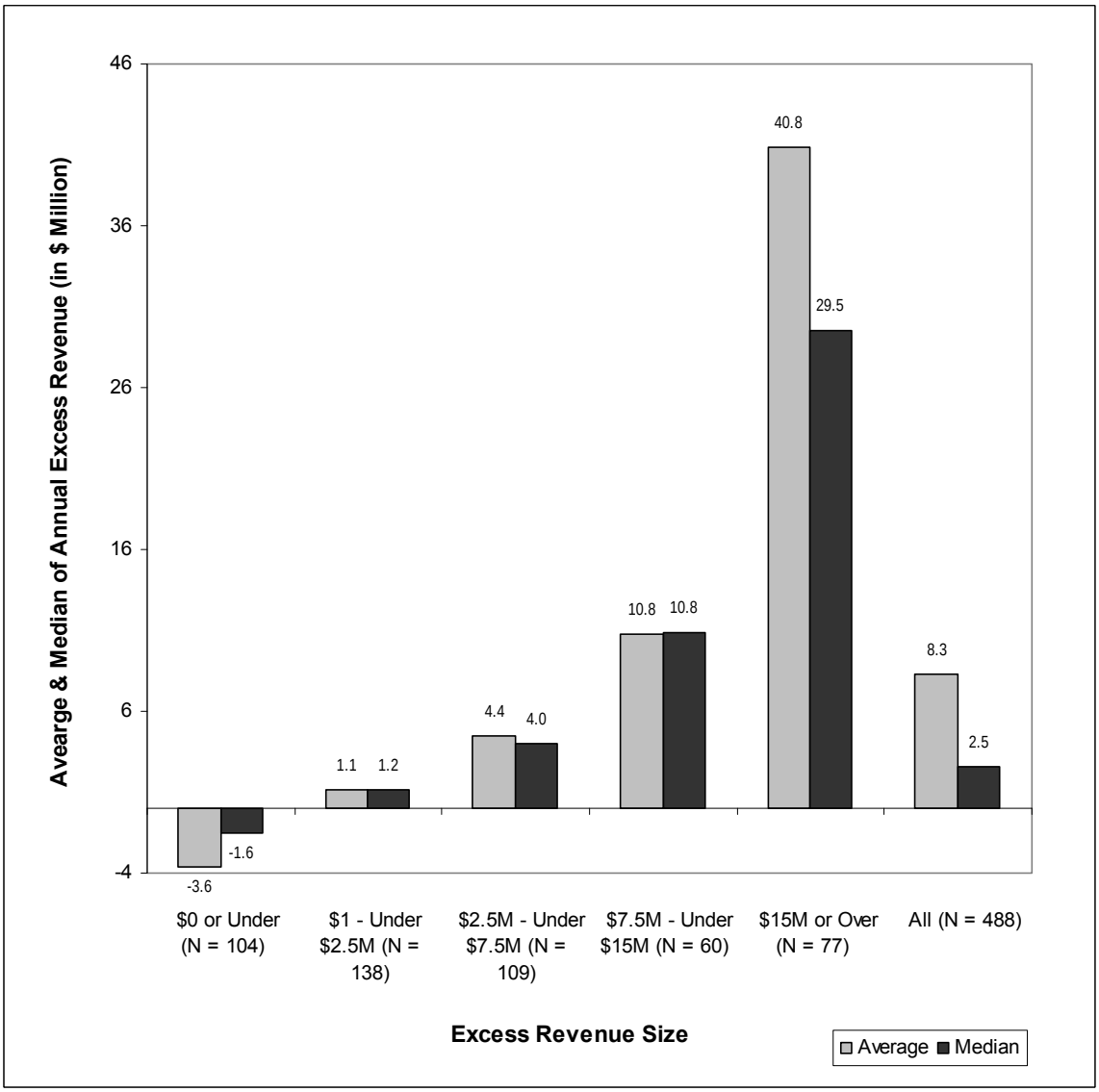


Figure 19 shows that hospitals with deficits or the smallest excess revenues tended to be those with lower total revenues (under $123 million average, under $83 million median).

Figure 21, below, shows the distribution of negative/positive excess revenues as a percentage of annual revenues by excess revenue sizes.

Figure 21. Distribution of Excess Revenue as a Percentage of Annual Total Revenue by Excess Revenue Size

Excess Revenue Size	All		Excess Revenue as a Percentage of Annual Revenue Range							
			0% or Negative		Positive to < 5%		5% - < 10%		10% or Over	
	N	% of all hospitals	N	% of revenue size	N	% of revenue size	N	% of revenue size	N	% of revenue size
Negative & 0	104	21	104	100	0	-	0	-	0	-
$1 - Under $2.5M	138	28	0	-	104	75	26	19	8	6
$2.5M - Under $7.5M	109	22	0	-	55	51	40	37	14	13
$7.5M - Under $15M	60	12	0	-	20	33	29	48	11	18
$15M or Over	77	16	0	-	11	14	46	60	20	26
All	488	100	104	21	190	39	141	29	53	11

Most of the hospitals in the $1 to under $7.5 million ranges (64%) reported excess revenues under 5% of total revenues. Most of the hospitals in the $7.5 million or over ranges (55%) reported excess revenues in the 5% to under 10% level.

V. DIFFERENCES IN COMMUNITY BENEFIT REPORTING ACROSS CERTAIN DEMOGRAPHICS - COMMUNITY TYPES, REVENUE SIZE

A. Introduction

The respondent hospitals were classified into two different demographic groups – community types and revenue size. The distribution of the respondent hospitals across these two groups is as follows.

Community types:

- "High population" – 94 hospitals (19%)
- "Other urban and suburban" – 249 hospitals (51%)
- "Critical access hospitals (CAH)" – 68 hospitals (14%)
- "Rural (non-CAH)" – 78 hospitals (16%)

Revenue size:

- Under $25 million – 85 hospitals (17%)
- $25 million to $100 million – 173 hospitals (36%)
- $100 million to $250 million – 133 hospitals (27%)
- $250 million to $500 million – 61 hospitals (13%)
- Over $500 million – 36 hospitals (7%)

Section V.B provides breakdowns by community type, and Section V.C provides breakdowns by revenue size, for aggregate community benefit expenditures, uncompensated care, medical education and training, medical research, and community programs.

B. Comparison of Certain Information by Community Type[40]

1. Summary of Key Findings – Community Type

a. The patient mix for each community type generally followed that for the overall group – in descending order, private insurance, Medicare, Medicaid, uninsured, and other public programs. All community types reported uninsured patients as 7% to 8% of total patients. CAHs reported the highest percentage of Medicare patients (36% compared to 31% overall), and high population hospitals reported the highest percentage of Medicaid patients (19% compared to 15% overall).

b. Between 94% and 96% of each community type reported uncompensated care expenditures. Although the percentage of hospitals reporting they provided community benefit did not vary materially across community types, there were some exceptions. Only 60% of CAHs reported providing medical education and training,

[40] For a description of the community types, see Section II.C, above.

compared to 77% overall. 40% of the high population hospitals reported medical research expenditures, compared to less than 5% of rural hospitals (CAH and non-CAH).

c. The median percentage of patients reported as receiving uncompensated care was 3% overall, ranging from 2% for rural hospitals to 6% for high population hospitals. The median percentages of patients reported as receiving uncompensated care were less than the overall percentage of patients without insurance for each community type. However, the average percentage of patients receiving uncompensated care was greater than the percentage of patients without insurance for the high population group (11% compared to 8%), the other urban and suburban group (10% compared to 8%), and the rural (non-CAH) group (8% compared to 7%).

d. The average and median percentages of total revenues reported as spent on uncompensated care were 7% and 4%, respectively. CAHs reported the lowest average (6%) and median (2%) percentages; high population hospitals reported the highest average (8%) and median (5%) percentages. The percentage of hospitals reporting uncompensated care expenditures at 3% or less of total revenues ranged from 33% for high population hospitals to 59% for CAHs. Over half of the hospitals in each community type (58% overall) reported uncompensated care expenditures at 5% or less of total revenues.

e. Uncompensated care represented the largest community benefit expenditure overall (56%) and for each community type. However, the percentage of overall community benefit expenditures reported as spent on uncompensated care ranged from 42% for high population hospitals to 77% for CAHs. The mix of community benefit expenditures among uncompensated care, medical research, medical education and training, and community programs varied considerably across community types.

f. The average and median percentages of total revenue reported as spent on medical research and on medical education and training varied considerably across community types. CAHs as a group consistently reported spending lower percentages of total revenues on these expenditures than did all other community types. High population hospitals as a group consistently reported spending higher percentages of total revenues on these expenditures than did all other community types.

g. There was considerable variation across the community types regarding community program expenditures. CAHs reported spending

19% of overall community benefit expenditures on community programs compared to a range of 5% to 7% for the other community types. Each community type reported spending most of its community program expenditures on improving access to health care and other health care promotion.

h. The median percentages of total revenue reported as spent on aggregate community benefit expenditures were 2.8% for CAHs, 3.2% for rural (non-CAH) hospitals, 5.8% for other urban and suburban hospitals, and 9.8% for high population hospitals. The same pattern followed for average percentages of total revenue reported as spent on aggregate community benefit expenditures: 6.3% for CAHs, 8.4% for rural (non-CAH) hospitals, 8.9% for other urban and suburban hospitals, and 12.7% for high population hospitals. The overall median and average percentages were 5.5% and 9.2%, respectively.

i. 47% of all hospitals reported spending less than 5% of total revenues on aggregate community benefit expenditures. These ranged from 32% for high population hospitals to 61% for CAHs. 46% of other urban and suburban hospitals, and 57% of rural (non-CAH) hospitals, reported spending less than 5% of total revenues on aggregate community benefit expenditures.

2. Patient Mix (Based on Type of Insurance Coverage) by Community Type

The table and charts below break down insurance coverage by community type for the 480 hospitals that reported this information. Overall, the average percentages reported by the hospitals were that 43% of their patients had private insurance, 31% were covered by Medicare, 15% were covered by Medicaid, 3% were covered by other public insurance programs, and 8% were uninsured.[41]

[41] According to the U.S. Census Bureau, the percentage of individuals without health insurance in 2005 was 15.3%. U.S. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement (as revised March 2007).

Figure 22. Distribution of Health Insurance Coverage by Community Type*

Community Type	Category of Health Insurance Coverage				
	Private Insurance (%)	Medicare (%)	Medicaid (%)	Other Public Insurance (%)	No Health Insurance (%)
High Population	43.5%	27.7%	19.3%	3.9%	7.8%
Critical Access	38.2%	36.4%	12.7%	2.6%	8.1%
Rural - Non Critical Access	44.2%	32.8%	13.2%	3.0%	7.1%
Other Urban & Suburban	44.4%	30.2%	14.7%	2.5%	7.6%
All patients	43.3%	31.0%	15.1%	2.9%	7.7%

*Some hospitals reported total patient amounts that did not equal the total number of patients reported in the various health insurance coverage categories.

Figure 23 and Figure 24, below, present the same health insurance coverage information in two different ways. Figure 23 groups the community type percentages for each type of coverage. Figure 24 shows the insurance coverage mix within each community type.

Figure 23. Percentage of Patients with Insurance Coverage by Community Type, by Type of Coverage (n=480)

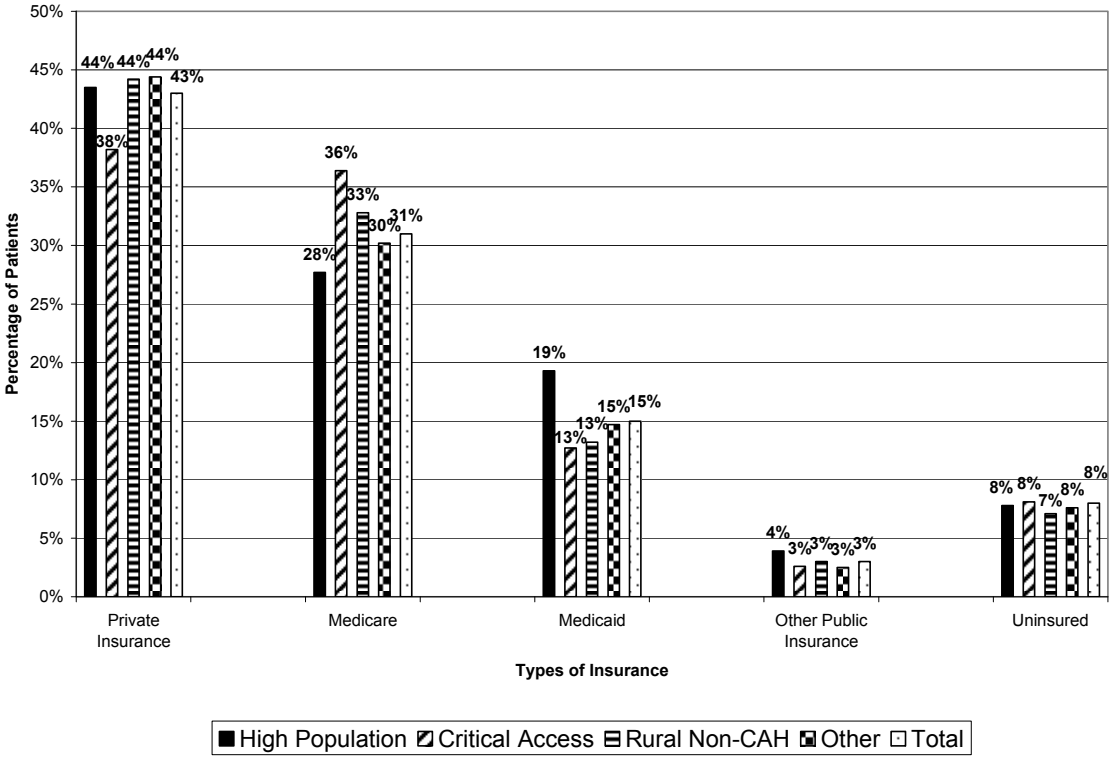
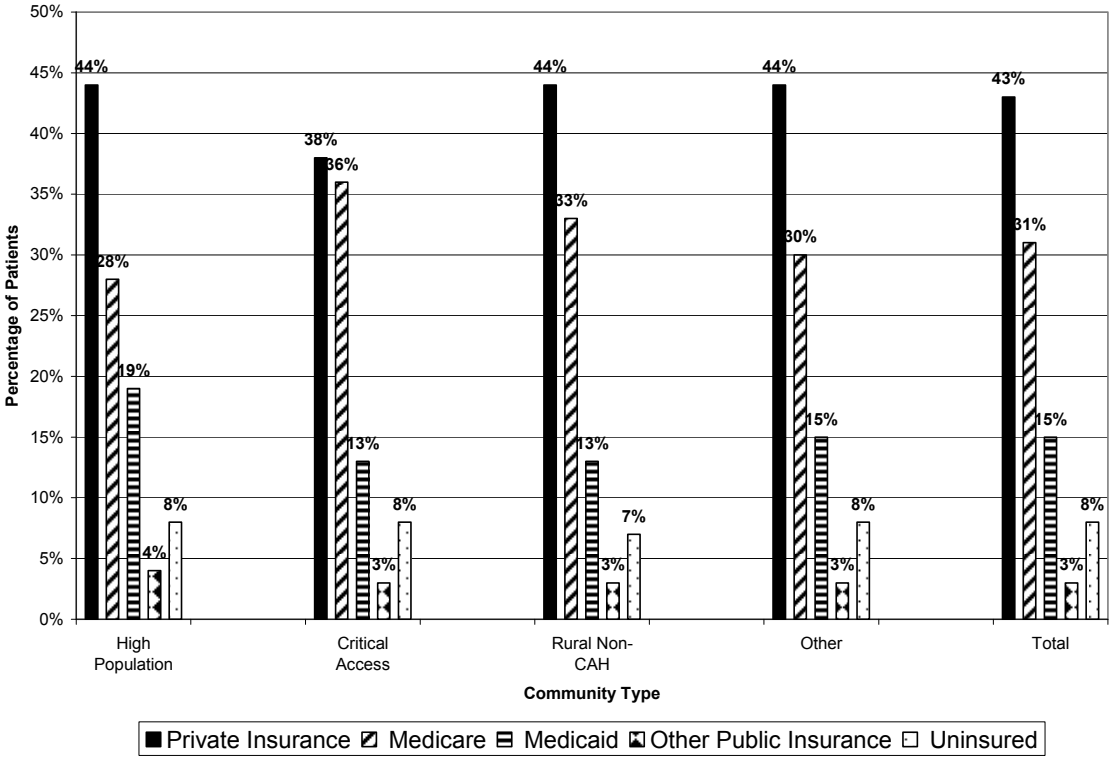


Figure 24. Percentage of Patients with Insurance Coverage by Type, by Community Type (n=480)



The distribution of types of coverage across the community types is relatively similar to the distribution of the entire respondent group. However, the hospitals located in high population areas reported a smaller percentage of patients with coverage through Medicare (28% vs. 31% overall) and a larger percentage of patients with coverage through Medicaid (19% vs. 15% overall) compared with the total group and each of the other community types. CAHs reported a smaller percentage of patients with private insurance (38% vs. 43% overall) and a larger percentage of patients with coverage through Medicare (36% vs. 31% overall) compared with the overall group and each of the other community types. All community types reported 7% to 8% of patients with no insurance coverage.

3. Number and Percentage of Hospitals Reporting Community Benefit Expenditures, by Expenditure Type within Community Type

485 of the 489 (99%) hospitals reported community benefit expenditures in one or more categories. Four hospitals did not report any expenditure amounts. This section reports percentages based on the 485 hospitals that reported expenditure amounts. Uncompensated care was the most commonly reported community benefit expenditure category overall and for each community type. Medical education and training was the next most common. Certain community programs were also widely provided such as lectures and community based

education, newsletters and publications, medical screening, and improving access to health care.

The table below shows the percentage of hospitals that reported the various types of community benefit expenditures.

Figure 25. Number and Percentage of Hospitals Reporting Community Benefit Expenditures by Expenditure Category and Community Type

Category of Community Benefit Expenditure	Community Type								Aggregate (N = 485)	
	High Population Hospitals		Critical Access Hospitals		Rural - Non Critical Access Hospitals		Other Hospitals			
	N	% of all hospitals in each category	N	% of all hospitals in each category	N	% of all hospitals in each category	N	% of all hospitals in each category	N	% of all hospitals
▪ Uncompensated Care	90	96%	64	94%	75	96%	237	95%	466	95%
▪ Medical, Education & Training	81	86%	41	60%	56	72%	200	80%	378	77%
▪ Medical Research	38	40%	**	**	**	**	60	24%	104	21%
▪ Lectures, seminars & education	67	71%	52	76%	66	85%	202	81%	387	79%
▪ Medical screening	67	71%	52	76%	63	81%	195	78%	377	77%
▪ Newsletter/ publications	71	76%	47	69%	64	82%	192	77%	374	76%
▪ Improving access to healthcare	64	68%	30	44%	43	55%	136	55%	273	56%
▪ Immunization programs	41	44%	33	49%	35	45%	93	37%	202	41%
▪ Other healthcare promotion	33	35%	21	31%	30	38%	70	28%	154	31%
▪ Studies on community's unmet health-care needs	30	32%	20	29%	14	18%	75	30%	139	28%
Total CBE		100%		100%		100%		100%		100%

**To prevent potential identification of respondent hospitals, the CAH and non-CAH rural hospitals were combined in calculating the number and percentage of hospitals reporting medical research expenditures. Within the combined rural hospitals category, 6 hospitals, 4%, reported research expenditures.

The percentage of hospitals reporting they provided specific types of community benefit generally did not vary materially across the community types. There were some exceptions. While 60% of CAHs reported providing medical education and training, at least 72% of hospitals in all the other categories reported doing so. In addition, 40% of hospitals in the high population group and 24% of hospitals in

the other urban and suburban category reported medical research expenditures, while 4% of rural hospitals reported such expenditures.

4. Aggregate Uncompensated Care by Community Type

The aggregate uncompensated care expenditures reported by 466 hospitals as a percentage of total revenues was 6.41%.[42] Uncompensated care expenditures were not evenly distributed by the hospitals in the study, but were concentrated in a relatively small number of hospitals. 14% of the hospitals reported 63% of the aggregate uncompensated care expenditures; 26% of the hospitals reported 82% of the aggregate uncompensated care expenditures.

Percentage of patients. Figure 26 shows the reported average and median percentages of patients receiving uncompensated care by the hospital's community type. The average and median percentages for the entire group were 9.8% and 3.4%, respectively.

Figure 26. Percentage of Patients Receiving Uncompensated Care by Community Type

Community Type	Number of hospitals	Average (%)	Median (%)
High population	86	11.2	6.0
Rural – CAH	59	6.7	1.9
Rural - Non CAH	73	8.4	1.7
Others	225	10.4	4.7
Total	443	9.8	3.4

Note: This table includes only those hospitals that reported the number of patients receiving uncompensated care.

Rural hospitals (CAH and non-CAH) reported lower average and median percentages than the other community types and the overall group. High population hospitals reported the highest average and median percentages of patients receiving uncompensated care.

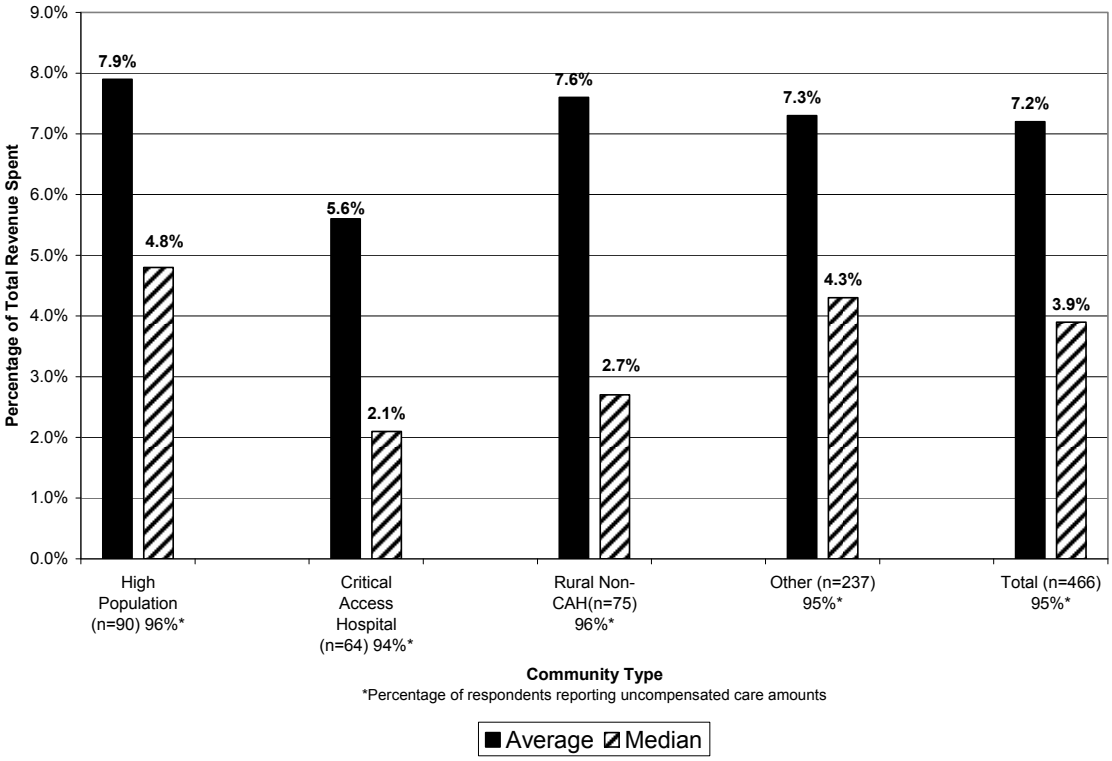
Percentage of revenues. Figure 27 and Figure 28 below show the average and median percentages of total revenue reported as spent by 466 hospitals on uncompensated care for each community type.

[42] This reflects total reported uncompensated care expenditures divided by total reported revenues for the entire group of 466 hospitals. This differs from the average and median percentages of individual hospitals' percentages reported below (e.g., Figure 27).

Figure 27. Percentage of Total Revenue Spent on Uncompensated Care by Community Type (Average and Medians) (n=466)

	Average	Median
High Population (n=90)	7.9%	4.8%
Critical Access (n=64)	5.6%	2.1%
Rural Non-CAH (n=75)	7.6%	2.7%
Other (n=237)	7.3%	4.3%
Total (n=466)	7.2%	3.9%

Figure 28. Percentage of Revenue Spent on Uncompensated Care by Community Type (Averages and Medians) (n=466)



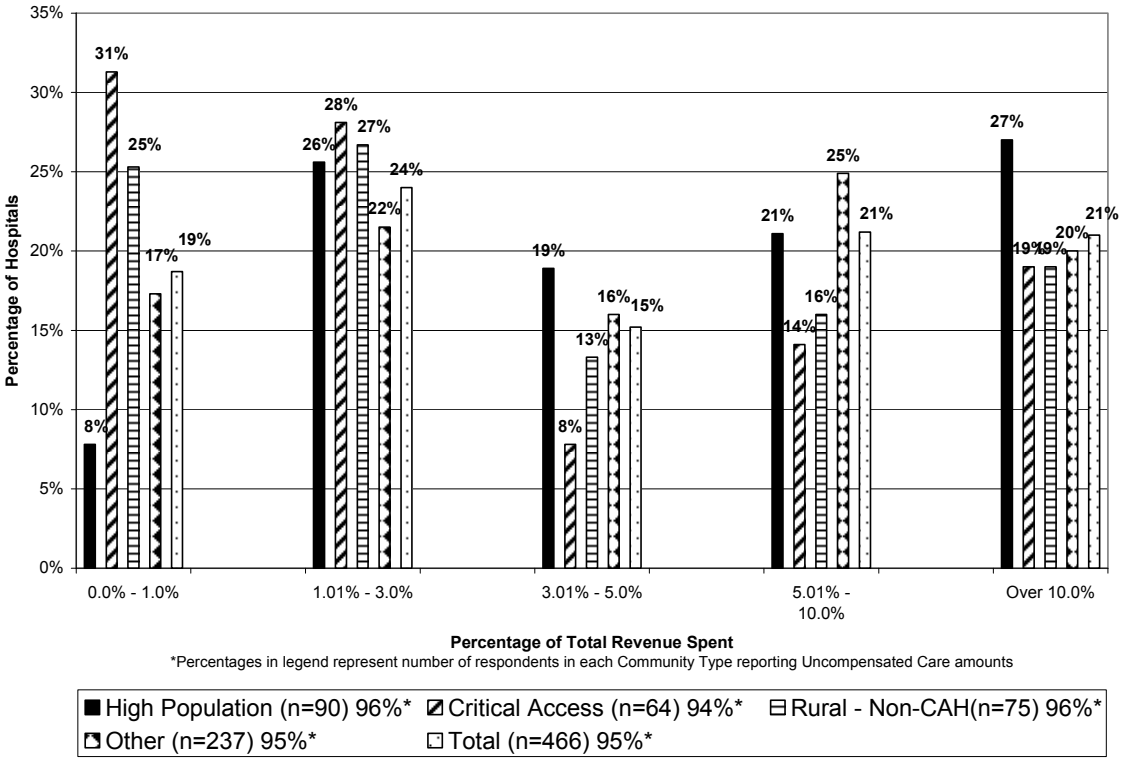
The median percentage of total revenue that was spent on uncompensated care is 3.9% and the average is 7.2%. All of the averages are between 7% and 8% with the exception of CAHs which reported an average of 5.6% of total revenue spent on uncompensated care. The medians are lower than the averages in all categories. This spread is widest in non-CAH rural hospitals where the average is 7.6% and the median is 2.7%. The medians range from 2.1% for CAHs to 4.8% for high population hospitals.

Figure 29 through Figure 32 show the percentage of hospitals within each community type that reported uncompensated care as a percentage of total revenues within certain ranges.

Figure 29. Number and Percentage of Hospitals with Reported Uncompensated Care as a Percentage of Total Revenue, by Community Type

Uncompensated Care Expenditure as Percentage of Total Revenues	Community Type								Overall	
	High Population		Critical Access		Rural-Non Critical Access		Other Hospitals			
	N	%	N	%	N	%	N	%	N	%
≤ 1%	7	8	20	31	19	25	41	17	87	19
Over 1% - ≤ 3%	23	26	18	28	20	27	51	22	112	24
Over 3% - ≤ 5%	17	19	5	8	10	13	39	16	71	15
Over 5% - ≤ 10%	19	21	9	14	12	16	59	25	99	21
> 10%	24	27	12	19	14	19	47	20	97	21
Total	90	100	64	100	75	100	237	100	466	100

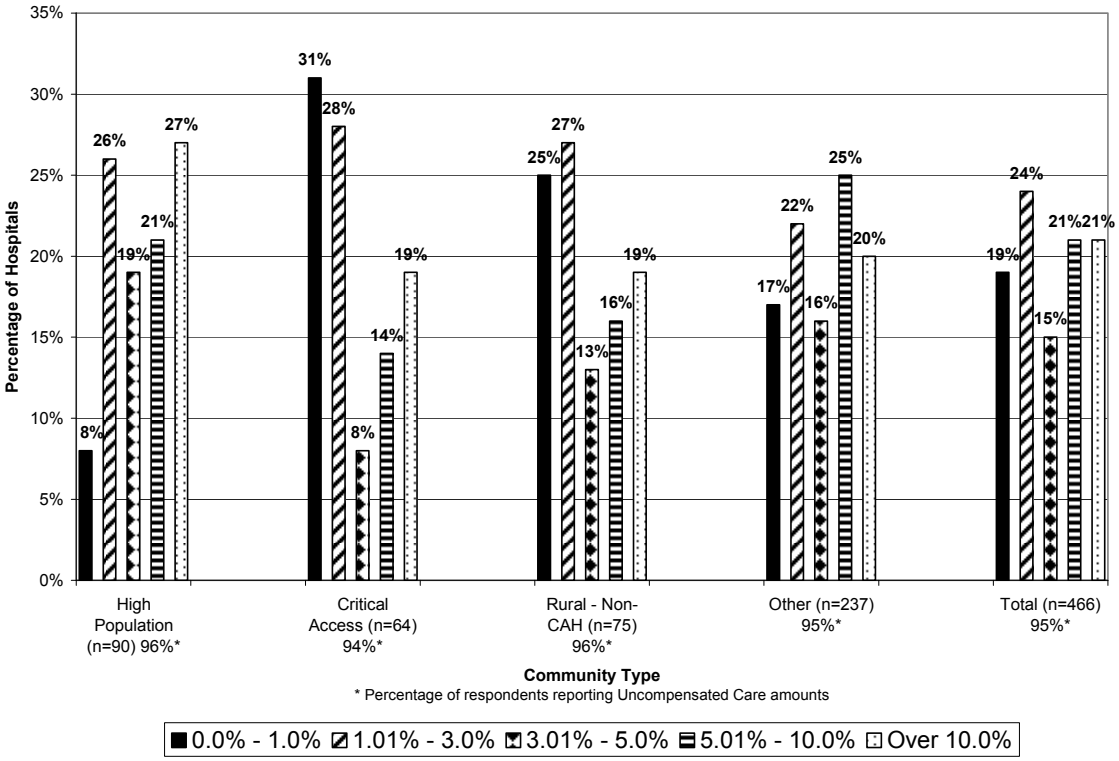
Figure 30. Distribution of Hospitals by Community Type Based on Percentage of Total Revenue Spent on Uncompensated Care (Averages) (n=466)



CAHs reported the highest percentage of hospitals in the low ranges (at or below 3%); high population hospitals reported the highest percentages of hospitals in the high range (over 10%).

8% of hospitals in high population areas reported spending 1% or less of their total revenue on uncompensated care while 31% of CAHs and 25% of non-CAH rural hospitals reported doing so. In the 1% to 3% of total revenue range, all categories of hospitals reported between 22% and 28%. High population and other urban and suburban hospitals reported the highest percentage of organizations in the 3% to 5% range, the 5% to 10% range, and the over 10% range.

Figure 31. Distribution of Hospitals by Community Type Based on Percentage of Total Revenue Spent on Uncompensated Care (Averages) (n=466)



While not shown in the chart above to prevent potential identification of respondent hospitals, a small number of hospitals in each community type reported spending over 50% of total revenues on community benefit expenditures.

Figure 32, below, shows the percentage of hospitals (on a cumulative basis) reporting uncompensated care expenditures at or less than specified percentage of revenue levels.

Figure 32. Percentage of Hospitals Reporting Uncompensated Care Expenditures at or Less Than Specified Percentage of Revenue Levels

Community Type	≤1%	≤3%	≤5%	≤10%
High population	8%	33%	52%	73%
CAHs	31%	59%	67%	81%
Rural (non-CAHs)	25%	52%	65%	81%
Other	17%	39%	55%	80%
Total	19%	43%	58%	79%

As Figure 32 shows, between one half and two thirds of the hospitals in each community type reported 5% or less of total revenues as spent on uncompensated care. Over one half of the rural hospitals reported uncompensated care expenditures of less than 3% of total revenues.

See Section VI.C.1, below, for an analysis of the reporting of various shortfalls and bad debt as uncompensated care by community type.

5. Aggregate Medical Research Expenditures by Community Type

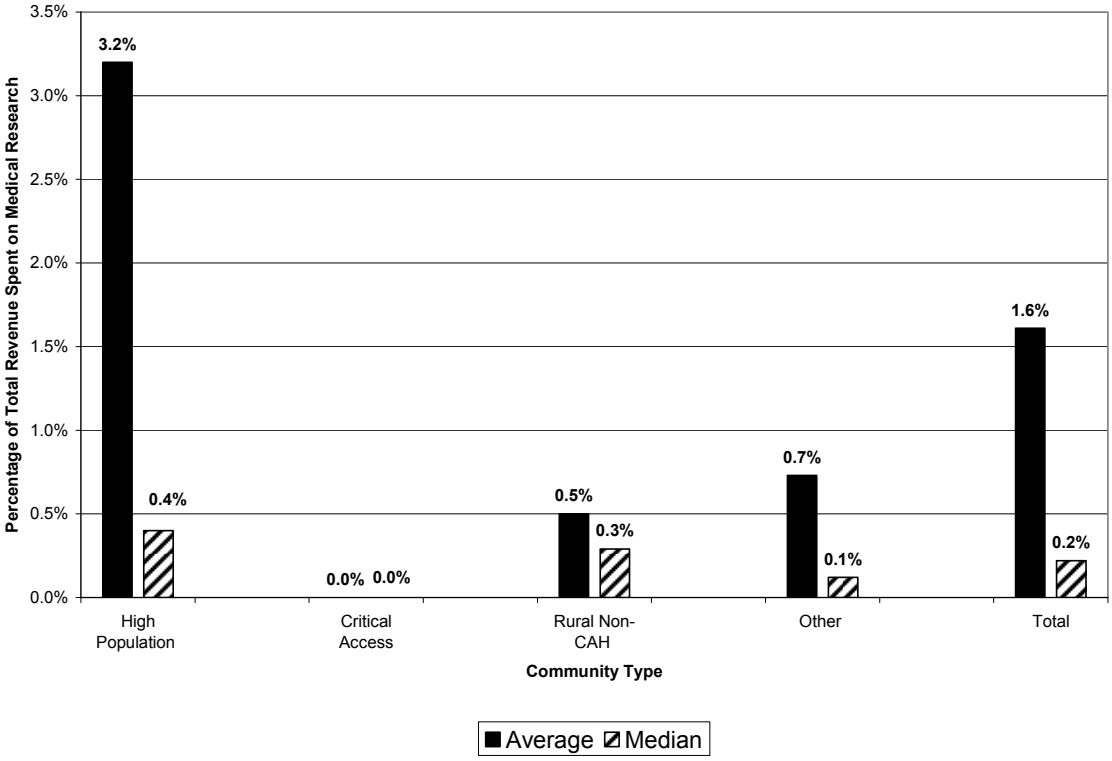
117 hospitals (24%) reported conducting medical research, but only 104 actually reported medical research expenditure amounts. The aggregate medical research expenditures reported by hospitals that reported such amounts was 3.48% of total revenues.[43] The average and median percentages of medical research expenditures as a percentage of total revenues were 1.6% and 0.2%, respectively.

A group of 15 hospitals reported 93% of the overall reported medical research expenditures. See Section VI.B, below, for an analysis of community benefit expenditures of this group.

Figure 33, below, shows the average and median percentages of total revenue that hospitals reported as spent on medical research across the community types. This chart includes only those 104 hospitals that reported an expenditure amount for medical research.

[43] This represents the total medical research expenditures divided by the total revenues for the entire group of 104 hospitals. This differs from the median and average percentages of the individual hospitals' percentages.

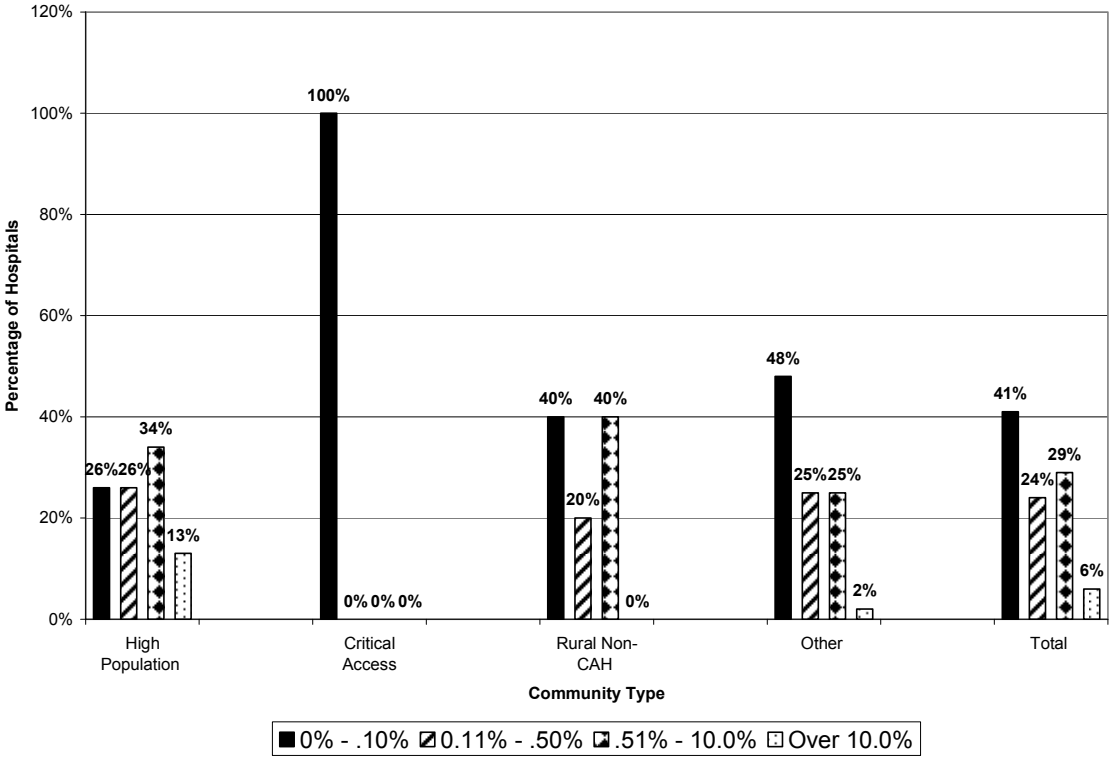
Figure 33. Percentage of Total Revenue Spent on Medical Research by Community Type (Averages and Medians) (n=104)



All of the medians are less than 0.5% and all the averages except for hospitals in the high population community type (and overall) are less than 1%. Hospitals in high population areas reported an average percentage of total revenue spent on medical research of 3.2%. A few hospitals in the high population category with comparatively large reported research expenditures as a percentage of their total revenues explains the significant variation between average and median amounts for this group and overall.

Figure 34 provides a breakdown of total revenue spent on medical research by the respondent group in four percentage bands by community type.

Figure 34. Distribution of Hospitals by Community Type Based on Percentage of Total Revenues Spent on Medical Research (n=104)



41% of the hospitals in the sample reported spending 0.1% or less of their total revenue on medical research. 24% reported spending between 0.11% and 0.5%, and 29% reported spending between 0.51% and 10%. 6% of hospitals reported spending more than 10% of their total revenue on medical research. No general pattern describes the reported data across community types.

6. Aggregate Medical Education and Training Expenditures by Community Type

77% of the hospitals reported medical education and training expenditures. The aggregate medical education and training expenditures reported as spent by these hospitals was 3.37% of total revenues.[44] The average and median percentages of medical education and training expenditures reported by 378 hospitals as a percentage of revenues were 1.3% and 0.3%, respectively.[45]

Figure 35 shows the average and median percentages of total revenue spent on medical education and training across community types.

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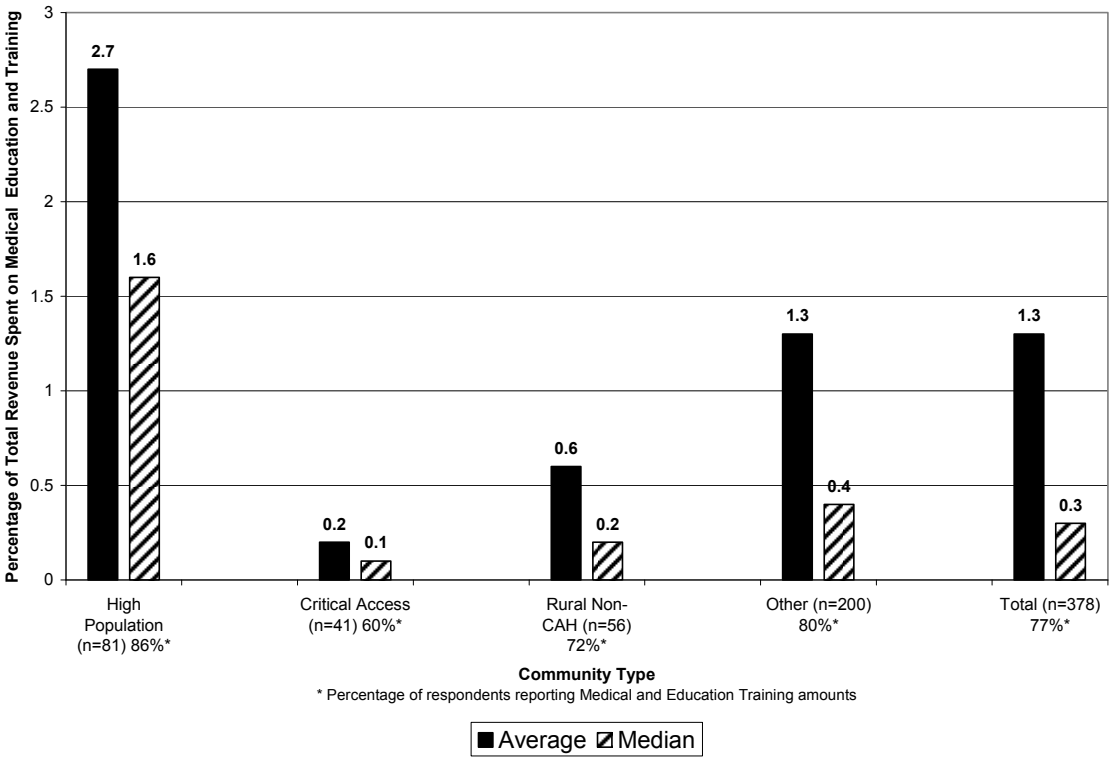
[44] This represents the total medical education and training expenditures divided by total revenues for the entire group of 378 hospitals.

[45] The group of 15 hospitals that reported 93% of the aggregate reported medical research expenditures also reported 58% of the aggregate reported medical education and training expenditures (see Section VI.B, below).

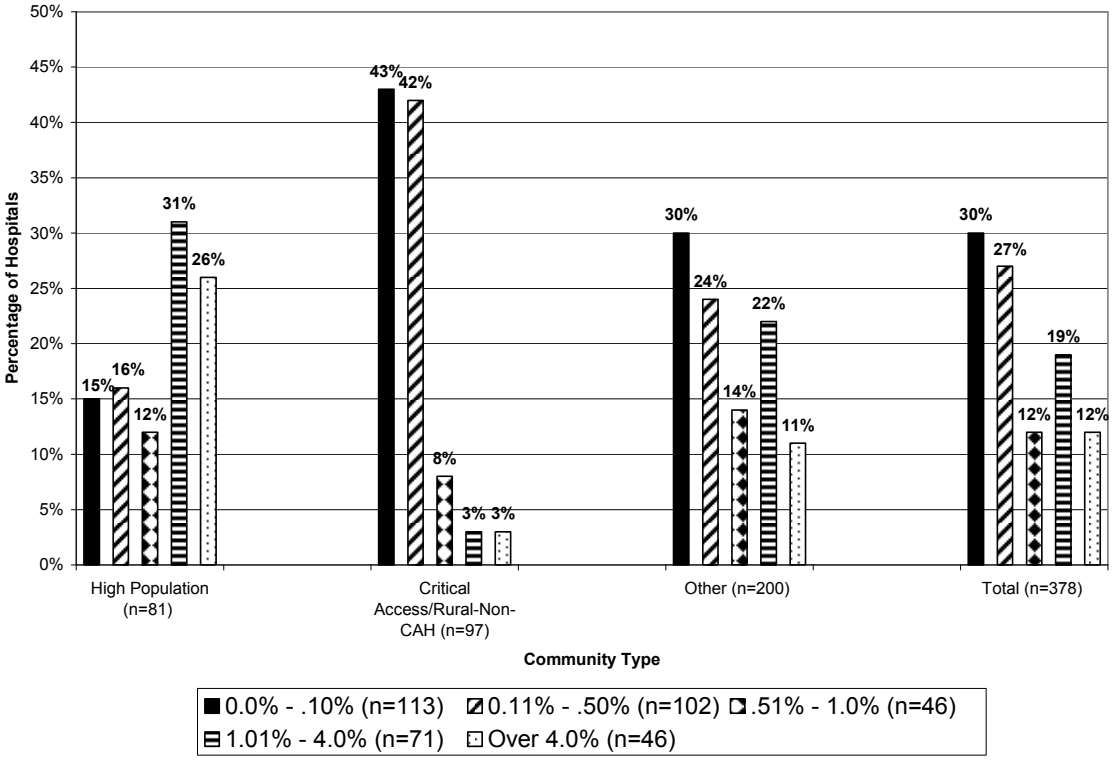
Figure 35. Percentage of Total Revenue Spent on Medical Education and Training by Community Type (Averages and Medians) (n=378)



Hospitals in high population areas and hospitals in other urban and suburban areas reported higher average and median percentages of total revenue spent on medical education and training than the rural hospitals in the study.

As Figure 36, below, shows, most hospitals (57%) reporting revenue spent on medical education and training reported spending no more than 0.5% of their total revenue on such activities. 12% reported spending over 4% on medical education and training.

Figure 36. Distribution of Hospitals by Community Type Based on Percentage of Revenues Spent on Medical Education and Training (Averages) (n=378)



In the figure above, the two categories of rural hospitals were combined to prevent potential identification of respondent hospitals. 93% of CAHs and 81% of non-CAH rural hospitals reported spending in the two lowest categories (i.e., 0.5% or less spent on medical education and training). 57% of hospitals in high population areas reported spending in the two highest ranges (i.e., over 1% spent on medical education and training).

7. Aggregate Community Program Expenditures by Community Type

The category of community program expenditures consists of seven separate sub-types: lectures, seminars and education; medical screening; newsletters and publications; improving access to health care; immunization programs; studies on community's unmet health care needs; and other health care promotion.

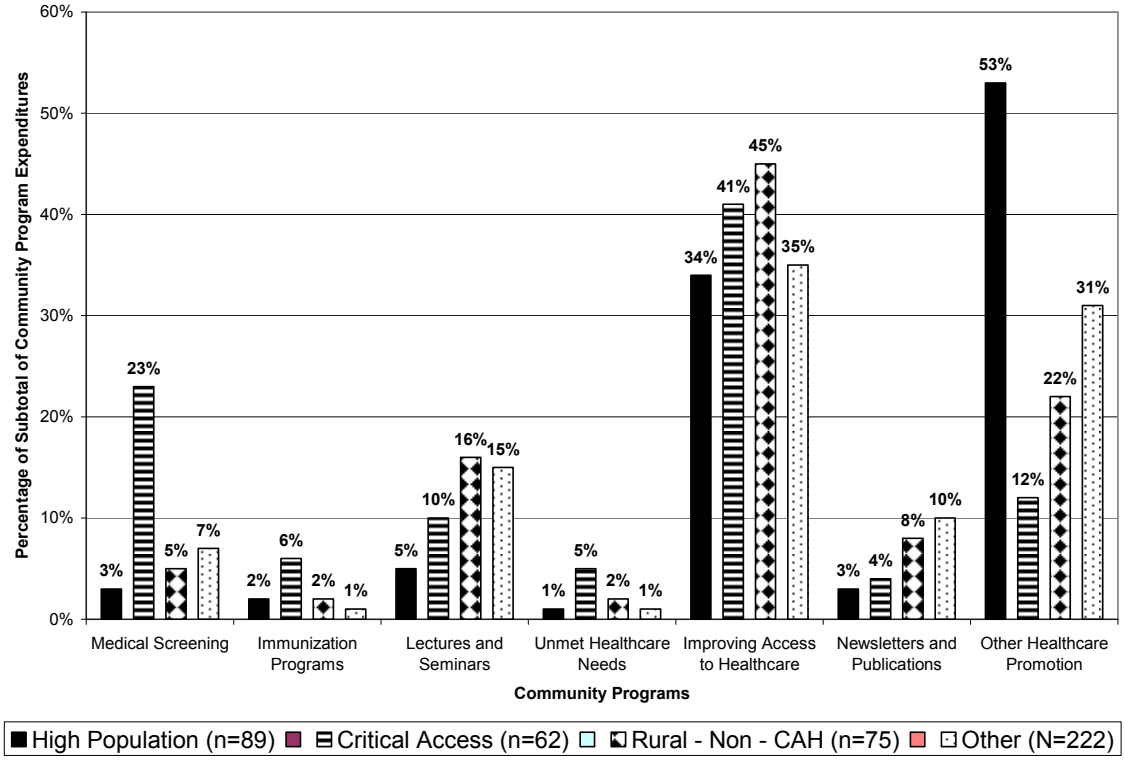
The following table summarizes community program expenditures by individual community type.

Figure 37. Amounts and Percentages of Community Program Expenditures, by Expenditure Category and Community Type

Community Program Expenditure	Community Type								Aggregate	
	High Population (N = 89)		Critical Access (N = 62)		Rural - Non Critical Access (N = 75)		Other Urban & Suburban (N = 222)		(N = 448)	
	Amount (in $ million)	% of total CPE	Amount (in $ million)	% of total CPE	Amount (in $ million)	% of total CPE	Amount (in $ million)	% of total CPE	Amount (in $ million)	% of total CPE
▪ Other healthcare promotion	174.0	53%	3.3	12%	6.9	22%	61.3	31%	245.5	42%
▪ Improving access to healthcare	111.4	34%	11.6	41%	14.3	45%	70.3	35%	207.6	35%
▪ Lectures, seminars, and education	15.5	5%	2.7	10%	5.1	16%	30.9	15%	54.2	9%
▪ Medical screening	11.1	3%	6.4	23%	1.7	5%	13.2	7%	32.4	6%
▪ Newsletter/ publications	8.5	3%	1.1	4%	2.7	8%	19.6	10%	31.9	5%
▪ Immunization programs	7.6	2%	1.8	6%	0.6	2%	2.0	1%	12.0	2%
▪ Studies on community's unmet healthcare needs	1.8	1%	1.4	5%	0.5	2%	2.7	1%	6.4	1%
Total Community Program Expenditures	329.9	100%	28.3	100%	31.8	100%	200.0	100%	590.0	100%

Figure 38, below, shows the distribution of community program expenditures broken out by expenditure category and community type.

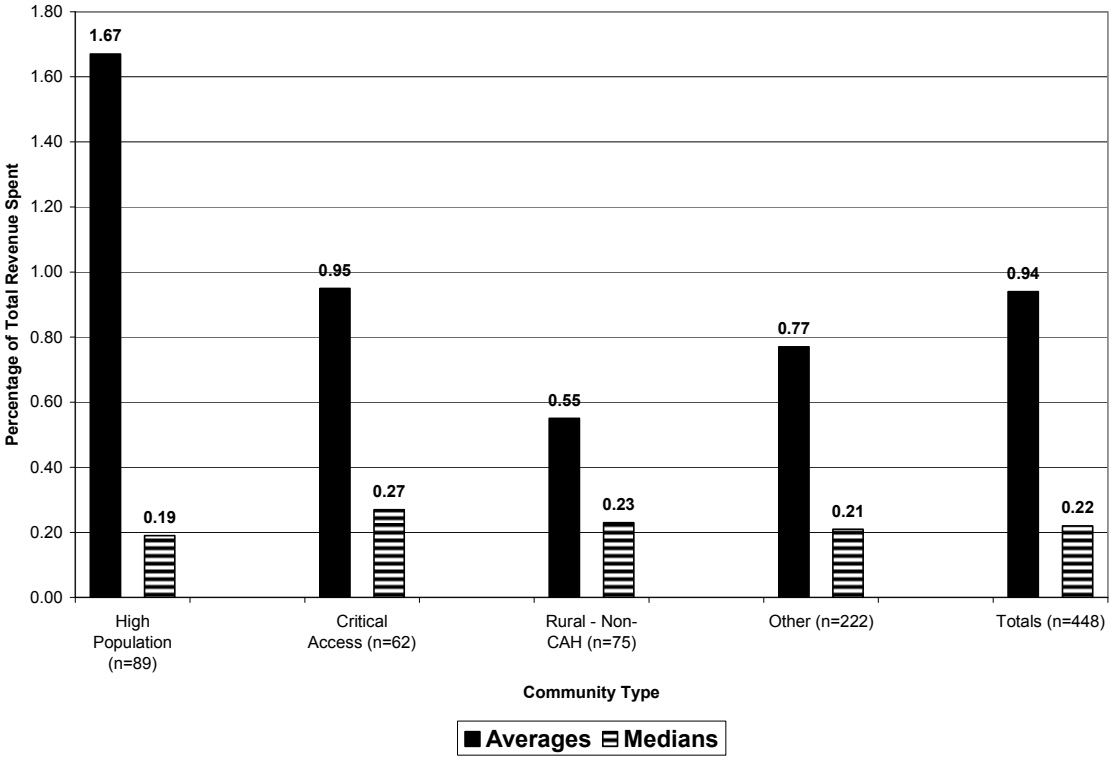
Figure 38. Percentages of Community Program Expenditures by Expenditure Category and Community Type (n=448)



The table and chart illustrate there is considerable variation across the community types regarding expenditures for the various components of community programs. For example, high population area hospitals reported 53% of their community program expenditures on other health care promotion and 3% on medical screening, whereas CAHs reported spending 12% and 23% respectively, of community program expenditures on those items.

Figure 39, below, shows the average and median percentages of total revenues spent on community programs by community type.

Figure 39. Percentage of Total Revenues Spent on Community Programs by Community Type (Averages and Medians) (n=448)



8. Aggregate Community Benefit Expenditures by Community Type

The entire respondent group of 485 hospitals reported aggregate community benefit expenditures of $9.4 billion. Uncompensated care was reported at $5.2 billion, medical education and training at $2.2 billion, medical research at $1.4 billion, and community programs at $0.6 billion. Aggregate community benefit expenditures were not evenly distributed by the hospitals in the study, but were concentrated in a relatively small number of hospitals. 9% of the hospitals reported 60% of the aggregate community benefit expenditures; 19% of the hospitals reported 78% of the aggregate community benefit expenditures.

Figure 40 and Figure 41, below, break down aggregate community benefit expenditure by community type, and provide a community benefit expenditure profile or mix showing the percentage of community benefit expenditures for each community type that is comprised of reported uncompensated care, medical education and training, medical research, and community programs.[46]

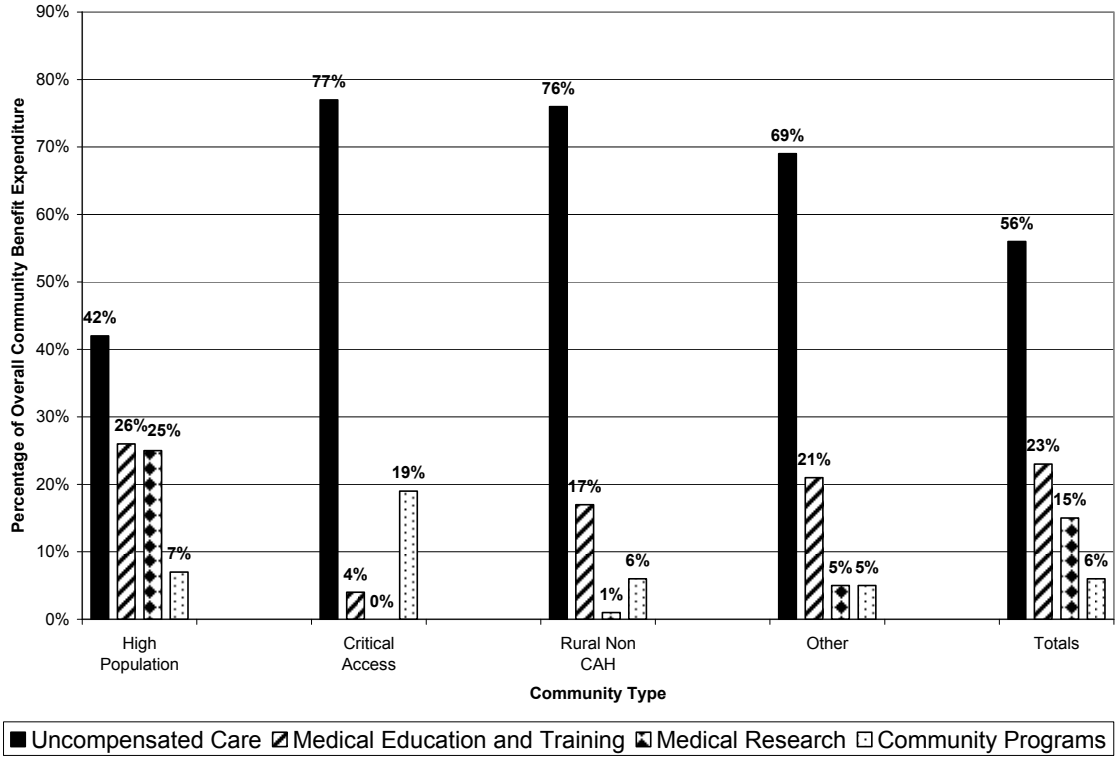
[46] The mix of community benefit expenditures changes when the group of 15 hospitals reporting 93% of aggregate reported medical research expenditures is isolated. See Section VI.B, below.

Figure 40. Amounts and Percentages of Total Community Benefit Expenditures by Expenditure Category and Community Type

Community Benefit Expenditure	Community Type								Aggregate (N = 485)	
	High Population		Critical Access		Rural - Non Critical Access		Other Urban & Suburban			
	Amount (in $ million)	% of total CBE	Amount (in $ million)	% of total CBE	Amount (in $ million)	% of total CBE	Amount (in $ million)	% of total CBE	Amount (in $ million)	% of total CBE
▪ Uncompensated Care	2,043.0	42%	115.9	77%	415.2	76%	2,653.3	69%	5,227.5	56%
▪ Medical, Education & Training	1,248.4	26%	5.7	4%	92.5	17%	817.9	21%	2,164.5	23%
▪ Medical Research	1,232.6	25%	0.0	0%	6.2	1%	173.3	5%	1,412.1	15%
▪ Community Programs	329.9	7%	28.3	19%	31.8	6%	200.0	5%	590.0	6%
Total Community Benefit Expenditures	4,853.9	100%	149.9	100%	545.7	100%	3,844.5	100%	9,394.1	100%

Figure 40 shows the distribution of aggregate reported community benefit expenditures across the community types in absolute dollars. Rural hospitals (CAH and other) comprised 30% of the hospitals, but reported 7% of aggregate community benefit expenditures. The amounts reported as spent on medical education and training, and on medical research, by rural hospitals were low compared to the other community types. High population hospitals comprised 19% of the hospitals, but reported 52% of aggregate community benefit expenditures, 87% of all amounts reported as spent on medical research, and 58% of amounts reported as spent on medical education and training.

Figure 41. Percentage of Community Benefit Expenditures by Expenditure Category and Community Type (n=485)



There are material differences in community benefit expenditure profiles across the community types. One contrast among the different types is that hospitals in the high population areas reported spending more than half (51%) of their community benefit expenditures on medical education and training and medical research. The hospitals in the other categories spent considerably less in these areas. 42% of the reported spending on community benefit expenditures for hospitals in the high population areas was spent on uncompensated care, compared to 69% to 77% for uncompensated care by the other community types. CAHs reported spending 19% of their community benefit expenditures on community programs compared to 5% to 7% for the other community types.

Figure 42, below, reports the average and median percentage of total revenue reported as spent on community benefit expenditures, by category and community type.[47]

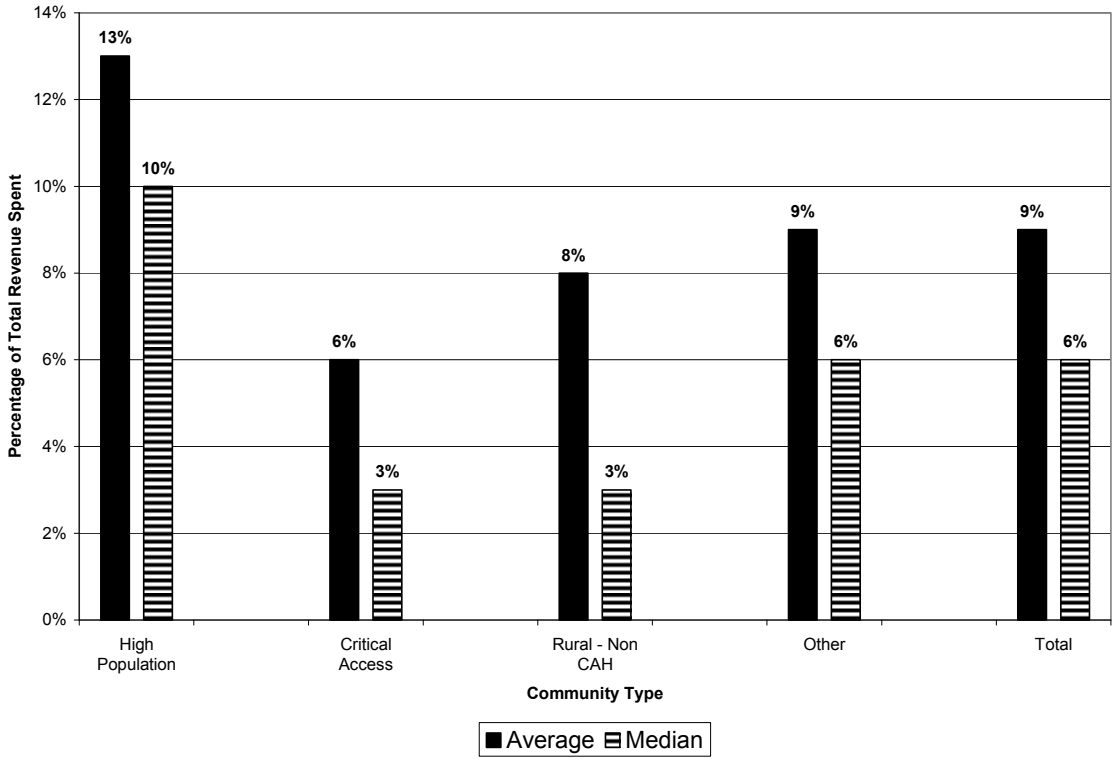
[47] The results change when the group of 15 hospitals that reported 93% of aggregate reported medical research expenditures is isolated. See Section VI.B, below.

Figure 42. Average and Median Percentage of Total Revenue Spent on Community Benefit Expenditures by Expenditure Category and Community Type

Category of Community Benefit Expenditure	Community Type								Aggregate (N = 485)	
	High Population Hospitals		Rural - Critical Access Hospitals		Rural - Non Critical Access Hospitals		Other Hospitals			
	Average (%)	Median (%)	Average (%)	Median (%)	Average (%)	Median (%)	Average (%)	Median (%)	Average (%)	Median (%)
▪ Uncompensated Care (N= 466)	7.88	4.82	5.59	2.14	7.57	2.74	7.28	4.33	7.21	3.88
▪ Medical, Education & Training (N = 378)	2.66	1.63	0.19	0.09	0.59	0.19	1.25	0.39	1.34	0.34
▪ Medical Research (N=104)	3.18	0.39	0.00	0.00	0.45	0.29	0.73	0.12	1.61	0.22
▪ Total Community Program Expenditures (N = 448)	1.67	0.19	0.95	0.27	0.55	0.23	0.77	0.21	0.94	0.22
Total Community Benefit Expenditures	12.70	9.84	6.33	2.84	8.36	3.17	8.87	5.75	9.18	5.50

Figure 43 below shows the (rounded) average and median total revenues spent on community benefit expenditures by community type.

Figure 43. Average and Median of Total Revenue Spent on Community Benefit Expenditures by Community Type (Averages and Medians) (n=485)



The average and median reported aggregate community benefit expenditures as a percentage of total revenues were 9% and 6%, respectively, for the entire group. The highest reported average and median amounts were for the high population group (13% and 10%, respectively), and the lowest were for the CAH group (6% and 3%, respectively).

Figure 44 and Figure 45, below, show the percentages of revenue (average and median) spent on various community benefit expenditures by expenditure and community type.

Figure 44. Percentage of Total Revenue Spent on Various Community Benefit Expenditures by Expenditure and Community Type (Averages) (n=485)

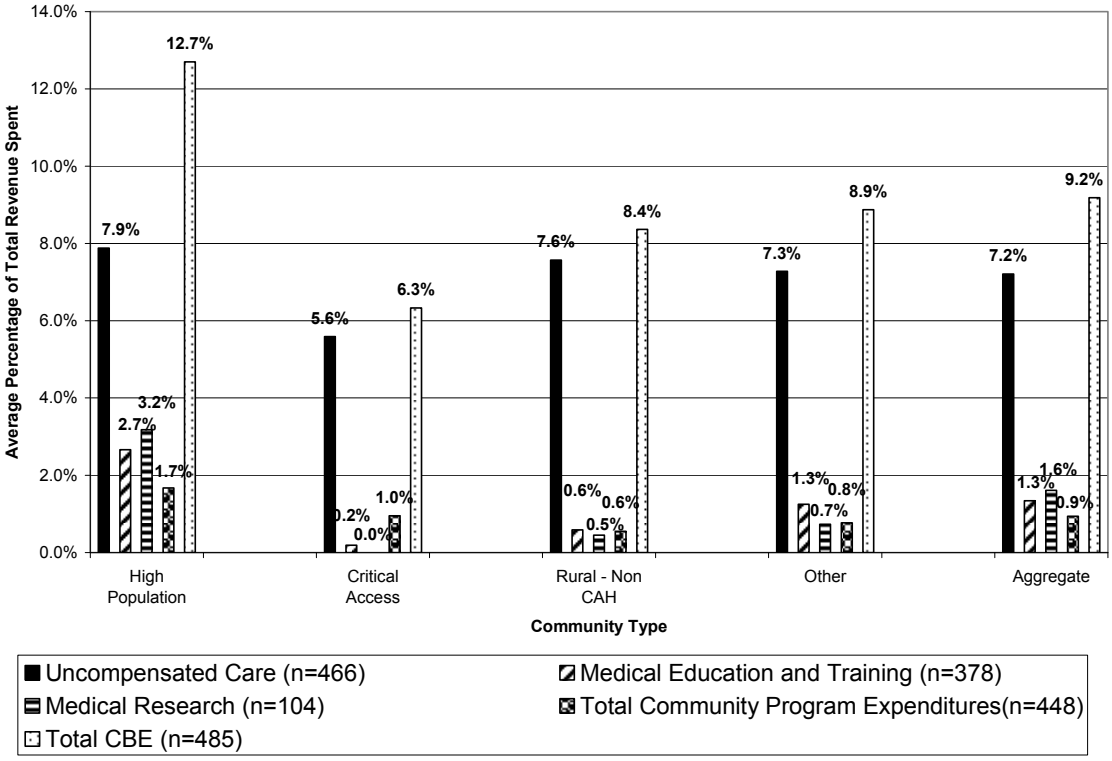
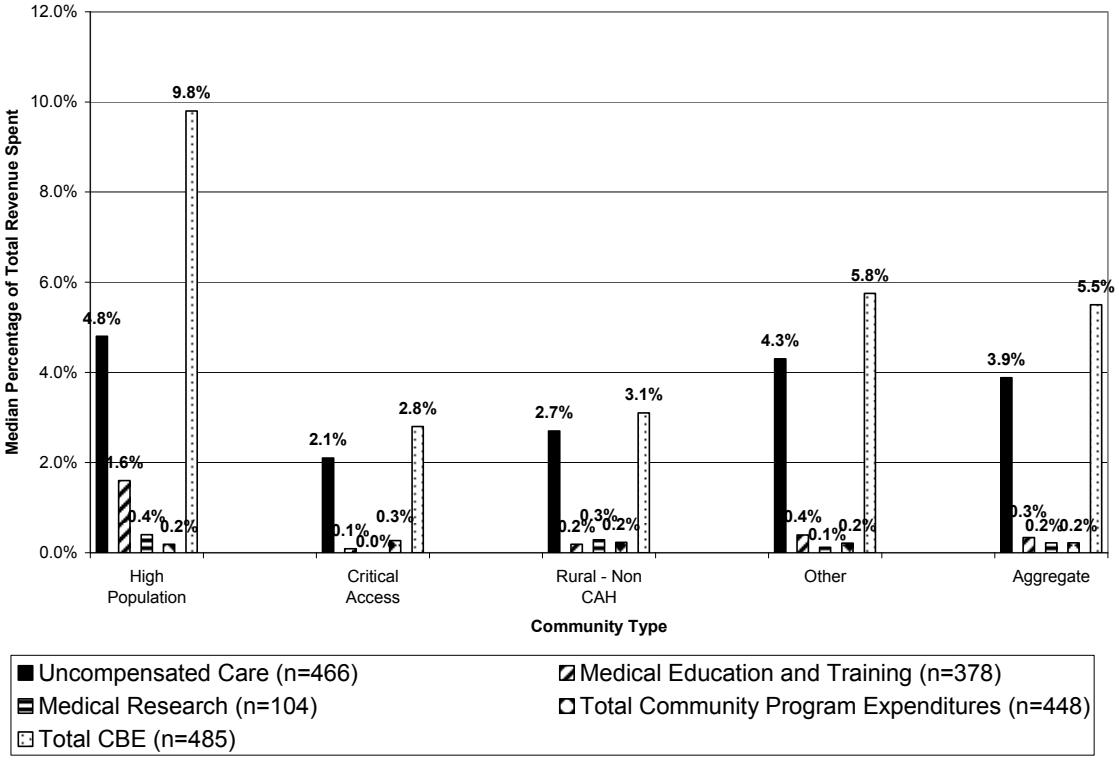


Figure 45. Percentage of Total Revenues Spent on Various Community Benefit Expenditures by Expenditure and Community Type (Medians) (n=485)



9. Aggregate Community Benefit Expenditures as a Percentage of Revenues

This section summarizes the distribution of aggregate community benefit reporting across the community types. Figure 46, Figure 47, and Figure 48 show the distribution of hospitals, by community type, with reported community benefit expenditures within specified percentages of total revenue ranges. Figure 49 displays the cumulative percentage of hospitals within each community type that reported aggregate community benefit expenditures as a percentage of total revenues at or less than specified levels (e.g., less than 5% of total revenues).

Figure 46. Number and Percentage of Hospitals with Reported Community Benefit Expenditures as Percentage of Total Revenue, by Community Type

Total Community Benefit Expenditure as Percentage of Total Revenues	Community Type									
	High Population Hospitals		Rural - Critical Access Hospitals		Rural-Non Critical Access Hospitals		Other Hospitals		All Hospitals	
	N	%	N	%	N	%	N	%	N	%
< 2%	10	11	*	39	*	31	41	17	101	21
2% - < 5%	20	21	*	22	*	26	73	29	128	26
5% - < 10%	18	19	*	19	*	22	65	26	113	23
10% - < 20%	29	31	*	14	*	13	51	21	99	21
≥ 20%	17	18	*	6	*	8	17	7	44	9
Total	94	100	*	100	*	100	247	100	485	100

* Not shown to prevent potential identification of respondent hospitals.

21% of all hospitals reported aggregate community benefit expenditures of less than 2% of total revenues; 47% reported aggregate community benefit expenditures of less than 5% of total revenues. Figure 47 and Figure 48, below, illustrate the variations across community types reported in the above table.

Figure 47. Percentage of Hospitals with Reported Community Benefit Expenditures as Percentage of Total Revenue by Community Type (n=485)

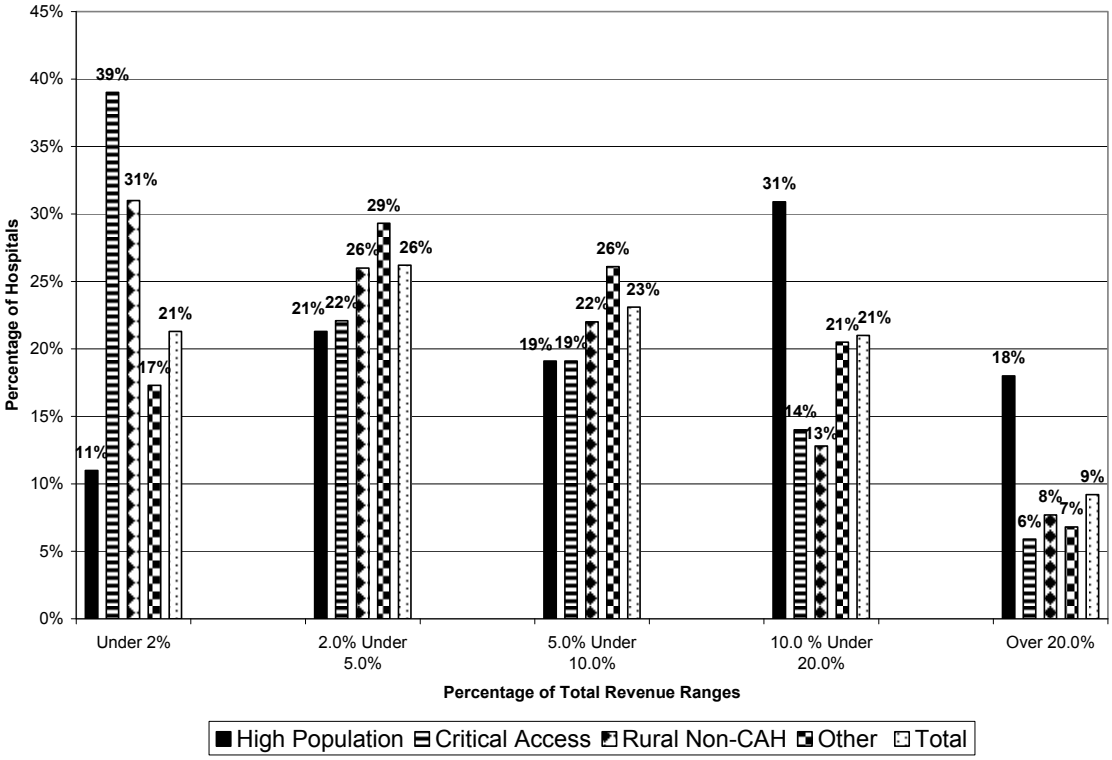
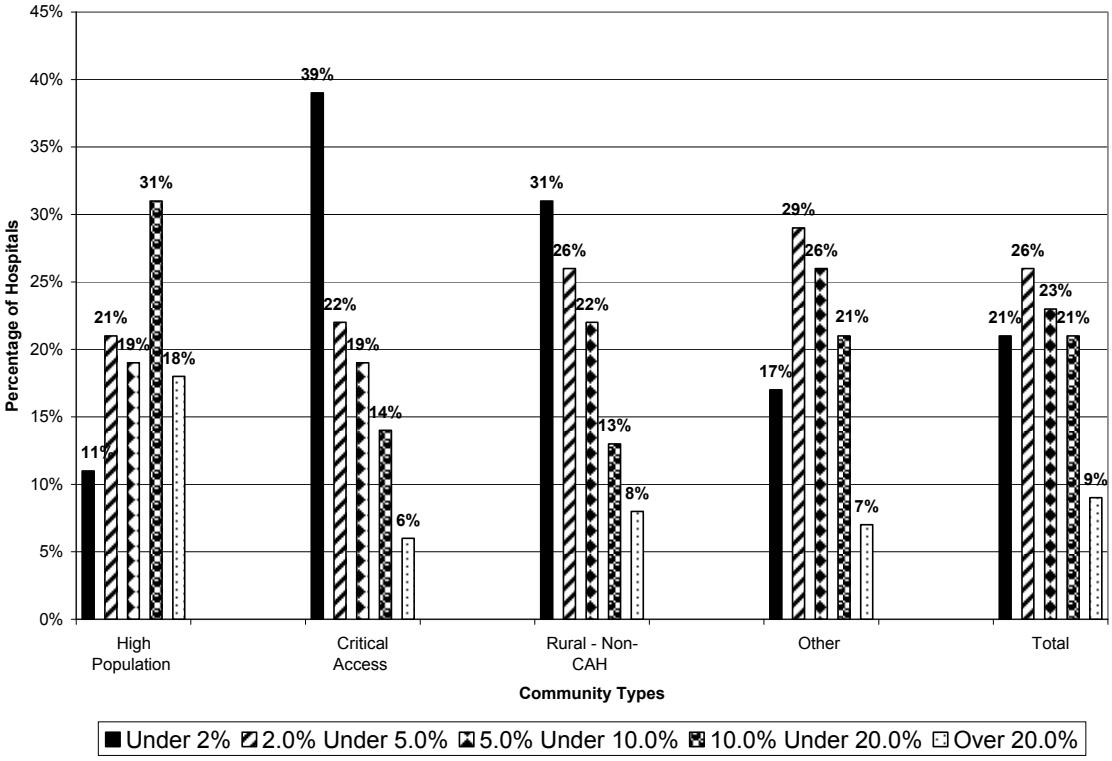


Figure 48. Percentage of Hospitals with Reported Community Benefit Expenditures as Percentage of Total Revenue by Community Type (n=485)



The figures above show the distribution of hospitals that reported spending a certain percentage of their total revenue on community benefit expenditures within specified ranges by community types. The percentage of hospitals in the high population areas that reported spending at least 10% of revenues was 49%, compared to 21% or less for rural hospitals. The percentages of CAHs and rural (non-CAH) hospitals that reported spending less than 5% of total revenues on community benefit expenditures were 61% and 57%, respectively, compared to 32% for high population hospitals.

Figure 49, below, shows, on a cumulative basis, the percentage of hospitals reporting community benefit expenditures at or less than specified percentages of revenue levels.

Figure 49. Percentage of Hospitals Reporting Community Benefit Expenditures Less Than Specified Percentage of Revenue Levels

Community Type	<2%	<5%	<10%
High population	11%	32%	51%
CAHs	39%	61%	81%
Rural (non-CAHs)	31%	57%	79%
Other	17%	46%	72%
Total	21%	47%	71%

Figure 49 shows that 21% of all hospitals reported spending less than 2% of total revenues on aggregate community benefit expenditures. 47% reported spending less than 5% of total revenues on community benefit expenditures. CAHs and rural (non-CAH) hospitals included the highest percentage of hospitals that reported community benefit expenditures below the 2% and 5% of total revenue levels. 49% of high population hospitals reported spending at least 10% of total revenues on community benefit expenditures, compared to 30% of hospitals overall.

C. Comparisons of Certain Information By Annual Revenue Size[48]

1. Summary of Key Findings – Revenue Size

a. The patient mix for each revenue size category generally followed that for the overall group – in descending order, private insurance, Medicare, Medicaid, uninsured, and other public programs. Each revenue size reported 7% to 9% of patients with no health insurance coverage. Hospitals with revenues under $25 million reported the highest percentage of Medicare patients (37% compared to 31% overall), and hospitals with revenues over $500 million reported the highest percentage of Medicaid patients (21% compared to 15% overall).

b. Between 92% and 98% of each revenue size category reported uncompensated care expenditures. Participation in most expenditure types was lowest for hospitals with under $25 million in revenues, and in many instances (medical education and training, medical research, and certain community programs) generally increased with revenue size. Participation in medical research ranged from under 10% of hospitals (those under $100 million in revenues) to 67% of hospitals (those over $500 million in revenues).

c. The median percentage of patients reported as receiving uncompensated care was 3% overall, but was highest for the larger revenue size categories (10% for revenues between $250 million and $500 million and 5% for revenues over $500 million). Four of the revenue size groups (hospitals with revenues between $250 million and $500 million were the exception) reported higher percentages of patients without insurance than their median percentages of patients receiving uncompensated care. Each revenue size reported higher average percentages of patients receiving uncompensated care than percentages of patients without insurance.

d. The average and median percentages of total revenues reported as spent on uncompensated care were 7% and 4%, respectively. The averages ranged from 6% to 9%; the medians ranged from 3% to 6%. Although the median percentages generally increased with revenue size, there was no correlation between size and the average percentage of total revenue spent on uncompensated care. The percentage of hospitals reporting uncompensated care expenditures at 3% or less of total revenues was 43% overall, and ranged from 33% to 49%, decreasing as hospital size increased. The percentage of hospitals reporting uncompensated care expenditures at 5% or less of

[48] For a description of the revenue size categories, see Section II.D, above.

total revenues was 58% overall, ranging from 49% to 61%, with no correlation to revenue size.

e. Uncompensated care represented the largest community benefit expenditure for the overall group (56%) and for each revenue size. However, the percentage of overall community benefit expenditures reported as spent on uncompensated care decreased with revenue size, ranging from 35% for hospitals with revenues over $500 million to 93% for hospitals with revenues under $25 million. The mix of community benefit expenditures among uncompensated care, medical research, medical education and training, and community programs varied considerably across revenue size categories.

f. The average and median percentages of total revenues reported as spent on medical research, and on medical education and training, varied considerably across revenue sizes. Average and median percentages of total revenues spent on medical education and training and on medical research were largest for hospitals with over $500 million in revenues. 15 hospitals reported 93% of the aggregate reported medical research expenditures. This group reported 58% of the aggregate reported medical education and training expenditures.

g. There was considerable variation across revenue sizes regarding community program expenditures. However, each revenue size category reported spending most of its community program expenditures on improving access to health care and other health care promotion.

h. The median percentage of total revenue reported as spent on aggregate community benefit expenditures increased with revenue size, ranging from 3% for hospitals with revenues under $25 million to 11% for hospitals with revenues over $500 million. The average percentage generally increased with revenue size. The overall median and average percentages were 5.5% and 9.2%, respectively.

i. The percentage of hospitals reporting spending less than 2%, and less than 5%, of total revenues on community benefit expenditures decreased with revenue size. 34% of hospitals with revenues under $25 million reported spending less than 2% of revenues on community benefit expenditures, compared to 5% of hospitals with revenues over $250 million. 60% of hospitals with revenues under $25 million reported spending less than 5% of total revenues on community benefit expenditures, compared to 47% overall.

2. Patient Mix (Based on Type of Insurance Coverage) by Revenue Size

Overall, hospitals reported that 43% of their patients had private insurance, 31% were covered by Medicare, 15% were covered by Medicaid, 3% were covered by other public insurance programs, and 8% were uninsured.[49] The following figures show breakouts of this distribution of types of patient insurance coverage across the five revenue categories.

Figure 50. Distribution of Health Insurance Coverage by Revenue Size Categories*

Revenue Size Category	Category of Health Insurance Coverage				
	Private Insurance (%)	Medicare (%)	Medicaid (%)	Other Public Insurance (%)	No Health Insurance (%)
Under $25M	35.1%	37.2%	15.6%	4.6%	9.2%
$25M under $100M	43.2%	30.1%	15.4%	2.5%	7.4%
$100M under $250M	46.5%	31.7%	13.1%	2.9%	6.8%
$250M under $500M	47.1%	27.5%	14.7%	2.1%	7.8%
Over $500M	45.5%	23.4%	20.6%	2.8%	8.3%
All patients	43.3%	31.0%	15.1%	2.9%	7.7%

* Some hospitals reported total patient amounts that did not equal the total number of patients reported in the various health insurance coverage categories.

[49] According to the U.S. Census Bureau, the percentage of individuals without health insurance in 2005 was 15.3%. U.S. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement (as revised March 2007).

Figure 51. Percentage of Patients with Insurance Coverage by Total Revenue Category, by Type of Coverage (n=479)

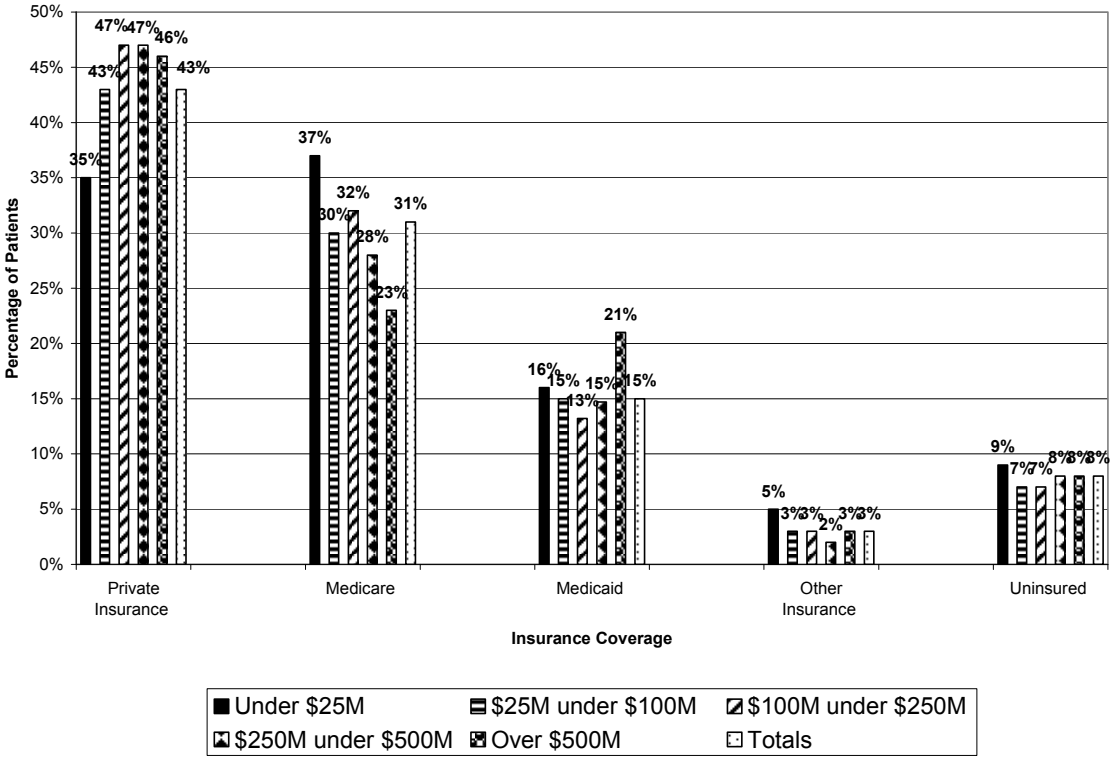
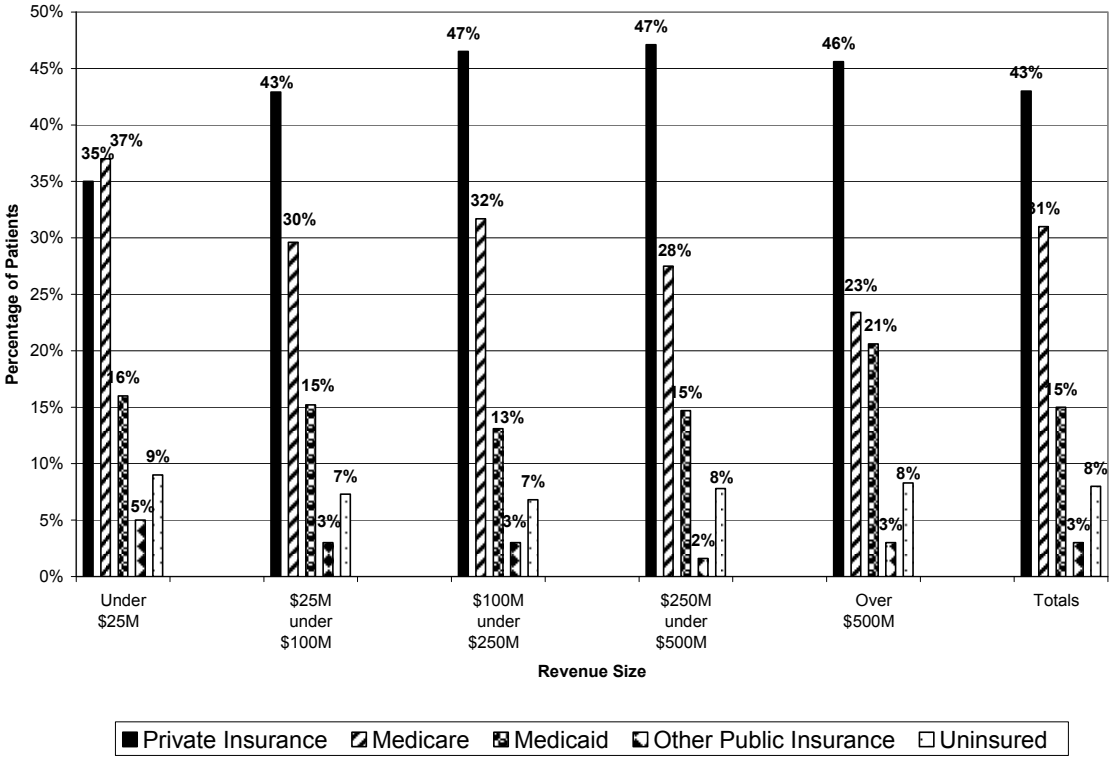


Figure 52. Percentage of Patients by Type of Insurance Coverage, by Total Revenue Size (n=479)



The distribution of types of coverage across the various revenue categories is similar to the distribution of the entire group. However, the hospitals with total revenues over $500 million reported a smaller percentage of patients with coverage through Medicare (23% vs. 31%) and a larger percentage of patients with coverage through Medicaid (21% vs. 15%) compared with the total group. Hospitals with total revenue under $25 million reported a smaller percentage of patients with private insurance (35% vs. 43%) and a larger percentage of patients with coverage through Medicare (37% vs. 31%) compared with the total group. Each revenue size category reported 7% to 9% of patients with no insurance coverage.

3. Number and Percentage of Hospitals Reporting Community Benefit Expenditures, by Expenditure Type within Revenue Size

The table below shows the percentages of hospitals that reported the various types of community benefit expenditures.

Figure 53. Number and Percentage of Hospitals Reporting Community Benefit Expenditures by Expenditure Category and Revenue Size

Category of Community Benefit Expenditure	Revenue Size										Aggregate (N = 485)	
	Under $25 M		$25M to Under $100M		$100M to Under 250M		$250M to Under $500M		$500M and Over			
	N	% of all hospitals in each category	N	% of all hospitals in each category	N	% of all hospitals in each category	N	% of all hospitals in each category	N	% of all hospitals in each category	N	% of all hospitals
▪ Uncompensated Care	80	93%	166	96%	127	95%	*	>95%	*	>90%	466	95%
▪ Medical, Education & Training	41	48%	125	72%	122	92%	57	93%	33	92%	378	77%
▪ Medical Research	*	Less than 10%	*	Less than 10%	37	28%	30	49%	24	67%	104	21%
▪ Lectures, seminars & education	53	62%	143	83%	118	89%	50	82%	23	64%	387	79%
▪ Medical screening	58	67%	132	76%	116	87%	46	75%	25	69%	377	77%
▪ Newsletter/ publications	42	49%	137	79%	116	87%	55	90%	24	67%	374	76%
▪ Improving access to healthcare	30	35%	88	51%	87	65%	49	80%	19	53%	273	56%
▪ Immunization programs	36	42%	70	40%	63	47%	19	31%	14	39%	202	41%
▪ Other healthcare promotion	15	17%	61	35%	49	37%	22	36%	7	19%	154	31%
▪ Studies on community's unmet health-care needs	13	15%	45	26%	44	33%	26	43%	11	31%	139	28%

*Not shown to prevent potential identification of respondent hospitals.

Each revenue size reported a higher participation rate for providing uncompensated care than for any other type of community benefit. The percentage of hospitals in the under $25 million revenue category that reported expenditures for medical education and training and for medical research is significantly less than the percentages reported for the other revenue groups. The same is true for several of the community program expenditures (e.g., newsletter and publications, improving access to healthcare care, and studies on unmet health needs). The percentage of hospitals reporting medical research

and medical education and training expenditures generally increased with revenue size.

4. Aggregate Uncompensated Care by Revenue Size

The aggregate uncompensated care expenditures reported by 466 hospitals as a percentage of total revenues was 6.41%.[50] Uncompensated care expenditures were not evenly distributed by the hospitals in the study, but were concentrated in a relatively small number of hospitals. 14% of the hospitals reported 63% of the aggregate uncompensated care expenditures; 26% of the hospitals reported 82% of the aggregate uncompensated care expenditures.

Percentage of patients. Figure 54 shows the reported average and median percentages of patients receiving uncompensated care, by revenue size groups.

Figure 54. Percentage of Patients Receiving Uncompensated Care by Revenue Size

Revenue Size	Number of hospitals	Average (%)	Median (%)
Under $25M	73	9.2	2.7
$25M - under $100M	159	8.1	2.5
$100M - under $250M	123	9.1	4.0
$250M - under $500M	58	12.9	9.8
$500M and over	30	16.6	5.3
Total	443	9.8	3.4

Note: Table only includes those hospitals that reported the number of patients receiving uncompensated care.

Figure 54 shows that the average percentage of patients receiving uncompensated care was 9.8 percent, with a median of 3.4 percent. With the exception of the under $25 million group, the average percentage of patients receiving uncompensated care increased as hospital revenue size increased. The medians did not correlate with revenue size.

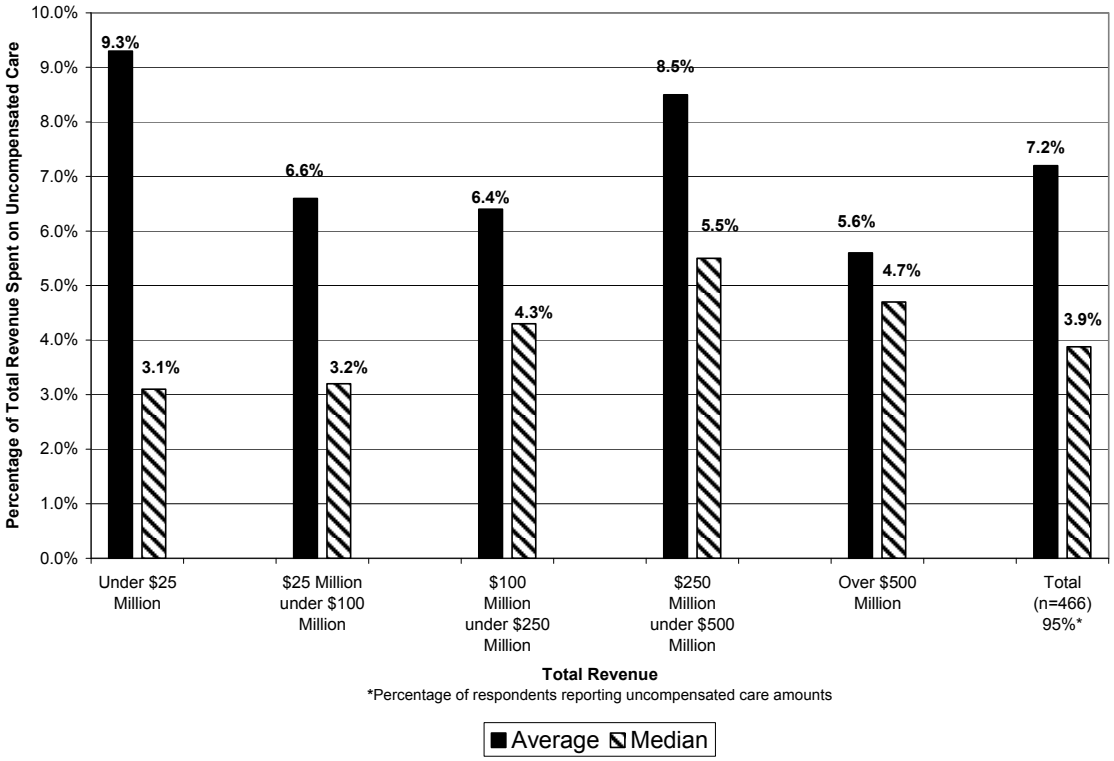
Percentage of revenues. Figure 55 and Figure 56 illustrate the average and median percentages of total revenue reported as spent on uncompensated care for each revenue size group.

[50] This reflects the total reported uncompensated care expenditures divided by total reported revenues for the entire group of 466 hospitals. This differs from the average and median percentages of individual hospitals' percentages reported below (e.g., Figure 55).

Figure 55. Percentage of Total Revenue Spent on Uncompensated Care by Revenue Size (Average and Median) (n=466)

Revenue Size	Average	Median
Under $25 Million	9.3%	3.1%
$25 Million to under $100 Million	6.6%	3.2%
$100 Million to under $250 Million	6.4%	4.3%
$250 Million to under $500 Million	8.5%	5.5%
Over $500 Million	5.6%	4.7%
Total	7.2%	3.9%

Figure 56. Percentage of Total Revenue Spent on Uncompensated Care (Average and Median) (n=466)



As measured by medians, the percentage of revenue spent on uncompensated care increases over the lower four total revenue categories, but declines somewhat in the largest total revenue category. As measured by averages, the percentage of total revenue spent on uncompensated care is highest in hospitals with revenue under $25 million (9.3%) and hospitals with total revenues between $250 million and $500 million (8.5%), and lower in the other three categories. Except for hospitals with total revenues over $500 million there is a sizeable difference between the average and median percentages of total revenue spent on uncompensated care.

Figure 57, below, shows the percentage of hospitals within each revenue size category that reported uncompensated care as a percentage of total revenues within certain ranges.

Figure 57. Number and Percentage of Hospitals with Reported Uncompensated Care as a Percentage of Total Revenue by Revenue Size

Uncompensated Care Expenditure as Percentage of Total Revenues	Revenue Size					Overall	
	< $25M	$25M < $100M	$100M < 250M	$250M < 500M	≥ $500M		
	%	%	%	%	%	N	%
≤ 1%	26	20	17	12	9	87	19
Over 1% - ≤ 3%	23	28	20	22	24	112	24
Over 3% - ≤ 5%	11	13	18	15	27	71	15
Over 5% - ≤ 10%	16	21	22	23	27	99	21
> 10%	24	17	22	28	12	97	21
Total	100	100	100	100	100	466	100

The number of hospitals is not included in each category to prevent potential identification of respondent hospitals.

Figure 58. Distribution of Hospitals by Revenue Size Based on Percentage of Total Revenues Spent on Uncompensated Care (Averages) (n=466)

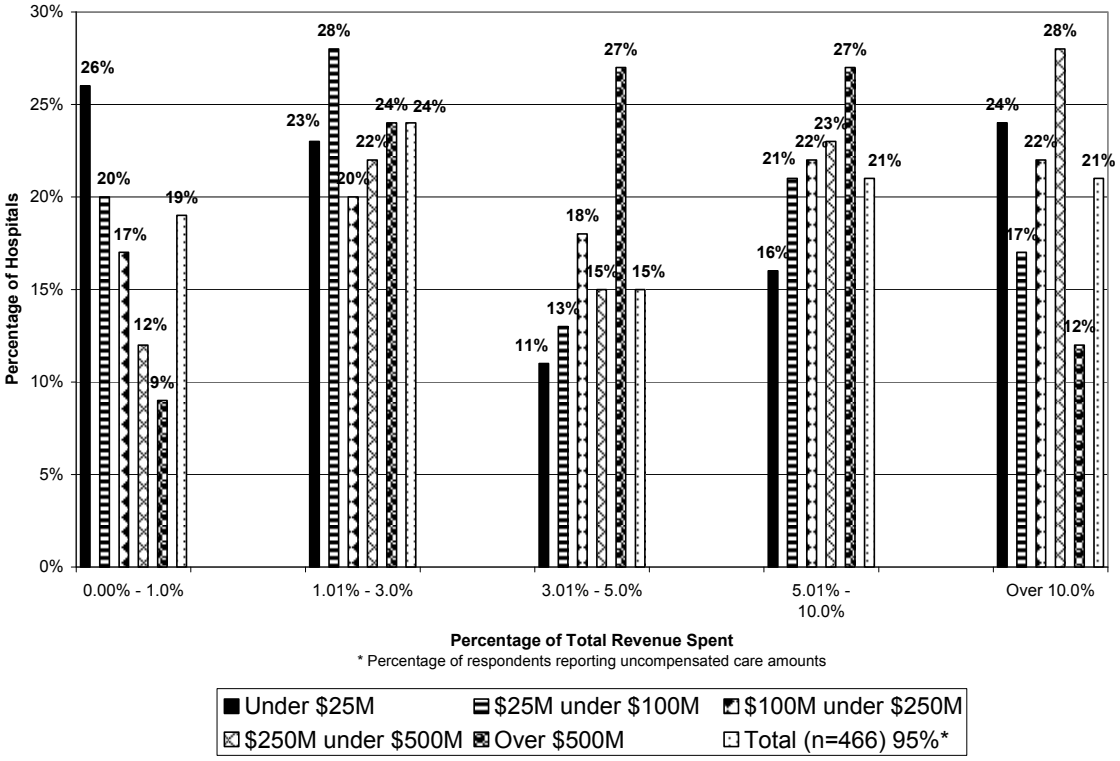


Figure 59. Distribution of Hospitals by Revenue Size Based on Percentage of Total Revenue Spent on Uncompensated Care (Averages) (n=466)

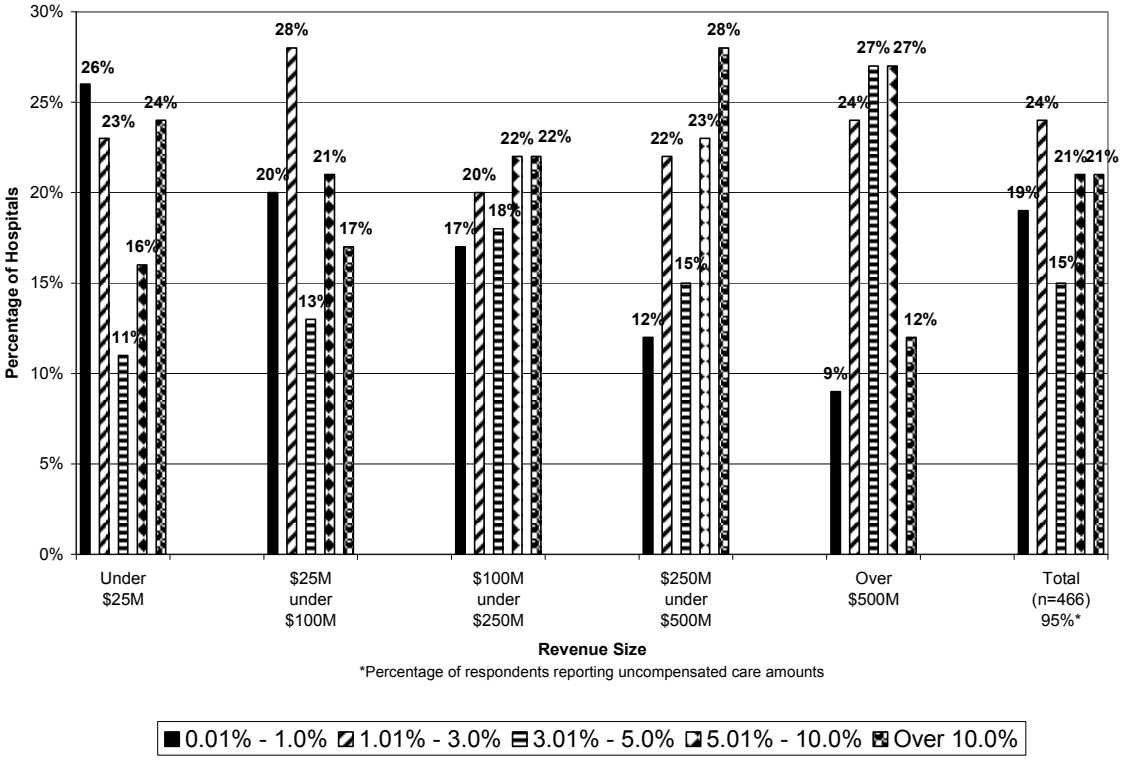


Figure 59, above, shows that almost half (49%) of the hospitals in the under $25 million revenue category reported expenditures in the two lowest percentage of revenue categories (i.e., less than 3%). More than half (51%) of the hospitals in the $250 to $500 million revenue category reported expenditures in the two highest percentages of revenue categories (i.e., more than 5%). 58% of all hospitals reported that uncompensated care expenditures were less than 5% of total revenues. While not included in the chart to prevent potential identification of respondent hospitals, a small percentage of hospitals in four of the revenue sizes reported expenditures greater than 50% of revenues.

Figure 60. Percentage of Hospitals Reporting Uncompensated Care Expenditures at or Less Than Specified Percentages of Revenue Levels

Revenue Size	≤1%	≤3%	≤5%	≤10%
Under $25 million	26%	49%	60%	76%
$25 million to under $100 million	20%	49%	61%	83%
$100 million to under $250 million	17%	37%	55%	77%
$250 million to under $500 million	12%	34%	49%	72%
Over $500 million	9%	33%	60%	87%
Total	19%	43%	58%	79%

As Figure 60 shows, between one third and one half of the hospitals in each revenue size category reported 3% or less of total revenues as spent on

uncompensated care. Approximately half (49%) or more of each category reported 5% or less of total revenues as spent on uncompensated care.

See Section VI.C.2, below, for an analysis of the reporting of various shortfalls and bad debt as uncompensated care by revenue size.

5. Aggregate Medical Research Expenditures by Revenue Size

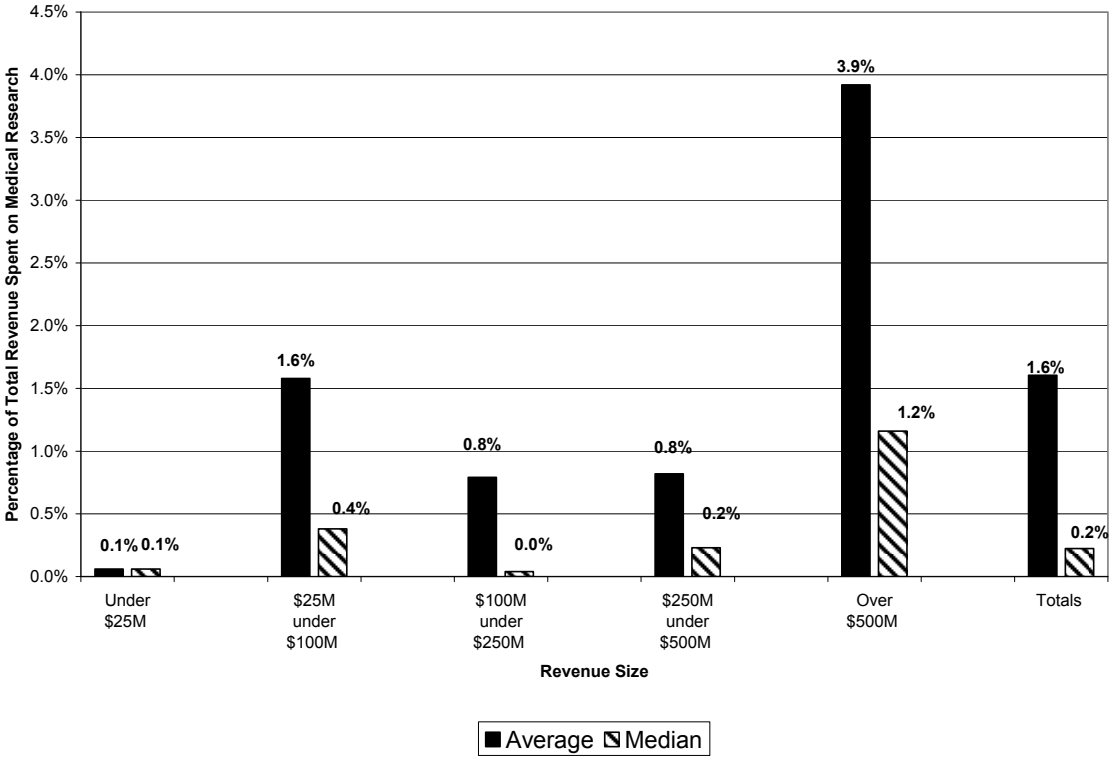
117 of the hospitals reported conducting medical research, although only 104 hospitals actually reported an amount of medical research expenditures. The aggregate medical research expenditures reported by the 104 hospitals that reported such amounts was 3.48% of total revenues.[51] The average and median percentages of medical research expenditures as a percentage of total revenues were 1.6% and 0.2%, respectively.

A group of 15 hospitals reported 93% of the overall reported medical research expenditures. See Section VI.B, below, for an analysis of community benefit expenditures of this group.

Figure 61, below, shows the average and median percentage of total revenue reported as spent by hospitals on medical research expenditures broken out by revenue size.

[51] This represents the total medical research expenditures divided by the total revenues for the entire group of 104 hospitals. This differs from the median and average percentages of the individual hospitals' percentages.

Figure 61. Percentage of Total Revenue Spent on Medical Research by Revenue Size (Averages and Medians) (n=104)



In general, there is a significant difference between the average and the median percentages reported as spent by revenue size categories on medical research. The largest hospitals, those with total revenue in excess of $500 million, reported spending the largest percentage of total revenue measured by average (3.9%) and median (1.2%). The next highest percentage was the second smallest revenue category of hospitals, those with total revenues between $25 million and $100 million, which was comparable to the overall group. All other categories reported spending smaller percentages of their total revenue on medical research.

Figure 62 illustrates the percentage of total revenue reported as spent on medical research by those hospitals reporting such expenditures.

Figure 62. Distribution of Hospitals by Revenue Size Based on Percentage of Total Revenue Spent on Medical Research (n=104)

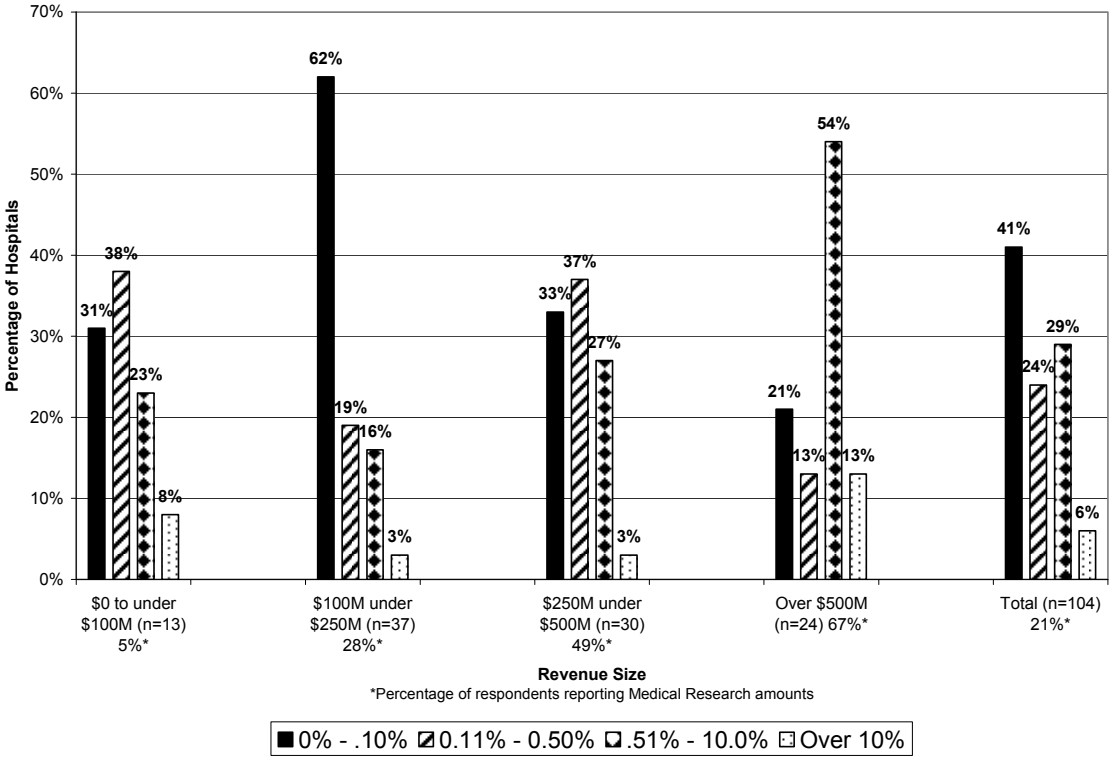


Figure 62 shows that 67% of the hospitals in the largest revenue category (over $500 million) reported spending more than 0.5% of revenues on medical research.[52]

6. Aggregate Medical Education and Training Expenditures by Revenue Size

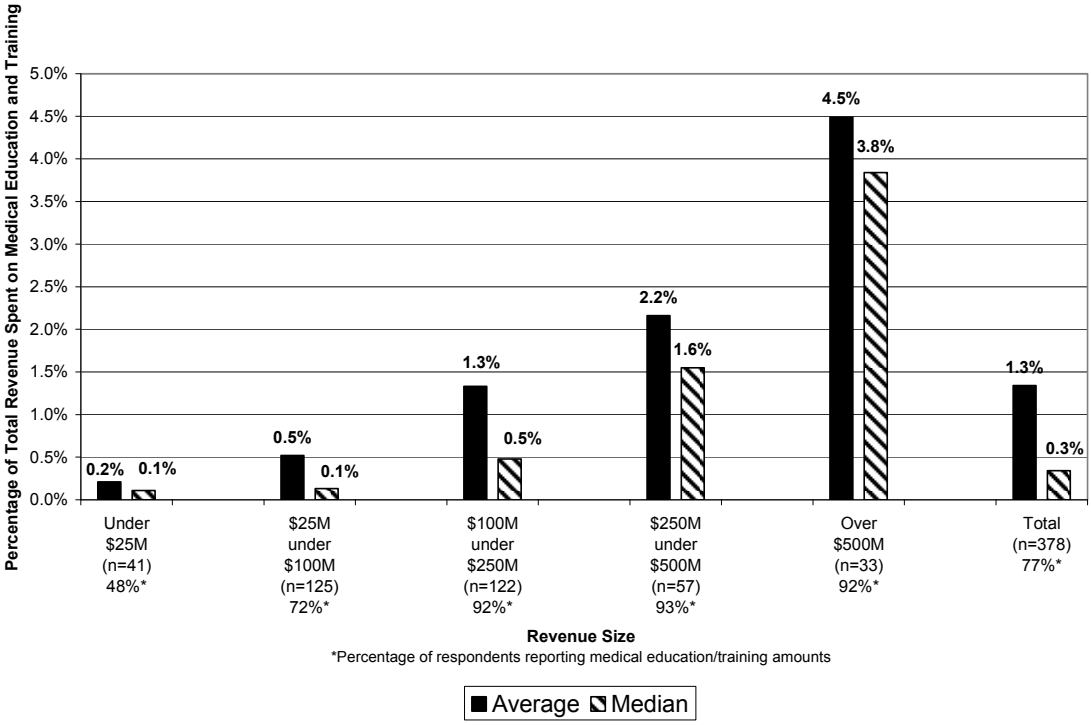
77% of hospitals reported medical education and training expenditures. The aggregate medical education and training expenditures reported as spent by these hospitals was 3.37% of total revenues.[53]

Figure 63 shows the average and median percentage of total revenues reported as spent by hospitals on medical education and training broken out by total revenue categories.

[52] The two smallest revenue sizes were combined to prevent potential identification of respondent hospitals.

[53] This represents the total medical education and training expenditures divided by the total revenues for the entire group of 378 hospitals. The group of 15 hospitals that reported 93% of the aggregate reported medical research expenditures also reported 58% of the aggregate reported medical education and training expenditures. See section VI.B, below.

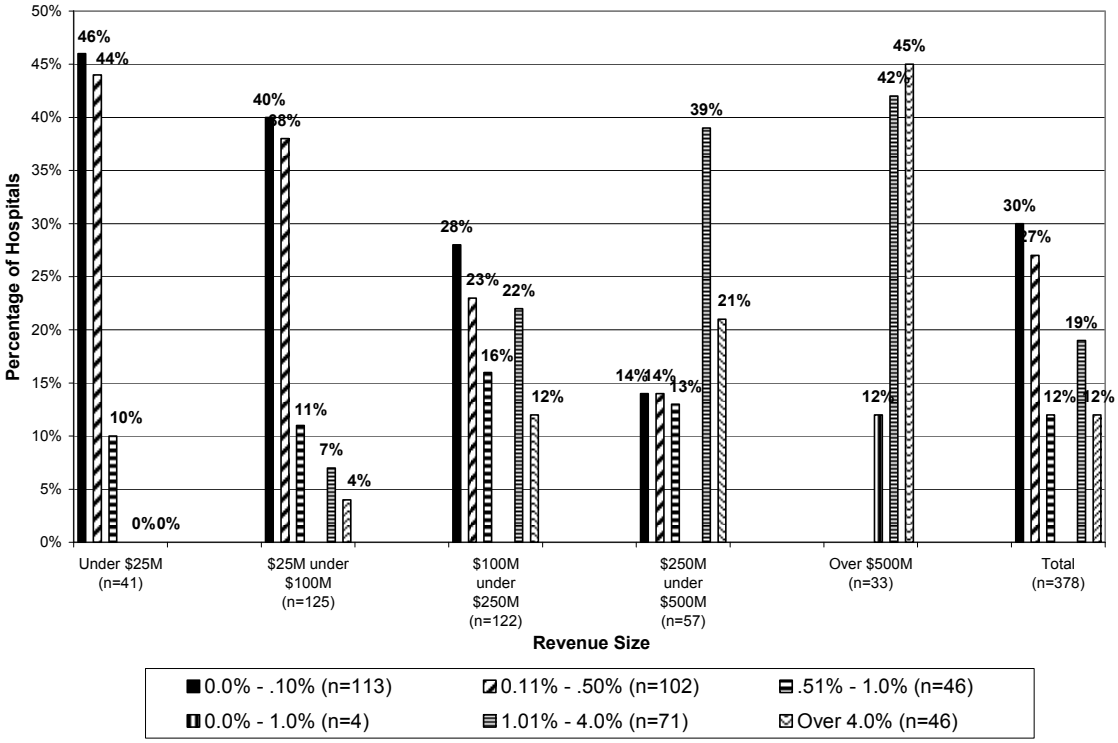
Figure 63. Percentage of Total Revenue Spent on Medical Education and Training by Revenue Size (Averages and Medians) (n=378)



The average and median percentages of medical education and training expenditures reported by 378 hospitals as a percentage of total revenues were 1.3% and 0.3%, respectively. Figure 63 above shows that larger hospitals as measured by total revenue reported spending a greater percentage of their total revenue on medical education and training than smaller ones.

Figure 64 shows the percentage of total revenue spent on medical education and training within revenue size groups.

Figure 64. Distribution of Hospitals by Revenue Size Based on Percentage of Total Revenue Spent on Medical Education and Training (Averages) (n=378)



The two smallest revenue size groups (under $25 million and $25 million to $100 million) reported significantly larger percentages (90% and 78%, respectively) of hospitals with medical education and training expenditures under 0.50% of total revenues. On the other hand, the two largest revenue size groups ($250 million to $500 million and over $500 million) reported significantly larger percentages of hospitals with such expenditures over 1% of their total revenues (60% and 87%, respectively). The three smallest percentage of revenue categories were combined into a single category (0% - 1%) for the over $500 million revenue size to prevent potential identification of respondent hospitals.

7. Aggregate Community Program Expenditures by Revenue Size

The following table summarizes community program expenditures by revenue size.

Figure 65. Amount and Percentage of Community Program Expenditures by Expenditure Category and Revenue Size

Community Program Expenditure	Revenue Size										Aggregate	
	Under $25 M (N = 70)		$25M to Under $100M (N = 161)		$100M to Under 250M (N = 127)		$250M to Under $500M (N = 61)		$500M and Over (N = 29)		(N = 448)	
	Amount (in $ million)	% of total CPE	Amount (in $ million)	% of total CPE	Amount (in $ million)	% of total CPE	Amount (in $ million)	% of total CPE	Amount (in $ million)	% of total CPE	Amount (in $ million)	% of total CBE
▪ Other healthcare promotion	1.2	18%	37.9	32%	74.2	48%	14.1	12%	118.1	61%	245.5	3%
▪ Improving access to healthcare	2.6	40%	44.0	37%	43.8	28%	63.8	56%	53.3	27%	207.5	2%
▪ Lectures, seminars, and education	0.8	12%	7.8	7%	15.0	10%	18.2	16%	12.4	6%	54.2	1%
▪ Medical screening	1.2	18%	14.8	12%	6.1	4%	6.2	5%	4.1	2%	32.4	0.3%
▪ Newsletter/ publications	0.5	8%	5.2	4%	12.2	8%	9.5	8%	4.5	2%	31.9	0.3%
▪ Immunization Programs	0.2	3%	8.1	7%	1.6	1%	0.9	1%	1.3	1%	12.1	0.13%
▪ Studies on community's unmet healthcare needs	0.01	0.2%	2.2	2%	2.2	1%	1.3	1%	0.7	0%	6.4	0.07%
Total Community Program Expenditures	6.5	100%	120.0	100%	155.1	100%	114.0	100%	194.4	100%	590.0	6%

Figure 66, below, shows the distribution of community program expenditures broken out by expenditure category and revenue size.

Figure 66. Percentage of Community Program Expenditures by Expenditure Category and Revenue Size (n=448)

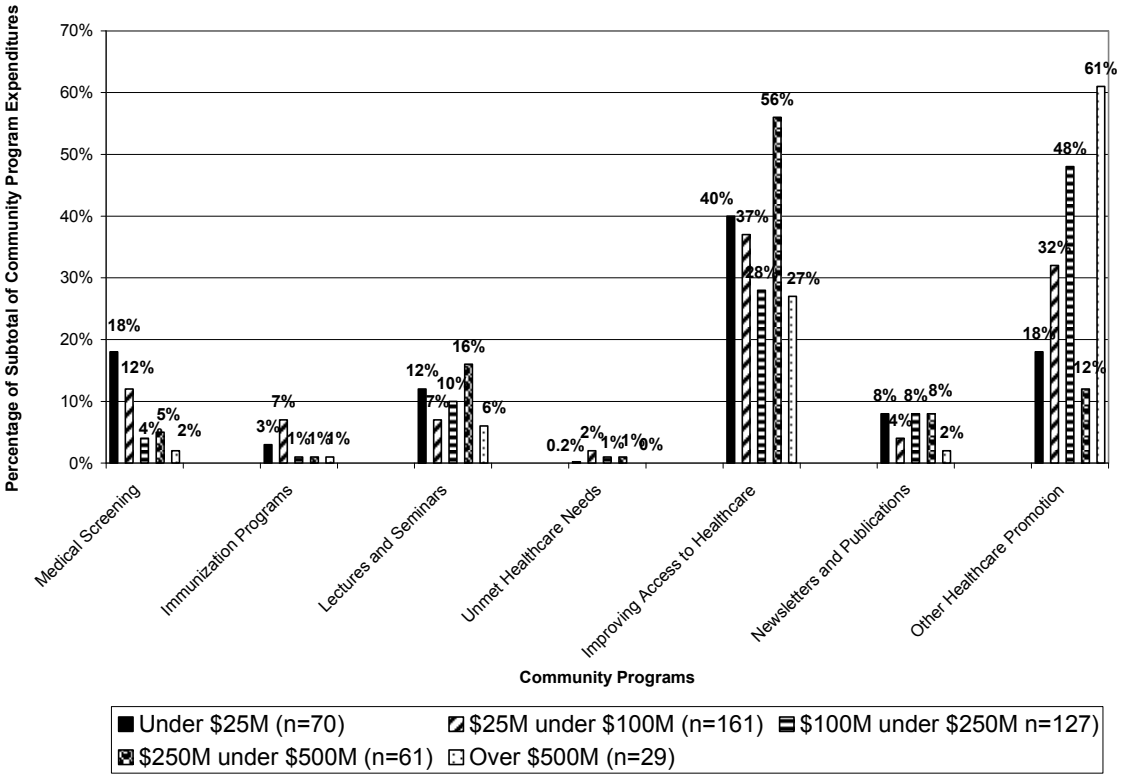
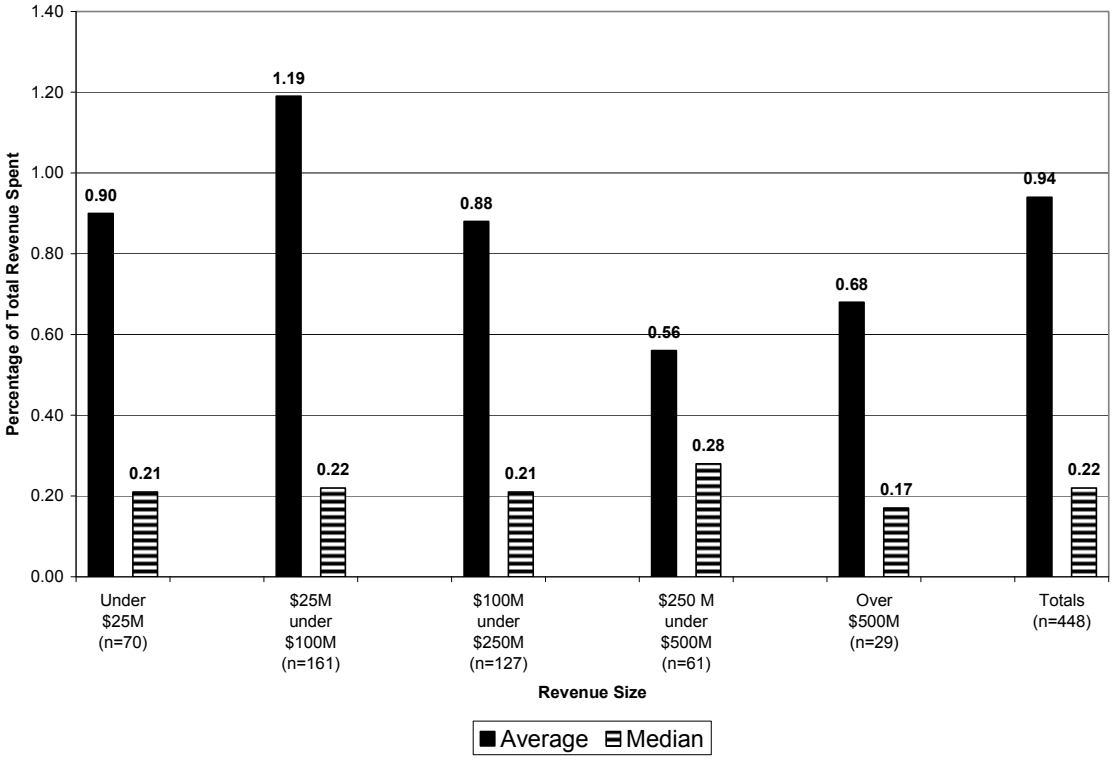


Figure 65 and Figure 66 illustrate there is considerable variation across the revenue size categories regarding expenditures for the various components of community programs.

Figure 67, below, shows the average and median percentages of total revenues spent on community programs by revenue size.

Figure 67. Percentage of Total Revenue Spent on Community Programs by Revenue Size (n=448)



8. Aggregate Community Benefit Expenditures by Revenue Size

As previously discussed, the entire respondent group reported aggregate community benefit expenditures of $9.4 billion. These expenditures were not evenly distributed by the hospitals in the study, but were concentrated in a relatively small number of hospitals. 9% of the hospitals reported 60% of the aggregate community benefit expenditures; 19% of the hospitals reported 78% of the aggregate community benefit expenditures.

Figure 68 and Figure 69 show a breakout of the categories of community benefit expenditures for five revenue categories of hospitals, and shows the differences in community benefit expenditure profiles across the revenue size groups.

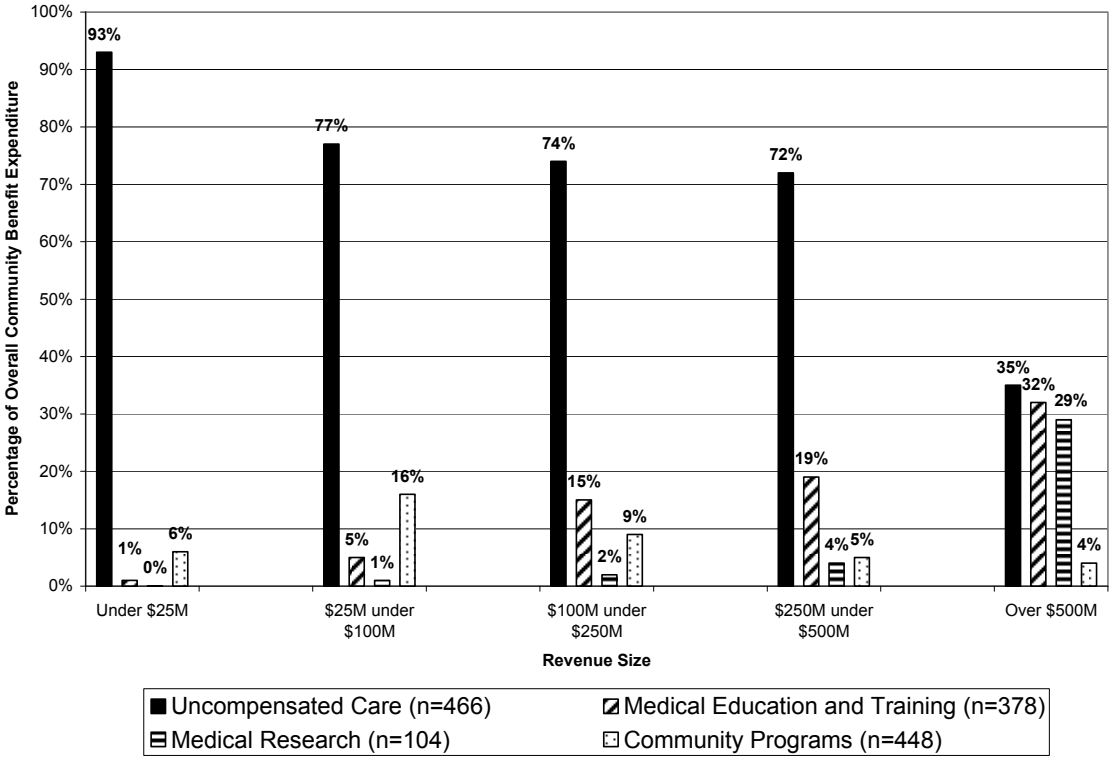
Figure 68. Amount and Percentage of Total Community Benefit Expenditures by Expenditure Category and Revenue Size

Community Benefit Expenditure	Revenue Size										Aggregate (N = 485)	
	Under $25 M		$25M to Under $100M		$100M to Under 250M		$250M to Under $500M		$500M and Over			
	Amount (in $ million)	% of total CBE	Amount (in $ million)	% of total CBE	Amount (in $ million)	% of total CBE	Amount (in $ million)	% of total CBE	Amount (in $ million)	% of total CBE	Amount (in $ million)	% of total CBE
▪ Uncompensated Care	104.2	93%	591.1	77%	1,316.9	74%	1,638.7	72%	1,576.5	35%	5,227.4	56%
▪ Medical, Education & Training	1.4	1%	41.8	5%	275.7	15%	445.3	19%	1,400.4	32%	2,164.6	23%
▪ Medical Research	0.0	0.0%	11.0	1%	38.6	2%	90.0	4%	1,272.6	29%	1,412.2	15%
▪ Community Programs	6.5	6%	120.0	16%	155.1	9%	114.0	5%	194.4	4%	590.0	6%
Total Community Benefit Expenditures	112.1	100%	763.9	100%	1,786.3	100%	2,288.0	100%	4,443.9	100%	9,394.2	100%

Figure 68 shows the distribution of reported community benefit expenditures across the revenue size categories.[54] For example, hospitals with revenues under $25 million comprised 17% of the hospitals, but reported 1% of aggregate community benefit expenditures. Hospitals with revenues over $500 million comprised 7% of the hospitals, but reported 47% of aggregate community benefit expenditures.

[54] The mix of community benefit expenditures changes when the group of 15 hospitals reporting 93% of aggregate reported medical research expenditures is isolated. See Section VI.B, below.

Figure 69. Percentage of Community Benefit Expenditures by Expenditure Category and Revenue Size (n=485)



Uncompensated care as a percentage of aggregate community benefit expenditures decreased as revenues increased. The smallest hospitals by total annual revenue reported spending the largest percentage of their community benefit expenditure dollars (93%) on uncompensated care. The largest hospitals by total annual revenue reported spending the smallest percentage of their community benefit expenditure dollars (35%) on uncompensated care. The three middle categories are between these two percentages, ranging from 72% of community benefit expenditure dollars reported as spent on uncompensated care to 77% of community benefit expenditure dollars spent on uncompensated care.

Conversely, the largest hospitals by total annual revenue reported spending a larger percentage of their community benefit expenditures on medical education and training (32%) and on medical research (29%). The percentage of total community benefit expenditure dollars reported as spent on medical education and training increased (from 1% to 32%) as revenue size increased. The percentage of total community benefit expenditure dollars reported as spent on medical research also increased as revenue size increased.

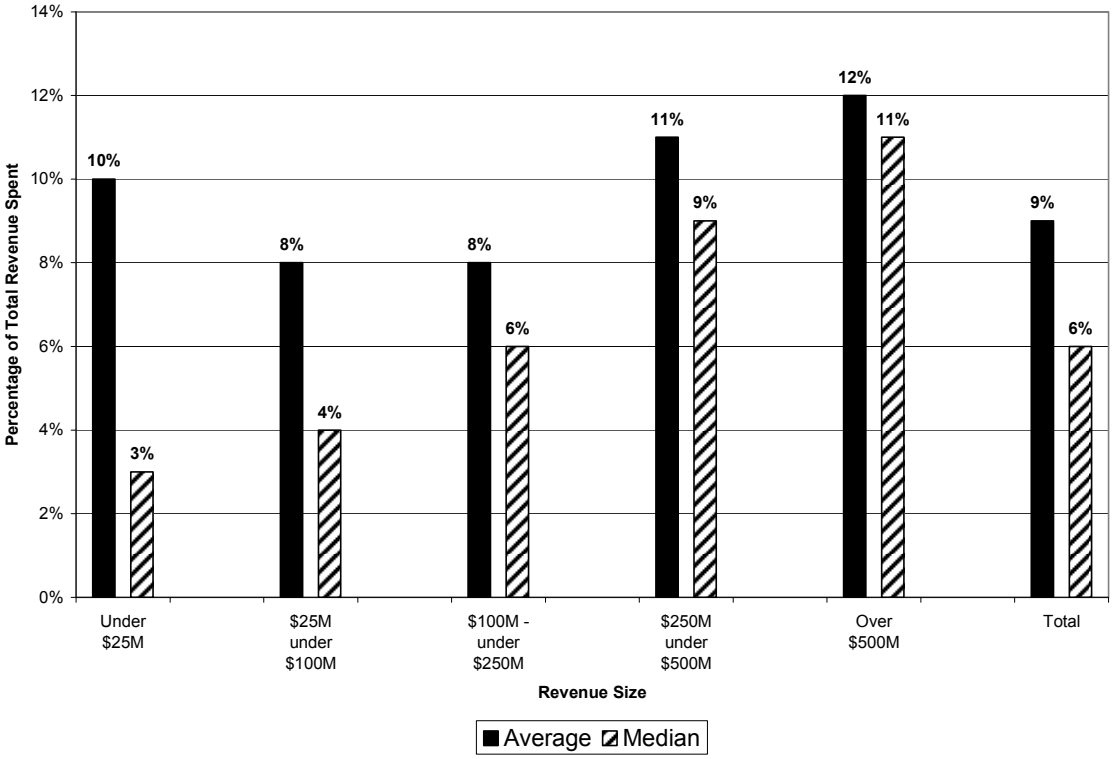
Figure 70 and Figure 71, below, show the average and median percentage of total revenue spent on community benefit expenditures by expenditure category and revenue size.[55]

Figure 70. Average and Median Percentage of Total Revenue Spent on Community Benefit Expenditures by Expenditure Category and Revenue Size

Category of Community Benefit Expenditure	Revenue Size										Aggregate (N = 485)	
	Under $25 M		$25M to Under $100M		$100M to Under 250M		$250M to Under $500M		$500M and Over			
	Average (%)	Median (%)	Average (%)	Median (%)	Average (%)	Median (%)	Average (%)	Median (%)	Average (%)	Median (%)	Average (%)	Median (%)
·Uncompensated Care (N=466)	9.33	3.12	6.63	3.18	6.44	4.33	8.47	5.53	5.62	4.68	7.21	3.88
·Medical Education & Training (N=378)	0.21	0.11	0.52	0.13	1.33	0.48	2.16	1.55	4.49	3.84	1.34	0.34
·Medical Research (N=104)	0.06	0.06	1.58	0.38	0.79	0.04	0.82	0.23	3.92	1.16	1.61	0.22
·Total Community Program Expenditures (N=448)	0.90	0.21	1.19	0.22	0.88	0.21	0.56	0.28	0.68	0.17	0.94	0.22
Total Community Benefit Expenditures	9.86	3.36	8.00	3.98	8.43	6.04	11.31	8.92	12.42	10.54	9.18	5.50

[55] The results change when the group of 15 hospitals that reported 93% of aggregate reported medical research expenditures is isolated. See Section VI.B, below.

Figure 71. Average and Median Total Revenue Spent on Community Benefit Expenditures by Expenditure and Revenue Size (n=485)



The average and median reported aggregate community benefit expenditures as a percentage of total revenues were 9% and 6%, respectively, for the entire group. The highest reported average and median amounts were for hospitals with revenues over $500 million (12% and 11%, respectively). The median percentages increased with revenue size, ranging from 3% for hospitals with revenues under $25 million to 11% for hospitals with revenues over $500 million.

Figure 72 and Figure 73, below, show the average and median percentages of total revenues spent on various community benefit expenditures by expenditure and revenue size.

Figure 72. Percentage of Total Revenue Spent on Various Community Benefit Expenditures by Expenditure and Revenue Size Categories (Averages) (n=485)

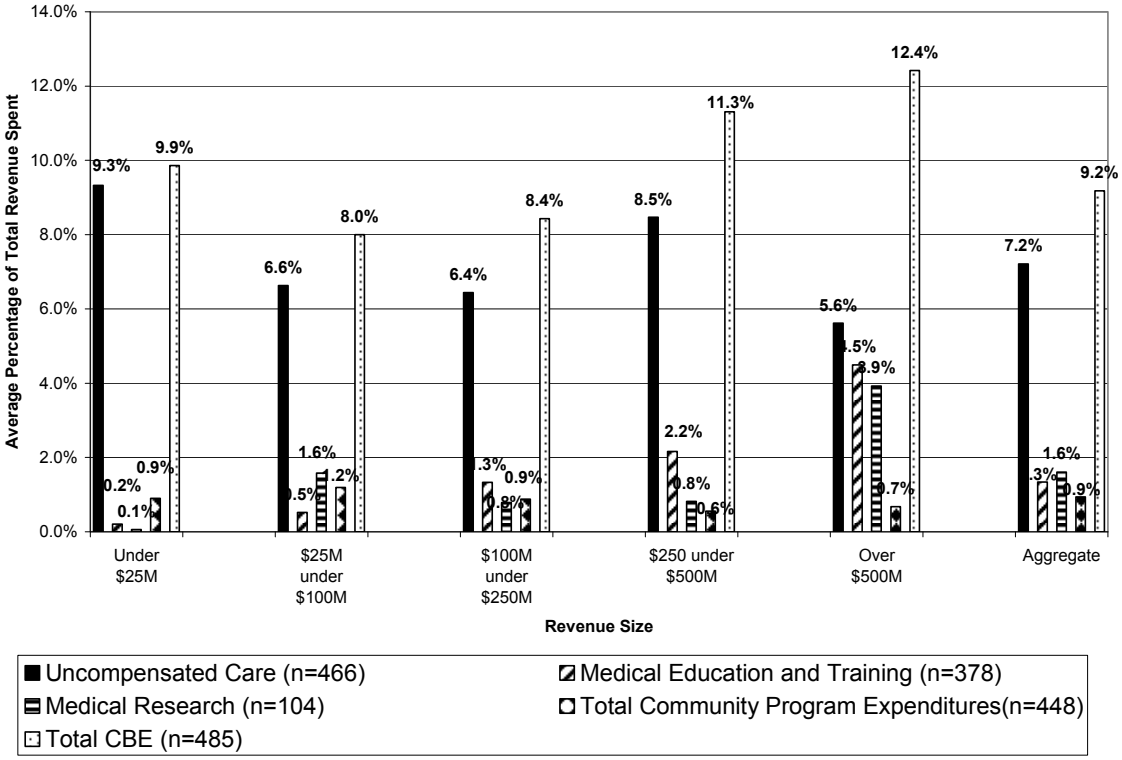
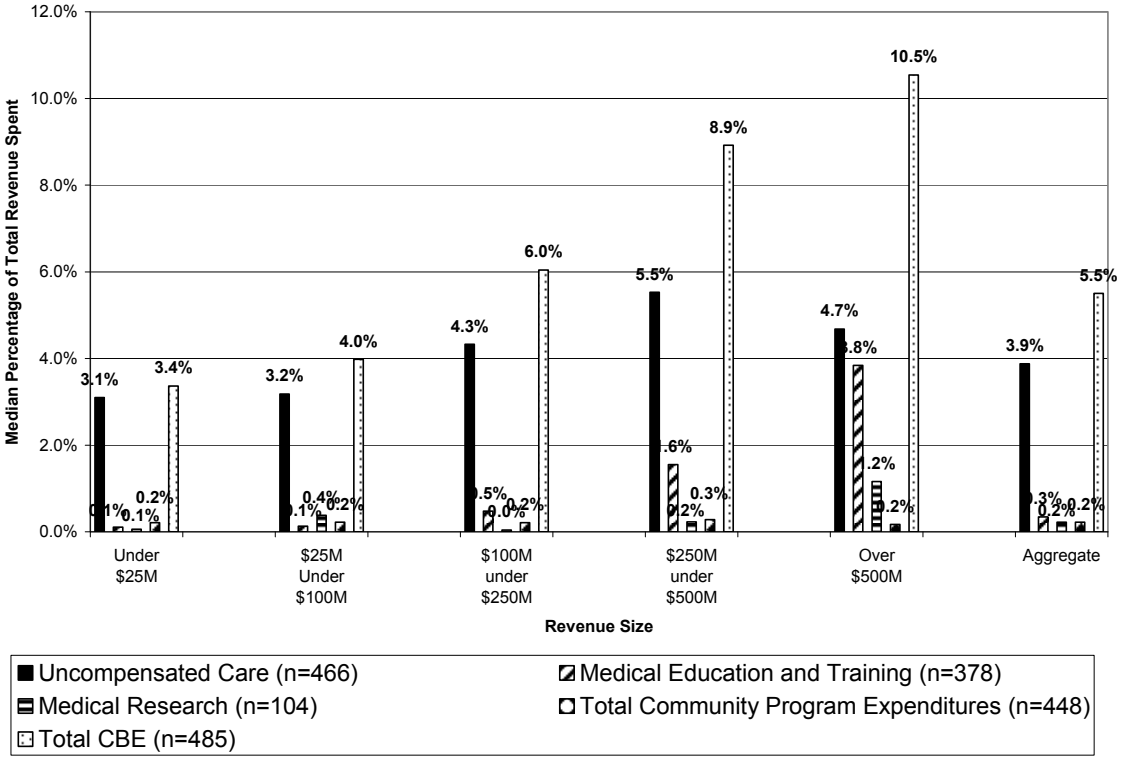


Figure 73. Percentage of Total Revenue Spent on Various Community Benefit Expenditures by Expenditure and Revenue Size Categories (Medians) (n=485)



The figures above show that hospitals in the smallest revenue size category (under $25 million) reported spending the largest average percentage of revenues on uncompensated care and the smallest average percentage of revenues for medical research. Hospitals in the largest revenue category reported spending the smallest average percentage of revenues on uncompensated care and the largest percentages on medical, education and training and medical research compared with the other revenue categories.

9. Aggregate Community Benefit Expenditures as Percentage of Revenues

This section summarizes the distribution of aggregate community benefit reporting across revenue sizes. Figure 74, Figure 75, and Figure 76 show the distribution of hospitals by revenue size, with reported community benefit expenditures within specified percentages of total revenue ranges. Figure 77 displays the cumulative percentage of hospitals within each revenue size that reported aggregate community benefit expenditures as a percentage of total revenues, at or less than specified levels (e.g., less than 5% of total revenues). The $250 million to under $500 million and $500 million and over categories were combined in these figures to prevent potential identification of respondent hospitals.

Figure 74. Number and Percentage of Hospitals with Reported Community Benefit Expenditures as a Percentage of Total Revenue by Revenue Size

Total Community Benefit Expenditure as Percentage of Total Revenues	Revenue Size								Overall	
	< $25M		$25M - < $100M		$100M - < $250M		≥ $250M			
	N	%	N	%	N	%	N	%	N	%
< 2%	*	34	*	30	16	12	5	5	101	21
2% - < 5%	*	26	*	26	40	30	21	22	128	26
5% - < 10%	*	17	*	23	35	26	25	26	113	23
10% - < 20%	*	13	*	13	30	23	35	36	99	21
≥ 20%	*	10	*	8	12	9	11	11	44	9
Total	*	100	*	100	133	100	97	100	485	100

* Not shown to prevent potential identification of respondent hospitals.

Figure 74, above, shows that in the two smallest revenue categories (under $100 million), 60% and 56% of the hospitals, respectively, reported spending less than 5% of total revenues on community benefit expenditures. Overall, 47% of all hospitals reported spending less than 5% of total revenues on community benefit expenditures.

Figure 75. Percentage of Hospitals with Reported Community Benefit Expenditures as a Percentage of Total Revenue by Revenue Size (n=485)

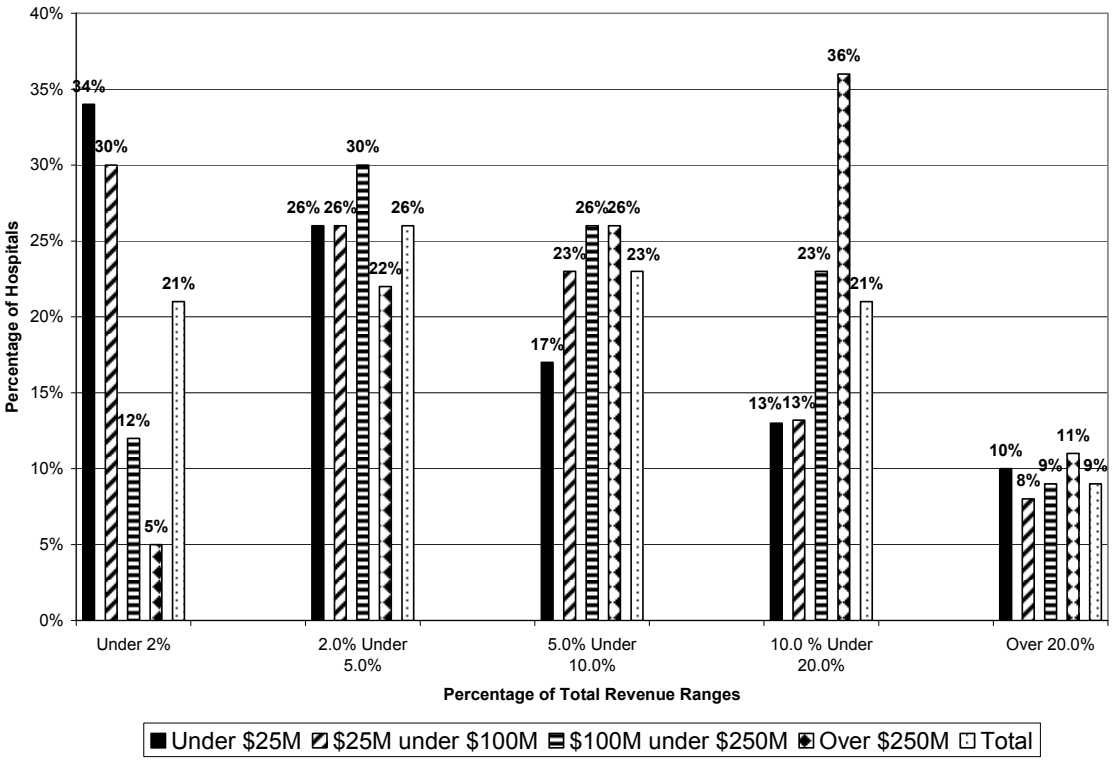
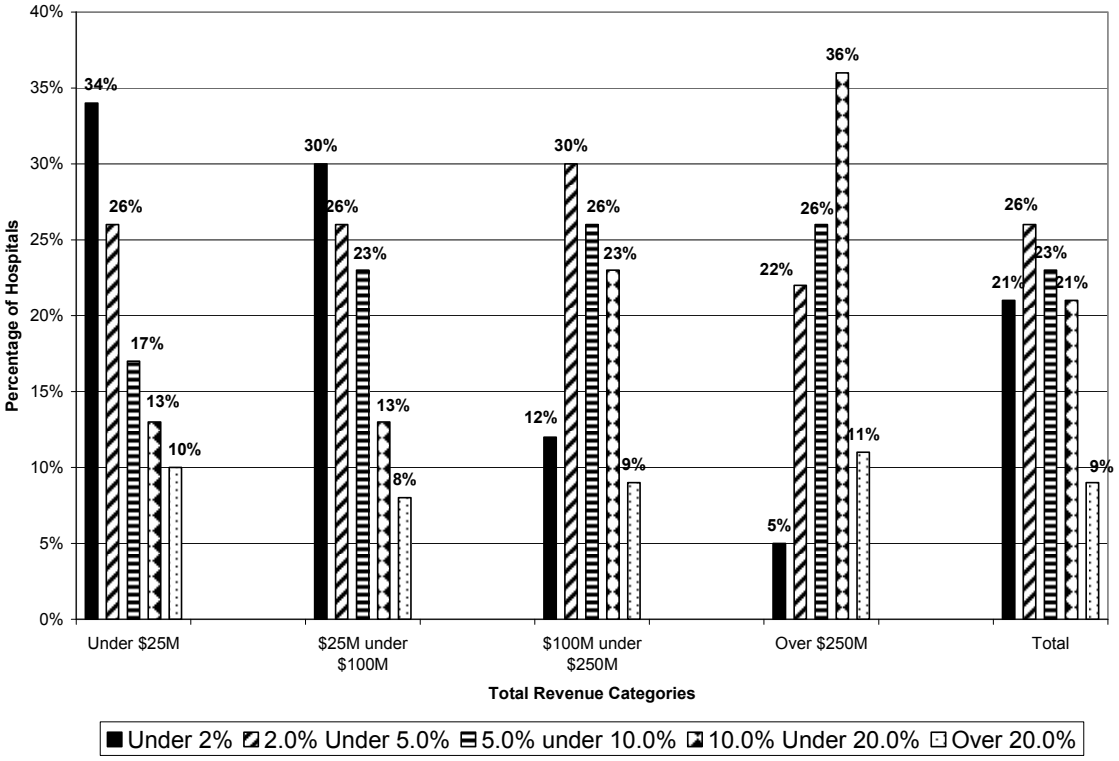


Figure 76. Percentage of Hospitals with Reported Community Benefit Expenditures as a Percentage of Total Revenue by Revenue Size (n=485)



A relatively large percentage of hospitals in the over $250 million revenue size category reported total community benefit expenditures of more than 10% of total revenues (47% compared with 30% for all hospitals).

Figure 77, below, shows, on a cumulative basis, the percentage of hospitals reporting community benefit expenditures at or less than specified percentages of revenue levels.

Figure 77. Percentage of Hospitals Reporting Community Benefit Expenditures at or Less Than Specified Percentages of Revenue Levels

Revenue Size	<2%	<5%	<10%
Under $25 million	34%	60%	77%
$25 million to under $100 million	30%	56%	79%
$100 million to under $250 million	12%	42%	68%
$250 million and over	5%	27%	53%
Total	21%	47%	70%

Figure 77 shows that 21% of all hospitals reported spending less than 2% of total revenues on aggregate community benefit expenditures; 47% reported spending less than 5% of total revenues on community benefit expenditures. The larger hospital categories included lower percentages of hospitals that reported community benefit expenditures at the under 2% and under 5% of revenue levels. The smallest hospital groups included the highest percentages of

hospitals that reported community benefit expenditures below the 2% and 5% of revenue levels.

VI. OTHER COMMUNITY BENEFIT REPORTING - BAD DEBT AND SHORTFALLS, RESEARCH, INCOME AND HEALTH INSURANCE COVERAGE LEVELS

A. Overview and Summary of Key Findings

Section VI summarizes the study's other demographic breakdowns of uncompensated care and community benefit expenditures. Section VI.B reports certain community benefit expenditure data for the group of 15 hospitals that reported 93% of the medical research expenditures, and analyzes the impact this group had on the overall results. Section VI.C provides uncompensated care breakdowns by community type and revenue size and analyzes reporting differences depending on whether shortfalls and bad debt are included in uncompensated care. Section VI.D includes a discussion of reported community benefit expenditures depending upon per capita income and insurance coverage levels in the communities surrounding the respondent hospitals.

The key findings of this section are:

1. A group of 15 hospitals, comprising 3% of all hospitals in the study, reported 93% of aggregate medical research expenditures and 58% of aggregate medical education and training expenditures reported by all hospitals in the study. These hospitals had a materially different community benefit mix than did the other hospitals, with medical research expenditures comprising 45% of their total community benefit expenditures, followed by medical education and training (28%), uncompensated care (22%), and community programs (5%). Although this group of 15 hospitals reported lower uncompensated care expenditures as a percentage of revenue than the overall group (6% average and 3% median, respectively, compared to 7% and 4%, respectively, for the overall group), it reported higher community benefit expenditures as a percentage of revenue than the overall group (19% average and median, respectively, compared to 9% and 6%, respectively, for the overall group).

2. Greater percentages of hospitals reported including bad debts and self pay shortfalls in uncompensated care than any other types of shortfalls. This was the case overall and for each community type and revenue size.

3. Rural hospitals (CAH and non-CAH) reported higher percentages of hospitals including private insurance and self pay shortfalls in uncompensated care than did the other community types. Urban and suburban hospitals (high population and other) reported higher percentages of hospitals including bad debt in uncompensated care.

4. The treatment of bad debt as uncompensated care varied slightly more across revenue size categories than it did across community types. The treatment of a particular shortfall as uncompensated care varied more across community types than across revenue size categories.

5. The study did not obtain information regarding the breakdown of reported uncompensated care amounts across bad debt or specific types of shortfalls. Accordingly, the study does not assess the impact that uniform treatment by all respondent hospitals would have on the uncompensated care or aggregate community benefit expenditure levels of the overall group or across the community types or revenue size categories.

6. The study did not find a correlation between community benefit expenditure levels and per capita income levels of the area surrounding the hospital. The average and median percentages of revenues spent on uncompensated care by the hospitals in the low per capita income categories were less than those reported by the overall group, and generally were less than those reported by hospitals in areas with per capita incomes at or above state or federal averages.

7. The study suggests a correlation between community benefit expenditure levels and the health insurance coverage levels of the area surrounding the hospital. The average and median percentages of total revenues reported as spent on community benefit expenditures increased as the surrounding area's health coverage level decreased (uninsured rate increased). The percentage of hospitals reporting spending more than 5% of total revenues on community benefit expenditures also increased as health insurance coverage levels decreased (uninsured rates increased).

B. Hospitals Reporting Largest Amounts of Medical Research Expenditures

A group of 15 hospitals, comprising 3% of the hospitals, reported 93% of aggregate medical research expenditures. Each of these hospitals reported more than $10 million in medical research expenditures.

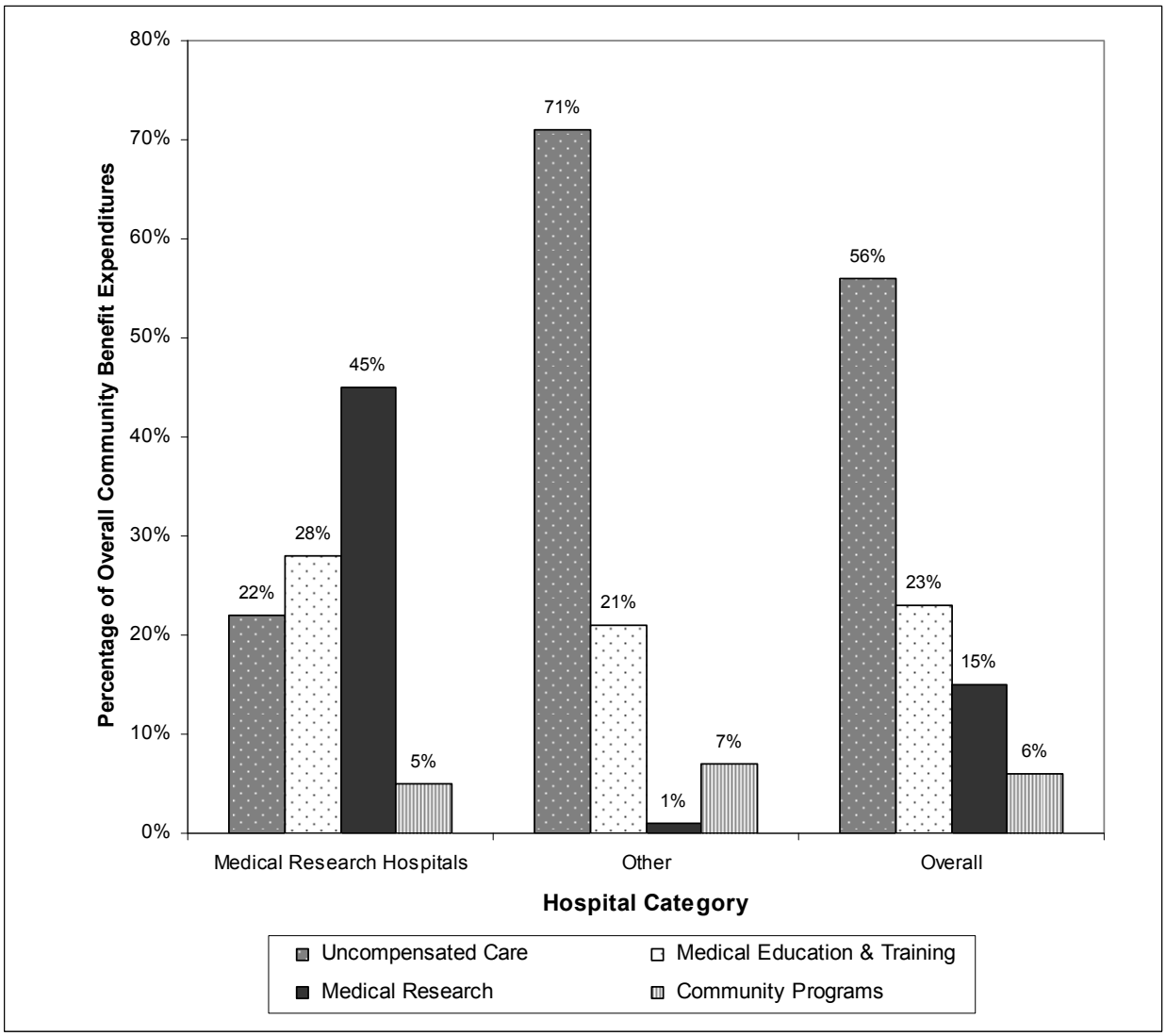
For purposes of this section, this group of 15 is referred to as "research hospitals". The classification is not dependent on whether the hospital considers itself a research hospital. As the case with the report in general, this data has limited use for several reasons, including the relatively small size of this group, that the information reported was not independently verified, and the different measurements and components of uncompensated care included by the respondent hospitals. A material percentage of this group was children's hospitals which also impacted the results.

The average and median medical research expenditure amounts of the 15 medical research hospitals ($87.9 million and $44.9 million, respectively) were significantly higher than those reported by the remaining 89 hospitals reporting medical research expenditure amounts ($1 million and $0.3 million, respectively). The average and median percentages of revenue reported as spent on medical research by the medical research hospitals (8.3% and 7.1% respectively) were higher than that reported by the other hospitals (0.5% and 0.1%, respectively) and the overall group (1.6% and 0.2%, respectively).

Patient insurance coverage. In general, the research hospitals reported a higher percentage of patients with private insurance (49%) and a lower percentage of patients with Medicare (16%). The lower percentage of Medicare, approximately half that of the overall group, may be affected by the material percentage of children's hospitals included in the group.

Community benefit expenditures mix. The chart below compares the community benefit expenditure mix of the group of 15 hospitals to the mix of all other hospitals in the study, then to the overall group.

Figure 78. Community Benefit Expenditure Mix



The group of 15 research hospitals is the only demographic in the study that did not report uncompensated care as its largest component of community benefit expenditures. When the group of 15 research hospitals was removed from the overall group, the overall mix changed, with uncompensated care increasing from 56% to 71%, and medical research decreasing from 15% to 1% of aggregate reported community benefit expenditures.

Percentage of revenues spent on other components of community benefit.

- **Uncompensated care:** Three research hospitals reported no uncompensated care amounts. The average and median percentages of revenues reported as spent on uncompensated care by the group of medical research hospitals that reported uncompensated care expenditures (6.2% and 3.3%, respectively) were less than the average and median for the other hospitals and the overall group (both 7.2% and 3.9%, respectively).

- **Medical education and training:** The medical research hospitals reported 58% of the aggregate medical education and training expenditures reported overall. The average and median percentages of revenues reported as spent on medical education and training by the medical research hospitals (4.9% and 3.8%, respectively) were higher than reported by the other hospitals (1.2% and 0.3%, respectively) and the overall group (1.3% and 0.3% respectively).
- **Community program expenditures:** The average percentage of revenues reported as spent on community program expenditures was similar to the other hospitals and the overall group. The median was significantly less (.03% in the case of medical research hospitals and 0.2% for other hospitals and overall).

Aggregate community benefit expenditures. The average and median percentages of revenues reported as spent on community benefit expenditures by the medical research hospitals (19% for both) were higher than reported by the other hospitals (9% and 5%, respectively) and the overall group (9% and 6%, respectively).

Excess revenues. The medical research hospitals reported higher average and median annual total revenues as well as average and median excess revenue amounts.

Figure 79. Annual Total Revenues, Total Expenses, and Excess/Deficit Revenues

Hospital Category	Annual Total Revenues			Annual Total Expenses			Annual Excess/Deficit Revenue		
	Aggregate (Billion $)	Average (Million $)	Median (Million $)	Aggregate (Billion $)	Average (Million $)	Median (Million $)	Aggregate (Billion $)	Average (Million $)	Median (Million $)
Medical Research (N = 15)	15.3	1,021.7	995.2	14.3	952.4	913.6	1.0	69.4	57.9
Other (N = 473)	72.2	152.6	85.1	69.2	146.3	83.2	3.0	6.4	2.3
Total (N = 488)	87.5	179.4	89.4	83.5	171.0	87.1	4.1	8.3	2.5

The aggregate excess revenues as a percentage of total revenues was 6.8% for the research hospitals, compared to 4.6% for the overall group. Eight of the 15 hospitals reported a deficit or positive excess revenues less than 5% of total revenues. Seven reported excess revenues as a percentage of revenues greater than 5%.

Percentage of hospitals with uncompensated care and community benefit expenditures at or less than certain revenue levels. All 15 medical research hospitals reported community benefit expenditures greater than 5% of revenues. 40% reported community benefit expenditures greater than 20%. Three hospitals reported no uncompensated care expenditures. Of the remaining hospitals in the group, four reported uncompensated care expenditures in each of the following ranges: over 1% and ≤3%; over 3% and ≤5%; over 5%.

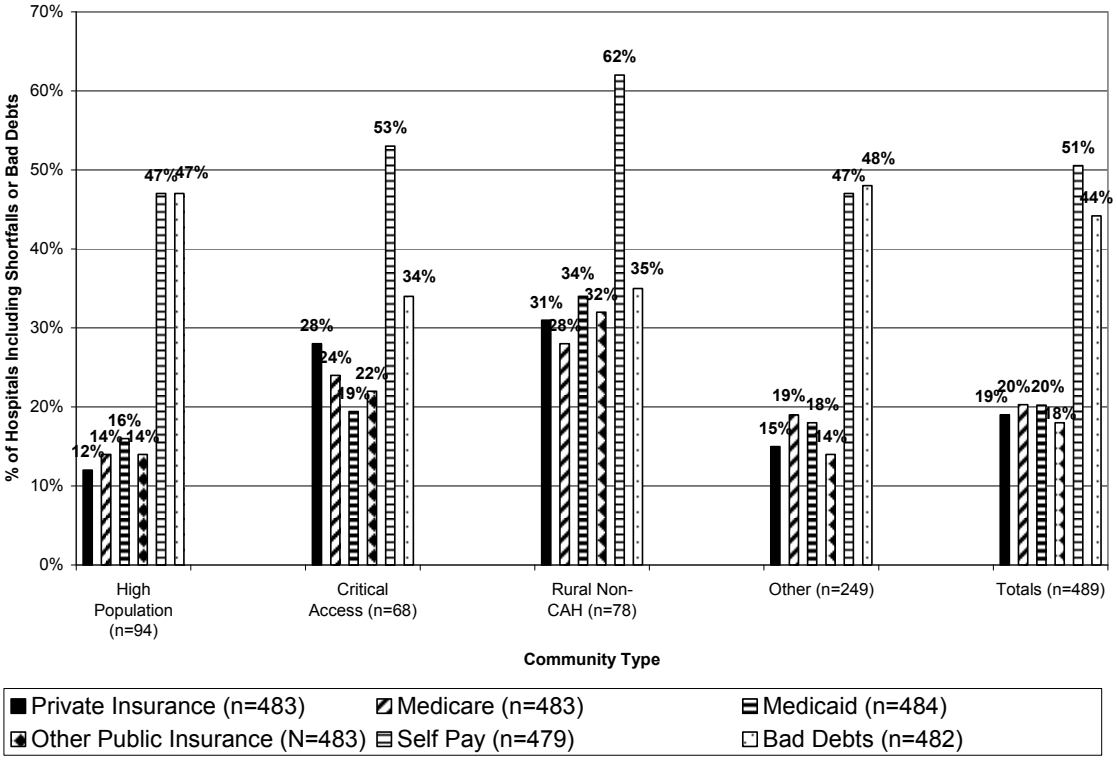
C. Analysis of Bad Debt and Shortfalls as Uncompensated Care

1. Reporting of Shortfalls and Bad Debt by Community Type

Between 18% and 20% of hospitals reported that they included the following items in their calculation of uncompensated care: the difference between hospital charges and the amount private insurance paid or allowed for services (private insurance shortfalls); the difference between hospital charges and the amount Medicare paid or allowed for services (Medicare shortfalls); the difference between hospital charges and the amount Medicaid allowed for services (Medicaid shortfalls); and the difference between hospital charges and the amount other public insurance programs allowed for services (other public program shortfalls). 51% of hospitals reported that they included the difference between hospital charges and the amount paid by individuals without insurance in their calculation of uncompensated care (self pay shortfalls). 44% of the hospitals reported including bad debt in uncompensated care.

Figure 80 below shows the percentage of hospitals in each community type that reported including these various amounts in uncompensated care.

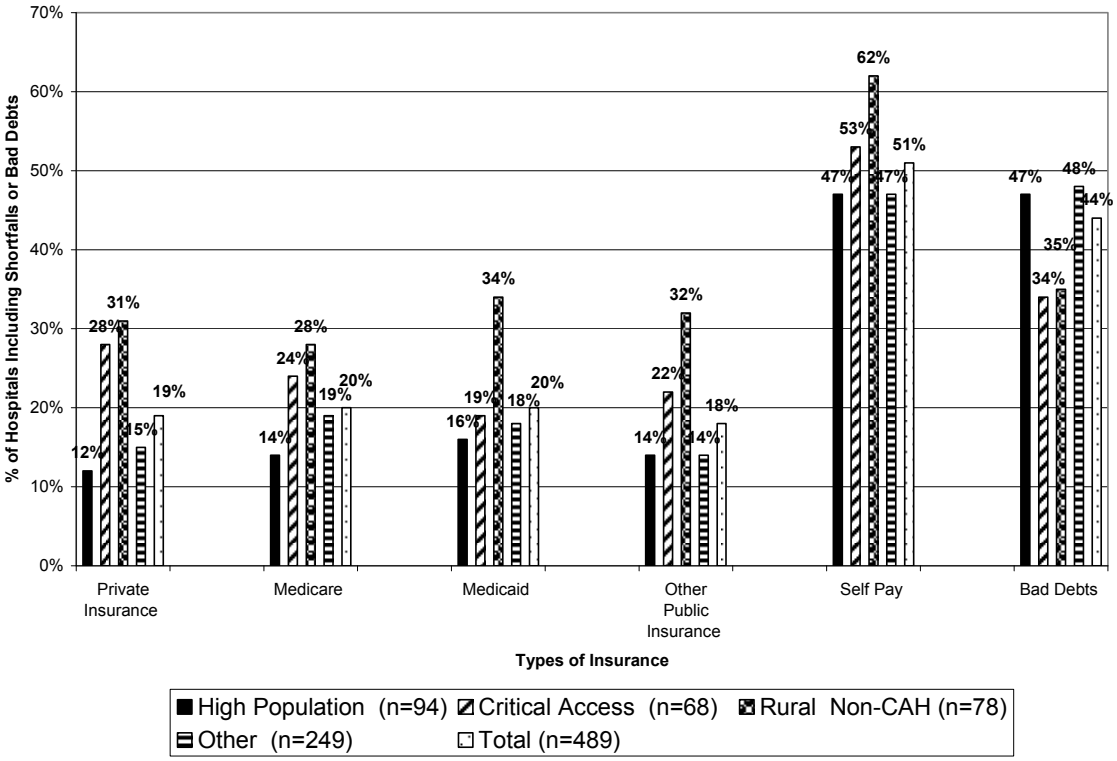
Figure 80. Percentage of Hospitals that Include Various Shortfall Amounts or Bad Debt in Uncompensated Care by Community Type (n=489)



In all categories, fewer hospitals reported including Medicare and Medicaid shortfalls than reported including self pay shortfalls and bad debt in uncompensated care. In most cases, the percentage of hospitals that reported including self pay shortfalls in uncompensated care was more than twice the percentage of hospitals that reported including Medicare, Medicaid, private insurance or other public program shortfalls in uncompensated care. A lower percentage of hospitals in both groups of rural hospitals reported including bad debt in uncompensated care (34% for CAHs and 35% for non-CAH rural) than was included by the other groups (47% for high population areas and 48% for other urban and suburban hospitals). A greater percentage of rural hospitals (28% for CAHs and 31% for non-CAHs) as compared with the other groups (12% for high population and 15% for other urban and suburban) reported including private insurance shortfalls in uncompensated care.

Figure 81 displays the results grouped by type of shortfall or bad debt instead of by community type.

Figure 81. Percentage of Hospitals that Include Various Shortfall Amounts or Bad Debt in Uncompensated Care by Type of Coverage (n=489)



The figure shows that greater percentages of hospitals across all community types reported including shortfalls from self pay patients and bad debt than from Medicare and Medicaid.

The following highlights various reported components of uncompensated care.

- **Bad debt as uncompensated care:** A smaller percentage of both groups of rural hospitals reported including bad debt in uncompensated care compared with the other groups.

- **Medicare shortfalls as uncompensated care:** A larger percentage of both groups of rural hospitals reported including the difference between hospital charges and the amount Medicare paid or allowed for services in uncompensated care compared with the other groups.

- **Medicaid shortfalls as uncompensated care:** Non-CAH rural hospitals reported the highest percentage of hospitals including the difference between hospital charges and the amount Medicaid paid or allowed for services in uncompensated care. The amount reported by non-CAH rural hospitals (34%) is much higher than reported by any other group.

- **Other public insurance shortfalls (other than Medicare and Medicaid) in uncompensated care:** A higher percentage of both types of rural hospitals (CAH and non-CAH) reported including the difference between hospital charges and the amount other public insurance programs paid or allowed in uncompensated care compared with the other groups.

- **Self pay shortfalls as uncompensated care:** At least 47% of the hospitals in each community type reported including the difference between hospital charges and the amount paid by self-pay patients for services as uncompensated care. Hospitals in the rural-non CAH category reported the highest percentage (62%).

- **Private insurance shortfalls as uncompensated care:** The percentage of rural hospitals that reported including the difference between hospital charges and the amount private insurance paid or allowed for services in uncompensated care was higher than that reported by hospitals in the other groups.

2. Reporting of Shortfalls and Bad Debt by Revenue Size

Figure 82 shows the percentage of hospitals in various revenue size categories that reported including shortfall amounts or bad debt in uncompensated care. The two largest revenue sizes ($250 million to $500 million and over $500 million) were combined to prevent potential identification of respondent hospitals.

Figure 82. Percentage of Hospitals that Include Various Shortfall Amounts or Bad Debt in Uncompensated Care by Revenue Size (n=489)

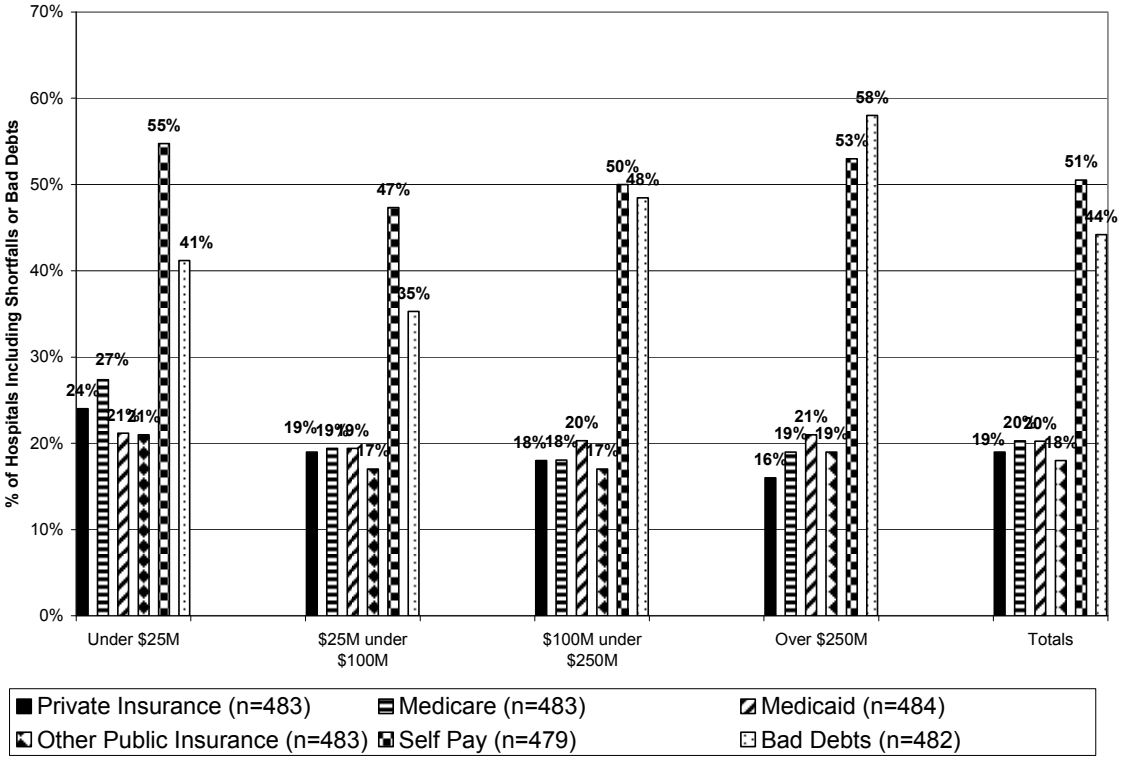
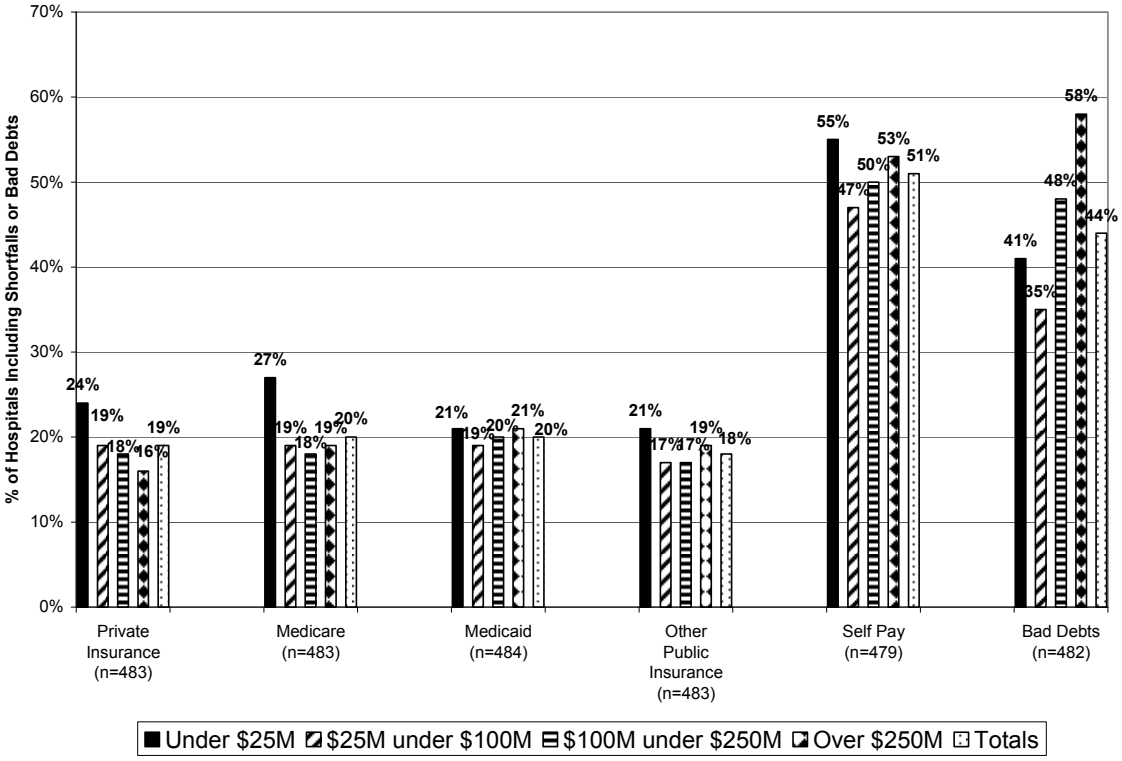


Figure 82 shows that the percentage of hospitals that reported including Medicare or Medicaid shortfalls was materially less than the percentage that reported including shortfalls from self pay patients or bad debt. This variance was more pronounced in hospitals that reported total revenues of more than $250 million, but was less pronounced in hospitals that reported total revenues under $25 million. Although not displayed in these figures to prevent potential identification of respondent hospitals, hospitals in the over $500 million revenue size had the highest percentage of hospitals including bad debt in uncompensated care and the smallest percentages of hospitals including private insurance, Medicare, Medicaid, or other public insurance in uncompensated care.

Figure 83 displays the results grouped by type of shortfall or bad debt instead of by revenue size.

Figure 83. Percentage of Hospitals that Include Various Shortfall Amounts or Bad Debt in Uncompensated Care by Type of Shortfall or Bad Debt (n=489)



The following highlights various reported components of uncompensated care.

- **Bad debt as uncompensated care:** By revenue size, with the exception of the under $25 million group, the percentage of hospitals including bad debt in uncompensated care increased as hospital size increased.

- **Medicare shortfalls as uncompensated care:** Hospitals in the under $25 million revenue category reported the highest percentage including Medicare shortfalls in uncompensated care. Although not displayed in the figures to prevent potential identification of respondent hospitals, the percentage of hospitals in the over $500 million revenue category was lower than that reported by all other groups.

- **Medicaid shortfalls as uncompensated care:** Although not displayed in the figures to prevent potential identification of respondent hospitals, hospitals in the $250 million to under $500 million revenue category reported the highest percentage of hospitals including Medicaid shortfalls in uncompensated care. Hospitals in the over $500 million revenue category reported a smaller percentage compared with the other groups. The percentage reported by the remaining groups was very similar.

- **Other public insurance shortfalls (other than Medicare and Medicaid) in uncompensated care:** Hospitals in the $25 million to under $250 million revenue categories reported percentages very similar to the total group. Although not displayed in the figures to prevent potential identification of respondent hospitals, hospitals in the largest revenue category (over $500 million) reported a smaller percentage of hospitals including other public insurance shortfalls in uncompensated care.

- **Self pay shortfalls as uncompensated care:** By revenue size categories, the percentages reported by the groups were similar, ranging from 47% ($25 million to under $100 million) to 55% (under $25 million).

- **Private insurance shortfalls as uncompensated care:** With the exception of the over $500 million revenue category, the percentage of hospitals that reported including private insurance shortfalls was similar ranging from 18% to 24%. Although not displayed in the figures to prevent potential identification of respondent hospitals, the percentage reported by the over $500 million category was smaller (9%).

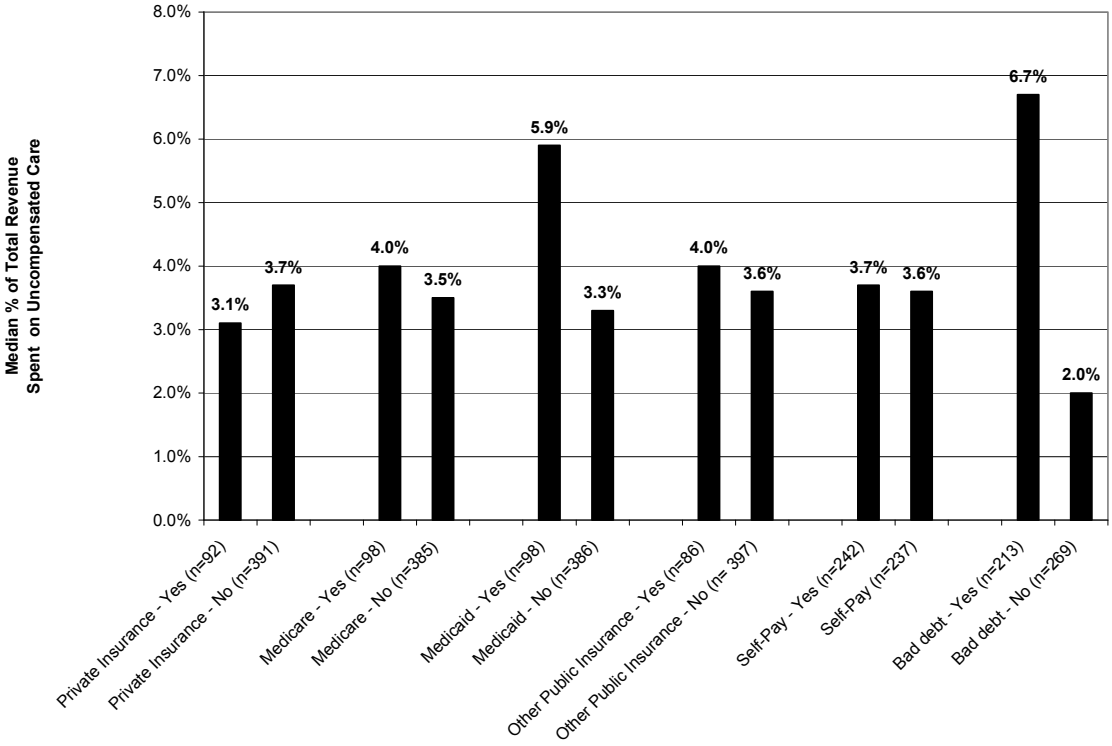
3. Reporting Differences when Shortfalls and Bad Debt are Included in Uncompensated Care

This section compares aggregate uncompensated care amounts reported by hospitals depending upon whether they included or excluded particular items of uncompensated care.

Figure 84, below, shows the median percentage of revenue reported as spent on all uncompensated care, depending on whether the hospital included or excluded the relevant shortfall or bad debt expense in uncompensated care. For example, the first two bars in the chart show that for the 92 hospitals that reported including private insurance shortfalls in uncompensated care, the median percentages of aggregate reported uncompensated care as a percentage of total revenues was 3.1%, contrasted with a median of 3.7% for the 391 hospitals that did not include private insurance shortfalls in uncompensated care.

The median percentage of revenues reported as spent on uncompensated care was relatively similar for respondents that reported including payment shortfalls from private insurance, Medicare, other public insurance, and individuals without insurance in their calculation of uncompensated care and those that did not. However, greater differences are shown in the median percentage of revenue reported as spent on uncompensated care, depending upon whether organizations included Medicaid shortfalls or bad debt expense in uncompensated care.

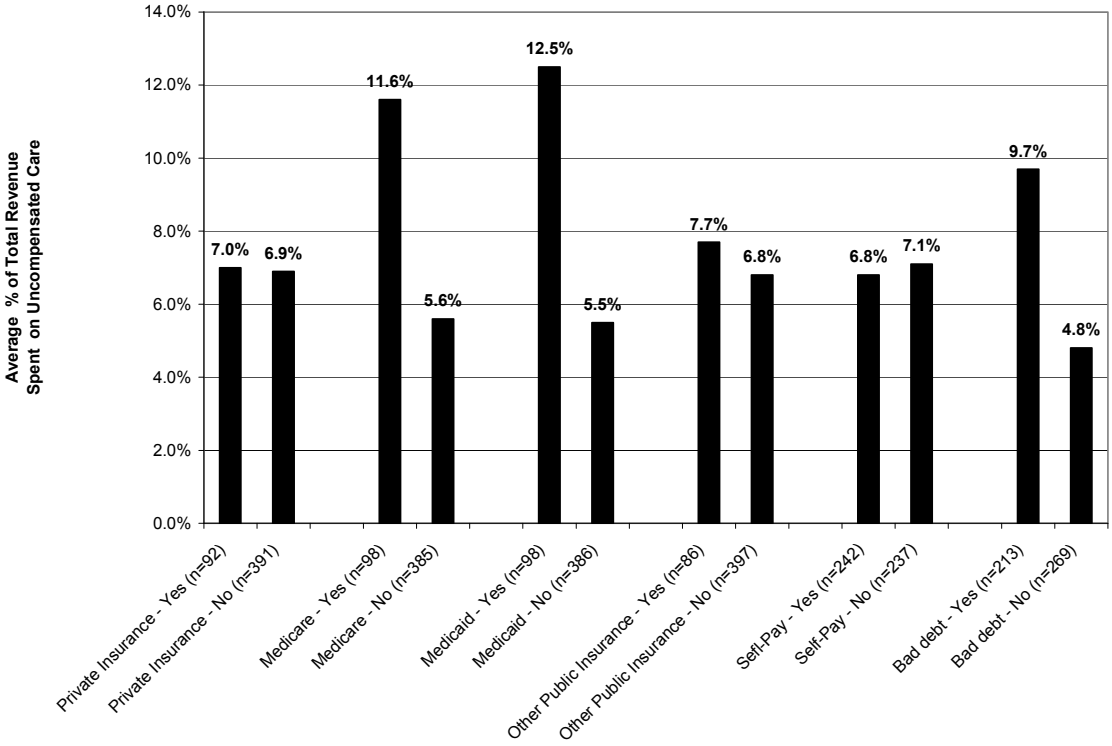
Figure 84. Reporting Differences When Shortfalls and Bad Debt are Included in Uncompensated Care (Median % of Revenue Spent)



The median percentage of revenue reported as spent on uncompensated care of respondents that included the difference between what Medicaid paid or allowed for services and hospital charges reported was 5.9% while the median percentage of those that did not include these amounts was 3.3%. The median percentage of revenue reported as spent on uncompensated care of respondents that included bad debt expense in uncompensated care was 6.7% while the median percentage of those that did not include bad debt in uncompensated care was 2%.

Figure 85 shows the average percentage of revenue reported as spent on uncompensated care was relatively similar for respondents that reported including payment shortfalls from private insurance, other public insurance, and individuals without insurance, in their calculation of uncompensated care and those that did not. However, greater differences are shown in the average percentage of revenue reported as spent on uncompensated care, depending on whether organizations included shortfalls from Medicare, Medicaid or bad debt expense in uncompensated care.

Figure 85. Reporting Differences When Shortfalls and Bad Debts are Included in Uncompensated Care (Average % of Revenue Spent)



The average percentage of revenue spent on uncompensated care was higher for respondents that reported including bad debt, Medicare, and Medicaid shortfalls than for those that excluded such items.

D. Comparison of Community Benefit Expenditures Across Various Income and Health Insurance Coverage Levels

1. Overview

This section examines whether there is a correlation between the level of community benefit expenditure and the income or health insurance coverage level of the community where the hospital is located. In looking at the connection between income levels and community benefit expenditures, the study focused on per capita income levels, using both a statewide and nationwide comparison. The possible connection between community benefit expenditures and health insurance coverage levels was also analyzed under two approaches. The first looked at insurance coverage rates within counties. The second compared the county coverage rate with coverage rates nationwide.[56]

[56] Two approaches were utilized to examine the possible connection between income and health insurance coverage levels to gauge the validity of the results and to determine whether a different methodology would produce materially different results.

2. Community Benefit Expenditures Across Community Per Capita Income Levels

Demographic information was collected from the US Census Bureau for each of the areas where the 485 respondent hospitals that reported community benefit expenditures were located. This information was collected and tabulated both by state and by county using the ZIP Code for each hospital's address that was on the questionnaire. Information collected included population, per capita income,[57] levels of insurance coverage,[58] and percentage of the population living in poverty.

Utilizing the information collected from the US Census Bureau, hospitals were classified based upon the per capita income of the surrounding geographic area, as designated by the county in which each hospital was located. Two different methods were employed to divide the sample into per capita income categories.

State per capita income method

The first method categorized hospitals based on how the per capita income in its county compared to the statewide per capita income (referred to as the "state per capita income" method). Under the state per capita income method, the hospitals were divided into the following categories:

- **Below state average**: includes respondents in counties where the per capita income was more than 5% below the per capita income of the corresponding state (276 hospitals);
- **At state average**: includes respondents in counties where the per capita income was within 5% above or below the per capita income of the corresponding state (89 hospitals); and
- **Above state average**: includes respondents in counties where the per capita income was more than 5% higher than the per capita income of the corresponding state (120 hospitals).[59]

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[57] Per capita income information was drawn from the U.S. Census Bureau's 2000 Census of Population and Housing. Per capita income is the average money income received in 1999 computed for every man, woman, and child in a geographic area. It is derived by dividing the total income of all people 15 years old and over in a geographic area by total population in that area. Income is not collected for people under 15 years old even though those people are included in the denominator of per capita income.

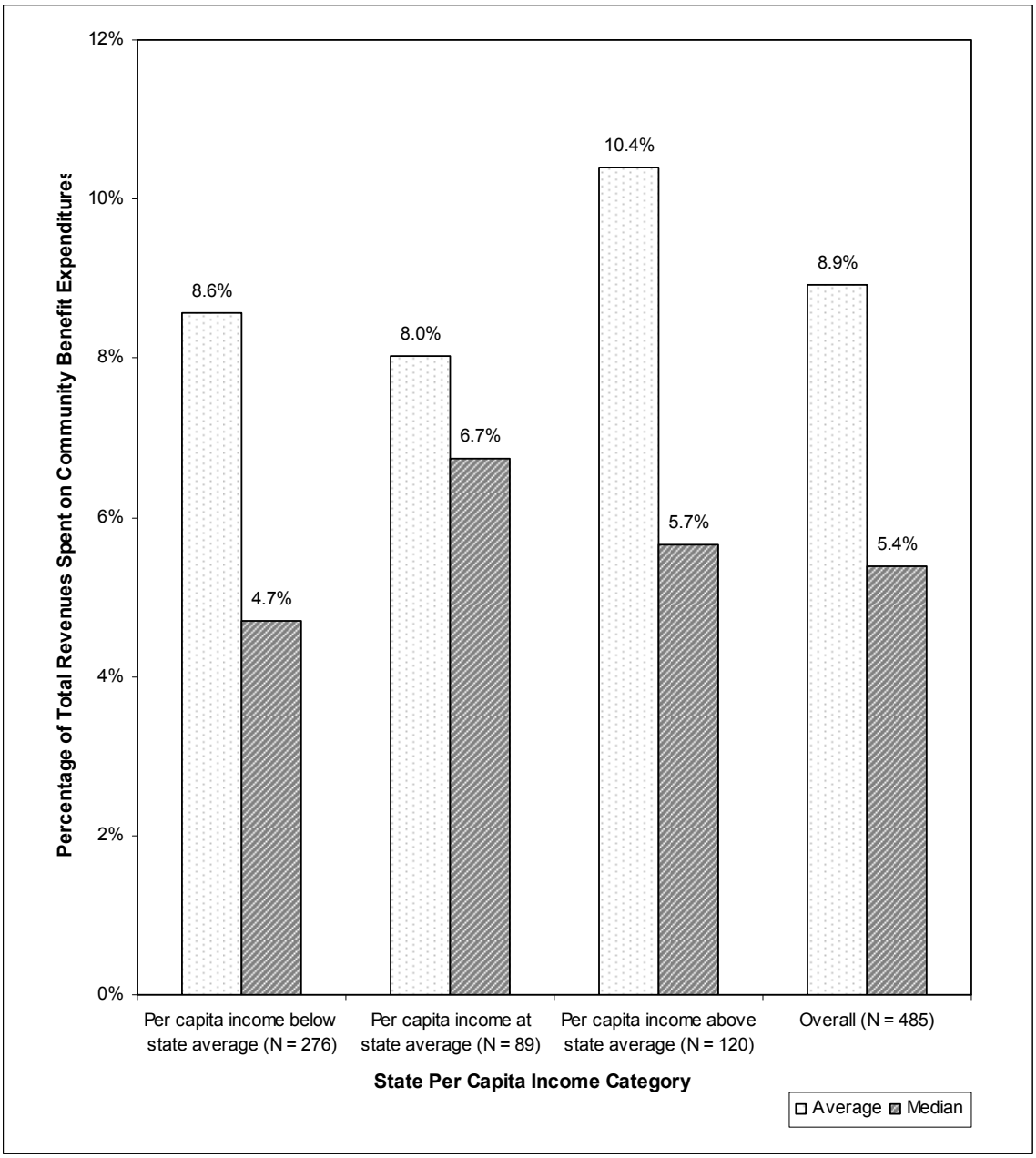
[58] Information on health coverage was drawn from the U.S. Census Bureau's 2000 Small Area Health Insurance Estimates (SAHIE). The Census Bureau defines persons insured as those who have health insurance coverage, including private health insurance, Medicaid, Medicare, and/or State Children's Health Insurance Program (but not including the Indian Health Service). Persons uninsured are those who are not categorized as insured through any of those programs. The SAHIE are experimental estimates. The SAHIE is a new program at the Census Bureau and the first ever set of estimates was released in July, 2005.

[59] 5% above or below was arbitrarily selected to represent a material deviation from the state average. This resulted in a greater distribution of hospitals in the "below state average" group than in the other groups. This might be the result of a study sample with a disproportionately

Figure 86, below, shows the percentage of total revenues reported as spent on community benefit expenditures across per capita income categories under the state per capita income method.

higher percentage of hospitals in areas with low per capita income amounts, or our selection of 5% as not accurately distinguishing “below” or “above” hospitals from the norm.

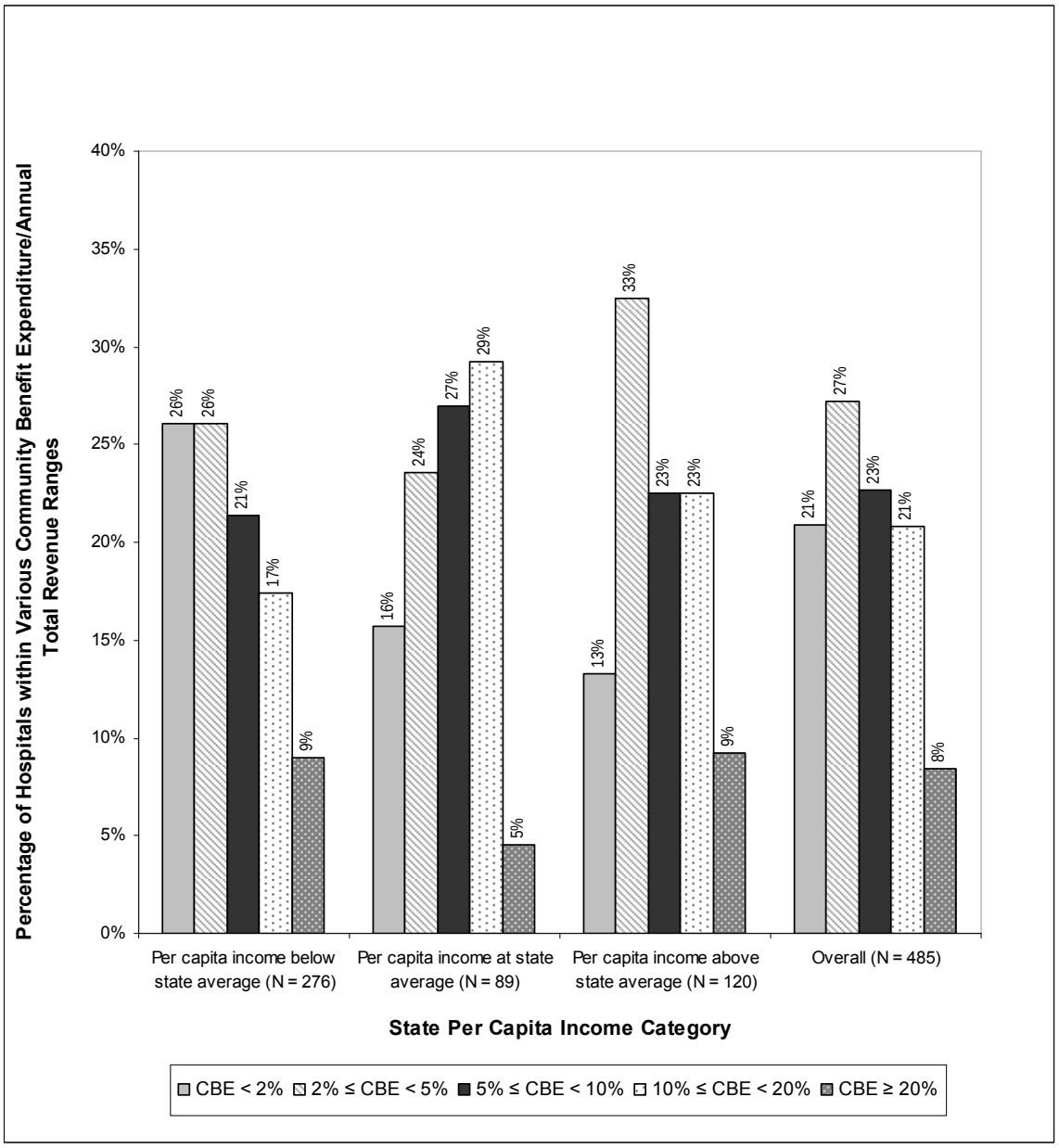
Figure 86. STATE PER CAPITA INCOME METHOD
Percentage of Total Revenues Spent on Community Benefit Expenditures
Across Various Per Capita Income Categories
(Averages and Medians)



The results indicate that hospitals in areas with per capita income above the state average reported spending a higher percentage of their total revenue on community benefit expenditures (average, 10.4% and median, 5.7%) than did respondents in areas with per capita income below the state average (average, 8.6% and median, 4.7%). The average and median percentages for the overall group of 485 hospitals were 8.9% and 5.4%, respectively.

Figure 87 illustrates the percentage of hospitals within each of various ranges of total revenue spent on community benefit expenditures across the three per capita income categories under the state per capita income method.

Figure 87. STATE PER CAPITA INCOME METHOD
Distribution of Community Benefit Expenditures Across Per Capita Income Categories



The chart does not show a clear correlation between per capita income and the level of community benefit expenditure. The percentage of hospitals that reported community benefit expenditures at less than 2% of revenues (i.e., the lowest percentage of revenue category) was highest (26%) when per capita income was below the state level and lowest (13%) when the per capita income was above the state level.

U.S. per capita income method

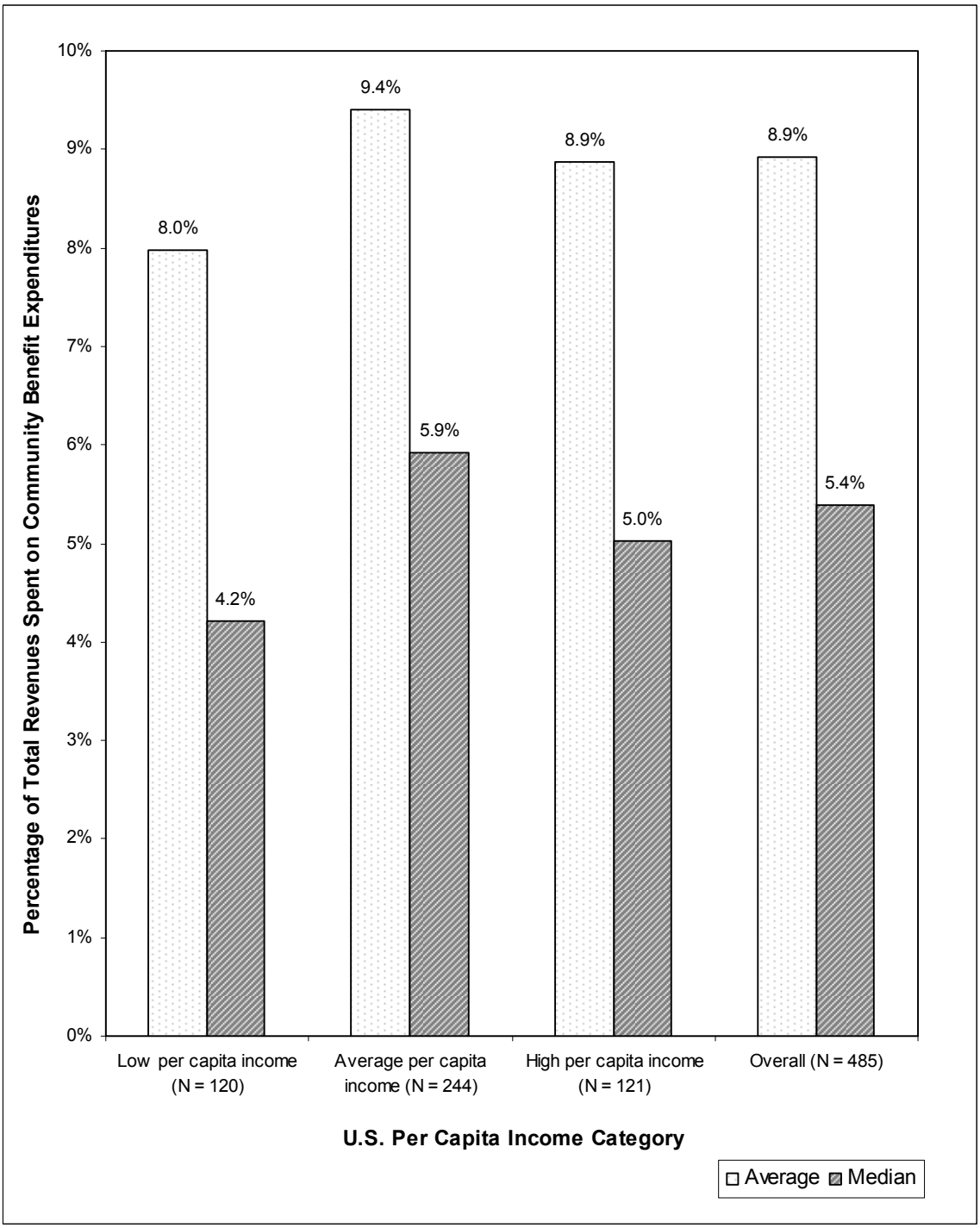
The second approach used to classify hospitals into per capita income categories was based on how the per capita income in the respondent's county compared to the per capita income of U.S. counties nationally (referred to as the "U.S. per capita income" method). Under the U.S. per capita income method the hospitals were divided into the following categories:

- **Low per capita**: includes respondents in counties where the per capita income was in the bottom 25% of U.S. counties nationwide (120 hospitals);
- **High per capita**: includes respondents in counties where the per capita income was in the top 25% of U.S. counties nationwide (121 hospitals); and
- **Average per capita**: includes respondents in the remaining U.S. counties that were not described in either of the above two categories (244 hospitals).[60]

Figure 88 shows the percentage of total revenues spent on community benefit expenditures across the per capita income categories under the U.S. per capita income method.

[60] This method forced a bell curve distribution to test whether the results would vary compared to the state per capita income method.

Figure 88. U.S. PER CAPITA INCOME METHOD
Percentage of Annual Total Revenues Spent on Community Benefit Expenditures
Across Various Per Capita Income Categories
(Averages and Medians)

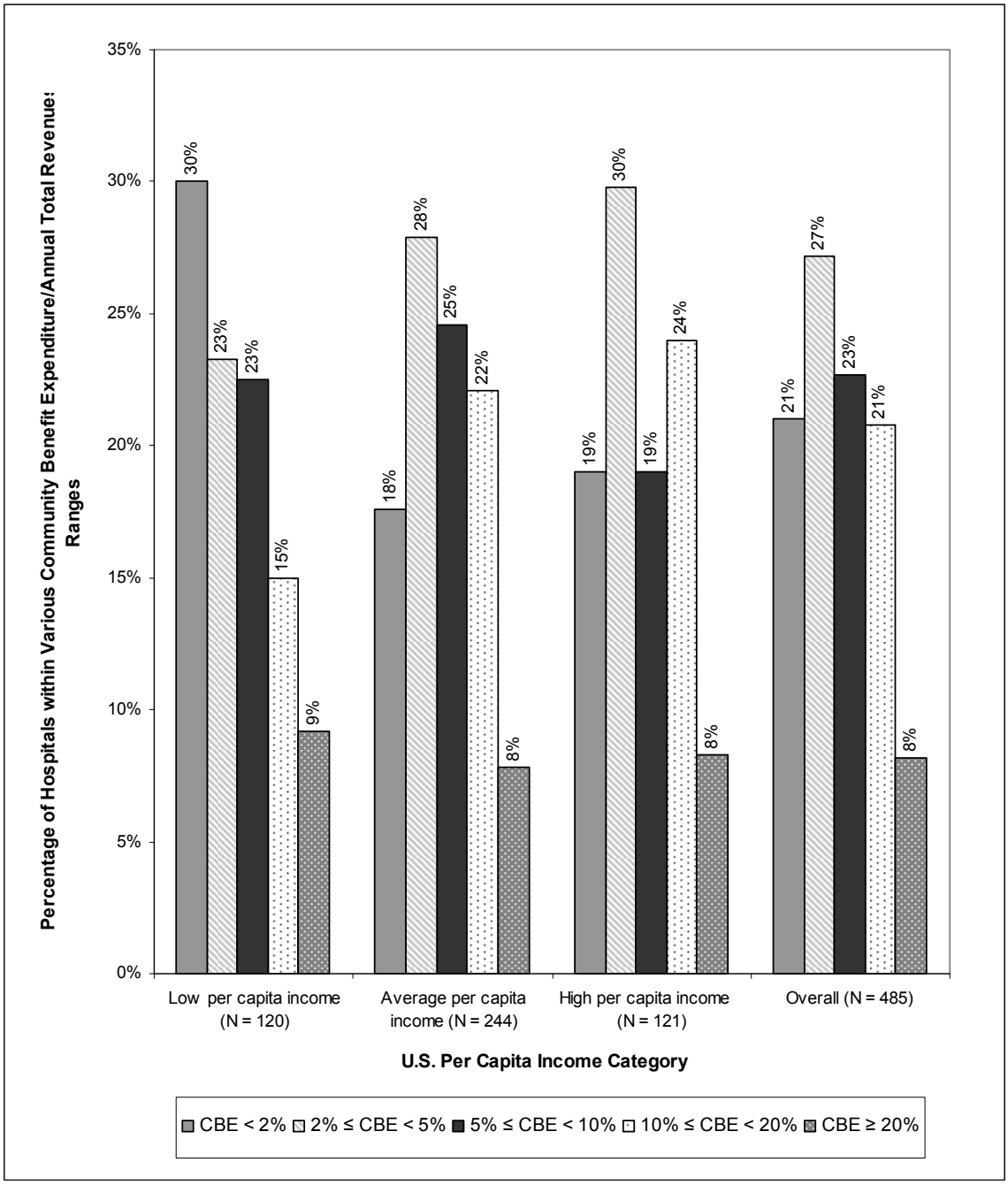


The chart shows relatively similar percentages for each group. The results indicate that respondent hospitals in areas with low per capita income under the U.S. per capita income method reported spending a slightly lower percentage of

their total revenue on community benefit expenditures (average, 8.0% and median, 4.2%) than did respondents in either of the two other per capita income categories. These results differed somewhat from those under the state per capita income method under which the amount of community benefit expenditure by the hospitals with per capita income below the state level was very similar to that of the overall group. The state per capita income method also showed a less uniform distribution in the averages and medians for the various groups than the chart above.

Figure 89 illustrates the percentage of hospitals that fall into various ranges of total revenue spent on community benefit expenditures across the three U.S. per capita income categories.

Figure 89. U.S. PER CAPITA INCOME METHOD
Distribution of Community Benefit Expenditures Across Per Capita Income Categories



This chart illustrates a similarity among all three categories in the percentage of hospitals that reported spending 20% or more of total revenue on community benefit expenditures (8%-9%). The percentage of hospitals that reported spending less than 2% of total revenues on uncompensated care was highest for hospitals in the low per capita income categories. This is consistent with the state per capita income method.

Based on the reported data, both the state and U.S. per capita income method suggest that there does not appear to be a correlation in the study group between per capita income of the surrounding area and the amount of community benefit expenditures incurred by the hospital.

3. Community Benefit Expenditures Across Community Health Insurance Coverage Levels

This section analyzes the extent to which aggregate community benefit expenditures varied depending upon the insurance coverage levels (uninsured rate) of the hospital's surrounding area.

Hospitals were analyzed based upon levels of insurance coverage in the county where the hospital is located. Two different methods were employed to divide the sample into insurance coverage rate categories. Both methods categorize respondents into three categories: high, medium, and low health coverage rates.

County uninsured rate method

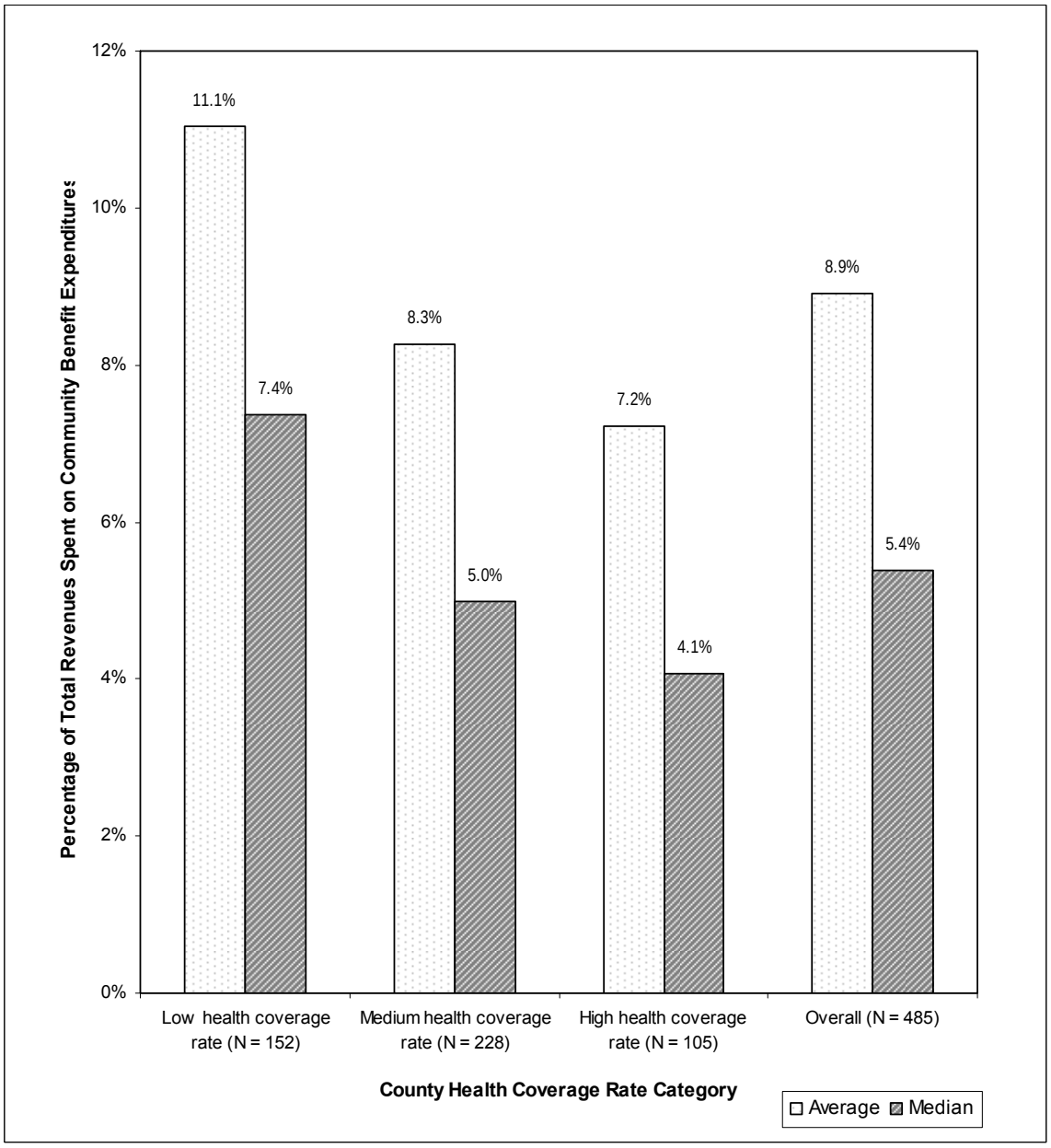
Under the first method (referred to as the "county uninsured rate" method), hospitals were divided into the following categories based on the uninsurance rate of the county where located:

- **Low health coverage rate:** includes counties where more than 13% of the population was uninsured (152 hospitals);
- **Medium health coverage rate:** includes counties where between 9% and 13% of the population was uninsured (228 hospitals); and
- **High health coverage rate:** includes counties where less than 9% of the population was uninsured (105 hospitals).[61]

Figure 90 shows the percentage of revenues spent on community benefit expenditures by hospitals as categorized under the county uninsured rate method.

[61] The coverage rates were selected based on the distribution of the coverage rates of the counties of the hospitals in the study.

Figure 90. COUNTY UNINSURED RATE METHOD
Percentage of Annual Total Revenues Spent on Community Benefit Expenditures
Across Health Coverage Categories
(Averages and Medians)

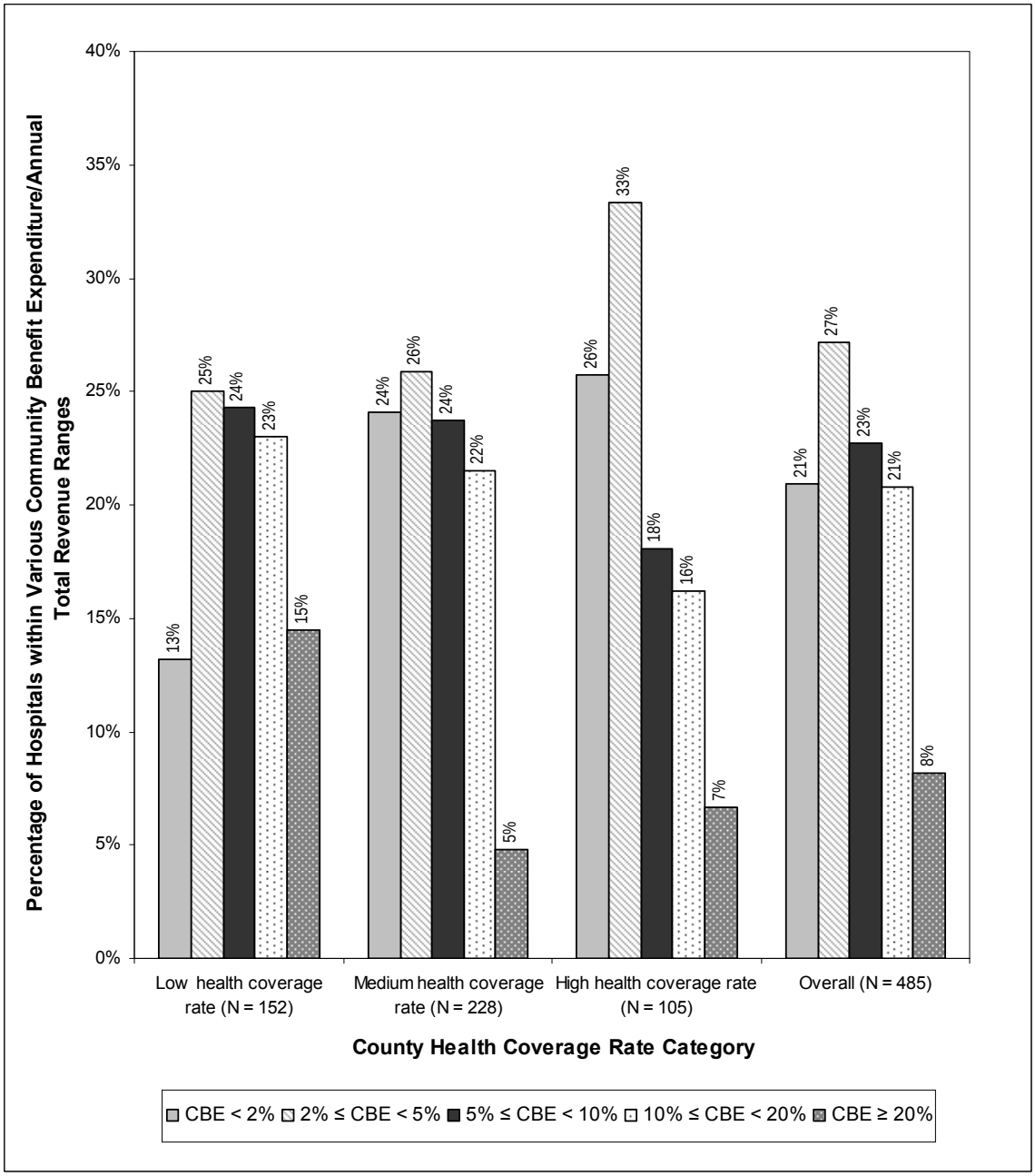


The results indicate that respondents in areas with low health coverage rates (higher uninsured rates) reported higher levels of community benefit expenditures. Under this method, the percentage of revenues reported as spent on community benefit expenditures increased as the percentage of uninsured individuals increased. Hospitals in low health coverage areas (higher uninsured rates) reported an average community benefit expenditure amount of 11.1% of their total revenue (median 7.4%) while hospitals in high health coverage areas

(lower uninsured rates) reported an average community benefit expenditure of 7.2% of total revenue (median 4.1%).

Figure 91 further illustrates the distribution of hospitals within varying community benefit expenditures across the different county health coverage rates under the county uninsured rate method.

Figure 91. COUNTY UNINSURED RATE METHOD
Distribution of Community Benefit Expenditures Across Health Coverage Categories



The chart shows that the low health coverage group reported a higher percentage of hospitals spending at least 20% of revenues on community benefit

expenditures. The largest percentage of hospitals spending less than 2% of revenues on community benefit expenditures was in the high health coverage (lower uninsured rates) group. The percentage of hospitals reporting <5% of total revenues on community benefit expenditures decreased as insurance coverage levels decreased. These results suggest a connection between community benefit expenditure levels and the uninsured rate of the area surrounding the hospital (i.e., expenditures generally increased as the uninsured rate increased).

Nationwide comparison method

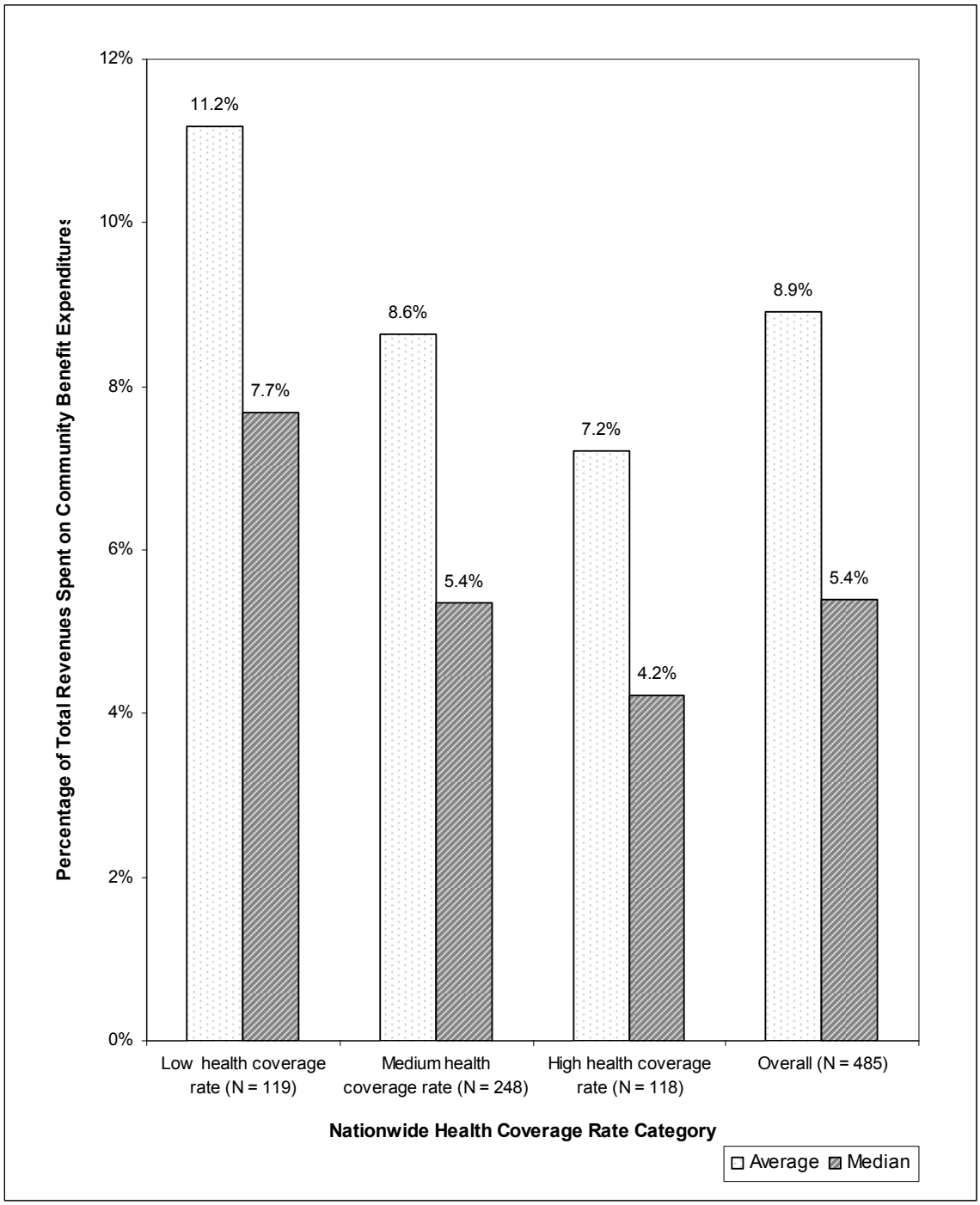
The second method used to assess the possible correlation of community benefit expenditures to health insurance coverage levels categorized the hospitals by comparing the county's percentage of insured individuals with the percentage for counties nationwide (referred to as the "nationwide comparison method"). Under this method, the communities were divided into the following three categories:

- **Low health coverage rate:** includes counties where the percentage of the population insured was in the bottom 25% of counties nationwide (119 hospitals);
- **High health coverage rate:** includes counties where the percentage of the population insured was in the top 25% of counties nationwide (118 hospitals); and
- **Medium health coverage rate**: includes the remaining counties that were not included in either of the above two categories (248 hospitals).[62]

Figure 92 reports the percentages of revenues spent on community benefit expenditures across these health insurance coverage categories.

[62] This method forced a bell curve distribution to test whether the results would vary compared to the county uninsured rate method.

Figure 92. NATIONWIDE COMPARISON METHOD
Percentage of Annual Total Revenue Spent on Community Benefit Expenditures
Across Health Coverage Categories
(Averages and Medians)

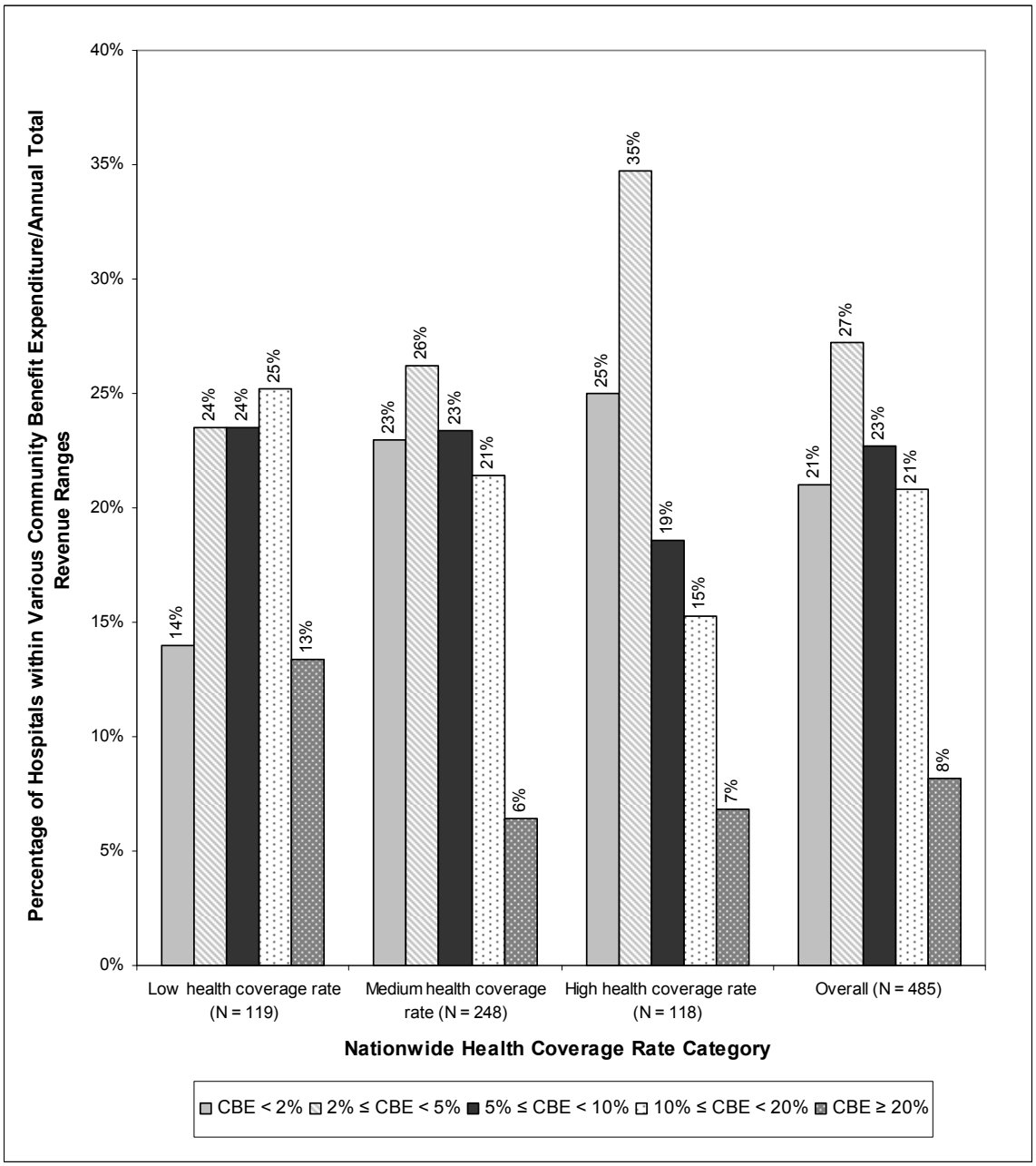


The results under this method are similar to those under the county uninsured rate method. As under the county uninsured rate method, the results indicate that respondents in areas with low health coverage rates reported higher levels of community benefit expenditures. Hospitals in low health coverage areas

reported an average community benefit expenditure amount of 11.2% of their total revenue (median 7.7%) while hospitals in high health coverage areas reported spending an average of 7.2% of their total revenue (median 4.2%) on community benefit expenditures.

Figure 93 shows the distribution of hospitals by the health coverage rate category determined under the nationwide comparison method and percentage of revenues spent on community benefit expenditures.

Figure 93. NATIONWIDE COMPARISON METHOD
Distribution of Community Benefit Expenditures Across Health Coverage Categories



This distribution is similar to that under the county uninsured rate method. As the charts above show, a greater percentage of hospitals in the low health coverage rate category spent more than 20% of revenues on community benefit expenditures. Hospitals in the high health coverage rate category had the greatest percentage of hospitals that reported spending less than 5% of revenues on community benefit expenditures. This was consistent with the results under the county uninsured rate method, and suggests a connection between community benefit expenditure levels and the uninsured rate of the area surrounding the hospital (i.e., expenditures generally increased as the uninsured rate increased).

4. Interaction Between Per Capita Income and Health Insurance Coverage

The figures presented earlier in this section suggest that there does not appear to be a correlation between per capita income and the aggregate amount of community benefit expenditure for the various hospitals, but there does appear to be a correlation between the amount spent on community benefit expenditures and the health insurance coverage rate (or uninsured rate) of the surrounding community.[63]

The figures below show the distribution of the hospitals as categorized under the per capita and health insurance coverage methods described above.

Figure 94 shows the distribution of the hospitals as categorized by the state per capita income method and the two health insurance coverage categories. Figure 95 shows the distribution of the hospitals by the U.S. per capita income method and the two health insurance coverage categories.

Figure 94. Distribution of Hospitals as Categorized by the State Per Capita Income Method and Health Insurance Coverage Categories

	Health Coverage under County Uninsured Rate Method				Health Coverage under Nationwide Comparison Method			
State per capita income	Low health coverage rate	Medium health coverage rate	High health coverage rate	Overall	Low health coverage rate	Medium health coverage rate	High health coverage rate	Overall
Below state level	91	140	45	276	73	148	55	276
At state level	24	45	20	89	16	50	23	89
Above state level	37	43	40	120	30	50	40	120
Total	152	228	105	485	119	248	118	485

[63] The study focused on comparing aggregate community benefit expenditures rather than on components thereof, such as uncompensated care.

Figure 95. Distribution of Hospitals as Categorized by the U.S. Per Capita Income Method and Health Insurance Coverage Categories

	Health coverage under County Uninsured Rate method				Health coverage under Nationwide Comparison method			
U.S. per capita income	Low health coverage rate	Medium health coverage rate	High health coverage rate	Overall	Low health coverage rate	Medium health coverage rate	High health coverage rate	Overall
Low per capita	55	56	9	120	49	61	10	120
Average per capita	76	107	61	244	53	118	73	244
High per capita	21	65	35	121	17	69	35	121
Total	152	228	105	485	119	248	118	485

VII. EXECUTIVE COMPENSATION

A. Overview

The executive compensation component of the study was twofold. It included an analysis of the results of the executive compensation questions included in the questionnaire. Section VII.B discusses these results. The executive compensation component of the project also included examination of 20 hospitals from the study selected based, in part, on responses provided to the questionnaire. These results are discussed in Section VII.C, below.

B. Summary of Compensation Practices as Reported by Responding Hospitals

This section summarizes respondent data from Part III – Compensation Practices of the questionnaire. Part III of the questionnaire requested information on the compensation practices of the respondents with respect to their officers, directors, trustees and key employees, and any business relationships with such persons.

Not every hospital answered every question, and much of the data is based on fewer than 489 responses. Throughout this section, the number of responses that underlie the particular data are included.[64]

Section 4958, the intermediate sanction on excess benefit transactions, provides that an excess benefit transaction occurs when a disqualified person (any person in a position to exercise substantial influence over the affairs of the tax exempt organization) receives an economic benefit from an exempt organization that exceeds the value of consideration received by the organization. Rather than revoking the charity's tax-exempt status, section 4958 allows the IRS to impose an excise tax against the disqualified person and possibly the organization manager. The section 4958 regulations provide a three-pronged rebuttable presumption process (independent governing body, reliance on comparable data, and adequate documentation) that public charities may use when establishing what appropriate compensation is for a disqualified person.[65]

While the questionnaire did not specifically ask about whether the hospitals were using the rebuttable presumption, Questions 3 through 8 asked for information relevant to the process. The responses to the questions asked (particularly Question 3 and Question 8) indicate that use of the rebuttable presumption appears to be widespread.

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[64] In some cases, the number of responses is not included to prevent potential identification of respondent hospitals.

[65] Treas. Reg. section 53.4958-6. See also, H. Rep. No. 104-506, 104th Cong., 2d Sess. at 56-57.

List and compensation of officers, directors, trustees, and key employees (Question 1)

Question 1 asked the hospital to provide the names and titles of the hospital's officers, directors, trustees and key employees, and the amounts of salary and other compensation paid to each. For this purpose, salary was described to include all forms of cash and non-cash compensation received whether paid currently or deferred. Other compensation was described to include contributions to employee benefit plans and deferred compensation plans and expense allowances from non-accountable plans.

There was some variation in the data reported on the questionnaires. While many did provide information concerning all of their officers, directors, trustees and key employees, others only provided information about some of those individuals and a few provided no information. Hospitals that were part of systems or had management companies frequently reported that some or all of the compensation for their officers, directors, trustees and key employees was paid by other entities, and in some instances reported those amounts and in others did not. Thus, there are instances where the hospital identified its officers, directors, trustees and key employees, but provided no compensation amounts. There were also instances where the hospital reported compensation data, but did not provide the individual's positions.

Much of this variation in reporting is consistent with certain problems the IRS has encountered generally with Form 990 reporting of executive compensation, in particular, a lack of clarity regarding which persons to report, and how to report compensation paid by certain other organizations. The changes made to the redesigned Form 990 executive compensation reporting, including clearer definitions of officer, director, trustee, and key employee, as well as reporting of compensation paid by related or by other organizations and management companies, will help improve uniform reporting in this area. The IRS will follow-up with certain of these organizations through review by our Review of Operations unit (ROO) after the redesigned Form 990 filings are received to determine whether improvements have been made to the reporting of compensation paid to top management officials and other executives.

While other compensation data was reviewed, such as Forms 990, to select organizations for examination, the following analysis only includes data reported on the questionnaire. The respondents' data was reviewed to determine the average and median reported salary, other compensation, and total compensation of the organizations' top management officials. The question regarding compensation amounts for officers, directors, trustees, and key employees did not ask the organizations to identify a top management official. For this purpose, however, persons listed in the responses as "CEO" or "Chief Executive Officer" were treated as the top management official. If no person was listed as CEO or Chief Executive Officer, persons listed in the questionnaire

responses as "President," "Executive Director," or "Administrator" were treated as the top management official.

Based on review of the responses, 421 of the respondents listed a person with a title that, under the convention described above, was regarded as a top management official and reported a compensation amount from all sources greater than zero for such person. In 352 (84%) of those cases, the identified top management official had the highest compensation reported on the questionnaire for that hospital. The average and median salary paid to the top management official were $408,927 and $323,858, respectively, while the average and median other compensation were $81,504 and $34,611. When looking at total compensation paid to the top management official, the average and median were $490,431 and $377,256, respectively.

The identified top management official had the highest compensation reported on the questionnaire for 75% of the critical access hospitals, compared to 85% for the other three community types. Across revenue size, the hospitals reported paying the identified top management official the highest compensation as follows:

Under $25 million	72%
$25 - $100 million	84%
$100 - $250 million	92%
$250 - $500 million	87%
Over $500 million	71%

The average and median salary, other compensation, and total compensation was lower for the rural hospitals (CAH and non-CAH) than for the suburban and urban hospitals (high population and other urban and suburban). Among the community types, critical access hospitals had the lowest average compensation amounts and the hospitals in the highest population areas had the highest average compensation amounts. The average and median salary, other compensation, and total compensation increased as revenue levels increased. The following charts show the average and median salary and other compensation reported for the top management official, by community type and then by revenue size.

Figure 96. Salary and Other Compensation Reported for the Top Management Official by Community Type (Average and Median)

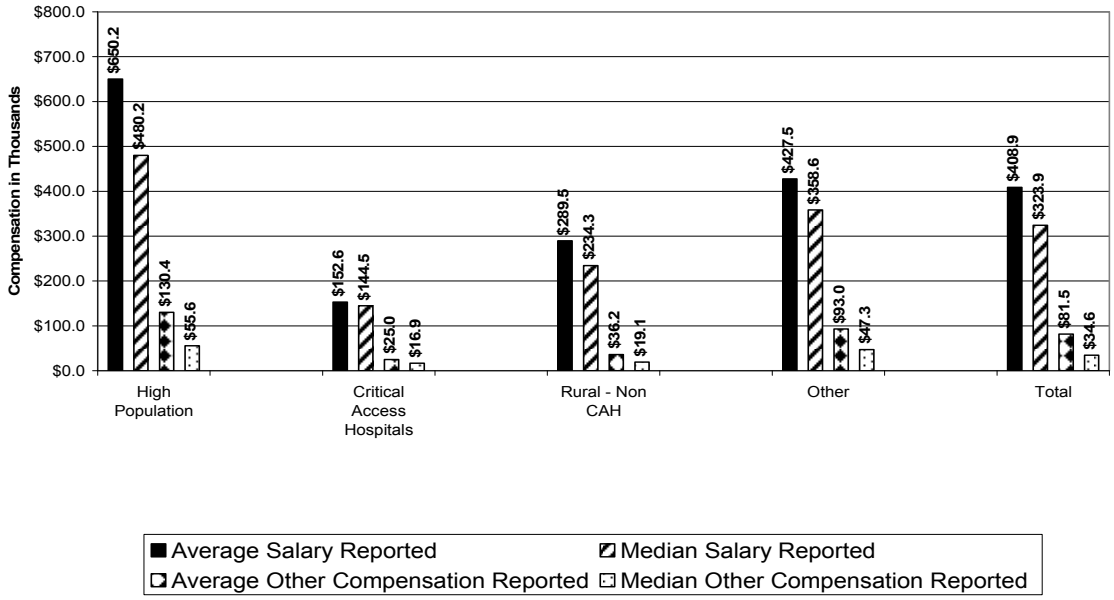
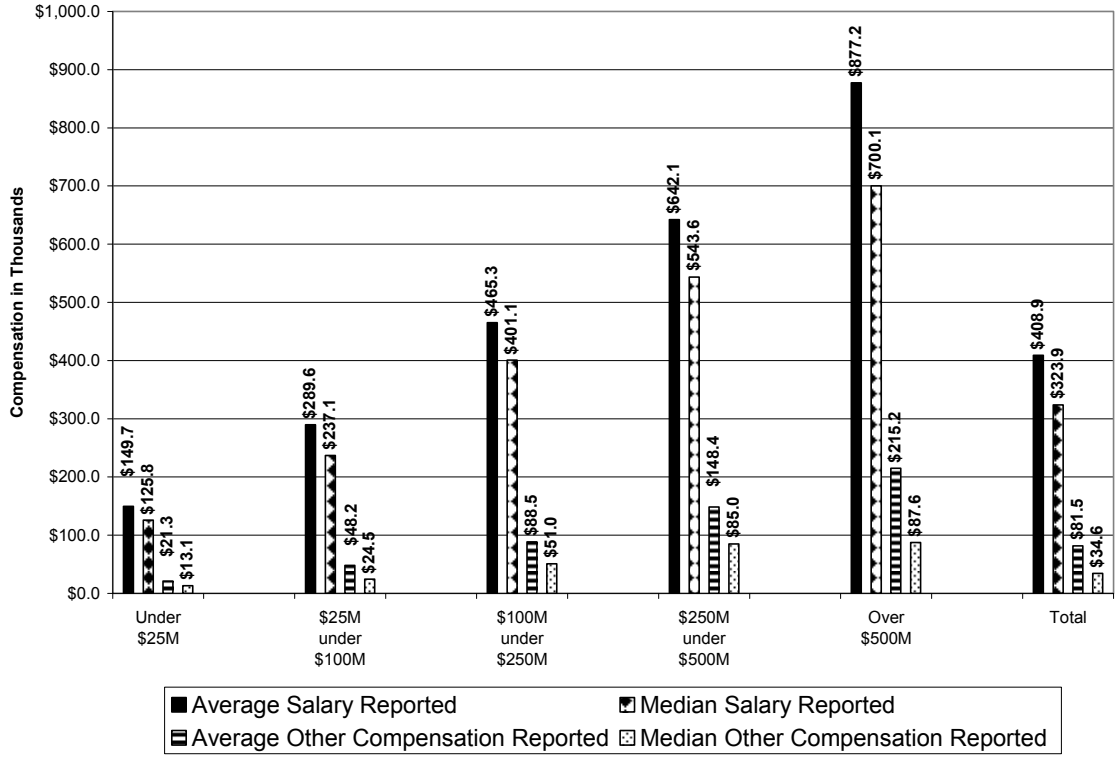


Figure 97. Salary and Other Compensation Reported for Top Management Official by Revenue Size (Average and Median)



The following charts show the average and median total compensation reported for the top management official, by community type and then by revenue size.

Figure 98. Total Compensation Reported for the Top Management Official by Community Type (Average and Median)

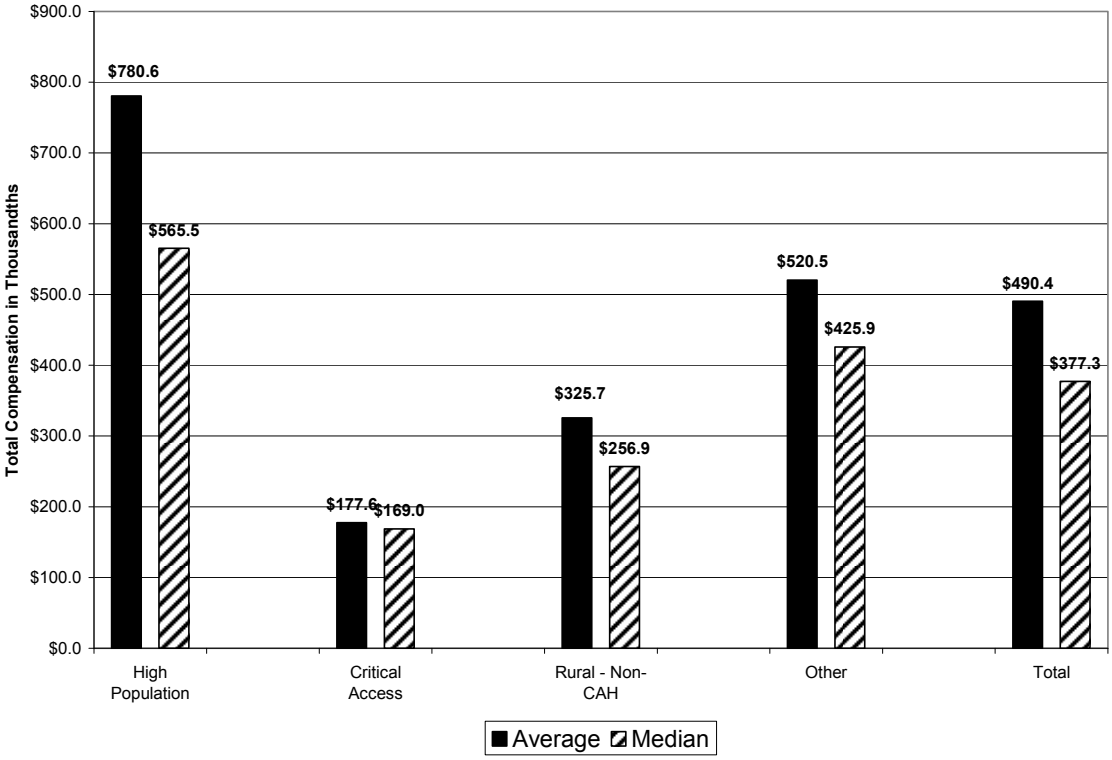
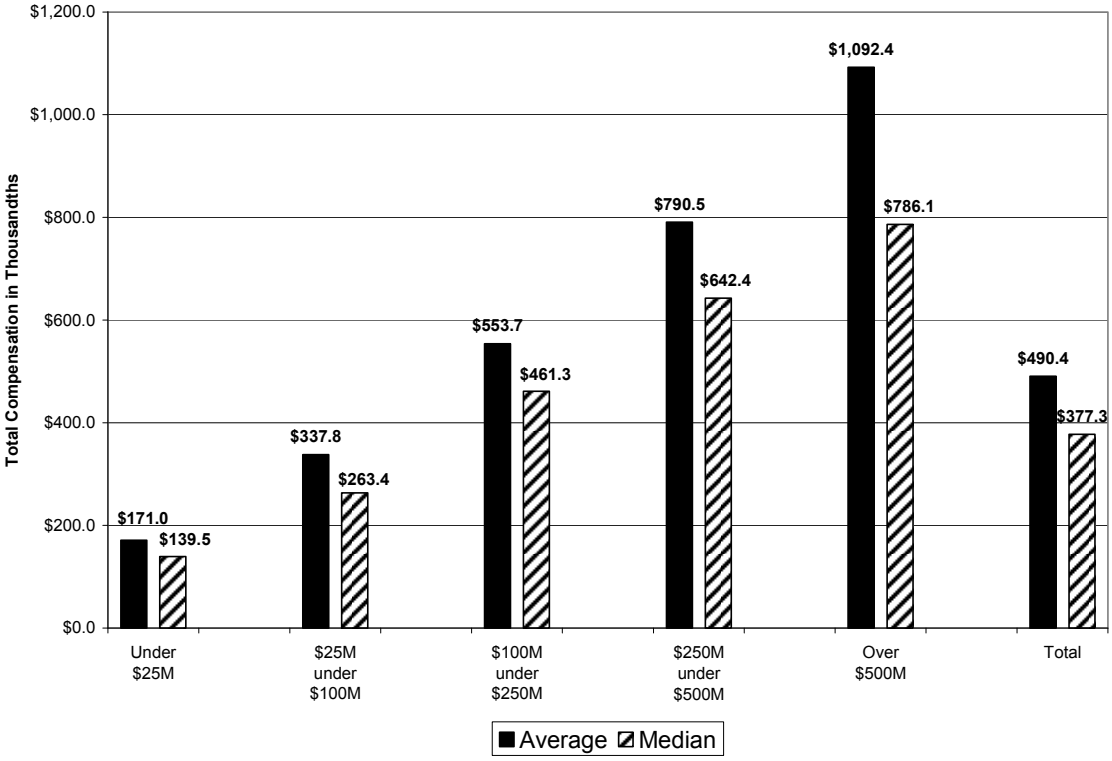


Figure 99. Total Compensation Reported for Top Management Official by Revenue Size (Average and Median)



Formal written compensation policy (Question 2)

Question 2 asked whether the hospital had a formal written compensation policy. 349 (73%) of 481 respondents reported having such a policy. This is generally consistent across community types, ranging from 64% to 79% of the hospitals having a formal written compensation policy. However, when looking at revenue size, only 54% of the hospitals with revenues under $25 million had a formal written compensation policy, while 87% of the hospitals with revenues between $250 million and $500 million did. The following charts show the percentage of hospitals that reported having a written compensation policy, first by community type and then by revenue size.

Figure 100. Percentage of Hospitals that Reported Having a Written Compensation Policy by Community Type

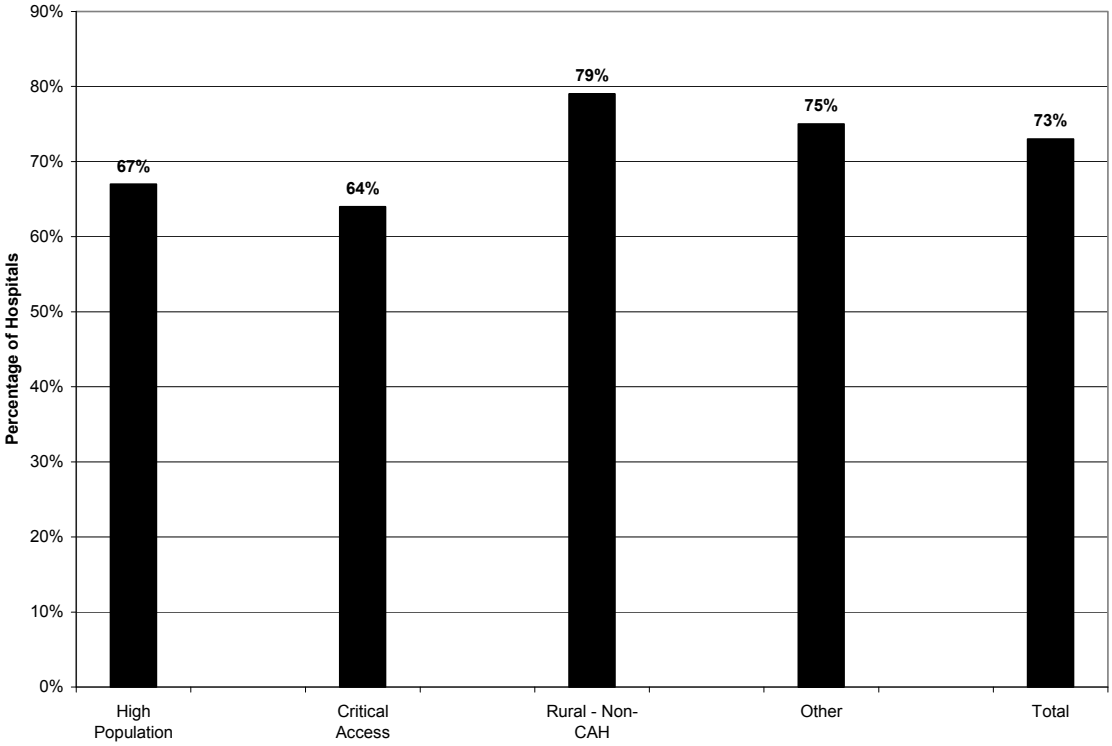
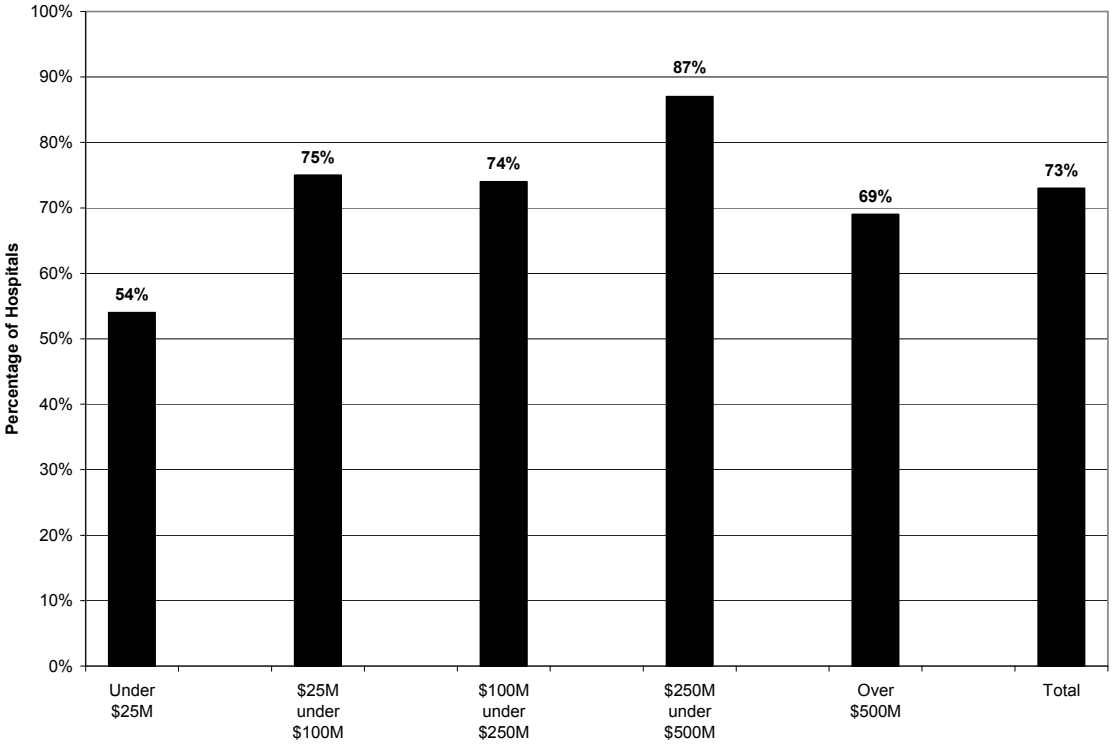


Figure 101. Percentage of Hospitals that Reported Having a Written Compensation Policy by Revenue Size



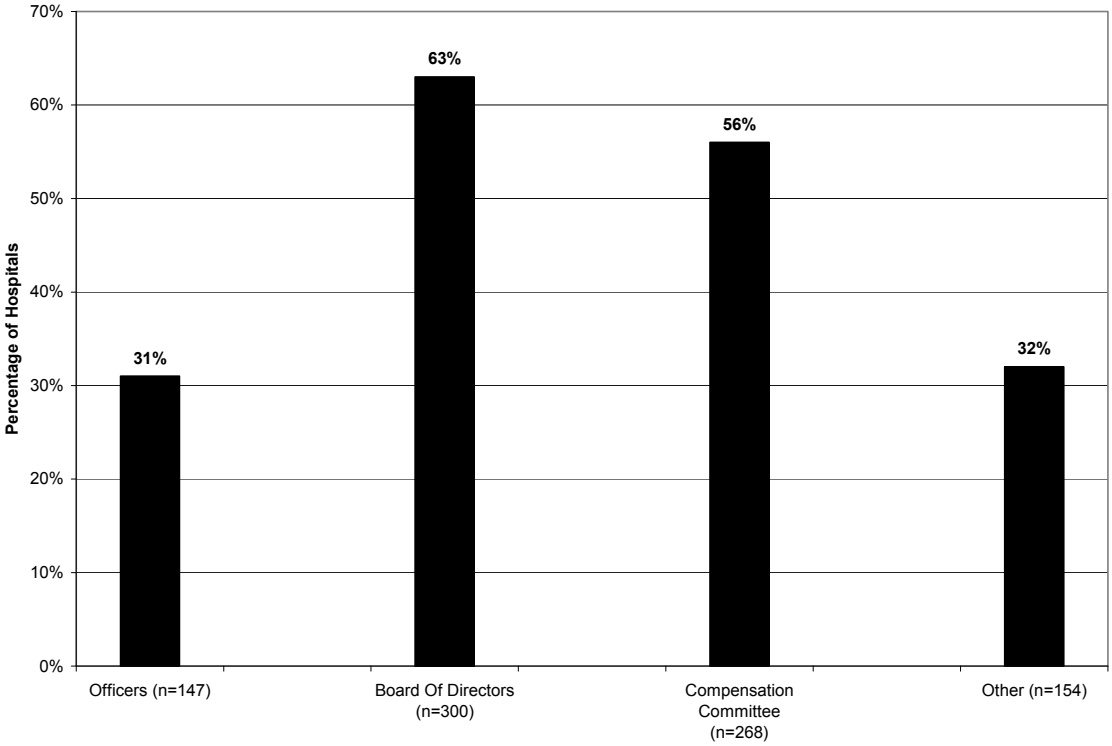
Approval of compensation in advance (Question 3)

Question 3 asked whether compensation was approved in advance by individuals that did not have a conflict of interest with the compensation arrangement being approved. 469 (98%) of 479 respondents reported that compensation was approved in advance by individuals that did not have a conflict of interest with the compensation arrangement being approved. Similar results were observed across community type and revenue size.

Organization officials responsible for establishing compensation (Question 4)

Question 4 asked who set the compensation for officers, directors, trustees, and key employees of the hospital – officers, the board of directors, a compensation committee, or others. The organization was instructed to check all that applied. For many respondents, compensation was determined by a combination of the categories.

Figure 102. Individual or Entity Reported to Determine Compensation (n=478)



Many of the organizations selecting "other" provided supplemental explanations which included one or more of the listed categories (for example, identifying specific officers that determined compensation). Also, some distinguished the Executive Committee of the Board as determining compensation, rather than the entire Board or a specific Compensation Committee. Some hospitals reported that the Human Resources Division determined compensation in a number of instances. Others reported that compensation was determined by the parent or another affiliated organization.

Compared to other community types, critical access hospitals reported the Board of Directors as setting compensation more often than the other groups (82% compared with 63% overall), while less than half of the hospitals located in the high population areas (48%) reported such. Of the community types, critical access hospitals reported the lowest incidence of the Compensation Committee setting compensation, while the urban and suburban hospitals (both those located in the high population areas and elsewhere) reported the highest. As the revenues increased for the hospitals, the percentage of hospitals that identified the Board of Directors as setting compensation generally decreased, while the percentage that identified the Compensation Committee significantly increased. Figure 103 and Figure 104, below, show the distribution of the individual or entity responsible for determining compensation, by community type and then by revenue size.

Figure 103. Distribution of Individual or Entity Reported to Determine Compensation by Community Type

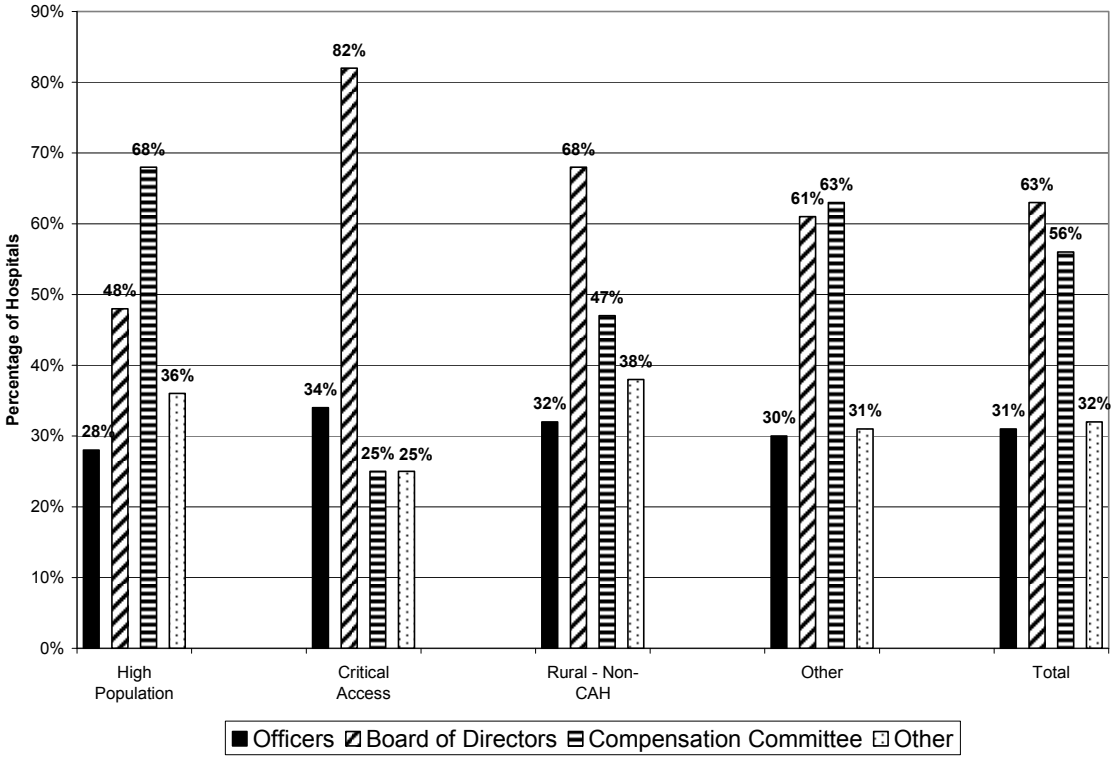
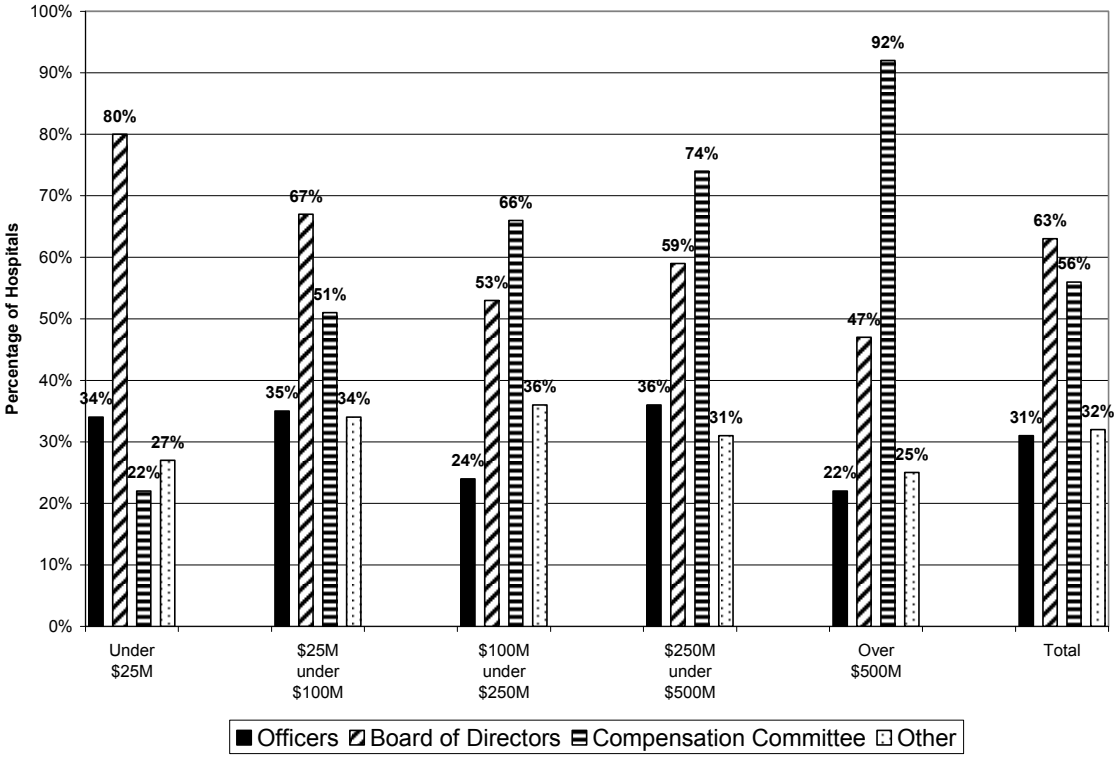
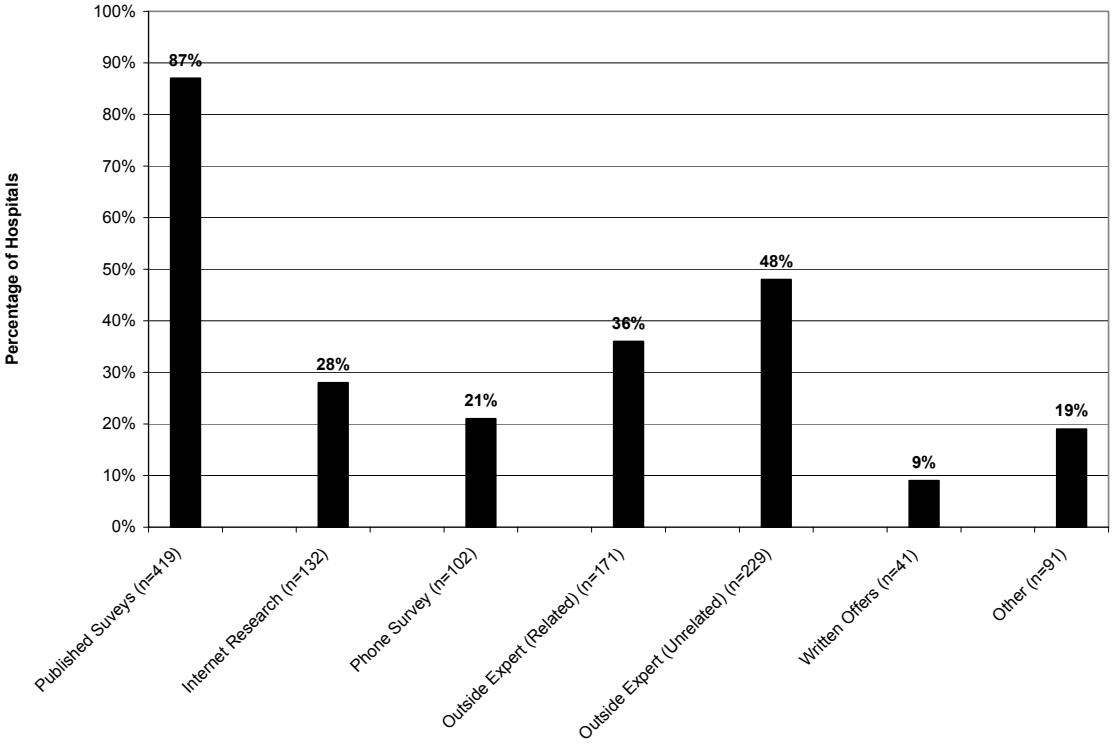


Figure 104. Distribution of Individual or Entity Reported to Determine Compensation by Revenue Size



Resources and methods used to establish compensation (Question 5)
Question 5 asked what resources and methods the hospital used to determine compensation amounts, identifying seven choices. 478 hospitals responded to this question. The chart below shows the percentage of respondents that indicated using each of the seven listed resources, with 87% of the respondents identifying the use of published surveys to determine compensation amounts and 9% identifying written offers. Published surveys was the most frequently reported tool, and written offers was the least frequently reported tool, across each community type and revenue size category.

Figure 105. Tools Used to Determine Compensation (n=478)



91 hospitals (19%) selected "other" and provided an additional explanation. In a number of instances, the hospital's additional explanation was to identify the particular survey or expert relied upon. For example, some hospitals relied upon Form 990 data.

The rural hospitals (both CAH and non-CAH) reported the highest percentages of hospitals using phone surveys to determine compensation amounts and the lowest percentages of use of an outside expert. Hospitals located in the high population areas reported the highest use of an outside expert report prepared by an expert employed by the hospital (referred to in the figures as "related"). The reported use of internet research and phone surveys generally declined as hospitals increased in revenue size, while the reported use of outside experts generally increased with revenue size.

Figure 106. Distribution of Reported Use of Tools to Determine Compensation Amounts by Community Type

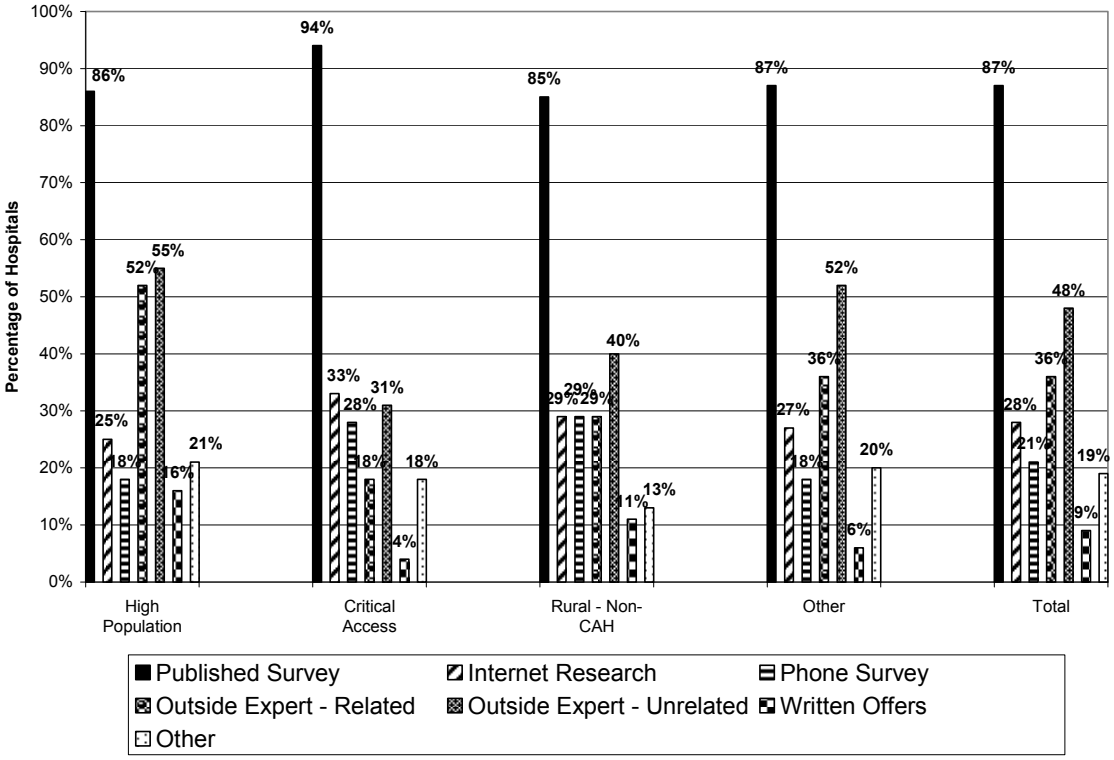
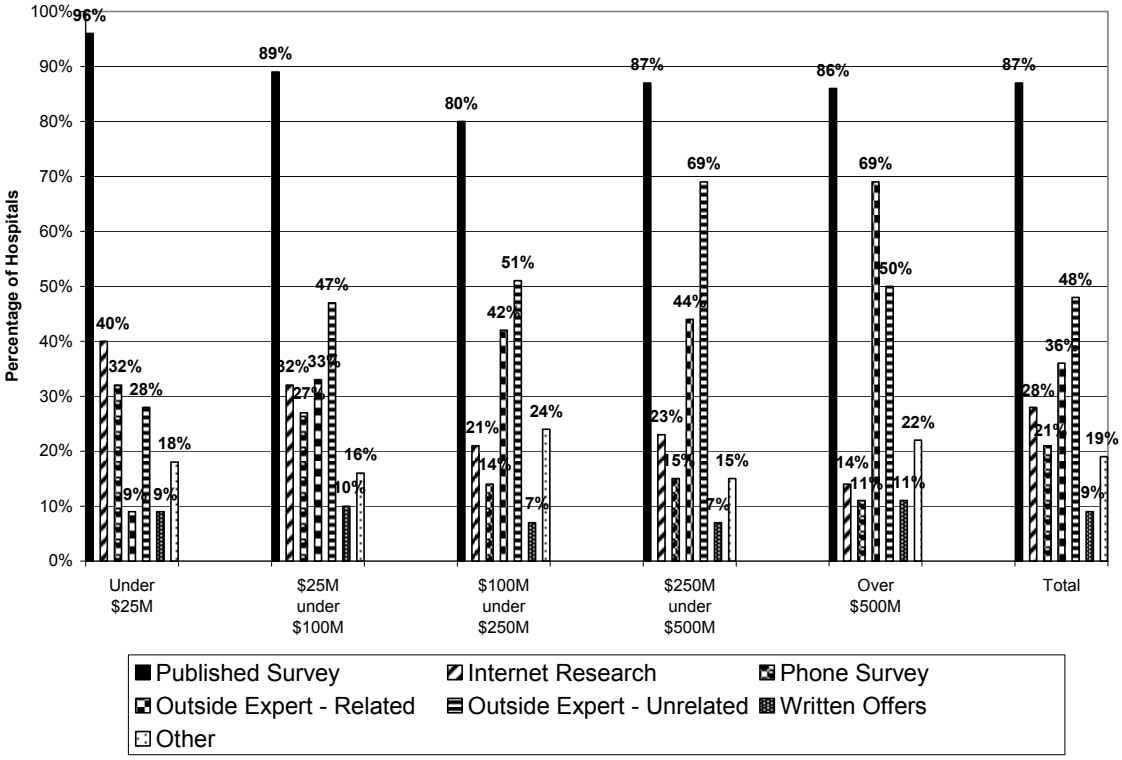


Figure 107. Distribution of Reported Use of Tools to Determine Compensation Amounts by Revenue Size

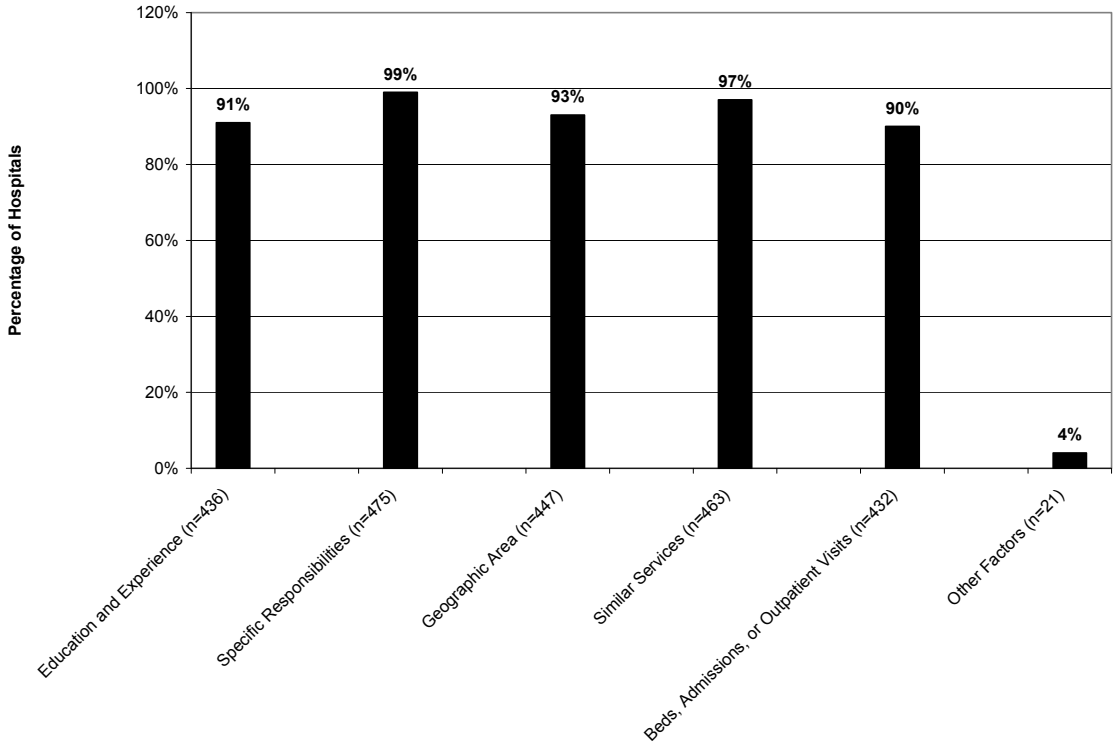


Factors included in comparability data used by the organization (Question 6)

Question 6 asked hospitals to show which of six identified factors were included in the comparability data used by the hospital. Respondents were also asked whether each factor was used for all employees described in section 4958(f)(1).[66] For each of the six identified factors, at least 90% of the respondents indicated they considered that factor, with 71% indicating that they considered all of the factors. The responses are summarized below.

[66] Section 4958(f)(1) defines disqualified persons subject to the excess benefit transaction tax.

Figure 108. Factors Included in Comparability Data



Hospitals that selected a given factor typically reported that they used that factor in their comparability analysis for all section 4958(f)(1) employees. Where hospitals indicated that other factors were considered that were not separately listed in the question, the most common explanation was that the hospital also considered entities with similar levels of revenue in determining comparability.

The most common explanation offered by hospitals for not considering factors was that the use of the factor depended upon whether the hospital was recruiting new hires or setting compensation for incumbents. For example, responses indicated that when recruiting new hires and using a national recruitment program, comparability might not be limited to entities in similar geographic areas, but when determining annual compensation for incumbents, education and experience might not be considered.

Among the community types, the rural non-critical access hospitals reported the lowest percentage of hospitals taking into account all of the identified factors, while those in the high population areas reported the highest, although the differences were modest. There was a slightly greater variation across revenue size, with the hospitals with revenue between $100 million and $250 million reporting the highest percentage considering all factors and the hospitals with revenue exceeding $500 million reporting the lowest.

Figure 109. Percentage of Hospitals that Considered all Comparability Factors by Community Type

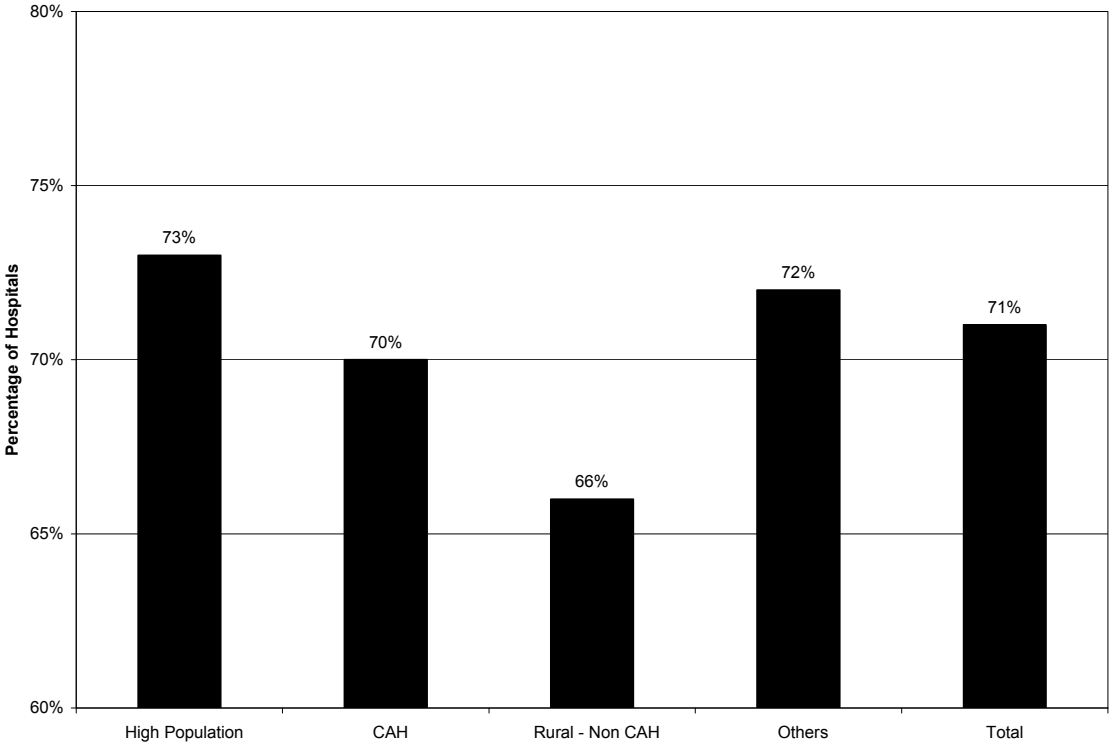
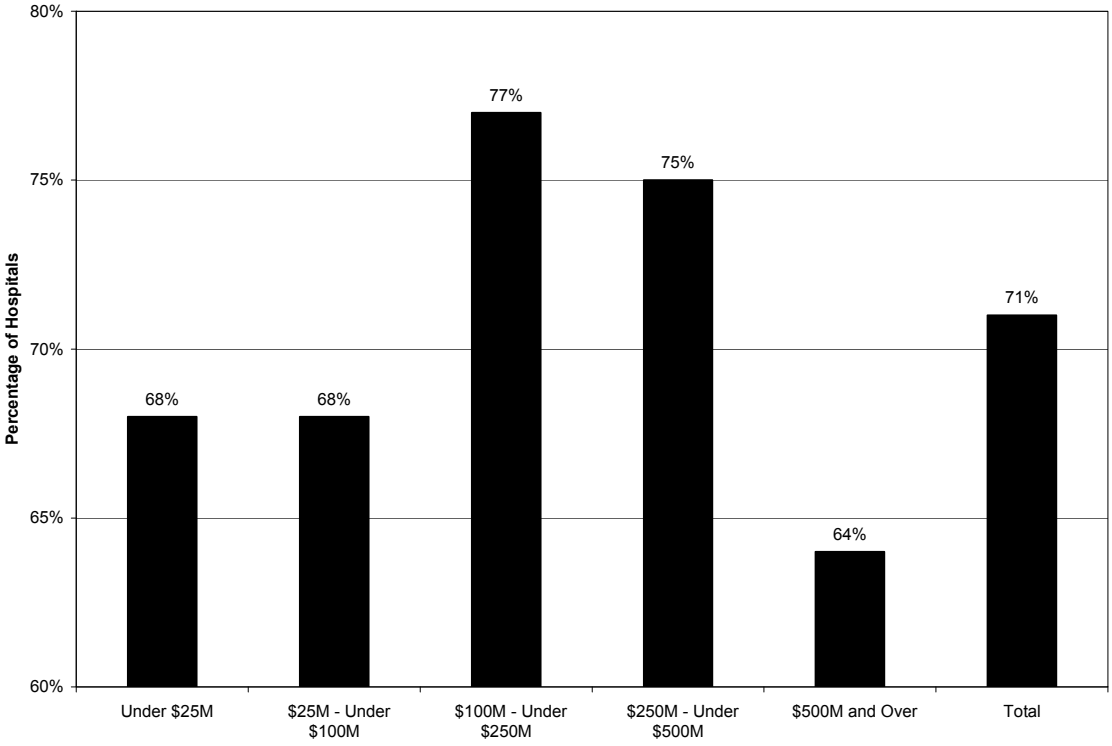


Figure 110. Percentage of Hospitals that Considered all Comparability Factors by Revenue Size



As Figure 111 and Figure 112 demonstrate, there was little variation in the consideration of specified factors across community types or revenue size groups.

Figure 111. Percentage of Hospitals that Considered Comparability Factors by Community Type

Community Type	Edu & Exp	Responsibility	Same Area	Similar Srvc	Similar Bed #
High Population	92%	100%	95%	97%	90%
CAH	93%	98%*	>95%	94%	91%
Rural - Non CAH	91%	98%*	94%	95%	91%
Others	91%	<100%	91%	98%	90%
Total (N = 479)	91%	99% *All rural hospitals	93%	97%	90%

*Both groups of rural hospitals (CAH and non-CAH) were combined to prevent potential identification of respondent hospitals.

Figure 112. Percentage of Hospitals that Considered Comparability Factors by Revenue Size

Revenue Size	Edu & Exp	Responsibility	Same Area	Similar Srvc	Similar Bed #
Under $25M	95%	98%*	95%	93%	88%
$25M - Under $100M	91%	98%*	97%	96%	91%
$100M - Under $250M	91%	100%	95%	98%*	92%
$250M - Under $500M	90%	100%	82%	98%*	88%
$500M and Over	89%	100%	83%	100%	89%
Total (N = 479)	91%	99% *Under $100M	93%	97% *$100M - <$500M	90%

*Revenue sizes were combined to prevent potential identification of respondent hospitals.

Use of other tax-exempt hospitals as comparability data (Question 7)
Question 7 asked whether the hospital's comparability data included information from other tax-exempt hospitals. 100% of 478 respondents indicated that their comparability data included information from other tax-exempt hospitals. The questionnaire did not ask about comparability data from for-profit hospitals.

Setting compensation within the range of comparability data (Question 8)
Question 8 asked whether the hospital set compensation within the range of comparability data. Nearly all of 478 respondents reported that compensation was set within the range of the comparability data.

Business relationships with officers, directors, trustees, and key employees (Question 9)
Question 9 asked whether the hospital had a business relationship with any of its officers, directors, trustees or key employees, other than through their position as officers, directors, trustees, or key employees, and to describe any such relationships. 303 (65%) of 468 reported having at least one such business relationship. Figure 113 and Figure 114 display the results by community type and revenue size. The two most commonly reported types of business relationships were the furnishing of goods, services or facilities by the officer,

director, trustee or key employee to the hospital and doing business with an entity in which the officer, director, trustee or key employee is a partner or investor.

Compared with rural hospitals (CAH and non-CAH), a higher percentage of urban and suburban hospitals (high population and other urban and suburban hospitals) reported having a business relationship with its officers, directors, trustees or key employees. The percentage of hospitals indicated having a business relationship with its officers, directors, trustees or key employees generally increased as revenue size increased, with less than half of the responding hospitals with less than $25 million in revenue indicating that they had such a relationship and over 80% of the hospitals with revenues exceeding $250 million doing so.

Figure 113. Percentage of Hospitals Reporting a Business Relationship with its Officers, Directors, Trustees, or Key Employees by Community Type

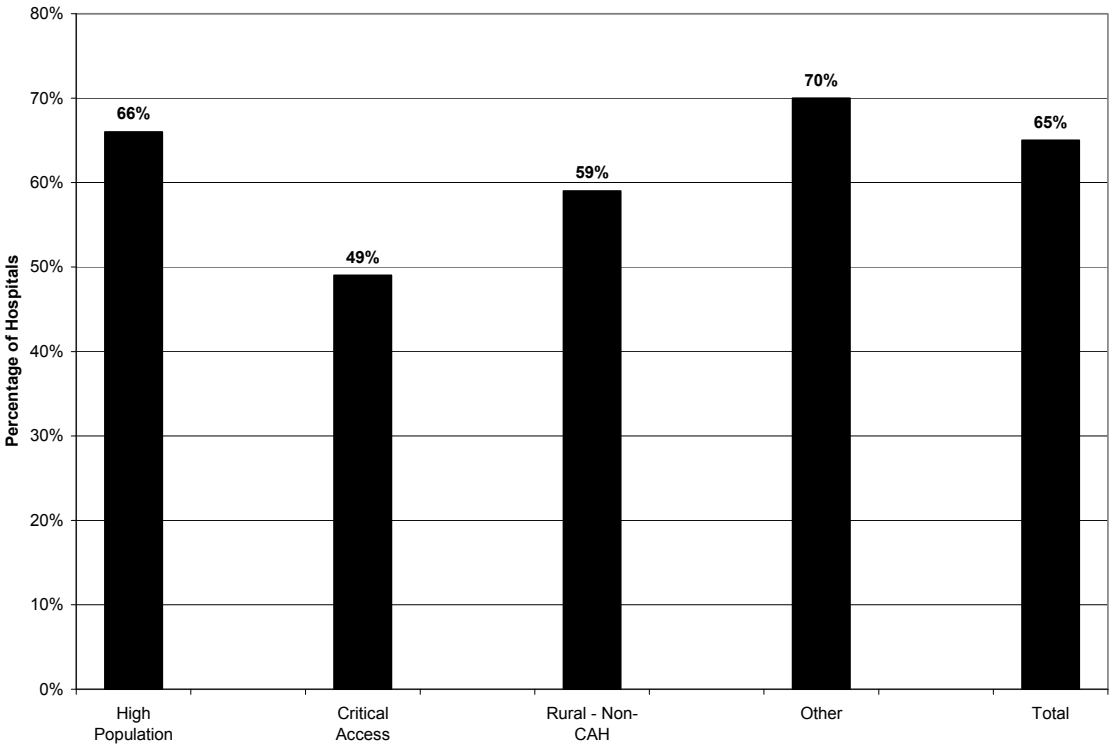
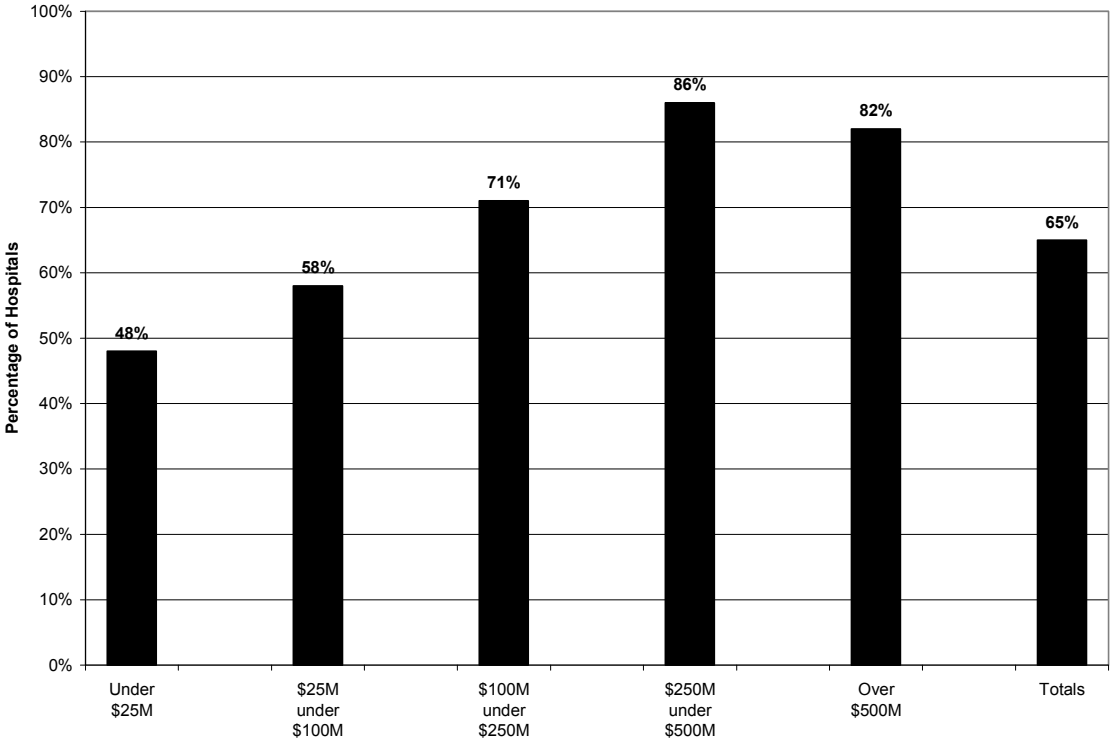


Figure 114. Percentage of Hospitals Reporting a Business Relationship with its Officers, Directors, Trustees, or Key Employees by Revenue Size



C. Summary of Examinations

1. Overview of Examination Component of the Project

The examination component of the Hospital Compliance Project is part of Exempt Organization's ongoing review of executive compensation in the tax-exempt sector.[67] In this study, the focus of the examinations was three-fold: (1) to follow up on the questionnaire responses regarding how organizations determined compensation, (2) to determine whether organizations were utilizing the rebuttable presumption, and (3) to determine whether the compensation so determined should be subject to tax as an excess benefit transaction under section 4958. Twenty hospitals from the study were selected for the examination component of the project.

To select the twenty hospitals to be included, IRS revenue agents and specialists reviewed the Forms 990, questionnaire responses, and other compensation information to identify the hospitals within the study that paid greater

[67] In 2007, EO issued its report on the Executive Compensation Compliance Initiative. Included in its recommendations were that future initiatives should focus on the correlation between satisfaction of the rebuttable presumption by an organization and the reasonableness of compensation paid to its disqualified persons by such an organization. Accordingly, this initiative included an executive compensation component focusing on these issues.

compensation amounts relative to the size and type of the organization. Their review focused on the highest paid and/or top management official, although in some cases they included up to four additional highly paid officials per organization in their review.

The process used to examine executive compensation of these twenty organizations was that regularly used to examine compensation paid by taxable and tax-exempt organizations to their officers, directors, trustees, key employees, and other high level officials. Accordingly, the examining agents used traditional risk analysis to assess whether they would request additional information from the organizations, conduct sampling of expense accounts and other compensation-related items, and seek the involvement of specialists to assist in conducting these examinations.

2. Examination Results

a. Overview

The twenty hospitals examined as part of this project constitute a small pool. Therefore, to prevent potential identification of examined hospitals, in many instances the findings below are discussed in generalities. Furthermore, the findings are not based on statistical sampling and cannot be applied to the general population. They merely reflect the organizations selected and are not representative of any portion of the hospital sector.

While the hospitals examined were selected based upon identifying highly paid individuals, consideration was given to the size and nature of the hospital. The twenty hospitals represent a reasonable cross section of the study's overall hospital group in terms of community type and revenue size. The hospitals are classified by community types and revenue size groups as follows:[68]

Community types:

- High population – 6 hospitals (30%)
- Rural (CAH and non-CAH) – 4 hospitals (20%)
- Other urban and suburban – 10 hospitals (50%)

Revenue sizes:

- Under $250 million – 8 hospitals (40%)
- $250 million - $500 million – 9 hospitals (45%)
- Over $500 million – 3 hospitals (15%).

In some instances, information concerning compensation was in the possession of another organization (e.g., a parent of the organization) so the organization

[68] Certain categories were combined to prevent potential identification of the examined hospitals.

that possessed such information was the entity examined, rather than the original respondent to the questionnaire.

b. Compensation amounts reported

As discussed above, the hospitals were selected for examination because they were identified as paying identified individuals greater compensation amounts, relative to the size and nature of the hospital. The examinations also reviewed compensation paid by other entities.

The total compensation paid by the twenty hospitals examined (including by related entities or common paymasters) to the individuals identified during the examination selection process is included in the table below. The twenty hospitals reported paying a total of $45.2 million, or 88% of the total of $51.3 million compensation paid to these individuals. The other 12% was paid by related entities, supporting organizations, or common paymasters. In those instances where compensation is paid by other entities, the average and median amount paid is 47% of the average and median amount paid by the hospitals examined.[69]

Figure 115. Total Compensation Paid to Identified Highly Compensated Individuals of Examined Hospitals

Description	Paid by Hospitals Examined	Paid by Other Entities	Total Paid by Examined Hospitals and Other Entities
Salaries	$30,704,177	$4,963,715	$35,667,892
Deferred Compensation	$6,333,625	$285,886	$6,619,511
Other Compensation	$8,190,340	$832,360	$9,022,700
Total Compensation	$45,228,142	$6,081,961	$51,310,103
Statistics of Total Compensation			
- Average	$753,802	$357,762	$801,720
- Median	$522,203	$246,402	$578,808

Total compensation paid to the CEO/President, the CFO/VP Finance, and all other identified highly compensated individuals is included in the following chart. These amounts include payments made by other entities. Primarily due to identifying relatively high paid individuals through the examination selection process, the average and median compensation paid to the CEO/President in the examined hospitals is substantially higher than the average and median salary reported for the top management officials on the questionnaires.

[69] The average and median compensation amounts paid by other entities are based on compensation paid to individuals reported to have received compensation from another entity. The calculation did not take into account cases in which no compensation was paid by another entity (thus, resulting in higher average and median amounts than if such cases had been taken into account).

Figure 116. Total Compensation to Identified Highly Compensated Individuals of Examined Hospitals by Position Title

	CEO/President	CFO/VP Finance	All Other Identified Individuals	Total
Salaries	$17,088,894	$12,070,679	$6,508,319	$35,667,892
Deferred Compensation	$5,022,047	$1,285,109	$312,355	$6,619,511
Other Compensation	$6,895,815	$1,494,154	$632,731	$9,022,700
Total Compensation	$29,006,756	$14,849,942	$7,453,405	$51,310,103
Statistics of Total Compensation				
- Average	$1,381,274	$571,152	$438,436	$801,720
- Median	$1,270,671	$549,347	$264,037	$578,808

c. How compensation was determined

The twenty examinations followed up on the questionnaire and looked at how compensation was determined, including review of the supporting documentation. The examinations confirmed that all twenty hospitals had a written conflict of interest policy that they adhered to.

85% of the hospitals examined had a written compensation policy, as compared to 73% of the hospitals that responded to the questionnaire. While in most cases if the hospital had a written compensation policy it followed that policy in all circumstances covered by its terms, there were a few instances where the hospital did not.

In all cases, compensation was approved in advance, nearly always by individuals that did not have a conflict of interest with the compensation arrangement being approved. This is comparable to the 98% of hospitals responding to the questionnaire that indicated that compensation was approved in advance by individuals that did not have a conflict of interest with the compensation arrangement being approved.

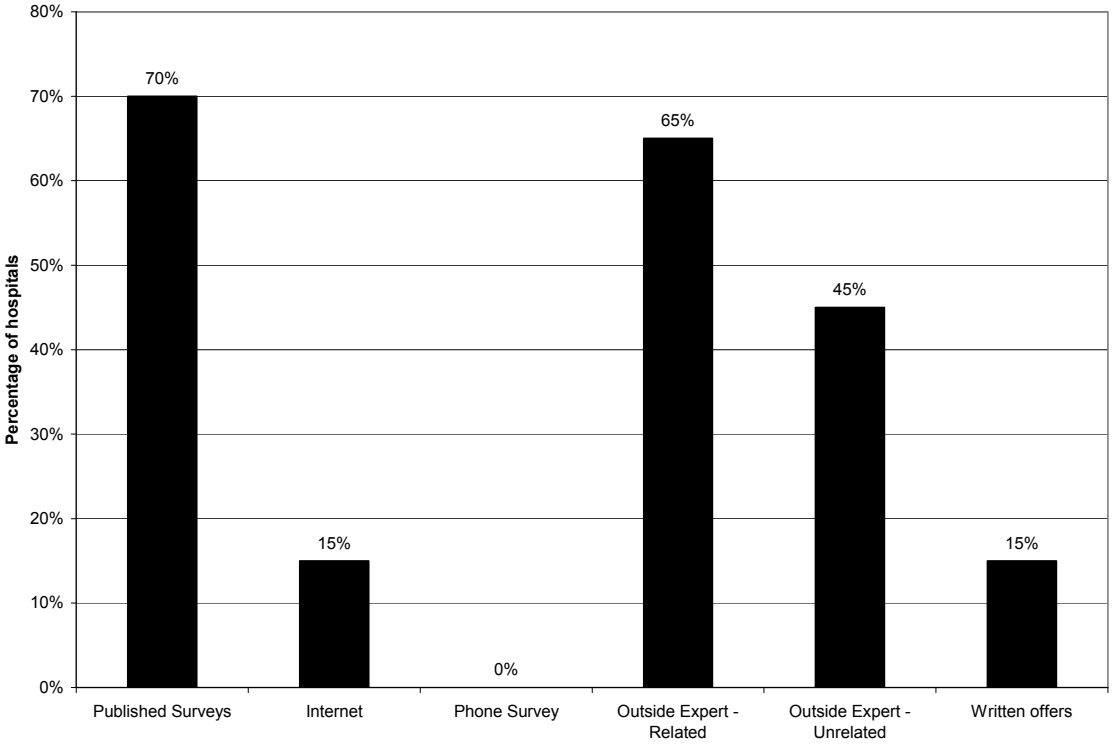
In 85% of the hospitals examined, hospitals had employment contracts with disqualified persons and in nearly all such cases the contract amount was found to be reasonable.

The amount of compensation was determined by the Compensation Committee at nearly all of the examined hospitals, with slightly over half of the examined hospitals also having compensation determined by the Board of Directors. This contrasts with the 56% of responding hospitals that indicated that the compensation was determined by the Compensation Committee on the questionnaire and compares similarly to the 63% of the questionnaire respondents that indicated the Board of Directors determined compensation. Few of the hospitals examined had compensation amounts determined by

officers. As was indicated in questionnaire responses, there were instances where the compensation was determined by an affiliated entity or by an Executive Committee.

70% of the examined hospitals used published surveys to establish compensation amounts (compared to 87% of the questionnaire respondents). 45% of the examined hospitals used an outside expert report prepared by an expert employed by an unrelated organization compared to 48% of the hospitals responding to the questionnaire. 65% of the examined hospitals used an outside expert report prepared specifically for the hospital by an expert employed by the hospital for that purpose (compared to 36% of the responding hospitals). None of the examined hospitals used phone surveys to determine compensation amounts (compared to 21% of the responding hospitals).

Figure 117. Examination Results - Tools Used to Determine Compensation



45% of the examined hospitals considered all of the identified factors included in comparability data, compared to 71% of the hospitals responding to the questionnaire. All of the examined hospitals used the specific responsibilities of the position, while only 60% used similar number of beds, admissions or out-patient visits in their comparability data. Although not all of the examined hospitals considered each of the remaining three identified factors, at least three-quarters of the examined hospitals considered each of them. As with the questionnaire responses, the most common factor considered other than the listed factors was similar levels of revenue. The factors were used consistently for all disqualified persons in 80% of the examined hospitals.

In all cases the examined organizations obtained comparability data involving tax-exempt hospitals, although not every examined hospital obtained comparability data regarding tax-exempt hospitals for all components of the compensation that was paid.

Nearly all of the examined hospitals set their actual compensation within the range of the comparability data.

Although 65% of the hospitals responding to the questionnaire indicated having a business relationship with any of its officers, directors, trustees or key employees, other than through their position as officers, directors, trustees, or key employees, a business relationship existed in only 40% of the hospitals examined. Most of these cases involved the furnishing of goods, services or facilities, although there were also instances involving loans and the sale or lease of property. In all cases where the business relationship was reviewed, no excess benefit transaction was found.

d. Rebuttable presumption analysis

After reviewing the process used by the hospital to establish compensation, the IRS then determined whether that process met the rebuttable presumption procedure described in Treasury Regulation section 53.4958-6.[70] This process involves three factors – an independent body to review and establish the amount of compensation in advance of actual payment, use of permissible comparability data to establish the compensation, and contemporaneous documentation of the process used to establish the compensation in the particular instance. Under the Regulations, compensation determined pursuant to a process that satisfies the rebuttable presumption requirements is presumed to be reasonable in amount, and the IRS has the burden of proving that the compensation is excessive for section 4958 excess benefit transaction tax purposes. If the rebuttable presumption is not met, the burden is on the organization to prove that the compensation is reasonable.

Organizations met the requirements of the rebuttable presumption process in 85% of the examined hospitals.

e. Information reporting and potential assessment of section 4958 excise tax

The compensation paid to the identified highly paid individuals was reviewed to determine whether the section 4958 excise tax should be assessed. In the case of the 85% of hospitals that met the rebuttable presumption, the burden of proof was on the IRS to show that compensation was not reasonable. This review included analysis of compensation data and surveys available to the IRS in addition to the comparables used by the organizations in setting compensation.

[70] See H. Rep. No. 104-506, 104th Cong., 2d Sess. at 56-57.

The IRS determined that no excess benefit tax should be assessed in these instances. The IRS may assess 4958 excess tax in certain other case(s), but to prevent potential identification of examined hospitals, specific details cannot be provided.

The IRS also reviewed whether compensation paid to the identified highly compensated individuals was properly reported on various federal forms. Nearly all of the examined hospitals properly reported compensation on Form 990. For Forms 941 and W-2, all compensation was properly reported. The Forms 1040 for the identified highly compensated individuals were also reviewed where appropriate. In all cases where the Form 1040 was reviewed, compensation was reported correctly.

VIII. FORM 990, SCHEDULE H, HOSPITALS

A. Overview of Schedule H, Hospitals

Form 990, Schedule H, Hospitals, will be used beginning with 2008 tax years to report information by an organization that operates one or more facilities that are licensed, registered, or similarly recognized by a state as a hospital. For years before 2008, the Form 990 did not provide for the reporting of community benefit activities or request important information regarding how nonprofit hospitals serve the public consistent with the tax exemption. Beginning with 2008 tax years, organizations operating one or more hospitals are required to report community benefit and other information pertinent to exempt status on Schedule H.

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; and Part VI, Supplemental Information. A copy of Schedule H is appended hereto as Appendix C.

An organization must file a single Schedule H that aggregates information for the tax year from the following:

1. Hospitals directly operated by the organization.
2. Hospitals operated by disregarded entities of which the organization is the sole member.
3. Other facilities or programs of the organization or any of the entities described in 1 or 2, even if provided by a facility that is not a hospital or if provided separately from the hospital's license.
4. Hospitals operated by any joint venture taxed as a partnership, to the extent of the organization's proportionate share of the joint venture.

Although information from all of the above sources is aggregated for purposes of Schedule H, the organization is required to list in Part V, Facility Information, each of its facilities that is required to be licensed, registered, or similarly recognized as a health care facility under state law, whether operated directly by the organization or indirectly through a disregarded entity or joint venture taxed as a partnership. In addition, the organization must report in Part VI summary information describing the number of other types of facilities for which it reports information on Schedule H (e.g., 2 rehabilitation clinics, 4 diagnostic centers).

B. Description of Schedule H, Parts I through VI

The following summarizes certain important information required to be reported on Schedule H:

- Part I, Charity Care and Certain Other Community Benefits at Cost (Optional for 2008)
    - Requires reporting of charity care policies, the availability of community benefit reports, and the cost of charity care and other community benefit programs
    - Eight separate categories of community benefit are reportable in Part I: charity care at cost, unreimbursed Medicaid, unreimbursed other means-tested government programs, community health improvement services and community benefit operations, health professions education and training, subsidized health services, research, and cash and in kind contributions to community groups
- Part II, Community Building Activities (Optional for 2008)
    - Provides for reporting the cost of various kinds of community building activities, including physical improvements and housing, economic development, community support, environmental improvements, community health improvement advocacy, coalition building, workforce development, and leadership development and training for community members
- Part III, Bad Debt, Medicare, & Collection Practices (Optional for 2008)
    - Requires reporting of bad debt expense and Medicare shortfalls at cost, and other information relating to such items
    - Medicare shortfall reporting in Part III is limited to expenses reportable on Medicare cost reports, although other revenue and expense information for other Medicare programs is to be reported in Part VI
    - Also requests certain information regarding the organization's debt collection practices
- Part IV, Management Companies and Joint Ventures (Optional for 2008)
    - Requires information regarding certain joint ventures and management companies in which the organization's officers, directors, trustees, key employees, and physicians have an aggregate ownership percentage exceeding 10% of such entity
- Part V, Facility Information
    - The organization must separately list each facility that is licensed, registered, or similarly recognized by a state as a health care facility (hospital or otherwise) (Required for 2008)
    - The organization must provide a narrative description of other facilities for which items are otherwise reported on the Schedule H (Optional for 2008)
- Part VI, Supplemental Information (Optional for 2008)
    - Requires information pertinent to determining how the organization is serving its communities, including community needs assessments, education of patients about eligibility for charity care and government assistance programs, relationships with others in an affiliated system, and descriptions that supplement responses to the other parts of the schedule

C. Transition Relief

Schedule H is phased in beginning in 2008. For 2008 tax years, only Part V, Facility Information, is required to be completed so that basic identifying information regarding the organization's facilities is collected. All other parts of Schedule H are optional for 2008. The entire Schedule H must be completed for tax years beginning in 2009.

D. Promoting Uniform Reporting through Schedule H

As the study demonstrates, the reporting of community benefit by organizations operating nonprofit hospitals has varied widely, both as to types of programs and expenditures classified as community benefit and the measurement of community benefits. Schedule H was designed to provide uniformity regarding the types and amounts of programs and expenditures reported as community benefit by nonprofit hospitals. It does so by providing clear standards regarding the types of programs and expenditures the filing organization is to report as community benefit in Part I, how to measure community benefit expenditures (by cost rather than by charges), and the treatment of two of the most significant areas of disparity reported in the study (bad debt and Medicare shortfalls). Hospitals filing Schedule H are required to use the most accurate costing method available to them to report the cost of community benefit on Schedule H.

Schedule H also provides organizations the opportunity to explain what amounts of bad debt expense, Medicare shortfalls, and community building activities it believes should be treated as community benefit even though the schedule does not permit it to treat them as community benefit at this time. Because not all aspects of community benefit are capable of quantitative measure, Part VI of the schedule requires the organization to provide certain information regarding non-quantifiable aspects of community benefit, and allows the organization to supplement the required information with other information it considers relevant to explaining how it benefits the communities it serves through the promotion of health.

Much of the information requested in the Hospital Study Questionnaire is included in Schedule H. The following describes which portions of Part II – Operations, of the Questionnaire are included in the Schedule H.

- Question 1 (type of hospital) – incorporated in Part V, the list of facilities, where the organization is to report the type of each facility that is licensed, registered, or similarly recognized as a health care facility by a state.
- Questions 2 through 8 (patients) – although similar information was included in the Schedule H discussion draft released in June 2007 (e.g., revenue information for each type of insurance or government

program, including self pay patients), the final Schedule H does not require this information.

- Questions 9 through 14 (emergency room) – portions incorporated in Part V by indicating whether the facility has an emergency room that is open at all times or at specified times.
- Questions 15 through 18 (board of directors) – portions incorporated in Part VI, question 6 regarding a description of how the community board furthers the organization's exempt purposes; also, Part VI of the Form 990's core form contains a governance section required to be completed by all organizations, including those operating hospitals.
- Questions 19 and 20 (medical staff privileges) - portions incorporated in Part VI, question 6 regarding a description of how the organization's open medical staff furthers the organization's exempt purposes.
- Questions 21 through 29 (medical research) – cost of medical research that constitutes community benefit is to be reported in Part I, line 7i.
- Questions 30 through 33 (professional medical education and training) – cost of health professions education that constitutes community benefit is to be reported in Part I, line 7f.
- Questions 34 through 42 (uncompensated care)
    - Questions regarding charity care policies, and the cost of charity care, Medicaid, and other means-tested government programs, were incorporated in Part I of the schedule.
    - Questions regarding bad debt and Medicare shortfalls were incorporated in Part III of the schedule, which requires reporting at cost.
- Questions 43 through 56 (billing and collection practices) – questions regarding collection practices were incorporated in Part III of the schedule.
- Questions 57 through 72 (community programs)
    - Questions regarding medical screening programs, immunization programs, educational programs for the community, and newsletters or publications are contained in Part I, line 7e regarding treatment of such items as community health improvement services and community benefit operations.
    - Questions regarding unmet health care needs of the community and improving access to health care are incorporated in Part VI, question 2 (describe how the organization assesses the health care needs of the communities it serves), question 3 (describe how the organization informs and educates persons about eligibility for assistance under public programs or charity care), question 4 (describe the communities served by the organization, including geographic and demographic constituents), and question 6 (provide other information regarding how the

organization furthers its exempt purposes), as well as Part I, line 7e (establishing community need for programs reported as community health improvement services and community benefit operations, and improving access to health services).

IX. SUMMARY OF FINDINGS BY DEMOGRAPHIC

This section provides a summary of the findings of the study overall and by community type, revenue size and other selected areas. These findings relate to patient mix, total revenues and excess revenues, various community benefit expenditures (including uncompensated care, research, education and training, and community programs), and executive compensation.

Demographics and Community Benefit Profile for All Hospitals in the Study

- Patient mix – private insurance (43%), Medicare (31%), Medicaid (15%), uninsured (8%), and other public programs (3%)
- Annual total revenues - $179 million (average) and $89 million (median)
    - Distribution - 53% with revenues under $100 million (17% under $25 million); 27% with revenues between $100 million and $250 million; 20% with revenues over $250 million (7% over $500 million)
- Excess revenues were 4.6% of total revenues, but increased with total revenue size
    - 3.3% (under $25 million) to 5.5% (over $500 million)
    - Average and median excess revenue amounts were $8.3 million and $2.5 million, respectively
    - 60% of hospitals reported excess revenues less than 5% of total revenues
        - 21% reported a deficit (total expenses greater than revenues)
        - 19% reported positive excess revenues less than 2.5% of revenues; 39% reported positive excess revenues less than 5% of total revenues
    - Excess revenues were concentrated in a small number of the most profitable hospitals – 16% of the hospitals (those reporting at least $15 million in excess revenues) reported 77% of the excess revenues
- Community benefit expenditure profile
    - Average and median community benefit expenditures reported as a percentage of total revenues were 9.2% and 5.5%, respectively
    - Mix across types of community benefit expenditure – 56% of reported expenditures were uncompensated care, followed by medical education and training (23%), medical research (15%), and community programs (6%)
        - The mix changes as follows when the 15 hospitals reporting 93% all of the reported research expenditures is removed from the group: 71% of reported community benefit expenditures were uncompensated care, followed by medical education and training (21%), community programs (7%), and medical research (1%)
- Uncompensated care
    - Average and median percentage of patients provided uncompensated care were 10% and 3%, respectively (compared to 8% of uninsured patients).

    - Average and median percentage of total revenues reported as spent on uncompensated care were 7.2% and 3.9%, respectively
    - 95% of hospitals reported uncompensated care; 44% reported treating bad debt and 51% reported treating uninsured shortfalls as uncompensated care; lesser percentages reported shortfalls from private insurance (19%), Medicare (20%), Medicaid (20%), other public programs (18%) as uncompensated care
- Research, education, and community programs
    - Average and median expenditures as percentage of total revenues, respectively: medical education and training (1.3% and 0.3%); medical research (1.6% and 0.2%); community programs (0.9% and 0.2%)
    - 77% of hospitals reported medical education and training, 21% reported medical research, and 92% reported community program expenditures
- Comparison of community benefit expenditure and uncompensated care levels to specified percentage of revenue levels
    - Community benefit expenditures under 2% of total revenues (21%); under 5% of total revenues (47%)
    - Uncompensated care under or equal to 1% of total revenues (19%); under or equal to 3% of total revenues (43%); under or equal to 5% of total revenues (58%)

By Community Type

The community benefit expenditure profile (i.e., the mix of uncompensated care, medical research, medical education and training, and community program expenditures) of the hospitals in the study varied materially depending upon the community type (CAH, rural (non-CAH), other urban and suburban, and high population). This variation tended to be greatest when comparing CAH hospitals to high population hospitals. CAHs often resembled rural (non-CAH) hospitals, but there were important differences between the two types in some areas. In general, the profile of the group of other urban and suburban hospitals generally reflected that of the overall group, in large part because of its sample size. Rural hospitals as a group (CAH and non-CAH) reported lower average and median percentages of aggregate community benefit expenditures than did urban and suburban hospitals (high population and other urban and suburban hospitals).

High Population Hospitals

High population hospitals were the largest of the hospitals in terms of average and median annual total revenues. They had a higher proportion of Medicaid patients, and a lower proportion of Medicare patients, than the other hospitals. High population hospitals reported the highest average and median percentages of aggregate community benefit expenditures, uncompensated care, medical education and training, and medical research, as a percentage of total revenues. They also had the highest percentage of hospitals reporting medical research and medical education and training expenditures. These hospitals are located in

the largest 26 urban areas in the U.S.; they comprised 19% of the hospitals in the study.

- Patient mix – private insurance (44%), Medicare (28%), Medicaid (19%), uninsured (8%), and other public programs (4%)
- Annual total revenues – the average and median total revenues were $389 million and $196 million, respectively; they comprised 41% of aggregate total revenues overall – on average, these hospitals had over twice the revenues of those overall
- Excess revenues – excess revenues as a percentage of total revenues was 4.5% (compared to 4.6% overall)
  - The average and median excess revenue amounts were $17.5 million and $4.2 million, respectively (greater than any other community type)
  - 22% of these hospitals reported a deficit, and 69% reported a deficit or positive excess revenues less than 5% of total revenues
- Community benefit expenditure profile
  - Average and median community benefit expenditures reported as a percentage of total revenues were 12.7% and 9.8%, respectively (both the largest of all community types)
  - Mix across types of community benefit expenditure– 42% of reported community benefit expenditures were uncompensated care, followed by medical education and training (26%), medical research (25%), and community programs (7%)
- Uncompensated care
  - Average and median percentage of patients provided uncompensated care were 11% and 6%, respectively (highest of all community types)
  - Average and median percentage of total revenues reported as spent on uncompensated care were 7.9% and 4.8%, respectively (highest of any community type)
  - 96% of these hospitals reported providing uncompensated care; a lesser percentage reported treating all types of shortfalls as uncompensated care, but a greater percentage reported treating bad debt as uncompensated care, compared to overall
- Research, education and community programs
  - Average and median expenditures as percentage of total revenues, respectively: medical education and training (2.7% and 1.6% - highest of all community types); medical research (3.2% and 0.4% - highest of all community types); community programs (1.7% and 0.2%)
  - 86% of hospitals reported medical education and training, and 40% reported medical research expenditures (both were the highest of all community types); 95% reported community program expenditures of some type
- Comparison of community benefit expenditures and uncompensated care to specified percentage of revenue levels
  - Community benefit expenditures under 2% of total revenues (11%); under 5% of total revenues (32%)

- Uncompensated care under or equal to 1% of total revenues (8%); under or equal to 3% of total revenues (33%); under or equal to 5% of total revenues (52%)

Critical Access Hospitals (CAHs)

CAHs were the smallest of the hospitals in terms of average and median annual total revenues across community types. They had a higher proportion of Medicare patients than did the other hospitals, but lower proportions of private insurance and Medicaid patients than the others. CAHs reported the lowest average and median percentages of aggregate community benefit expenditures, uncompensated care, medical education and training, and medical research, as a percentage of total revenues. They also had the lowest percentage of hospitals reporting medical research and medical education and training expenditures.

- CAH refers to those hospitals designated as such under federal law; they comprised 14% of hospitals in the study
- Patient mix – private insurance (38%), Medicare (36%), Medicaid (13%), uninsured (8%), and other public programs (3%)
- Annual total revenues – the average and median total revenues for CAHs were $29 million and $20 million, respectively; CAHs comprised 2% of aggregate total revenues overall (smallest of community types based on revenues)
- Excess revenues – excess revenues as a percentage of total revenues was 3.5% (lowest of the community types)
  - the average and median excess revenue amounts for CAHs were $1.0 million and $0.5 million, respectively (also lowest of the community types)
  - 34% of all CAHs reported a deficit, and 66% reported a deficit or positive excess revenues less than 5% of total revenues
- Community benefit expenditure profile
  - Average and median community benefit expenditures reported as a percentage of total revenues were 6.3% and 2.8%, respectively
  - Mix across types of community benefit expenditures – 77% of reported community benefit expenditures were uncompensated care, followed by community programs (19%), medical education and training (4%), and medical research (0%)
- Uncompensated care
  - Average and median percentage of patients provided uncompensated care were 7% and 2%, respectively (lowest of the community types)
  - Average and median percentage of total revenues reported as spent on uncompensated care were 5.6% and 2.1%, respectively (lowest of the community types)
  - 94% of CAHs reported providing uncompensated care; a greater percentage of CAHs reported treating most types of shortfalls as uncompensated care, but a lesser percentage reported treating bad debt as uncompensated care, compared to overall
- Research, education and community programs

  - Average and median expenditures as percentage of total revenues, respectively: medical education and training (0.2% and 0.1%); medical research (0% and 0%) (both lowest of all community types); community programs (1% and 0.3%)
  - 60% of CAHs reported medical education and training; 91% reported community program expenditures of some type
- Comparison of community benefit expenditures and uncompensated care to specified percentage of revenue levels
  - Community benefit expenditures under 2% of total revenues (39%); under 5% of total revenues (61%)
  - Uncompensated care under or equal to 1% of total revenues (31%); under or equal to 3% of total revenues (59%); under or equal to 5% of total revenues (67%)

Rural (non-CAH) Hospitals

This group was the second smallest community type in terms of average and median annual total revenues, after CAHs. Rural (non-CAH) hospitals had a relatively low percentage of Medicaid patients compared to the other community types, and reported the lowest percentage of uninsured patients of all the community types. The community benefit expenditure and uncompensated care profile for this group resembled that of CAHs, in that they generally reported relatively low average and median aggregate community benefit expenditures, uncompensated care, medical education and training, and medical research, as a percentage of total revenues, when compared to the other hospitals (except for CAHs). However, rural (non-CAH) hospitals reported higher percentages of medical education and training expenditures, and lower percentages of community program expenditures, as a percentage of total revenues, than did CAHs.

- Includes those hospitals outside the urban and suburban areas that were not designated as CAHs; they comprised 16% of hospitals in the study
- Patient mix – private insurance (44%), Medicare (33%), Medicaid (13%), uninsured (7%), and other public programs (3%)
- Annual total revenues – the average and median total revenues were $93 million and $68 million, respectively; these hospitals comprised 8% of aggregate total revenues overall – on average, these rural hospitals had greater revenues than CAHs
- Excess revenues – excess revenues as a percentage of total revenues was 6.0% (highest of any community type)
  - the average and median excess revenue amounts were $5.6 million and $3.4 million, respectively (greater than CAHs)
  - 13% reported a deficit and 42% reported a deficit or positive excess revenues less than 5% of total revenues (both were lowest percentages of any community type)
- Community benefit expenditure profile
  - Average and median community benefit expenditures reported as a percentage of total revenues were 8.4% and 3.2%, respectively

  - Mix across types of community benefit expenditures – 76% of reported community benefit expenditures were uncompensated care, followed by medical education and training (17%), community programs (6%), and medical research (1%)
- Uncompensated care
  - Average and median percentage of patients provided uncompensated care were 8% and 2%, respectively
  - Average and median percentage of total revenues reported as spent on uncompensated care were 7.6% and 2.7%, respectively
  - 96% of these hospitals reported providing uncompensated care; a greater percentage reported treating all types of shortfalls as uncompensated care, but a lesser percentage reported treating bad debt as uncompensated care, compared to overall
- Research, education and community programs
  - Average and median expenditures as percentage of total revenues, respectively: medical education and training (0.6% and 0.2%); medical research (0.5% and 0.3%); community programs (0.6% and 0.2%)
  - 72% of hospitals reported medical education and training; 96% reported community program expenditures of some type
- Comparison of community benefit expenditures and uncompensated care to specified percentage of revenue levels
  - Community benefit expenditures under 2% of total revenues (31%); under 5% of total revenues (57%)
  - Uncompensated care under or equal to 1% of total revenues (25%); under or equal to 3% of total revenues (52%); under or equal to 5% of total revenues (65%)

Other Urban and Suburban Hospitals

This group was the second largest community type in terms of average and median annual total revenues, after high population hospitals, and its average and median total revenue measures closely resembled those of the overall responding group. Its patient mix was nearly identical to that of the overall responding group. This community type generally was around the middle (rather than on the high or low ends) with respect to most measures of aggregate community benefit expenditures, uncompensated care, medical education and training, and medical research, as a percentage of total revenues. Its mix of community benefit expenditures differed from the overall group, however. Other urban and suburban hospitals reported higher aggregate community benefit expenditures as uncompensated care and lower expenditures as medical research as compared to the overall group.

- Includes those hospitals located in urban and suburban areas other than in the largest 26 urban areas in the U.S.; they comprised 51% of the hospitals in the study
- Patient mix – private insurance (44%), Medicare (30%), Medicaid (15%), uninsured (8%), and other public programs (3%)

- Annual total revenues – the average and median total revenues were $169 million and $114 million, respectively; they comprised 48% of aggregate total revenues overall – on average, this group's revenue profile was close to that of the overall group
- Excess revenues – excess revenues as a percentage of total revenues was 4.6% (same as that for overall group)
  - the average and median excess revenue amounts were $7.7 million and $3.1 million, respectively (similar to overall group)
  - 20% of these hospitals reported a deficit, and 60% reported a deficit or positive excess revenues less than 5% of total revenues
- Community benefit expenditure profile
  - Average and median community benefit expenditures reported as a percentage of total revenues were 8.9% and 5.8%, respectively (similar to that of overall group)
  - Mix across types of community benefit expenditures – 69% of reported community benefit expenditures were uncompensated care, followed by medical education and training (21%), community programs (5%), and medical research (5%)
- Uncompensated care
  - Average and median percentage of patients provided uncompensated care were 10% and 5%, respectively
  - Average and median percentage of total revenues reported as spent on uncompensated care were 7.3% and 4.3%, respectively (similar to overall group)
  - 95% of these hospitals reported providing uncompensated care; a lesser percentage reported treating all types of shortfalls as uncompensated care, but a greater percentage reported treating bad debt as uncompensated care, compared to overall
- Research, education and community programs
  - Average and median expenditures as percentage of total revenues, respectively: medical education and training (1.3% and 0.4%); medical research (0.7% and 0.1%); community programs (0.8% and 0.2%)
  - 80% of hospitals reported medical education and training, and 24% reported medical research expenditures; 89% reported community program expenditures of some type (lowest of the community types)
- Comparison of community benefit expenditures and uncompensated care to specified percentage of revenue levels
  - Community benefit expenditures under 2% of total revenues (17%); under 5% of total revenues (46%)
  - Uncompensated care under or equal to 1% of total revenues (17%); under or equal to 3% of total revenues (39%); under or equal to 5% of total revenues (55%)

Group of 15 Hospitals Reporting Highest Medical Research Expenditures
This group of 15 hospitals comprised 3% of all hospitals in the study, but reported 93% of all medical research expenditures and 58% of all medical

education and training expenditures. This group reported larger total revenues and excess revenues than did the other hospitals in the study, and reported a materially different community benefit mix than did the other hospitals (e.g., it was the only demographic that did not report uncompensated care as its largest component of community benefit expenditures). The group's higher reported medical research expenditures materially increased the reported overall average medical research expenditures, and altered the community benefit mix, of the overall group.

- Annual total revenues – the average and median total revenues were both $1.0 billion, compared to $179 million and $89 million, respectively, for the overall group
- Excess revenues – the average and median excess revenues were $69 million and $58 million, respectively, compared to $8 million and $3 million, respectively, for the overall group. Excess revenues as a percentage of total revenues was 7%, compared to 5% overall.
- Community benefit expenditure profile
    - Average and median community benefit expenditures reported as a percentage of total revenues were both 19%, compared to 9% and 6%, respectively, for the overall group
    - Mix across types of community benefit expenditures – 45% of aggregate community benefit expenditures were medical research, followed by medical education and training (28%), uncompensated care (22%), and community programs (5%)
    - The community benefit mix for the overall group changed when this group of hospitals was removed, with uncompensated care increasing from 56% to 71% of overall community benefit expenditures, medical education and training decreasing from 23% to 21%, medical research decreasing from 15% to 1%, and community program expenditures increasing from 6% to 7%
- Uncompensated care
    - The average and median percentages of revenues reported as spent on uncompensated care for the group of 15 hospitals was 6% and 3%, respectively, compared to 7% and 4% respectively, for the overall group
- Research, medical education and training expenditures
    - The average and median percentages of revenues reported as spent on medical research were 8.3% and 7.1%. The overall average and median percentages for the overall group decreased from 1.6% and 0.2%, respectively, to 0.5% and 0.1%, respectively, when these hospitals were removed from the overall group.
    - The average and median percentages of revenues reported as spent on medical education and training were 4.9% and 3.8%, respectively, compared to 1.3% and 0.3%, respectively, overall.
- Comparison of community benefit expenditures and uncompensated care to specified percentage of revenue levels

- All hospitals in the group of 15 reported community benefit expenditures greater than 5% of revenues
- Three hospitals in the group reported no uncompensated care; of the remaining 12 hospitals in the group, four reported uncompensated care expenditures in each of the following ranges: over 1% but less than or equal to 3%, over 3% but less than or equal to 5%, and over 5%.

By Hospital Size (Annual Total Revenues)
The community benefit profile of the hospitals in the study generally followed a pattern across the hospital size categories: the largest percentage of community benefit expenditures was reported as spent on uncompensated care, generally followed by medical education and training, community program expenditures, and medical research. However, the relative percentages spent on each type of community benefit expenditure varied across the hospital size categories.

Less than $25 million revenue size
This group had the highest percentage of uninsured patients and patients covered by Medicare or other public insurance, and the lowest percentage of patients covered by private insurance. This group had the lowest participation rates in medical research and medical education and training, and generally had relatively low participation rates in the various community programs. This group had the lowest median percentage, but the highest average percentage, of total revenues reported as spent on uncompensated care. The group of hospitals with total revenues under $25 million reported the highest percentage of aggregate community benefit expenditures spent on uncompensated care, and the lowest percentages spent on medical research and medical education and training.

- Comprised 17% of hospitals in the study.
- Patient mix – private insurance (35%), Medicare (37%), Medicaid (16%), uninsured (9%), and other public programs (5%).
- Annual total revenues – the average and median total revenues were $14 million and $15 million, respectively. Comprised 1% of total revenues.
- Excess revenues – excess revenues as a percentage of total revenues was 3.3% (lowest of the revenue sizes)
  - the average and median excess revenue amounts were $0.5 million and $0.3 million, respectively (also lowest of the revenue sizes)
  - 35% of all hospitals in this revenue category reported a deficit (highest of all revenue sizes), and 63% reported a deficit or positive excess revenues less than 5% of total revenues
- Community benefit expenditure profile
  - Average and median community benefit expenditures reported as a percentage of total revenues were 9.9% and 3.4%, respectively.
  - Mix across types of community benefit expenditures – 93% of reported community benefit expenditures were uncompensated care, followed by community programs (6%), medical education and training (1%), and medical research (0%).
- Uncompensated care

- Average and median percentage of patients provided uncompensated care were 9.2% and 2.7%, respectively.
- Average and median percentage of total revenues reported as spent on uncompensated care were 9.3% and 3.1%, respectively (highest average percentage, but lowest median percentage of the revenue sizes).
- 93% reported providing uncompensated care; a greater percentage reported treating most types of shortfalls as uncompensated care, but a lesser percentage reported treating bad debt as uncompensated care, compared to overall.

- Research, education and community programs
  - Average and median expenditures as percentage of total revenues, respectively: medical education and training (0.2% and 0.1%); medical research (0.1% and 0.1%); community programs (0.9% and 0.2%)
  - 48% reported medical education and training (compared to 77% overall); 82% reported community program expenditures of some type.
- Comparison of community benefit expenditures and uncompensated care to specified percentage of revenue levels
  - Community benefit expenditures under 2% of total revenues (34%); under 5% of total revenues (60%).
  - Uncompensated care under or equal to 1% of total revenues (26%); under or equal to 3% of total revenues (49%); under or equal to 5% of total revenues (60%).

Over $500 million revenue size[71]

The hospitals with total revenues over $500 million had the highest percentage of Medicaid patients and the lowest percentage of Medicare patients. This group had a participation rate in uncompensated care that was less than that of the other hospital size groups, and in medical research that was greater than that of the other groups. It had a relatively high participation rate in medical education and training, and relatively low participation rates in most of the community program expenditure types. This group had relatively high average and median percentages of total revenues reported as spent on community benefit expenditures. The group of hospitals with total revenues over $500 million had relatively high percentages of aggregate community benefit expenditures reported as spent on medical education and training and medical research, and relatively low percentages reported as spent on uncompensated care and community programs. This group's average and median percentages of total revenues spent on medical research and medical education and training were the largest reported percentages of all of the hospital size categories.

- Comprised 7% of hospitals in the study.
- Patient mix – private insurance (46%), Medicare (23%), Medicaid (21%), uninsured (8%), and other public programs (3%); lowest percentage of Medicare and highest percentage of Medicaid of all revenue sizes.

[71] Certain information included in this section is not displayed in the figures included earlier in the report to prevent potential identification of respondent hospitals.

- Annual total revenues – the average and median total revenues for the group were $964 million and $735 million, respectively. Comprised 40% of revenues of all hospitals.
- Excess revenues – excess revenues as a percentage of total revenues was 5.5% (highest of the revenue sizes)
  - The average and median excess revenue amounts were $53.4 million and $38.3 million, respectively (also highest of the revenue sizes).
  - 50% of the hospitals in this category reported a deficit or positive excess revenues less than 5% of total revenues.
- Community benefit expenditure profile
  - Average and median community benefit expenditures reported as a percentage of total revenues were 12.4% and 10.5%, respectively.
  - Mix across types of community benefit expenditures – 35% of reported community benefit expenditures were uncompensated care, followed by medical education and training (32%), medical research (29%), and community programs (4%).
- Uncompensated care
  - Average and median percentage of patients provided uncompensated care were 16.6% and 5.3%, respectively.
  - Average and median percentage of total revenues reported as spent on uncompensated care were 5.6% and 4.7%, respectively.
  - More than 90% reported providing uncompensated care; the greatest percentage reported treating bad debt as uncompensated care, but the lowest percentage reported treating private insurance, Medicare, Medicaid and other public insurance as uncompensated care, compared to overall
- Research, education and community programs
  - Average and median expenditures as percentage of total revenues, respectively: medical education and training (4.5% and 3.8%) (highest of any revenue size); medical research (3.9% and 1.2%) (highest of any revenue size); community programs (0.7% and 0.2%)
  - 92% reported medical education and training ; 67% reported medical research expenditures (highest of any revenue size); 81% reported community program expenditures of some type
- Comparison of community benefit expenditures and uncompensated care to specified percentage of revenue levels
  - Community benefit expenditures under 5% of total revenues (19%)
  - Uncompensated care under or equal to 1% of total revenues (9%); under or equal to 3% of total revenues (33%); under or equal to 5% of total revenues (60%)

Other Revenue Size Categories ($25 million to $500 million)

In general, the hospitals in the middle three revenue size categories (covering $25 million to $500 million) reported data similar to the overall group of hospitals. In this section, these three revenue size categories ($25 million to $100 million, $100 million to $250 million and $250 million to $500 million) are discussed together as there are few significant variations between the groups.

- The remaining three revenue size groups comprised 75% of the hospitals in the study.
- Patient mix was similar to the overall group.
- Annual total revenues of the three groups comprised 59% of revenues of all hospitals.
- Excess revenues as a percentage of total revenues ranged from 3.8% to 4.4%
- The percentage of hospitals that reported a deficit decreased as revenue size increased.
- Within the three revenue sizes, the average and median community benefit expenditures reported as a percentage of total revenues increased with revenue size.
- Uncompensated care
  - Within the three revenue sizes, the average and median percentages of patients provided uncompensated care increased with revenue size.
  - The percentage of hospitals within the three revenue sizes providing uncompensated care was at least 95%. The percentage of community benefit expenditures represented by uncompensated care ranged from 72% to 77%.
- Research, education and community programs
  - Percentages of hospitals within the three revenue sizes providing education and training ranged from 72% to 93%; providing research ranged from under 10% to 49%; and providing community programs ranged from 93% to 100%.
  - Percentage of hospitals that reported conducting education and training and medical research increased with revenue size.
- Comparison of community benefit expenditures and uncompensated care to specified percentage of revenue levels
  - Community benefit expenditures under 2% of total revenues for the three revenue sizes ranged from under 10% to 30%; under 5% of total revenues ranged from under 35% to 56%. The percentages decreased as revenue size increased.
  - Uncompensated care under or equal to 1% of total revenues for the three revenue sizes ranged from 12% to 20%; under or equal to 3% of total revenues ranged from 34% to 49%; under or equal to 5% of total revenues ranged from 49% to 61%. The percentages decreased as revenue size increased.

Other Findings and Observations

- Excess revenues analysis
  - Excess revenues as a percentage of total revenues varied by community type. The largest percentage (6%) was reported by the rural-non CAH group of hospitals. The lowest was reported by CAHs (3.5%).
  - Excess revenues as a percentage of total revenues increased with revenue size (3.3% for smallest to 5.5% for largest; 4.6% overall). The percentage of hospitals reporting a deficit decreased with revenue size.

- Community benefit expenditure analysis
  - Overall community benefit expenditures
    - High population hospitals reported spending a significantly higher percentage of average and median total revenues on community benefit expenditures compared with the other community types. The lowest percentage was reported by CAHs.
    - With the exception of the under $25 million category, the average percentages of revenue spent on community benefit expenditures increased with revenue size. The median percentages increased with revenue size for all categories.
  - Uncompensated care
    - High population hospitals reported highest average and median percentages of revenues spent on uncompensated care, and highest average and median percentage of patients receiving uncompensated care compared with all other community types. CAHs reported spending the lowest average and median percentages of revenue on uncompensated care and the lowest average and median percentage of patients receiving uncompensated care.
    - Smaller hospitals tended to report spending higher percentages of aggregate community benefit expenditures on uncompensated care. The average and median percentages of revenue spent on uncompensated care varied by revenue size. The highest average was reported by hospitals in the under $25 million category (9.3%). The average percentage of patients receiving uncompensated care generally increased by revenue size, while the medians varied.
  - Research
    - High population hospitals reported conducting significantly more research than any other community type.
    - The percentage of hospitals that reported conducting medical research increased with revenue size, with hospitals in the over $500 million category reporting the highest average and median percentages of revenues (3.9% and 1.2%, respectively).
  - Concentration of expenditures
    - Uncompensated care, medical research, and aggregate community benefit expenditures were not evenly distributed by the hospitals in the study, but were concentrated in a relatively small number of hospitals. 14% of the hospitals reported 63% of the aggregate uncompensated care expenditures; 26% of the hospitals reported 82% of the aggregate uncompensated care expenditures. 9% of the hospitals reported 60% of the aggregate community benefit expenditures; 19% of the hospitals reported 78% of the aggregate community benefit expenditures. 15 hospitals reported 93% of the aggregate reported medical research expenditures. This group also reported 58% of the aggregate reported medical education and training expenditures.

Per Capita Income and Health Insurance Coverage

- Per capita income categories
    - Hospitals were divided into categories (below state average, at state average, and above state average) based on comparison of county per capita income and statewide per capita income.
    - In a separate comparison, hospitals were divided into categories (low per capita, high per capita, average per capita) based on comparison of county per capita income and income of all U.S. counties.
    - Key findings – There does not appear to be a correlation between community benefit expenditures and per capita income levels. However, under both methods, hospitals in the lower income categories reported average and median percentages of revenues spent on community benefit expenditures slightly lower than the overall group. Hospitals in the lower income levels had the highest representation in the lowest percentage of revenues spent on community benefit expenditures category (i.e., community benefit expenditures less than 2% of revenues).
- Health insurance coverage levels
    - Hospitals were divided into categories (low health coverage rate, medium health coverage rate, high health coverage rate) based on the uninsured rate of the county where located.
    - In a separate comparison, hospitals were divided into the same categories based on the comparing the county's percentage of insured individuals with the percentages for counties nationwide.
    - Key findings – The results suggest a correlation between community benefit expenditures and health insurance coverage levels. The average and median percentages of total revenues reported as spent on community benefit expenditures increased as the health coverage level decreased. Hospitals with low health coverage rates (high percentage of uninsured individuals) reported the highest percentage of hospitals reporting community benefit expenditures greater than 20% of revenues.

Executive Compensation Findings by Community Types

- The average and median salary, other compensation, and total compensation was lower for rural hospitals (CAH and non-CAH) than for the suburban and urban hospitals (high population and other urban and suburban).
- The average and median total compensation amounts, respectively, reported by the respondents in the study for the top management official were as follows:
    - For critical access hospitals - $178,000 and $169,000
    - For non-CAH rural hospitals - $326,000 and $257,000
    - For other urban and suburban hospitals - $521,000 and $426,000
    - For high population hospitals - $781,000 and $566,000

- Overall, $490,000 and $377,000

Executive Compensation Findings by Revenue Size Categories

- The average and median salary, other compensation, and total compensation increased as revenue levels increased.
- The average and median total compensation amounts, respectively, reported by the respondents in the study for the top management official were as follows:
    - Revenues under $25 million - $171,000 and $140,000
    - Revenues from $25 million to $100 million - $338,000 and $263,000
    - Revenues from $100 million to $250 million - $554,000 and $461,000
    - Revenues from $250 million to $500 million - $791,000 and $642,000
    - Revenues over $500 million - $1,092,000 and $786,000
    - Overall, $490,000 and $377,000

Summary Tables of Certain Demographics and Reported Data

The following charts provide an overview of key demographics and community benefit expenditure information reported by the hospitals in the study.

Figure 118. Summary of Reported Data - Demographic Information

Item	High Population	CAHs	Rural – non CAHs	Other Urban & Suburban	Revenues under $25M	Revenues over $500M	Overall
Number of hospitals	94	68	78	249	85	36	489
% of total hospitals	19%	14%	16%	51%	17%	7%	100%
Average total revenues ($M)	$389	$29	$93	$169	$14	$964	$179
Median total revenues ($M)	$196	$20	$68	$114	$15	$735	$89
% of hospitals with total revenues < $100 M	25%	*	*	45%	100%	0%	53%
% of hospitals with total revenue >$250 M	40%	*	*	21%	0%	100%	20%
% of total revenues	41%	2%	8%	48%	1%	40%	100%
% of total excess revenues	40%	2%	11%	48%	1%	47%	100%
Average excess revenues ($M)	$18	$1	$6	$8	$1	$53	$8
Median excess revenues ($M)	$4	$1	$3	$3	$0	$38	$3
Excess revenues as % of total revenues	5%	4%	6%	5%	3%	6%	5%
% hospitals with deficit excess revenues	22%	34%	13%	20%	35%	*	21%
% of hospitals with excess revenue <2.5% of total revenue	47%	44%	28%	40%	51%	*	40%
% of hospitals with excess revenue <5% of total revenue	69%	66%	42%	61%	64%	*	60%
% of patients with Medicare	28%	36%	33%	30%	37%	23%	31%
% of patients with Medicaid	19%	13%	13%	15%	16%	21%	15%
% of patients uninsured	8%	8%	7%	8%	9%	8%	8%
% of patients with private insurance	44%	38%	44%	44%	35%	46%	43%
% of patients with other public insurance	4%	3%	3%	3%	5%	3%	3%

M=million. * Not shown to prevent potential identification of respondent hospitals.

Figure 119. Summary of Reported Information - Community Benefit Expenditure Data

Item	High Population	CAHs	Rural – non CAHs	Other Urban & Suburban	Revenues under $25M	Revenues over $500M	Overall
Community benefit expenditures as % of total revenue (average)	13%	6%	8%	9%	10%	12%	9%
Community benefit expenditures as % of total revenue (median)	10%	3%	3%	6%	3%	11%	6%
% of hospitals with community benefit expenditures <2% of total revenue	11%	39%	31%	17%	34%	*	21%
% of hospitals with community benefit expenditures <5% of total revenue	32%	61%	57%	46%	60%	*	47%
Uncompensated care as % of community benefit expenditures	42%	77%	76%	69%	93%	35%	56%
Medical education & training as % of community benefit expenditures	26%	4%	17%	21%	1%	32%	23%
Research as % of community benefit expenditures	25%	0%	1%	5%	0%	29%	15%
Community program expenditures as % of community benefit expenditures	7%	19%	6%	5%	6%	4%	6%
Uncompensated care as % of total revenue (average)	8%	6%	8%	7%	9%	6%	7%
Uncompensated care as % of total revenue (median)	5%	2%	3%	4%	3%	5%	4%
% of hospitals with uncompensated care ≤ 1% of total revenue	8%	31%	25%	17%	26%	9%	19%
% of hospitals with uncompensated care ≤ 3% of total revenue	33%	59%	52%	39%	49%	33%	43%
% of hospitals with uncompensated care ≤5% of total revenue	52%	67%	65%	55%	60%	60%	58%
% of patients receiving uncompensated care (average)	11%	7%	8%	10%	9%	17%	10%
% of patients receiving uncompensated care (median)	6%	2%	2%	5%	3%	5%	3%
% of hospitals including bad debt as uncompensated care	47%	34%	35%	48%	41%	*	44%
% of hospitals including Medicare shortfalls as uncompensated care	14%	24%	28%	19%	27%	*	20%
% of hospitals including Medicaid shortfalls as uncompensated care	16%	19%	34%	18%	21%	*	20%
% of hospitals including private insurance shortfalls as uncompensated care	12%	28%	31%	15%	24%	*	19%
% of hospitals including uninsured shortfalls as uncompensated care	47%	53%	62%	47%	55%	*	51%
% of hospitals including other public program shortfalls as uncompensated care	14%	22%	32%	14%	21%	*	18%

* Not shown to prevent potential identification of respondent hospitals.

X. KEY OBSERVATIONS AND LESSONS LEARNED

Key Observations

1. There are multiple reasons why community benefit reporting varied across the demographics. The study observed differences in a demographic group's general treatment of an activity as community benefit (e.g., lower percentages of high population hospitals generally treated Medicare and other shortfalls as uncompensated care than did other hospitals) and varying costing methodologies used by the hospitals. Undoubtedly other factors, including many not analyzed in this study, contributed to these variations. These factors and limitations must be considered when reviewing the study's findings. The new Form 990 Schedule H reporting should reduce much of this variation in reporting.

2. Any revised standard would affect the different types and sizes of hospitals differently depending upon the types of activities required to be taken into account as community benefit, the quantitative measure (if any), and the extent to which it provides exceptions or special rules to address special circumstances and demographics (e.g., an exception from a quantitative standard if the nonprofit hospital is the sole provider in the community).

3. A significant percentage of the hospitals in the study reported uncompensated care and aggregate community benefit expenditures that were below various "percentage of revenues" levels. For example, although the reported data is subject to a number of limitations, the data indicates that a significant percentage of all types and sizes of hospitals in the study would fail to satisfy an exemption standard requiring uncompensated care expenditures of at least 3% of total revenues, or aggregate community benefit expenditures of at least 5% of total revenues. In large part, this is attributable to the concentration of uncompensated care and aggregate community benefit expenditures in a relatively small number of hospitals. The data also suggests that an attempt to draw bright lines could have disproportionate impacts on hospitals depending upon their size, where they are located, their community benefit mix, and other hospital and community demographics.

4. Financial capacity also varied within the sample. In general, smaller hospitals, including CAHs, had lower profit margins than larger hospitals in the study. Also, the percentage of hospitals reporting deficits decreased as revenue size increased.

5. Those respondent hospitals that reported information regarding how they established executive compensation, including use of the rebuttable presumption procedure, almost unanimously reported that they complied with key elements of that procedure. High levels of compliance with the procedure were confirmed in the examinations. The hospitals selected for examinations generally were selected because they reported executive compensation amounts at relatively high levels compared to other hospitals of similar size and type. The traditional

risk analysis and examination methodologies used in these examinations confirmed widespread compliance with reasonable compensation standards. More work must be done to assess the impact that the rebuttable presumption procedure (including the use of for profit comparables) and the initial contract exception (which provides that the Section 4958 excise tax does not apply to an initial contract between an organization and a disqualified person) are having on establishing executive compensation amounts and the ability of the IRS to challenge compensation paid by many tax-exempt organizations.

6. Beginning with the 2009 tax year (2010 filing season), the Form 990, Schedule H, *Hospitals*, should promote uniform and accurate reporting of quantitative and qualitative community benefit information by tax-exempt hospitals. Looking ahead, particular areas of inquiry are expected to include the following: (a) accuracy of costing methodologies used to measure community benefit; (b) medical research funded by for-profit organizations or not made widely available to the public; (c) amounts reported as bad debt that are actually attributable to charity care; (d) treating portions of Medicare shortfalls or certain community building activities as community benefit; and (e) review of non-quantifiable aspects of community benefit.

Lessons Learned

1. Many of the questionnaire's questions proved to be ambiguous or difficult to answer without a supplemental explanation, and some were criticized as being judgmental or value laden. In future initiatives, the IRS will strive to work more closely with other experts in designing the questions to be asked of the respondents in the study, and will consider using pilots and samples to test a draft questionnaire before implementation of the final questionnaire.

2. Studies of this nature are subject to disclosure rules designed to prevent direct or indirect disclosure of a taxpayer's identity or taxpayer information. This caused the IRS to combine or omit certain data in the report, or sometimes use general descriptions by using terms such as "nearly all" or "a few" instead of referring to specific numbers or percentages. This was especially true in the case of the study's reporting of executive compensation examinations. The IRS will more carefully consider disclosure issues at the front end as it designs future questionnaires and studies.

3. The comprehensive nature of the study and the large volume of data received, including significant amounts through narrative descriptions and attachments, resulted in it taking longer to analyze the data and complete the report than was expected. The release of an interim report to summarize the aggregate data as reported to the IRS proved to be a valuable tool, both in helping the IRS determine which areas required further work, and in assuring transparency to the public regarding the process. The IRS anticipates using interim reports in those future compliance initiatives it expects will take a substantial period of time to complete. Further, studies of this nature require

dedication of significant resources of IRS personnel that must be trained for the study's specific tasks, and more training specific to the study should be built in at the front end of these initiatives to maximize the quality and quantity of information obtained from the study.

4. The questionnaire's response rate was high and the overall quality of responses was very good. The quality of the report is of course dependent on the quality of responses and the willingness of the respondents to participate in the study. The IRS will study ways to assure that response rates remain high in future initiatives.

5. In areas where the tax-exempt organizations being studied operate in competition with or along side of for-profit organizations, it would also be helpful to have a deeper understanding of those for-profit organizations. Future initiatives should attempt to take into account relevant studies or other bodies of knowledge regarding such organizations, whenever possible.

6. The classification of respondents into various categories to analyze reported data across certain demographics is helpful and interesting, but its utility depends upon the soundness of the classifications. Although some classifications cannot be determined until the data is received and preliminarily analyzed, to the extent possible, the IRS should build possible classification criteria into the design of the initial questionnaire.

APPENDIX A. LIST OF CHARTS AND TABLES

Below is a list of charts and tables (by Figure number) included in the Final Report. In virtually all cases, information provided by community type is also provided by revenue size in a corresponding figure.

Figure 1 through Figure 21 include general demographic information. Figure 1 shows overall patient insurance coverage. Figure 2 through Figure 7 show financial information by revenue size. This information by community type is included in Figure 8 through Figure 13. Figure 14 through Figure 16 display the overlap between community type and revenue size. Figure 17 through Figure 21 include financial information by excess revenue categories.

Figure 22 through Figure 24 show patient information by community type. This information is shown by revenue size in Figure 50 through Figure 52. Figure 25 through Figure 49 show reported community benefit expenditure information and analysis, both on an aggregate basis and by the various components of community benefit by community type. This same information is shown by revenue size in Figure 53 through Figure 77.

Figure 78 and Figure 79 relate to the group of 15 hospitals that provided 93% of the aggregate medical research expenditures. Figure 80 through Figure 85 show the analysis of the inclusion of bad debt and various shortfalls in uncompensated care. Figure 86 through Figure 89 show community benefit expenditures across various income levels. Figure 90 through Figure 93 show community benefit expenditures across various health insurance coverage levels. Figure 94 and Figure 95 show the overlap between the income and health insurance coverage groups.

Figure 96 through Figure 117 relate to the executive compensation portion of the project.

Figure 118 and Figure 119 show a summary of demographics and reported community benefit expenditure data.

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APPENDIX B
FORM 13790, Compliance Check Questionnaire Tax-Exempt Hospitals

Form **13790** (May 2006)	**COMPLIANCE CHECK QUESTIONNAIRE TAX-EXEMPT HOSPITALS**	OMB No. 1545-2015

This questionnaire asks for information about your hospital and how it operates. Answer the questions based on your hospital's ***most recently completed tax period.*** *If additional space is needed, attach additional sheets. Please complete the questionnaire and follow the instructions in the letter for returning the information to us.*

PART I – ORGANIZATION

Name of Hospital:	EIN:	Most Recently Completed Tax Period:

PART II – OPERATIONS

1) Please indicate the category below that best described your hospital or the type of service it provided to the majority of admissions. ***Check only one box.***

- ☐ General medical and surgical
- ☐ Hospital unit of an institution *(prison, college etc)*
- ☐ Hospital unit within an institution for the mentally retarded
- ☐ Surgical
- ☐ Psychiatric
- ☐ Tuberculosis and other respiratory diseases
- ☐ Cancer
- ☐ Heart
- ☐ Alcoholism and other chemical dependency
- ☐ Organization is not a §501(c)(3) hospital. If you checked this box, stop here and return the questionnaire to us.
- ☐ Obstetrics and gynecology
- ☐ Eye, ear, nose and throat
- ☐ Rehabilitation
- ☐ Orthopedic
- ☐ Chronic disease
- ☐ Institution for the mentally retarded
- ☐ Acute long-term care
- ☐ Other — Specify: _____

Patients

	Inpatients	Outpatients	Emergency Room Patients
2) What were the total number of:			
3) How many had private insurance?			
4) How many had Medicare?			
5) How many had Medicaid?			
6) How many had other public insurance?			
7) How many had no insurance?			

8) Did your hospital deny medical services to any individuals with:

a) private insurance? ☐ Yes ☐ No

If yes, please explain.

b) Medicare? ☐ Yes ☐ No

If yes, please explain.

c) Medicaid? ☐ Yes ☐ No

If yes, please explain.

d) other public health insurance? ☐ Yes ☐ No

If yes, please explain.

e) no insurance? ☐ Yes ☐ No

If yes, please explain.

Emergency Room

9) Did your hospital operate an emergency room? ☐ Yes ☐ No

If no, please explain.

10) What were the emergency room's hours of operation?

☐ 24 hours a day, 365 days a year

☐ Other — please explain. _____

11) Did your hospital's emergency room have a trauma center? ☐ Yes ☐ No

12) If yes, what was the trauma center's level of certification?

☐ Level I ☐ Level IV

☐ Level II ☐ Level V

☐ Level III ☐ Other — please describe. _____

13) Did your hospital's emergency room provide services to all members of the community regardless of their ability to pay?

☐ Yes ☐ No

If no, please explain.

14) Did your hospital's emergency room deny services to any individuals that requested such services? ☐ Yes ☐ No

If yes, please explain.

Board of Directors

15) How many directors were on your hospital's board? _____

16) What was the professional background of each director?
Please indicate the number of directors in each category listed below.

_____ Accounting	_____ Government	_____ Philanthropy
_____ Banking/Finance	_____ Insurance	_____ Public/Elected Official
_____ Business	_____ Law	_____ Religion
_____ Community Service	_____ Management	_____ Retail
_____ Education/Academia	_____ Manufacturing	_____ Social Services
_____ Fine Arts	_____ Medicine/Health Care	_____ Other *(specify)* _____

17) How often did the board of directors meet?

☐ Monthly ☐ Quarterly ☐ Annually

☐ Other — please describe. _____

18) On average, how many of the directors were present at each meeting? _____

Medical Staff Privileges

19) Were all qualified physicians in your community eligible for medical staff privileges at your hospital? ☐ Yes ☐ No

If no, please explain.

20) Have you denied any qualified physician's application for medical staff privileges? ☐ Yes ☐ No

If yes, please explain.

Medical Research

21) Did your hospital conduct any medical research programs? ☐ Yes ☐ No
If yes, please answer questions 22 through 24. If no, go to question 25.

22) How much did your hospital spend on medical research programs? $_____

23) How much of your hospital's funding for medical research came from:

a) public sources *(for example, government grants)* $_____

b) private sources *(for example, contracts with for-profit corporations)* $_____

24) Did your hospital limit public access to the findings or results from any of its medical research programs? ☐ Yes ☐ No
If yes, please explain.

25) How much did your hospital provide in grants to individuals or organizations to fund medical research programs? $_____

26) Was public access limited to the findings or results from any medical research programs for which your hospital provided grants? ☐ Yes ☐ No
If yes, please explain.

27) Did your hospital conduct any medical trial studies? ☐ Yes ☐ No
If yes, answer questions 28 and 29. If no, go to question 30.

28) How much of your hospital's funding for medical trial studies came from:

a) public sources *(for example, government grants)* $_____

b) private sources *(for example, contracts with for-profit corporations)* $_____

29) Did your hospital limit public access to the findings or results from any of its medical trial studies? ☐ Yes ☐ No
If yes, please explain.

Professional Medical Education and Training

30) Did your hospital conduct any professional medical education and training programs? ☐ Yes ☐ No
If yes, answer questions 31 and 32. If no, go to question 33.

31) How much did your hospital spend on professional medical education and training programs? $_____

32) How much of your funding for professional medical education and training came from:

a) public sources *(for example, government grants)* $_____

b) private sources *(for example, contracts with for-profit corporations)* $_____

33) Did your hospital provide grants to individuals or organizations to fund professional medical education and training programs? ☐ Yes ☐ No

If yes, how much did it spend? $_____

Uncompensated Care

34) Did your hospital have a written policy stating the circumstances under which it would provide uncompensated care? ☐ Yes ☐ No

Please explain.

35) How many individuals received uncompensated care from your hospital? _____

36) How much did your hospital spend on uncompensated care? $_____

37) Did your hospital treat as uncompensated care the excess of what it charged for services and the amount:

a) private insurance paid or allowed for such services (including any patient co-payments and deductibles)? ☐ Yes ☐ No

If yes, please explain.

b) Medicare paid or allowed for such services (including any patient co-payments and deductibles)? ☐ Yes ☐ No

If yes, please explain.

c) Medicaid paid or allowed for such services (including any patient co-payments and deductibles)? ☐ Yes ☐ No

If yes, please explain.

d) other public insurance paid or allowed for such services (including any patient co-payments and deductibles)? ☐ Yes ☐ No

If yes, please explain.

e) individuals without insurance paid your hospital for such services? ☐ Yes ☐ No

Please explain.

38) Did your hospital treat bad debts as uncompensated care? ☐ Yes ☐ No

Please explain.

39) Did your hospital treat any other items or costs as uncompensated care? ☐ Yes ☐ No

If yes, please explain.

40) Did your hospital report its expenditures for uncompensated care to a state government? ☐ Yes ☐ No

If yes, what amount did it report? $_____

41) Did your hospital provide:

a) inpatient services to any individual without compensation? ☐ Yes ☐ No

If yes, please describe your policy.

b) outpatient services to any individual without compensation? ☐ Yes ☐ No

If yes, please describe your policy.

c) emergency room services to any individual without compensation? ☐ Yes ☐ No

If yes, please describe your policy.

42) If you answered yes to 41 a, b, or c, indicate below, for each category of patient, when your hospital determined that it would provide services to any individual without compensation? Check all that apply.

	At or before providing services	**Less than 30 days after providing services**	**30 to 90 days after providing services**	**More than 90 days after providing services**	**When insurance denied all or part of claim**	**Other** *(explain below)*
Inpatient	☐	☐	☐	☐	☐	☐
Outpatient	☐	☐	☐	☐	☐	☐
Emergency Room	☐	☐	☐	☐	☐	☐

If you checked the other box, please describe:

Billing Practices

43) Did your hospital require all individuals to pay, or make arrangements to pay, prior to, or at the time it provided:

a) inpatient services? ☐ Yes ☐ No

b) outpatient services? ☐ Yes ☐ No

c) emergency room services? ☐ Yes ☐ No

44) In the space provided below, please explain your payment policies for:

a) inpatients

b) outpatients

c) emergency room patients

45) How many days after your hospital provided services did it send the patient a bill? _____

46) How many days after the billing date did the patient have to pay for services? _____

47) If a patient failed to pay for services, how many notices did your hospital send before it began collection actions? _____

48) Did your hospital refer all past due bills to collection agencies? ☐ Yes ☐ No

49) Did your hospital enter into installment agreements or other extended payment arrangements with patients who were unable to pay? ☐ Yes ☐ No

50) Please describe the circumstances in which you would enter into installment agreements or other extended payment arrangements with patients who were unable to pay.

51) How many days after a patient had not paid all or part of a bill did your hospital classify it as a bad debt? _____

52) Did your hospital charge all patients the same price for the same services? ☐ Yes ☐ No
If yes, go to question 57. If no, answer questions 53-56.

53) Did your hospital charge patients with private insurance higher prices for hospital services than patients with public insurance (including Medicare and Medicaid)? ☐ Yes ☐ No
Please explain.

54) Did your hospital charge patients with no insurance higher prices for hospital services than patients with public insurance (including Medicare and Medicaid)? ☐ Yes ☐ No
Please explain.

55) Did your hospital charge patients with no insurance higher prices for hospital services than patients with private insurance? ☐ Yes ☐ No
Please explain.

56) Did your hospital charge individuals different prices for hospital services based on their income, assets or ability to pay for such services? ☐ Yes ☐ No
Please explain.

Community Programs

57) Did your hospital provide medical screening programs for the community? ☐ Yes ☐ No
If yes, answer questions 58 through 60. If no, go to question 61.

58) How much did your hospital spend on medical screening programs for the community? $ _____

59) Were all members of the community eligible for your hospital's medical screening programs? ☐ Yes ☐ No
If no, please explain.

60) Did the hospital charge a fee for any community medical screening programs? ☐ Yes ☐ No
If yes, please explain.

61) Did your hospital provide immunization programs for the community? ☐ Yes ☐ No
If yes, answer questions 62 through 64. If no, go to question 65.

62) How much did your hospital spend on immunization programs for the community? $ _____

63) Were all members of the community eligible for your hospital's immunization programs? ☐ Yes ☐ No
If no, please explain.

64) Did your hospital charge a fee for its community immunization programs? ☐ Yes ☐ No
If yes, please explain.

65) Did your hospital provide any lectures, seminars or other educational programs for the community? ☐ Yes ☐ No
If yes, answer questions 66 through 68. If no, go to question 69.

66) How much did your hospital spend on lectures, seminars and other educational programs for the community? $ _____

67) Were all members of the community eligible for your hospital's community educational programs? ☐ Yes ☐ No
If no, please explain.

68) Did your hospital charge a fee for its community education programs? ☐ Yes ☐ No
If yes, please explain.

69) Did your hospital conduct studies on the unmet health care needs of the community? ☐ Yes ☐ No
If yes, how much did your hospital spend on these studies? $ _____

70) Did your hospital have programs to improve access to health care for individuals who lacked insurance? ☐ Yes ☐ No
If yes, how much did your hospital spend on these programs? $ _____

71) Did your hospital produce or distribute newsletters or publications that provided information to the community on health care issues? ☐ Yes ☐ No
If yes, how much did your hospital spend on these newsletters or publications? $ _____

72) Did your hospital have any other programs or activities that promoted health for the benefit of the community?

☐ Yes ☐ No

If yes, please explain and indicate how much was spent on these programs and activities.

PART III – COMPENSATION PRACTICES

Please answer the questions in this part as it pertains to employees in your hospital who are disqualified persons within the meaning of Internal Revenue Code (IRC) Section 4958(f)(1).

1) Please provide the names and titles of your hospital's officers, directors, trustees and key employees and amounts of salary and other compensation paid by your hospital to such officers, directors, trustees and key employees. Add additional sheets if necessary.

Name	Title	Salary[1]	Other Compensation[2]

[1] *Salary includes all forms of cash and non-cash compensation received whether paid currently or deferred.*

[2] *Other Compensation includes contributions to employee benefit plans and deferred compensation plans, and expense allowances from non-accountable plans.*

2) Did your hospital have a formal written compensation policy? ☐ Yes ☐ No

3) Was compensation approved, in advance, by individuals that did not have a conflict of interest with the compensation arrangement being approved? ☐ Yes ☐ No

4) Who in your hospital set the compensation for officers, directors, trustees, and key employees? Check all that apply.

☐ Officers ☐ Board of Directors ☐ Compensation Committee

☐ Other — please explain: _____

5) Please check any of the following that your hospital used to determine compensation amounts:

☐ Published surveys of compensation at similar institutions;

☐ Internet research on compensation at similar institutions conducted by your employees;

☐ Phone survey(s) of compensation at similar institutions conducted by your hospital's employees;

☐ Outside expert report prepared specifically for your hospital by an expert employed by your hospital for this purpose;

☐ Outside expert report prepared by an expert employed by an unrelated organization;

☐ Written offers of employment from similar institutions; and

☐ Other — please describe: _____

6) Please check the appropriate boxes, in the following chart, regarding factors included in the comparability data used by your hospital:

COMPARABILITY FACTORS:	YES	NO	Was factor checked used for all § 4958(f)(1) employees? *	
			Yes	No*
Level of Employee Education and Experience				
Specific Responsibilities of Position				
Same Geographic or Metropolitan Area				
Services of a Similar Nature Provided				
Similar Number of Beds, Admissions, or Outpatient Visits				

Other Factors. Please explain.

*If no, please explain.

7) Did your hospital's comparability data include information from other tax-exempt hospitals? ☐ Yes ☐ No
If no, please explain.

8) Was your hospital's actual compensation set within the range of comparability data? ☐ Yes ☐ No
If no, please explain.

9) Did your hospital have a business relationship with any of its officers, directors, trustees or key employees other than through their position as officers, directors, trustees, or key employees? ☐ Yes ☐ No

If yes, identify the individuals and describe the business relationship below.

Name	Title	Description of Business Relationship

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APPENDIX C
Form 990, Schedule H, Hospitals

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