



Schedule H: New Community Benefit Reporting Requirements for Hospitals

BACKGROUND
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EILEEN SALINSKY, *Consultant*

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OVERVIEW — In recent years, some policymakers have questioned whether not-for-profit hospitals benefit the communities they serve at a level commensurate with the tax exemptions they receive as charitable organizations. This background paper reviews the new community benefit reporting requirements hospitals will face in 2009 under Schedule H of the Internal Revenue Service's revised Form 990 (the return used by organizations exempt from federal income tax). The paper provides a descriptive summary of the quantitative and qualitative information to be reported on Schedule H, such as charity care, bad debt, and the unreimbursed costs of Medicaid and Medicare.

National Health Policy Forum

2131 K Street, NW
 Suite 500
 Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

Judith Miller Jones
Director

Sally Coberly, PhD
Deputy Director

Monique Martineau
Publications Director

Contents

NEW HOSPITAL REPORTING REQUIREMENTS 5

 Who Must File? 7

 Charity Care and Means-Tested Programs 9

 Figure 1: Examples of Approaches to Charity Care Valuation..... 12

 “Certain Other” Community Benefits 13

 Shades of Gray: Bad Debt, Medicare Shortfall,
 and Community Building 15

 Table 1: States with Mandatory or Voluntary
 Community Benefit Reporting:
 Inclusion of Bad Debt and Medicare Shortfall..... 16

 Supplemental Information 20

METHODOLOGICAL CONCERNS 21

 Figure 2: Illustrative Example of a Potential Gaming Scenario 23

CONCLUSION 24

ENDNOTES 24

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Over the past several years, Congress has increasingly scrutinized the practices and policies of not-for-profit organizations, probing the extent to which these organizations merit the tax-exempt status currently afforded them under federal, state, and local laws. These oversight activities have focused on the diverse array of organizations exempt from federal income tax under section 501(c)3 of the Internal Revenue Code, including educational institutions, private foundations, and not-for-profit hospitals. Tax-exempt organizations vary widely in terms of size, assets, and revenues and also reflect a range of charitable, religious, and educational endeavors.

In general, government provides tax exemption to private, not-for-profit organizations that are thought to provide public benefit, perform services which would otherwise fall to government, or promote other activities broadly valued by society. Federal law provides tax exemption to organizations that are structured and operated exclusively for statutorily defined “exempt purposes” and forbids the inurement of benefits to private individuals or parties. Challenges to tax exemption typically focus on allegations that an organization has engaged in (and derived income from) activities that do not further an exempt purpose, has provided inappropriate benefits to private interests, or has committed a combination of these tax law violations.

A number of congressional committees have held hearings and called for investigations related to concerns regarding tax-exempt organizations. Hospitals and educational institutions have received special attention, in part because of the large amount of assets and revenues concentrated in these sectors. The IRS estimates that the top 1 percent of charitable organizations accounts for 61 percent of the assets and 66 percent of the revenues of the tax-exempt, not-for-profit sector.¹ The monetary benefits of tax exemption can be substantial for institutions with sizeable financial resources. The aggregate value of federal, state, and local tax exemption for the not-for-profit hospital sector has been estimated at between \$12.6 to \$20 billion per year.² In addition to the large amount of foregone taxes

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these exemptions represent, high levels of public funding contribute to the operating revenues of these organizations, further heightening policymakers' interest.

The scale of federal investment in hospitals and other types of not-for-profit organizations has led some policymakers to question the benefits provided by, and the incentives established for, these organizations. Senator Grassley (R-IA) has been particularly active in voicing the need for more rigorous oversight of tax-exempt organizations. In a May 2007 letter to the Department of the Treasury, Senators Grassley and Baucus (D-MT) urged the gathering of more and better information: "While we always hear that sunshine is the best disinfectant, sunshine can't do its work unless we open the blinds. The sooner we open those blinds the better."³

In response to these and other calls for increased transparency in the operations and impact of not-for-profit organizations, the Internal Revenue Service (IRS) has recently completed significant revisions to Form 990, the primary mechanism used to monitor exempt organizations' compliance with federal tax law. These changes include an overhaul of the "core form" that captures select information regarding exempt organizations' financial status, governance, staffing, and employee compensation, as well as the creation of several schedules which seek to standardize reporting for information that had previously been provided through filer-designed attachments.

Among these new schedules is Schedule H, which is specifically designed to describe the charitable activities of hospitals. Most private hospitals in the United States are recognized as tax-exempt, charitable organizations, are required to file Form 990, and will be required to file Schedule H, beginning in 2009 (for the 2008 tax year). While many state and local governments have pursued increasingly stringent requirements for hospital tax exemption in recent years, Schedule H represents the first major shift in federal oversight in nearly three decades. For the first time, hospitals are being asked to provide the IRS with detailed, quantified information using standardized definitions to describe how they are fulfilling their charitable mission.

Although not specifically identified in section 501(c)3, private, not-for-profit hospitals have historically qualified for tax exemption as charitable organizations that engage in activities deemed consistent with the exempt purposes described in statute.⁴ The regulatory parameters

for defining a hospital's charitable purpose have changed little since the issuance of a 1969 IRS revenue ruling. Known as the "community benefit standard," the ruling sets out a rather flexible framework for gauging the charitable performance of hospitals.

In order to establish a charitable purpose, the community benefit standard requires that hospitals promote the health of a class of persons broad enough to benefit the community as whole. Prior to 1969, hospitals were explicitly required to provide charity care to the extent of their financial ability to do so.⁵ The community benefit standard established that the provision of free and discounted services to the poor is one of several ways that hospitals can promote community health and fulfill their community benefit obligations. Notably, the 1969 revenue ruling does not define "community" in any way, nor does it require hospitals to explicitly identify the community or communities they serve.

The new Schedule H reporting requirements do not modify the community benefit standard used to qualify hospitals for tax exemption, but these filings will provide significantly more detailed information to the IRS and the public for monitoring hospitals' community benefit activities and have the potential to trigger future policy changes. The following provides an overview of the revised Form 990, describes Schedule H reporting requirements in detail, and identifies methodological concerns related to these reporting requirements.

NEW HOSPITAL REPORTING REQUIREMENTS

The Form 990 reporting revisions are substantial and are expected to yield a wealth of data on not-for-profit hospitals' business practices and community benefit activities. The new 990 core form consists of 11 pages that will help the IRS more effectively monitor all types of tax-exempt organizations' compliance with the law related to inurement, exempt purpose, and private benefit. Major changes to the core form include a new section on organizational governance, as well as expanded queries related to compensation of officers, directors, trustees, key employees, and highly compensated employees. The new Form 990 also includes 16 schedules to be completed by organizations that meet the requirements applicable to each schedule.

These schedules seek to collect in-depth information on a range of topics, including public charity status and applicable public support tests, identification of contributors, political campaign and lobbying activities, supplemental financial information related to certain organizational assets (such as endowments and donor advised funds), private schools, foreign activities, fundraising and gaming activities, hospitals, grants to other organizations, compensation practices, tax-exempt bonds, transactions with interested parties, non-cash contributions, liquidation of assets, supplemental information, related organizations, and partnerships with unrelated organizations.

Among the new schedules is Schedule H: Hospitals, which is intended to provide a comprehensive, structured overview of hospitals' community benefit and related activities. Schedule H is organized into six parts:

- Part I: Charity Care and Certain Other Community Benefits
- Part II: Community Building Activities
- Part III: Bad Debt, Medicare, and Collection Practices
- Part IV: Management Companies and Joint Ventures
- Part V: Facility Information
- Part VI: Supplemental Information

In response to comments received regarding the burden inherent in collecting all the information required under Schedule H, the IRS provided transition relief for most portions of the schedule. For the 2008 tax year (2009 filing), hospitals are only required to submit Part V (Facility Information), which requests the name and address of all facilities licensed, registered, or similarly recognized as a health care facility under state law. Filing of Parts I through IV and Part VI are optional for the 2009 filing, but hospitals will be required to submit the complete schedule for the 2009 tax year (2010 filing).

Schedule H attempts to establish a more consistent, uniform approach to community benefit accounting. Based in large part on voluntary reporting guidelines first developed by the Catholic Health Association (CHA), Schedule H identifies the types of costs that can be "counted" as community benefit expenses and clearly labels and disaggregates these cost items.

Who Must File?

Schedule H must be completed by any tax-exempt organization required to file Form 990 that also operates at least one facility that is licensed, registered, or similarly regulated by the state as a hospital. Of the 4,900 non-federal hospitals in the United States, approximately 59 percent will be subject to Schedule H reporting.⁶ Hospital organizations not required to file Form 990 do not file Schedule H. This includes for-profit hospitals; certain government-owned hospitals, such as municipal hospitals and federal hospitals, like Veterans Affairs facilities; and some state universities that operate hospitals. However, some hospitals affiliated with state universities are organized as 501(c)3 organizations separate from state government, and these hospitals will file Form 990 and Schedule H.

EIN-based reporting may not fully reflect the organizational structure of complex health systems and could complicate comparative analyses.

The “unit of analysis” for Schedule H is defined by the Employer Identification Number (EIN) issued by the IRS. In practical terms, each tax-exempt organization with a unique EIN that also operates one or more hospitals must file a single Schedule H. This form is intended to provide an aggregate account of relevant community benefit activities for all the hospitals and health care facilities operated or owned, in whole or in part, by the filing organization.

It is important to note that EIN-based reporting may not fully reflect the organizational structure of complex health systems and could complicate comparative analyses. Individual hospitals owned by a multi-hospital system may operate under separate EINs. Alternatively, all hospitals within a system may operate under a single EIN. In the former case, separate Schedule H forms may be filed, while in the latter case, information will be aggregated across participating hospitals and other entities on a single Schedule H.

The IRS has recognized that hospitals and health systems often have complex organizational structures that may include multiple legal entities, physical sites, levels of care, and operating licenses, as well as joint venture agreements with other organizations. Parts IV and V of Schedule H focus primarily on identifying the relevant facilities, services, and programs operated by the filing organization and clarifying the ownership status of those activities. Filing organizations are instructed to report relevant community benefit information for any joint venture activities on a prorated basis, reflecting the filing

organization's appropriate financial share in the joint venture activity. In addition to clarifying which facilities and legal entities are reflected in the filing organization's Schedule H reporting, Part IV also explores the percentage of profits or stock ownership from the joint venture received by officers, directors, trustees, key employees, or medical staff members.

Clearly identifying the operating units reflected in Schedule H reporting will be critical. The detailed itemization of facilities and programs to be provided in Parts IV and V aim to specify the organizational actors reflected in community benefit accounting and minimize potential "double counting" of community benefit activities across related organizations. Submission of Part V (Facility In-

formation) for tax year 2008 will allow the IRS to estimate the number of organizations that will be providing complete information for tax year 2009 and develop a clearer sense of the range of organizational configurations that will be represented.

Although hospitals (or health systems that include hospitals) are the only health care providers required to file Schedule H, the community

benefit activities reported on this form may reflect a range of services beyond inpatient care. The filing hospital may be part of a complex health care enterprise that includes multiple hospitals and other health care facilities. Schedule H is designed to capture community benefit activities associated with outpatient clinics, diagnostic and laboratory testing, home health services, rehabilitation, research, and other relevant activities if these services are owned or operated by the filing organization. However, the inclusion or exclusion of these services in Schedule H reporting may depend on the organizational structure and EIN conventions used by the filing organization and affiliated entities. In order to simplify the following narrative, which describes the information to be collected through Schedule H, the terms "hospital" and "filing organization" are used interchangeably. However, it should be recognized that only a portion of Schedule H filings will represent a single inpatient facility.

Although hospitals (or health systems that include hospitals) are the only health care providers required to file Schedule H, the community benefit activities reported on this form may reflect a range of services beyond inpatient care.

Charity Care and Means-Tested Programs

Part I of Schedule H collects both qualitative and quantitative information about specific community benefit activities that have been widely accepted as the basis of hospitals' charitable purpose and broadly validate the legitimacy of these organizations' tax-exempt status. These activities are divided into two categories (i) charity care and unreimbursed care for persons covered by means-tested government insurance programs and (ii) "certain other" community benefit activities that advance population-based health objectives.

The first category focuses on the provision of patient care to specifically identified low-income individuals (those enrolled in a means-tested government insurance program or offered financial assistance through the organization's internal charity care program). Means-tested government programs include any publicly sponsored insurance program for which eligibility is dependent on a person's income and/or assets, such as Medicaid or CHIP. Reimbursement provided by these programs may not fully cover the costs of providing care. A hospital's willingness to serve patients insured through means-tested programs and absorb the associated unreimbursed costs is typically viewed as a community benefit contribution.

Under Schedule H, the charity care designation is limited to free or discounted care provided to persons deemed unable to pay for all or a portion of those services based on the organization's own criteria for financial assistance. The definition of charity care used for Schedule H specifically excludes bad debt expenses. Although charity care may be reserved for low-income persons who lack third-party health insurance coverage, hospitals may elect to extend charity care to insured persons deemed unable to pay the cost-sharing obligations associated with their insurance coverage.

While hospitals have latitude in establishing their own charity care policies, Schedule H requires reporting of key pieces of information about these policies and activities, generally through simple yes or no questions such as:

- Does the hospital have a charity care policy? Is this policy in writing?
- Does the policy apply uniformly to all hospitals represented in the filing organization's report?

- Does this charity care policy include accommodations for the medically indigent (defined as persons unable to pay their medical bills due to unusually high or catastrophic costs who would not otherwise qualify for charity care based solely on income-related criteria)?
- Does the organization budget for charity care expenses? Did actual expenses exceed budgeted amounts? Was charity care denied to any eligible patients due to budgetary considerations?
- Does the hospital prepare an annual community benefit report? Is the report made available to the public?

Hospitals must also report the specific criteria used to determine eligibility for both free and discounted care, assuming different income thresholds might exist for each. If the hospital uses Federal Poverty Guidelines (FPG) to set eligibility thresholds for free or discounted care, those limits must be reported. If the hospital does not use FPG, the specific income-based criteria must be provided, including any asset test or alternative threshold that may be used.

Part I of Schedule H also quantifies in monetary terms the magnitude of the reporting hospital's community benefit contributions regarding charity care and subsidization of Medicaid and other means-tested government programs. These contributions are captured as "net community benefit expenses," which are reported on a cost basis and account for any offsetting revenues derived from these activities, such as payments from uncompensated care pools, reimbursement received from public insurers, and Medicaid Disproportionate Share Hospital (DSH) payments.

To the extent that offsetting revenues exceed reported costs, items must be reported as negative values and deducted from the organization's aggregate valuation of net community benefit expenses. Net community benefit expenses are also reported as a percentage of total expenses⁷ in order to put these expenses into a broader context with respect to the organization's overall financial commitments. Reporting on the number of community benefit programs and the number of individuals served is optional.

Schedule H allows hospitals to count any Medicaid provider taxes paid to the state as community benefit contributions, provided that any revenue received from uncompensated care pools or DSH payments are also reported as offsetting revenues. In determining whether to report these payments and revenues under charity care or Medicaid, hospitals are asked to consider the "primary purpose"

of the state taxation mechanism. In cases where the tax has multiple purposes, hospitals should allocate these costs and revenues proportionately in a reasonable manner. The costs and revenues associated with Medicaid provider taxes and payments from uncompensated care pools or DSH payments are itemized in an optional worksheet, but are subsumed within aggregate totals for charity care and means-tested government programs in the data reported on Schedule H.

Schedule H asks hospitals to use their most accurate costing methodology to calculate the community benefit expenses reported. Hospitals may use a cost accounting system, a cost-to-charge ratio, or a combination of the two methods to estimate the real expenses associated with charity care services. An optional worksheet provides instructions for calculating a cost-to-charge ratio, and hospitals must provide a description of the costing method used in Part VI (Supplemental Information). The worksheet clarifies that the total costs used in the cost-to-charge ratio should be based on operating expenses (from audited financial statements) associated with providing patient care. Non-patient care expenses should be deducted from these costs. But specific criteria for designating costs as patient care or non-patient care are not provided. Also, the optional worksheet provided with Schedule H suggests that hospitals are not required to deduct any sliding scale fees paid by qualified patients from the charity care costs reported.

Prior efforts to measure and compare the burden hospitals bear related to charity care have been hampered by inconsistencies in the methods used to calculate the monetary value of these contributions. Significant differences in hospital financial practices (regarding billing, accounting, and reporting practices) have hindered comparative analyses. Some hospitals have reported their charity care contributions based on what they charge, rather than what it costs to provide services. Critics have argued that charges are an arbitrary and inflated measure of charity care contributions. However, even among hospitals that report charity care on a cost basis, a variety of costing approaches have been used. Figure 1 (next page) provides examples of the various ways hospitals have valued and reported charity care in the past and illustrates the significant differences that result from these methodological approaches.

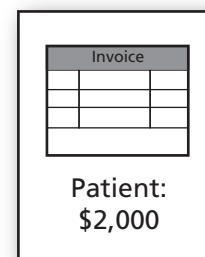
Prior efforts to measure and compare the burden hospitals bear related to charity care have been hampered by inconsistencies in the methods used to calculate the monetary value of these contributions.

The specificity of the instructions for Schedule H is likely to alleviate some of the problems encountered in past attempts to assess hospitals' community benefit activities, but some methodological differences are likely to remain. The cost-based reporting requirement will eliminate the least conservative, charge-based valuations

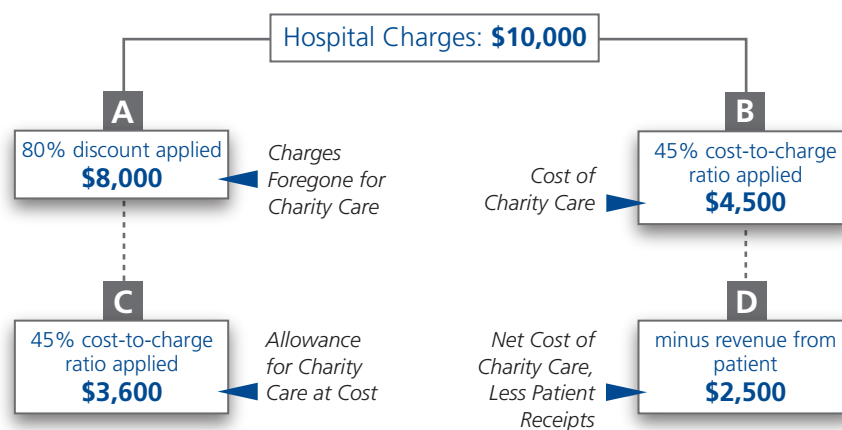
FIGURE 1: Examples of Approaches to Charity Care Valuation

Scenario: A low-income person is admitted to the hospital for a two day hospital stay that results in \$10,000 in charges. The hospital has an aggregate cost-to-charge ratio of 45 percent. The patient is found to qualify for discounted care through the hospital's charity care program. Based on the patient's income and the terms of the hospital's sliding fee scale for those deemed eligible for charity care, the hospital grants an 80 percent reduction in charges.

The patient is billed \$2,000 and subsequently pays that bill in full.



Prior to the new Schedule H reporting requirements, hospitals had a great deal of discretion in whether and how to determine the value of charity care. The scenario described above might have been reported in a variety of ways; possible calculations are illustrated below in examples A through D:



In all of these examples, amounts may have been reported as "charity care" without qualifying language. With the new reporting requirements under Schedule H, only the calculations C and D would be allowed.

of charity care, yielding more realistic estimates of the financial burden borne by hospitals in caring for the poor. However, hospitals still have discretion in determining both who is eligible for financial assistance and how the actual costs of providing care to these people will be calculated.

“Certain Other” Community Benefits

In addition to the patient care activities described above, Part I of Schedule H also identifies a number of population-based activities that hospitals may pursue to address their community benefit obligations. Reporting requirements seek to quantify the expenses that hospitals incur in conducting the following activities: community health improvement and community benefit operations, health professions education, subsidized health services, research, and cash and in-kind donations. Expenses may be calculated with the use of optional worksheets, which hospitals are not required to file.

Community health improvement and community benefit operations — These activities represent the efforts that the hospital undertakes to identify, plan for, and respond to community health needs. Net expenses are reported as an aggregate amount on Schedule H, but an optional worksheet allows for the tabulation of specific efforts and initiatives. Examples include efforts to reduce barriers to service access, eliminate health disparities, enhance public health department activities, and educate the community about minimizing health risks. A documented need—identified through a needs assessment process, a collaborative partnership with other tax-exempt community groups, or other type of document process—must be established for any community health improvement activity reported under Part I of Schedule H. However, hospitals are not required to file this documentation with the IRS.

Activities conducted primarily for marketing purposes (such as to increase patient referrals), to benefit the organization (such as those restricted to individuals affiliated with the organization), or for licensure purposes cannot be reported. Hospitals may report expenses associated with grant writing or fund raising to support these efforts. However, grant dollars received to support community health improvement activities are not counted as direct offsetting revenues, and hospitals are not required to deduct these funds from their net expenses.

Health professions education — Activities that the hospital undertakes to support either (i) educational programs that result in a degree, certificate, or training required to practice as a health professional according to state law or (ii) continuing education required by the state or a professional board are acknowledged as community benefit. The IRS specifies that in order to report these activities under Part I of Schedule H, participation in training or scholarship programs must be open to all qualified participants and cannot be limited to employees of the organization. For example, costs associated with nursing education programs can be reported if graduates are free to seek employment at any organization upon graduation, but cannot be reported if such programs require graduates to work at the sponsoring organization. Costs for training medical residents and interns, including the salary and benefits of those staff, may be included. Direct offsetting revenues associated with these programs, such as Medicare and Medicaid reimbursement for direct graduate medical education (GME) and tuition and fees paid by participants, must be included in calculating the net costs of these programs to the sponsoring institution. Only the aggregate costs and offsetting revenues are reported on Schedule H, but optional worksheets allow for disaggregation across types of training programs and disciplines.

Subsidized health services — The IRS defines subsidized health services as “clinical services provided despite a financial loss to the organization.” A documented community need for these services must exist, and the reported costs associated with subsidizing these services must account for all offsetting revenues derived from these services. Costs reported for subsidized services must exclude charity care costs, unreimbursed costs from Medicaid and other means-tested government programs, and bad debt expenses, as these costs are captured elsewhere in Schedule H.

Examples of services that may qualify as subsidized health services include neonatal intensive care, inpatient psychiatric units, and emergency department services. If a hospital reports costs associated with subsidized physician clinics, these costs must be discretely identified and described in Part VI. However, all other subsidized service costs are reported in the aggregate, and qualifying services, other than physician clinics, are not specifically identified on Schedule H. Services may be itemized on an optional worksheet for the organization’s record-keeping purposes.

Research — Research includes any study or investigation seeking to generate generalizable knowledge that will be made available to the public. Examples include efforts to elucidate the underlying biological mechanisms of health and disease, natural processes, or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease (such as clinical trials and studies of therapeutic protocols); laboratory-based studies; epidemiology, health outcomes, and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal). Costs may include compensation for research staff, facility costs, equipment, supplies, compliance with regulatory requirements, and dissemination of research results.

Similar to grant funding received for community health improvement efforts, research grants are not counted as direct offsetting revenue, and hospitals are not required to deduct such funding from their net research expenses. Research funded by organizations that are not tax-exempt must be excluded from community benefit totals, but may be described in Part VI (Supplemental Information).

Cash and in-kind donations — Contributions made by the hospital to other health care providers or community groups in order to further any of the community benefit activities identified in Part I of Schedule H are also acknowledged as community benefit expenses. These contributions, both funding grants and in-kind costs associated with personnel or donated space, supplies, or equipment, must be restricted to community benefit activities.

Shades of Gray: Bad Debt, Medicare Shortfall, and Community Building

Fairly broad consensus exists that the aforementioned activities identified in Part I of Schedule H are legitimate community benefit activities. Some hospital representatives have argued that a wider range of activities should be recognized as providing benefit to the community served. Bad debt expenses, the unreimbursed costs of caring for Medicare patients, and the costs associated with building community assets are commonly cited by hospital representatives as examples of expenses that should be included in attempts to quantify community benefit contributions. These activities are also

recognized as community benefits by some states, as summarized in Table 1.

The final configuration of Schedule H represents a compromise of sorts. The decision of the IRS to label Part I “Charity Care and ‘Certain Other’ Community Benefits” appears quite purposeful. This phrasing suggests that the activities specifically identified under Part I may not be exhaustive, yet also withholds the community benefit designation from activities that are not identified under Part I. The first discussion draft of Schedule H released in June 2007 clearly labeled Part I of Schedule H “Community Benefit Report” and appeared to exclude bad debt, Medicare shortfall, and community building expenses.

Parts II and III of Schedule H examine these disputed activities. In response to comments received on the June 2007 discussion draft of Schedule H, the IRS added these sections to collect additional

TABLE 1 | States with Mandatory or Voluntary Community Benefit Reporting: Inclusion of Bad Debt and Medicare Shortfall

STATE	Mandatory Reporting*	Bad Debt	Medicare Shortfall	STATE	Voluntary Reporting	Bad Debt	Medicare Shortfall
California	✓		•	Massachusetts	✓		
Connecticut	✓			Michigan	✓	•	•
Georgia	✓			Missouri	✓	•	•
Idaho	✓	•	•	Nebraska	✓	•	•
Illinois	✓	•	•	North Carolina	✓		•
Indiana	✓		•	Oregon	✓	•	•
Maryland	✓		•	Pennsylvania	✓	•	•
Minnesota	✓			Tennessee	✓	•	•
New Hampshire	✓			Utah	✓		•
New York	✓			Wisconsin	✓		
Rhode Island	✓	•					
Texas	✓	•	•				
Washington	✓						

* Connecticut, Georgia, and New York do not specify reporting standards.

Source: Minnesota Department of Health, Minnesota Hospitals: Uncompensated Care, Community Benefits, and the Value of Tax Exemptions, January 2007; available at www.health.state.mn.us/divs/hpsc/hep/publications/costs/uc2007report.pdf.

information on controversial areas and invited respondents to provide a rationale for why these items should be viewed as community benefit. The following narrative describes the information related to community building, bad debt, and Medicare shortfall that hospitals must report under Schedule H.

Community building — Part II of Schedule H allows hospitals to report a variety of activities intended to strengthen community infrastructure, including physical improvements and housing development, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health advocacy, workforce development, and other activities. This section focuses on activities that, while not directly related to community health improvement (and thus inappropriate for reporting under Part I), arguably have a significant, if indirect, effect on the health of the population served. The illustrative examples of community building activities provided by the IRS stress that these activities should benefit the community broadly, with a special emphasis on the needs of vulnerable populations. For example, appropriate activities identified under workforce development include, but are not limited to, recruiting health professionals to serve in medical shortage areas. CHA recognizes community building as a community benefit activity and it is noteworthy that the IRS elected to depart from CHA policies regarding this item.

Bad debt and collection practices — Part III of Schedule H (sections A and C) requires reporting on hospital bad debt expenses, as well as on debt collection and accounting practices. In addition to reporting bad debt expenses (at cost), hospitals are asked to describe their costing methodology, estimate the proportion of bad debt attributable to patients eligible under the organization's charity care policy, and provide a rationale for including bad debt as a community benefit expense. Schedule H also asks hospitals to provide the text of footnotes used in the organization's financial statements that describe bad debt expenses. Not all hospitals incorporate such a footnote in their audited financial statements, and those that do not are asked to supply comparable language to describe how bad debt expenses are handled in the organization's financial accounts.⁸

Hospitals are also asked to indicate whether the organization reports bad debt expense in accordance with Healthcare Financial Management Association (HFMA) Principles and Practices Board Statement 15 (see text box, next page), which provides instructions for record

Statement 15

HFMA updated Statement 15 in 2006 to clarify the distinction between bad debt and charity care. Key features of Statement 15 recommendations include:

- Hospitals should take early action to determine the eligibility status of patients who may be candidates for charity care under the organization's clearly defined charity care policy. Ideally this determination is done at the time services are rendered. However, Statement 15 recognizes that, due to the realities of patients' medical needs (which may be urgent) and the complexities of documentation requirements, charity care determinations may be delayed until after bills have been generated and debt collection procedures have been initiated.
- Charity care allowances should be recorded as a reduction from revenue, but hospitals should also report charity care on a cost basis and should deduct from these costs any revenue received from charity care patients.
- Bad debt should be recorded as an expense and should reflect the amount that was reasonably expected to be paid. HFMA advises that hospitals should be conservative in recognizing revenue associated with self-pay patients ineligible for charity care and advises that revenue should only be recognized when payment is reasonably assured. In practice this means that hospitals should establish reasonable charges for uninsured patients who do not qualify for charity care. These discounts should be recorded as an allowance for doubtful accounts (distinct from the allowance for charity care and analogous to a contractual allowance). Allowances for doubtful accounts reduce accounts receivables, revenues, and ultimately bad debt expense incurred.

Hospitals are not required to adhere to Statement 15, but the policy represents a recommended approach to the valuation of, and accounting for, charity care and bad debt. Anecdotal reports suggest that relatively few hospitals have adopted these practices, but the precise proportion of hospitals compliant with Statement 15 has yet to be documented. A wide variety of reasons may explain why Statement 15 has not been more widely adopted, including:

- Until the advent of Schedule H, federal regulators had not required clear distinctions between charity care and bad debt and few states have imposed separate reporting requirements.
- Charity care policies can be costly in terms of the staff time needed to identify and process charity care accounts and can be challenging to administer.
- A significant number of patients potentially eligible for charity care may be unable to complete the eligibility determination process at any time.
- The conservative accounting principles outlined in Statement 15 run counter to financial incentives facing hospitals. Various factors (including tax-exempt bond financing for capital improvements, third-party payment with a cost-based reimbursement legacy, and their charitable status) create incentives for not-for-profit hospitals to report strong revenues, yet modest margins.

keeping, valuation, and disclosure of charity care and bad debts on audited financial statements. Statement 15 clearly indicates that charity care and bad debt are distinct from both a conceptual and accounting perspective: Charity care represents services for which the hospital has elected to forego revenue and is treated as a deduction from revenue for record-keeping purposes. Bad debt represents uncollectable payment for services rendered and is treated as an expense.

In addition to capturing a quantitative assessment of bad debt expenses, Schedule H (section C of Part III) also requests information about debt collection practices. Hospitals are asked whether a written debt collection policy is in place and if that policy contains provisions for patients likely to be eligible for charity care. Details regarding these provisions, such as procedures for internal review prior to initiating legal action or engaging an outside collection agency, are also requested. The Schedule H reporting requirements are exploratory in nature and do not require hospitals to adhere to proscribed debt collection standards.

Medicare shortfall — Like bad debt expenses, the unreimbursed costs associated with Medicare patients (commonly referred to as “Medicare shortfall”) are another expense item lacking a clear consensus for inclusion as a community benefit contribution. Schedule H requires hospitals to report total revenues received from Medicare (including DSH, indirect medical education (IME), and bad debt payments)⁹; the cost of caring for Medicare patients; and the difference between these two amounts (whether a surplus or shortfall). Medicare patient care costs reported in Part III of Schedule H are limited to those allowable costs reported to the Centers for Medicare & Medicaid (CMS) on the organizations’ Medicare Cost Report(s) and must exclude allowable Medicare costs already reported in Part I under subsidized health services and health professions education.

The costing methodology that hospitals will use to calculate Medicare shortfall is likely to differ from the method that will be used to calculate unreimbursed patient care costs associated with charity care, means-tested government programs, and bad debt. Medicare allowable costs have been established through agency regulation and reinforced through institutional audit reports. In contrast, the costing methodology associated with the other patient care items is

The Schedule H reporting requirements are exploratory in nature and do not require hospitals to adhere to proscribed debt collection standards.

tied to the hospital's audited financial statement, which has broader parameters for designating patient care costs. A variety of patient care costs are commonly reported in a hospital's audited financial statements, but not allowable under Medicare. For example, Medicare does not allow costs related to entertainment (such as television services) in patient rooms, but these types of costs are likely captured as operating costs in the hospital's financial accounts. It is difficult to predict the significance of this methodological difference. Medicare shortfall amounts reported on Schedule H are likely to represent a more limited range of allowable costs, and will therefore be a more conservative estimate of costs, relative to the other types of subsidized patient care costs reported.

Beyond these differences in costing methods, the IRS recognizes that the costs included in Medicare Cost Reports and the payments associated with those services may not reflect a hospital's total Medicare revenues and expenses. Examples of excluded activities include freestanding ambulatory surgery centers, physician services, clinical laboratory services, and revenues and costs related to Medicare managed care and prescription drug plans. Because these services do not have a legacy of cost-based reimbursement and are not reflected in any Medicare Cost Report, they are not incorporated in Schedule H. In Part IV, hospitals may report a reconciliation of the Medicare shortfall or surplus that was reported in Part III with the organization's total Medicare revenue and costs.

The adequacy of Medicare payments is clearly a highly contentious and politically charged issue. The IRS did not provide a rationale regarding its decision to limit Schedule H reporting of Medicare shortfall to areas addressed by the Medicare cost reports. Presumably it decided to limit examination of Medicare shortfall to those areas with well-defined conventions regarding allowable costs and a well-documented history of cost reporting.

Supplemental Information

Part VI, the final section of Schedule H, focuses on open-ended qualitative information that more fully explains the hospital's community benefit activities, including the required descriptive information identified in the preceding parts (such as the income-based criteria used for the organization's charity care policy, the amount of subsidized service costs attributable to physician clinics, and

descriptions of cost accounting methodologies). Part VI also asks hospitals to describe the community served (including geographic and demographic descriptions), how community health care needs are assessed, how patients are informed about eligibility for financial assistance, how community building activities reported in Part II promote community health, and the extent to which bad debt and Medicare shortfall reported in Part III should be treated as community benefit.

Hospitals are also asked to provide any other information describing how the organization furthers its exempt purpose. The illustrative examples provided by the IRS highlight the various dimensions of the community benefit standard as articulated in IRS revenue ruling 69-545, such as maintenance of an open medical staff and governance by a community board. Part VI also includes additional probes regarding the respective role of the filing organization within a broader affiliated health care system, as well as the identity of all states with which the organization or a related organization files a community benefit report.

METHODOLOGICAL CONCERNS

Schedule H addresses many of the data problems observed in previous efforts to measure hospital charity care and other forms of subsidized services and is likely to improve monitoring of hospital community benefit activities. However, some methodological concerns remain that may influence the analytic value and comparability of Schedule H filings. These concerns center largely on differences in the size, structure, and scope of Schedule H filing organizations; filer discretion in selecting costing methods; and offsetting revenue exemptions.

- **Differences in provider type.** Because the IRS uses EINs to identify discrete organizations required to file Form 990 and Schedule H, data will be reported by both multi-hospital systems and individual hospitals. Some organizations will include outpatient and post acute services, while others will not. These differences may not necessarily reflect true differences in the scope and organizational structure of the hospital, but simply the EIN conventions the hospital and its affiliated health facilities have adopted. The lack of facility-by-facility reporting will make it difficult to compare activities across various provider types and may complicate efforts to

analyze Schedule H filings in concert with other data sources, such as Medicare Cost Reports and Medicaid DSH reporting.

- **Variations in cost accounting methods.** Schedule H will reduce large discrepancies in community benefit valuations by eliminating the charge-based accounting practices that some hospitals used in the past. However, filers still have flexibility in estimating the cost of services. Some will rely on cost-to-charge ratios, others will use internal cost accounting systems, and some will use a combination of methods. These differences are likely to yield varying estimates of costs and the validity of some approaches may ultimately be disputed.

- **Offsetting revenue exemptions.** The decision to allow hospitals to exclude offsetting revenues associated with program and research grants from their calculations of net community benefit expenses has generated some controversy. Those in favor of the revenue offset exemptions maintain that hospitals should be encouraged to attract program and research grant dollars to the communities they serve and should not be penalized by having to deduct these revenues from their community benefit totals. Critics cite the potential opportunity for abuse these exemptions provide. Others worry that the grant exemptions will disproportionately benefit the small number of academic medical centers that operate large research programs.

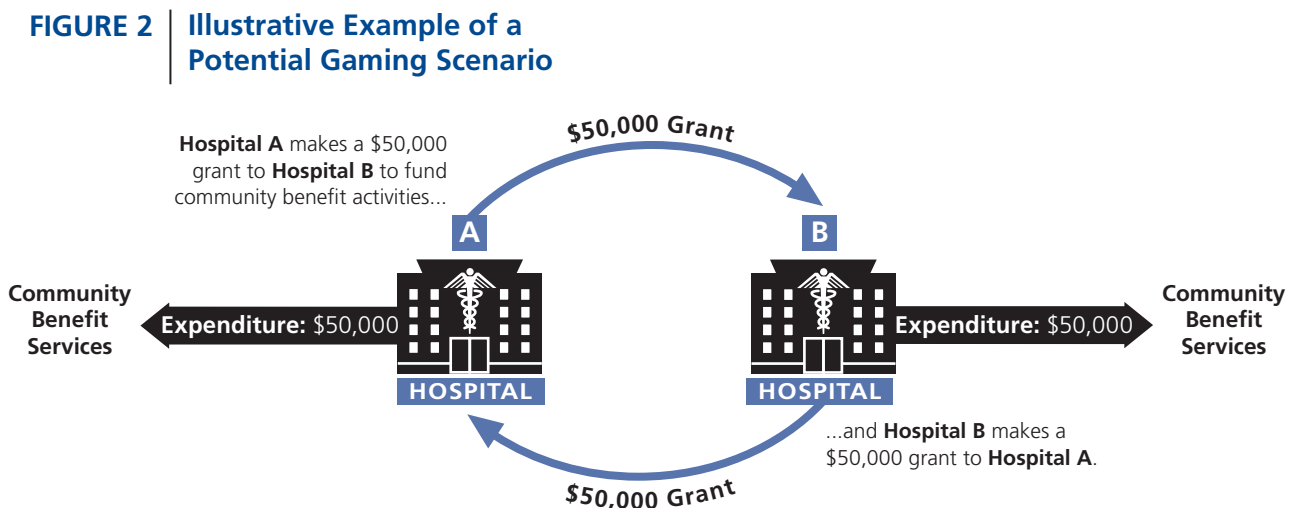
Although Schedule H excludes expenses associated with research funded by for-profit organizations, such as pharmaceutical companies, some observers believe that research hospitals should also be required to report the public and not-for-profit grant revenues that offset these expenses. Federal grant funding through the National Institutes of Health and other federal agencies is considerable, and critics have challenged the notion that hospitals are permitted to “take credit” for the activities paid for by these publicly funded grants.

A small number of hospitals that maintain extensive medical research programs are likely to benefit the most from the decision to exempt grant funds from revenue offsets. A recent survey by the IRS found that just 15 of the 489 hospitals responding reported any expenses related to medical research, and these expenses accounted for a significant portion of the total community benefit contributions of these organizations. These research hospitals reported the highest level of community benefit expenditures (19 percent of total revenue) relative to other responding hospitals, and 45 percent of research hospital community benefit expenses were attributable

to medical research.¹⁰ Unlike Schedule H, the recent IRS survey included research funded by both public and private entities. In light of this difference, amounts reported for medical research are likely to decrease under Schedule H reporting, but the survey results suggest that these costs will remain concentrated within a small group of hospitals.

Some critics worry that the revenue offset exemptions will do more than simply distort the community benefit contributions of a small subset of hospitals and have cautioned that exempting grant revenues from net community benefit calculations could lead to gaming among hospitals and widespread inflation of community benefit expenditures. As the scenario illustrated in Figure 2 suggests, hospitals can substantially increase their reported community benefit expenses through inter-organization grants.

IRS instructions forbid related organizations (such as members of a multiple hospital system each filing separate Schedule H reports) from reporting pass-through grants more than twice (that is, Hospital A funds Hospital B, which then funds Hospital C, which then



Each hospital is permitted to report \$100,000 in community benefit expenses to the IRS. Both hospitals spent \$50,000 in grant donations to the other hospital. However, if both the donation made to the other institution and the operational expenses incurred in providing the community benefit services are counted, while disregarding the grant revenues received, then the \$100,000 expense is considered valid.

funds Hospital D). However, these reporting restrictions are limited to cases where the donation from an intermediary hospital is funded by a grant from a related organization. Dollars are fungible, and the source of donated funds may be difficult to verify.

Data from initial Schedule H filings are likely to reveal the magnitude and pervasiveness of these various methodological concerns, and the IRS has indicated that it will consider future revisions to the form and instructions as issues related to data validity become more apparent.

CONCLUSION

Schedule H represents a significant step forward in the government's ability to measure and assess hospital community benefit activities. Despite some remaining methodological concerns, Schedule H will improve the ability of IRS officials, policymakers, and the public to examine and compare the community benefit contributions and practices of not-for-profit hospitals. The information reported on Schedule H will quantify the the relative value of various types of community activities, initially for individual filing organizations and eventually for the not-for-profit hospital field as a whole. Importantly, this reporting delineates charity care, bad debt, and the unreimbursed costs of Medicaid and Medicare and attempts to identify other differences in financial accounting (such as cost accounting methods) that could hinder apples-to-apples comparisons.

The new Schedule H reporting requirements do not change the community benefit standard that hospitals must meet to retain their federal tax exemption. However, the breadth and depth of these reporting requirements—and the increased consistency and transparency these reports promise—may portend future policy changes.¹¹ While the nature and likelihood of such change is highly debatable, Schedule H is certain to provide grist for the mill.

ENDNOTES

1. Internal Revenue Service (IRS), "Background Paper, Redesigned Draft Form 990," June 14, 2007; available at www.irs.gov/pub/irs-tege/form_990_cover_sheet.pdf.
2. Senate Finance Committee, Minority Staff, "Tax-exempt Hospitals: Discussion Draft," staff document, p. 2; available at <http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf>.

3. Committee on Finance, U.S. Senate, “Grassley, Baucus work to build confidence in nonprofits through greater transparency,” press release, May 29, 2007; available at <http://finance.senate.gov/press/Bpress/2007press/prb052907.pdf>.
4. The National Health Policy Forum publication, “What Have You Done for Me Lately? Assessing Hospital Community Benefit” (Issue Brief No. 821, April 19, 2007; available at www.nhpf.org/library/details.cfm/2560) provides a more detailed summary of the federal and state policies guiding hospital tax exemption and how these policies have evolved since the passage of Medicare and Medicaid in 1965.
5. IRS Revenue Ruling 56-185; available at <http://www.irs.gov/pub/irs-tege/rr69-545.pdf>.
6. Government Accountability Office, “Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements,” GAO-08-880, September 2008; available at <http://www.gao.gov/new.items/d08880.pdf>.
7. Total expenses are defined as the amount reported under Form 990, Part IX, line 25, column A, excluding bad debt expenses.
8. The record-keeping methodology advised by Statement 15 differs somewhat from the instructions given for Schedule H reporting. These requests for descriptive information appear to be an attempt to recognize and reconcile differences between audited financial statements and Schedule H.
9. Defined as total patient service revenue associated with allowable costs the organization reports in its Medicare Cost Report(s) including indirect medical education (IME) except for Medicare Advantage IME, DSH, outliers, capital, bad debt, and any other amounts paid to the hospital based on the Medicare Cost Reports criteria.
10. IRS, IRS Exempt Organizations (TE/GE), Hospital Compliance Project, Final Report, February 2009, pp. 6–7; www.irs.gov/pub/irs-tege/frepthospproj.pdf.
11. The National Health Policy Forum publication, “Show Me the Money: The Implications of Schedule H” (Issue Brief No. 831, April 21, 2009) provides a more detailed examination of how Schedule H reporting has the potential to shape future policy decisions regarding hospital tax exemption and the community benefit standard.