Issue Analysis 05-01

The Relationship of Community Benefit to Hospital Tax-Exempt Status

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ABOUT P&P BOARD ISSUE ANALYSES

This is the fifth Issue Analysis of the Healthcare Financial Management Association's Principles and Practices (P&P) Board. The P&P Board writes issue analyses to provide short-term, practical assistance on emerging issues in healthcare financial management. To expedite information to the industry, issue analyses are not sent out for public comment. Therefore, they are factual, but not authoritative. The purpose of IA 05-01, The Relationship of Community Benefit to Hospital Tax-Exempt Status, is to provide some clarity to the healthcare industry on the charitable attributes that merit tax-exempt status and how to effectively communicate those attributes to stakeholders.

SUMMARY

- Charity care is an important community benefit that has increased in significance as the uninsured and underinsured population increases.

- IRS documents affirm that charity care is not the sole justification of tax-exempt status for hospitals; the promotion of health care is in itself a charitable activity.

- Tax-exempt hospitals should accurately document and quantify the entire range of the community benefits provided.

- Tax-exempt hospitals should communicate these community benefits regularly and clearly to their many stakeholders, including the community, bondholders, regulators, and legislators.
I. INTRODUCTION

The challenging of local, state, or Federal tax-exempt status is a perennial issue for nonprofit institutional healthcare providers. Challenges become more frequent in times of Federal and state budget shortfalls when revenue collectors are under intense pressure to find every available dollar to fill the treasury’s coffers. IRS audits of compliance with tax-exemption requirements can also be prompted by a local business’ complaint of unfair competition.

Under current law, hospitals may be exempted from taxes because these institutions promote the health of residents of their communities. Such community benefit is deemed to be a charitable purpose. Tax-exemption is often also considered as a subsidy for the costs the Federal or local government would otherwise incur to provide important but costly health services.

The consequences of an institution losing its Federal tax-exempt status are serious. They include taxation of the institution’s net income, a decline in or elimination of fundraising revenue because donors can no longer deduct their donations to the institution, and, in many cases, loss of the institution’s exemption from state and local taxes, such as property and sales taxes. Additional consequences include loss of access to tax-exempt bond financing, loss of grants from private foundations and the Federal government, the potential return of Hill-Burton grants for construction or modernization of facilities, loss of Securities and Exchange Commission registration exemption, and loss of bulk-rate mailing privileges.

Another significant impact of a loss of tax-exempt status is that existing tax-exempt debt is generally converted to taxable debt retroactive to the issue date, representing a material adverse event to bondholders. In turn, bond covenants generally require the immediate call of the outstanding bonds if exemption is revoked.

Recently, several groups have argued that tax exemption is linked directly to the amount of charity care the exempt hospital provides, and that institutions are violating their conditions of exemption if they do not provide charity care equaling the amount of benefit from the tax exemption. This argument has raised confusion in the healthcare community and among the public about the purpose of and conditions for tax exemption.

This issue analysis consolidates IRS positions on the role of community benefit in determining tax-exempt status, describes the wide array of charitable community benefits, and recommends practices on how to quantify and communicate those benefits. Issues of pricing transparency and discounted rates for uninsured or underinsured patients, while important issues that tax-exempt hospitals must address, are beyond the scope of this paper.

Tax-exempt hospitals should accurately document and quantify the entire range of the community benefits provided and communicate these benefits regularly and clearly to their many stakeholders, including the community, bondholders, regulators, and legislators. Except for certain states, such as California, where annual reporting is required.

II. CURRENT TECHNICAL GUIDANCE ON FEDERAL QUALIFICATIONS FOR TAX EXEMPTION

Overview of Exemption Requirements

To be exempt from Federal income tax, an organization must meet specific statutory and regulatory requirements. The organization must establish through its articles of incorporation and bylaws that it is exclusively organized for charitable purposes. In addition, those documents should not permit the organization to engage substantially in activities unrelated to its exempt purposes or allow individuals to gain unreasonable benefit from the organization.

The Treasury Department sets forth exempt purposes in Treas. Regs. 1.1501(c)(3)-1(d)(2), which states that the term "charitable" is used in its generally accepted legal sense. This is not limited to charity care but also includes other purposes, including religious, educational, scientific, public safety, and the lessening of government burdens.

Charity Care

Charity care has been the flashpoint of the current, highly publicized round of Federal tax-exemption challenges. In 1956, the IRS issued Revenue Ruling 56-185, which required an exempt hospital to provide charity care "to the extent of its financial ability for those not able to pay." Charity hospitals cannot "refuse to accept patients... who cannot pay for such services."

In 1969, the agency broadened its standard of community benefit, but there is still only limited guidance on the subject, and important questions are still unanswered. The following are the key guidance on charity care:

IRS Revenue Ruling 69-545. The IRS removed the requirements relating to caring for patients without charge or at rates below cost. The ruling stated that "The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from the activities of the organization does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community." Evidence of the promotion of health standard includes:

- Governance by an independent community board of trustees
- Open medical staff
- Privileges available to all qualified physicians
The Relationship of Community Benefit to Hospital Tax-Exempt Status

- An emergency room that accepts patients regardless of ability to pay
- Acceptance of Medicare and Medicaid patients
- The use of excess funds for charitable purposes, such as improving the quality of patient care, expanding facilities, or advancing medical training, education, and research

The ruling also noted that "The absence of particular factors [such as charity care through the emergency room] ... will not necessarily be determinative."

It is worth noting that in Eastern Kentucky Welfare Rights Org. v. Simon, 506 F.2d 1378 (D.C. Cir. 1974), the court ruled that an acceptance of Medicare and Medicaid patients may do more to benefit the poor than a charity care requirement.

IRS Revenue Ruling 83-157. The IRS stated that while charity care offered through the emergency room is strong evidence of community benefit, it is not required. Other factors can be taken into account to establish community benefit, to accommodate charitable providers such as specialty hospitals (for instance, eye hospitals and cancer hospitals), which are not likely to have an emergency room, or hospitals where certificate of need laws have determined that an emergency room would be duplicative.

2001 Field Service Advice (FSA 200110030 (Feb. 5, 2001)). In this field service advice, the IRS clarified that if a charity care policy is included as a justification for an organization’s exempt status, then the entity must demonstrate that the policy is communicated to the public. That charity care is actually provided at reasonable levels, and that charity care patients are not routinely discriminated against.

FY 2002 CPE Text—Healthcare Update. If the hospital does not have an emergency room, then a charity care policy is a “highly significant factor” in establishing community benefit. However, most hospitals have emergency rooms open to all, so additional charity care is generally not required. If the hospital does not have an emergency room open to all and a charity care policy, then community benefit can presumably still be established by other factors of 60-545, such as the treatment of Medicare and Medicaid patients.

Private Inurement

Tax exemption and charitable giving are meant to promote community needs rather than private interests. The issue of private inurement, or the receipt of excess benefit by individuals within the exempt organization, is relevant to the issue of community benefit in that communities and Federal authorities expect every dollar of an exempt organization to be devoted to its charitable purpose—especially in situations where community health needs outstrip available resources.

The technical guidance on private inurement is set forth in the following documents:

Internal Revenue Code Section 501(c)(3). This rule articulates the prohibition for private inurement and calls for an institution’s assets to be dedicated to an approved exempt purpose (a list of which is in the Code). It states that to be tax-exempt under IRC Section 501(c)(3), an organization must be organized and operated exclusively for one or more of the purposes set forth in IRC Section 501(c)(3) and none of the earnings of the organization may inure to any private shareholder or individual. State requirements usually impose a condition that nonprofit entities serve public interests or that property be used exclusively for charitable purposes.

The IRS has indicated that physicians, officers, administrators, directors, and certain employees with a measure of influence can be considered insiders and subject to sanctions. Therefore, hospitals wishing to remain exempt must be careful to avoid arrangements that could be viewed as resulting in excessive compensation. Exempt organizations also should be cautious and seek legal advice in entering into relationships such as:

- Joint ventures with commercial entities
- Rental arrangements with or sales of property to staff or affiliates
- Agreements providing benefits in connection with physician recruitment
- Loans or loan guarantees to individuals.

Even special arrangements with health maintenance organizations or preferred provider organizations may cause inurement problems unless the price can be shown to be fair.

Public Law No. 104-168, In 1996, Congress enacted the Taxpayer Bill of Rights, which included authority for the IRS to impose fines on providers involved in private inurement transactions, rather than revoke exempt status, which was the only recourse previously available. The law was significant in two ways:

- It allowed the IRS to more actively pursue the private inurement law, and
- It allowed the agency to penalize not only the individuals receiving the excess benefit, but also the financial managers who were involved in or aware of the benefit arrangement.

Other Areas of IRS Concern

There are other areas of IRS concern that may challenge an institution’s tax-exempt status but that are not directly relevant to the issue of community benefit. These include unrelated business income, partnerships or joint ventures with physicians or for-profit entities, investment earnings on temporarily unspent tax-exempt bond proceeds, income from leasing debt-financed medical office buildings, guarantees backing debts of taxable entities, and lavish facilities where charitable service cannot be demonstrated. Running afoul of the IRS in any of these areas is likely to result in the income earned through the venture being taxed and could result in loss of tax-exempt status.
III. TYPES OF COMMUNITY BENEFIT

In 1988, HFMA formed a chairman's task force to identify the specific attributes institutional healthcare providers meet to be tax-exempt. The task force reported its findings in 1991. The following are the characteristics of institutional healthcare providers that the task force identified as meriting tax-exempt status.

Major Attributes of Tax-Exempt Institutional Healthcare Providers

Tax-exempt healthcare organizations are formed to address the specific needs of their communities; therefore, the exempt organization's attributes that merit tax-exemption are not standard across all institutions. These attributes may be characteristics of an organization or functions it provides. An organization might cite one or several of these attributes, but probably not all, to justify its exempt status.

1. Mission to Provide Community Benefit

Mission is a cornerstone of granting tax-exemption. According to federal law, the tax-exempt provider must have a clearly defined mission statement committing the institution to charitable endeavors. This mission refers to the philosophical tenets underlying the organization’s service to the community. The provider then uses the mission to develop its strategic plan for the future, which in turn drives the organization’s financial plan to deliver community benefits.

Both the institution's historical background and the community's needs are important in determining the mission statement. A mission that bears no relevance to the community’s needs makes the organization irrelevant.

2. Use of Financial Surpluses

No individual may receive any portion of a tax-exempt institution's financial surpluses as a result of ownership. All financial surpluses, or profits, must go towards furthering the organization’s charitable purpose. Both Federal and state laws require this of all tax-exempt institutions. These rules concerning private inurement are critical in evaluating the appropriateness of compensation arrangements and other business dealings, such as providing benefits to physicians. Incentive compensation and bonus arrangements are permissible, but must be carefully constructed to reflect fair market value for services rendered. Recipients cannot set the amount of their personal compensation, and rewards must relate to performance, not ownership.

3. Accountability

The organization’s board of trustees must hold itself answerable to its community for maximizing the entity’s contribution to the community. Through policymaking and direction, the board must set priorities based on the community’s service needs, while taking into account the organization’s financial limitations. Generally, this community representation is achieved through a board that is comprised of community members who fairly represent the segments, needs, and desires of every element of the community.

4. Provision of Charity Care

Free or discounted care is an important component of many hospitals' tax-exempt missions, but should not be construed as the only function that hospitals perform to merit tax-exempt status.

Organizations that provide charity care must establish and communicate a clear charity care policy based on community needs and input. The policy should include easy-to-understand, written eligibility criteria. The organization can then identify the resources that can be devoted to such services and, at the same time, exercise good stewardship in managing expenditures. HFMA's P&P Board Statement Number 15, Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Healthcare Providers, provides guidelines that allow each organization to exercise appropriate latitude in establishing eligibility for charity care.

The method of measuring charity care based on charges has been criticized as not meaningful because a provider with high charges would appear to provide more charity care than a provider with lower charges for the same level of services.

In paragraph 10.27 of the Audit and Accounting Guide for Health Care Organizations, the AICPA states:

"Management’s policy for providing charity care, as well as the level of charity care provided, should be disclosed in the financial statements. Such disclosure generally is made in the notes to the financial statements and is measured based on the provider's rates, costs, units of service, or other statistical measure.”

In P&P Board Statement No. 15, section 5, the Board concluded that charity service charges disclosure in the notes to the financial statements does not represent the relative significance of charity services and should be accompanied by additional information such as costs, units of service, or statistical data on the types of services provided.

5. Reduction of Government Burden

Many tax-exempt hospitals provide services that government otherwise would have to provide. Although many government-owned organizations provide healthcare services, they are too limited to fully meet community demand. Government provision of healthcare services would have to increase dramatically, or the needs might go unmet, if tax-exempt institutional healthcare providers did not assume as much of the burden.

Services especially demanded from tax-exempt healthcare providers include high-tech, high-intensity services, chronic care, long-term care, and unprofitable services.
6. Provision of Essential Healthcare Services

Provision of essential healthcare services is very similar to the above attribute of relieving government burden. Tax-exempt healthcare providers are often the sole providers of healthcare and related services that are so essential to the promotion or protection of community health that tax-exempt status is warranted. Someone must provide these services, but neither government organizations nor for-profit entities are willing or able to provide them.

Examples of essential services include outpatient clinics serving low-income patients and emergency rooms.

7. Provision of Unprofitable Services

The provision of unprofitable services is commonly a provider’s charitable response to a community need. Unprofitable services lose money because of high costs combined with low volume or inadequate payment, rather than inefficient operations. Tax-exempt organizations provide unprofitable health-related services based on community need, rather than profit-making considerations, as resources permit.

Common examples of unprofitable services include barn, neonatal, and trauma centers; ambulance, home health, and educational operations; indigent clinics; community mental health centers; and “meals on wheels” programs.

Additional Tax-Exempt Status Attributes

Any of the above-listed attributes are sufficient justification for an organization’s tax-exempt status; most healthcare providers qualify in several of these ways. There are other noteworthy attributes that are insufficient to warrant tax-exemption on their own, but that complement the above-listed attributes.

8. Public Education

Teaching institutions, of course, are exempt because of their role in the advancement of education and science, as set forth in IRC Section 501(c)(3). Most tax-exempt healthcare providers, however, provide a range of educational programs to enhance either public health or the provision of healthcare. Examples of such programs include public health education, wellness programs, and the sponsorship of education activities.

Providers should be diligent in documenting educational programs as community benefit because of criticism that the programs are really marketing efforts for specific products and services. If sales are the intended result of an education effort, the effort is properly classified as marketing. Examples of public education programs that constitute community benefit include programs oriented to wellness, weight management, and smoking cessation.

9. Serving Other Unmet Human Needs

Some tax-exempt hospitals provide important services that are tangentially related to health care but that are not by any other entity in the service area. Examples of these activities include senior citizen education and outreach programs, care for “boarder” babies, or the operation of a soup kitchen or “meals on wheels” program.

Often, healthcare institutions are the logical choice in the community to perform such services because they already have the necessary infrastructure and administrative efficiencies in place. Also, the healthcare institution is usually in a position to be flexible as the quantity of service needs changes. Programs that require dietary services, for example, or other ancillary services that an institution must have for patient care can benefit from institutional operations that already exist. In the long run, the community saves by not having to duplicate facilities or staffing capabilities.

10. Goodwill

Goodwill is an intangible attribute characteristic of successful tax-exempt hospitals continuing their mission of providing care and meeting their community responsibility over a long period of time. Tax-exempt hospitals have been regarded as community institutions and, as such, have enjoyed reputations and community support that set them apart from tax-paying institutions. Their reputations have been significant in obtaining donations and voluntary support that enhance their charitable roles. Such an organization usually has a stable ownership and governance structure and regularly receives philanthropic support or significant volunteer support to further the organization’s mission.

If such organizations were to lose their tax-exempt status, the loss of their goodwill image would result in a loss of donations and volunteer support that would compromise their ability to provide charitable services and thus result in an adverse effect in their communities.

IV. QUANTIFYING COMMUNITY BENEFIT

This section was based largely on excerpts from Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability, which was prepared by VHA Inc., the Catholic Health Association of the United States, and Lyon Software. The P&P Board thanks the Catholic Health Association of the United States for permission to use this material.

The quantification of community benefit is essential to communicating the value that a hospital delivers in exchange for its tax-exempt status. The process begins with determination of whether each program or cost is a community benefit, as opposed to a routine service or a marketing initiative. The following questions can help with that determination:

- Does the activity address an identified community need?
- Does the activity support an organization’s community-based mission?
- Is the activity designed to improve health?
The Relationship of Community Benefit to Hospital Tax-Exempt Status

- Does the activity produce a measurable community benefit?
- Does the activity survive the "laugh" test (meaning it is not of a questionable nature that could jeopardize the credibility of the community benefit report)?
- Does an activity require subsidization (meaning it results in a net financial loss after applying grants and other supplemental revenue)?

To be included in a quantifiable community benefit inventory, services generally will:
- Result in a financial loss to the organization, requiring subsidization of some sort
- Best be quantified in terms of dollars spent, or numbers of persons served
- Not be of a questionable nature that jeopardizes the credibility of the community benefit report
- Have an explicit budget

Some community benefit services are not easily counted or are inadequately portrayed quantitatively. These items are better reported through a narrative summary and include services that:
- Are of significant community benefit, but break even or involve minimal cost
- Are better appreciated by a reader when described in terms of benefit provided rather than dollars spent
- Are provided entirely by volunteers or involve staff donating their own time to the program
- Are somewhat controversial as to whether they represent a "true" community benefit

The topic of nonquantifiable benefits will be addressed at greater length below.

Accounting Guidelines and Calculating Costs

**Direct Costs.** Direct costs include salaries, employee benefits, supplies, interest on financing, travel, and other costs that are directly attributable to the specific service or department that would not exist if the service or effort did not exist.

**Indirect Costs.** Indirect costs are not attributed directly to products or services that are included in the calculation of costs for community benefit. These could include but are not limited to human resource and finance departments, insurance, support departments, and overhead expenses. An indirect cost factor is determined by dividing total indirect costs by total direct costs.

Rather than calculating a separate, indirect cost per activity, we recommend computing an indirect cost factor and using this factor to allocate indirect costs to each category as indicated. Apply this formula to arrive at total indirect costs:

\[
\text{Indirect Cost Factor} = \frac{\text{Total Indirect Costs}}{\text{Total Direct Costs}}
\]

Example:

<table>
<thead>
<tr>
<th>Expense</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Operating Expenses</td>
<td>$80,000,000</td>
</tr>
<tr>
<td>(less Bad Debts)</td>
<td></td>
</tr>
<tr>
<td>Total Direct Expenses</td>
<td>-60,000,000</td>
</tr>
<tr>
<td>Total Indirect Expense</td>
<td>$20,000,000</td>
</tr>
<tr>
<td>To calculate the indirect cost factor, divide (A) by (B)</td>
<td></td>
</tr>
<tr>
<td>Total Indirect Costs (A)</td>
<td>$20,000,000</td>
</tr>
<tr>
<td>Total Direct Costs (B)</td>
<td>$60,000,000</td>
</tr>
<tr>
<td>Answer: 33.3%</td>
<td></td>
</tr>
</tbody>
</table>

Calculating Community Benefit Costs

A uniform methodology for calculating community benefit costs cannot be established in the current healthcare environment because some facilities use a cost accounting method while others use a cost-to-charge ratio. Therefore, a footnote to the community benefit report should explain the method used to determine the expense reported.

Two sources of financial information are available to calculate costs in this area: an organization's financial statement and the Medicare cost report. Healthcare organizations that have cost accounting systems in place can use such a system to more accurately determine costs, but because the adoption of these systems is inconsistent in the field, each hospital or health system needs to strive for the most accurate accounting practices possible and improve reporting accuracy from year to year, rather than assume consistent methodology for comparative purposes.

Subsidized Health Services

Subsidized health services include costs for billed services that are subsidized by the healthcare organization. These services generate a bill for reimbursement, and include clinical patient care services that are provided despite a negative margin because they are needed in the community and other providers are unwilling to provide the services, or the services would otherwise not be available to meet patient demand. The amount the healthcare organization subsidizes to maintain these services should be counted, but not what it subsidizes for individual patients.

Care should be taken not to double-count information. Services in this category should be separated from charity care and Medicaid/Medicare shortfalls. For example, assume a scenario in which a hospital emergency department operates at an annual loss of $200,000. Medicare and Medicaid shortfalls, together with charity care, account for one half of the total loss, and are reported elsewhere. Thus, only one half, or $100,000, of the emergency department loss would be counted as a community benefit in the subsidized health services area.
Care needs to be taken to ascertain whether the negative contribution margin is truly community benefit.

In all categories, count negative contribution margin departments or services. Do not include bad debt. Calculate the “payment shortfall,” not the contractual allowance, by extracting data from audited financial statements.

**Charity Care**

Charity care results from a provider’s policy to provide free or discounted healthcare services to individuals who meet specific, written financial criteria. Generally, a bill must be generated and recorded and the patient must meet the organization’s criteria for charity care, and demonstrate an inability to pay. There is general consensus that traditional charity care should be reported in terms of costs, not charges.

Quantifiable community benefit amounts are the expenses incurred by the provision of charity care, preferably using financial statements as the source of data. Report indirect costs only if they have not already been included in calculating costs. Do not report the portion of charity care costs already included in the subsidized healthcare services category.

Charity care does not include bad debt. Bad debt is uncollectible charges excluding contractual adjustments, arising from the failure to pay by patients whose care has not been classified as charity care.

For a detailed discussion of distinguishing bad debt from charity care, see P&P Board Statement Number 15, Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Healthcare Providers.

**Government-Sponsored Health Care**

Government-sponsored healthcare community benefit includes the shortfall created when a facility receives payments that are less than costs for caring for public program beneficiaries. This payment shortfall is not the same as a contractual allowance, which is the full difference between charges and government payments. All shortfalls must be based on costs, not charges.

Unpaid costs of public programs include losses related to:
- Medicaid
- Medicare in some circumstances (discussed below)
- Local or state medical programs for the indigent, medically indigent, or people not eligible for Medicaid

At the time this paper was published, wide diversity of practice exists regarding whether to include Medicare shortfalls as community benefit. Based on current debate and practice, the P&P Board observes that some support is emerging for reporting costs both with and without Medicare shortfalls, with sufficient detail and context to help readers understand each reported cost calculation.

Arguments in favor of including Medicare losses are:
- One element of the theory behind granting tax-exempt status is that, unless services were provided by the not-for-profit organization, the services would become a government obligation, since the Federal, state, or local government would need to fulfill this responsibility. Under this argument, Medicare losses should be included as a community benefit because the losses are incurred in performing an important public service.
- Under the Balanced Budget Act of 1997 (and subsequent refinements), it is highly likely that Medicare gains will be reduced in the next few years (or that losses will grow). If Medicare is not included in the inventory of community benefits, it will be difficult to capture this important development for advocacy or other purposes.
- Some not-for-profit facilities extend services to elderly patients and adults with disabilities as a major mission commitment. Many may serve particularly difficult or chronic patients who need special services beyond direct hospital patient care, such as “meals on wheels” or transportation. In providing these mission-driven services, facilities incur higher losses (or generate lower earnings) than they would otherwise.

Arguments against including Medicare losses are:
- In many communities, Medicare is one of the best payers for healthcare services, providing higher payments than managed care rates for similar services.
- Serving Medicare patients does not truly differentiate not-for-profit hospitals from for-profit institutions. Hospitals of all kinds compete aggressively to attract Medicare patients to their facilities—something that cannot be said of Medicaid and uncompensated or undercompensated care patients.
- Medicare losses may be associated with inefficiency, rather than underpayment. If facilities are losing money, one could argue that the losses are the result of poor operating practices, not inadequate reimbursement.

In deciding whether to include Medicare shortfalls in community benefit reports, the following guidelines may be helpful:

Count Medicare shortfalls when:
- There is a clear mission commitment to serving elderly patients that can be demonstrated through the provision of specific subsidized programs developed not for marketing reasons, but to help improve the health status of the elderly.
A credible argument can be made that losses are not due primarily to operational inefficiency, or losses are material, meaning that negative margins under Medicare are greater than 5 percent or some threshold of that nature.

In reporting community benefits for a hospital system, Medicare gains at one facility should be offset by Medicare losses at other hospitals, so that a net, system-wide perspective can be reported.

In summary, report unpaid costs, or "shortfalls" of public programs for:
- Medicaid
- Medicare (if that option is chosen)
  - Consider adding in disallowed costs that do not qualify for Medicare reimbursement, but do reflect community benefit
- Public or indigent care
- Other public programs

Other Financial Reporting Guidelines

To express community benefit categories as a percentage of annual expenses or revenue, it is important to include final audited amounts, when available, for the fiscal year being reported. There are two consistency issues here:

1. It is important for an institution to be consistent from year to year;
2. It could be important for an institution, in comparing itself with other institutions, to be consistent in terms of which components of revenue and expense are included here.

Standard recommended financial data include:
- Operating revenue
  - Net patient service revenue
  - Other revenue
- Operating expenses
  - Total operating expenses
- Net revenue (loss) from operations
- Nonoperating gains
  - Interest income and other nonoperating gains
  - Net revenue (loss)

When calculating community benefit as a percent of revenue or operating expenses, use the total operating revenue, which includes net patient service revenue and other revenue. When calculating community benefit as a percent of operating expenses, use only the total operating expenses figure.

Financial Statements

Financial statements are the preferred source for calculating the cost-to-charge ratio for several reasons: financial statements most accurately reflect internal accounting practices for tracking community benefit programs and services, negative margin departments (subsidized health services) are easily identified and tracked, and calculating community benefit can be done in conjunction with an organization's annual financial audit.

Medicare Cost Reports

The Medicare cost report is not the preferred source for calculating the cost-to-charge ratio, because it is based upon certain "allowable" expenses for reimbursement, while other expenses are "disallowed" and cost centers can be "nonreimbursable." While these expenses may not be included in an organization's cost report or internal accounting practices for grouping costs, these expenses can qualify as community benefit. Therefore, total community benefit may not be captured if the cost-to-charge ratio is calculated using Medicare cost reporting criteria. Also, because of the cycle associated with completing cost reports and finalizing cost reports, estimates are often used. Estimates do not always accurately capture total community benefit.

The Medicare cost report can be useful in calculating the in-kind community benefit expense of providing hospital space for regular meetings or special events to nonprofit community-based organizations or informal community groups, such as neighborhood associations or social service networks. To do this, determine the value of room space on a square foot basis by using the unit cost multiplier of the cost report. The multiplier includes depreciation costs, maintenance and repairs, operation of plant, and housekeeping. These will be multiplied against the square footage of the rooms used.

Take Care Not to Double Count

It must be emphasized that when considering the total unreimbursed costs of care in the health care service areas, be sure to carefully think through what is included before applying a cost-to-charge ratio, because double-counting can occur so easily.

Similarly, report indirect costs only if they have not already been included in calculating direct costs or if they have not been included in other community benefit categories, such as medical education or community health services.

Finally, subtract any supplemental revenue or grants to determine costs.

Capital Items and Depreciation Expenses

Report depreciation expenses, not initial costs or net book values, for capital equipment items that are used to provide community benefit. For example:
- Call center telecommunications equipment.
V. COMMUNICATING COMMUNITY BENEFIT

The issue of how to report community benefits and charity care is in flux as the current spate of tax-exempt challenges works its way through the legal system. One emerging practice is to mark charity care or community benefit footnotes as unaudited. This topic is currently under review by the AICPA. Another emerging practice is to disclose the information through IRS Form 990 filings, particularly for Medicare and community benefits. (Form 990s are used by tax-exempt organizations to provide key information to the IRS, and are a primary source of organizational information used by policymakers and the public.)

The P&P Board believes healthcare providers should identify, measure, and prominently disclose all the attributes of their organizations that warrant tax-exempt status. Many critics of tax-exemption focus on only one attribute, ignoring the cumulative effect of activities that make tax-exemption appropriate. Therefore, it is important that government officials, the media, community leaders, and the public understand all the reasons why an organization qualifies for tax-exemption.

Input from financial managers is essential to ensuring that the hospital's executive team, communications department, and board can do a good job communicating the complete community benefit story to stakeholders. Financial managers should understand the organization's communications goals and core audiences so that they can provide accurate financial documentation to support the organization's key messages.

Here are some actions to consider for developing and implementing an effective communication plan:

Make the mission statement a living document. The mission statement should undergo relatively frequent (every five years) examination by the organization's board of trustees to ensure that it is still relevant to the community. The organization must constantly ensure that its activities are consistent with the mission and should publicize the range of activities that fulfill the mission.

Ensure strong board involvement. All boards are well advised to maintain a high level of communication with the community. Regular opportunities for communication will help ensure that the board is well informed about the community's needs and desires as it makes program decisions.

Regularly involve the community. If the community is included in the process of assessing, planning, and evaluating the healthcare provider's initiatives and services, its members are more likely to be receptive to understanding the broad community benefits provided. Furthermore, an established communication process will ensure that dissatisfied community members have an opportunity to air their concerns and have them addressed in a constructive way.

Tell the whole story. Provision of charity care is an important attribute of tax-exemption, but is only one of several benefits that most healthcare organizations provide. It is helpful if the organization can avoid disproportionate attention on the provision of charity care, which could lead to a specific trade-off between the amount of charity care provided and the amount of tax-exemption allowed.

Ways in which exempt hospitals relieve government burden and provide essential community health services are probably the attributes that are most often overlooked as contributions to the community, yet they are central to the concept of tax-exemption. Each institution should look carefully at its mission and services to identify ways in which it relieves government of a burden that would otherwise increase the community's taxes. Call attention to services that would be unavailable if the tax-exempt organization were not present.

Talk about unprofitable essential services. Good management requires careful analysis of any service with a financial loss, as well as aggressive action to ensure operational efficiency and appropriate payment. If this analysis concludes that a service is well managed but still unprofitable due to community need, the organization should publicize this fact.

Put a human face on community benefits. Numbers are important, but they don't tell the whole story. To make clear the value of community benefits, consider using the personal stories of employees, volunteers, donors, and patients (honoring patients' privacy, of course) that show the personal side of the services delivered.

Build health education partnerships. Healthcare organizations often work with elementary and high schools to meet important health education needs. Such activities are
another good opportunity to build positive relations with the community, and should be included in the organization’s comprehensive reporting of community benefits.

Model fiscal responsibility. Healthcare executives and financial managers need to be sensitive to their role in the community, both in ensuring judicious financial relationships and in the lifestyles of the leadership. The perception of an individual reaping a financial windfall at the expense of the organization, its programs, and the community should be avoided.

The information contained in this issue analysis is believed to be current as of the date issued. Readers are cautioned that changes to laws and regulations are likely. Validity of the information may decrease in proportion to the time lapse from the issue date.

APPENDIX A

Creating a Record of Charity Care Policies and Activities

If charity care is a core component of a charitable mission, the following questions provide useful guidance in demonstrating fulfillment of that mission. They are from the 2001 IRS Field Service Advice, and list the features that the IRS considers to make up a factual record on the charitable care policies and activities of a hospital. There are no IRS requirements to address these questions point-by-point; however, it is worthwhile to periodically review these questions and determine how they should be addressed in the event of an audit.

1. Does the hospital have a specific, written plan or policy to provide free or low-cost healthcare services to the poor or indigent?
2. Under what circumstances may, or has, the hospital deviated from its stated policies on providing free or low-cost healthcare services to the poor or indigent?
3. Does the hospital broadcast the terms and conditions of its charity care policy to the public?
4. Does the hospital maintain and operate a full-time emergency room open to all people, regardless of their ability to pay?
5. What directives or instructions does the hospital provide to ambulance services about bringing poor or indigent patients to its emergency room?
6. What inpatient, outpatient, and diagnostic services does the hospital actually provide to the poor or indigent for free or for reduced charges?
7. Under what circumstances does the hospital deny healthcare services to the poor or indigent?
8. Does the hospital operate with the expectation of receiving full payment from all people to whom it renders services?
9. How and when does the hospital ascertain whether a patient will be able to pay for the hospital’s services?
10. What documents or agreements does the hospital require poor or indigent patients to sign before receiving care?
11. What is the hospital’s policy on admitting poor or indigent patients as inpatients and outpatients?
12. Under what circumstances does the hospital refer poor or indigent individuals who require services to other hospitals in the area that admit poor or indigent patients?
13. Does the hospital maintain separate and detailed records about the number of times, and circumstances under which, it actually provided free or reduced care to the poor or indigent?
14. Does the hospital maintain a separate account on its books that segregates the costs of providing free or reduced-cost care to the poor or indigent? Does this account include any other items, such as write-offs for care to patients who were not poor or indigent?
APPENDIX B

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