

II. INTERIM REPORT AND ADDITIONAL WORK UNDERTAKEN FOR FINAL REPORT

A. Questionnaire Content Included in Final Report

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

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

B. Significant Adjustments to the Interim Report

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

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

The most significant changes are described as follows.

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

- hospitals in the study were adjusted upward to \$179 million and \$89 million, respectively. These upward adjustments in total revenues affected many of the percentages reported in the Interim Report that used total revenues in the denominator (e.g., percentage of total revenues spent on community program expenditures).
2. Patient Mix. The Final Report shows a change in the reported patient insurance coverage mix from 46% to 43% for private insurance, 46% to 49% for public programs (Medicare, Medicaid, and other public programs), and 7% to 8% with no insurance coverage.
 3. Medical Research. The average of the percentages of total revenues spent on medical research by these hospitals was adjusted downward from 8% to 2% while the median decreased from 0.24% to 0.22%.³
 4. Community Programs. The averages and medians of the percentages of total revenue spent on aggregate community programs, and on the various components of community programs (e.g., immunization programs), have been revised. The most significant change was the downward adjustment of the average percentage of total revenue reported to have been spent on aggregate community programs from 3.4% to 0.9%.

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

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

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

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

- “High population” – 94 hospitals (19%)

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

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

The community types are defined as follows:

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

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



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

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

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

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

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

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

D. Breakdown of Hospitals by Revenue Size

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

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

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

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

E. Hospitals Reporting Largest Amounts of Medical Research Expenditures

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

F. Analysis of Bad Debt and Shortfalls as Uncompensated Care

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

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

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

H. Executive Compensation

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

I. Form 990, Schedule H, Hospitals

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