Nonprofit Policy Forum

Volume 2, *Issue* 1 2011 *Article* 5

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Recommended Citation:

Waymire, Tammy R. and Christensen, Douglas J. (2011) "Tax Exemptions for Nonprofit Hospitals: Toward Transparency and Accountability," *Nonprofit Policy Forum*: Vol. 2: Iss. 1, Article 5.
DOI: 10.2202/2154-3348.1014

Tax Exemptions for Nonprofit Hospitals: Toward Transparency and Accountability

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Abstract

Whether nonprofit hospitals fulfill their implicit obligation to provide benefits to the public that are commensurate with the benefits associated with their tax exemptions is an important policy question. To contribute to this discussion, we examine the variation in charity care provided, scaled by net patient revenues and by imputed federal income taxes, in a sample of nonprofit hospitals that are subject to Single Audit requirements. We find that small hospitals tend to provide more charity care than large hospitals, and that rural hospitals tend to provide more charity care than urban hospitals. Interestingly enough, we find little difference in charity care amounts provided by hospitals in high income areas v. low income areas, suggesting that demand for charity care, at least in this setting, has little effect on hospital behavior regarding the provision of charity care. As a result of our analyses, we make recommendations for increased availability of hospital financial statements, as well as specific disclosures of other components of community benefits, which represent the applicable standard for evaluating tax exemptions. These recommended disclosures and increased transparency would permit more meaningful policy analysis regarding nonprofit hospitals as well as a comparison to for-profit and governmental hospitals.

KEYWORDS: tax exemptions, nonprofit hospitals, charity care

Author Notes: The authors are grateful to the three anonymous reviewers and to Dennis Young for their helpful suggestions for improving the paper.

I. Introduction

Tax exemptions are extended to nonprofit organizations with the expectation that services will be provided that will benefit the public at large. Fundamentally, governments forego tax revenues that would otherwise be collected because doing so mitigates the need for governments to provide the services directly. The implicit obligation of nonprofit organizations to provide services commensurate with the value of their tax exemptions has received scrutiny in many parts of the nonprofit sector. The nonprofit hospital industry has perhaps received the most scrutiny because of its size relative to the nonprofit sector as a whole, the concerns over growing healthcare costs, and the potential for revocations of tax exemptions to help meet state and local government budget shortfalls (Barniv et al. 2005; Carlson 2010; Mason 2010).[1] The standard for evaluating whether nonprofit hospitals have fulfilled their implicit obligations has evolved from one of charity care, i.e., healthcare services provided to the poor, to one of community benefit, which encompasses charity care, but more broadly captures activities that promote health. From both parties' perspectives, hospital management and government officials, a better understanding of the cross-sectional variation in the amounts of charity care and community benefits provided is needed to develop comprehensive policy recommendations.

In this study, we analyze the cross-sectional variation in charity care amounts provided, measured as charges foregone, in a sample of nonprofit hospitals subject to Single Audit requirements. Nonprofit hospitals comprise more than 50% of all hospitals in the United States (AHA 2010) and have experienced increased scrutiny as states have faced budget crises and revocations of certain elements of tax exemptions have increased accordingly (Carlson 2010). Although less than 10% of nonprofit hospitals are subject to Single Audit requirements on an annual basis, this setting offers a unique opportunity to examine the cross-sectional variation in charity care because the audited financial statements are available providing transparency to any interested stakeholders and because the stringent Single Audit requirements add credibility to the disclosed amounts.

We examine the levels of charity care provided by 127 nonprofit hospitals subject to Single Audit requirements, scaling the charity care amounts by two different denominators: (1) revenues, which serves as a proxy for size and

[1] For example, the property tax exemption of Provena Covenant Medical Center in Urbana, Illinois was revoked following a lengthy battle over between the hospital and the state revenue department over the level of charity care provided by the hospital (Carlson 2010). Mason (2010) suggests that property tax exemptions may present significant risks for nonprofit hospitals because of the potential volume of tax revenues associated with hospital-owned property (significant investments in fixed assets) and because property taxes are not contingent on profits earned by the hospital. Our discussions with public accounting professionals specializing in the healthcare industry also reveal significant concerns related to tax exemptions for the nonprofit hospital clients.

provides a means for making meaningful comparisons across hospitals regardless of cost-of-living implications (Eldenburg and Vines 2004), and (2) imputed federal income tax, based on the corporate tax rates, which provides a means for evaluating how charity care provided compares to the federal income taxes foregone. Using these scaled charity care amounts, we then examine differences across three variables: (1) size of the hospital, based on net revenues, (2) location of the hospital, either urban or rural, and (3) per capita income, which serves as an inverse proxy for the potential demand for charity care services, i.e., presumably a lower per capita income would suggest a higher demand for charity care for a given area.

We note that, on average using scaled amounts, smaller hospitals provide more charity care than larger hospitals, rural hospitals provide more charity care than urban hospitals in our sample, and, interestingly enough, income levels have little impact on the amount of charity care, suggesting that the demand for charity care may have less influence than would have been expected. We draw no conclusions about causality because it is unclear whether hospitals that are subject to the degree of scrutiny resulting from the Single Audit behave differently than those hospitals with less transparency. For example, it seems counterintuitive that hospitals in high per capita income areas provide more charity care than those in low per capita income areas because the demand for charity care would presumably be less. However, concerns with revocations of tax exemptions may encourage hospitals in high income areas to provide more charity care, especially given the degree of transparency associated with a Single Audit. Moreover, charity care is the only element of community benefits that is consistently and comparably reported. Hospitals may take different approaches in meeting their implicit obligations, and reporting requirements would need to be changed to result in the transparency necessary to comprehensively evaluate the fulfillment of nonprofit hospitals' implicit obligations.

As a result of our findings, we make recommendations that would lead to increased transparency that would be helpful in policy evaluation. Although recent changes in the informational Form 990, Return of Organizations Exempt from Tax, have begun to require more comprehensive community benefit information, we present recommendations for disclosures of community benefit information within the audited financial statements of nonprofit hospitals, as well as other organizational forms, including for-profit and governmental. The American Institute of Certified Public Accountants (AICPA) could make these changes to its Audit and Accounting Guide (2009), with applicability for all hospitals. The level of assurance associated with audits would lend credibility to the amounts and permit more meaningful, comprehensive evaluation of nonprofit hospitals' approaches to meeting the implicit obligation associated with tax exemptions. In addition, these additional disclosures would permit meaningful

DOI: 10.2202/2154-3348.1014

comparisons across organizational forms. In the sections that follow, we present a background of the implicit obligation associated with a nonprofit hospitals' tax-exempt status, including the disclosure environment; present our sample selection, analysis and findings, and recommendations; and offer our conclusions.

II. Background of the Implicit Obligation and the Disclosure Environment

The rationale for tax exemptions for nonprofit hospitals is better understood within an historical context. The modern hospital industry began largely as a nonprofit industry; the U.S. government extended this favorable tax treatment to the industry to recognize the charity care provided that, at that time, was not subject to recovery of payments via the indigent patient or an insurance provider – whether private or public. Tax exemptions have traditionally exempted nonprofit hospitals from a wide range of taxes including federal and state income tax, property tax, and sales tax, as well as provided indirect benefits associated with the income tax benefits their bondholders and donors enjoy.[2] The landscape shifted with the rapid increase in the proportion of Americans covered by employer-sponsored insurance programs during the 1940s (Santerre and Neun 2004) and again with the implementation of Medicare and Medicaid programs in the 1960s (Starr 1982). These programs, and in particular, the Medicare and Medicaid programs providing coverage to the elderly, disabled, and indigent, mitigated the need for the indirect payments received by hospitals via tax exemptions. Furthermore, the recently passed Patient Protection and Affordable Care Act of 2010 (the Act) may continue to narrow the gap by requiring that individuals purchase health insurance coverage.

Against this historical backdrop, the Internal Revenue Code (IRC) has also evolved from a narrow focus on charity care, a term that denotes healthcare services provided to the indigent, to a broader focus on community benefits, a term that encompasses charity care, but also includes other health promotion activities that may benefit the public at large. Through the 1950s, charity care was the initial standard for evaluation. Revenue Ruling 56-185 (1956) established a "charity care standard" that included requirements that nonprofit hospitals provide services to those unable to pay. Revenue Ruling 69-545 (1969) dramatically altered the standard for evaluating a nonprofit hospital's fulfillment of its implicit obligation. The Ruling established a "community benefit standard" which required the provision of benefits to the broader community rather than focusing

[2] It should be noted, however, that 117 municipalities in 18 states have voluntary payment in lieu of taxes (PILOTs). Designed to serve as a substitute for foregone property taxes, the expectation is that PILOTs will increase as municipalities seek opportunities to resolve budget concerns (LILP 2010; Brock 2011). Although voluntary, the focus on tax exemptions may make nonprofit hospitals feel compelled to participate (LILP 2010).

exclusively on charity care provided to the indigent. Although the community benefits term certainly encompasses charity care services, the broader standard has resulted in more ambiguity about the expectations for nonprofit hospitals.[3]

The latitude offered in the IRC leaves states responsible for determining the definition and application of community benefit standards, and the U.S. Government Accountability Office (GAO) has identified wide variation in the states' definitions of community benefit (GAO 2008). Furthermore, only 15 states have established community benefit requirements, and, of these, only five specify a minimum amount of community benefit or charity care to be compliant (GAO 2008). Texas has been particularly stringent in its interpretation and standards for evaluation by establishing a minimum level of charity care to be provided based on net patient revenues (Bryce 2001). This strict standard is not without criticism, however. While Kennedy et al. (2010) find that the change in Texas law that specified a minimum level of charity care as a percentage of revenue resulted in hospitals below the threshold increasing their charity care spending, they also find that hospitals above the threshold decrease their charity care spending in response.

In related research, Eldenburg and Vines (2004) examine the change in nonprofit manager behavior in response to a change in disclosure requirements regarding charity care. Their study was conducted following a change in disclosure requirements that moved from the reporting of uncompensated care (which included charity care and bad debts) in the financial statements to the reporting of charity care (measured as charges foregone) in the notes to the financial statements. The study finds evidence of reclassification of bad debts to charity care, suggesting incentives for the management of charity care as a percentage of revenue (Eldenburg and Vines 2004). These incentives should be considered in a broader stream of literature which tends to suggest that there is little difference between charity care provided by nonprofit and for-profit hospitals (Colombo 2006; Sloan 2000; Duggan 2000). Collectively, we know that there are incentives to manipulate reported charity care amounts, and we know that there may be little difference in nonprofit and for-profit hospital approaches to charity care. What remains relatively unexplored is the cross-sectional variation in charity care provided within the nonprofit sector which may yield insight into previous findings that nonprofit and for-profit hospitals behave similarly.

[3] For a thorough analysis of the history of the Internal Revenue Code as it relates to nonprofit hospitals and tax exemptions, see Smith and Crabtree (2006).

III. Sample, Analysis and Findings, and Recommendations

Sample

Our sample is comprised of 127 nonprofit hospitals subject to Single Audit requirements. These hospitals are located in 40 states, have average annual net patient revenues of approximately $700 million, and provide charity care, measured as charges foregone, of approximately $49 million, or 7% of net patient revenues. In spite of the variation in the financial statement variables, these hospitals comprise a fairly narrow sample within the hospital industry. While nonprofit hospitals comprise the majority of hospitals in the United States, less than 10% of these nonprofit hospitals were subject to Single Audit requirements in 2006. Single Audits are triggered when an organization expends more than $500,000 in federal awards on an annual basis, exclusive of fee-for-service reimbursements from Medicare and Medicaild (OMB Circular A-133 2007), with certain financial and audit-related information on repository with the Federal Audit Clearinghouse. Because we needed information beyond what was available for download through the Federal Audit Clearinghouse website, we requested and obtained the audited financial statements of 127 nonprofit hospitals subject to oversight by the Department of Health and Human Services (DHHS) via the Freedom of Information Act (FOIA). The audited financial statements are from the 2007 reporting period and include fiscal years ending in 2006.

Charity care amounts were reported within the notes to the financial statements, consistent with requirements established by the American Institute of Certified Public Accountants (AICPA) Audit and Accounting Guide for Health Care Organizations (2009). The Guide requires that hospitals disclose their policies for providing and calculating charity care, as well as the amounts of charity care provided measured as charges foregone (see Figure 1).[4] The measure is therefore standardized; however, because charges may be expected to vary with billing practices and with cost of living differences around the country, we then scale these charity care amounts by two different denominators: (1) revenues, net of contractual allowances, and (2) imputed federal income taxes, determined by applying the corporate tax rates. The first denominator, consistent with Eldenburg and Vines (2004), scales charity care to allow comparisons of the levels of charity

[4] Because hospitals are only required to report charity care, and not community benefits, in the audited financial statements, most hospitals do not report community benefits. For the few that voluntarily report this information, there are no governing principles, and the result is a general lack of comparability, exacerbated by the variation in definitions of community benefit established at the state level. While we investigate variation in the levels of charity care within our study, a more comprehensive analysis would be afforded by required community benefit disclosures based on common definitions, given that this is the standard for evaluating fulfillment of the implicit obligations of nonprofit hospitals.

care among the hospitals in our sample, irrespective of size. Scaling charity care by the second denominator can be interpreted as follows: values over one suggest that the hospital provided more charity care than the value of its exemption from federal income tax. Although federal income tax is only one of the benefits available to nonprofit hospitals, it is a benefit to all of the nonprofit hospitals in our sample.

Figure 1

The current disclosure requirements for community benefit information are limited to charity care information including policies for establishing these amounts, as well as the actual amount of charity care provided. The AICPA Audit and Accounting Guide for Health Care Organizations (2009) provides the following example of these disclosures:

"The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue."

"The amount of charges foregone for services and supplies furnished under the Hospital's charity care policy aggregated approximately $4,500,000 and $4,100,000 in 20X7 and 20X6, respectively."

The hospitals in our sample can be distinguished from nonprofit hospitals not subject to Single Audit requirements by their level of transparency. Unlike nonprofit hospitals that do not trigger Single Audits, the sample hospitals are required to provide electronic information regarding the results of their external audits, including financial statements and auditor opinions, as well as results of the external auditors' evaluations of the hospitals' internal controls and compliance with laws and regulations, to the Federal Audit Clearinghouse. This translates into transparency that exceeds that of other nonprofit hospitals, which may or may not provide access to their financial statements to the general public.[5]

[5] In fact, in conducting our research, we also considered obtaining charity care and/or community benefit information from the audited financial statements of nonprofit hospitals from a broader cross-section. Audited financial statements were generally not available from nonprofit hospital websites, and our requests for these financial statements were often denied or ignored. We anticipated some difficulty in obtaining audited financial statements, given the lack of requirements for systematic disclosure of audited financial statements for nonprofit hospitals. However, the resistance we encountered was significant enough to prohibit the analysis of a broad

The narrowness of our sample requires an assessment of the potential for bias in our analyses. Although perhaps not generalizable to nonprofit hospitals outside our setting of Single Audit hospitals, two characteristics make our sample particularly attractive. First, the organizational structure of the hospitals in our sample as nonprofits subject to the same Single Audit requirements provides a homogeneity that would bias against finding variation in the scaled amounts of charity care provided. Second, the level of assurance associated with the external audits and the transparency associated with Single Audit hospitals lends credibility to our measure of charity care. Unlike 990 data, which does not come with the same assurance afforded by an external audit and which has been determined to be subject to manipulation (e.g., Krishnan et al. 2006), data from Single Audit reports implies potentially greater accuracy.

To examine the variation in the scaled amounts of charity care among the hospitals in our sample, we consider three defining characteristics and then perform descriptive analyses and t-tests to test for statistically significant differences. We consider size, measured as net patient revenues, where the lower tercile of hospitals had annual revenues of less than $300 million, middle tercile hospitals had revenues between $300 million and $700 million, and upper tercile hospitals had revenues greater than $700 million. We also consider whether the hospitals are located in urban or rural areas, captured by the U.S. Census Bureau categorization. Finally, we also consider per capita income for the city in which the hospital is located, also measured with U.S. Census Bureau data. Income levels serve as an inverse proxy for the demand for charity care provided, i.e., the higher the income level, presumably the lower the need for charity care.

Analysis and Findings

Beginning with some simple graphs to understand the data, we identified significant variation in charity care amounts based on the size of the hospital. Although the largest hospitals in our sample, with net patient revenues in the top tercile, comprised approximately 70% of the entire sample, they only provided 55% of total charity care. Scaling charity care by net patient revenues, Figure 2 Panel A reveals that large hospitals provided charity care of 5.5% of total net patient revenues, on average, while medium and small hospitals, provided 10.0% and 12.1%, respectively. Although we make no predictions at the outset, one might expect larger hospitals to provide more charity care than smaller hospitals, if we expect that larger hospitals stand to benefit from economies of scale. Our results are in contrast with this expectation, but have policy implications, if smaller nonprofit hospitals are bearing a disproportionate share of charity care.

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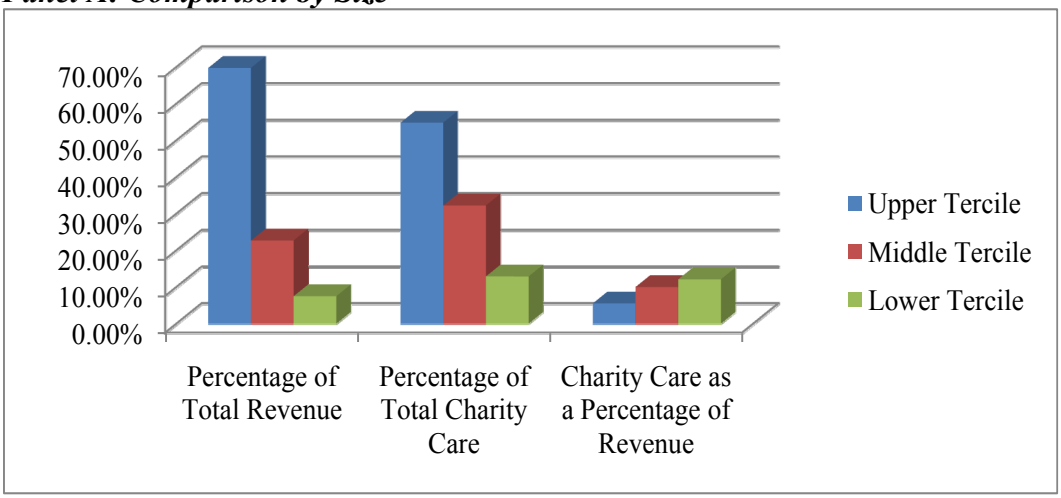
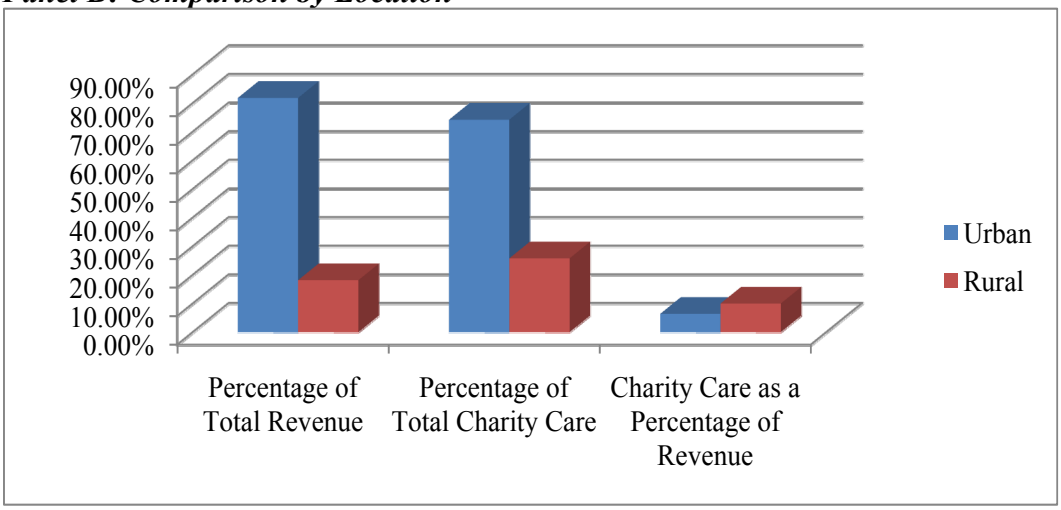
sample of nonprofit hospitals. In the alternative, we narrowed our scope to hospitals subject to Single Audits, but believe that the selected sample has merits as well.

Figure 2
Comparison of Hospital Data by Size, Location, and Income Levels

Panel A: Comparison by Size

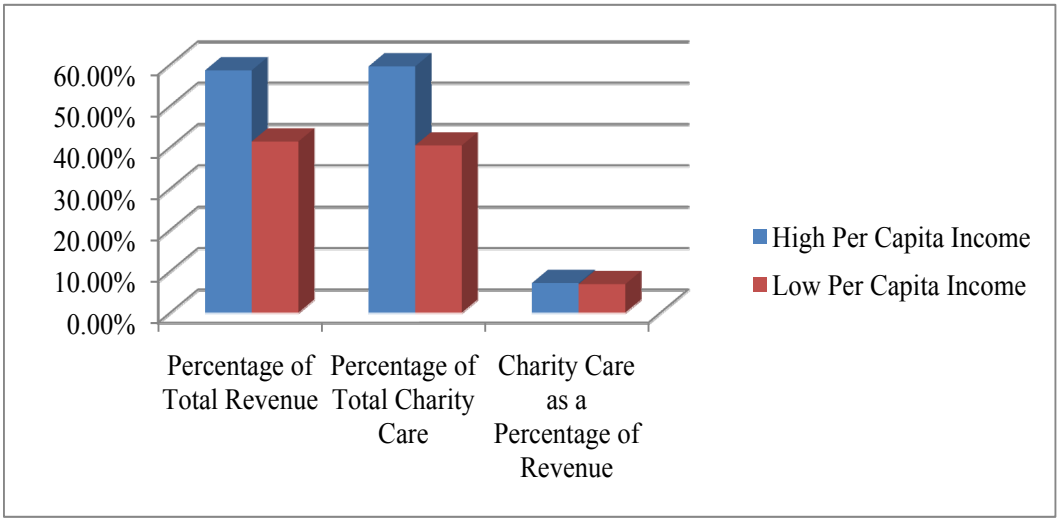


Panel B: Comparison by Location



DOI: 10.2202/2154-3348.1014

Panel C: Comparison by Income Levels



Note: Terciles were established based on the hospitals' annual net patient revenue amounts. There are 42 hospitals each in the lower and middle terciles, and 42 hospitals in the upper tercile. Urban and rural classifications were determined by U.S. Census designation of the city/town in which the hospital is located. High per capita income areas are those identified by the U.S. Census Bureau as having per capita income in excess of $20,000, and low per capita income areas are those below $20,000.

We also prepared a similar analysis that categorized hospitals as urban or rural based on U.S. Census Bureau data. Although urban hospitals in our sample comprise more than 82% of the revenues, they only provide 74% of the charity care. As a percentage of their own net patient revenues, urban hospitals provide charity care of 6.4%, while rural hospitals provide 10.0%. If we presume that competition among hospitals in urban areas is greater, these results may support the notion that charity care falls in the presence of greater competition (e.g., Mann et al. 1995). These results, presented in Panel B of Figure 2, and the results related to hospital size may also suggest that organizational characteristics, such as size and urban v. rural locations, may dictate how a nonprofit hospital fulfills its implicit obligation.

As presented in Panel C of Figure 2, we consider the possibility that demand for charity care may be influential in the results depicted in Panels A and B. We expected at the outset that higher demand for charity care, as proxied by low per capita income, would be associated with higher levels of charity care

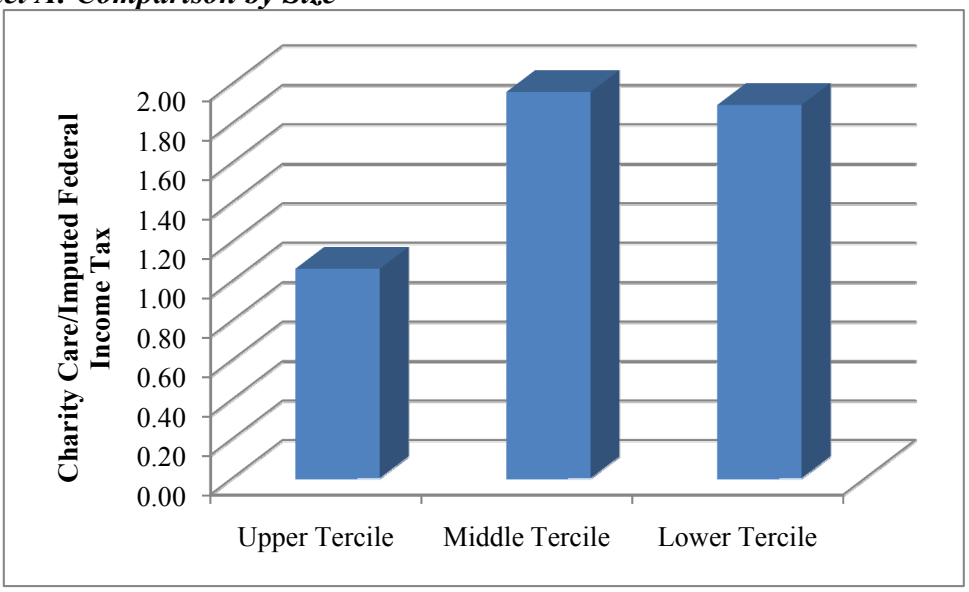
provided. However, the results do not support this assertion. Rather, as depicted, hospitals in high per capita income areas provide roughly equivalent charity care, 7.2% of net patient revenues, as hospitals in low per capita income areas, 6.9% of net patient revenues. The absence of a significant difference in the two groups may lend some support to the idea that organizational characteristics may dictate different approaches to fulfilling the implicit obligation associated with tax-exempt status.

To fully evaluate whether tax exempt hospitals are fulfilling their implicit obligations, one would ideally evaluate total community benefits provided (inclusive of charity care) relative to the total benefits associated with tax exemptions. We provide an initial attempt that, although limited due to data availability constraints, draws upon reliable data and affords simple comparisons. Specifically, we evaluated graphically whether the hospitals in our sample provided a level of charity care commensurate with the foregone federal income taxes they would be required to pay absent their tax exemptions. Using the change in each hospital's net assets, i.e., net income, plus the amount of charity care provided, as an approximation of taxable income,[6] we applied the corporate tax rate structure to calculate an estimate of the federal income tax liability. We could then analyze the amounts of charity care provided relative to the benefits associated with the federal income tax exemption. Consistent with Figure 2, we find that hospitals in the middle and lower terciles provide more charity care relative to the amount of federal income taxes foregone than large hospitals. In Figure 3, a value of one on the y-axis would suggest charity care provided roughly equivalent to the foregone federal income tax revenue. As depicted in Figure 3 Panel A, large hospitals provide a level of charity care of roughly equivalent to the amount of federal income tax benefit. Small and medium hospitals provide a level of charity care equivalent to 2.0 and 1.9 times the amount of the benefits associated with federal income tax exemptions, respectively. Although nonprofit hospitals receive other tax benefits beyond the federal income tax exemption, our analysis affords a simple comparison based on the federal income tax benefits and confirms the relationship identified in Figure 2.

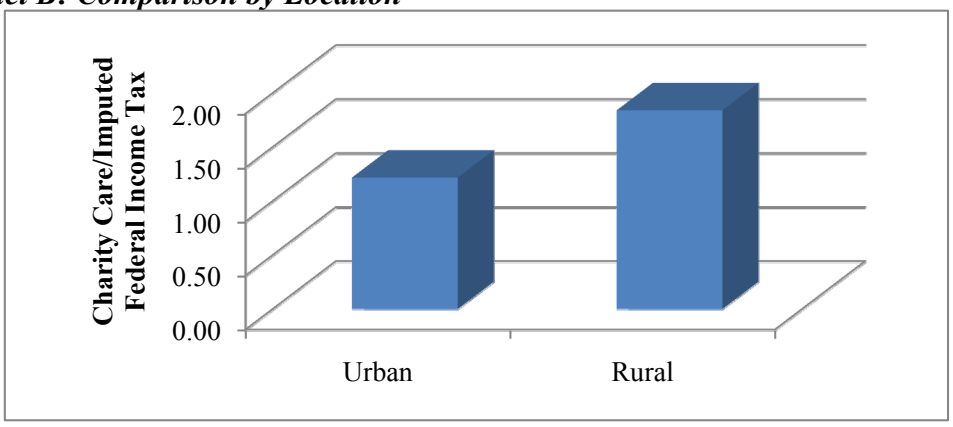
[6] Presumably, the revocation of tax-exempt status could lead a then for-profit hospital to eliminate the provision of charity care from its mission. The taxes generated would then be needed to cover services currently expected as part of the community benefit standard applied to nonprofit hospitals.

Figure 3
Charity Care Relative to Imputed Federal Income Tax by Hospital Size, Location, and Income Levels

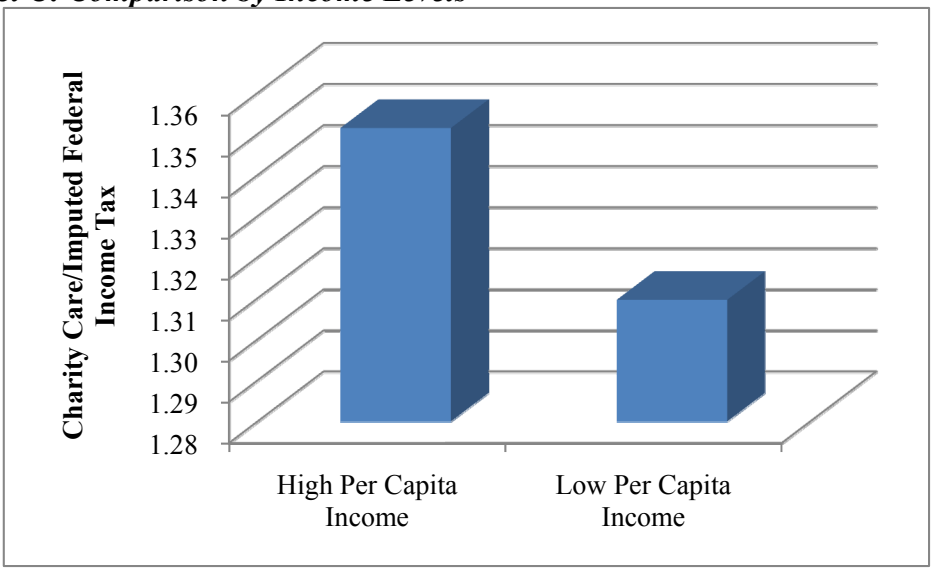
Panel A: Comparison by Size



Panel B: Comparison by Location



Panel C: Comparison by Income Levels



Note: Terciles were established based on the hospitals' annual net patient revenue amounts. There are 42 hospitals each in the lower and middle terciles, and 42 hospitals in the upper tercile. Urban and rural classifications were determined by U.S. Census designation of the city/town in which the hospital is located. High per capita income areas are those identified by the U.S. Census Bureau as having per capita income in excess of $20,000, and low per capita income areas are those below $20,000.Imputed federal income tax amounts are based on the corporate tax schedule, and the y-axis reflects the amounts of charity care, scaled by imputed federal income tax.

We also conduct a similar analysis for hospitals categorized as urban or rural, presented in Panel B of Figure 3. Also consistent with the visual evidence offered in Figure 2, urban hospitals appear to be providing less charity care relative to the imputed federal income tax than rural hospitals. Urban hospitals are providing charity care at a rate of 1.2 times the imputed federal income tax, while rural hospitals are providing charity care at a rate of 1.8 times the imputed federal income tax. These results may support the idea that urban hospitals take a different approach to meeting their implicit obligations, and, at a minimum, these results suggest the need for a more comprehensive analysis that could only be afforded by additional disclosures.

With this visual evidence in hand, we then conduct t-tests to determine differences in scaled charity care amounts based on size and location, and we also factor in the impact of demand for charity care, using per capita income as a proxy. Figure 4 presents the results of the t-tests that evaluate size and location (rural v. urban). The tests consider both scaled charity care measures, charity care as a percentage of net patient revenues and charity care as a percentage of imputed federal income taxes. The 2×2 matrix also allows us to address the statistical significance of the differences in the four resulting quadrants which are each compared to the averages of the other three quadrants combined. As indicated in the margins, there are basic differences in the relative levels of charity care based on size and location. Specifically, larger hospitals tend to provide lower levels of charity care, and urban hospitals also tend to provide lower levels as well. The results are particularly striking when we compare large, urban hospitals with the other three possible categories. At 0.05 and 0.01 levels of significance for the amounts of charity care provided relative to revenue and imputed federal income tax respectively, these large, urban hospitals appear to provide much lower amounts of charity care, 4.3% of net patient revenues and 0.802 times the imputed federal income tax. Compared to the overall averages of 8.3% and 1.079 for scaling by net patient revenues and imputed federal income tax, respectively, the results suggest something unique about these hospitals. Furthermore, these results provide statistical evidence of the relationships identified in Panel A of Figure 2 and Figure 3.

Figure 4
Analysis of Average Charity Care Amounts by Size and Location

		Hospital Size: Lower/Middle Terciles	Hospital Size: Upper Tercile	Totals	
Location	Rural	**28**	**7**	**35**	**N**
		0.076 *ns*	0.104 *ns*	0.081	Charity Care/Revenue
		1.223 *ns*	1.539 **	1.299	Charity Care/Imputed Federal Income Tax
	Urban	**57**	**35**	** **92** *ns*	**N**
		0.108 *	0.043 **	0.084	Charity Care/Revenue
		1.134 *ns*	0.802 ***	1.004	Charity Care/Imputed Federal Income Tax
		85	**42**	**127**	**N**
		0.098 * 0.054		0.083	Charity Care/Revenue
		1.161 * 0.931		1.079	Charity Care/Imputed Federal Income Tax

Note: t-tests were performed to determine whether charity care scaled by revenues and charity care scaled by imputed federal income tax differed among the four possible nonprofit hospital categories. For the four internal quadrants, t-tests compared the means for each of the quadrants relative to the averages of the other three quadrants collectively. For the margins, t-tests were performed to determine statistical differences in charity care amounts for rural v. urban and lower/middle v. upper terciles based on size. Significance is denoted by *ns*, *, **, and ***, to reflect no statistical difference, differences at the 0.10, 0.05, and 0.01 levels, respectively.

To evaluate the impact of demand for charity care, using per capita income as an inverse proxy, we also use the 2×2 design to evaluate size against per capita income, as well as urban/rural against per capita income. The results are presented in Figures 5 and 6. As seen in the bottom margins, there is no statistical difference between hospitals in areas with high v. low per capita income, where high per capita income is designated as that over $20,000 annually based on U.S. Census Bureau data. Within the four quadrants, large hospitals in low income (i.e., high demand) areas have the lowest level of charity care provided, 3.2% of net patient revenues and 67.7% of imputed federal income taxes, and the difference between this quadrant and the remaining three is statistically significant for both charity care measures. This result is counterintuitive on both dimensions and underscores the need for additional understanding of the cross-sectional variation in charity care provided by nonprofit hospitals.

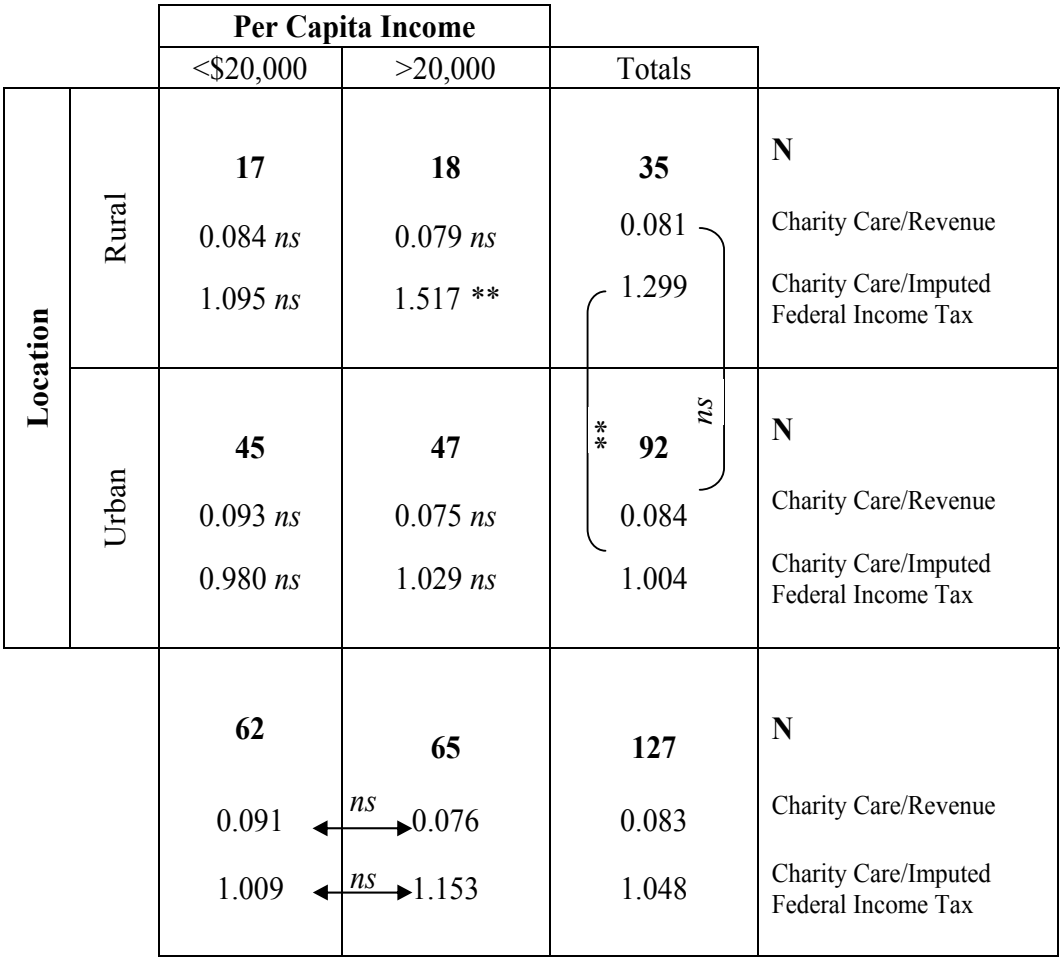
Figure 6 analyzes charity care provided across the rural v. urban and high v. low per capita income dimensions. Beyond the insight that the demand for charity care seems to affect charity care spending very little, we find that, in particular, the rural high income areas spend more on charity care as a percentage of imputed federal income taxes than the other three quadrants represented, at a rate of 1.517 times imputed federal income tax. This adds an additional nuance to our finding in Figure 4 that suggests that rural hospitals spend more on charity care than urban hospitals. In addition, we believe that the cross-sectional variation identified warrants additional consideration, particularly within the context of studies that suggest little or no difference in the way for-profit and nonprofit hospitals provide charity care (e.g., Duggan 2000).

Figure 5
Analysis of Average Charity Care Amounts by Per Capita Income and Size

		Per Capita Income			
		<$20,000	>20,000	Totals	
Size	Lower/Middle Terciles	**48**	**37**	**85**	**N**
		0.108 *	0.085 *ns*	0.098	Charity Care/Revenue
		1.115 ns	1.230 *	1.161	Charity Care/Imputed Federal Income Tax
	Upper Tercile	**14**	**28**	* **42** *	**N**
		0.032 *	0.064 *ns*	0.054	Charity Care/Revenue
		0.677 **	1.068 *ns*	0.931	Charity Care/Imputed Federal Income Tax
		62	**65**	**127**	**N**
		0.091 *ns*	0.076	0.083	Charity Care/Revenue
		1.009 *ns*	1.153	1.079	Charity Care/Imputed Federal Income Tax

Note: t-tests were performed to determine whether charity care scaled by revenues and charity care scaled by imputed federal income tax differed among the four possible nonprofit hospital categories. For the four internal quadrants, t-tests compared the means for each of the quadrants relative to the averages of the other three quadrants collectively. For the margins, t-tests were performed to determine statistical differences in charity care amounts for low per capital income v. high per capita income and lower/middle v. upper terciles based on size. Significance is denoted by *ns*, *, **, and ***, to reflect no statistical difference, differences at the 0.10, 0.05, and 0.01 levels, respectively.

Figure 6
Analysis of Average Charity Care Amounts by Per Capita Income and Location



Note: t-tests were performed to determine whether charity care scaled by revenues and charity care scaled by imputed federal income tax differed among the four possible nonprofit hospital categories. For the four internal quadrants, t-tests compared the means for each of the quadrants relative to the averages of the other three quadrants collectively. For the margins, t-tests were performed to determine statistical differences in charity care amounts for low per capita income v. high per capita income and rural v. urban. Significance is denoted by *ns*, *, **, and ***, to reflect no statistical difference, differences at the 0.10, 0.05, and 0.01 levels, respectively.

Policy Recommendations

Our analyses lead us to certain policy recommendations that would allow for more comprehensive analyses of whether nonprofit hospitals are fulfilling their implicit obligations. First, to extend the transparency across hospitals and provide for more meaningful comparisons, we recommend that all hospitals, regardless of organizational form, receiving any type of federal or state government funding (whether grants, Medicare, Medicaid, or other sources) be required to provide their audited financial statements via their websites. Requiring such access among nonprofit hospitals would improve the current reporting environment and allow stakeholders to evaluate the fulfillment of the implicit obligation. Moreover, requiring such access among all hospitals would permit comparisons across organization types. Although they comprise a smaller portion of the hospital industry, for-profit and government (federal, state, county) hospitals all provide community benefits. Understanding the differences in charity care and other community benefits provided by different organization types would permit full policy analysis related to tax exemptions for nonprofit hospitals. More specifically, the comparison of charity care and community benefits provided by the various hospital types would permit policy makers to discern the marginal benefits associated with the nonprofit organizational structure and whether tax exemptions are warranted.

Second, although our analysis of the financial statements of the 127 hospitals in our sample focused on charity care, measured as charges foregone, we also examined the way community benefit information was reported. Among those that reported additional community benefit information, this information was often not included in the same note to the financial statements, and the components of community benefits reported varied widely. Among the hospitals that voluntarily disclosed other non-charity care components of community benefits, terms like "community benefits programs," "other programs for the poor," and "unpaid cost of public programs for the poor" were reported, but not in a consistent manner that would provide stakeholders with the means to evaluate whether implicit obligation is being met or to compare hospitals based on the broader community benefit standard. Based on the inconsistencies we observed related to voluntary disclosures beyond those required by the AICPA (2009), we believe that changes to the mandatory disclosures are warranted. Although the Financial Accounting Standards Board (FASB) recently issued Accounting Standards Update (ASU) No. 2010-23, *Measuring Charity Care for Disclosur*e, requiring that charity care be reported at cost, rather than charges foregone (FASB 2010), no standardized disclosures are yet required regarding community benefits.

One might argue that recent changes to Form 990, which now require a Schedule H for hospitals, would provide these additional disclosures for nonprofit

hospitals which comprise approximately half of the hospitals in the U.S. The new Schedule H will require qualitative and quantitative information regarding charity care and community benefits provided. However, there is concern about the credibility of these disclosures given that Form 990 is an informational return, i.e., there is not tax due as a result of the filing of the return. In addition, the level of assurance associated with tax filings is minimal. Unlike financial statements which come with expressed assurance, i.e., an opinion by an independent, external auditor, about the reasonableness of the contents, tax preparers rely strictly upon the representations of an organization's managers in preparing the return. Furthermore, previous studies have concluded that the incentives to misreport in an informational return can result in significant discrepancies between actual and reported amounts. As an example, Krishnan et al. (2006) presented evidence of manipulation in program ratios as reported in Form 990s, while amounts reported in the audited financial statements were found to be more reliable. Specifically, they found that many nonprofit organizations receiving public support reported zero fundraising activities, 40% of which were determined to be misreporting those activities as program activities.[7]

To lend credibility to the new Form 990 Schedule H disclosures, we propose that audited external financial statements be required to disclose charity care amounts, with each separately disclosed: (1) charity care at cost, as is currently being implemented (2) unreimbursed Medicaid, and (3) unreimbursed costs from other government programs (IRS 2008). Reporting charity care at cost represents an improvement to the existing requirement that charity care be reported at foregone charges because of the potential manipulation in amounts reported as charges (FASB 2010), but these additional disclosures of uncompensated care are needed to allow for comprehensive analyses. We also recommend that the audited financial statements include community benefit disclosures that mirror those of the new Form 990 Schedule H disclosures including five components: (1) community health improvement services and community benefit operations, (2) health professions education, (3) subsidized health services, (4) research, and (5) cash and in-kind contributions to community groups (IRS 2008). These required disclosures would lend credibility to the new Form 990 disclosures and also permit analysis across all hospital types – for-profit, nonprofit, and governmental. Considered collectively with our recommendation for increased access to audited financial statements, the additional disclosures would permit full analysis of policy alternatives associated

[7] Although the audit firm may also be engaged to prepare the 990, these findings underscore the potential for misreporting in the 990 and underscore the need for credibility, both in actuality and perception, of other reported amounts that would be subject to manipulation, like charity care and community benefits. Hence, we recommend additional disclosures in the audited financial statements.

with tax exemptions for nonprofit hospitals. Moreover, if these changes are made to the AICPA Audit and Accounting Guide for Health Care Organizations, all hospitals would be required to report this information, and the level of assurance would also be equivalent across all hospitals.

Finally, we recognize that requiring disclosure of audited financial statements, including requirements for additional disclosures, may be met with resistance. Undoubtedly, hospitals relying on the information asymmetry that exists between them and regulators may argue these requirements will result in additional costs. However, we are only recommending these requirements for those hospitals which already obtain external audits. Therefore, the incremental cost associated with auditing these disclosures likely would not be substantial, and our interviews with public accounting partners specializing in the healthcare industry suggest that they are already evaluating community benefits, but simply not reporting them. Moreover, as identified by Schlesinger et al. (2004), public trust in our healthcare system has diminished which may have implications for charitable giving to hospitals. Given the sensitivity that donations have to the program ratio, which represents a widely used efficiency measure in nonprofits (Krishnan et al. 2006), we believe that increased transparency may have benefits for hospital giving. We believe that these factors, taken together, support the merits of additional disclosures.

IV. Summary and Conclusion

In evaluating charity care in a narrow sample of nonprofit hospitals subject to Single Audit requirements, we find cross-sectional variation in amounts that suggests that organizational characteristics may drive charity care policies and the approach toward meeting their implicit obligations associated with tax exemptions. Specifically, large and urban hospitals tend to provide less charity care, scaled by revenues and imputed federal income tax, than small and rural hospitals, and demand for charity care, proxied by per capita income appears to have little influence on charity care spending in our setting. The visual and statistical evidence presented are a significant contribution in the policy discussions regarding the merits of various organizational forms of hospitals. Although some studies have found little differences in the managerial practices of nonprofit and for-profit hospitals (e.g., Duggan 2000; Brickley and Van Horn 2002), these discussions can be informed by digging into the cross-sectional variation in each of these groups. That is where we believe our findings make a contribution and can serve as a foundation for future causal approaches to evaluating the reasons for the cross-sectional variation identified.

In terms of limitations, we acknowledge that our sample is quite narrow. Nonprofit hospitals subject to Single Audits represent less than 10% of all

nonprofit hospitals, and this reporting regime results in greater transparency than that of non-Single Audit hospitals. While we believe that there are merits to this sample including the homogeneity of the sample and perhaps greater credibility associated with the reported amounts resulting from the increased transparency, we acknowledge that the generalizability of the results is compromised. It is this limitation and other data availability limitations that lead us to recommendations for changes to the AICPA Audit and Accounting Guide for Health Care Organizations.

Recent changes by the FASB will improve the reporting of charity care amounts, by requiring that these amounts be reported at cost, rather than charges, which can be manipulated and therefore not comparable across hospitals. However, this is just a first step in standardizing disclosures, and would only be applicable to for-profit and nonprofit hospitals, excluding governmental hospitals. To be the most beneficial, any disclosure requirements related to charity care and community benefits should be applicable to all hospitals, regardless or organizational form (for-profit, nonprofit, and governmental). Furthermore, the disclosures in audited financial statements should include other elements of uncompensated care, including unreimbursed Medicaid and unreimbursed costs from other governmental programs, as well as community benefits consistent with new Form 990 Schedule H requirements. These disclosures would add credibility to the new Form 990 Schedule H disclosures, and likely add little to the costs of hospitals for compliance. The incremental cost associated with auditors evaluating and expressing assurance on uncompensated care and community benefit disclosures should be fairly minimal, given what we know about auditors already evaluating this information. Furthermore, making audited financial statements available via hospital websites would require minimal costs.

These disclosures would offer researchers, policymakers, and other interested stakeholders the opportunity to evaluate a hospital's fulfillment of its implicit obligation to provide public benefits commensurate with the value of its tax exemptions. Furthermore, the disciplining effect that results may be preferable to explicit requirements for minimum charity care provision. Colombo (2006) discusses the merits and disadvantages of such strict standards, and Kennedy et al. (2010) find empirical evidence that these standards can result in hospitals, that were previously exceeding the threshold, reducing the levels of charity care provided. These additional disclosures may be a particularly attractive solution in light of the Act which will change, once again, the landscape of the number of individuals needing charitable care. Once the data are available, it will be important to assess the variation in overall community benefits provided, and the resulting analyses may be beneficial in future policy development efforts.

Although hospitals have to varying degrees argued against a more streamlined definition of community benefit and disclosure of these amounts,

hospitals also stand to benefit from such an effort. Increased transparency regarding these community benefits provides an opportunity for hospitals to strengthen their relationships with the communities they serve. Attaining a closer relationship with the surrounding community allows the hospital to better understand and measure community health needs, which in turn can improve resource management capabilities (i.e., shifting resources from lower to higher productive uses). Moreover, greater cost and quality information sharing can contribute to more effective and efficient operations and overall community healthcare. Finally, increased access to industry benchmark data would contribute to better information in the development of community benefit policies at the individual hospital level, as well as in the aggregate.

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