

# Does It All Add Up?

## Flaws in Schedule H community benefit reporting will affect nonprofit multihospital systems

**B**eginning in 2010 for tax year 2009, organizations that operate nonprofit hospitals will be required to report community benefit activities and expenditures on a new Schedule H Form 990, the "Return of Organization Exempt from Income Tax." Many concerns have been raised about the Internal Revenue Service decision, one of which is how such a requirement will work for health care systems that operate multiple hospitals. Almost 60 percent of nonprofit hospitals are part of systems that have multiple hospitals.

At the American Hospital Association's request, we studied the role of nonprofit multihospital systems regarding community benefit.

Three questions were at the core of our research:

- Do system-level policies and practices influence community benefit performance and reporting at the individual hospital level?
- Do systems engage in activities that convey public benefit that are not expected to generate an economic return, whether or not these are reportable as community benefit?
- What reporting issues are associated with community benefit activities in systems?

To answer these questions, we first visited 12 large hospital systems between March and May 2009 to interview senior executives, tax professionals and staff responsible for community benefit programming and reporting. We used a structured interview protocol developed with the advice of AHA staff and an advisory committee. Then, to gain a broader perspective, an Internet survey was conducted of the 210 systems with three or more nonprofit hospitals, receiving 76 responses (a 36 percent response rate). Survey responses were consistent with interview responses and enhanced our understanding of the frequency of issues we learned about in the site visits.

What we found raises questions about the usefulness of Schedule H, particularly with regard to systems. The reporting requirements will result in some systems reporting on a single Schedule H form and other systems reporting on multiple seemingly unconnected Schedule H forms. Cross-subsidies among hospitals within systems will not necessarily be captured on the form, resulting in a distorted picture of community benefit spending. The requirement that expenses for entities other than hospitals be included in the schedule will probably skew downward the amounts of reported community benefit, again leading to a less than accurate picture, particularly for systems. While these flaws can and should be corrected, it is likely that the initial Schedule H filings will be disappointing to those hoping for a reliable tool to accurately capture and compare community benefit among different hospitals and the systems to which many belong.

### System-Level Community Benefit Activities

Most types of community benefit activities in systems occur at the hospital level but are affected by system-level policies and activities. We learned in our site visits that:

- Systems may convey expectations to hospitals regarding community benefit and standardize important aspects, such as charity care policies, planning or budgeting community benefit activities, and data collection and reporting.
- Systems may create a "community benefit culture" by raising visibility of the issue through activities such as awards programs and by establishing mechanisms for sharing ideas such as working groups involving staff from multiple hospitals.
- Systems provide technical expertise for hospitals regarding such matters as legal requirements, needs assessments, planning, evaluations and reporting.

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The survey data in the table on Page 25 shows the system policies and activities that affect community benefit at the hospital level. It is common for systems to standardize charity care policies, provide education and training, prepare hospitals' community benefit reports and provide financial support for community benefit activities. In a few systems, hospital executive compensation includes incentives related to community benefit.

Systems also assist their hospitals in important ways that are only indirectly related to community benefit but may be very important to the communities in which the hospitals are located. These include providing economies of scale, which can reduce hospitals' operating costs and in some cases help enable the survival of financially precarious hospitals. They may also facilitate access to capital that supports the full range of hospitals' activities, including community benefit.

Systems do commonly make donations and in-kind contributions at the system level, focusing generally on the geographic area in which the corporate offices are located. While amounts are generally quite modest (compared with the amount of community benefit expense at the hospital level), about one-third of systems have made more substantial contributions by creating departments, centers or foundations at the system level aimed at improving community health, often in conjunction with hospitals and other community organizations. This may involve significant investments related to community benefit. Systems that serve a single metropolitan area or state seem most likely to take on this type of endeavor.

### Reporting Issues

It became apparent on our site visits that the ways systems are organized and operated affects the amount and value of the activities that are reportable on Schedule H, as well as the comparability of Schedule H information. These effects can be independent of the amount of community benefit they provide.

The first page of Schedule H ends with a calculation of total community benefit expenses as a percentage of total expenses. This percentage, along with the cost of charity care as a percentage of total expenses, will likely be the most widely discussed figures on Schedule H. These percentages are also likely to vary widely across Schedule H reports, and they will be affected—probably dramatically—by how systems are organized. Comparability will be compromised.

This bears explanation. The requirement to include a Schedule H with a nonprofit's 990 filing is triggered if it operates one or more nonprofit hospitals. Unfortunately, like the rest of the 990, the information reported on Schedule H applies to the whole filing organization, as defined by its tax ID number (employer identification number, or EIN). The problem arises because of organizational differences among systems.

Hospitals in some systems have separate EINs, so each will be covered by a separate Schedule H. However, some or all hospitals in some systems are covered under a single EIN. If all of a system's hospitals are covered by a single EIN, it will file only one Schedule H. Most systems surveyed will be affected by this requirement: although 41 percent of the systems said that each of their hospitals will be in a separate Schedule H, 24 percent said that all or most of their hospitals would be in a single Schedule H and 30 percent have a mix, with some hospitals reporting together and some individually. Because the number of hospitals covered by Schedule H will vary from system to system, comparisons across systems will be problematic at best.

A second organizational factor that will affect the calculation of community benefit is what entities other than hospitals exist under the EIN of the filing organization. This issue is not limited to multihospital systems since they commonly operate a wide

variety of ambulatory and long-term care services, foundations, and other entities. Schedule H is commonly described as a filing requirement for hospitals, but the expenses of nonhospital components in the same EIN as the hospital will be included in Schedule H calculations.

The inclusion of expenses of these nonhospital components will obviously affect the calculation of community benefit expenses as a percent of total expenses. This percentage is

most likely to be lower—perhaps substantially lower—than calculations based only on hospitals' expenditures for two reasons.

First, many—perhaps most—of these components are not themselves subject to community benefit expectations so that the percent of their expenses that go to community benefit is likely to be lower than in hospitals. Second, collecting community benefit expenditure information is challenging, and many organizations that file Schedule H may not capture it for their nonhospital components.

The inclusion of expense information from nonhospital components of filing organizations will also affect the cross-organizational comparability of Schedule H information. Not only do systems vary with regard to the number, types and size of their nonhospital components, but they also vary by whether these components are covered by the same EINs as are their hospitals.

In our survey, 34 percent of systems or their hospitals reported that their Schedule H would not include some expenditures that convey a public benefit and were not undertaken for economic gain. About 20 percent had expenditures at the system level that would not be in a Schedule H because it was not in the same EIN as a hospital. Twenty-four percent said that they had such expenditures elsewhere in the system that were not in an EIN with a hospital. Only 8 percent said that they had expenditures that didn't fit the categories in Schedule H; this low number may reflect a lack of experience with the form.

The inclusion in Schedule H of multiple hospitals and of nonhospital components seems likely to lead to much disappointment

## BEFORE SCHEDULE H

Prior to the introduction of Schedule H, most of the systems surveyed had experience with some type of community benefit reporting: 75 percent said that all of their hospitals had prepared community benefit reports in the past; only 13 percent said that none had done so. About half said they had produced such reports to meet state or local government requirements, but many indicated that reporting was done because of systems' own policy decisions. Almost all systems make their community benefit reports public.



## FORMS OF SYSTEM INVOLVEMENT IN THEIR HOSPITALS' COMMUNITY BENEFIT ACTIVITIES

(percentage of systems reporting)



Source: AHA/Urban Institute 2009 Survey of Multihospital Systems

among people who are interested in what Schedule H will tell us about hospitals' charitable activities.

### Other Reporting Issues

The ability to cross-subsidize among hospitals may be one of the most important benefits that systems offer to their constituent hospitals. Internal cross-subsidies support charitable activities in many systems. Our survey of systems showed that about half do this: 27 percent said they routinely use revenues from some hospitals to support other hospitals, and 25 percent said this happens occasionally.

In response to a question about sources of support for hospitals' community benefit activities, we learned that although hospitals' own operating revenues are by far the most important source of funding for community benefit activity, approximately half of the systems who responded to our survey used combined revenues from multiple hospitals. Variability among systems regarding cross-subsidization will again affect comparability across systems, but the more serious problem is that Schedule H is not configured to capture cross-subsidies within systems.

Cross-subsidies within systems will not be visible on Schedule H. Where cross-subsidies occur among organizations within the same EIN, the subsidized expenditure will at least be included in the Schedule H that covers the subsidizing hospital. However, if a system uses revenues from a hospital covered by one EIN to subsidize the charitable activities of hospitals covered in other EINs, the contribution of the subsidizing hospital won't be captured in its Schedule H, making it appear less charitable than it is. Including it in both Schedule H forms would amount to double counting, but not including it results in an inaccurate picture of the subsidizing hospital and fails to capture the nature of systems themselves as charitable organizations.

Another issue regarding Schedule H is that the calculation on its first page of community benefit expenses as a percent of total expenses does not include several items that many hospital officials believe should be counted. Two of these—bad debt expense and Medicare shortfalls—are controversial and have been widely discussed. The form requests this information and invites explanation of why they should be considered a community

benefit. More puzzling is the IRS' decision to put community building expenditures—for physical improvements in the neighborhood, economic development, workforce development and the like—on the second page of Schedule H. The IRS' decision regarding community building has a doubly negative effect: not only is it not counted in the numerator of the calculation of community benefit expense as a percent of total expenses, but its inclusion in the denominator means that engaging in community development activities, as many systems do, will actually have the effect of reducing the percent of their expenses that are reported for community benefit.

In addition to the problems we have already discussed, it should be expected that the quality of the information in Schedule H will be uneven for several years, as systems become accustomed to the new reporting requirements. Organizations need specialized internal reporting systems to capture most of the information to be reported in Schedule H. For many hospitals and systems, this will be an altogether new and quite challenging task, since reportable activities can occur in virtually all departments of a hospital or system. Some organizations will undoubtedly be more successful than others at collecting this information. Moreover, variations in interpretation of what should be included are certain to occur. All of this will affect comparability across organizations, but such problems are inherent in the development of a new reporting requirement and should diminish as experience grows and the reporting requirement is improved.

### Not the Whole Story

Schedule H is the most important change in the accountability of nonprofit organizations since the Form 990 itself was implemented almost 70 years ago. It will generate a great deal of public information about a wide array of community benefit activities. However, though most hospitals are part of multihospital systems, the role of systems will not be visible in Schedule H. Organizational differences among systems will affect both reports of the percent of total expenditures devoted community benefit and cross-organizational comparability. Systems in which all components are covered by the same EIN will be reporting as a whole. Other systems may want to generate their own system-level reports for



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A final point concerns the use of expense information to measure community benefit. A metric that permits comparison has obvious advantages, made less so in this case by the noncomparability of the reporting entities, as discussed in this article. But expenditures are a very crude measure of community benefit. Consider the wisdom of using expenditures to assess programs to reduce teenage pregnancy or hospitalizations for childhood asthma. Is the value of sustaining a money-losing program that provides needed services best measured by the amount of subsidy it requires? What about a system that helps a struggling sole community hospital to survive? Eighty percent of the systems surveyed reported engaging in activities to reduce the use of the emergency department. Similarly, 68 percent of respondents engaged in activities to reduce hospital admissions, and 64 percent said they had engaged in activities to reduce the use of other hospital services. Clearly, dollars expended is a poor measure of the benefit of reducing the need for hospital services.

The importance of "telling the story" came up repeatedly in our site visits, but Schedule H is not designed for that purpose. Most systems already do community benefit reports. With the advent of Schedule H, public understanding can be further enhanced if hospitals and systems use such reports to tell a story, particularly about activities that have produced measurable improvements in such matters as emergency department use and preventable hospitalizations.

More thought should be given to developing new metrics to measure community benefit, measuring community benefit in multihospital systems, and separating out the expenses of nonhospital components of organizations that operate nonprofit hospitals. Schedule H will provide a more accessible picture of the charitable activities of nonprofit hospitals, but its shortcomings need to be addressed if it is to become a truly useful tool for the communities that hospitals serve. **T**

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