Internal Revenue Service
Form 990 Redesign for Tax Year 2008
Schedule H, Hospitals – Highlights
December 20, 2007

Rationale and Overview

The Form 990 has failed to keep pace with the increasing size, diversity, and complexity of the nonprofit hospital sector. The current form does not provide for the reporting of community benefit activities or request important information regarding how nonprofit hospitals serve the public consistent with the privileges and benefits of tax exemption. The Draft proposed a Schedule H to be completed by nonprofit organizations that operate one or more hospital facilities.

The Draft Schedule H included five parts: Part I, Community Benefit Report; Part II, Billing and Collections; Part III, Management Companies and Joint Ventures; Part IV, General Information; and Part V, Facility Information.

Part I of the Draft schedule relied on the Catholic Health Association's (CHA) community benefit reporting model that it developed in cooperation with VHA, Inc. (formerly known as Volunteer Hospitals of America) and with the support of other associations and organizations. The schedule included charity care, means-tested government programs, research, training and education, and numerous other activities that promote the health of the communities the organization serves. Part I did not include bad debt expense or Medicare shortfalls.

Part II requested summary Medicare and other billing revenue information by patient category, and an explanation of how the organization calculated bad debt.

Part III contained a table requiring information about management companies and joint ventures in which the organization's executives and physicians held an aggregate 5% or greater ownership interest. Required information included the name of the entity, description of the entity's primary activity, and respective ownership percentages of the organization, the aggregate of executives, and the aggregate of physicians. Certain passive investment vehicles and publicly traded entities were excluded from this reporting. This reporting supplemented joint venture reporting contained elsewhere in Part VII, Question 8 of the core form and on Schedule R.

Part IV asked for narrative information about the organization's assessment of community needs, its patient intake process regarding notification of eligibility for financial assistance, emergency room policies and procedures, and any other information important to its exempt purposes. These questions provided organizations an opportunity to explain how the nonquantifiable aspects of community benefit were delivered, such as through an open medical staff, use of any surplus funds, or a community board.

Part V was a list of facilities by name, address, type of service provided, and activities and programs conducted at each.

We received over 225 public comments regarding the Schedule H and related hospital provisions in the Draft. The major areas of comment involved the following:

- How to determine which organizations must complete the Schedule H;
- Whether to permit or require reporting of charity care and other community benefit on a hospital-by-hospital, EIN, or a health care system wide basis;
- The components of community benefit and the items to be reported in Part I, including bad debt expense, Medicare shortfalls, and community building activities;
- Whether the Part II billing table would result in undue burden and competitive disadvantages to some hospitals;
- Whether the schedule's Part III supplemental joint venture reporting should be extended more broadly to all filing organizations, rather than just hospitals;
- How to report nonquantifiable aspects of community benefit; and
- The length and type of any transition relief that hospitals will need to prepare to complete Schedule H for the first time.

Definition of Hospital

Many comments indicated that the definition of hospital proposed in the Draft was overly broad and should be narrowed to include only those facilities that are licensed or certified as hospitals under state law. Our intent is that the schedule's instructions will define hospital by reference to state licensing or certification. This will include hospital facilities operated by exempt organizations whose primary exempt purpose is something other than the promotion of health, such as a college or university. The IRS is considering whether a second category of facilities is necessary to ensure reporting by all 501(c)(3) organizations that provide hospital or medical care and will address this in instructions.

Reporting on Entity (EIN) Basis

Many commented that hospitals should be permitted to report various parts of Schedule H on an affiliated healthcare system basis, because that is necessary in order to fully display the organization's provision of community benefit. Others suggested that organizations should be required or permitted to report certain portions of the Schedule H on a hospital-by-hospital basis. Because tax exemption is determined on an entity-by-entity basis, Schedule H will require reporting on that basis.

Community Benefit Reporting

Some comments on the Part I table expressed concern that the instructions were unclear regarding the treatment of bad debt and Medicare shortfalls. Others suggested that the table be revised to distinguish charity care from means-tested

government programs, such as Medicaid, to comport with the generally understood meaning of charity care in the hospital sector. As a result, the title and line descriptions in Part I of the Draft were modified to make this distinction, and the instructions will explicitly state that that bad debt expense and Medicare shortfalls are not to be reported in Part I.

Other changes to Part I include:

- Breaking out the Draft's charity care policy question into multiple yes/no questions, and inserting them before the Part I table to provide context for the information reported in the Part I table;
- Allowing columns (a) and (b) (numbers of programs and persons served) of the table to be completed on an optional basis; and
- Adding a question asking the organization to identify any states with which it files a community benefit report.

Bad Debt Expense

The Draft excluded bad debt expense from Part I, and asked the organization to describe how it calculates bad debt expense in Part II. Under current financial reporting standards, many organizations have a difficult time determining whether certain expenses are properly charity care or bad debt, because they are unable to obtain the information required to classify charity care expenses properly and timely for financial reporting purposes. A significant percentage of nonprofit hospitals do not treat bad debt as community benefit because they regard bad debt as a cost of doing business incurred by both nonprofit and for-profit hospitals. Because of the substantial divergence of practices and views in this area, the Draft and the final Schedule H exclude bad debt from Part I. However, Part III has been revised to include additional reporting of bad debt expense information outside of Part I.

The new Part III requires a hospital to report aggregate bad debt expense, at cost, provide an estimate of how much is attributable to persons who qualify for financial assistance under its charity care policy, and provide a rationale for what portion of bad debt it believes should constitute community benefit. In addition, the organization must report whether it has adopted Healthcare Financial Management Association Statement No. 15, and provide the text of its footnote to its financial statements that describes bad debt expense. This approach does not include bad debt in Part I, but obtains important and uniform reporting of bad debt expense information and permits an organization to explain why certain portions of bad debt should be considered community benefit.

Medicare

Similar to bad debt expense, the Draft excluded Medicare underpayments from the Part I table. Many hospitals, however, take the position that all or some portion of Medicare shortfalls should count as community benefit. Some others

stated that Medicare shortfalls should not count as charity care because of lack of means-testing, but should be reflected somewhere on the new Schedule H or Form 990, as being relevant to providing a picture of the hospital's revenue and activities.

As a result, the schedule's new Part III collects Medicare shortfall information, outside of Part I. The revised Part III requires reporting of aggregate Medicare reimbursements (including DSH and IME, but not GME), and the aggregate cost to deliver care reimbursed by Medicare, in order to report aggregate Medicare surpluses or shortfalls. In addition, a hospital will be able to describe what portion of Medicare shortfalls it believes should constitute community benefit and explain its rationale for its position. This approach collects important information regarding Medicare revenues and costs, shortfalls or surpluses, and costing methodologies, provides for uniform Medicare reporting by all hospitals, and permits an organization to explain which portion should be treated as community benefit.

Community Building Activities

The Draft excluded from the Part I table costs related to community building activities. This position differs from the CHA/VHA reporting model, which includes physical improvements and housing, economic development, community support, environmental improvements, leadership development and training, coalition building, community health improvement advocacy, and workforce development as community benefit. The comments indicate widespread support for including these costs in the table. While the IRS believes that certain of these community building activities might constitute community benefit or other exempt purpose activities, more data and study is required. The Schedule H permits reporting of community building in Part II, and asks the organization to explain how such activities promote the health of the communities it serves, in order to collect important information regarding the possible characterization of some community building costs as community benefit.

Draft's Part II Billing Table

The Draft proposed requesting certain billing and revenue data in tabular form, based on patient category. There was universal opposition to the collection of this information. Many hospitals stated they do not keep records on this basis. In addition, many expressed that this information is proprietary, and its disclosure might result in violation of contracts with insurance companies and others, and place hospitals at a competitive disadvantage relative to other hospitals. Based on these comments, the billing table was eliminated.

Supplemental Joint Venture Reporting

The Draft proposed reporting on hospitals' joint ventures with officers, directors, trustees and key employees as well as physicians. Many comments were

received that organizations may need to change their recordkeeping practices to report this information. Other comments requested that this information be required of all organizations, not just hospitals. The unique relationship between hospitals and physicians resulting from their special status of having medical staff privileges without regard to employment status appears to have no clear analogy in other exempt organization contexts. As a result, Schedule H retains the joint venture reporting included in the Draft, but will increase the aggregate ownership reporting threshold from 5% to 10% to reduce the number of ventures that must be reported. The IRS will continue to explore extending supplemental joint venture reporting of the type required by Schedule H to others.

Facility Information
The Draft's Part V narrative description was converted to a "check-the-box" column format so that an organization can check all that apply. The revised format is more useful for data collection purposes, and allows the IRS to collect information regarding a facility's status as a critical access hospital, children's hospital, research or teaching hospital, or other type of hospital or facility, and information about the facility's emergency room services.

Supplemental Information
The Draft included Part IV, General Information, which asked questions about the organization's assessment of community needs, its patient intake process regarding notification of eligibility for financial assistance, its emergency room policies and procedures, and any other information important to its exempt purposes. Many commented that additional space should be provided to allow an organization to provide more comprehensive responses, particularly regarding aspects of nonquantifiable community benefit. In response to these comments, the questions were revised, and new questions were added to describe the community served by the organization and the organization's role in an affiliated health care system (if applicable). The Draft's exempt purpose question was modified to expressly refer to open medical staff, use of surplus funds, and community board, to solicit information regarding nonquantifiable aspects of community benefit.

Transition Relief
When the Draft was released, the IRS requested comments on what, if any, transition relief would be appropriate for Schedule H. Many organizations will need some additional time to make decisions and establish or modify reporting systems to complete the Schedule H for the first time. The majority of comments requested implementation for tax year 2010 (filing year 2011). However, these comments were based on the Draft's content, much of which has been revised to reduce overall reporting burden.

Based on the changes to the Draft and numerous discussions with nonprofit hospitals, Schedule H will be phased in beginning in 2008. For 2008 tax years, only Part V will be required to be completed so that certain identifying information regarding the organization's facilities is collected. All other parts of Schedule H will be optional for 2008. The entire Schedule H must be completed for tax years beginning in 2009.

IRS records indicate that 50% of organizations that checked box 7 on Forms 990, Schedule A, Part VI for tax year 2005 report on a fiscal year that ends between June 30 and November 30. This means that approximately one-half of hospitals will have until June 1, 2009 or later to implement reporting systems to track the community benefit and other information required by Parts I through IV and VI of the Schedule H.

Expected Impact on Burden

Most of the information requested in Schedule H is not required in the current Form 990. Although many hospitals may maintain records currently to complete some parts of the schedule, e.g., charity care, bad debt expense, Medicare revenues and costs, they may need to establish or modify recordkeeping systems to compile or report information for other parts of the Schedule. The additional burden could be substantial for many hospitals, particularly for the first year of reporting.